If you have issues viewing or accessing this file contact us at NCJRS.gov.

GOVERNOR'S EXECUTIVE ADVISORY COUNCIL

Examining

Insurance Fraud

First Report

on

Issues and Recommendations

12-8-93 MFI

14245

ıryland
ɔnald Schaefer

February, 1993

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

William Donald Schaefer
GOVERNOR

GOVERNOR'S EXECUTIVE ADVISORY COUNCIL

MARSHALL M. MEYER
Chairman
(301) 323-4480

BALTIMORE OFFICE
ROOM 1513
301 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201
(301) 225-4800

IN REPLY REFER TO

March 12, 1993

The Honorable William Donald Schaefer
Governor, State of Maryland
State House
Annapolis, Maryland 21404

Dear Governor Schaefer:

I am pleased to submit for your consideration the first report of findings and recommendations of the Governor's Advisory Panel on Insurance Fraud. The report documents the serious nature of insurance fraud in Maryland, assesses various approaches and alternatives to help alleviate the problem, and makes recommendations to improve insurance fraud control efforts.

Insurance fraud directly or indirectly affects every man, woman, and child in our State. False and inflated insurance claims raise the price of premiums citizens and businesses must pay for automobile, health, property, liability, and casualty insurance. Similarly, fraud in State programs such as Medicaid and Workers' Compensation increases the need for more tax revenue.

The Panel submits this interim report with the knowledge that it does not provide comprehensive answers to the insurance fraud problem in the State of Maryland. I do believe, however, that it can serve as a solid base upon which we may build our anti-fraud strategy. The members of the Panel have worked diligently since the Panel's formation in February of 1992 and will continue their efforts in all areas of insurance fraud. One area that will receive special consideration from the Panel in the future is Workers' Compensation, a costly national problem that is a heavy burden for business and industry as well as our State Treasury.

The members of the Panel and I appreciate your encouragement and your support. We are particularly gratified by your confidence in us, which you demonstrated when you created the insurance fraud investigative bureau.

I thank Mr. Joseph T. Kelly, Assistant Insurance Commissioner, who is the able chair of the Panel, and I thank his Panel members, whose enthusiasm and professional expertise contributed to this vital endeavor.

Sincerely,

Marshall M. Meyer
Chairman

Enclosure

147245

GOVERNOR'S EXECUTIVE ADVISORY COUNCIL

First Report
of the
Governor's Advisory Panel Examining
Insurance Fraud

NCJRS

MAY 17 1993

ACQUISITIONS

A joint study by the Office of the
Governor and the Office of the Insurance
Commissioner, State of Maryland

William Donald Schaefer
Governor

John A. Donaho
Insurance Commissioner

Marshall M. Meyer
Council Chairman

Joseph T. Kelly
Assistant Insurance Commissioner
Panel Chairman

142245

U.S. Department of Justice
National Institute of Justice

This document has been reproduced exactly as received from the person or organization originating it. Points of view or opinions stated in this document are those of the authors and do not necessarily represent the official position or policies of the National Institute of Justice.

Permission to reproduce this copyrighted material has been granted by

Maryland Governor's Executive Advisory Council

to the National Criminal Justice Reference Service (NCJRS).

Further reproduction outside of the NCJRS system requires permission of the copyright owner.

EXECUTIVE SUMMARY

In February 1992 the Governor of Maryland empaneled a special Committee, under the auspices of his Executive Advisory Council, to study the spectrum of insurance fraud and its impact on the citizens of Maryland. The Committee was comprised of 50 members which included attorneys, public and private investigators, insurance industry executives, physicians and law enforcement professionals; they represent every discipline which could be brought to bear in the effort to combat insurance fraud. Divided into sub-committees, they spent ten months, at no cost to the State, identifying and analyzing the many schemes and indicators used to commit insurance fraud in seven major areas: Fraud on the Consumer, Claimant Fraud, 3rd Party (Provider) Fraud, Investigative Protocols, Education, Data Collection and Workers' Compensation Fraud.

A 1992 study conducted by the Battelle Seattle Research Center found that, within the three major insurance sectors (Property and Casualty, Health and Life) external insurance fraud is the second largest economic crime in America, exceeded only by tax evasion. Within the Property and Casualty sector alone, fraud is involved in 10% of all claims, at a cost of $17 Billion per year. Health care fraud costs more than $50 Billion per year, and Life insurance fraud considerably less.

Health care and fraud appear to be the fastest growing areas of insurance fraud. The number of health care providers convicted of fraud increased by 234% between 1979 and 1986, compared with a 79% increase in income tax fraud convictions and a 41% increase in mail fraud convictions. From 1986 to 1989, medical scams and staged automobile accidents increased by 100% and 50% respectively. Without strong countermeasures, the escalation in insurance fraud is likely to continue. First, insurance fraud tends to be self-perpetuating; fraud contributes to higher premiums which, in turn, leads to more fraud. Second, insurance fraud tends to increase during periods of economic recession.

The costs of insurance fraud are now being felt not just by the insurance companies but by the general public as well. For example, the property and casualty estimate that 10% of all claims dollars are attributable to fraud translates into 8% of all premium dollars paid out by those insured. The situation is far worse in some geographic areas and for some types of insurance. In Los Angeles, for example, there is some evidence that auto insurance fraud is double the national average, and excessive Workers' Compensation insurance has cost the state some 6-8% of its jobs.

Insurance fraud also undermines business and professional ethics; it's a crime that, in some form, is condoned and/or perpetrated by 25 - 30% of otherwise upright, law-abiding citizens. It is not at all uncommon for doctors and auto body shop operators to inflate bills to cover their clients' deductible; a survey in 1988 found that 40% of the respondents reported they knew of health care providers who engaged in deceptive billing practices.

There are several industry service organizations that specialize in anti-fraud activities, and many insurers have Special Investigation Units, but they have concentrated their efforts on combatting the particular types of fraud perpetrated within their insurance domain. Anti-fraud efforts are thus fragmented by insurance sector and, in some cases, by type of coverage. Eleven state insurance departments have established state fraud bureaus to bring greater law enforcement attention to bear on the problem, and regionalized federal efforts have been attempted. Still, there is little evidence of any reduction in the amount of insurance fraud being committed. This fragmented approach is inefficient and ineffective; there is an urgent need for a coordinated national effort to link together not only the databases but also the anti-fraud efforts.

Deterrence inflicts penalties severe enough to deter subsequent criminal acts by those who have been prosecuted, and raises the fear of apprehension and punishment in those who might consider committing the crime. Prevention combats crime by reducing the opportunities for gain and the social acceptance for committing the crime. Prevention is a pro-active approach, whereas deterrence is a reaction to the crime. By reducing opportunities for gain, it may be possible to more effectively and directly prevent insurance fraud than is possible through deterrence.

In combatting insurance fraud, the industry clearly must continue its lead role; to be effective, anti-fraud efforts will require:

(a) public education and outreach programs, and
(b) enhanced legal and regulatory remedies.

The industry must present itself in a more advantageous manner, make an organized effort to effect change internally, and educate the public to the link between fraud and premium increases by stressing the fact that honest insureds are being made to pay for fraud that others commit. The industry also needs to adopt greater uniformity in anti-fraud training and procedures to facilitate communication between crime fighters.

The Committee made the following recommendations:

- A comprehensive insurance fraud section should be added to Article 48A, Annotated Code of Maryland (Insurance Code). The section should contain a precise definition of insurance fraud, a definitive standard for determining probable cause to believe insurance fraud was committed, statutory immunity granted to insurance companies investigating and/or reporting suspected fraud pursuant to law and both felony and misdemeanor penalties and accompanying said penalties the latitude to impose severe fines.

- A comprehensive false claims section should be incorporated into Article 48A, Annotated Code of Maryland (Insurance Code).

- This section should provide for both civil remedies vis a vis the confiscation of assets and criminal remedies.

- Insurance companies conducting business in Maryland should be required by law to report fraud related data to a bureau of choice.

- Insurance companies conducting business in Maryland should be required by law to present anti-fraud related training to affected employees on an annual basis or more frequently as needed.

- The State of Maryland should join with the private sector to develop and implement a comprehensive public education campaign targeting insurance fraud and its effects on the insurance industry and the consuming public.

- The Governor should authorize this Panel to undertake a comprehensive study of fraud in Workers' Compensation.

- Insurance companies doing business in Maryland should be required by law to conduct a visual inspection of property prior to issuing a policy of insurance. When insuring vehicles and vessels the condition should be recorded and VIN confirmed.

TABLE OF CONTENTS

A. INTRODUCTION

During the month of February 1992, the Governor of Maryland empaneled a special Committee, under the auspices of the Executive Advisory Council, to study the spectrum of insurance fraud and its impact on the citizens of Maryland. The Committee was carefully selected so as to include experts from every discipline which could be brought to bear in the effort to combat insurance fraud.

At the first meeting of the Committee, it was decided that because the Committee consisted of forty-nine members and a chairperson, the group would be divided into seven sub-committees, each consisting of a sub-chair and six members to study a specific area of insurance fraud. The sub-committee chairs would then meet in executive session with the Chairman once per month to discuss issues and exchange information.

The compositions of the group is as follows:

CHAIRMAN: Joseph T. Kelly
Assistant Insurance Commissioner
State of Maryland
Department of Licensing and Regulation
Insurance Division
Baltimore, Maryland

Secretary: Kathy Liberto
Department of Licensing and Regulation
Insurance Division

Sub-Committee of <u>Workers' Compensation</u>

Sub-Committee Chair: Jeffrey R. Schmieler, Esq.
Attorney
Saunders & Schmieler
Silver Spring, Maryland

Member: Sara F. Clary
Asst. Vice President
Federal Affairs
Alliance of American Insurers
Alexandria, Virginia

Member: John H. Hunt, Jr.
Hunt & Associates
Glenelg, Maryland

Member: Donna Jacobs
Attorney at Law
Semmes, Bowen & Semmes
Baltimore, Maryland

Member:	Marie R. Kinietz Director, Government, Consumer and Ind. Affairs National Council on Comp. Insur.
Member:	Lourdes S. Morales President World Travel Assoc., Inc. Baltimore, Maryland
Member:	Melony Richards Controller for Maryland Subsidiary Corp. Ins. Admin. Culbertson of Maryland Glen Burnie, Maryland
Member:	Julia Romaniuk Branch Manager Continental Insurance Company Mount Ranier, Maryland 20712

Sub-Committee of Data Collection

Sub-Committee Chair:	August F. Alegi Group Vice President GEICO Insurance Company Washington, D.C.
Member:	Alan N. Gamse Insurance Attorney Semmes, Bowen & Semmes Baltimore, Maryland
Member:	Albert Kaufman Executive Director Maryland Cab Assoc. Baltimore, Maryland
Member:	Jeffrey D. Rouch Government Affairs Rep. Nationwide Insurance Company Annapolis, Maryland
Member:	Craig D. M. Rouston Senior Officer, Managing Dir. Marsh & McLennan Baltimore, Maryland
Member:	Jeremiah J. Smith Special Agent National Insurance Crime Bureau Springfield, Virginia

Sub-Committee of Investigative Protocols

Sub-Committee Chair:	Dennis E. Seymour President Dennis E. Seymour & Assoc. Annapolis, Maryland
Member:	Kevin J. Casey Asst. Vice President Maryland Insurance Group Baltimore, Maryland
Member:	William C. Megary Asst. Special Agent in Charge Federal Bureau of Invest. Baltimore, Maryland
Member:	Richard D. Nevin Special Investigator Keystone Insurance Company Baltimore, Maryland
Member:	Christopher J. Romano Acting Chief, Criminal Invest. Office of the Attorney General Baltimore, Maryland

Sub-Committee of Education

Sub-Committee Chair:	Martin J. Ermanis Director of Education AAA Maryland Ins. Agency, Inc. Baltimore, Maryland
Member:	Ronald W. Fuchs Vice President Eccleston & Wolf Baltimore, Maryland
Member:	Frank X. Gallagher Senior Partner Gallagher, May & Burgoyne Baltimore, Maryland
Member:	Susan Kaskie Public Affairs Officer Public Safety and Correc. Serv. Baltimore, Maryland
Member:	Matthew W. Nayden, Esq. Ober, Kaler, Grimes & Shriver Baltimore, Maryland

Member:	Sally L. Swann Asst. General Counsel Maryland Commission on Human Relations Baltimore, Maryland

Sub-Committee of Fraud on Consumer

Sub-Committee Chair:	John A. Picciotto V.P. and Chief Legal Officer Blue Cross/Blue Shield of MD Baltimore, Maryland
Member:	William W. Cahill, Jr. Partner, Attorney at Law Weinberg and Green Baltimore, Maryland
Member:	Barbara B. Gregg Executive Director Montgomery County Office of Consumer Affairs Rockville, Maryland
Member:	Gary C. Harriger V.P., Secy., & General Counsel Baltimore Life Insurance Company Baltimore, Maryland
Member:	Richard W. Kiefer Senior Law Partner Hooper, Kiefer & Cornell Baltimore, Maryland
Member:	Randi F. Reichel Counsel Dept. of Licensing & Regulation Baltimore, Maryland
Member:	Deborah Rivkin, Esq. Attorney, Exec. Director League of Life/Health Insurers Shapiro & Olander Baltimore, Maryland
Member:	Lloyd D. Yavener Executive Vice President Bankers Independent Insur. Co. Gaithersburg, Maryland

Sub-Committee of 3rd Party (Provider)

Sub-Committee Chair:	David E. Ordunia Security Specialist Ordunia Investigative Services Hunt Valley, Maryland
Member:	Victoria E. Fimea Practicing Atty., ULLICO, Inc. Washington, D.C.
Member:	Brenda Kemp Field Investigator Fireman's Fund Insurance Co. Cockeysville, Maryland
Member:	William A. S. Lingenfelter Division Manager State Farm Insurance Company Frederick, Maryland
Member:	Eli M. Lippman, M.D. Orthopedic Surgeon Baltimore, Maryland
Member:	William G. Stephens Director, Special Investigations Blue Cross/Blue Shield of MD Baltimore, Maryland
Member:	John W. Sternberg U.S. Postal Inspector U.S. Postal Service Baltimore, Maryland

Sub-Committee of Claimant

Sub-Committee Chair:	Michael Van Nostrand Owner/Licensee Vann & Assoc. Private Investigative Agency Hunt Valley, Maryland
Member:	Bradford L. Browning Claims Division Manager Brethren Mutual Insurance Co. Hagerstown, Maryland
Member:	Ward W. Caddington, Jr. Fire/Explosion Ins. Consult. Maryland Arson Invest. Assoc. Upper Marlboro, Maryland

Member:	Rocco J. Gabriele State Fire Marshall Pikesville, Maryland
Member:	Frank Lotman Manager, Security Firm Baltimore, Maryland
Member:	Howard R. Stansbury Worker's Comp. Investigator Travelers Insurance Company Baltimore, Maryland
Member:	David A. Titman, J.D. Attorney at Law Ellicott City, Maryland

The above members have donated hundreds of hours of their corporate and personal time to this endeavor. The committee has functioned and continues to function at no cost to the State of Maryland except that which has been incurred through the utilization of a meeting facility at the Governor's Office in Baltimore, Maryland. On behalf of the Governor, William Donald Schaefer, Advisory Council Chairman Marshall M. Meyer, and Insurance Commissioner John A. Donaho, the Chairman personally thanks the members.

B. SCHEMES AND INDICATORS

Through the course of ten months of meetings and study, the sub-panels were able to identify and analyze the many schemes and indicators used to commit insurance fraud. The following list of schemes and indicators covers the major topical areas in the insurance arena. However, in no way should the list be considered as all inclusive as new schemes and methods are being devised routinely.

Automobile Insurance Schemes

A large number of fraud schemes involve automobiles simply because insurers and agents generally don't conduct visual inspections before binding coverage. Following are six scams which are easy to spot once you're aware of the indicators.

Ditching

The National Automobile Theft Bureau estimates 30 percent of all stolen car reports are actually frauds against insurance companies, whereby the car owner gets rid of the car to cash in on an insurance policy.

This scheme often involves an additional insurance claim against the insured's homeowners' policy for property allegedly contained in the "stolen" vehicle.

Indicators

1. The car is very expensive, and was recently purchased with a small down payment.

2. There is a substantial lien against the vehicle.

3. Expensive tires or luxury accessories were allegedly recently purchased.

4. Receipts for temporary car rental service are provided by a friend or neighbor rather than by a car rental agency.

5. Accessories were purchased from an individual rather than from a commercial outlet.

6. The car is recovered but is burned or in disrepair.

Past Posting

In horse racing, "past posting" is a scheme in which bettors attempt to beat bookies by placing bets on races that have already been run.

The same kind of scheme can prove profitable to an uninsured driver. When such a person becomes involved in an automobile accident or is the victim of a car theft, he or she may decide to take a chance at "past posting" insurance coverage.

The "Victim" may take the simple approach of going directly from the scene of the accident or theft to an insurance agency or create an elaborate scheme of events.

For example, after an accident, an uninsured driver may purchase coverage, wait a few weeks, then report a fictitious one-car accident to the police and the insurance company. The key is, the coverage must appear to have been in force at the time of the accident.

Indicators

1. The accident or theft occurs within hours, days or weeks of insurance coverage.

2. The police report of the accident is taken at a Police Station, days after the actual occurrence.

3. No evidence of the accident turns up at the reported scene of a one-car collision.

Automobile Repair

Traditionally, the No. 1 consumer complaint in Maryland concerns automobile repairs, and most insurance frauds in the automobile repair industry involve claims for auto body repair work.

In this scheme, damaged parts are repaired or are replaced by used parts, but the insurance company (and ultimately the insurance consumer) are actually charged for new parts.

Sometimes the insurance company authorizes payment based on a repair order, which calls for new parts. Yet the work order, which shows the actual work and parts used, never reaches the insurance company. Instead, it goes to the policyholder (who usually does not see the repair order). A simple comparison of the two orders can sometimes reveal the scheme.

It is also not uncommon for crooked body repair shop owners to offer kickbacks to adjusters to inflate the amount on an automobile.

Indicators

1. The body shop has received an extensive number of consumer complaints.

2. An unusual number of "mistakes" on repairs are claimed by the body shop.

Automobile Smuggling

People seldom profit from the sale of a used automobile, but there is one way a person can profit twice on such a transaction, without even paying the full price of the car. Those who profit follow these seven basic rules.

1. Purchase a new automobile with maximum available financing;
2. Obtain a counterfeit certificate of the car title which shows free and clear ownership;
3. Insure the automobile, making sure to obtain minimum deductible theft coverage;
4. Ship the car to a foreign port;
5. Report the car stolen to the police and the insurance company;
6. Sell the car at its new location; and

7. Collect the insurance.

Naturally, no payments are actually made to the lending institution which originally financed the car. The lender is left holding a legitimate title to a car which was insured, shipped, and sold using a counterfeit title. The counterfeit title is used to collect on the theft claim, and a duplicate is usually needed to sell the car abroad.

Indicators

1. The claimant has had a number of vehicles stolen and never recovered.

2. The vehicle is reported stolen shortly after being purchased.

3. A duplicate title has been issued on the vehicle.

4. No payments have been made to the lending institution.

Paper Cars

The state certificate of title showing legal ownership of an automobile is, on its own, worth very little. Despite this fact, insurance companies, through their authorized agents, write insurance policies virtually every day insuring the title instead of the car. Collecting a theft claim on a car that never existed or a worthless vehicle is one of the easiest crimes to commit.

Indicators

1. The car is insured only for a short time before the theft.

2. The car was recently retitled and insured in the state where the theft occurs.

3. Several auto theft reports by the victim are on file with the National Automobile Theft Bureau.

4. Autos previously reported stolen have not been recovered.

5. Several personal autos are registered to the victim's neighborhood.

Staged Accidents

Although it is hardly necessary to stage an automobile accident to defraud an insurer, there are some people who insist on going to the trouble. Perhaps the temptation to collect from more

than one insurer in a multi-car staged accident provides the incentive. Staged accident rings change locations as fast as their members change names and insurance companies. They do, however, use the same cars more than once, and occasionally, too often. Different names signed by the same person can be identified by an expert, and photographs of the same individual using different names can be identified by anyone. Most staged accident rings ignore state lines, and the more they cross state lines, the more complicated prosecution becomes.

One simple rule in such cases is: when you can substantiate a charge, even if for only one accident, file it!

Indicators

1. A police report of a multi-car accident is taken at the police station, not at the scene of the accident.

2. The scene of the accident is too clean for damages allegedly sustained by the cars involved.

3. Accident victims display a detailed knowledge of the claims process.

4. Extensive and hasty repairs are made on parts not apparently damaged in the accident.

5. The same lawyer represents the drivers of several different cars involved in the accident.

6. All cars involved are taken to the same repair shop.

7. The victims' doctor and lawyer submit reports which lack specificity.

Medical and Health Schemes

The following is a scheme involving unscrupulous doctors and lawyers: Ambulance Chasing

Ambulance Chasing (Doctor/Lawyer Conspiracies)

This scheme usually requires three key players to be successful: A lawyer, a runner, and a doctor.

The Lawyer

The lawyer is usually the prime mover in the ambulance chasing ring. Whether the case involves altogether phony or greatly exaggerated injuries, it is the lawyer who profits most in almost every case. Most automobile accident cases are accepted by

GOVERNOR'S EXECUTIVE ADVISORY COUNCIL

EXECUTIVE DEPARTMENT, STATE OF MARYLAND

WILLIAM DONALD SCHAEFER
GOVERNOR

MARSHALL M. MEYER
CHAIRMAN

FACTS ABOUT THE COUNCIL

THE GOVERNOR'S EXECUTIVE ADVISORY COUNCIL IS A DIVERSIFIED PROJECT-ORIENTED GROUP OF MEN AND WOMEN, ACTIVE AND RETIRED, DEDICATED TO SERVING THEIR STATE AND NATION.

FORMED IN FEBRUARY, 1988 UNDER EXECUTIVE ORDER, TO SERVE GOVERNOR WILLIAM DONALD SCHAEFER, HIS STAFF AND DEPARTMENT HEADS AND THROUGH THEM THE CITIZENS OF MARYLAND, THE COUNCIL HAS GROWN INTO A GROUP OF OVER 250 SENIOR BUSINESS EXECUTIVES, EDUCATORS, ENGINEERS, SCIENTISTS, DOCTORS, LAWYERS, SPECIALISTS IN MANY DISCIPLINES, FEDERAL, STATE AND LOCAL LAW ENFORCEMENT PROFESSIONALS AND CRIMINAL JUSTICE OFFICIALS AND CONCERNED CITIZENS. EACH IS AN UNPAID VOLUNTEER GIVING THEIR TIME AND PERSONAL RESOURCES.

MANY PROJECTS ARE ONGOING AND ONCE A STUDY OR RESEARCH EFFORT HAS BEEN COMPLETED A REPORT IS RENDERED TO THE GOVERNOR AND APPROPRIATE STATE, FEDERAL, AND LOCAL OFFICIALS. THE GROUP THEN MOVES ON TO OTHER ACTIVITIES. SOME CURRENTLY INCLUDE:

- SELECT PANELS EXAMINING DANGEROUS SUBSTANCE ABUSE AND ITS MANY RAMIFICATIONS AFFECTING OUR CITIZENS. SPECIAL EMPHASIS IS GIVEN TO EDUCATION, ADOLESCENT ALCOHOLISM, DRUGS IN THE WORK PLACE, AND MEDICAL AND PUBLIC AWARENESS.

- AN IN DEPTH STUDY ON "VIOLENCE IN AMERICA" AND HOW IT AFFECTS MARYLANDERS. AN EXAMINATION SEEKING ANSWERS TO A MOST SERIOUS PROBLEM FOR OUR NATION.

- A HIGHLY SUCCESSFUL INVOLVEMENT IN THE CORRECTIONAL SYSTEM'S "BOOT CAMP" PROGRAM. ONE OF THE NATION'S BEST.

- THE COUNCIL "LEGISLATIVE ADVISORY" SUB-PANEL REVIEWS LEGISLATIVE INITIATIVES OF GOVERNMENT AGENCIES AND COORDINATES WITH OUTSIDE PUBLIC SAFETY AND CRIMINAL JUSTICE GROUPS. ASSURES THAT THE NEEDS OF MARYLAND CITIZENS ARE BEING ADDRESSED. ALL COUNCIL MEMBERS ARE REQUIRED TO SUPPORT THE DEVELOPMENT OF NEW AND EFFECTIVE LEGISLATION.

OFFICE OF THE GOVERNOR

Dedicated to keeping Maryland a better and safer place to live, work and do business!

Baltimore Office - 301 W. Preston Street, Baltimore MD 21201
(410) 225-4800 Fax (410) 333-6059

(OVER)

- o A SELECT PANEL IS CURRENTLY EXAMINING, UNDER THE GOVERNOR'S DIRECTION, "INSURANCE FRAUD" IN COORDINATION WITH THE STATE INSURANCE COMMISSIONER. THIS IS A SERIOUS GROWING AREA OF PUBLIC CONCERN. THE STUDY PANEL IS SEEKING THE BEST LEGISLATIVE APPROACH TO REDUCE THIS COSTLY PROBLEM. A FRAUD BUREAU HAS BEEN FORMED BY GOVERNOR SCHAEFER BASED ON COUNCIL RECOMMENDATIONS.

- o THE GOVERNOR, DEEPLY CONCERNED WITH THE SAFETY OF MARYLAND CITIZENS, HAS ISSUED AN EXECUTIVE ORDER FORMING A HIGH-LEVEL CAR-JACKING "COMMISSION" DEDICATED TO THE EXAMINATION OF "VEHICLE THEFT" AND RELATED CRIME AND CRIMINAL ASSAULTS AGAINST PERSONS VISITING PUBLIC ACCESS AREAS WHERE PEOPLE ARE VULNERABLE TO ASSAULT.

- o THE COUNCIL HAS PUBLISHED A WIDELY ACCLAIMED BOOKLET, "WHAT IF", IDENTIFYING THE DANGERS OF LEGALIZATION OR DECRIMINALIZATION OF DRUGS AND THE CONSEQUENCES OF WHAT COULD HAPPEN IF THIS IDEA WAS ADOPTED. THIS BOOKLET IS IN ITS SECOND PRINTING AND IS A REFERENCE IN THE DEPARTMENT OF JUSTICE LIBRARY.

- o AN IMPORTANT REFERENCE ON THE "IMPACT OF CRIME ON BUSINESS IN MARYLAND" HAS BEEN DEVELOPED. WHAT THE SMALL TO MEDIUM BUSINESS OWNER SHOULD DO TO AVOID INTERNAL THEFT IS NOW IN PUBLICATION.

- o "IN BRIEF," THE COUNCILS' SPONSORED NEWSLETTER OF SPECIAL ISSUES IS REACHING THOUSANDS OF POLICY MAKERS IN GOVERNMENT, PUBLIC SAFETY, CRIMINAL JUSTICE AND MAJOR BUSINESS LEADERS IDENTIFYING AREAS OF NATIONAL AND LOCAL CONCERN.

- o THE COUNCIL HAS MANY NON-PUBLIC SAFETY ACTIVITIES. JUST ONE INCLUDES A GROUP OF KNOWLEDGEABLE BUSINESS EXECUTIVES WHO ACT IN AN ADVISORY CAPACITY TO THE SECRETARY "DEPARTMENT OF TRANSPORTATION." OTHER DEPARTMENTS AND AGENCIES ARE SUPPORTED BY INDIVIDUAL OR GROUP ASSIGNMENTS.

GOVERNOR WILLIAM DONALD SCHAEFER HAS STATED HIS CONCERNS THAT "EVERY CRIMINAL ACT IS AN EVENT IN HISTORY THAT AFFECTS ALL OF OUR RESIDENTS, INCREASES COST FOR GOVERNMENT, DIMINISHES EDUCATIONAL STANDARDS AND AFFECTS THE WELL-BEING OF EVERYONE IN OUR STATE AND NATION. . ."

THE CITIZENS OF MARYLAND ARE INVITED TO PARTICIPATE IN COUNCIL ACTIVITIES BY PROVIDING IDEAS, SUGGESTIONS AND SUPPORT.

THE BUSINESS COMMUNITY IS ENCOURAGED TO EXAMINE THEIR SAFETY AND SECURITY CONCERNS AND TO CALL ON THE COUNCIL FOR ASSISTANCE TO ASSURE THAT EVERY MARYLANDER ENJOYS THE FREEDOM FROM FEAR TO WHICH THEY ARE ENTITLED.

GEAC-ATC-R/1/93-1

(OVER)

personal injury lawyers on a contingent-fee basis. This means the lawyer and the client agree that the fee will be based on a percentage of the settlement or court award in the case. If no settlement or court award is made, the lawyer will not be paid.

To operate a law practice exclusively in this manner requires a high volume of cases to insure a steady cash flow. A high volume of cases may dictate use of runners. It also follow that the higher the settlement, the higher the reward. Lawyers running personal injury mills, as they are called, are not anxious to engage in litigation. They rely on the insurance company's desire to settle quickly, realizing the expense a company must absorb by going to court to fight any claim, even a frivolous one.

Lawyers who use runners will usually attempt to entice an accident victim to cooperate in the scheme by promising a big "payday" from the insurance company. The big payday often never arrives for the victim, since medical fees, runner fees, and contingency fees may be deducted before the victim gets his or her share. Some ambulance-chasing lawyers blatantly rip-off their clients by forging the signature of the victim on the insurance company check. Even if these victims discover they were cheated by their lawyer, they are reluctant to report fraud, since they too conspired to defraud the insurance company.

The Runner

To build their clientele, some lawyers and often doctors, use "runners" to entice motor vehicle accident victims to become clients or patients. The runner may be paid a flat fee or a percentage of the final take. Runners monitor police scanners or listen to helicopter traffic reports of accidents to find potential clients.

Whether the runner approaches the victim at the scene of the accident or later, ambulance chasing schemes begin with this contact.

The Doctor

In most phony or inflated personal injury cases, the best way to lend authenticity to the scheme is by finding a doctor who will prescribe unneeded treatments. The doctor can cause medical expenses to escalate quickly and fuel the desire to settle, even if the claim is suspicious. A doctor working in collusion with a lawyer and one or more runners may collect a prearranged fee for a false medical report, or will actually prescribe unnecessary treatments for accident victims and collect a usual per visit fee from the insurance company.

Even in cases with real injuries, some doctors grossly inflate the number of treatments normally prescribed. Victims of minor

collisions resulting in less than $1000 physical damage have submitted claims for more than 40 doctors visits. Most allegedly involve some form of physiotherapy, such as heat packs, diathermy, or ultrasonic treatments.

Some unscrupulous doctors may change for visits never made by the accident victim, then split the insurance payments for the non-visits with the lawyer. The doctor may also charge an insured patient up to twice as much as an uninsured patient for the same service, whether the service is even performed.

Indicators

1. The lawyer's "demand letter" and "letter of representation" pre-date any medical information.

2. Injuries are largely, if not completely, soft tissue.

3. The nature and extent of the injuries claimed are inconsistent with the type of accident (i.e., a low speed rear-end collision with minor damage to the vehicle however, the claimant alleges incapacitating injuries).

4. The submission of bills or claims by subscribers/beneficiaries or providers for services not received or rendered (e.g. subscriber or beneficiary complains that services were not received or provider states he did not render service).

5. The provider bills for a non-covered service in a manner which makes it coverable (e.g. routine foot care billed as a more involved form of foot care to obtain reimbursement as a covered service).

6. A known component biller bills for total charges.

7. An anesthesiologist reports incorrect (e.g. padded) time units.

8. Provider double bills by charging for services reported on another claim.

9. Provider bills for an ineligible recipient.

10. A physician's or beneficiary's bill which appears to have been altered.

11. Provider, supplier, subscriber or beneficiary involved in a kickback scheme where monies are paid to entice another party to refer patients or allow his or her membership to be used to submit false claims.

Abuse

Abuse generally refers to practices which, although not usually consider fraudulent acts, may directly or indirectly cause financial losses to the Corporation. Abuse ranges from simply taking advantage of arguably ambiguous language to practices which may constitute fraud if provable, such as over servicing and misreporting. Both Blue Shield and Medicare B expressly exclude from coverage any services that are not reasonable and necessary for the diagnosis or treatment of injury or illness. This is often a subjective determination which is difficult to prove fraudulent beyond a reasonable doubt. The key elements of abuse are that it is intentional and improper but does not necessarily imply the violation of a specific law nor the presence of false representation.

Indicators

1. Physician classifies the majority of his in-hospital medical care as extended visits.

2. Physician or supplier provides unnecessary services.

3. Physician or supplier provides excessive services.

4. Physician does not properly code bills to identify multiple visit situations.

5. Subscriber or beneficiary utilizes unnecessary services (e.g. going from hospital to hospital or physician to physician complaining of a nonexistent medical problem to receive medications).

Note: Cases involving abuse on the part of physician or supplier are referred to the appropriate Utilization Review Department (Blue Shield or Medicare B) for review and appropriate action. The Special Investigation Unit conducts reviews of subscriber or beneficiary abuse only.

Property Schemes

Property fraud usually involves claims on inflated inventory or property that never existed. Here are three samples of this kind of fraud.

Inflated Inventory

The inflated inventory scheme has nothing to do with the crime of arson. A person can commit arson without committing or conspiring to commit fire insurance fraud. Conversely, a person can commit this type of fire insurance fraud without committing, or

conspiring to commit arson. Property owners have been known to turn tragedies into golden opportunities. Property previously sold, discarded, relocated or never owned in the first place, may be included on the inventory list furnished to the insurance company.

Arson is probably the most difficult case to prove in court, but a careful check of the inventory list submitted to an insurance company may reveal the scheme. A person who conspires to burn personal property for insurance money probably would not hesitate to double the size and value of the loss to reap a greater profit.

Indicators

1. The property is grossly over-insured.

2. There is a recent increase on structure and contents coverage in the victim's policy.

3. Evidence of more than one policy on structure and/or contents surfaces.

4. Too much documentation for items listed on loss inventory is presented.

5. Property described in the insurance policy application does not match what is actually found (i.e., the contents are badly in need of repair).

6. Items listed on loss inventory are not consistent with the kind of structure.

7. Police reports of burglary or fire are "supplemented" later with extensive lists of additional property lost.

Phony or Inflated Thefts

Any law enforcement officer who has worked on burglary detail has probably had the following experience:

A burglar, "Caught-in-the-Act" has confessed to a long series of burglaries, furnishing the date, time, method of entry, and other details. Yet when shown the inventories of items taken in each burglary, the burglar exclaims in shocked amazement, "I didn't get half that stuff!"

Any victim who has decided to capitalize on this misfortune by grossly inflating the burglary loss to the insurer, has committed a felony in Maryland, and if payment was made by the insurer, that victim has stolen money from all the premium-paying policyholders. However, these victims are perhaps the most difficult to identify.

Suspicious burglary reports should, therefore, be scrutinized carefully.

Indicators

1. With a stolen vehicle, the thief allegedly took expensive items, such as a color television, watch, diamond ring, or other property that would not normally be left in an unattended vehicle.

2. The burglary scene is incompatible with the reported stolen contents, e.g., a family living in a $15,000 mobile home reports a burglary of a pre-historic Columbian art collection valued at $400,000.

3. Additional articles stolen in the burglary are reported long after the initial report and tend to be more expensive, improbable items.

Paper Boats

The paper boat scheme is simple. All a person has to do is obtain a bill of sale or other documentation to register a boat in Maryland. The registration can then be insured by an unsuspecting insurance agent. After a reasonable period of time, the owner reports the boat stolen and submits a claim to the insurance company through the unsuspecting agent. It is difficult to prove that a paper boat has not been sunk or that it has not really been stolen. It can, however, be proven that the boat existed only on paper.

Indicators

1. The boat has been insured for only a short time prior to the theft.

2. The boat registration was recently transferred from out-of-state.

3. The claimant has made multiple claims for theft losses of boats which are never recovered.

4. The claimant names numerous expensive accessories on the boat and presents receipts from stores that are no longer in business or are out of state.

5. A person with a low or moderate income claims to own an extremely expensive boat or yacht.

Agent Schemes

Although most agents are reputable, some unscrupulous agents may pocket premiums or use high-pressure tactics to gain a large commission. Three of the more common agent schemes follow.

Pocketing Premiums

In pocketing schemes, an unscrupulous agent, issues a binder indicating the customer is insured against specific losses but never forwards the customer's premium payment to the insurance company.

Indicators

1. The agency employs large numbers of support staff and has only one licensed agent (who is frequently absent).

2. Insureds are largely uneducated, young, or otherwise high-risk drivers.

3. The agent only accepts premium payments in cash or money orders.

4. No policy is received for an extended period of time.

Sliding

The term "sliding" means the art of including (secretively) additional coverages with those requested by an insurance consumer. The extra charges are hidden in the total premium. Since the insurance consumer does not know about the extra coverages, claims against those coverages are practically nonexistent, and the profits for the agent, astounding. Since many insurance consumers do not read their insurance policies, the crime may go undetected.

Coverages easiest to slide are motor club memberships, accidental death and travel accident policies which carry premiums usually less than $100 per year. Therefore, it is possible that no single violation of felony theft will be committed by the slider. In certain circumstances, however, the amounts of each theft can be aggregated (added together) to meet the threshold for a grand theft charge.

Indicators

1. "The breakdown of coverages" provided by the agent lists coverages in addition to that requested.

2. Insurance applications and other forms are quickly shuffled in front of the consumer, and a signature is required on each.

3. The agent offers a "package deal" which includes accidental death, travel accident or motor club coverages.

Twisting

Twisting as a form of dance may have gone the way of the Edsel, but as a get-rich scheme against the elderly, it is still thriving. Twisting is nothing more than the replacement, by high-pressure sales techniques, of existing policies for new ones, where the primary reason for doing so is to enrich the sales agent.

The first-year sales commission on some policies may be as much as three times (or more) that of commissions for policy renewals. On the other hand, because of pre-existing condition limitations, (except on Medicare supplement replacements) first-year benefits for the policyholder are few. The unsuspecting victim of an unscrupulous agent will usually pay more and more in premiums for less and less in coverages, and never have one policy long enough for it to be worthwhile.

Indicators

1. The agents suggest that the policy, which is less than 1-year old be replaced with a new and "better" policy.

2. When the consumer declines replacement coverage, the agent employs high pressure tactics.

Life Insurance Fraud Schemes

Fraudulent Death Claims

"Gentlemen! The reports of my death are greatly exaggerated," wrote Mark Twain to the Associate Press, which had prematurely reported his demise while he was vacationing abroad. Mark Twain's death does not stand today as the only greatly exaggerated one. The life insurance thief can rely on fraudulent death certificates for insured persons who are still very much alive, or "past post" coverage on someone who is already dead. In either case, a little help from an unscrupulous insurance agent or a less-than-honest claims examiner can make detection of the crime difficult.

With the assistance of an unscrupulous insurance agent, death claims may be submitted on actual clients without their knowledge. Benefit checks are mailed to the agent, who can then forge the name of the beneficiary and harvest the fruit of the crime. Fraudulent

death certificates are easily obtained and are seldom scrutinized in relatively small death benefit settlements.

A more complicated scheme, resulting in a bigger payday, involves the past-posting of insurance coverage on persons who recently died. A fraudulent death certificate may not be needed in this scheme if a co-conspirator is a company claims examiner. The examiner can pay the claim without question even though the policy application predates the death certificate by only a few days. Also, a false death certificate may not be needed if the unscrupulous insurance agent predates the policy application to a reasonable period of time before the actual death. If both an agent and a claims examiner can be drawn into the conspiracy, the scheme can be extremely profitable and long-lasting, involving multiple companies across the United States.

Indicators

1. The policy's effective date is close to the date of death.

2. The deceased is not well known by relatives and lived alone.

3. Policies tend to be for small coverages which are many times available in mass offerings, i.e., in magazines.

4. The agent's "loss ratios" appear unusually skewed, considering the size of the market, and the types of people insured.

5. Policies requiring physical examinations are almost never present.

Murder for Profit

Murder for profit schemes involve killing (or arranging for the killing) of a person to collect life insurance proceeds. To do this, a conspirator must either be a beneficiary on the policy, be in collusion with the beneficiary, or be in a position to forge the name of the beneficiary on the claims draft.

The methods used to carry out this scheme can range from shooting a person, to tampering with a parachute, or pushing the victim in front of a herd of stampeding cattle.

Unlike some of the other insurance fraud schemes commonly encountered, murder-for-profit is a violent crime which can result in life imprisonment or capital punishment.

Indicators

1. The effective date of the policy is close to the date of death.

2. Numerous life insurance policies were purchased on the victim.

3. Different carriers were used in securing coverages for no apparent reason.

4. The coverage amount is not commensurate with the social position of the deceased, e.g., a low income clerical worker has a life insurance estate of millions.

5. An unusually large number of death certificates were obtained by the beneficiary.

Fraudulent Bond Schemes

Surety and performance bonds guarantee that certain events will or will not occur. A performance bond for example, might guarantee the completion of a major highway project; whereas a surety bond might protect the public against damages sustained as a result of the construction of the highway project. Certain insurance agents specialize in this kind of market and earn an excellent income.

Other less scrupulous persons use the bond market to generate a far greater income by issuing worthless bonds. In this scheme, the unscrupulous salesperson manufactures worthless paper which he issues to a consumer, usually for high risk coverage. This might include bridge construction, building demolition, fireworks displays, transportation or storage of explosives, or other potentially hazardous situations. The agent issues the bonds in hopes that no claims will be made. If a claim is made, the agent either pays the claim with available funds, uses delay tactics, or skips town.

Indicators

1. No bond or endorsements are received from the agent.

2. The bond is a photocopy or the bond paper bears no company watermark.

3. The agent requests payments by cash, money order, or cashier's check made payable to him or to a company other than the insurance carrier.

4. Checks are returned, having been cashed or deposited to the agent's personal account.

5. The insurance company allegedly issuing the coverage is not authorized to sell insurance in Maryland or is unknown to the Department of Insurance.

Injury Fraud Schemes

Workers' compensation fraud is the most common injury fraud committed. With this scheme, what usually begins as a minor injury on the job develops into a golden opportunity for an early retirement, a paycheck without having to work, or an income supplement from the insurance company.

Here, false information is presented to the workers' compensation carrier, the report describes the claimant as totally or partially disabled and either unable to work at all, or only able to work part time. In many cases, these schemes are enhanced with the assistance of an unscrupulous doctor who for an extra fee, provides a false diagnosis of the claimant's condition and fabricates medical records for phony treatments.

Greedy claimants have collected workers' compensation benefits and worked full -or part-time on another job, sometimes under another name.

Indicators

1. The employee has a history of prior workers' compensation claims.

2. Injuries are soft tissue kinds.

3. The employee claims to be incapacitated but is seen engaging in activities that require full mobility.

Liability Fraud Schemes

Liability fraud schemes usually involve claimants who are just as eager to settle out-of-court as they are to file suits. Here are two of the better known schemes.

Broken Tooth Caper

In product liability schemes, such as the broken tooth caper, the claimant usually enters a restaurant, orders a meal, then tells the attendant and manager that he or she broke or lost a tooth. In some cases, the claimant even produces a rock or a piece of tooth as evidence. In other cases, the claimant swallowed the object and the tooth.

Since these claimants know that the restaurant cannot afford any negative publicity, they can usually expect a prompt payment from the restaurant's insurer.

Indicators

1. The claimant has a record of prior similar claims in the index bureau.

2. There is no noticeable injury to the tooth.

3. Dentists who allegedly examined the victim cannot be located.

4. The victim threatens a lawsuit immediately, but is extremely willing to settle quickly.

Note: Other examples include finding insects or rodents in food items, or claiming foods were contaminated.

Slip and Fall

If it were possible to document the first liability insurance fraud case in history, it just might be a phony slip and fall.

The scheme usually begins with the victim found lying on the floor of a large retail store or perhaps on the walkway of a large shopping center. Often a witness to the fall cannot be found but the victim is able to recount the accident in great detail. A lawsuit may be threatened or actually initiated by the victim, and a quick settlement leaves the insurance company, the merchant, and the victim satisfied.

Slip and fall artists are extremely transient, so to successfully prosecute one, a cooperative effort between one or more law enforcement agencies and perhaps several insurance companies may be required.

Indicators

1. The site of the accident is a large chain store or publicly-owned property.

2. No eyewitnesses saw the actual fall.

3. The victim is extremely willing to sign a complete release for a quick settlement.

4. The victim is just passing through the city and is in a hurry to leave town.

5. Injuries are soft tissue type.

6. The victim threatens lawsuit immediately.

C. NATIONAL CONSIDERATIONS

In 1991, the Insurance Information Institute commissioned the Battelle Seattle Research Center, to undertake a study of insurance fraud in America. The resultant study was published in March 1992, under the title "Fighting the Hidden Crime - A National Agenda to Combat Insurance Fraud". Pages 22 - 43 deal with the issues surrounding a national agenda and strategies for creating and accomplishing the agenda.

THE NEED FOR A NATIONAL AGENDA

Although little adequate data on the magnitude of insurance fraud exist, there is no doubt that this crime has reached serious proportions. Speculative estimates of the costs of external fraud within the three major insurance sectors (property and casualty, health, and life) suggest that it is the second largest economic crime in America, exceeded only by tax evasion. External fraud in the property and casualty sector is estimated to account for 10% of all claims dollars (costing over $17 billion a year). The cost of health care fraud has been estimated at over $50 billion a year. No estimates of life insurance fraud were found in the literature, but experts believe that fraud in this sector of the industry is far less prevalent than in other sectors.

Insurance fraud is also believed to be rapidly escalating, but again little reliable data exist. Official statistical data (such as convictions) do not indicate the extent to which observed increases reflect better detection and law enforcement or actual changes in the amount of fraud committed. However, in some cases, increases have been so large that enhanced law enforcement is unlikely to account for all the change. For example, the number of health care providers convicted of insurance fraud increased by 234% between 1979 and 1986, as compared with a 79% increase in income tax fraud convictions and a 41% increase in mail fraud convictions (Bucy, 1989). Referral statistics to a major fraud investigatory service organization of the property and casualty sector indicate that medical scams and staged automobile accidents have shown the greatest increases (approximately 100% and 50%, respectively, from 1986 to 1989). A crude method of estimating

increases in auto-related fraud suggests that some companies have experienced a 50% increase in the last decade. Based on existing information, health care and auto appear to be the fastest growing areas of insurance fraud.

Unless strong countermeasures are taken, this escalation in insurance fraud is likely to continue. First, insurance fraud tends to be self-perpetuating; fraud contributes to higher premiums which, in turn, increases fraud (Florida Insurance Research Center, 1990). Second, insurance fraud tends to increase in recessions (National Underwriter, 1991). The magnitude of this crime has already reached the point where it can no longer be seen as just an insurance industry problem.

The Consequences

The increased significance of the insurance fraud problem stems from the fact that the costs are now being acutely felt, not just by insurance companies, but by the general public. The property and casualty estimate that 10% of all claims dollars attributable to fraud translates into 8% of all premium dollars paid out by insureds. The situation is far worse in some areas and for some types of insurance. For example, there is some evidence that auto insurance fraud in Los Angeles is at least double the national average (Mooney, 1991).

Moreover, while the economic consequences of fraud are major, they are not the only relevant issue. Insurance fraud also poses a serious threat to the moral integrity of the community and to professional and business ethics. The range of perpetrators and public attitudes toward insurance fraud underscores the depth of this problem. It is a crime that, in some form, is condoned and/or perpetrated by a significant percentage (approximately 25-30%) of otherwise upright, law-abiding citizens. The Insurance Information Institute's document, Insurance Fraud Project: Report on Research (I.I.I., 1990), states that it is not uncommon for doctors and body shop operators to inflate bills to cover their clients' deductible. Although factual statistics on the relative frequency of these practices by service providers are not available, a survey, sponsored by Aetna Life and Casualty (National Family Opinion Corporation, 1988), found that 40% of the respondents reported they knew of health providers who engaged in deceptive billing practices.

Anti-Fraud Efforts

There has been a growing awareness of the need to address this problem. Several industry service organizations have been created that specialize in anti-fraud activities. In January 1992, the industry established a new organization, called the National Insurance Crime Bureau (NICB), devoted exclusively to fighting insurance crime. NICB merged the fraud-fighting investigative

expertise of the Insurance Crime Prevention Institute (ICPI) with the extensive anti-auto theft knowledge of the National Auto Theft Bureau (NATB).

Other organizations provide some specialized anti-fraud services, such as databases designed to facilitate the detection of fraud or the development of model laws to assist in prosecuting this crime. More recently, the number of insurance companies that have established anti-fraud units, usually referred to as special investigation units (SIUs), has grown tremendously.

However, insurance carriers and their service organizations have concentrated on combating the particular types of external fraud perpetrated within their insurance domain. Anti-fraud efforts are thus fragmented by insurance sector (property and casualty, health, and life) and, in some instances, by type of insurance coverage (homeowners, fire auto, workers compensation, disability, types of health insurance, and malpractice). These divisions have produced serious limitations in combating fraud. Since perpetrators of fraud do not neatly conform to these categories, fragmentation of anti-fraud efforts often work to the advantage of criminals, not insurers. In addition, the nature of the fraudulent acts are in many cases similar or overlapping, but strategies for combating them are not being shared among all the relevant anti-fraud personnel. For example, disability and workers compensation fraud, though closely related, are dealt with separately because they fall into different insurance sectors (the former is part of health; the latter is under property and casualty). This fragmented approach to the problem has been both ineffective and inefficient. There is a great need to link the fraud databases that exist in the different sectors and to forge greater investigatory Insurance Services Group (AISG), which administers two of the largest index systems. The AISG database systems have self-insured organizations as members and include claims filed under many different types of insurance. These databases are available to support NICB. The databases also have been opened to the health insurance sector.

In addition to industry efforts, 11 state insurance departments have established, or are in the process of establishing, state fraud bureaus in an attempt to more rigorously address the problem of insurance fraud. Since the regulatory mandate is to police the industry for purposes of protecting consumers, regulators have primarily focused on internal forms of insurance fraud. This tendency is now changing to some extent. Some of these state fraud bureaus are including efforts to address the more costly forms of external fraud, such as auto fraud. In fact, the New Jersey state fraud bureau primarily focuses on automobile-related fraud in response to the escalation in the cost of automobile insurance. Because state fraud bureaus are an effective means of bringing greater law enforcement attention to bear on the problem, the industry should promote cooperation with

the bureaus. Such cooperation could include sharing of data. Currently, AISG databases are available to agencies in the 20 states, where such access has been required or where participation in the AISG databases is mandated by statute. Another way that the industry can encourage cooperation with bureaus is to assist regulators in combating internal forms of insurance fraud.

There has also been greater law enforcement activity directed at insurance fraud, such as the creation of a federal task force in Philadelphia and special insurance fraud sections in prosecutors' offices, such as those in Los Angeles and in the New Jersey Division of Criminal Justice.

In spite of increased efforts, there is little evidence of an overall reduction in the amount of insurance fraud being committed. Many of these anti-fraud efforts are too new to yield results at this time, but many involved in these efforts are acutely aware of the obstacles that presently limit the results they can expect to achieve. These efforts often only address some aspect of the overall problem, encouraging perpetrators to find different forms of fraud, or more vulnerable companies or geographical areas to target. Anti-fraud activities are typically bound by organizational and jurisdictional boundaries that criminals can use to their advantage. These efforts have made it clear that a coordinated, national effort is necessary to achieve an overall reduction in insurance fraud.

STRATEGY OF A NATIONAL AGENDA TO COMBAT INSURANCE FRAUD

National agendas have been implemented to enhance coordination and increase effectiveness in addressing other types of social problems, such as drunk driving and arson. Both these efforts appear to have achieved a measure of success, although the strategies employed differed substantially. Determining what strategies will be most effective for a national strategy requires understanding the underlying structure of the particular problem.

Determining the Strategy of the National Agenda

There are two conceptually distinct but interrelated approaches to combating criminal behavior: prevention and deterrence. Deterrence, the dominant paradigm in criminological theory, emphasizes the costs associated with behavior. The basic idea is to increase potential costs to the point that they offset the promise of potential gains. There are two types of deterrence, specific and general. Specific deterrence, aimed at those who have already committed the crime, attempts to inflict penalties severe enough to deter perpetrators from committing subsequent criminal acts. General deterrence, aimed at the larger body of persons who might consider committing the crime, works by increasing their fear of being apprehended and punished if they commit the crime.

Prevention combats crime by reducing the opportunities and social acceptance for committing the crime. For white-collar crimes, like insurance fraud, the potential for altering the opportunity for gain is a significant factor. By reducing the opportunities for gain, it may be possible to more effectively and directly prevent insurance fraud than is possible through deterrence.

Prevention can also be achieved through changing societal attitudes, at least when the costs and benefits associated with the criminal act are relatively minor. In fact, theory and research indicate that in instances where both costs and benefits are minimal, societal attitudes are a more important determinant of action than is deterrence (North, 1981; Paternoster, 1989). Levi, 1988, shows that even when the costs and benefits are significant, a large amount of compliance with various types of social or contractual obligations (such as paying taxes or fulfilling one's military obligations) is voluntary or quasi-voluntary. Voluntary compliance derives from: (1) a sense of justice or fairness; and (2) the belief that others are complying (individuals do not want to feel they are "suckers"). Quasi-voluntary compliance stems from a fear of social condemnation, based on one's perception that others would not approve of non-compliant behavior. These factors are relevant to insurance fraud. Surveys of public attitudes have found that people believe that insurance carriers are making big profits at their expense, and that a growing proportion of the population holds the opinion that insurance companies are not giving them "fair" coverage for premiums paid. People also believe that many ordinary citizens are committing insurance fraud, further justifying possible fraudulent behavior of their own.

Prevention is a pro-active approach that is achieved by changing public attitudes and reducing opportunities for gain; deterrence strategies react to crimes once they have been attempted or committed through detection, investigation, and prosecution. Prevention and deterrence are interrelated in that deterrence is intended to prevent future criminal acts. They are also interrelated in that they involve five successive levels of action: changing public attitudes; decreasing opportunities; improving detection capabilities; increasing investigative efforts; and promoting rigorous prosecution. These successive levels can be viewed in terms of a strategic anti-fraud pyramid (see figure A, page 27). At each of these levels, there are direct and indirect inputs from the bottom up and feedback potential from the top down. Detection is the midpoint between prevention and deterrence in that although the attempt to defraud was not prevented, detection can perhaps prevent the successful commission of the act. Detection is thus the end point of pro-active prevention and the beginning point for enforcement actions that contribute to deterrence.

The extent to which this pyramid, in terms of the number of persons that can be affected, is wider at the bottom than the top

will determine the potential gains of preventive versus deterrent types of action. In other words, the choice and importance of strategies is partially determined by the degree to which there are proportionately greater numbers of people at each successive level that can be affected (beginning from the bottom level). This will depend on the extent to which:

- the number of people who tolerate the commission of some form of insurance fraud exceeds the number of people who take advantage of, or actively seek out opportunities to commit fraud;
- the number of people who take advantage of, or actively seek out opportunities, to commit fraud exceeds the number of people who are detected;
- the number of people who are detected exceeds the number of people who are investigated; and finally,
- the number of people who are investigated exceeds the number of people who are prosecuted.

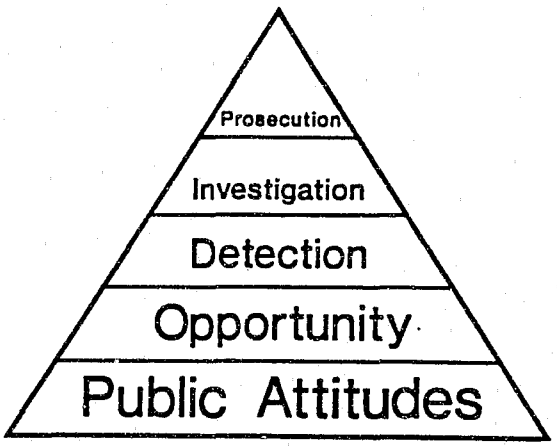


Figure A: Prevention/Deterrence Pyramid

In addition, the relative importance of each of these levels of deterrence and prevention strategies depends on the nature of the perpetrators and the underlying causes of their criminal behavior. In the case of insurance fraud, perpetrators range from one-time non-professionals to "hard-core" professional criminals who engage in fraud as a business. The term "semi-professional" perpetrator is used in this report to refer to persons who commit fraud with some degree of repetition, but do not rely on fraud as a major source of their livelihood. An example would be a service provider, such as a medical practitioner or body shop operator, who more or less routinely submits padded billings for insurance reimbursement.

Penalties for committing insurance fraud are particularly important for "hardcore" professionals. Because the potential for gain from fraud can be extremely large, fraud will remain a lucrative business unless potential costs are sufficient to offset expected gains. With regard to small scale fraud, because of the difficulty in detecting minor offenses, deterrence by either increasing the actuality of, or the fear of, apprehension and penalties has a limited effect. People may not believe that law enforcement, or even insurance companies, have the capacity or the commitment to address small scale fraud. For less serious forms of insurance fraud, decreasing the opportunities for gain ("taking the profit out of the crime") through careful operational practices on the part of insurers may be a more effective strategy. Finally, given that the vast majority of perpetrators are non-professionals, changing the public's attitude of the behavior also can be a highly effective strategy.

Comparisons with Other National Agendas

A comparison of strategies of national agendas to address different types of social problems should help clarify these points. The national agenda to combat arson, unlike the national agenda to combat drunk driving, did not require a concerted effort to change public attitudes. Arson was never tolerated or condoned by a large proportion of the population. Nor were opportunities for gain easily subject to willful manipulation. Better detection and investigation through improved techniques, shared expertise, and coordination among relevant actors, combined with a greatly increased threat of penalties (the possibility of triple damages in many states) formed the cornerstone of the national agenda to combat arson. The major problem confronting this national agenda was how to enhance coordination across fire fighters, law enforcement agencies, and insurance investigators to improve detection, investigation, and prosecutive efforts. The passage of immunity laws for arson reporting was of great assistance in promoting coordination among the various parties.

The success of the national agenda against drunk driving was in large part due to an increase in public awareness and a change in social attitudes. Activist groups like Mothers Against Drunk Driving (MADD) and media exposure were as critical to achieving success as were the efforts to increase law enforcement activities directed at apprehending violators and stiffening the legal penalties that could be inflicted on them. There was also a major effort directed at reducing opportunities by raising the legal age for drinking to 21 and by increasing the legal responsibility of bartenders (and even private hosts) to monitor and control the amount of alcohol served. Detection and investigation are a lot simpler for drunk driving than for insurance fraud and involved proportionally less effort than other aspects of the campaign. At the prosecution level, penalties were raised and judicial awareness

as to the seriousness of the crime was increased. Thus the main focus of the national agenda against drunk driving was on increasing the amount of attention given to the problem on the part of law enforcement, public interest groups, and the media, and on increased coordination between these groups.

In the case of a national agenda to combat insurance fraud, all of these levels of strategic action are necessary. Preventive actions are important because so much fraud is committed by non-professional and semi-professional perpetrators. Changing public attitudes should bring about a real change in the amount of fraud being committed increasing the amount of voluntary and quasi-voluntary compliance. There has been, however, little coordination action on this front. While the insurance industry can make some effort in this direction, consumer groups and the business sector are in a position to give this effort greater credibility and to provide invaluable aid in terms of resources. Thus, there needs to be an effort to identify and encourage the participation of groups that are potentially "natural allies," meaning that they suffer from the same external assaults as does the insurance industry. These include:

(a) self-insurers who currently account for about 22% of the property/casualty market share, and are the fastest growing segment of the commercial insurance market (Johnson and Higgins, 1991);

(b) government and state and city agencies that are on the receiving end of false liability claims; and

(c) the business sector (most Fortune 500 companies are concerned with increases in the rate of health care claims that are clearly related to fraud and abuse). Other potential allies, such as regulators protecting the public and organized consumer groups, are concerned with ever-escalating premiums that hurt their constituencies.

Efforts to decrease opportunities are also an extremely important strategy for preventing insurance fraud. Efforts to change the public's tolerance of fraud can, to some small extent, contribute to a reduction of opportunities; for example, a national publicity campaign aimed at making all forms of fraud less socially acceptable could inhibit service providers from suggesting mutually beneficial fraudulent practices to their clients. The public could be encouraged to become more directly engaged in the campaign to combat fraud by encouraging and sponsoring programs that (1) educate them to recognize suspicious practices (such as billings, etc.), and (2) promote methods (such as a hot line) for them to report suspicious or fraudulent actions. All these factors would enhance quasi-voluntary compliance. The primary method of decreasing opportunities, however, is by direct action on the part of the insurance companies. Decreasing opportunities requires a

fully integrated anti-fraud program encompassing all phases of company operations (sales, underwriting, claims processing/adjusting, administration and management). Currently, many anti-fraud efforts are largely directed at detecting and reacting to attempted claim fraud, rather than making it more difficult for fraud to be attempted in the first place. Most industry persons interviewed stressed the need for more preventive anti-fraud programs to be implemented at earlier stages in the insurance process.

Preventive actions should greatly enhance the effectiveness of detection by reducing the number of cases of fraud that need to be detected. As the number of cases that need to be detected becomes more manageable, the tension between the insurance company's need to control day-to-day operational costs and the longer term goal of reducing cost due to fraud will be reduced. Presently, increased detection could easily overwhelm the resources available to deal with these claims. Insurers and their SIUs are aware that they can only tap the tip of the iceberg at this point in time. One strategy that may overcome this problem to a large extent would be to enhance detection capabilities and to publicize that some random proportion of claims, no matter how small, will be selected for extensive investigation (similar to the strategy employed by the Internal Revenue Service (IRS)).

Benefits of successful detection should be felt in two ways. First, public awareness of sophisticated detection methods should deter non-professional and semi-professional perpetrators, as well as make it more difficult, and perhaps more costly, for hard core criminals to successfully execute their scams. Second, as the comprehensiveness of anti-fraud programs and the sophistication of detection methodologies increase, investigation will be made easier by increasing the likelihood that the evidence required to deny a fraudulent claim will surface in a more complete and usable form. Effective programs of detecting insurance fraud are the basis for successful deterrence.

The effectiveness of individual company efforts (and those of investigative service organizations such as NICB) in detecting fraud in large part depends on the progress that has been made in the past several years in developing databases. Several databases have been developed by industry service organizations that cater to the particular interest of their member companies. These databases tend to be geared to discrete insurance claim arenas (such as auto, bodily injury, property loss, arson, disability, workers compensation, and health). It is now becoming clear that more centralized databases are needed. There is currently some movement toward centralizing databases, such as AISG combining its two major databases and NICB combining databases that had been previously maintained by the two organizations that merged to form this new service organization.

Finally, regardless of the success made in preventing and detecting fraud, deterrence deriving from investigation and deterrence deriving from prosecution will continue to be necessary components. Although maximum deterrence flows from criminal prosecution, this level of action is not always possible and often not required. Prosecutors may not accept a good case because of competition for their limited resources or their own assessments of the prosecutive quality of the case. For all but "hard core" criminals, there may be reasonable civil options. The possibilities of recovering funds should not be too quickly downgraded. Although recovering funds often cannot be cost-justified on an individual case basis, it can have significant deterrent value. Investigations must therefore have a flexible orientation. While some cases should be investigated with the intention of criminal prosecution (requiring proof beyond a reasonable doubt), others need only be investigated to the point of being able to deny the claim or initiate civil prosecution (requiring only a preponderance of evidence). Strong guidelines should be developed to help make these decisions.

Successful investigations often require cooperation between insurance companies, between companies and industry service organizations, as well as between industry service organizations and law enforcement agencies. Cooperation requires mutual trust and confidence, not only in the integrity of cooperating parties, but also in their competence. It also requires sensitivity to the legal issues raised by the sharing of information, as well as the ability to discriminate between real and presumed legal perils associated with such sharing. Consideration should be given to structuring a formal relationship between the industry, regulatory bodies and select law enforcement agencies which would provide for the determination of the appropriate legal mechanism for a variety of offenses.

It is important to emphasize that cooperation with law enforcement involves obligations as well as opportunities. Once law enforcement has accepted a case, it often expects additional investigatory work from insurance companies. This should be seen as an opportunity to foster mutual confidence between the industry and law enforcement. Improved cooperation can make it possible to move to higher levels of joint investigatory efforts, such as pro-active investigations, sting operations, and task forces.

This level of cooperation does not always exist. Many companies are frank about the fact that they approach insurance fraud from a straightforward business perspective. When a fraudulent claim is suspected, their main interest is in developing sufficient evidence to deny the fraudulent claim. They will cut off investigatory activities at that point. This approach does not promote a unified effort to combat insurance fraud. It may merely encourage perpetrators to seek out easier targets (more vulnerable insurance companies) rather than adequately deterring the amount of

fraud committed. Moreover, this orientation can work against maintaining good relations with law enforcement. There is some feeling on the part of law enforcement that the industry often asks for help but then will not go the distance, or will even undercut its efforts by settling with claimants.

In instances in which insurers want to pursue criminal prosecutions, their referrals must compete for the attention and resources of agencies whose efforts are largely consumed by violent crime and drug trafficking. Thus the referral process is very much a sales process. The product must be well constructed and documented for easy use, and backed by a warranty of future service. It must also be marketed, which means persuasively presented. This calls for the development of effective referral "packages" and pre-selling strategies (such as contacts with law enforcement officials to inform them of significant cases being developed, prompt their interest and input, and elicit their commitment once the case appears before them).

Enhanced prosecution may also require greater pressure from potential "natural allies" as well as better coordination among law enforcement agencies. Even if sufficient pressure is brought to bear on law enforcement, as is often the case in areas of white-collar crimes that have not yet received high priority, law enforcement agencies are not always set up to effectively deal with the problem. In several areas special strategies have been developed to enhance law enforcement coordination, such as the special insurance fraud sections established in prosecutors' offices.

Conclusion

A national agenda to combat insurance fraud will require efforts to:

(a) enhance the effectiveness of each of the levels of prevention and deterrence, and

(b) coordinate anti-fraud activities among "existing" and "potential" anti-fraud professionals.

The industry should begin to implement initiatives that will increase effectiveness and promote coordination in addressing each of these levels of prevention and deterrence.

CREATING A NATIONAL AGENDA

The insurance industry must clearly assume the lead role in bringing a national agenda into existence. No other group has the motivation and resources to fill this role. To do this, it must act collectively. Questionnaires and interviews conducted with

many anti-fraud professionals within and outside the industry revealed that coordination among industry groups and insurance companies was their highest priority. Such coordination would not only enhance the effectiveness of the industry's overall effort, but would also reduce any unnecessary duplication. The areas identified as requiring greatest attention included databases, more comprehensive anti-fraud procedures implemented at each stage of the insurance process, and training. Two additional action areas were also identified by industry and relevant non-industry professionals as being important: efforts to enhance legal and regulatory remedies, and public education and other outreach programs. Both of these action areas entail promoting participation on the part of non-industry groups, particularly legislatures, regulators, law enforcement agencies, and potential private and state sector allies with related interest.

A significant amount of overlap exists between these identified areas, especially between anti-fraud procedures and training since training is a major contributor to improved procedures. For this reason, anti-fraud procedures and training will be discussed together. Training can also improve the use of databases, increase awareness of actual and potential legal and regulatory remedies, and help to improve public education efforts and outreach programs. Public education and outreach programs can help bring pressure to promote legal and regulatory remedies, and legal and regulatory remedies can, in turn, promote awareness and participation on the part of the general public and various interest groups.

Together, these four action areas would go a long way toward addressing each of the levels of the strategic pyramid (see figure B).

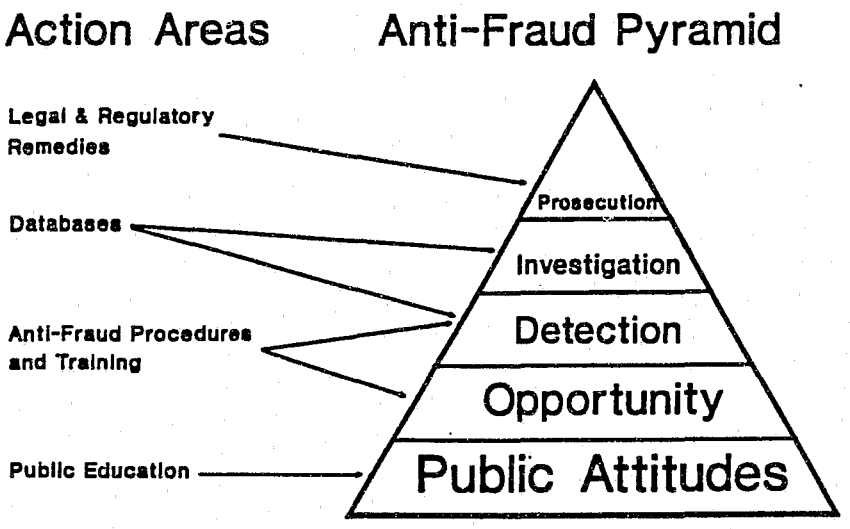


Figure B: Relation of Action Areas to Anti-Fraud Pyramid

Databases and anti-fraud procedures and training will primarily reduce opportunities, increase detection capabilities, and improve investigation. These two action areas, by improving detection and investigation, as well as cooperation with law enforcement, should also help improve the chances of successful prosecution as well. In addition, the more the industry undertakes the initiative to combat insurance fraud, the better position it will be in to influence public attitudes. Legal and regulatory remedies would be primarily directed at enhancing both the investigation and prosecution of insurance fraud, while public education and outreach programs would be directed at changing public attitudes, and to a lesser extent decreasing the ease with which insurance fraud can be committed (decreasing the opportunities).

There was significant agreement between what theoretically appeared to be the critical areas of strategic importance and what both industry and key non-industry professionals identified as areas needing attention. To a large extent these action areas can be implemented by improving coordination within the industry which will, in turn, promote even greater coordination with groups outside the industry.

1. Public Education and Outreach Programs

The insurance industry is well aware of the problem posed by existing public attitudes toward the insurance industry and the high level of public indifference or tolerance of insurance fraud. It is obvious that a change in these attitudes would be highly beneficial, but not all are convinced that increased public awareness of the problem of insurance fraud would bring about the desired effect. Although changing public attitudes is an extremely important goal of a national strategy aimed at combating crimes committed in large part by non-professional and semi-professional perpetrators, public education is a delicate matter. For example, research suggests that increased awareness that others are not playing by the rules, coupled with a sense of unfairness, may exacerbate the problem. Because of the potential dangers of enhancing public awareness, public education must be done very strategically. Various strategies and techniques for increasing public awareness are discussed here and analyzed in terms of their potential benefits, as well as potential dysfunctions.

The biggest danger is for the industry to do nothing or engage in half-measures to promote public awareness and education. As the problem becomes more serious, it will inevitably receive greater public attention and concern. If the public does not see the industry as being highly involved in combating this problem, the industry will be perceived in an even more negative manner.

The industry must, therefore, take the lead role in a public education campaign; but to do so, it must be seen as taking serious

steps internally to combat fraud. It must make an organized and committed effort to effect change internally if it is to advocate change in other sectors. To suggest that the industry assume the lead role does not mean that it should pursue this effort alone. Involving others with parallel interest in the public education campaign effort is necessary to give the message credibility. Thus, in conjunction with a public education campaign, it is important to develop outreach programs to consumer groups and other key political bodies aimed at cultivating their support and endorsement of the effort.

Developing a national agenda and a plan of action in which the industry is assuming the leading role is an extremely important step in enlisting the support of other sectors. Although assuming responsibility for initiating a national effort to combat insurance fraud is a major step for the industry, it should be noted that many groups within the industry are conducting other important anti-fraud activities. For example, the Industry Research Council, a service organization sponsored by property/casualty insurance companies, conducted a public attitude survey demonstrating the extent to which the public not only tolerates but condones various acts of insurance fraud. Two other major studies, the Automobile Insurance Fraud Study (Florida Insurance Research Center, 1990) and the Bodily Injury Liability Claims Study (Weisberg and Derrig, 1990), reviewed a sample of closed claims to estimate the extent of fraud in these particular insurance areas. These research efforts have been important factors contributing to a heightened level of attention directed to the problem by persons outside the industry.

The industry can present itself in a more advantageous manner. Many people in the industry indicated to the project staff that they felt that the public was insufficiently aware of the link between fraud and increases in their premiums and that this should be a primary focus of public education efforts. While this may be true, it is not clear that recognizing this connection would make much of a difference. In fact, stressing that honest insureds are being made to pay for fraud that others commit may contribute to the tendency of persons to rationalize engaging in fraudulent behavior themselves. It may even increase public anger by making it appear that insurance companies have not done enough to reduce the fraud problem. Another approach frequently suggested by members of the industry was to educate the public as to the nature of the insurance contract, i.e., to impress upon it that premiums are not simply exchanged for services rendered but to provide protection against risk. If everyone expected premiums to pay off, insurance companies could not provide this security. The problem may not be that persons fail to understand the nature of the exchange, but that too many insureds view the exchange as "unfair." Many do not expect insurers will give them a fair settlement when they file an honest claim. Insureds are also all too aware that they are being forced to pay the price of those who do not play by the rules governing the contractual exchange. The industry must

more clearly align itself with the majority of honest insureds and reestablish their trust.

By the same token, it is important for the industry to stress the fact that most insureds are honest. Internal industry articles tend to stress that 1 in 4, or 1 in 5, persons condone one or another act of insurance fraud. While the numbers may be startling, the vast majority of the population does not condone or commit any form of insurance fraud. Research has shown that the more people are led to believe that everyone else is cheating, the more likely they are to engage in the behavior themselves (they do not want to be a "sucker"). In order not to contribute to the feeling that only "suckers" don't cheat, it is necessary to stress that most persons continue to act honestly in spite of growing temptation or perceived grievances. The industry should continually emphasize the common interest between it and the vast majority of premium payers. Only then can the alignment shift so that it is the industry and honest insureds on one side, and those who commit fraud on the other.

Concrete actions undertaken to combat fraud are probably the most effective means of conveying a positive message to the public. In addition to developing a national agenda and assuming responsibility for promoting anti-fraud efforts, smaller scale activities can be undertaken by the insurance industry, and sometimes by individual companies, to generate favorable local media attention. For example, supporting law enforcement sting operations is an effective means of getting local media attention and has the added benefit of ferreting out fraud. Individual insurance companies have supported such operations, with great benefit. Programs that encourage individuals to report suspected fraud also can be very useful, not only in detecting fraud, but in showing that the industry and law enforcement are active in fighting fraud.

Individual insurance companies should be encouraged to implement and publicize anti-fraud measures. The fear that insureds will react negatively to company or industry anti-fraud measures may be completely unwarranted. An insurance company in Australia reports that it gained market share on the basis of advertising a strong anti-fraud program. In this country, some companies appear to be running successful anti-fraud advertising campaigns. The industry ought to encourage companies in these efforts, and examine such activities to determine whether they generate positive or negative effects. This information can then be circulated throughout the industry.

The example of organizations in fighting other crimes can be usefully reviewed. In particular, some aspects of the IRS communications strategy could be adopted. The IRS attempts to get wide publicity for the apprehension of major tax evaders. Such publicity serves as a deterrent to serious criminals and also as a

deterrent to the general public, who feel that the IRS may pursue them for minor tax evasion as vigorously as it pursues major evaders. Another aspect of the IRS strategy is that it communicates to the general public the notion that each tax return is scrutinized. This helps with compliance, in that people believe that it is not easy to "rip off" the system. It also enhances support for the system because it increases credibility in its fairness.

Recommendations

(a) The insurance industry needs to have strong anti-fraud actions in place before it undertakes major public education projects.

(b) The insurance industry must take a lead role in a public education campaign, but to be fully successful, it must encourage other sectors to become involved. Public campaigns need the participation of governmental representatives, law enforcement, and consumer advocates.

(c) Major guilty verdicts and exposure of "scams" should be highly publicized. Insurance company involvement in prosecuting such cases should be publicized, so that the public realizes that the industry is concerned about and involved in fighting fraud.

(d) The industry should let the public know that anti-fraud procedures are in place. This would help reduce the larceny in some hearts and also enhance the view that the system is fair.

(e) Individual companies should be encouraged to undertake and publicize their own anti-fraud programs; an industry service organization should track such efforts and disseminate information on what succeeds and what fails.

2. Anti-Fraud Procedures and Training

Anti-fraud procedures differ from company to company. Each carrier sets up its own anti-fraud programs and procedures, based on its own perception of the threat, the potential benefits, and its internal expertise. Over time, greater uniformity is likely to develop as techniques that work become better known, and those that are ineffective are discarded. Greater uniformity in training and procedures is considered a benefit in fighting crime because it allows for better communication between crime fighters, and also economizes on overall training costs because employees need not be totally retrained as they move from company to company.

Although uniform training has not been developed, some training resources are available. NICB offers training materials

(such as a handbook for insurance personnel which mainly deals with procedures governing relations between NICB and its member companies, a list of "red flag" indicators to be used in identifying suspect claims, and some special topic videos). It also provides investigative training to its own employees. According to the International Association of Special Investigation Units (IASIU), the umbrella organization of internal company SIUs, its annual four-day meetings constitute a very extensive collective training service. IASIU is, however, fully aware this constitutes less than a comprehensive training program. Education programs are also conducted by the American Insurance Services Group (AISG) and many other trade groups.

Industry organizations could provide a higher level of service to their member companies by providing more extensive specialized training to anti-fraud personnel and general training assistance to carriers in implementing and maintaining anti-fraud programs and practices. SIU personnel are clearly aware of the need for more extensive training. Many companies need greater assistance in establishing and operating SIUs. More and more companies are establishing SIUs, but there is a shortage of experienced personnel and supervisors for these units. Some companies have hired experienced SIU agents away from other companies, but more often retired police officers with no SIU or insurance fraud experience are hired to set up and run SIUs. Training should include input from law enforcement, so that the experience and problems of persons involved in the criminal prosecution of insurance fraud are communicated to insurance personnel.

Some industry personnel have suggested that SIU training should be as systematic and standardized as the training required for other specialized industry personnel, such as underwriters. Standardized training and private certification would not only make individual SIUs more effective, but should also encourage cooperation among companies and promote better working relations with law enforcement. SIUs currently hesitate to provide information requested by another company's SIU unless the requestor is know and trusted. Standardized training and certification should increase inter-company confidence that information exchanged will not be misused, and thus promote greater willingness to share standards of professional conduct. Training should also focus on relations with law enforcement and the legal limits governing SIU investigative activities. It should both promote good relations with law enforcement and reduce the exposure of companies to lawsuits. Moreover, if specialized training in detecting and investigating fraud is offered to industry personnel, it could easily be offered to key anti-fraud professionals outside the industry as well, such as law enforcement officials, regulators, independent adjusters, and even municipal authorities and businesses that are wholly or partially self-insured.

Specialized training in procedures and operations, detection and investigation techniques, pertinent legal issues, and professional standards of conduct, is only the beginning. Anti-fraud programs, if they are to be effective, cannot be confined to a separate unit. Only a few companies have any periodic anti-fraud training for claims personnel, underwriters, and sometimes agents. Much more systematic training should be directed at all these operation levels. Involvement and diligence on the part of agents, underwriters, and claims personnel are essential to the success of anti-fraud efforts. Even the most cursory examination of insurance fraud reveals the host of problems that arise from a lack of anti-fraud measures at every stage of the insurance process.

Supervisor and executive training is particularly important. There is still a widespread view in the industry that detecting and investigating fraud is not cost effective, and that anti-fraud programs might be viewed as anti-consumer. The industry must, however, do more than educate company executives, managers, and supervisors; there should be assistance to help companies devise and implement organizational processes that support anti-fraud policies. Routine operating practices that inhibit fraud prevention must be identified and rectified, and "model" operating procedures suggested. For example, particular attention should be directed at devising "model" procedures for employee performance evaluations that support and bolster anti-fraud policies, and providing incentives, not disincentives, for anti-fraud diligence exercised by all categories of employees.

Training assistance, in the broadest sense, is essential for getting the industry to effectively present itself to the public as caring about this issue. Until the industry is perceived to be doing all it can to prevent fraud, it will be extremely difficult for it to encourage others to become serious about combating fraud.

Recommendations

(a) Training and consulting assistance for establishing Special Investigation Units (SIUs) should be developed and made available to insurance companies.

(b) Industry experience and expertise on procedures for analysis of claims and methods and techniques of investigation should be more systematically gathered and disseminated in training materials.

(c) Official training programs and "certification" procedures for SIU agents should be developed. Training should minimally cover:

- specialized detection and investigatory methods and techniques

- standards of professional conduct
- guidelines for information exchanges and use of this information
- legal limitations to SIU investigatory activities
- relations with law enforcement and development of referral packages.

(d) Training should be offered to key non-industry personnel, such as law enforcement officers, regulators, independent adjusters, self-insuring government authorities and businesses.

(e) Industry experience and expertise should be gathered to develop training materials addressing anti-fraud procedures and practices to be employed by agents, underwriters, claims appraisers and adjusters.

(f) Emphasis should be given to the development of "model" comprehensive anti-fraud programs that encompass all phases of company operations (sales, underwriting, claims processing/adjusting, administration, and management) and industry-wide standards of conduct and accountability.

3. Databases

The area where coordinated action is most needed is information collection and dissemination. Several databases have been developed to address this problem. These databases contain useful information and have facilitated the process of detecting and investigating insurance fraud. There are, however, a number of areas where improvements can be made.

Most existing industry and non-industry databases have been developed within particular insurance domains to address fairly specialized needs; for example, the North American Theft Information System (NATIS) has a database on auto thefts and The Index System contains information on bodily injury claims.

Several state fraud bureaus have recently mandated the reporting of "suspect" claims (usually only for certain types of insurance). There appears to be much doubt as to the utility of this approach, since there is no accepted standard for determining whether a claim should be classified as "suspect."

The restricted nature of existing databases is seen by many as a weakness of the overall system. Insurance fraud criminals may not restrict their activities to one line of insurance, delineated by insurance industry definitions. Also, when professional

operations like medical clinics or lawyers' offices are involved in fraud, their operations typically spread over a number of insurance lines, including health, auto and workers compensation insurance.

Although it is clear that a more coordinated and comprehensive database system is desirable, how this is to be achieved is somewhat less clear. An interface of information now contained in some of the diverse databases has already begun and this effort should continue. For example, AISG has expended its property loss database and plans to have it interface with The Index System to provide comprehensive claims searching.

A comprehensive system (for all companies and all claims), would access reports on all incoming claims, as a standard component of claims processing. It is important to have this information reported as soon as claims are filed. In this way, when an insurer begins to process a claim, it can check to see if any duplicate claims have been filed recently with other companies. Filing more than one claim with different insurers is one tactic occasionally employed in insurance fraud scams. Current databases allow for this kind of checking claims filed for the same type of insurance, but do not allow for checking across all lines of insurance. Current AISG databases allow for checking across property/casualty lines but do not allow access to life/health systems. After a claim has been closed, additional information could be reported, especially for claims identified as fraudulent. The form and content of the information to be reported will need to be determined (for example, a past claims history of the claimant, names of third parties, a brief description of the fraudulent scheme, and a list of key words). Specialized information in specific topic areas could be developed into subsets that would be linked to and coordinate through the comprehensive (all-company, all-claim) System. The specialized databases could also be linked to many of the existing databases (such as those on automobile histories, comprehensive automobile losses, or bodily injuries), as appropriate. A comprehensive system would need to be based on the existing separate databases. An analogy - imperfect as are most analogies - would be with the NEXIS system of databases run by Mead Data Central. The NEXIS system consists of many separate databases, such as the full text of magazines like Forbes and Fortune, but with a common form of access. In this system, a user can choose to search individual databases, a select group of databases or the whole group of databases.

There are many advantages to having an all-company, all-claim system. First, all claims could be immediately available for on-line claim processing checks. Second, immunity issues may not be a major consideration if standardized data forms were filled out and submitted for all incoming claims, rather than only "suspect" claims. Moreover, a great deal of potentially useful information is not collected when reporting is limited to "suspect" claims, and monitoring and enforcing compliance becomes much more difficult

since no standards exist for determining whether a claim should be identified as "suspect." Third, having a single parent claim system (with specialized databases) would simplify the reporting process and make reporting less onerous. To make such a system maximally effective, all companies should have computerized claim processing systems. Fourth, databases having information on both legitimate and fraudulent claims would be highly useful for developing a better system of indicators (both legitimate and "red flag" indicators) that can serve as a basis for developing computerized assessments of in-coming claims with respect to their level of "uncertain" or "inconclusive" legitimacy to help determine whether further investigation is warranted. Fifth, on the basis of the additional information collected upon the disposition of claims, an investigative database can begin to be developed. Several interviewees suggested that an investigative database would be very useful in producing intelligence reports and identifying useful techniques for investigating and proving fraud.

A comprehensive, coordinated system of databases is one of the most important tools in detecting and investigating fraud. Eventually, as database resources become more sophisticated, both the need to employ obtrusive (potentially confrontational) tactics in questioning claimants and the time required to investigate claims should be significantly reduced. There should also be an effort to ensure that reporting requirements mandated by state fraud bureaus are coordinated with and facilitated by this system. Currently, AISG databases are available to bureaus in 20 states and can be made available to all states.

Recommendations

(a) A comprehensive (all-company, all-claims) database system should be initiated by a leading industry service organization. Existing databases, like those run by the American Insurance Services Group, could form the basis for the comprehensive system. In developing a comprehensive system, special care should be devoted to issues of consumer privacy and accuracy.

(b) Where cost effective, databases could be expended to include information on the disposition of claims, especially when some element of fraud is involved.

(c) Reporting requirements should not be overly burdensome and incentive systems to encourage thorough reporting should be considered.

(d) A computerized methodology (expert system) for processing claims and detecting "red flags" should be developed; eventually, more sophisticated methodologies need to be developed to determine the degree to which claims are

characterized as being of "uncertain" or "inconclusive" legitimacy.

D. MODEL LEGISLATION

The National Association of Insurance Commissioners has continued to advocate the enactment of Model Fraud Legislation by states. The model bills proposed by the NAIC were developed via consensus approach and ratified by insurance commissioners in all states and territories. The proposed legislation addresses the actual crime of insurance fraud and secondly, the concept of fraud units located in insurance divisions.

1. NAIC Model Insurance Fraud Statute

Table of Contents

Section 1. Scope

Any person who, with the intent to injure, defraud, or deceive any insurance company:

(A) Presents or causes to be presented to any insurer, any written or oral statement including computer-generated documents as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; or

(b) Assists, abets, solicits, or conspires with another to prepare or make any written or oral statement that is intended to be presented to any insurance company in connection with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

Is guilty of a felony and shall be subjected to a term of imprisonment not to exceed five (5) years, or a fine not to exceed $5,000, or both, on each count.

Section 2. Warning on Policy Label

All claims forms shall contain a statement that clearly states in substance the following: "Any person who knowingly, and with intent

to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony." The lack of such a statement shall not constitute a defense against prosecution under this section.

Section 3. Definition of Statement

For the purposes of this Section, "statement" includes, but is not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, x-rays, test result or other evidence of loss, injury or expense.

2. States in Compliance with Statute

Compliance as of October 1991

NAIC MEMBER	MODEL/SIMILAR LEGIS	RELATED LEGIS./REGS.
Alabama		NO ACTION TO DATE
Alaska		ALASKA STAT. § 21.36.360 (1984).
Arizona		ARIZ. REV. STAT. ANN. § 20-458 (1981).
Arkansas		ARK. STAT. ANN. § 23-66-301 (1959).
California		CAL. INS. CODE §§ 1871 to 1871.4 (1990/1991)
Colorado	NO ACTION TO DATE	
Connecticut		CONN. GEN. STAT. §§ 53-440, 53-443 (1987) (Health Care False Claims Act).
Delaware	DEL. CODE ANN. TIT. 11 § 913 (1983).	
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. § 626.9541(1)(u) (1982/1985).

Georgia		GA. CODE ANN. § 33-1-9 (1960).
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho	IDAHO CODE §§ 41-1325, 41-1331 (1982)	See also IDAHO CODE § 41-250 (1981).
Illinois	NO ACTION TO DATE	
Indiana	NO ACTION TO DATE	
North Dakota	NO ACTION TO DATE	
Ohio	NO ACTION TO DATE	
Oklahoma		OKLA. STAT. TIT. 21 § 1662 (1971).
Oregon	NO ACTION TO DATE	
Pennsylvania		PA. STAT. ANN. TIT. 40 §§ 3-901 to 3-902 (1921/1978) (Misdemeanor offense).
Puerto Rico	NO ACTION TO DATE	
Rhode Island	NO ACTION TO DATE	
South Carolina	S.C. CODE ANN. § 38-43-245 (1988)	S.C. CODE ANN. § 38-55-170 (1988).
South Dakota	NO ACTION TO DATE	
Tennessee	NO ACTION TO DATE	
Texas	NO ACTION TO DATE	
Utah	NO ACTION TO DATE	
Vermont	NO ACTION TO DATE	
Virgin Islands	NO ACTION TO DATE	
Washington	NO ACTION TO DATE	
West Virginia	NO ACTION TO DATE	
Wisconsin	NO ACTION TO DATE	
Wyoming	NO ACTION TO DATE	

3. Model Legislation Creating Fraud Unit in Insurance Division

Model Legislation Creating a Fraud Unit in a State Department of Insurance

Table of Contents

Section 1. Purpose.

There is created within the Department of Insurance a Division of Insurance Fraud.[1] The Division, if, by its own inquiries or as a result of complaints, has reason to believe that a person has engaged in, or is engaging in, an act or practice that violates the Insurance Fraud Statute or any other provision of the Insurance Code, may administer oaths and affirmations, serve subpoenas ordering the attendance of witnesses, and collect evidence.

Section 2. Examining Materials Located Out of State.

If matter that the Division seeks to obtain by request is located outside the State, the person so requested may make it available to the Division or its representative to examine the matter at the place where it is located. The Division may designate representatives, including officials of the State in which the matter is located, to inspect the matter on its behalf, and it may respond to similar requests from officials of other states.

Section 3. Confidentiality of Evidence.

The Division's papers, documents, reports, or evidence relative to the subject of an investigation under this Section shall not be subject to public inspection for so long as the Division seems reasonably necessary to complete the investigation, to protect the person investigated from unwarranted injury, or to be in the public interest. Further, such papers, documents, reports, or evidence

---

[1] Maryland has created a fraud bureau by Executive Order which differs from this concept. Executive Order is appended as Attachment B.

relative to the subject of an investigation under this Section shall not be subject to subpoena until opened for public inspection by the Division, unless the Division consents, or until after notice to the Division and a hearing, the court determines the Division would not be unnecessarily hindered by such subpoena. Division investigators shall not be subject to subpoena in civil actions by any court of this State to testify concerning any matter of which they have knowledge pursuant to a pending insurance fraud investigation by the Division.

Section 4. Duties of Companies.

Any company which believes that a fraudulent claim is being made shall, within 60 days of the receipt of such notice, send to the Division of Insurance Fraud, on a form prescribed the Divisions, the information requested and such additional information relative to the claim and the parties claiming loss or damages because of the accident as the Division may require. The Division of Insurance Fraud shall review such reports and select such claims as, in its judgement, may require further investigation. It shall then cause an independent examination of the facts surrounding such claim to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim. The Division of Insurance Fraud shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and prosecutive authority having jurisdiction with respect to any such violation.

Section 5. Civil Immunity.

No insurer, employees or agents of any insurer, or any other person acting without malice, shall be subject to civil liability for libel or otherwise by virtue of the filing of reports or furnishing other information required by this section or required by the Division of Insurance Fraud as a result of the authority herein granted.

Section 6. Funding.

All costs of administration and operation of said Division of Insurance Fraud shall be borne by the General Revenue Fund of the State, and any monies, or other property which is awarded to the Division as costs of investigation, or as a fine, shall be credited to the General Revenue Fund.

Section 7. Peace Officer Status.

Division investigators shall have the power to make arrests for criminal violations established as a result of their investigations. The General Laws applicable to arrest by peace officers of this State shall also be applicable to such investigators. Such investigators shall have the power to execute

arrest warrants and search warrants for the same criminal violations, serve subpoenas issued for the examination, investigation, and trial of all offenses determined by their investigations, and arrest upon probable cause without warrant any person found in the act of violating any of the provisions of applicable laws.[2]

Section 8. Unlawful to Resist Arrest.

It is unlawful for any person to resist an arrest authorized by this Section or in any manner to interfere, either by abetting or assisting such resistance or otherwise interfering, with Division investigators in the duties imposed upon them by law or Department regulation.

The committee further concluded that, in addition to model legislation providing remedies for the act of insurance fraud and legislation providing for the implementation and conduct of anti-fraud bureaus, a model false claim act would endeavor to curtail a criminal act by allowing the state and interested parties to recover both civilly and criminally. Committee member, David A. Titman, a former Assistant U.S. Attorney, now in private practice, crafted the following draft act which is based in part upon the Federal False Claim Act (31 USC 3729 et seq.).

Section 1 Definitions

(a) **Knowing and knowingly** - For purposes of this act, the terms "knowing" and "knowingly" mean that a person, with respect to information:

(1) has actual knowledge of the information;

(2) acts in deliberate ignorance of the truth or falsity of the information; or

(3) acts in reckless disregard of the truth or falsity of the information, and no proof of specific intent to defraud is required.

(b) **Claim** - For purposes of this act, "claim" includes any request or demand, whether under a contract or otherwise, for money or property which is made to a contractor, grantee, or other recipient

---

[2] This would require investigators to sucessfully complete Maryland Police training commission requirements for peace officers. Maryland's current Insurance Fraud Bureau is comprised of Maryland State Police Officers, assisted by Insurance Division personnel and Attorneys General. The Committee has concerns with investigators, other than Police Officers, having the authority to affect arrests.

if the State of Maryland, or enterprize, provides any portion of the money or property which is requested or demanded, or if the State will reimburse such contractor, grantee, or other recipient for any portion of the money or property which is requested or demanded.

(c) **Enterprise** - For purposes of this act, "enterprise" means any insurance company incorporated under the laws of the State of Maryland, or authorized to do business in the State of Maryland.

Section 2 A person is liable to the State of Maryland for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the State, or enterprise, sustains because of the act of that person who:

(a) knowingly presents, or causes to be presented, to an officer or employee of the State of Maryland, or other enterprise, a false or fraudulent claim for payment or approval;

(b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the State of Maryland, or other enterprise;

(c) conspires to defraud the State of Maryland, or other enterprise, by getting a false or fraudulent claim allowed or paid.

(d) has possession, custody, or control of property or money used, or to be used, by the State of Maryland, or other enterprise, and, intending to defraud the State, or other enterprise, or willfully to conceal the property, delivers, or causes to be delivered, less property than the amount for which the person receives a certificate or receipt; or

(e) knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the State, or enterprise.

Section 3 Civil Actions for false claims

(a) Responsibilities of the Attorney General - The Attorney General diligently shall investigate a violation under Section 2. If the Attorney General finds that a person has violated or is violating Section 2, the Attorney General may bring a civil action under the section against the person.

(b) Actions by private persons -

(1) A person may bring a civil action for a violation of Section 2 for the person and for the State of Maryland. The action shall be brought in the name of the State. The action may be dismissed only if the court and the Attorney General give written consent to the dismissal and their reasons for consenting.

(2) A copy of the complaint and written disclosure of substantially all material evidence and information the person possesses shall be served on the State. The complaint shall be filed in camera, shall remain under seal for at least 60 days, and shall not be served on the defendant until the court so orders. The State may elect to intervene and proceed with the action within 60 days after it receives both the complaint and the material evidence and information.

(3) The State may, for good cause shown, move the court for extensions of the time during which the complaint remains under seal under paragraph (2). Any such motions may be supported by affidavits or other submissions in camera. The defendant shall not be required to respond to any complaint filed under this section until 30 days after the complaint is unsealed and served upon the defendant pursuant to the Maryland Rules.

(4) Before the expiration of the 60-day period or any extensions obtained under paragraph (3), the State shall:

(A) proceed with the action, in which case the action shall be conducted by the State; or

(B) notify the court that it declines to take over the action, in which case the person bringing the action shall have the right to conduct the action.

(5) When a person brings an action under this section, no person other than the State may intervene or bring a related action based on the facts underlying the pending action.

(c) Rights of the parties to Qui Tam actions -

(1) If the State proceeds with the action, it shall have the primary responsibility for prosecuting the action, and shall not be bound by an act of the person bringing the action. Such person shall have the right to continue as a party to the action, subject to the limitations set forth in paragraph (2).

(2)(A) The State may move to dismiss the action notwithstanding the objections of the person initiating the action if the person has been notified by the State of the filing of the motion and the court has provided the person with an opportunity for a hearing on the motion, and the court finds good cause for the granting of the motion.

(B) The State may settle the action with the defendant notwithstanding the objections of the person initiating the action if the court determines, after a hearing, that the proposed settlement is fair, adequate, and reasonable under all the circumstances. Upon a showing of good cause, such hearing may be held in camera.

(C) Upon a showing by the State that unrestricted participation during the course of the litigation by the person initiating the action would interfere with or unduly delay the State's prosecution of the cause, or would be repetitious, irrelevant, or for purposes of harassment, the court may, in its discretion, impose limitations on the person's participation, such as:

i) limiting the number of witnesses the person may call;

ii) limiting the length of the testimony of such witnesses;

iii) limiting the person's cross-examination of witnesses; or

iv) otherwise limiting the participation by the person in the litigation.

(D) Upon a showing by the defendant that unrestricted participation during the course of the litigation by the person initiating the action would be for purposes of harassment or would cause the defendant undue burden or unnecessary expenses, the court may limit the participation by the person in the litigation.

(3) If the State elects not to proceed with the action, the person who initiated the action shall have the right to conduct the action. If the State so requests, it shall be served with copies of all pleadings filed in the action and shall be supplied with copies of all deposition transcripts (at the State's expense). When a person proceeds with the action, the court, without limiting the status and right of the person initiating the action, may nevertheless permit the State to intervene at a later date upon a showing of good cause.

(4) Whether or not the State proceeds with the action, upon a showing by the State that certain actions of discovery by the person initiating the action would interfere with the State's investigation or prosecution of a criminal or civil matter arising out of the same facts, the court may stay such discovery for a period of not more than 60 days. Such a showing shall be conducted in camera. The court may extend the 60-day period upon a further showing in camera that the State has pursued the criminal or civil investigation or proceedings with reasonable diligence and any proposed discovery in the civil action will interfere with the ongoing criminal or civil investigation or proceedings.

(d) Award to Qui Tam Plaintiff -

(1) If the State proceeds with an action brought by a person under subsection (b), such person shall, subject to the second sentence of this paragraph, receive at least 15% but not more than 25 percent of the proceeds of the action or settlement of the claim

depending upon the extent to which the person substantially contributed to the prosecution of the action. Where the action is one which the court finds to be based primarily on disclosures of specific information (other than information provided by the person bringing the action) relating to allegations or transactions in a criminal, civil, or administrative hearing, in a legislative, administrative, or State report, hearing, audit, or investigation, or from the news media, the court may award such sums as it considers appropriate, but in no case more than 10 percent of the proceeds, taking into account the significance of the information and the role of the person bringing the action in advancing the case to litigation. Any payment to a person under the first or second sentence of the paragraph shall be made from the proceeds. Any such person shall also receive an amount for reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and cost. All such expenses, fees, and cost shall be awarded against the defendant.

(2) If the State does not proceed with an action under this section, the person bringing the action or settling the claim shall receive an amount which the court decides is reasonable for collecting the civil penalty and damages. The amount shall be not less than 25 percent and not more than 30 percent of the proceeds of the action or settlement and shall be paid out of such proceeds. Such person shall also receive an amount of reasonable expenses which the court finds to have been necessarily incurred, plus reasonable attorneys' fees and costs. All such expenses, fees, and costs shall be awarded against the defendant.

(3) Whether or not the State proceeds with the action, if the court finds that the action was brought by a person who planned and initiated the violation of Section 2 upon which the action was brought, then the court may, to the extent the court considers appropriate, reduce the share of the proceeds of the action which the person would otherwise receive under paragraph (1) or (2) of this subsection, taking into account the role of that person in advancing the case to litigation and any relevant circumstances pertaining to the violation. If the person bringing the action is convicted of criminal conduct arising from his or her role in the violation of Section 2, that person shall be dismissed from the civil action and shall not receive any share of the proceeds of the action. Such dismissal shall not prejudice the right of the State to continue the action, represented by the Office of the Attorney General.

(4) If the State does not proceed with the action and the person bringing the action conducts the action, the court may award to the defendant its reasonable attorney's fees and expenses if the defendant prevails in the action and the court finds that the claim of the persons bringing the action was clearly frivolous, clearly vexatious, or brought primarily for purposes of harassment.

(e) Certain actions barred -

(1) In no event may a person bring an action under subsection (b) which is based upon allegations or transactions which are the subject of a civil suit or an administrative civil money penalty proceeding in which the State is already a party.

(2)(A) No court shall have jurisdiction over an action under this section based upon the public disclosure of allegations or transactions in a criminal, civil, or administrative hearing, in a legislative, administrative, or State Controller Office report, hearing, audit, or investigation, or from the news media, unless the action is brought by the Attorney General or the person bringing the action is an original source of the information.

(B) For purposes of this paragraph, "original source" means an individual who has direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the State before filing an action under this section which is based on the information.

(f) State not liable for certain expenses - The State is not liable for expenses which a person incurs in bringing an action under this section.

(g) Fees and expenses to prevailing defendant - In civil action brought under this section by the State shall be responsible for expenses the same as a person in section (d) (4).

(h) Employers retaliation - Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against in the terms and conditions of employment by his or her employer because of lawful acts done by the employee on behalf of the employee or others in furtherance of an action under this section, including investigation for, initiation of, testimony for, or assistance in an action filed or to be filed under this section, shall be entitle to all relief necessary to make the employee whole. Such relief shall include reinstatement with the same seniority status such employee would have had but for the discrimination, 2 times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation cost and reasonable attorney's fees.

Section 4 False Claims Procedure

(a) A civil action under Section 2 may not be brought:

(1) more than 3 years after the date on which the violation of Section 2 is committed, or

(2) more than 3 years after the date when facts material to the right of action are known or reasonable should have been known by the official of the State charges with responsibility to act in the circumstances, but in no event more than 10 years after the date on which the violation is committed, whichever occurs last.

(b) In any action brought under Section 2, the complainant shall be required to prove all essential elements of the cause of action, including damages, by a preponderance of the evidence.

(c) Notwithstanding any other provision of law, a final judgement rendered in favor of the State in any criminal proceeding charges fraud or false statements, whether upon a verdict after trial or upon a plea of guilty or nolo contendere, shall estop the defendant from denying the essential elements of the offense in any action which involves the same transaction as in the criminal proceeding and which is brought under Section 2.

Section 5 False Claims Jurisdiction

Actions under Section 2 - Any action under Section 2 may be brought in any county in which the defendant, or in the case of multiple defendants, any one defendant can be found, resides, transacts business, or in which any act proscribed by Section 2 occurred.

E. THE MARYLAND INSURANCE FRAUD STATUTE

Panel member Alan N. Gamse, a partner in the Baltimore law firm of Semmes, Bowen and Semmes was asked to prepare a legal brief outlining the genesis of the Maryland anti-fraud section of the Insurance code (Art. 48A, Section 233B) and the pro's and con's of the section. The following is an abbreviated version of Mr. Gamse's brief.

COMPLIANCE WITH INSURANCE ANTI FRAUD PLAN STATUTES

A. Introduction

The subject of insurance fraud was placed before the 1991 Session of the Maryland Legislature by the Governor's Commission on Insurance. That blue-ribbon body, which included representatives of the insurance industry, examined issues concerning solvency and antitrust as well as fraud. As a result of the report of the Governor's Commission, the Administration introduced SB 220 and HB 208. These proposals were considered and amended by the Legislature. Ultimately, HB 208 was enacted into law as Chapter 265, Laws of Maryland, 1991.

While the provisions of HB 208 appear to be straightforward, they are truly fraught with danger for insurers seeking to comply with the various requirements therein. Although fighting

"insurance fraud" is viewed as a universal good, like supporting motherhood and apple pie, the efforts of the Maryland Legislature have been less than precise in defining insurance fraud or in explaining how to combat it. HB 208 cannot be ignored since it requires affirmative action by insurers. Compliance with the statute, as enacted, may, however, prove to be quite difficult.

HB 208 is essentially divided into two portions. The first portion, which became effective on July 1, 1991, requires the report to the "appropriate federal, state, or local law enforcement authorities" of situations where there is "probable cause to believe that insurance fraud . . . has been or is being committed." The second part requires insurers to promulgate, implement and maintain an antifraud plan by December 31, 1991.

B. The Historical Background of HB 208

When the Governor's Commission on Insurance considered the subject of insurance fraud, it did so in very broad fashion. The Commission looked at the financial impact of insurance fraud, the ability of the Maryland Insurance Division to investigate and prosecute such fraud and the antifraud efforts which needed to be implemented by insurers. The Commission recommended that the Insurance Division's authority to investigate non-licensees be clarified and that the Insurance Division be given sufficient financial resources to combat fraud by prosecution and by recordkeeping and maintenance of fraud-oriented data and statistics.

With respect to insurers, the Governor's Commission noted the reluctance of insurers to report fraud due to potential civil liability and recommended adoption of the immunity provision of the NAIC Fraud Unit Model Bill; the Commission specifically noted that 24 states had adopted such immunity statutes as of the time of the Report. The Commission also found that insurers should be required to certify that they had antifraud plans which would be available upon request from the Insurance Division and would be subject to review during market conduct examinations.

As initially introduced, HB 208 required the reporting of fraud by insurers when they had "reason to believe" that insurance fraud has been or is being committed. There was also a broad immunity provision which granted insurers immunity from civil actions so long as there was no "malice, fraudulent intent, or bad faith." The insurance industry strongly supported the legislation, and industry testimony before legislative committees emphasized the need for immunity provisions to remain in the proposals.

SB 220 passed the Senate with several minor amendments and with one major change: the immunity provision was deleted. Subsequently, the House of Delegates considered both HB 208 as

introduced and SB 220 as amended. The Administration supported the retention of the immunity provisions, but, unfortunately, the House deleted the specific grant of immunity and merely added a preamble that indicated the intention not to change any currently existing civil immunities.

The House made an additional, very significant change in HB 208. It amended the standard for reporting insurance fraud from "reason to believe ..." to a more rigorous, but conceptually vague, standard of "probable cause to believe. . . ." The combination of these amendments makes compliance with HB 208 in Maryland much more difficult than compliance with similar legislation enacted in other states which follows the NAIC Model Act.

C. The probable Cause Standard

As HB 208 was originally introduced, the standard for reporting incidents of insurance fraud was "reason to believe;" this standard was revised by the Legislature to the more rigorous "probable cause to believe." In the context of criminal law, probable cause connotes the accumulation of sufficient facts to meet a burden of proof as determined by judicial authority. Prosecutors who are expert in such matters prepare a case for submission to a grand jury or to a judge, but it is the judicial authority that makes the determination as respects whether or not probable cause exists in the specific factual situation.

The concept of "probable cause" as used in the context of HB 208 creates a difficult situation for insurers. When experienced prosecutors are regularly being told by judicial authorities that probable cause does not exist with respect to prosecutorial actions which they have undertaken, insurers or their claims representatives, agents or counsel cannot be expected to make such a determination. The stakes are raised considerably, of course, where a wrong guess by the insurer or its representative could result in a legal action for damages based upon malicious prosecution, defamation or other tortious theories.

The scenario is even worse when an "appropriate" law enforcement authority may not recognize the existence of probable cause due to extraneous factors such as overwork or unwillingness to undertake prosecution of a complex, white-collar criminal action. The potential for prosecutorial refusal to act on reports of alleged insurance fraud is particularly high in today's economic climate where severe, arbitrary budget cuts have impaired the staffing and functional abilities of police, prosecutors and courts. Where there is difficultly in finding the necessary resources to prosecute "simple" offenses such as drug crimes and robbery, insurance fraud may be a very low priority on the law enforcement totem pole. The most likely result of prosecutorial reluctance to pursue reported allegations of insurance fraud is that the prosecutor will try to save face by denying the existence

of probable cause for further action, thus setting up the fraud suspect's civil action.

D. Immunity

The original form of HB 208 included a specific immunity provision afforded in connection with reporting perceived instances of insurance fraud to law enforcement authorities. This was deleted from the bill and replaced with a rather nebulous preamble that declares that reporting of insurance fraud should not entitle the reporter to any immunities other than those generally found in existing law. The deletion reduces any protection to insurers to a vague qualified immunity which must ultimately be determined by a jury or other finder of fact.

At first blush, the Attorney General's opinion concerning immunity seems to indicate that the existing common law qualified immunity is almost as broad as the proposed, but rejected, statutory immunity. The Assistant Attorney General may be opining from an "ivory tower," however. In the context of an adversarial proceeding before a jury, the jury may well find that a report of alleged fraudulent activity resulted from efforts to save the insurer's money or to avoid paying a loss that jury believes should have been paid rather than from the insurer's efforts to see a criminal brought to justice. In practice, insurers will always be subject to charges of maintaining another agenda and the existence of immunity will probably be a jury question. Thus, insurers defending malicious prosecution or defamation suits arising from efforts to prosecute insurance fraud will be required to assume the burden of their own defense costs even if a finding of immunity ultimately brings a defense verdict.

E. The Regulatory Scope of HB 208

The Governor's Commission on Insurance noted that there was a question concerning the regulatory authority of the Insurance Commissioner to investigate and take action with respect to insurance fraud promulgated by persons who were not subject to licensure by the Insurance Division. New §25 (1)(b) of the Insurance Code, clearly specifies that the Commissioner can investigate "any complaint alleging that a fraudulent claim has been submitted to an insurer." This should cure any real or apparent jurisdiction problem with respect to claims fraud.

There has been some confusion among insurers concerning the scope of the applicability of HB 208. § 233B(a)(1) specifies that the fraud reporting and antifraud plan requirements apply to "an authorized insurer." §7 of the Maryland Insurance Code, clearly and unambiguously defines an "authorized" insurer as "one duly authorized, by subsisting certificate of authority issued by the (Maryland Insurance) Commissioner, to engage in the insurance business in this State." Thus, the fraud reporting and antifraud

plan requirements apply to all insurers, including surety, life and health; it is not limited to motor vehicle insurers as is the case with the Pennsylvania fraud legislation.

Another problem with the legislation is the use of vague, generic terminology which is not defined elsewhere in the law. "Insurance fraud," for instance, is not explained or defined except for the reference in §233B(b)(3)(i) that it includes "internal fraud,", "misrepresentations on applications" and "claims fraud." These are not defined further, and the outer bounds of insurance fraud are not specified. Similarly, there is no guidance or direction to help insurers identify "appropriate law enforcement authority." Other undefined issues include determining what comprises "probable cause," determining whether there is a difference between "civil insurance fraud" and "criminal insurance fraud" and, if there is, determining whether the reporting requirements apply to both.

An interesting and unresolved question regarding the scope of HB 208 arises from the practice of many insurers to contract out underwriting and/or claims responsibilities to outside service organizations. §233B(a)(1) provides that the fraud reporting requirements run to "an authorized insurer, its employees, producers . . . or agents." Although the term "agent" usually designates a person licensed as an agent under Subtitle 11 of the Maryland Insurance Code, it is possible, and perhaps likely, that the Legislature intended the use of the term "agent" in the fraud reporting context to be interpreted as that term is defined in the law of agency. An outside adjusting service which functions in lieu of the claims department of an insurer is probably included within the scope of §233B(a)(1) as an "agent" of the insurer; indeed, failure to include the outside adjusting service would leave a rather large gap in what is intended to be a broad antifraud effort. Thus, prudence dictates that an antifraud plan developed by an insurer functioning in such a manner should treat the outside provider of claims services as if it were an integral part of the insurer's claim department. Similar considerations would seem to apply for insurers utilizing outside underwriting managers with respect to specific kinds or lines of business.

F. Pitfalls in the Promulgation of an Antifraud Plan

The duty to report perceived instances of insurance fraud is considerably complicated by the second portion of HB 208, which requires that an anti-fraud plan be promulgated and in place before December 31, 1991. The antifraud plan must contain specific provisions and protocols relating to the prevention and reporting of insurance fraud. According to personnel at the Maryland Insurance Division, compliance with the antifraud plan requirement will be focused upon during the course of market conduct examinations by the Maryland Insurance Commissioner's Office. Presumably, the market conduct examinations will check for both the

promulgation of a plan and its proper implementation. Failure to properly promulgate or implement a plan can lead to severe statutory penalties.

The interrelationship between the two sections of HB 208 immediately creates a difficult position for an unwary insurer seeking to be in full compliance with the law. On the one hand, insurers may promulgate antifraud plans with broad reach and noble purpose. Then, faced with vague and limited immunity for making reports to law enforcement officials, they may disregard the reporting requirements of their own plans. Another pitfall may be an insurer's adoption in Maryland of an antifraud plan prepared for use in another state which has different standards for content, reporting and immunities; this, too, could lead both to non-compliance penalties and civil liability in the Maryland situation.

G. Contents of an Antifraud Plan

The requirements for the contents of an insurance antifraud plan are specified in §233B(b)(3). Basically, the requirements are that protocols be established which will (i) prevent insurance fraud; (ii) establish reporting requirements; (iii) provide for cooperation with prosecutorial authorities; and (iv) provide for reporting of fraud-related data to the Insurance Commissioner.

In reality, insurance fraud is hard to identify. Claims representatives, underwriters, inside and outside counsel and agents must be "sensitized" to identify the existence of factors which could evidence the possibility of insurance fraud. Insurers will probably be best circumstanced, however, if responsibility for insurance fraud investigation and reporting is placed in the hands of a small number of well-trained personnel.[3] Thus, an antifraud protocol might contain checklists of identifying factors which might serve as triggers to line employees for an internal report of a potential insurance fraud situation. Some of these lists may be directed towards particular types of insurance fraud, such as arson or motor vehicle claims fraud; underwriters and claims personnel will be particularly helpful in creating such

---

[3] The proper training and supervision of investigatory personnel is crucial, and knowledgeable Maryland counsel must be consulted with respect to permissible investigatory techniques. For instance, the broad scope of the Maryland Wiretap Law prescribes criminal sanctions for recording a telephone conversation without consent. Thus, an overly zealous claims representative or investigator could face criminal charges when an unauthorized tape recording is presented to "appropriate" law enforcement authorities as proof of suspected insurance fraud. The constantly evolving law concerning the proper bounds of video surveillance presents another area where consultation with and review by Maryland counsel would be wise.

lists. Other lists might be developed with the assistance of an insurer's outside auditors for the purpose of detecting internal fraud, such as theft of claims drafts or other accounting or computer-type frauds.

Once a possible fraudulent situation has surfaced, the protocol should provide for a thorough internal investigation and for consultation with counsel to determine whether counsel believes a "probable cause" standard has been met and, if so, to identify where the report should be made.[5] Independent counsel may also help to distinguish the overly suspicious theories of a too zealous claims representative from situations where probable insurance fraud really does exist.[6]

An antifraud plan protocol should provide for maintenance of an internal log of potential insurance fraud situations and an indication of the resolution of each situation; maintenance of such logs will show the Insurance Division's examiners that the antifraud plan is actually being implemented when the mandatory examinations under §233B(d)(5) are made. The log will also serve as the basis for the periodic reports of "fraud-related data" to the Insurance Commissioner as required by §233B(b)(3)(iv).[7]

---

[5] Obviously, not all types of "insurance fraud" warrant reporting to law enforcement authorities. For example, efforts to collect a collision deductible as a part of an inflated bill from a body shop are attempted insurance fraud, but criminal prosecution is unlikely. Similarly, life insurers find that misrepresentation cases comprise a large portion of their resisted claims, but it is also unlikely that prosecutors are going to be willing to remove such conflicts from a civil forum.

[6] Insurers must not let their antifraud efforts become "the tail that wags the dog." Maryland and other states have passed Unfair Claims Settlement Practices Acts and supporting regulations. See, e.g., §230A of the Maryland Insurance Code; COMAR 09.30.76.01, et. seq. These statutes and regulations limit the timeframe available for adjustment of losses. Those persons charged with ferreting out and reporting suspected insurance fraud must, therefore, act with reasonable promptness and must coordinate their actions with the Unfair Claims Settlement Practices Act requirements.

[7] Conversations with personnel at the Maryland Insurance Division indicate that the protocol should provide this fraud-related data to the Insurance Commissioner in generic, statistical form. The Commissioner does not expect to receive detailed descriptions of specific situations with the participating parties identified.

H. Conclusion

The Maryland Insurance Fraud statute is a fact of life for insurers and requires prompt affirmative action. There are now statutory obligations on members of the insurance community to report suspected fraud, and the mandated antifraud plans must set forth protocols for doing so. Moreover, regulatory examinations will review compliance with these plans. Thus, insurers' antifraud plans must be carefully developed, and the personnel responsible for implementation must be knowledgeable, experienced and conscientious. Due to the manifold uncertainties of the law and the potential for civil actions to be brought against insurers due to the vague status of immunity, the active involvement of independent counsel is also strongly recommended.

F. THE MARYLAND EXPERIENCE

A specified issue the Committee felt compelled to address was the extent of losses incurred within the parameters of Maryland during a calendar year. To the best of the collective knowledge of the Committee, this figure had never been determined. In order to address the question, it was decided that a survey instrument, would be sent to the insurer domiciled in the state. The instrument was constructed to be unscientific as a research questionnaire, however, its sole purpose was to gather general data and feedback from the insurance companies concerning their specific anti-fraud experience. (Refer to Attachment A.) Of the 82 domestic companies surveyed, 56 or 68% responded. Since the survey was considered informative in scope as opposed to scientific, the Committee agreed to utilize the respondent number as a representative sampling. Responding company size range from the top one third in premium volume, the middle one third in premium volume to, lastly, the bottom one third in premium volume.

The statistical and analytical conclusions of the survey were as follows:

SURVEY ON FRAUD DETECTION AND PROSECUTION

STATISTICAL CONCLUSIONS

1. 10 companies (18% of respondents) have a special investigation unit, 19 companies (34%) use a private contractor and 36 companies (64%) have a claims/legal unit. (Refer to Graph #1.)

2. 17 companies (30% of respondents) use a commercial indexing bureau; the most frequently mentioned were the ASIG Index System, PILR and NICB. (Refer to Graph #2.)

3. 34 companies (61% of respondents) provide anti-fraud training. Virtually all of the training is done "in-house" through memos, committee meetings and training manuals from the NICB; only 3 companies used outside contractors to provide such training. (Refer to Graph #3.)

4. Only 5 companies (9% of respondents) have a published anti-fraud telephone number. (Refer to Graph #4.)

5. 38 companies (68% of respondents) indicated that lack of immunity from wrongful intervention was a hindrance to or prevented the investigation of possible fraudulent claims. 22 of the companies which indicated this problem specifically stated that, without immunity, the costs, risks and liabilities associated with the investigation of possible fraud far outweighed any benefits to be gained from successful intervention and prosecution. (Refer to Graph #5.)

PROPERTY INSURANCE (OTHER THAN AUTOMOBILE)

21 companies provide this product; in 1991 they paid 89,353 claims totaling $266 million. The average estimate of fraudulent claims was over 6%; if accurate, that means more than $16 million in claims had some fraudulent aspects. One company dealing solely in Marine Property Insurance estimated that exaggerated claims by boat owners, marine repair facilities and adjusters occurred in almost 50% of its cases.

The 21 companies identified 1,749 specific claims where fraud was suspected. Of these, claims submitted by the 1st Party averaged $2,966, those submitted by a 3rd Party averaged $1,193 in size.

Of the 1,749 claims where fraud was suspected, only 166, or less than 10% were denied.

Of the 1,749 claims where fraud was suspected, only one (1) was prosecuted. - that's only 1/20 of 1% of all cases of suspected fraud for this type of insurance. (Refer to Graph #6.)

CASUALTY INSURANCE (OTHER THAN AUTOMOBILE)

25 companies provide this product; in 1991 they paid 13,906 claims totaling almost $196 million. The average estimate of fraudulent claims was just under 3%; if accurate, that means over $5 million in claims had some type of fraudulent activity.

The 25 companies identified 173 specific claims where some type of fraud was suspected. There is no average dollar value of fraudulent 1st Party claims, but for 3rd Party claims involving

suspected fraud, the average claim was $1,136.

Of the 173 claims possibly involving fraud, only 9 of 111 3rd party claims were denied; NONE were prosecuted. No 1st Party claims were denied or prosecuted. (Refer to Graph #7.)

HEALTH INSURANCE

13 companies stated they provided this product; they range in size from Blue Cross/Blue Shield of Maryland to Union Labor Life Insurance Company to United Healthcare Insurance Company. These companies paid almost 8 million health claims averaging $334 each, for a total of over $2.62 billion. BC/BS of Maryland alone had over 6 million claims averaging $160 each, for a total of over $960 million. Union Labor Life paid over 1 million claims averaging $192 each, for a total of over $202 million.

The 13 companies estimate that about 1-1/2% of all health claims involved fraud; that being the case, almost $39 million of claims paid involved some form of fraud. The BC/BS of Maryland believes fraud is far more prevalent among providers than among 1st Party claimants, by a factor of 4 to 1.

Only Bankers Independent Insurance Company was able to give the number of claims denied: 10 - 1st Party and 10 - Provider. BC/BS was certain there were some. Only BC/BS prosecuted any fraudulent claims, and won all 12 cases brought against 1st Party claimants. (Refer to Graph #8.)

LIFE INSURANCE

12 companies offer this product; the companies range in size from Fidelity and Guaranty to Maryland Southern Life Insurance Company. These companies paid 60,218 claims averaging $15,000 in size, for a total of over $900 million. Only one company, Fidelity and Guaranty Life Insurance Company, believed it had received any fraudulent claims, and even then perhaps only 1/10 of 1% of claims may have involved fraud. Of the almost 4,000 life insurance claims paid in 1991 by Fidelity and Guaranty Life, there were perhaps 3 involving fraud by the insured/beneficiary and perhaps 1 involving an agent. All 4 claims were denied. The average claim in these cases was $2,500. F&G prosecuted one case against an insured/beneficiary but was unsuccessful. (Refer to Graph #9.)

AUTOMOBILE INSURANCE

18 companies provide this product; among the largest are Government Employees Insurance Company and Blue Ridge Insurance

Company. The average estimate of the incidence of fraudulent claims was just over 9%, which means that over $18 million of claims involved fraud. Total automobile claims paid in 1991 was almost $200 million.

The 18 companies believe there were over 5,200 fraudulent claims in 1991, with almost half originating with 3rd Party claimants. In claims where fraud was suspected, the average claim from a 1st Party claimant was $1,323; the average claim from a 3rd party claimant was almost $2,500.

Of the 5,279 claims possibly involving fraud, only 310 1st Party claims were denied out of 1,214, and only 139 out of 2,495 possibly fraudulent 3rd Party claims were denied. None of the 1,570 possibly fraudulent provider claims was denied. In no cases were possibly fraudulent claims prosecuted. (Refer to Graph #10.)

TITLE AND SURETY

8 companies provide this product; they range in size from Chicago Title Insurance Company of Maryland to Fidelity and Deposit Company of Maryland to Atlantic Bonding Company. These companies paid 292 claims in 1991 totaling just over $2 million. The incidence of fraud is estimated to be about 1/10 of 1%.

Only one company, Security Title Guaranty, reported any cases of suspected fraud. Neither of the two cases had the claim denied, but the one case of suspected provider fraud for $250,000 was prosecuted, but unsuccessfully. (Refer to Graph #11.)

COMMENTS ON THE QUESTIONNAIRE

Several companies stated they had not collected or compiled data on fraud in 1991, and a few seemed upset that they were being asked for data now (late 1992) which they were not required to collect.

One company stated its belief that "if insurance is known to be available, doctors, attorneys and contractors take advantage of the insurance company".

Two companies reported that some of their estimates of percentages of claims involving fraud were based on anecdotal evidence; one reported its "data" was based on national figures and rates.

One company suggested a $1.00 annual surcharge per policy to fund a State Fraud Unit.

Upon reviewing the data compiled via the survey instrument, the Committee was concerned that the statistics, although collected as a representative sampling of Maryland domestics, were not representative of the actual Maryland experience, visa vis, a large book of business is maintained by foreign companies, especially in the area of personal lines. Therefore, the 1991 claims experience from the top fourteen property and casualty producers in Maryland, both domestic and foreign, was examined. As indicated from the following Graph (Graph 12) the application of generally accepted fraud and abuse percentages of 10% (low end) and 25% (high end) resulted in total slippage ranging from 147,535,239 (10%) to 368,838,096 (25%). These numbers are clearly unacceptable.

G. WORKERS' COMPENSATION

To the extent possible, given the limited scope of the sub-committee, Workers' Compensation fraud was explored. In 1992, approximately 96 million American workers are covered by Workers' Compensation insurance. Cost are spiraling upward from approximately 22.8 billion dollars per year in 1982 to an astronomical 62.0 billion dollars per year in 1992. In San Francisco in the past two years, the amount spent on claims has increased by an estimated 40%. In 1990-1991 fiscal year, 8223 claims were filed by the city's 25,000 person work force. In Philadelphia, the city's 6200 present and former employees received disability compensation totaling 86 million dollars annually at a cost to the taxpayers of 20 million per year or approximately 5.9% of the city's budget. Fraud and abuse of the system must be curtailed.

Jeffrey R. Schmieler of Saunders and Schmieler chaired the sub-committee on Workers' Compensation Fraud. Mr. Schmieler submitted the following:

By Chapter 800 of the Acts of 1914, Maryland joined most other states in enacting a workers' compensation law. The basic purpose of this legislation was to provide relief to the increasing numbers of workers in the rapidly expanding industrial society who were being injured in hazardous employments. These workers, and, in death cases, their dependents, often had no remedy to recover damages under the existing law because of such common law defenses as the fellow servant rule, contributory negligence and assumption of risk. The Legislature in the preamble declared its intent as follows: That all phases of extra-hazardous employments be, and they are hereby withdrawn from private controversy, and sure and certain relief for workers injured in extra-hazardous employments and their families and dependents are hereby provided for, regardless of questions of fault and to the exclusion of every other remedy, except as provided in this Act.

What is deemed absolutely essential is a major attack on Workers' Compensation Insurance Fraud consisting of a complete and thorough review, analysis and re-codification of the Maryland Workers' Compensation Statute as presently set forth in the Labor and Employment Section of the Maryland Annotated Code.

The Governor's Advisory Panel on Insurance Fraud has undertaken an exhaustive and broad spectrum effort to identify and combat insurance fraud in whatever form that it exists in the State of Maryland. While Workers' Compensation fraud shares common characteristics with other modalities of insurance fraud, it is unique and stands alone - separate and distinct - from other modalities of insurance fraud in one material respect - Workers' Compensation is entirely a creature of statute. In view of the fact that entitlement to Workers' Compensation benefits is purely a statutory right created by the Legislature and administered by the Executive Department of the State of Maryland - its abuses, and misuses are directly controllable by the State providing the State's program for Workers' Compensation is properly structured in the first instance (legislatively) as well as properly controlled and regulated (administratively) in the second instance.

In recognition of the fact that Workers' Compensation is entirely a creature of statute, given birth by the Legislature and given life by the Executive Department, it is axiomatic that the reduction or elimination of fraud, which can be found in many facets of the Maryland Workers' Compensation system, can only be achieved by the concerted action of a reformed minded legislature and the strong will of the Executive Department.

While the original concept of Workers' Compensation and the Workers' Compensation legislation was laudable social legislation, the abuses and misuses of the Workmens' Compensation system is a current crisis of high proportions and is a great and growing concern of Maryland employers and business interest which cries out for a crack-down on fraud and other factors which are rapidly driving up the costs of Workers' Compensation Insurance for Maryland employers.

Other areas of insurance fraud which are currently being analyzed by the Governor's Advisory Panel on Insurance Fraud are the result of external fraud perpetrated by claimants, third parties and providers in the personal injury and property tort recovery system as contrasted to Workers' Compensation fraud which is being perpetrated and advanced as part of the Workers' Compensation system committed by claimants, attorneys and health care providers and promulgated by a Workers' Compensation Statute in need of revision.

It therefore is recommended that rather than continuing the efforts of the Sub-Panel on Workers' Compensation Fraud, which will or may ultimately result in a "piecemeal" or "patchwork" series of

recommended proposals for specific legislative changes in the existing statute, that a major attack on Maryland Workman's Compensation fraud is necessary and the recommended modality is a thorough and comprehensive review and analysis of the existing Workers' Compensation review and analysis of the existing Workers' Compensation Statute followed by the revision of the Workmens' Compensation laws of the State of Maryland.

The Committee therefore recommends the Governor establish a blue ribbon commission to study the aspects of fraud attributable to Workers' Compensation and to recommended appropriate legislative modalities for correction of the abuses.

H. RECOMMENDATIONS

After careful consideration of all issues, the Committee has determined the following recommendations to be the most cogent:

1. A comprehensive insurance fraud section should be added to Article 48A, Annotated Code of Maryland (Insurance Code).

The section should contain a precise definition of insurance fraud, a definitive standard for determining probable cause to believe insurance fraud was committed, statutory immunity granted to insurance companies investigating and/or reporting suspected fraud pursuant to law and both felony and misdemeanor penalties and accompanying said penalties the latitude to impose severe fines.

2. A comprehensive false claims section should be incorporated into Article 48A, Annotated Code of Maryland (Insurance Code).

This section should provide for both civil remedies vis a vis the confiscation of assets and criminal remedies.

3. Insurance companies conducting business in Maryland should be required by law to report fraud related data to a bureau of choice.

4. Insurance companies conducting business in Maryland should be required by law to present anti-fraud related training to affected employees on an annual basis or more frequently as needed.

5. The State of Maryland should join with the private sector to develop and implement a comprehensive public education campaign targeting insurance fraud and its effects on the insurance industry and the consuming public.

6. The Governor should appoint a special commission to undertake a comprehensive study of fraud within the Workers' Compensation Commission.

7. Insurance companies doing business in Maryland should be required by law to conduct a visual inspection of property prior to issuing a policy of insurance. When insuring vehicles and vessels the condition should be recorded and VIN confirmed.

QUESTIONNAIRE

Directions:

Please print or type responses. All questions should be answered. Questions which require a numerical response may be rounded off to the most appropriate number.

1. My company utilizes the following investigative staff:

   A. SIU _____ (Number of Staff) _____
   B. Private Contractor _____
   C. Claims/Legal _____
   D. Other _____ (Please specify) _____

2. My company utilizes the services of a commercial indexing bureau. Yes _____ No _____

   If yes, please specify _____

   _____

3. My company provides anti-fraud training for its employees. Yes _____ No _____

   If yes, specify how training is accomplished, i.e., in-house, private contractor, etc. _____

   _____

4. My company has a published telephone line for reporting fraud. Yes _____ No _____

5. The issue of immunity from bad faith claims or potential suits alleging invasion of privacy is a consideration in my company's decision to pursue a possible fraudulent claim. Yes _____ No _____

   Comments: _____

   _____

   _____

   _____

This part of the questionnaire will deal with specific types of suspected fraud by product line encountered by your company during calendar year 1991. Please answer all questions as thoroughly as possible, specifying the type of suspected fraudulent claim and the number of each type encountered.

PROPERTY (other than automobile)

1. My company provides this product line. Yes _____
   No _____ (If no, please proceed to next page.)

2. Total claims paid in calendar year 1991. _____

3. Average cost of claim. _____

4. Percentage of total claims suspected fraudulent. _____

5. Type of suspected fraudulent claims encountered:

   A. 1st Party Claimant (Number) _____
   B. 3rd Party Claimant (Number) _____
   C. Provider (Number) _____

6. Average cost of suspected fraudulent claim by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

7. Number of suspected fraudulent claims denied by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

8. Number of suspected fraudulent claims prosecuted by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

9. Number of fraudulent claims prosecuted which resulted in a conviction:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

This part of the questionnaire will deal with specific types of suspected fraud by product line encountered by your company during calendar year 1991. Please answer all questions as thoroughly as possible, specifying the type of suspected fraudulent claim and the number of each type encountered.

CASUALTY (other than automobile)

1. My company provides this product line. Yes _____
   No _____ (If no, please proceed to next page.)

2. Total claims paid in calendar year 1991. _____

3. Average cost of claim. _____

4. Percentage of total claims suspected fraudulent. _____

5. Type of suspected fraudulent claims encountered:

   A. 1st Party Claimant (Number) _____
   B. 3rd Party Claimant (Number) _____
   C. Provider (Number) _____

6. Average cost of suspected fraudulent claim by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

7. Number of suspected fraudulent claims denied by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

8. Number of suspected fraudulent claims prosecuted by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

9. Number of fraudulent claims prosecuted which resulted in a conviction:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

This part of the questionnaire will deal with specific types of suspected fraud by product line encountered by your company during calendar year 1991. Please answer all questions as thoroughly as possible, specifying the type of suspected fraudulent claim and the number of each type encountered.

HEALTH

1. My company provides this product line. Yes _____
   No _____ (If no, please proceed to next page.)

2. Total claims paid in calendar year 1991. _____

3. Average cost of claim. _____

4. Percentage of total claims suspected fraudulent. _____

5. Type of suspected fraudulent claims encountered:

   A. 1st Party Claimant (Number) _____
   B. Provider (Number) _____

6. Average cost of suspected fraudulent claim by type:

   A. 1st Party Claimant _____
   B. Provider _____

7. Number of suspected fraudulent claims denied by type:

   A. 1st Party Claimant _____
   B. Provider _____

8. Number of suspected fraudulent claims prosecuted by type:

   A. 1st Party Claimant _____
   B. Provider _____

9. Number of fraudulent claims prosecuted which resulted in a conviction:

   A. 1st Party Claimant _____
   B. Provider _____

This part of the questionnaire will deal with specific types of suspected fraud by product line encountered by your company during calendar year 1991. Please answer all questions as thoroughly as possible, specifying the type of suspected fraudulent claim and the number of each type encountered.

LIFE

1. My company provides this product line. Yes _____
   No _____ (If no, please proceed to next page.)

2. Total claims paid in calendar year 1991. _____

3. Average cost of claim. _____

4. Percentage of total claims suspected fraudulent. _____

5. Type of suspected fraudulent claims encountered:

   A. Insured/Beneficiary (Number) _____ Define_____
   B. Agent (Number) _____

6. Average cost of suspected fraudulent claim by type:

   A. Insured/Beneficiary _____
   B. Agent _____

7. Number of suspected fraudulent claims denied by type:

   A. Insured/Beneficiary _____
   B. Agent _____

8. Number of suspected fraudulent claims prosecuted by type:

   A. Insured/Beneficiary _____
   B. Agent _____

9. Number of fraudulent claims prosecuted which resulted in a conviction:

   A. Insured/Beneficiary _____
   B. Agent _____

This part of the questionnaire will deal with specific types of suspected fraud by product line encountered by your company during calendar year 1991. Please answer all questions as thoroughly as possible, specifying the type of suspected fraudulent claim and the number of each type encountered.

AUTOMOBILE

1. My company provides this product line. Yes _____
   No _____ (If no, please proceed to next page.)

2. Total claims paid in calendar year 1991. _____

3. Average cost of claim. _____

4. Percentage of total claims suspected fraudulent. _____

5. Type of suspected fraudulent claims encountered:

   A. 1st Party Claimant (Number) _____
   B. 3rd Party Claimant (Number) _____
   C. Provider (Number) _____

6. Average cost of suspected fraudulent claim by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

7. Number of suspected fraudulent claims denied by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

8. Number of suspected fraudulent claims prosecuted by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

9. Number of fraudulent claims prosecuted which resulted in a conviction:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

This part of the questionnaire will deal with specific types of suspected fraud by product line encountered by your company during calendar year 1991. Please answer all questions as thoroughly as possible, specifying the type of suspected fraudulent claim and the number of each type encountered.

TITLE AND SURETY

1. My company provides this product line. Yes _____
   No _____ (If no, please proceed to next page.)

2. Total claims paid in calendar year 1991. _____

3. Average cost of claim. _____

4. Percentage of total claims suspected fraudulent. _____

5. Type of suspected fraudulent claims encountered:

   A. 1st Party Claimant (Number) _____
   B. 3rd Party Claimant (Number) _____
   C. Provider (Number) _____

6. Average cost of suspected fraudulent claim by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

7. Number of suspected fraudulent claims denied by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

8. Number of suspected fraudulent claims prosecuted by type:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

9. Number of fraudulent claims prosecuted which resulted in a conviction:

   A. 1st Party Claimant _____
   B. 3rd Party Claimant _____
   C. Provider _____

11. Comments: _____

_____

_____

_____

_____

Name of Person Completing Questionnaire _____

Title _____

Company Name _____

Address _____

Area Code and Telephone Number _____

Thank you for your cooperation!

ATTACHMENT B

The State of Maryland

Executive Department

EXECUTIVE ORDER
01.01.1992.24

Insurance Fraud Unit

WHEREAS, Insurance fraud is a growing and costly problem, with nationwide estimates of insurance fraud ranging from 5% to 25% of all claims made; and

WHEREAS, A fraud rate of only 5% in automobile insurance claims alone means that over $50 million is paid out in Maryland in fraudulent claims; and

WHEREAS, Independent studies have found that in a single state, Florida, over $350 million was paid out in a single year for fraudulent claims; and

WHEREAS, The General Accounting Office has found that unscrupulous health care providers cheat health insurance companies and programs out of billions of dollars annually; and

WHEREAS, Insurance fraud is a crime, and payments made for fraudulent claims contribute unnecessarily to increasing insurance premiums for all citizens; and

WHEREAS, Chapter 265 of the Acts of 1991, requires insurers to implement an insurance antifraud plan with procedures for preventing insurance fraud and for reporting insurance fraud and fraud-related data to appropriate authorities; and

WHEREAS, An Insurance Fraud Unit can assist insurers in their efforts to implement Chapter 265 of the Acts of 1991, and can supplement and complement the efforts of special investigative units currently operated by many insurers; and

WHEREAS, It is intended that persons providing information concerning insurance fraud to law enforcement officials, the Insurance Division, and the Insurance Fraud Unit should be entitled to any immunities from liability that currently exist in law;

NOW, THEREFORE, I, WILLIAM DONALD SCHAEFER, GOVERNOR OF THE STATE OF MARYLAND, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY THE CONSTITUTION AND LAWS OF MARYLAND, HEREBY PROCLAIM THE FOLLOWING EXECUTIVE ORDER, EFFECTIVE IMMEDIATELY:

A. Insurance Fraud Unit.

(1) There is established an Insurance Fraud Unit within the Department of Licensing and Regulation.

(2) The head of the Fraud Unit shall be the Administrator.

(3) The Administrator shall be appointed by the Governor, shall serve at the pleasure of the Governor, and shall be directly responsible to the Governor.

(4) The Insurance Fraud Unit shall be staffed by personnel from the Insurance Division, the Maryland State Police, and the Maryland Attorney General's Office.

(5) The Insurance Fraud Unit may accept funds, grants and services from public and private sources to carry out its duties and powers.

B. Responsibilities. The Insurance Fraud Unit shall:

(1) Investigate complaints, and where appropriate, prosecute suits and actions concerning fraudulent insurance acts, as defined in Article 48A of the Code and any other applicable provisions of law;

(2) Cooperate with and assist insurers, the Insurance Division, the Maryland State Police, the Attorney General's Office, the State's Attorney, the Federal Bureau of Investigation and other appropriate law enforcement authorities in the investigation and prosecution of fraudulent insurance acts;

(3) Operate a toll-free telephone number for the reporting of fraudulent insurance acts;

(4) Conduct public outreach and awareness programs on the costs of insurance fraud to the public;

(5) Maintain data and statistics relating to insurance fraud; and

(6) Report to the Governor by November 1 of each year on the work of the Fraud Unit and its progress in enforcing the provisions of this Executive Order and all relevant fraud related laws.

C. Prosecution. Pursuant to Article V, Section 3(a)(2) of the Maryland Constitution, the Attorney General is directed to investigate, commence and prosecute suits and actions involving fraudulent insurance acts, whether criminally or civilly, on the part

of the State of Maryland or in which the State may be interested. In such actions or suits, the Attorney General shall seek whatever civil damages or other relief are allowed by law.

D. Insurance Fraud Advisory Council.

(1) There is an Insurance Fraud Advisory Council.

(2) The Advisory Council shall consist of the following 9 members, appointed by the Governor:

(a) A representative of the Attorney General's Office, recommended by the Attorney General;

(b) A representative of the Maryland State Police, recommended by the Superintendent of State Police;

(c) A representative of the Insurance Division, recommended by the Insurance Commissioner;

(d) Three representatives of insurance companies doing business in Maryland, including both domestic and foreign insurers;

(e) A representative of professional insurance agents in Maryland; and

(f) Two representatives of the general public.

(3) The Governor shall appoint a chair for the Advisory Council from among its members.

(4) The term of a member is 3 years. A member may be reappointed at the end of a term. The terms of the members shall be staggered, so that one-third of the members will be appointed each year. All members serve at the pleasure of the Governor.

(5) The members of the Advisory Council may not receive any compensation for their services.

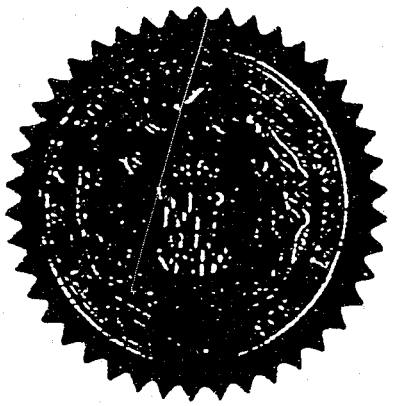
(6) The Advisory Council shall:

(a) advise and assist the Insurance Fraud Unit in implementing the provisions of this Executive Order;

(b) advise the Governor on matters relating to insurance fraud; and

(c) recommend to the Governor, on an annual basis, any changes to the operation of the Fraud Unit.

GIVEN Under My Hand and the Great Seal of the State of Maryland, in the City of Annapolis, this 13th day of November, 1992.



William Donald Schaefer
Governor

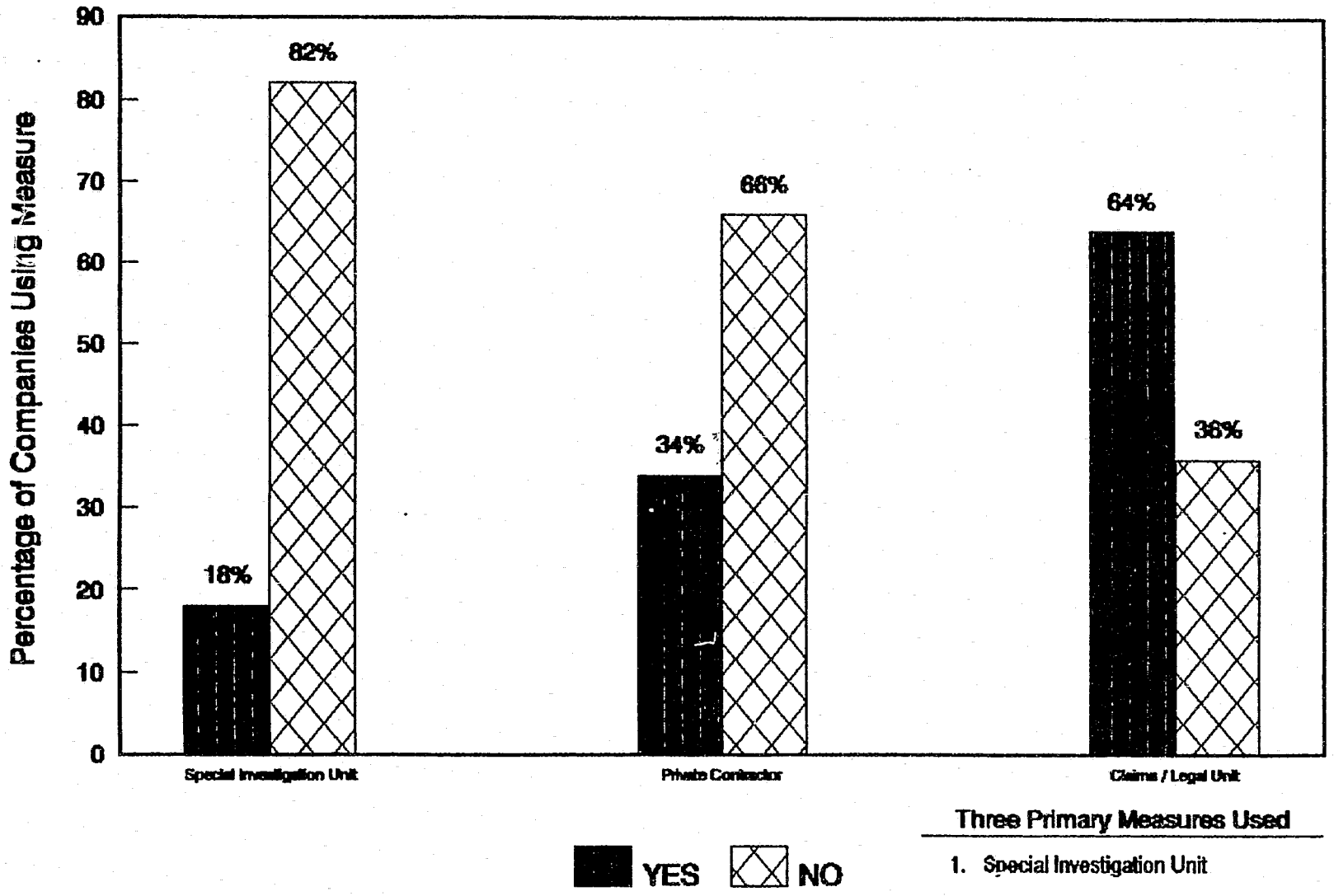
ATTEST:

Winfield M. Kelly
Secretary of State

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

Detection and Investigation of False Claims



Three Primary Measures Used

1. Special Investigation Unit
2. Private Contractor
3. Claims / Legal Unit

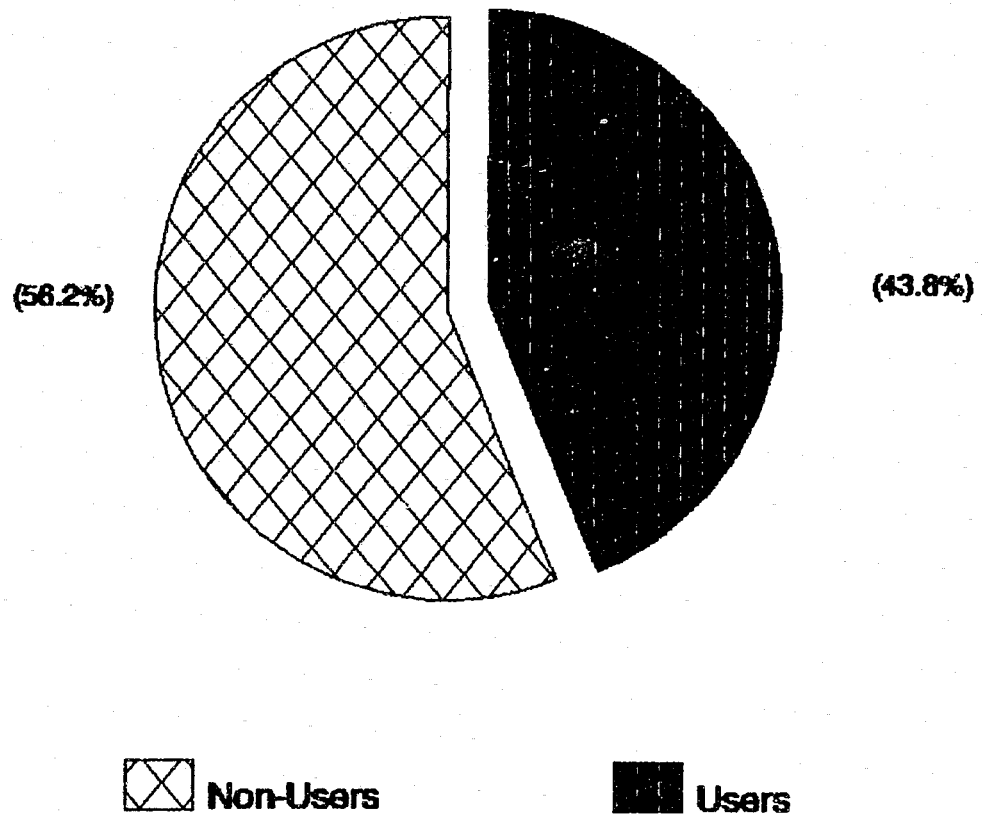
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 1

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

Use of Commercial Indexing Bureaus



SOURCE: Ins. Div. Survey (9/92)

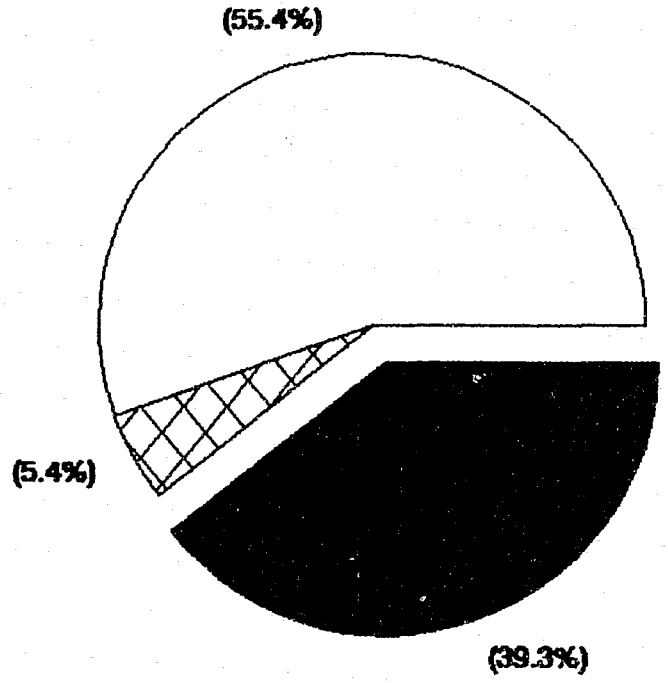
56 respondents of 82 surveyed

GRAPH # 2

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

Anti-Fraud Training



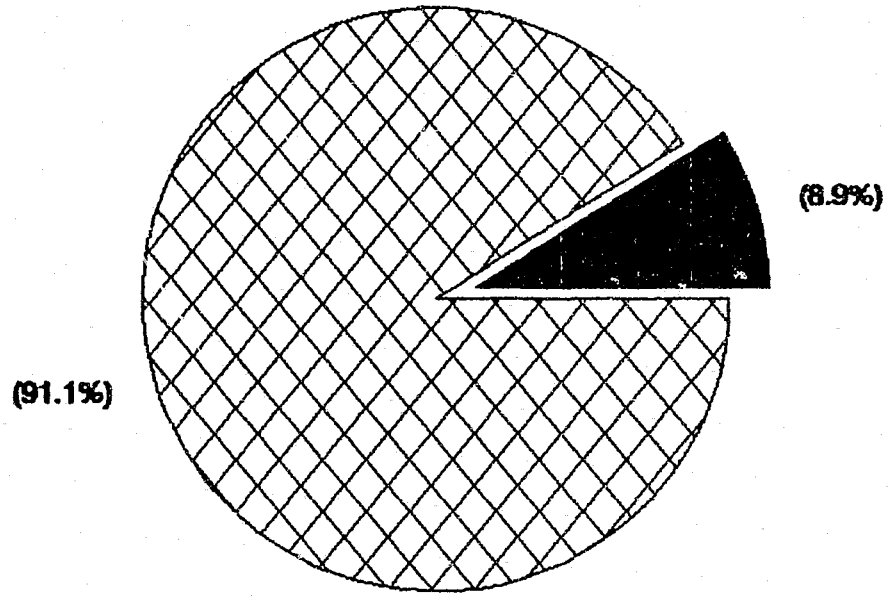
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 3

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

Published Anti-Fraud Hot-Line



Do Not Utilize Anti-Fraud Hot-Line

Publish Anti-Fraud Hot-Line

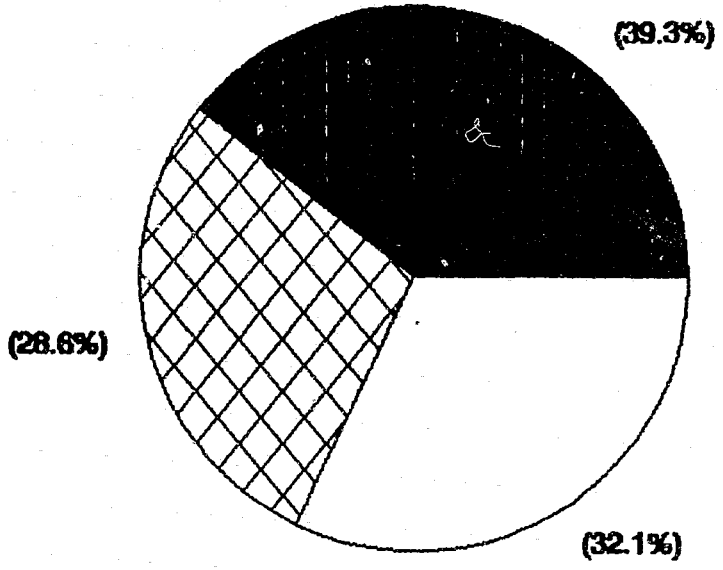
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 4

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

Immunity as an Impediment to Reporting Suspected Fraud



Definitely a Problem

Risks Far Outweigh Benefits

Not a Problem / no Response

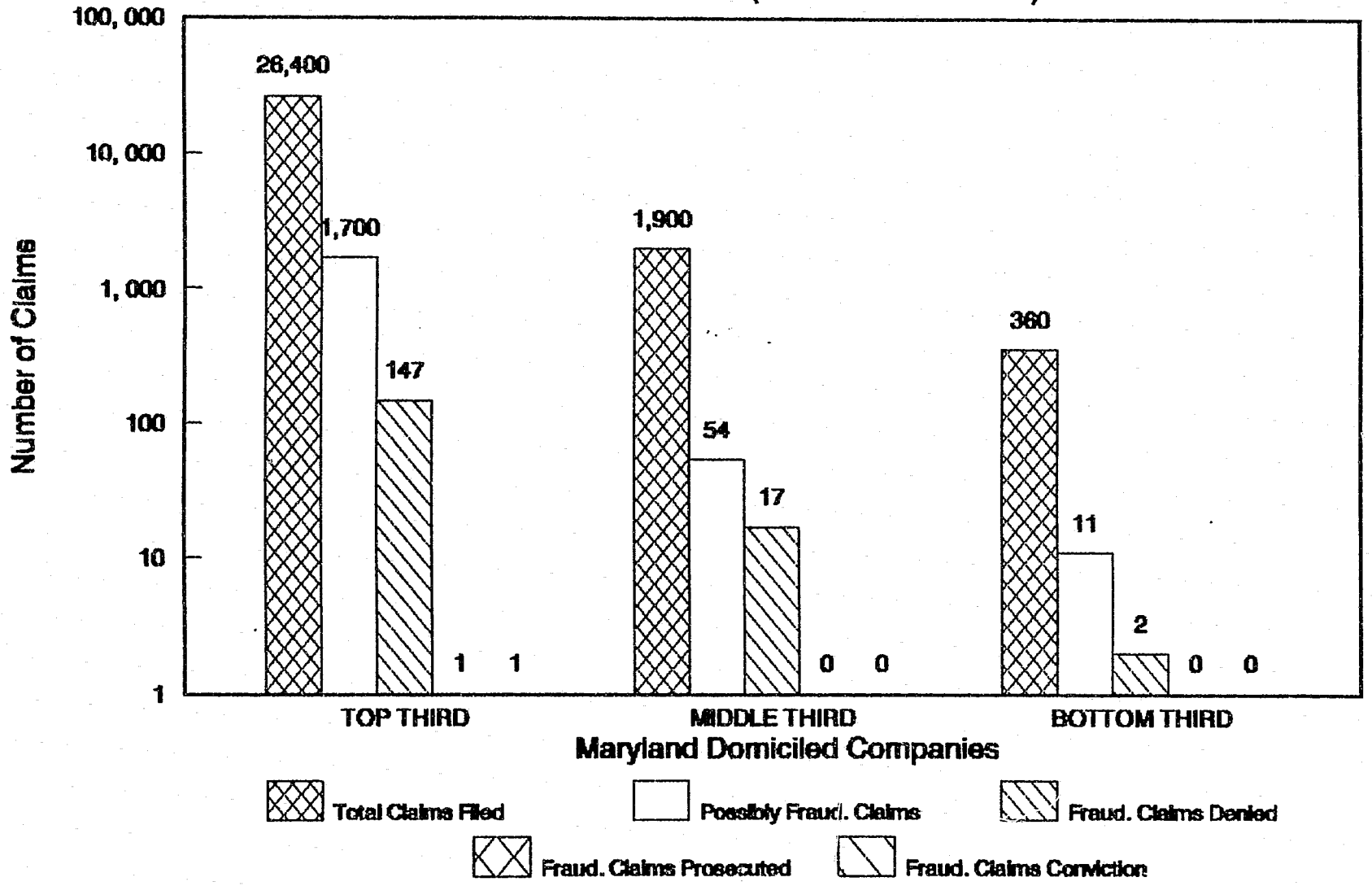
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 5

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

PROPERTY (other than auto)



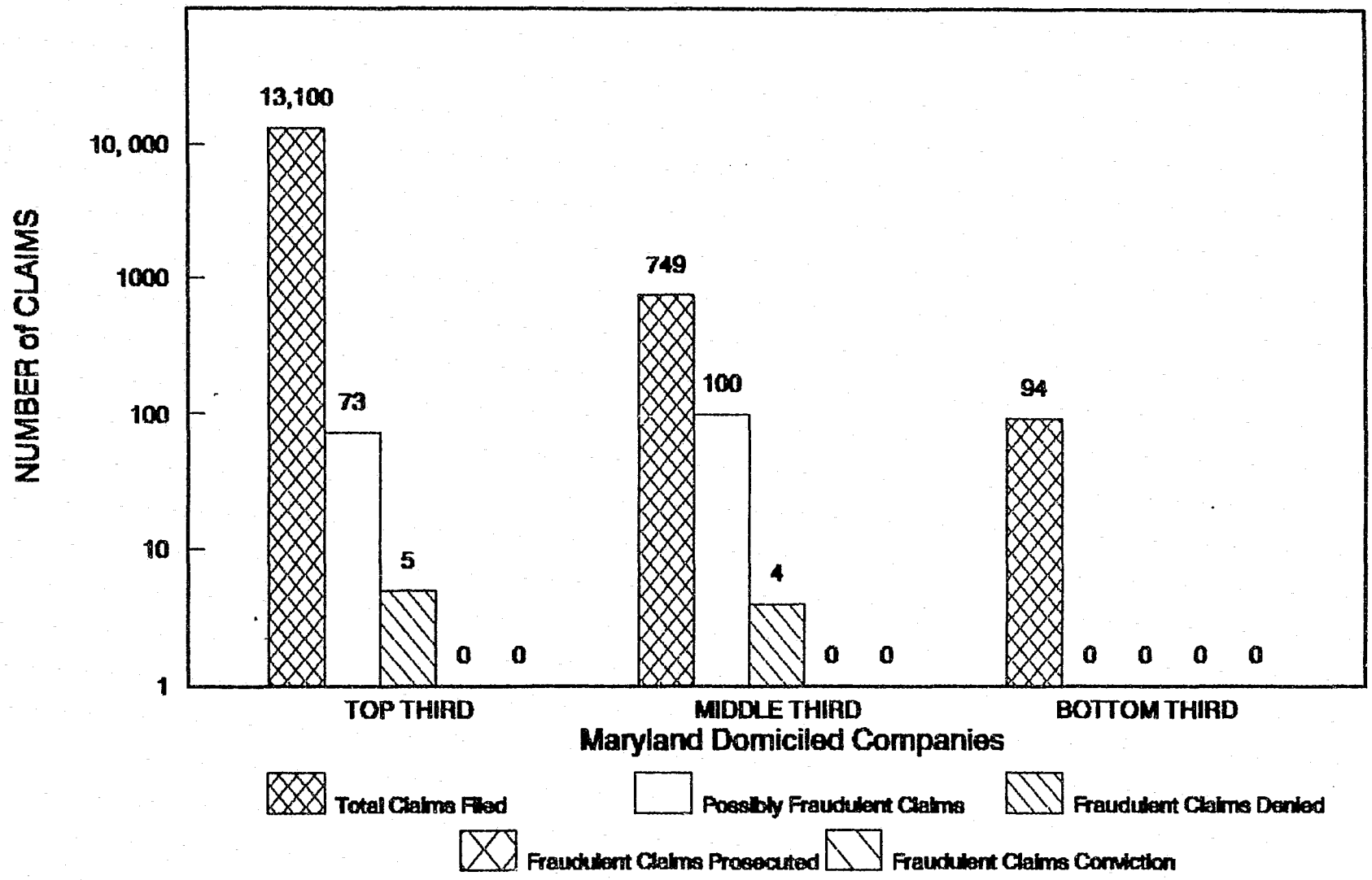
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 6

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

CASUALTY (other than auto)



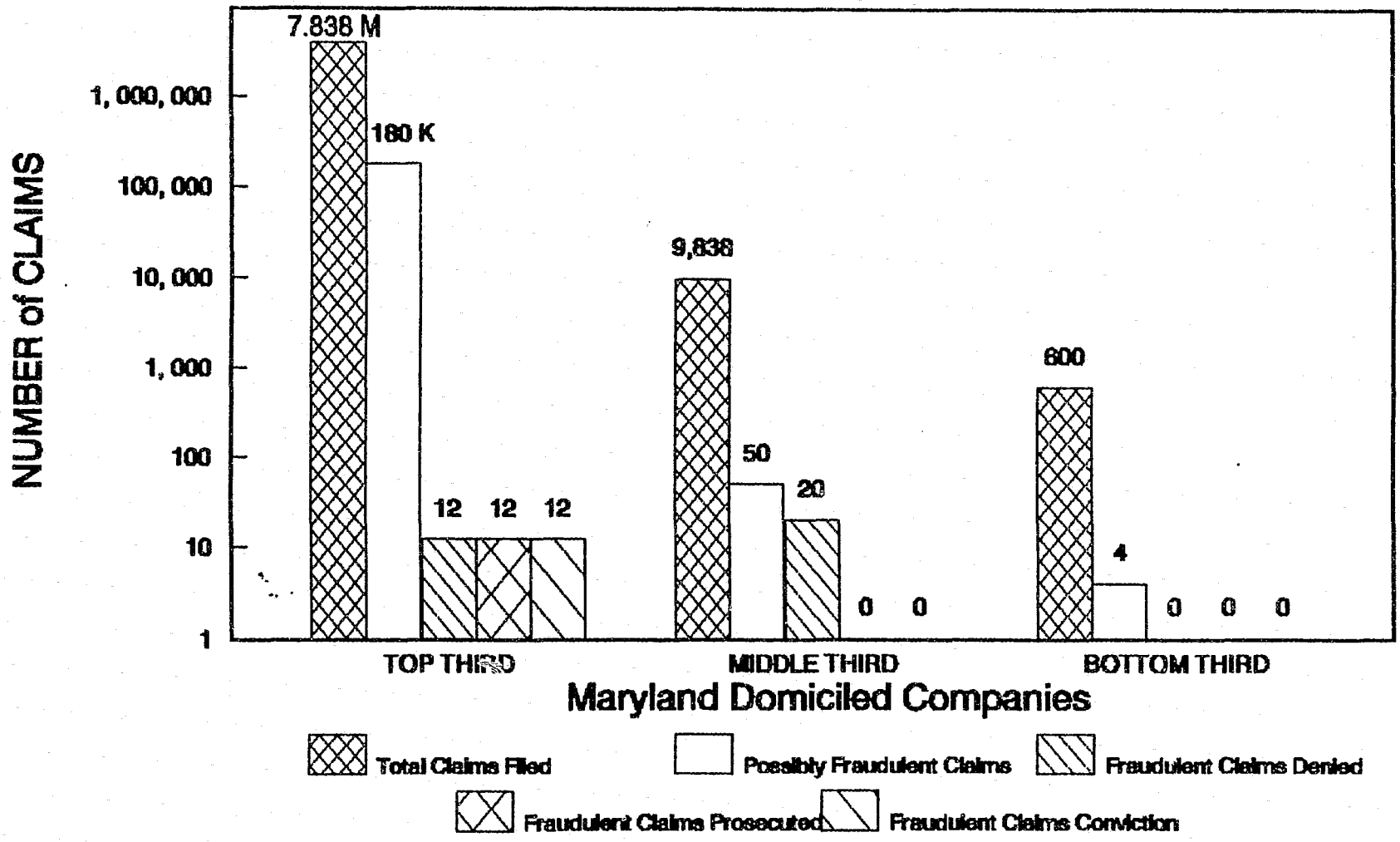
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 7

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurersd

HEALTH INSURANCE



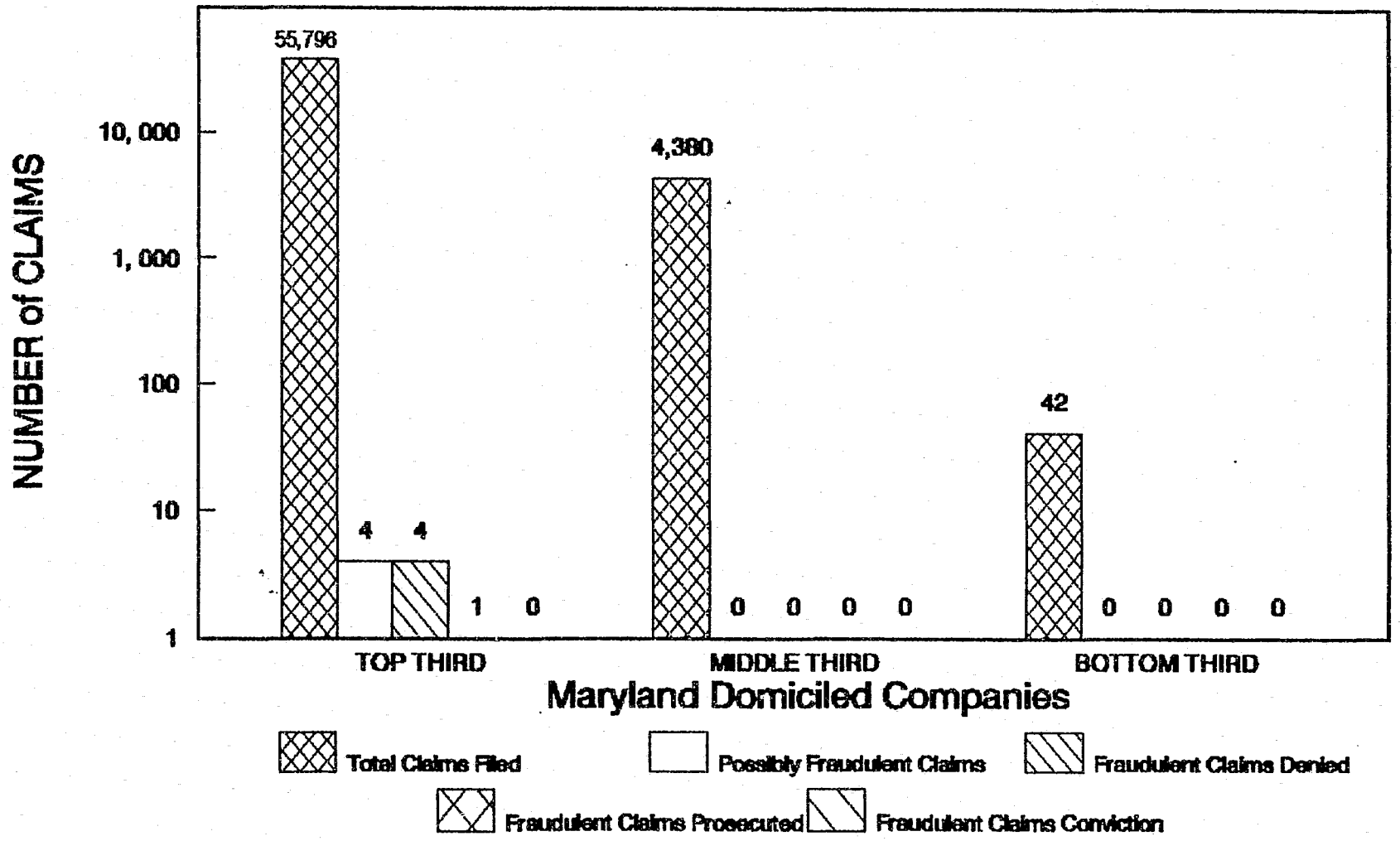
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 8

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

LIFE INSURANCE



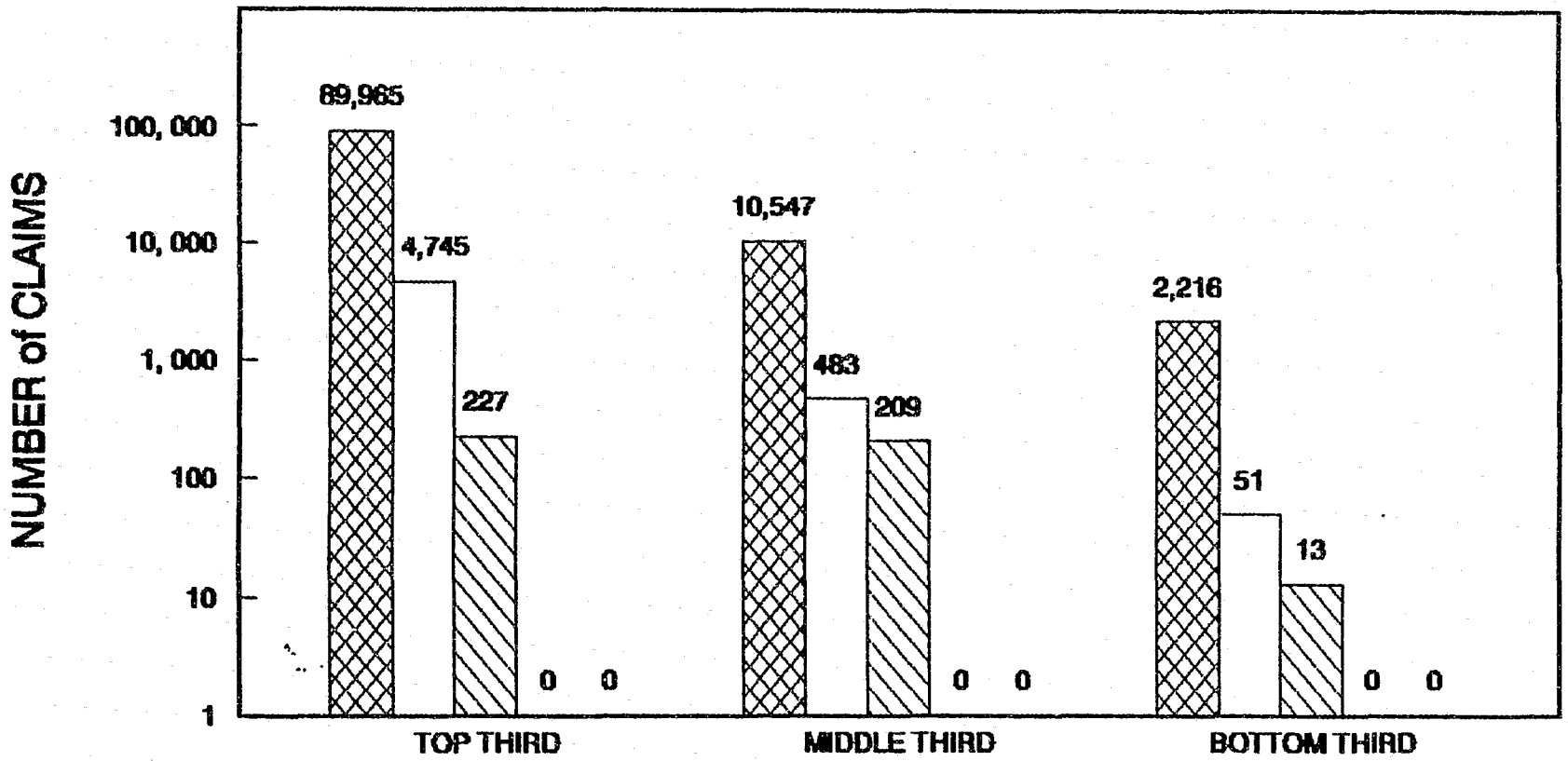
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 9

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

AUTOMOBILE INSURANCE



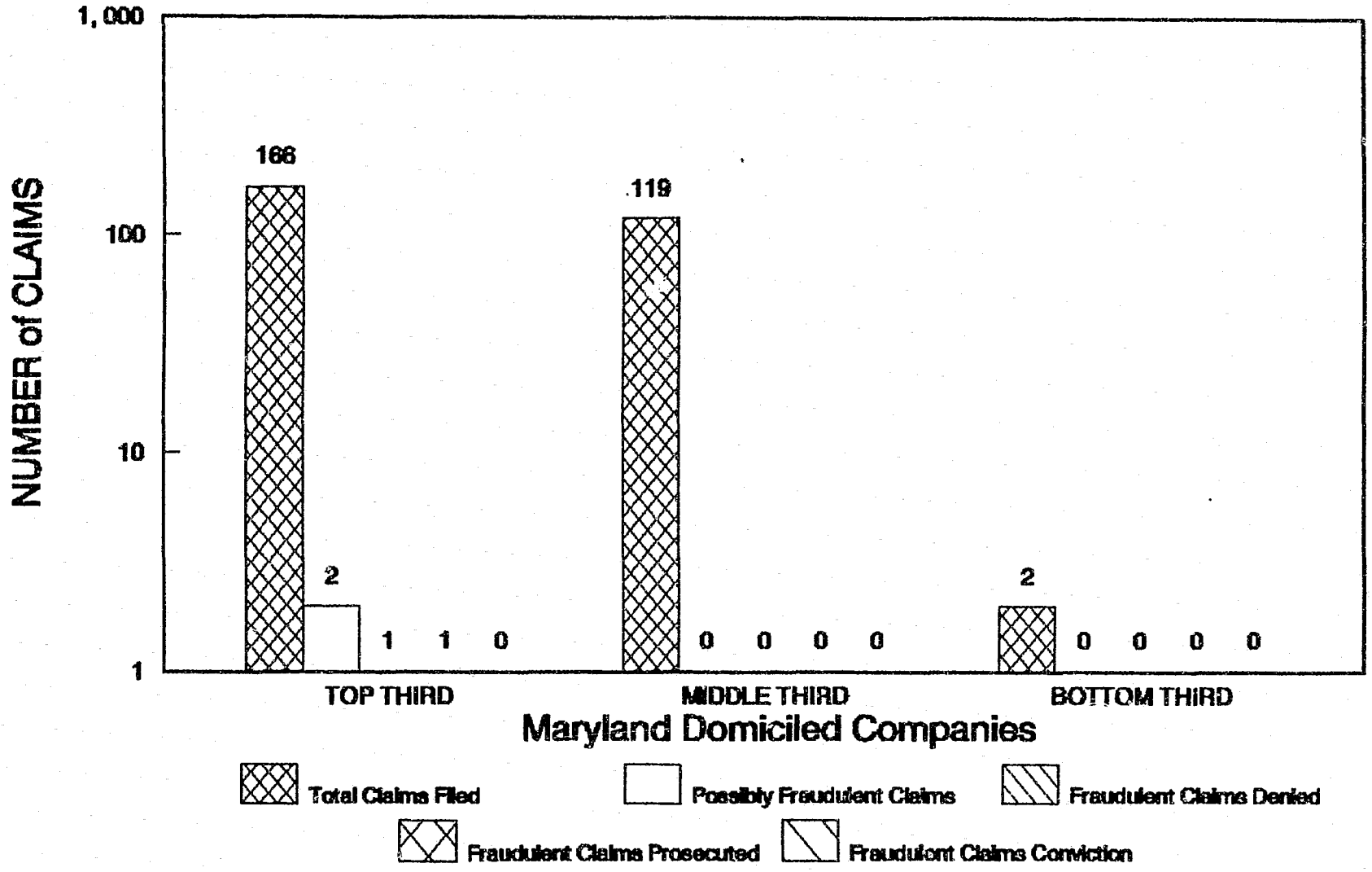
SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 10

INSURANCE DIVISION

1991 Fraud Survey of
Maryland Domestic Insurers

TITLE & SURETY INSURANCE



SOURCE: Ins. Div. Survey (9/92)
56 respondents of 82 surveyed

GRAPH # 11

1991 MARYLAND INSURANCE DIRECT LOSSES
(MD Business Only)

Company	Auto (1) Dir. Losses Incurred	Losses (2) Other than Auto	Total Losses Incurred
GROUP A			
Company 1	205,087,240	9,739,394	214,826,634
Company 2	55,788,133	60,978,769	116,766,902
GROUP B			
Company 1	174,819,178	41,187,366	216,006,544
Company 2	63,945,655	845,690	64,791,345
GROUP C			
Company 1	96,306,030	5,544,486	101,850,516
Company 2	6,490,297	0	6,490,297
Company 3	7,996,603	69,412	8,066,015
Company 4	4,241,047	22,174,689	26,415,736
Company 5	1,191,550	1,064,465	2,256,015
GROUP D			
Company 1	110,407,059	6,142,222	116,549,281
Company 2	24,598,889	269,455	24,868,344
Company 3	4,806,962	0	4,806,962
Company 4	1,408,658	0	1,408,658
GROUP E			
Company 1	9,362,162	643,548	10,005,710
Company 2	49,476,804	19,574,265	69,051,069
GROUP F			
Company 1	42,553,398	10,057,888	52,611,286
Company 2	16,006,412	1,202,329	17,208,741
GROUP G			
Company 1	7,520,451	(6,229,996)	1,290,455
Company 2	14,720,940	19,464,097	34,185,037
Company 3	11,928,183	8,267,421	20,195,604
GROUP H			
Company 1	21,786,924	30,636,594	52,423,518
Company 2	6,677,092	4,182,002	10,859,094

1991 MARYLAND INSURANCE DIRECT LOSSES
(MD Business Only)

Company	Auto (1) Dir. Losses Incurred	Losses (2) Other than Auto	Total Losses Incurred
GROUP I	14,180,777	12,450,197	26,610,974
GROUP J	10,944,416	33,045,314	43,989,730
GROUP K	9,073,912	27,002,588	36,076,500
GROUP L	143,000,278	0	143,000,278
GROUP L	12,454,705	18,349,808	30,804,513
GROUP M	17,297,241	4,639,386	21,936,627
TOTALS	**1,144,050,996**	**331,301,389**	**1,475,352,385**
10 % of Totals	**114,405,100**	**33,130,139**	**147,535,239**
25 % of Totals	**286,012,749**	**82,825,347**	**368,838,096**

(1) Includes all private and commercial vehicle lines

(2) Includes all other Property & Casualty and Life & Health lines

\\EDLOTUS\fraudsum