A Report to the Joint Standing Committee on

Insurance and Financial Services of the

122nd Maine Legislature

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

Submitted by the Bureau of Insurance,

Department of Professional and Financial Regulation

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I. Introduction

A. Legislation Authorizing Study

During the 122nd Legislative Session the Legislature adopted Resolve 2005, chapter 47, Resolve, To Study the Feasibility of Establishing an Insurance Fraud Unit within the Bureau of Insurance. Resolve 2005, chapter 47 requires the Superintendent of Insurance to conduct a feasibility study regarding the establishment of an insurance fraud unit within the Bureau of Insurance to address fraudulent conduct by consumers, insurance producers and insurers. The Resolve requires the Superintendent to submit a report on the feasibility study, and any proposed legislation, to the Joint Standing Committee on Insurance and Financial Services by December 5, 2005 and authorizes the Committee to report out a bill following its review of the request. A copy of the Resolve is included as Appendix A.

The Superintendent is required by 24-A M.R.S.A. § 2186 to submit annually a report to the Joint Standing Committee on Insurance and Financial Services that includes "aggregate information detailing the fraudulent insurance activity experienced by insurers" in Maine during the previous calendar year. Recognizing that the study required by Resolve 2005, chapter 47 was to be conducted by the Superintendent over the summer and fall, the Superintendent advised the Committee that he would be incorporating the annual fraud report required by § 2186 into the report on the feasibility study. Accordingly, the annual fraud report is incorporated herein at pages 10-22.

B. Study Process

As required by Resolve 2005, chapter 47, the Bureau of Insurance (the "Bureau") consulted with interested persons and other state agencies and studied the feasibility of establishing an unit within the Bureau to investigate, prosecute and prevent insurance fraud. The following details the process and results of this project.

The Bureau researched insurance fraud unit statutes from other states as well as national models adopted by the Coalition Against Insurance Fraud (CAIF) and the National Association of Insurance Commissioners (NAIC). Our background research included preliminary discussions with a number of sources including the CAIF and the Fraud Unit of the New Hampshire Insurance Department. As part of that research, it became clear that in order for an insurance fraud unit to be effective, both investigatory and prosecutorial resources need to be in place. The Bureau consulted with the Office of the Attorney General in order to ascertain their view as to the most effective way of providing for prosecutorial resources as well as to gain from their criminal prosecution experience. Based upon the foregoing effort, the Bureau prepared a draft legislative proposal that was circulated to interested parties in the project. The proposal not only creates a Fraud Unit but also moved all of the existing insurance fraud laws into one chapter. The proposal is discussed more fully below at Section III(B) and appears as Appendix C to this report.

The Bureau met with interested parties on September 26, 2005. Interested persons specifically invited included legislative sponsors of LD 1561 which became Resolve 2005, chapter 47; persons who had testified on that bill; Colleen McCarthy Reid, Esq., the Office of Policy and Legal Analysis staff person assigned to the Joint Standing Committee on Insurance and Financial Services; and representatives of the Office of Attorney General with whom we have consulted regarding this project.

Organizations and persons participating in the interested persons meeting included:

- Insurers: Peerless Insurance Company; Liberty Mutual Insurance Company; OneBeacon Insurance Company; Patrons Oxford Insurance Company; State Farm Insurance Company; UnumProvident Insurance Company, Maine Employers Mutual Insurance Company (MEMIC); Nationwide Insurance Company; Anthem Healthplans of Maine, and Progressive Insurance Company

- Industry-related Associations: Maine Association of Insurance Companies, American Insurance Association, Property Casualty Insurance Association, Maine Insurance Agents Association; American Council of Life Insurance; Coalition Against Insurance Fraud; Maine Association of Insurance Companies, and the National Association of Legal Investigators

- Private Investigation Firms: Atlas Agency and Surette Investigations

- State Agencies: Maine Workers Compensation Board

- Office of Policy and Legal Analysis: Colleen McCarthy Reid, Esq.

Several of the interested persons attending and offering comments were employees with Special Investigative Units at various insurers who are directly engaged in anti-fraud efforts of the insurance industry. Their insights and experience were especially useful.

The Bureau received a number of comments from interested persons regarding the draft proposed legislation. Representatives of the Maine Association of Insurance Companies, the American Insurance Association and the Property Casualty Insurers Association recommended that the draft legislation be amended to address what they view as a longstanding problem created by the Maine Supreme Judicial Court's decision in American Home Assurance Company v. Ingeneri, 497 A.2d 897 (Me. 1984). In that case the Law Court interpreted 24-A M.R.S.A. §2411 to mean that misrepresentations, omissions, concealment of facts and incorrect statements must be both fraudulent and material to the acceptance of the risk in order to prevent a recovery under an insurance policy despite the fact that the statute expressly refers to conduct that is either "…. fraudulent or material …". In 1999, the life and health insurance industry successfully pursued an amendment to §2411 to clarify that "or" is, indeed, disjunctive with respect to policies or contracts issued by insurers within those segments of the market (see P.L. 1999, c. 223), but similar efforts by the property and casualty insurance industry have failed. Inasmuch as the Bureau focused its efforts on determining the feasibility of establishing a fraud unit and

not on technical changes to existing law tangential to that charge, the Bureau has not included the provision sought by the property and casualty insurers within the draft legislation. Should the Legislature determine that such an amendment to current law is desirable, the Bureau will comment at that time.

All written and oral comments received at and subsequent to the interested persons meeting were considered and a number of enhancements were made in the draft proposal as a result of the input received. Appendix B sets forth the written comments received.

II. Background

A. Existing Law

The Legislature has previously enacted a number of laws appropriate and necessary to combat insurance fraud. The most notable of these provisions is P.L. 1997, ch. 675.

The Maine Criminal Code currently provides for the crimes of "insurance deception"[1] and "deceptive insurance practices".[2] The Maine Insurance Code establishes the commission of a "fraudulent insurance act" as a civil violation.[3] In any civil action in which it is proven that a person committed a fraudulent insurance act, the Court may award reasonable attorney's fees and costs to the insurer, but if it is determined that no reasonable basis existed for the fraud allegation, the accused party can recover attorney's fees and costs.[4] Insurers are currently required to provide fraud warning labels on all insurance applications and claim forms that states "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."[5] Insurers are required to report annually to the Bureau the aggregate number of Maine-related incidences of insurance fraud affecting them which they know or reasonably believe have been committed during the prior year.[6] All insurers doing business in Maine are required to have antifraud plans which must provide for specific procedures for the insurer to utilize to prevent, detect and investigate insurance fraud, educate employees regarding the plan and fraud detection, provide for the hiring of or contracting for fraud investigators and for reporting of insurance fraud to appropriate law enforcement and regulatory authorities.[7] The Superintendent is required to provide the Joint Standing Committee on Insurance and Financial Services with an annual report regarding insurance fraud.[8]

Current law also provides that certain authorized investigatory, prosecutorial and regulatory agencies that are engaged in enforcement work relating to insurance fraud has the right to receive from and share with each other and with insurers at interest relevant information

[1] 17-A M.R.S.A. §354-A
[2] 17-A M.R.S.A. §901-A
[3] 24-A M.R.S.A. §2186(2)
[4] 24-A M.R.S.A. §2186(7)
[5] 24-A M.R.S.A. §2186(3)
[6] 24-A M.R.S.A. §2186(3)
[7] 24-A M.R.S.A. §2186(5)
[8] 24-A M.R.S.a. §2186(4)

relating to insurance fraud. These agencies include the Attorney General, district attorneys, the Federal Bureau of Investigation, the State Fire Marshal, the Superintendent of Insurance, the Superintendent of Financial Institutions, the U.S. Attorney's Office, State Police and local law enforcement and the National Association of Insurance Commissioners.[9] In the absence of fraud, malice or bad faith, any person or authorized agency that furnishes information relating to suspected, anticipated or completed fraudulent insurance acts is provided immunity from civil liability for information furnished to or received by an authorized agency.[10] Authorized agencies or insurers receiving information pursuant to this provision are required to hold the information as confidential until its release is required by a criminal or a civil proceeding.[11]

Current law further provides for insurers to apply to the Superintendent of Insurance for the Bureau to conduct an inquest into insurance fraud and to report the findings of the result of the inquest to the insurer.[12] This provision has been rarely, if ever, used as the Bureau of Insurance does not have fraud investigators while insurers have fraud investigatory capabilities of their own. The Bureau is not aware of this process having been utilized within the last 25 years.

B. Existing Bureau of Insurance Investigative Process

Under current Maine law, the Bureau of Insurance is required to advise the Attorney General when it has reason to believe that any person has violated any provision of the Maine Insurance Code or other law as to insurance operations for which criminal prosecution is provided and would be in order.[13] With respect to insurance fraud, information of this nature may come to the Bureau's attention in several ways. From time to time the Bureau may receive the results of an investigation by the Special Investigative Unit of an insurer, from the Insurance Fraud Unit of another state or from a member of the public that indicates suspected insurance fraud involving a person within this State. In those situations the Bureau forwards the information received to the Attorney General. The Bureau may also in connection with its activities associated with enforcing the provisions of the Insurance Code discover conduct by regulated or non-regulated persons that may constitute criminal conduct as well as violations of the Insurance Code. In those situations, the Bureau will make the referral and endeavor to work in cooperation with the Attorney General's Office toward an appropriate resolution of both civil and criminal matters. Unfortunately, Bureau staff does not include any persons with criminal investigatory expertise. Therefore the receipt of a referral requires the Attorney General to initiate a second investigation conducted by criminal investigators associated with that office. This process inevitably leads to substantial duplication of state resources that are in extremely short supply as well as substantial delays in the administration of justice. It should be noted that these investigations may involve complex unauthorized insurance or fake insurance schemes operating in and from a number of states and countries. Close cooperation between all of Maine

[9] 24-A M.R.S.A. §2187
[10] 24-A M.R.S.A. §2187(5)
[11] 24-A M.R.S.A. §2187(6)
[12] 24-A M.R.S.A. §2179
[13] 24-A M.R.S.A. §214(2).

resources is essential to an ability to cooperate with the federal, international and other state authorities often involved.

Currently no criminal prosecutors exist in Maine whose work focuses primarily on insurance fraud. The Office of Attorney General does contain a Financial Crimes and Civil Rights Division that oversees the prosecution of white collar and financial crimes and all frauds against Maine State government, including welfare fraud, Medicaid fraud, tax crimes, and securities violations as well as a variety of civil rights programs. Experience reported by other states and by several of the interested persons suggests that efforts to investigate insurance fraud are most successful when trained, dedicated fraud investigators can work closely with dedicated prosecutors to pursue cases to conclusion. Anecdotal comments from interested persons further suggests that the current lack of those public resources is a primary reason why very few fraud referrals are made by insurers to the state despite the number of cases of suspected insurance fraud occurring noted in this report.

C. General Discussion of Insurance Fraud Issues

The Coalition Against Insurance Fraud (CAIF) is a national advocacy organization of consumer groups, public interest organizations, government agencies and insurers. Its website notes "insurance fraud is hard to measure because so much goes undetected, and complete research has yet to be done. Still, we have enough evidence to know that fraud is widespread — and expensive."[14]

National studies conducted by the Insurance Research Council (IRC) show that auto insurance, workers' compensation and health insurance are the lines that are most vulnerable to fraud. The IRC estimates that one-third of all bodily injury claims from auto accidents contain some amount of fraud, usually in terms of padding or exaggerating a claim, but only 3% are totally fraudulent such as staged accidents. Another form of fraud, lying on applications in order to reduce premium, costs auto insurers $13.7 billion annually (Insurance Information Institute, or III).

As to workers' compensation fraud, one of the most common forms of workers' compensation fraud in Maine is a faked or exaggerated injury, an area within the jurisdiction of the Maine Workers' Compensation Board's Fraud and Abuse Unit to investigate. There are, however, other forms of workers compensation fraud are employers who misrepresent payroll or the type of business in order to reduce their insurance premiums and real or bogus entities that purport to provide real or bogus workers compensation coverage or "alternatives" to coverage to employers.

As to healthcare fraud, CAIF estimates that healthcare fraud alone costs Americans $54 billion per year.[15] The Health Insurance Association of America (HIAA) states that 80% of healthcare fraud is committed by medical providers, 10% by consumers and 10% by other

[14] www.insurancefraud.org/stats
[15] www.insurancefraud.org/stats

parties. Medicare/Medicaid fraud is a "huge" part of health insurance fraud (III). In late 1999 the Governmental Accounting Office found that organized crime is heavily involved in health insurance fraud and that the criminals identified were not health care workers, per say, but individuals already prosecuted for securities fraud, forgery and auto theft. With the enactment of HIPAA (Health Insurance Portability and Accountability Act of 1996) detection and prosecution of health insurance fraud received a boost. The Department of Justice calls health care fraud and abuse its number two law enforcement priority, after violent crimes. In 1996, according to the FBI, Congress provided an added $54 million over seven years for health care fraud enforcement.

Property insurance, based upon the Bureau's 2004 data, had the third highest fraud and abuse count by line of business at 165 reported cases. According to the National Fire Protection Association, arson or suspected arson account for nearly 500,000 fires each year, or one in four fires in the United States. Arson and suspected arson are the largest causes of property damage in the U.S.

Despite what may appear to be a bleak picture, a number of tools exist for combating fraud. In addition to those Maine Insurance and Criminal Code provisions, previously discussed, several federal laws are used to address fraud. These include: The Federal Mail Fraud Statute, the Racketeer Influenced and Corrupt Organizations (RICO) and the Health Insurance Portability and Accountability Act (HIPAA). Also, the Violent Crime Control and Law Enforcement Act of 1994 makes insurance fraud a federal crime when it affects interstate commerce.

Certain state agencies work with insurers to address fraud, as well. The Workers' Compensation Board's Fraud and Abuse Unit tackles issues such as fakes or exaggerated injuries, the Fire Marshal's Office investigates possible arson, and the Department of Human Services takes on Medicare and Medicaid fraud. Recently, one DHS employee received the Office of the Inspector General Integrity Award for her investigative and logistical support in a Medicare and Medicaid fraud case in Bangor Federal Court.

Fraud has also gotten the attention of the National Association of Insurance Commissioners (NAIC), which encourages the insurance industry to take a proactive role in controlling fraud. The NAIC offers states support through their Antifraud Task Force. The mission of the Antifraud Task Force is to serve the public interest by assisting state insurance supervisory officials, individually and collectively, in the following fundamental antifraud activities:

- Promotion of the public interest through the detection, monitoring and appropriate referral for investigation of insurance crime, both by and against consumers.
- Provision of assistance to the insurance regulatory community through the maintenance and improvement of electronic databases regarding fraudulent insurance activities.
- Disseminate the results of research and analysis of insurance fraud trends as well as case-specific analysis to the insurance regulatory community and state and federal law enforcement agencies.
- Provision of the liaison function between insurance regulators, law enforcement and other specific antifraud organizations.

Highlights of the 2004 charges of the Antifraud Task Force include: compile and maintain detailed information on antifraud databases maintained by antifraud organizations, financial regulators, and law enforcement; consider developing further guidelines for use by the industry in determining when suspicious claims should be reported; review industry compliance with antifraud initiatives; develop methods to enhance the investigation and prosecution of financial services fraud; and establish guidelines on the investigation and prosecution of insider insurance industry fraud.[16]

Additionally, in 2005 the NAIC created a "Fraud Webline," an online insurance fraud reporting system located on the Web site of the National Association of Insurance Commissioners (NAIC) at www.naic.org. The system allows consumers to provide information anonymously.

The new fraud reporting system was developed as part of the response by insurance regulators to the national allegations about misconduct involving compensation agreements between some insurance companies and brokers. The allegations of improper activity spurred regulators to improve their abilities to collect information from consumers, producers and insurance company employees. Maine participates in the online fraud reporting system, in conjunction with the NAIC, as part of an effort to address alleged misconduct and violation of Maine insurance law.

The online fraud reporting system lets consumers anonymously supply detailed information regarding suspected fraudulent activities to the NAIC where the information is then forwarded to the appropriate state. Although consumers may identify themselves, no personal identifying information is required to report an allegation of suspected fraud. Consumers are required to designate the state where the suspected fraud occurred and the name and address of the business or individual. A text box is included for the consumer to provide the details of the suspected fraud. Other optional fields on the form include phone number, date of birth, date of suspected fraud, and amount of loss.

Despite the anti-fraud activities of state and federal agencies discussed above, the Bureau notes that an enforcement and prosecutorial gap exists in current Maine government operations insofar as no entity exists that is focused on investigation and prosecution of fraudulent insurance acts and the crimes of insurance deception and deceptive insurance acts. Both the comments of interested persons and the data contained in this report suggest that insurance fraud is a serious matter in Maine. The Maine Association of Insurance Companies, the American Insurance Association and the Property Casualty Insurers Association and several of the individual fraud investigators who commented as interested persons all noted the frustration when hard work has been expended to develop a case and local prosecutors have refused to prosecute or believe that it is not a serious crime meriting their attention. The interested persons believe that a strong and effective insurance fraud unit would be effective not only in punishing those convicted of insurance fraud, but in deterring others.

[16] Source: National Association of Insurance Commissioners

Forty other states currently have insurance fraud units. The Director of the Fraud Division of the New Hampshire Insurance Department shared his concern with the Joint Standing Committee on Insurance and Financial Services during his testimony on L.D. 1561 that organized insurance fraud rings are gravitating toward those jurisdictions with the least regulation, including Maine, for the conduct of their affairs. That concern has been echoed by other interested persons as well.

D. 2004 Annual Fraud Report Information

This is the sixth year that insurers have been required to report on insurance fraud and abuse activities in Maine however, this is only the second year that the Bureau has taken measures to ensure reporting compliance from licensed insurers. These measures include adding a reminder to the Annual Statement Instructions; offering completely automated on-line reporting; and sending reminder letters to some delinquent insurers. For the years ending 2003 and 2004, 1,007 and 1,189 insurers filed reports with the Bureau, respectively. This is a significant increase over the approximately 450 companies that filed for the year ending 2002

As a result of the increased reporting for 2003 and 2004, it is difficult to discern any particular trends from the aggregate statistics developed. The report reflects, in a number of categories, significant increases which could be attributed to any number of factors. However, the precise cause cannot be ascertained due to spotty reporting in the past.

Table One: Five Year Summary

	2004	2003	2002	2001	2000	1999
Automobile	800	768	516	348	260	262
Workers' Compensation	366	283	226	464	325	472
General Liability	50	66	26	33	39	15
Life	1	3	94	26	31	46
Health	76	90	46	75	122	72
Inland Marine	3	5	3	13	11	15
Property	165	190	72	81	92	89
Other Lines	27	50	429	486	220	24
Total	**1,488**	**1,455**	**1,412**	**1,526**	**1,110**	**995**

As we move forward we will continue with improved compliance and will continue working closely with companies to assure a reasonable level of credibility to the numbers. Thus, over the next 3-5 years we will be able to discern a more statistically valid trend and the numbers will prove more meaningful.

Overall, there was a modest increase in reported insurance fraud from years 2003 to 2004, mostly due to two areas that saw the greatest increase, namely commercial and workers compensation insurance. The other areas (general liability, life, health, inland marine, property and other lines) saw slight decreases in reported insurance fraud.

Table 2: Total Number of Suspected Fraud Claims by Line of Business

Auto	
1999	262
2000	260
2001	348
2002	516
2003	768
2004	800

Workers' Compensation	
1999	472
2000	325
2001	464
2002	226
2003	283
2004	366

General Liability	
1999	15
2000	39
2001	33
2002	94
2003	66
2004	50

Life	
1999	46
2000	31
2001	26
2002	94 [5]

2003	3
2004	1

Health (Including Medicare/Medicaid)	
1999	72
2000	122
2001	75
2002	46
2003	90
2004	76

Inland Marine	
1999	15
2000	11
2001	13
2002	3
2003	5
2004	3

Property	
1999	89
2000	92
2001	81
2002	72
2003	190
2004	165

Other	
1999	24
2000	220
2001	486
2002	429 [5]
2003	50
2004	27

Table 3: Total Number of Suspected Fraud Claims by Type of Insurance

Personal	
1999	432
2000	626
2001	906
2002	712
2003	971
2004	875

Commercial	
1999	563
2000	464
2001	622
2002	369
2003	387
2004	533

Table 4: Fraud Committed by Claimant

Faked Property Damage	
1999	70
2000	74
2001	63
2002	34
2003	316 [1]
2004	323

Inflated Financial Loss	
1999	65
2000	58
2001	101
2002	45 [2]
2003	150
2004	103

Faked/Exaggerated Injury	
1999	530
2000	463
2001	374
2002	183 [2]
2003	539

2004	457

Staged Accident/Injury	
1999	21
2000	20
2001	47
2002	21
2003	38
2004	53

Been Known To File Suspect Claims, Including Faking, Exaggerating, or Extending Total or Partial Disability	
1999	53
2000	42
2001	78
2002	21
2003	60
2004	67

Other	
1999	82
2000	157
2001	190
2002	510 [3]
2003	187
2004	157

Table 5: Fraud Committed by Legal Provider

Hired or Paid Cappers/Chasers to Recruit Clients	
1999	2
2000	0
2001	0
2002	0
2003	0
2004	0

Charged Fees Inconsistent with Services Provided	
1999	0
2000	0
2001	11
2002	0
2003	0
2004	0

Other	
1999	4
2000	1
2001	0
2002	1
2003	1
2004	0

Table 6: Fraud Committed by Medical Provider

Provided an Inaccurate /Incomplete History	
1999	4
2000	6
2001	4
2002	0
2003	1
2004	23

Billed for Services Not Provided	
1999	10
2000	15
2001	13
2002	2
2003	26
2004	27

Upcoded or Billed for Excessive Treatments	
1999	233 [4]
2000	10
2001	24
2002	8
2003	23
2004	12

Unbundled Services	
1999	1
2000	2
2001	0
2002	2
2003	1
2004	3

Received Compensation for Referral to Medical or Legal Providers	
1999	3
2000	1
2001	0
2002	0
2003	0
2004	0

Hired or Paid Cappers/Chasers to Recruit Clients	
1999	10
2000	0
2001	0
2002	0
2003	0
2004	1

Fabricated Services	
1999	3
2000	0
2001	11
2002	4
2003	10
2004	3

Provided an Inaccurate/Incomplete History	
1999	0
2000	2
2001	1
2002	0
2003	0
2004	0

Operated Without a License	
1999	0
2000	0
2001	1
2002	3
2003	1
2004	3

Other	
1999	11
2000	7
2001	12
2002	11
2003	15
2004	13

Table 7: Fraud Committed by Other Person or Entity

Received/Paid Compensation for Referral	
1999	1
2000	0
2001	0
2002	0
2003	0
2004	0

Fabricated Services	
1999	10
2000	1
2001	3
2002	1
2003	0
2004	0

Charged Inconsistent with Services Provided	
1999	10
2000	10
2001	3
2002	0
2003	17
2004	0

Provided an Inaccurate/Incomplete History, or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance Premium	
1999	16
2000	11
2001	5
2002	29
2003	34
2004	42

Other	
1999	18
2000	16
2001	12
2002	20
2003	13
2004	19

The number of fraud referrals noted in the table below is substantially less than the number of cases of suspected insurance fraud noted by the insurers. The Bureau would note the positive correlation between this discrepancy and the comments made by fraud investigators within the insurance industry that they often don't bother with fraud referrals due to their perception that nothing will happen if they make a referral.

Table 8: Number of Cases Reported/Referred to Law Enforcement Agency

District Attorney's Office	
1999	4
2000	34 [6]
2001	4
2002	63 [6]
2003	4
2004	8

U.S. Attorney's Office	
1999	2
2000	5
2001	3
2002	0
2003	7
2004	4

Other Law Enforcement	
1999	36
2000	16
2001	17
2002	12
2003	13
2004	57

Workers' Compensation Board Abuse and Fraud Unit	
1999	0
2000	1
2001	1
2002	2 [2]
2003	21 [7]
2004	27

National Insurance Crime Bureau	
1999	78
2000	95
2001	63
2002	14 [2]
2003	109
2004	230

Other, Including U.S. Postal Authorities	
1999	18
2000	17
2001	149
2002	5 [2]
2003	3 [7]
2004	2

As an accompaniment to the numbers of reported fraud cases noted in the tables above, Table 9 is useful in viewing insurance fraud in Maine from a dollars and cents perspective. Table 9 reflects the financial benefit of pursuing suspected fraud by capturing the amount of claims that might otherwise have been paid had suspected fraud not been pursued.

Table 9: Amount of Money NOT Paid on Suspected Fraudulent Cases

Year	Amount
1999	$8,985,366
2000	$3,527,186
2001	$5,646,901
2002	$4,597,730
2003	$5,657,053 [8]
2004	$5,926,490

Notes to Tables

[1] An auto insurer with a growing market share in Maine reported that most of its suspected or confirmed fraud within the State of Maine occurs when a person applies for and receives auto coverage over the telephone and then reports a claim within 72 hours of securing coverage. Upon investigation, it is usually found that the accident occurred when the policyholder did not have coverage and lied about when the accident took place in order to have the insurance company pay for the loss. This insurer states that only 1% of its Maine claims were referred to an investigator.

[2] Several large carriers in Maine did not file reports for year-ending 2002.

[3] An auto insurer reported misrepresentations on applications to reduce premium (such as not listing all drivers in the household or not disclosing speeding tickets) in this category in this year but did not report this figure in years prior or subsequent.

[4] Workers' Compensation carriers were reporting cases where a physician submitted a bill for reimbursement and the amount submitted was higher than that which was allowed by statute. It was determined that the physicians were most likely billing their usual and customary fees, which just happened to be higher that the amount allowed by the Workers' Comp reimbursement tables. This is neither fraud nor abuse and was not reported in subsequent years.

[5] One national life insurance carrier reported fraud and abuse numbers on a national basis for many years. The Bureau worked with the company and only Maine numbers were filed this year. The company has been advised that in the future it should report Maine-only statistics.

[6] The same national life insurance carrier referred to in Note 4 would report all outside referrals in one category and this changed between 'District Attorney's Office' and 'Other' from year-to-year. The company has been advised that it needs to report on a consistent basis between years.

[7] A workers' compensation carrier used to report its outside referrals in the 'Other' category and then changed to the 'Workers' Compensation Board Abuse and Fraud Unit' category in 2003 because it better suited where the referrals were sent. The company will use reporting consistent with 2003 in future years.

[8] One insurer amended its 2003 report in 2005 to show $445,434 instead of $10,445,434 as originally reported, as the result of a data entry error.

E. Information and Written Comments from Interested Persons

As noted elsewhere in this report, interested persons representing principally various segments of the insurance industry generally see the development of an insurance fraud unit with dedicated prosecutorial resources as a positive development in fighting insurance fraud; however, they caution that their support for any specific proposal for which they are either directly or indirectly responsible for funding will depend on their cost/benefit analysis of the proposal. Elements they believe necessary for a fraud unit to be successful include dedicated investigatory and prosecutorial resources, sufficient investigatory powers vested in the unit, the ability of the fraud unit and insurers to work together in many ways and appropriately worded immunity for reporting insurance fraud or fraud-related information.

III. Recommendations

A. Creation of a Fraud Unit

Based on the information received from interested persons; the Bureau's analysis of existing law and the Bureau's consideration of available models from other jurisdictions and the NAIC, we have determined that the creation of an Insurance Fraud Unit within the Bureau of Insurance is feasible. The creation of such a Unit in conjunction with a coordination of efforts with the Office of the Attorney General appears to be the most feasible and effective manner within which to address insurance fraud within Maine. To that end, the Bureau is proposing legislation authorizing the creation of such a unit within the Bureau of Insurance and under the direction of the Superintendent.

B. Proposed Legislation

Based upon the Bureau's conclusion that the creation of a fraud unit within the Bureau of Insurance is feasible, the Bureau has drafted proposed legislation for consideration by the Committee. That proposal is attached as Appendix B to this report.

The draft proposal preserves the majority of the substantive provisions of these laws, but combines them with new provisions establishing an Insurance Fraud Unit within the Bureau of Insurance thus creating a new chapter in the Insurance Code. This requires a reallocation in the Insurance Code of several current provisions.

Governmental insurance fraud units within the United States vary greatly in size and design. In preparing the draft legislation, the Bureau has looked primarily to states with similar demographics and resources as Maine. Additionally, the NAIC's Insurance Fraud Prevention Model Act is heavily drawn upon as a drafting resource.

Under the draft legislation, an Insurance Fraud Unit would be created as a division within the Bureau of Insurance. Organization and staffing of the unit would be done pursuant to 24-A M.R.S.A. §§205 and 207, the same laws that govern other Bureau operations. These laws authorize the Superintendent of Insurance to organize the Bureau of Insurance in a manner the Superintendent determines necessary for the discharge of the Superintendent's duties and to employ such personnel as the business of the Bureau may require, subject to the approval of the Commissioner of the Department of Professional and Financial Regulation. In light of these laws, it is not necessary to include additional provisions related to the organization of a fraud unit as part of the draft legislation. If the draft legislation is enacted in the near future, the Bureau contemplates creating a three person unit within the Bureau of Insurance, staffed by a Director and two investigators of varying levels of expertise. A dedicated Assistant Attorney General, housed within the Attorney General's Office, would provide a means for prosecution of criminal cases. The unit would be funded through existing financial conventions used currently to fund the activities of the Bureau. To the extent an additional allocation of funds beyond the existing fiscal resources of the Bureau is needed, the Superintendent may make an assessment pursuant to 24-A M.R.S.A. § 237. The Bureau estimates the need for approximately $400,000

per year to adequately fund an Insurance Fraud Unit. A detailed fiscal note will be prepared should a proposed bill be introduced.

As noted above, pursuant to current 24-A M.R.S.A. §214(2), on those occasions when the Superintendent has reason to believe that a person has violated a law for which criminal prosecution would be in order, a referral to the Office of Attorney General is done. This referral may occur after investigation by Bureau staff under the Insurance Code; however, once a possible criminal violation is noted, the cases need to be reinvestigated by criminal investigators within the Office of Attorney General before criminal prosecution can be considered. One of the goals of the draft legislation is to reduce the potential for duplication of effort and generate efficiencies in the process. By having personnel within the Bureau with specialized investigative expertise and developing a coordinated effort with the Office of the Attorney General through the use of an assistant attorney general dedicated to insurance fraud matters, it is believed that cases can be investigated and prosecuted more efficiently and effectively.

In some jurisdictions, investigators within an Insurance Fraud Unit are law enforcement officers with the authority to serve search warrants and to perform arrests. In other jurisdictions, the authority of investigators is limited to typical investigatory functions such as the review of documents and interview of witnesses. The NAIC Model Fraud Prevention Act provides optional wording to capture either structure. Some interested persons have expressed a desire for investigators of any Maine Insurance Fraud Unit to have full law enforcement powers including the ability to issue search warrants. However, after discussions with the Office of Attorney General and a review of powers of analogous investigatory units in other Maine agencies, the Bureau does not recommend full law enforcement powers for the Insurance Fraud Unit.

The proposed legislation retains those provisions of current Maine law noted above that require insurers to place fraud warning labels on insurance applications and claim forms and to maintain antifraud plans. The current legal requirement for insurers to submit an annual report to the Superintendent regarding aggregate cases of suspected insurance fraud along with the provision that requires the Superintendent to provide an annual report to the Joint Standing Committee on Insurance and Financial Services are also retained.

In addition to existing requirements, the draft legislation would require insurers to refer specific cases of suspected insurance fraud to the Superintendent. Differing points of view were expressed by interested persons on this point. Some believe that discretionary rather than mandatory referral would result in fewer, but higher quality, referrals to the Fraud Unit. Others believe that mandatory fraud reporting provides a greater protection to the reporting entity against collateral legal action by the subject of the report. The draft legislation resolves this conflict in favor of mandatory reporting which is consistent with the NAIC model. In light of mandatory reporting, current insurance fraud reporting immunity provisions are retained and strengthened.

A provision providing for the confidentiality of investigatory records of the Insurance Fraud Unit is provided for which is based upon a combination of the NAIC Model Fraud Prevention Act and current Maine law. Additionally, the ability of the Insurance Fraud Unit to

cooperate with and share otherwise confidential information with a wider variety of local, state, federal and international law enforcement and regulatory agencies than provided for in the current law is clarified. The Bureau understands that should the draft legislation as written be considered by the Legislature, the confidentiality provision may require consideration by the Joint Standing Committee on Judiciary as well as the Insurance and Financial Services Committee.

After careful consideration and consultation with interested persons including governmental agencies, the Bureau is of the view that the time is right to create an Insurance Fraud Unit within the Bureau. The Bureau offers the attached proposal for consideration by the Committee in the hopes of enhancing State resources for the investigation and prosecution of fraudulent activities.

APPENDIX A

STATE OF MAINE

IN THE YEAR OF OUR LORD
TWO THOUSAND AND FIVE

H.P. 1099 - L.D. 1561

Resolve, To Study the Feasibility of Establishing an Insurance Fraud Unit within the Bureau of Insurance

Sec. 1. Feasibility study; report. Resolved: That the Superintendent of Insurance shall study, in consultation with other state agencies and interested persons, the feasibility of establishing an organizational unit within the Department of Professional and Financial Regulation, Bureau of Insurance dedicated to the investigation, prosecution and prevention of insurance fraud, including, but not limited to, the fraudulent conduct of consumers, insurance producers and insurers. By December 5, 2005 the Superintendent of Insurance shall submit a report on the feasibility study to the Joint Standing Committee on Insurance and Financial Services. The report must include the superintendent's findings and recommendations, including any suggested legislation, regarding the feasibility of establishing, implementing and funding an insurance fraud unit. Following receipt and review of the report, the Joint Standing Committee on Insurance and Financial Services may report out a bill related to the report to the Second Regular Session of the 122nd Legislature.

APPENDIX B

An Act to Create An Insurance Fraud Division Within the Bureau of Insurance

Be it enacted by the People of the State of Maine as follows:

Sec. 1. Title 24-A M.R.S.A. §2179 is repealed.

Sec. 2. Title 24-A M.R.S.A. §2186 is repealed.

Sec. 3. Title 24-A M.R.S.A. §§2187 is repealed.

Sec. 4. Title 24-A M.R.S.A. Chapter 91 is enacted to read as follows:

Chapter 91
Insurance Fraud

Sec.7001. Purpose

The Legislature finds that the business of insurance involves many transactions that have potential for fraud, abuse and other illegal activities. This Chapter is intended to permit full utilization of the expertise of the superintendent to investigate and discover fraudulent insurance acts and receive assistance from state, local and federal law enforcement and regulatory agencies in enforcing laws prohibiting fraudulent insurance acts, insurance deception and deceptive insurance practices.

Sec. 7002. Definitions

For purposes of this chapter, the following words and terms have the following meanings:

1. "Deceptive insurance practices" has the meaning set forth in 17-A M.R.S.A. §901-A;

2. A person commits a "fraudulent insurance act" when he knowingly:

(1) Presents, or causes to be presented, or prepares any information containing false representations as to a material fact with the intent to defraud an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

(a) An application for the issuance or renewal of an insurance policy;

(b) The rating of an insurance policy;

(c) A claim for payment or benefit pursuant to an insurance policy;

(d) Payments made in accordance with an insurance policy; or

(e) Premiums paid on an insurance policy;

(2) Presents, or causes to be presented, or prepares any information containing false representations as to a material fact with the intent to defraud an insurer, insurance producer or other person engaged in the business of insurance concerning any of the following:

(a) A document filed with the superintendent or the insurance regulatory official or agency of another jurisdiction;

(b) The financial condition of an insurer;

(c) The formation, acquisition, merger, reconsolidation, dissolution or withdrawal from one or more lines of insurance in all or part of this State by an insurer;

(d) The issuance of written evidence of insurance; or

(e) The reinstatement of an insurance policy;

(3) Solicits or accepts new or renewal insurance risks on behalf of an insurer or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(4) Removes, conceals, alters or destroys the assets or records of an insurer or other person engaged in the business of insurance;

(5) Embezzles, exercises unauthorized control over or converts money, funds, premiums, credits or other property of an insurer or other person engaged in the business of insurance;

(6) Transacts the business of insurance in violation of laws requiring a license, certificate of authority or other legal authority for the transaction of the business of insurance; or

(7) Attempts to commit, aids or abets in the commission of, or conspires to commit the acts or omissions described in this subsection.

3. "Insurance deception" has the meaning set forth in 17-A M.R.S.A. §354-A;

4. "Insurer" means, except as otherwise noted in this chapter, an authorized insurance company, reinsurer, surplus lines insurer, unauthorized insurer, nonprofit hospital and medical service organization, health maintenance organization, risk retention group or multiple employer welfare organization. "Insurer" also includes an insurance producer or other person acting on the behalf of an insurer;

5. "Policy" means an individual or group policy, group certificate, contract or arrangement of insurance or reinsurance affecting the rights of a resident of this state or bearing a reasonable relation to this State, regardless of whether delivered or issued for delivery in this State; and

6. "Reinsurance" means a contract, binder of coverage (including placement slip) or arrangement under which an insurer procures insurance for itself in another insurer as to all or part of an insurance risk of the originating insurer.

Sec. 7003. Insurance Fraud Division

1. Division established. The Insurance Fraud Unit Division, referred to in this Chapter as the division, is established within the Bureau of Insurance . The division shall work in coordination with other bureau sections and staff and other regulatory and law enforcement agencies to accomplish it duties.
2. Duties. It shall be the duty of the division to:
    A. initiate independent inquiries and conduct independent investigations when the insurance fraud unit has cause to believe that a fraudulent insurance act, insurance deception or deceptive insurance practices may be or has been committed;
    B. review reports or complaints of alleged fraudulent insurance activities, insurance deception and deceptive insurance practices from federal, state and local law enforcement and regulatory agencies, persons engaged in the business of insurance and the public to determine whether the reports require further investigation and to conduct these investigations;
    C. conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts;
    D. assist the superintendent in developing and implementing programs to prevent fraudulent insurance acts and abuse, deceptive insurance acts and insurance deception;
    E. assist the Attorney General in the prosecution and prevention of insurance fraud, deceptive insurance acts and insurance deception
    F. prepare any reports regarding insurance fraud required by law.

3. Authority. The insurance fraud unit shall have the authority to
    A. inspect, copy or collect records and evidence;
    B. serve subpoenas;
    C. administer oaths and affirmations;
    D. subject to section 216, subsection 5 of this Title, share records and evidence with federal, state or local law enforcement or regulatory agencies;
    E. make criminal referrals to prosecuting authorities; and
    F. conduct investigations outside of this state. If the information the division seeks to obtain is located outside this State, the person from whom the information is sought may make the information available to the division to examine at the place where the information is located. The division may designate representative, including officials of the state in which the matter is located, to inspect the information on behalf of the division and the division may respond to similar requests from officials of other states.

Sec. 7004. Other Law Enforcement or Regulatory Authority

Nothing in this Chapter shall:

A. preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine and prosecute suspected violations of law;

B. prevent or prohibit a person from disclosing voluntarily information concerning insurance fraud, insurance deception or deceptive insurance practices to a law enforcement or regulatory agency other than the division; or

C. limit the powers granted elsewhere by the laws of this State to the superintendent or the division to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

Sec. 7005. Fraudulent insurance acts prohibited.

A person may not commit a fraudulent insurance act.

Sec. 7006 Insurance fraud prevention.

1. Fraud warning required. Fraud warnings are required in accordance with the following.

A. All applications and claim forms for insurance used by insurers in this State, regardless of the form of transmission, must contain the following statement or a substantially similar statement permanently affixed to the application or claim form: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits."

B. The lack or omission of the statement required in paragraph A does not constitute a defense in any criminal prosecution or civil action for a fraudulent insurance act.

C. This subsection applies to all insurers except reinsurers.

2. Annual reporting of fraudulent insurance acts. Fraudulent insurance acts must be reported in accordance with this subsection.

A. An insurer shall, annually on or before March 1st or within any reasonable extension of time granted by the superintendent, file with the superintendent a report relating to fraudulent insurance acts that the insurer knew or reasonably believed had been committed during the previous calendar year. The report must contain information required by the superintendent in the manner prescribed by the superintendent. The information must be

reported on an aggregate basis and may not contain any information identifying any individuals or entities. The superintendent shall adopt rules necessary to define the information that must be reported. Rules adopted pursuant to this subsection are routine technical rules as defined in Title 5, chapter 375, subchapter II-A.

B. On or before July 1 of each year, the superintendent shall report to the joint standing committee of the Legislature having jurisdiction over insurance matters. The report must include aggregate information detailing the fraudulent insurance activity experienced by insurers in this State.

3. Reporting of specific fraudulent insurance acts

A. A person engaged in the business of insurance having knowledge or a reasonable belief that a fraudulent insurance act is being, will be or has been committed shall provide to the superintendent the information required by, and in a manner prescribed by, the superintendent.

B. Any other person having knowledge or a reasonable belief that a fraudulent insurance act is being, will be or has been committed may provide to the superintendent the information required by, and in a manner prescribed by, the superintendent.

3. Insurer antifraud plans. Every insurer writing direct insurance shall prepare and implement an antifraud plan. This subsection does not apply to any agency, producer or other person acting on behalf of an insurer. The superintendent may review an insurer's antifraud plan to determine if the plan complies with the requirements of this subsection. The antifraud plan must outline specific procedures, appropriate to the lines of insurance the insurer writes in the State, to:

A. Prevent, detect and investigate all forms of insurance fraud;

B. Educate appropriate employees on the antifraud plan and fraud detection;

C. Provide for the hiring of or contracting for fraud investigators; and

D. Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

Section 7007. Insurance fraud reporting immunity

1. Definitions. As used in this section, unless the context otherwise indicates, the following terms have the following meanings.

A. "Action" includes nonaction or the failure to take action.

B. "Authorized agency" or "authorized agencies" means:

(1) The Administrator of the Office of Securities;

(2) The Attorney General;

(3) A district attorney responsible for prosecution in the municipality where the fraud occurred;

(4) The Federal Bureau of Investigation, or any other federal agency, only for the purposes of subsection 2;

(5) The International Association of Insurance Supervisors;

(6) The International Criminal Police Organization;

(7) The National Insurance Crime Bureau;

(8) Non-U.S. insurance supervisors or law enforcement authorities;

(9) The State Fire Marshal;

(10) The Superintendent of Insurance;

(11) The Superintendent of Financial Institutions;

(12) The United States Attorney's office when authorized or charged with investigation or prosecution of the insurance fraud in question, only for the purposes of subsection 2;

(13) The State Police or local law enforcement officials;

(14) The National Association of Insurance Commissioners or

(15) The Workers' Compensation Board.

2. Information disclosed. An authorized agency investigating insurance fraud may, in writing, require the insurance company at interest to release to the requesting agency any relevant information or evidence determined to be important to the authorized agency that the company may have in its possession relating to the insurance fraud in question. This information includes, but is not limited to:

A. A history of previous claims made by the insured;

B. Insurance policy information relevant to fraud under investigation and any application for that policy;

C. Material relating to the investigation of the loss including statements and proof of loss; and

E. Policy premium payment records.

3. Exchange of information. An authorized agency or insurer provided with information pursuant to this section may release or provide that information to any other authorized agency or insurer with an interest in the insurance fraud under investigation.

4. Right to receive upon request. Any insurer providing information to an authorized agency pursuant to this section has the right, upon request, to receive other information relevant to the fraud from that authorized agency within 30 days.

5. Immunity. In the absence of fraud, malice or bad faith, any person, including, but not limited to, an insurer or authorized agency, that furnished information relating to suspected, anticipated or completed fraudulent insurance acts is not liable for any damages in any civil action for furnishing the information if that information is furnished to or received from an authorized agency. Nothing in this subsection is intended to abrogate or modify in any way any common law or statutory privilege or immunity previously enjoyed by any person.

Section 7008. Confidentiality.

1. Documents, materials or other information in the possession or control of the Bureau of Insurance that are provided pursuant to Section 7007 of this Act or obtained by the superintendent in an investigation of suspected or actual fraudulent insurance acts shall be confidential by law and privileged, shall not be subject to disclosure as public records under 1 M.R.S.A. chapter 13, shall not be subject to subpoena and shall not be subject to discovery or admissible in evidence in ay private civil action. However, the superintendent is authorized to use the documents, materials or other information in the furtherance of any regulatory or legal action brought as a part of the superintendent's official duties.

2. Neither the superintendent nor any person who received documents, materials or other information while acting under the authority of the superintendent shall be permitted or required to testify in any private civil action concerning any confidential, documents or information subject to subsection 1.

3, In order to assist in the performance of the superintendent's duties, the superintendent may share or receive documents, materials or other information, including the confidential and privileged documents, materials or information subject to subsection 1 as provided for and in accordance with section 216, subsection 5 of this Title.

4. Nothing in this section shall prohibit the superintendent from providing information to or receiving information from any local, state, federal or international law enforcement authoritie, including any prosecutorial authority; or from complying with subpoenas or other lawful process in criminal actions; or as may otherwise be provided in this Act.

5. No waiver of any applicable privilege or claim of confidentiality in the documents, materials or information shall occur as a result of disclosure to the superintendent under this chapter or as a result of sharing as authorized in subsection 3 of this section.

Section 7009. Civil penalties

Any violation of this chapter is subject to suspension or revocation of license or certificate of authority issued pursuant to Title 24 or this Title or civil penalties and other remedies as provided in section 12-A or both. Notwithstanding section 2165-A, subsection 1, the superintendent may issue emergency cease and desist orders on the basis of conduct involving fraudulent insurance acts.

Section 7010. Recovery costs

In a civil action in which it is proven that a person committed a fraudulent insurance act, the court may award reasonable attorney's fees and costs to the insurer. In a civil action in which the insurer alleges that a party committed a fraudulent insurance act that is not established at trial, the court may award reasonable attorney's fees and costs to the party if the allegation is not supported by any reasonable basis of law or fact.

Section 7011. Rulemaking

The superintendent may promulgate routine technical rules deemed necessary by the superintendent for the administration of this Chapter.