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FINAL REPORT

of the

COMMISSION TO STUDY

INSURANCE FRAUD

January 15, 1998

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EXECUTIVE SUMMARY

The Commission to Study Insurance Fraud was established by Resolve 1997, Chapter 77 (Attachment A.). L.D. 933 "Resolve, to Establish a Commission to Study Insurance Fraud" brought to the attention of the Legislature that insurance fraud is a serious concern of both the insurance industry and law enforcement; the purpose of the Commission is to study the laws related to insurance fraud to determine the extent of the problem in the State and to develop recommendations to strengthen the State's laws governing insurance fraud. The Commission consisted of 12 members representing the insurance industry, health care providers, hospitals, the private bar, the State Fire Marshal's Office, Department of Human Services and Legislators (Attachment B.) and met 5 times. The specific duties were to study the following:

- The current statutory provisions governing insurance fraud in this State including the civil and criminal penalties available and the effectiveness of those provisions:
- Any model legislation relating to insurance fraud proposed by the National Association of Insurance Commissioners and the laws concerning insurance fraud in other states: and
- Any other issues concerning insurance fraud determined relevant to the study by the Commission.

The Commission submits its findings and recommendations for strengthening the State's laws governing insurance fraud.

Background

To many consumers, insurance fraud is perceived as a victimless crime, no one loses but the insurance company. Generally, consumers do not draw the conclusion that fraudulent claims are paid with premium dollars and that less fraud can lead to lower premiums. According to the Coalition Against Insurance Fraud, a national alliance of consumer groups, government agencies and insurance companies that combats all forms of insurance fraud through legislative advocacy and consumer education, insurance fraud is considered to be one of the most costly white-collar crimes in the United States, ranking second to tax evasion. Insurance fraud has traditionally been a "low risk - high gain crime". Until the low risk is transformed to high risk and the premium paying public recognizes that insurance fraud is not "victimless", the incidence and cost of fraud can be expected to increase.

Summary

The first and possibly the most difficult objective of the Commission was to attempt to determine the extent and dollar impact of insurance fraud in Maine. Since there are no reporting requirements currently in place, the data estimates were provided by the insurance industry. Depending upon the particular line of business, industry estimates of insurance fraud range from

10% to almost 20% of claims. Approximately 69% of the insurance fraud is in the health care arena.

The Commission received testimony from the Coalition Against Insurance Fraud which offered a perspective on programs and legislation in other states. Special Agent Peter McCarthy, from the National Insurance Crime Bureau, presented testimony concerning his experience in investigation and assisting both local and federal prosecution of insurance fraud in Maine. Marc Fecteau, Department of Human Services, presented information on Medicaid fraud in Maine. Sgt. David Loranger, Saco Police Department, described barriers to investigations due to inadequate immunity laws in Maine.

The Commission recognized that there has been a general trend in the industry to combat fraud. According to a 1996 survey conducted by the Insurance Research Institute, approximately 76% of those companies in the property-casualty market now have Special Investigative Units. The 150 companies that participated in the survey, representing 77 percent of the property-casualty market, showed an increase in fraud control spending from $200 million in 1992 to $650 million in 1996. The regulatory environment has moved in the same general direction with 42 states now defining claims fraud as a specific crime, of these 34 classify it as a felony. Fraud bureaus exist in 33 states and 45 states have some type of immunity statute (Attachment C.).

The Commission conducted its study under the presumption that insurance fraud is a subject that should be addressed in Maine. Model fraud legislation from the National Association of Insurance Commissioners and the Coalition Against Insurance Fraud was reviewed along with current fraud statutes from a number of other states. Additional testimony was received from the Maine Attorney General's Office, Maine Civil Liberties Union and Maine Criminal Defense Lawyers Association. The latter three organizations expressed concern with the proposed definition of insurance fraud, criminal classification of insurance fraud and immunity statutes.

As a result of the Commission's investigation, it is recommending that legislation be drafted which includes the following provisions:

1. **Create a specific statutory provision making insurance fraud a felony.**
2. **Require a warning be placed on claim forms and insurance applications that insurance fraud is illegal and subject to criminal penalty.**
3. **Require notification of licensing authorities when a licensee is convicted of insurance fraud.**
4. **Provide immunity to insurers and law enforcement, when sharing fraud information.**
5. **Require insurers to develop antifraud plans.**
6. **Require reporting by insurers of fraud data in the aggregate to the Bureau of Insurance on an annual basis.**
7. **For the purposes of annual reporting and the definition of fraud, MEDICAID will be considered an insurer.**

Commission Proceedings

1st Meeting:

Prior to the first meeting, Commission staff provided members with the following information:

1. National Association of Insurance Commissioners (NAIC) Insurance Fraud Prevention Model Act (Attachment D.).
2. Packet of media releases from the Florida Insurance Commissioner's office describing insurance fraud actions taken in Florida.
3. Information from the Internet on National Insurance Crime Bureau (NICB).
4. Model Insurance Fraud Act as proposed by the Coalition Against Insurance Fraud (Attachment E.),
5. Model Insurance Fraud Bureau Act as proposed by the Coalition Against Insurance Fraud .
6. Various articles released by the Coalition Against Insurance Fraud.

The first meeting of the Commission was held on October 17,1997, with a quorum of members present. Commission staff provided members with a brief explanation of information previously supplied to members. Staff also explained that a major impediment to the mission of the group would be the unavailability of statistical data to document the number of known or suspected insurance fraud acts in Maine and the associated dollar value.

2nd Meeting:

The second meeting of the Commission was held on November 7,1997. As requested at the first meeting, staff provided Commission members the following information prior to the meeting:

1. Banking and Insurance Committees carryover bills, LD 889 and LD 1783, related to unfair claims practices .
2. Side-by-side comparisons of these bills to current law and NAIC Model Unfair Claims Practices Act .
3. Current Maine law related to unfair claims practices .
4. Bureau of Insurance discussion draft bill on unfair claims and fraudulent practices (the fraud piece was not in LD 1783, the bill presented to the Legislature). Members were advised that Bureau of Insurance's proposed legislation LD 1783, in its draft form contained an insurance fraud prevention section, which closely paralleled the NAIC's Fraud Prevention Model Act. This section was removed by the Bureau prior to final submission.
5. Current Maine law addressing unfair trade practices and fraud in Title 24-A .
6. Copies of statutes from selected states which deal with fraud: Maine, Minnesota, New Hampshire, New Jersey and Rhode Island .

The majority of the meeting was devoted to testimony of invited speakers.

Speakers:

Howard Goldblatt, Director of Government Affairs for the Coalition Against Insurance Fraud, after giving a brief history of the Coalition, described the Coalition's work in fighting insurance fraud through the development of a model insurance fraud act and a model insurance fraud bureau act. Both of the models closely parallel the NAIC's models but are a little more broad in scope. The Coalition participated in the development of the NAIC's models. Following his prepared presentation, Mr. Goldblatt responded to a variety of questions from Commission members. Mr. Goldblatt was able to provide data demonstrating positive results measured in other states as a result of fraud legislation. He further testified that if individual states do not have fraud laws or require any type of fraud reporting you have no base data to measure against. This is a problem shared across the country. He also explained that without required reporting and standardization of measuring criteria, it is extremely difficult to determine a cost/benefit value for insurance fraud activities.

Peter McCarthy, Special Agent, Eastern Region, National Insurance Crime Bureau (NICB), gave a brief explanation of the goals and objectives of the NICB along with some of the functions it performs. He then described a variety of fraud cases in Maine, both past and present, that he has had some degree of involvement with the investigation and prosecution.

Sgt. David Loranger, Saco Police Department, testified in regard to his personal frustration with his inability to communicate suspected insurance fraud to other appropriate law enforcement agencies and insurance companies due to the lack of an adequate immunity law. He was also in favor of insurance fraud being classified as a crime.

Marc Fecteau, Asst. Program Mgr., Surveillance & Utilization Review Unit of the Bureau of Medical Services, explained that his unit is responsible for monitoring, identifying, and investigating potential fraud and abuse cases in the Maine Medicaid Program. He discussed some of the more recent fraud cases and the dollar amount of overpayment by the Maine Medicaid program. Of note, was that ten of the most recent ongoing or completed cases represented over $4 million in fraudulent billing to the Maine Medicaid Program.

3rd Meeting:

Prior to the third session on November 21st, Commission members received:

1. Copy of Florida's insurance fraud laws .
2. Copy of Maine law addressing law enforcement anti-immunity .
3. Side-by side comparison of Bureau's draft, NAIC model and Coalition Against Insurance Fraud's model.

At the November 21st meeting the following items were discussed and agreed to:

- ✓ That there was a need to create specific statutory provision making insurance fraud a crime. It was also decided additional testimony on this item would be appropriate. The following organizations were invited to offer testimony: Maine Attorney General's Office, Maine Prosecutors Association, Maine Civil Liberties Union and Maine Criminal Defense Lawyers Association.
- ✓ Require that claim forms and insurance policy applications carry a warning that insurance fraud is illegal and subject to criminal and civil penalty. It was recommended that the wording of the warning be generic to allow the warning to be used in multiple jurisdictions. The Commission also discussed the use of the warning on other documents produced by insurance companies.
- ✓ Require the reporting of convictions for insurance fraud of licensed individuals or businesses to their respective licensing agencies. The requirement should be limited to reporting and not include mandated action by the licensing authority.
- ✓ To address the need to provide immunity to insurers and law enforcement to allow the sharing of fraud information. Wording to be determined at a subsequent meeting.
- ✓ It is not necessary to establish a state insurance fraud bureau at this time.

4th Meeting:

The fourth meeting was held on December 8th. The first order of business was to receive testimony from invited participants.

Judith S. Chamberlain, Asst. Attorney General, presented a prepared statement on behalf of the Attorney General's Office. Her testimony alerted the Commission to a number of policy issues which it may wish to consider in the course of its deliberation. It did not represent the position of the Department of the Attorney General. Among the issues were:

- The apparent lack of data specific to Maine. Without specific data, how do you determine how significant the need is in Maine? What need exists which is not being met by the current criminal code?
- The penalty appears excessive in relation to the offense.
- The apparent inaccurate assumption regarding the priority given insurance fraud by prosecutors.
- The need for a cost/benefit analysis.
- Possible interim solutions:
  A. Assess the level of need for stepped up enforcement.
  B. Determine what impediments, if any, to prosecutions exist.
  C. Improved communications between law enforcement and insurance companies.

Sally Sutton, from the Maine Civil Liberties Union (MCLU), expressed varied concerns from the consumer protection perspective, particular concern was the use of individual medical records. The MCLU's position is that an insurance company should have access to no more information than is needed to pay a claim. Additionally, Ms. Sutton pointed out the potential of patients, because they are afraid that doctor/client information may be released, don't give the doctor all the necessary medical information and subsequently receive less medical treatment

than is needed. Any change in immunity laws that would allow access to patient information was seen as an erosion of personal rights and protections. She expressed the need to define the difference between a consumer experiencing a disagreement in the claims process and someone committing a fraudulent act. The concern is that claimants will fail to exercise their rights in the claims process because they may fear reprisal of being accused of insurance fraud. Her final comment dealt with the criminal classification of insurance fraud, which would create additional burdens on the criminal justice system without additional resources being allocated.

Stephen Schwartz, from the Maine Criminal Defense Lawyers Association, opened his comments by questioning if insurance fraud is a problem. He expressed concern at the possible changes to the existing immunity standards and the criminalization of insurance fraud. He raised the possibility of incarceration for doing something you didn't know was against the law. Mr. Schwartz did express approval for the proposed warnings to be included on claims and applications but found the definition of insurance fraud utilized by the Commission to be problematic.

Following the invited testimony, rigorous discussion was conducted on the following topics and conclusions and recommendations were reached by the Commission.

- Specific crime of insurance fraud - The Commission recommends that insurance fraud be defined as a specific crime. Insurance fraud would be a class B felony crime if the value of the property, services or benefits wrongfully obtained exceeds $10,000 and a Class C crime if the value of the property, services or benefits wrongfully obtained exceed $5,000 but less than $10,000.
- Changes to civil action burden of proof - The burden of proof will remain at the level of "clear & convincing"
- Immunity issues - it was determined to use Maine's "Arson Reporting Immunity Act" as the basis for a new insurance immunity section.
- Require reporting of insurance fraud to the Bureau of Insurance - various reporting scenarios were discussed. Reporting of individual suspected fraud cases to the Bureau was seen to lack merit from both the Industry and the Bureau. A favorable alternative is an annual summarizing report submitted to the Bureau.
- Requirement that insurers develop specific antifraud plans - it was agreed to recommend that insurers be required to develop antifraud plans. These plans would not require state approval and would be maintained by the insurer. It was recommended to utilize "Antifraud Plans" section of the Coalitions model act.

5th Meeting

On January 5, 1998, the Commission held its fifth and final meeting. The meeting began with comments by Bureau of Insurance Acting Superintendent Alessandro A. Iuppa. Superintendent Iuppa addressed the following areas:

- The reporting of fraudulent insurance acts should be in the aggregate as opposed to individual suspected fraud claims. He also suggested that the implementation date be for the first full calendar year following the adoption of rules by the Superintendent.
- Under insurer antifraud plans, he suggested that the plans not be submitted to the Bureau of Insurance. It was further suggested that if the Committee wished to provide discretionary authority for the Superintendent to review such plans, that language be incorporated to require insurers to submit such plans within 14 or 30 days after a request by the Superintendent.
- Insurance fraud reporting immunity definition of "Authorized agency" should include the Superintendent of Banking. The sale of insurance products by banks is now fully authorized as a result of legislation passed and singed into law in 1997.

The Commission then proceeded to review the draft report. With the exception of a few minor grammatical and spelling corrections, the only major change was the addition to the final recommendations to include language that would define Medicaid as an insurer for the purposes of fraud reporting.

The proposed legislation was reviewed with the following changes:

Title 24-A MRSA § 2183-A Insurance Fraud Prevention

- 1.B. - Medicaid was added under the definition of "insurer".
- 4. - Reporting of fraudulent insurance acts. Rules adopted pursuant to the subsection will be substantive as opposed to technical rules.
- 5. - Insurer anti-fraud plans. The requirement for insurers to submit their plans to the Bureau of Insurance was deleted.

Title 24-A MRSA §2183-B. Insurance Fraud Reporting Immunity

- 1.B. - Definitions. Addition of item (9) Superintendent of Banking

Title 17-A MRSA §373 Reporting of insurance fraud convictions

- Have the Court forward a copy of the conviction or plea to the individual's licensing authority.
- Have the Court order the individual to report the conviction or plea to their licensing authority.

Recommendations

The Commission has prepared draft legislation which contains its recommendations. Please see Attachment F. for the draft legislation.

ATTACHMENT A

RESOLVE 1997, CHAPTER 77

APPROVED

JUN 12'97

BY GOVERNOR

CHAPTER

77

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-SEVEN

H.P. 681 - L.D. 933

Resolve, to Establish a Commission to Study Insurance Fraud

Emergency preamble. Whereas, Acts and resolves of the Legislature do not become effective until 90 days after adjournment unless enacted as emergencies; and

Whereas, it has come to the attention of the Legislature that insurance fraud is a serious concern of both the insurance industry and law enforcement; and

Whereas, a study of the laws related to insurance fraud is necessary to determine the extent of the problem in the State and to develop possible recommendations to strengthen the State's laws governing insurance fraud; and

Whereas, this resolve establishes the Commission to Study Insurance Fraud; and

Whereas, members of the commission established by this resolve must be appointed prior to the expiration of the 90-day period; and

Whereas, in the judgment of the Legislature, these facts create an emergency within the meaning of the Constitution of Maine and require the following legislation as immediately necessary for the preservation of the public peace, health and safety; now, therefore, be it

Sec. 1. Commission established. Resolved: That the Commission to Study Insurance Fraud, referred to in this resolve as the "commission," is established; and be it further

Sec. 2. Commission membership. Resolved: That the commission consists of the following 12 members:

1. Ten members appointed by the Governor representing the following interests and constituent groups: five representatives from the insurance industry; one representative of the Office of the State Fire Marshal; one representative of the Medicaid fraud unit of the Department of Human Services; one representative of the private bar; one representative of a hospital; and one representative of health care providers. Trade groups representing these interests may make recommendations to the Governor regarding appointees to the commission; and

2. Two Legislators, one of whom must be a Senator appointed by the President of the Senate and one of whom must be a Representative appointed by the Speaker of the House; and be it further

Sec. 3. Appointments; meetings. Resolved: That all appointments must be made no later than 30 days following the effective date of this resolve. The Executive Director of the Legislative Council must be notified by all appointing authorities once the selections have been made. Within 15 days after the appointment of all members, the Chair of the Legislative Council shall call and convene the first meeting of the commission. The commission shall select a chair from among its members; and be it further

Sec. 4. Duties. Resolved: That the commission shall study the following issues:

1. The current statutory provisions governing insurance fraud in this State including the civil and criminal penalties available and the effectiveness of those provisions;

2. Any model legislation relating to insurance fraud proposed by the National Association of Insurance Commissioners and the laws concerning insurance fraud in other states; and

3. Any other issues concerning insurance fraud determined relevant to the study by the commission; and be it further

Sec. 5. Staffing assistance. Resolved: That the Bureau of Insurance shall provide staffing assistance to the commission. The Office of Policy and Legal Analysis may also serve as a resource to the commission; and be it further

Sec. 6. Reimbursement. Resolved: That the legislative members of the commission are entitled to legislative per diem and reimbursement for travel and other necessary expenses upon

application to the Executive Director of the Legislative Council; and be it further

Sec. 7. Meetings. Resolved: That the commission may meet up to 5 times; and be it further

Sec. 8. Report. Resolved: That the commission shall submit its report and recommendations, together with any necessary implementing legislation, to the joint standing committee of the Legislature having jurisdiction over insurance matters no later than January 1, 1998. If the commission requires an extension, it may apply to the Legislative Council, which may grant the extension; and be it further

Sec. 9. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1997-98
LEGISLATURE	
Commission to Study Insurance Fraud	
Personal Services	$550
All Other	1,000
Provides funds for the per diem and expenses of legislative members and miscellaneous costs, including printing, of the Commission to Study Insurance Fraud.	
TOTAL	$1,550

Emergency clause. In view of the emergency cited in the preamble, this resolve takes effect when approved.

ATTACHMENT B

COMMISSION TO STUDY INSURANCE

FRAUD MEMBERSHIP LIST

Attachment B.

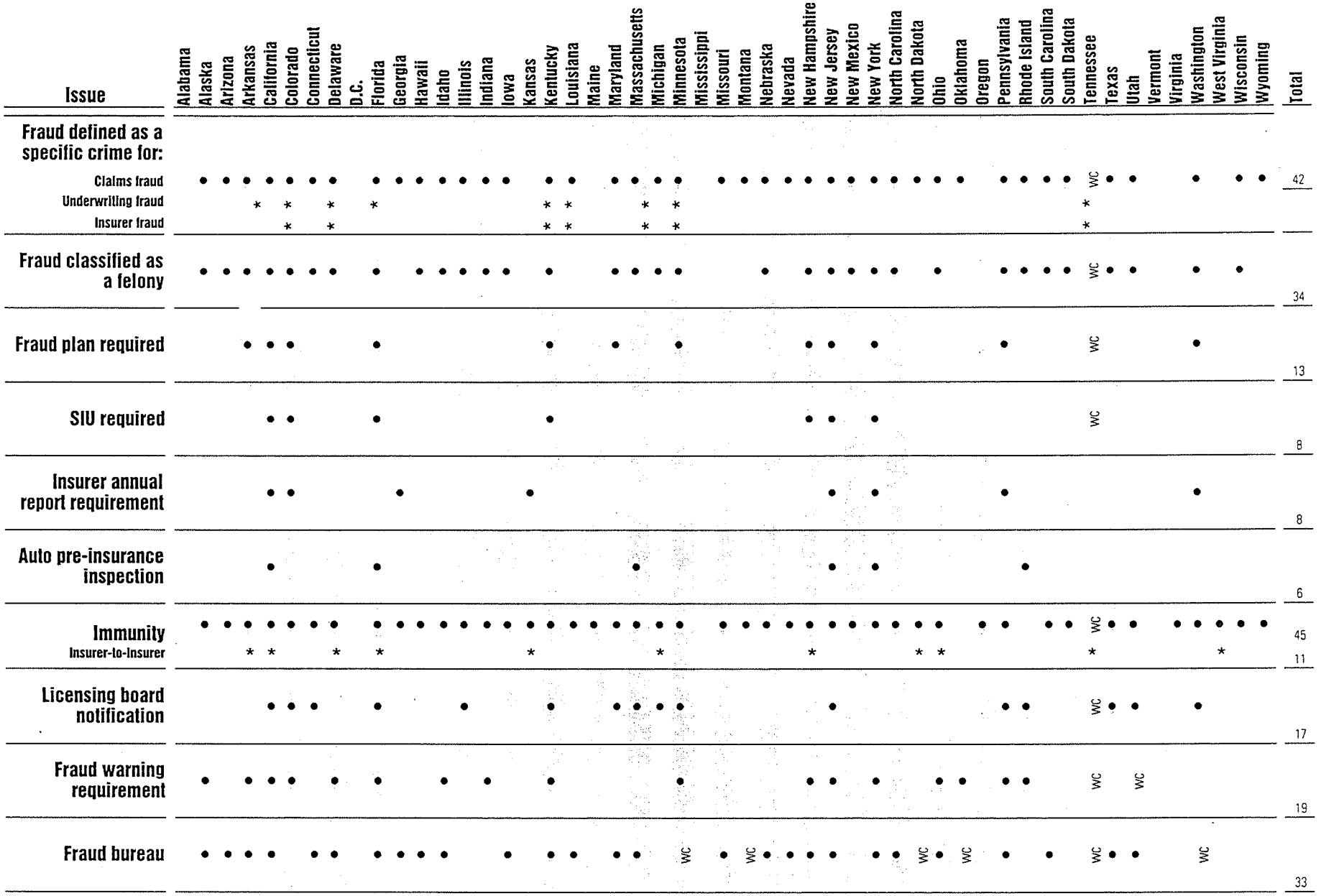
Commission to Study Insurance Fraud
Membership List

Senator Lloyd P. LaFountain, III Commission Chairperson (elected)	282-6131
Representative Christopher P. O'Neil	284-8850
Ladd Alcott, Acting State Fire Marshal State Fire Marshal's Office	287-3473
Margaret Ross, Director Division of Surveillance & Utilization Review, DHS	624-5220
Representing Private Bar: Ms. Louise Thomas Pierce Atwood Attorneys	791-1100
Representing Hospitals: Edward McGeachey Southern Maine Medical Center	283-7000
Representing Health Care Providers: Lewis N. Estabrooks, D.M.D.	772-4063
Representing Insurance Industry: Jeffrey Huston, UNUM	770-2211
Dennis Jay, Coalition Against Insurance Fraud	(202) 393-7330
Donald W. Moore, BlueCross BlueShield of Maine	822-7303
Judith E. Plummer, Acadia Insurance Company	645-3586
Mark Willett, CPCU, Guard Insurance Group	283-3609
Commission Staff: Colleen McCarthy Reid Office of Policy & Legal Analysis	287-1670
Van Sullivan Bureau of Insurance, Market Conduct Division	624-8463

ATTACHMENT C

STATE INSURANCE FRAUD STATUTES

State Insurance Fraud Statutes



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ATTACHMENT D

NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS INSURANCE FRAUD PREVENTION MODEL ACT

c 1995 by NAIC

INSURANCE FRAUD PREVENTION MODEL ACT

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Section 1. Purpose

The [insert name for state's legislature] finds that the business of insurance involves many transactions that have potential for fraud, abuse and other illegal activities. This Act is intended to permit full utilization of the expertise of the commissioner to investigate and discover fraudulent insurance acts more effectively, halt fraudulent insurance acts and assist and receive assistance from state, local and federal law enforcement and regulatory agencies in enforcing laws prohibiting fraudulent insurance acts.

Section 2. Definitions

As used in this Act:

A. "Business of insurance" means the writing of insurance or the reinsuring of risks by an insurer, including acts necessary or incidental to writing insurance or reinsuring risks and the activities of persons who act as or are officers, directors, agents or employees of insurers, or who are other persons authorized to act on their behalf.

B. "Commissioner" means the commissioner of insurance, the commissioner's designees or the department of insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner"appears.

C. "Fraudulent insurance act" means an act or omission committed by a person who, knowingly and with intent to defraud, commits, or conceals any material information concerning, one or more of the following:

(1) Presenting, causing to be presented or preparing with knowledge or belief that it will be presented to or by an insurer, a reinsurer, broker or its agent, false information as part of, in support of or concerning a fact material to one or more of the following:

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

(b) The rating of an insurance policy or reinsurance contract;

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

(d) Premiums paid on an insurance policy or reinsurance contract;

(e) Payments made in accordance with the terms of an insurance policy or reinsurance contract;

(f) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;

(g) The financial condition of an insurer or reinsurer;

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

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

(j) The reinstatement of an insurance policy;

(2) Solicitation or acceptance of new or renewal insurance risks on behalf of an insurer reinsurer 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;

(3) Removal, concealment, alteration or destruction of the assets or records of an insurer, reinsurer or other person engaged in the business of insurance;

(4) Willful embezzlement, abstracting, purloining or conversion of monies, funds, premiums, credits or other property of an insurer, reinsurer or person engaged in the business of insurance;

(5) Transaction of 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

(6) Attempt to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions specified in this subsection.

D. "Insurance" means a contract or arrangement in which one undertakes to:

(1) Pay or indemnify another as to loss from certain contingencies called "risks," including through reinsurance;

(2) Pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies;

(3) Pay an annuity to another; or

(4) Act as surety.

E. "Insurer" means a person entering into arrangements or contracts of insurance or reinsurance and who agrees to perform any of the acts set forth in Subsection D of this section. A person is an insurer regardless of whether the person is acting in violation of laws requiring a certificate of authority or regardless of whether the person denies being an insurer.

Drafting Note: A state may include other persons, such as fraternal benefit societies, medical and hospital service corporations, health maintenance organizations, certain types of self insurers, "county mutuals" or other types of insurance entities in the definition of insurer. In somecases, it may be necessary to amend other laws to bring these entities within the Act since the portions of state law applicable to these entities may provide that no other portion of the insurance code applies to these entities without a specific reference to the other provision.

F. "NAIC" means the National Association of Insurance Commissioners.

G. "Person" means an individual, a corporation, a partnership, an association, a joint stock company, a trust, an unincorporated organization, or any similar entity or any combination of the foregoing.

H. "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.

I. "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.

Section 3. Fraudulent Insurance Acts, Interference and Participation of Convicted Felons Prohibited

A. A person shall not commit a fraudulent insurance act.

B. A person shall not knowingly or intentionally interfere with the enforcement of the provisions of this Act or investigations of suspected or actual violations of this Act.

C. (1) A person convicted of a felony involving dishonesty or breach of trust shall not participate in the business of insurance.

(2) A person in the business of insurance shall not knowingly or intentionally permit a person convicted of a felony involving dishonesty or breach of trust to participate in the business of insurance.

Section 4. Fraud Warning Required

A. Claim forms and applications for insurance, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

B. The lack of a statement as required in Subsection A of this section does not constitute a defense in any prosecution for a fraudulent insurance act.

C. Policies issued by unauthorized insurers [use the term "unlicensed" or "nonadmitted" insurers in accordance with the terminology used in the state insurance code] shall contain a statement disclosing the status of the insurer to do business in the state where the policy is delivered or issued for delivery or the state where coverage is in force. The requirement of this subsection may be satisfied by a disclosure specifically required by [insert reference to insurance code provisions. Excess and surplus lines statutes and risk retention and purchasing group statutes are likely to be cited here in nearly every state].

Section 5. Investigative Authority of the Commissioner

The commissioner may investigate suspected fraudulent insurance acts and persons engaged in the business of insurance.

Section 6. Mandatory Reporting of 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 commissioner the information required by, and in a manner prescribed by, the commissioner.

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 commissioner the information required by, and in a manner prescribed by, the commissioner.

Section 7. Immunity from Liability

A. There shall be no civil liability imposed on and no cause of action shall arise from a person's furnishing information concerning suspected, anticipated or completed fraudulent insurance acts, if the information is provided to or received from:

(1) The commissioner or the commissioner's employees, agents or representatives;

(2) Federal, state, or local law enforcement or regulatory officials or their employees, agents or representatives;

(3) A person involved in the prevention and detection of fraudulent insurance acts or that person's agents, employees or representatives; or

(4) The NAIC or its employees, agents or representatives.

B. Subsection A of this section shall not apply to statements made with actual malice. In an action brought against a person for filing a report or furnishing other information concerning a fraudulent insurance act, the party bringing the action shall plead specifically any allegation that Subsection A of this section does not apply because the person filing the report or furnishing the information did so with actual malice.

C. This section does not abrogate or modify common law or statutory privileges or immunities enjoyed by a person described in Subsection A of this section.

Section 8. Confidentiality

A. The documents and evidence provided pursuant to Section 6 of this Act or obtained by the commissioner in an investigation of suspected or actual fraudulent insurance acts shall be privileged and confidential and shall not be a public record and shall not be subject todiscovery or subpoena in a civil or criminal action.

B. Subsection A of this section does not prohibit release by the commissioner of documents and evidence obtained by the insurance fraud unit in an investigation of suspected or actual fraudulent insurance acts:

(1) In administrative or judicial proceedings to enforce laws administered by the commissioner;

(2) To federal, state, or local law enforcement or regulatory agencies, to an organization established for the purpose of detecting and preventing fraudulent insurance acts or to the NAIC; or

(3) At the discretion of the commissioner, to a person in the business of insurance that is aggrieved by a fraudulent insurance act.

C. Release of documents and evidence under Subsection B of this section does not abrogate or modify the privilege granted in Subsection A of this section.

Section 9. Creation and Purpose of the Insurance Fraud Unit

A. The [insert name of state] insurance fraud unit is established within the [insert designation of organization, such as department of insurance]. The commissioner shall appoint the full-time supervisory and investigative personnel of the insurance fraud unit, who shall be qualified by training and experience to perform the duties of their positions. The commissioner shall also appoint clerical and other staff necessary for the insurance fraud unit to carry out its duties and responsibilities under this Act.

B. It shall be the duty of the insurance fraud unit to:

(1) Initiate independent inquiries and conduct independent investigations when the insurance fraud unit has cause to believe that a fraudulent insurance act may be, is being or has been committed;

(2) Review reports or complaints of alleged fraudulent insurance activities 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; and

(3) Conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.

C. The insurance fraud unit shall have the authority to:

(1) Inspect, copy or collect records and evidence;

(2) Serve subpoenas;

(3) Administer oaths and affirmations;

(4) Share records and evidence with federal, state or local law enforcement or regulatory agencies;

(5) Execute search warrants and arrest warrants for criminal violations of this Act;

(6) Arrest upon probable cause without warrant a person found in the act of violating or attempting to violate a provision of this Act;

Drafting Note: If the insurance fraud unit has only civilauthority, the state should omit Paragraphs (5) and (6) from Subsection C.

(7) Make criminal referrals to prosecuting authorities; and

(8) Conduct investigations outside of this state. If the information the insurance fraud unit seeks to obtain is located outside this state, the person from whom the information is sought may make the information available to the insurance fraud unit to examine at the place where the information is located. The insurance fraud unit may designate representatives, including officials of the state in which the matter is located, to inspect the information on behalf of the insurance fraud unit, and the insurance fraud unit may respond to similar requests from officials of other states.

Section 10. Other Law Enforcement or Regulatory Authority

This Act shall not:

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 to a law enforcement or regulatory agency other than the insurance fraud unit; or

C. Limit the powers granted elsewhere by the laws of this state to the commissioner or the insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

Section 11. Insurer Antifraud Initiatives

Insurers shall have antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Antifraud initiatives may include:

A. Fraud investigators, who may be insurer employees or independent contractors; or

B. An antifraud plan submitted to the commissioner. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

Section 12. Regulations

The commissioner may promulgate regulations deemed necessary by the commissioner for the administration of this Act.

Section 13. Penalties

A person who violates this Act is subject to the following:

A. Suspension or revocation of license or certificate of authority, civil penalties of up to $[insert amount] per violation, or both. Suspension or revocation of license or certificate of authority and imposition of civil penalties shall be pursuant to an order of the commissioner issued under [insert reference to statutes relating to hearings conducted by the commissioner]. The commissioner's order may require a person found to be in violation of this Act to make restitution to persons aggrieved by violations of this Act; or

B. A person convicted of a violation of Section 3 of this Act by a court of competent jurisdiction [states should insert here classifications for misdemeanor and felony penalties which match provisions in their penal codes for theft offenses]. A person convicted of a violation of Section 3 of this Act shall be ordered to pay restitution to persons aggrieved by the violation of this Act. Restitution shall be ordered in addition to a fine or imprisonment, but not in lieu of a fine or imprisonment; and

C. A person convicted of a felony violation of this Act pursuant to Subsection B of this section shall be disqualified from engaging in the business of insurance.

Legislative History (all references are to the Proceedings of the NAIC).

1995 Proc. 2nd Quarter (adopted).

This model replaces and incorporates three earlier models:

Model Insurance Fraud Statute

1980 Proc. II 22, 25, 176, 181 (adopted).

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

1980 Proc. II 22, 25, 176, 179-180 (adopted).

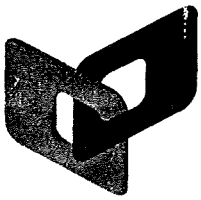
Model Immunity Act

1983 Proc. II 16, 22, 25, 30 (adopted).
1990 Proc. I 6, 30, 840, 872, 891-893 (amended and reprinted).

ATTACHMENT E

COALITION AGAINST INSURANCE FRAUD'S

MODEL INSURANCE FRAUD ACT



COALITION AGAINST INSURANCE FRAUD

Member Organizations

American Insurance Association

American International Group

Atlantic Mutual Companies

CNA Insurance Companies

Consumer Action

Consumer Federation of America

Consumer Fraud Watch

Fireman's Fund Insurance

General Accident

General Reinsurance Corporation

International Association of Insurance Fraud Agencies

The Hartford

National Association of Consumer Agency Administrators

National Association of Insurance Commissioners

National Conference of Insurance Legislators

National Criminal Justice Association

National District Attorneys Association

National Insurance Crime Bureau

National Urban League

Nationwide Insurance

Office of Attorney General, Minnesota

State Farm Insurance Companies

Travelers Property/Casualty

USF&G

.....

Dennis Jay
Executive Director

A national coalition of consumers, government agencies and insurers dedicated to combating all forms of insurance fraud through public information and advocacy.

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MODEL INSURANCE FRAUD ACT

- Summary of Provisions
- Model Language

Proposed by the Coalition Against Insurance Fraud
September 1995

website address:
www.InsuranceFraud.org

MODEL INSURANCE FRAUD ACT

(Adopted March 2, 1995; amended September 20, 1995)

Summary of Provisions

COALITION AGAINST INSURANCE FRAUD

Background

Insurance fraud in the United States — whether committed by claimants, providers, employees or insurers — is pervasive and expensive; its cost to consumers, the insurance industry and governments in 1992 was an estimated $79.9 billion. Direct and indirect costs attributable to insurance fraud amounted to nearly $1,000 per American family.

Insurance fraud increases premiums, thus decreasing consumer capital for other goods and services, and overall lowers our nation's standard of living. Businesses have been forced to reduce staff, restrict growth and in some cases, relocate because of high levels of fraud. Further, a high percentage of insurance company insolvencies have been linked to internal fraud, and have left claimants in financial ruin. Insurance fraud is perceived by many to be a high-reward, low-risk endeavor; without substantive penalties, it's viewed as an easy way to make a buck.

The coalition believes the effort to combat insurance fraud must be a partnership among consumers, the insurance industry and government. Currently, states vary in their statutory efforts to fight fraud. A total of 40 states currently define insurance fraud as a specific crime, and 32 states further define certain classifications of insurance fraud as a felony.

Insurance fraud laws are essential to combat the increasing effect of fraud on the cost of insurance. There are three categories of fraud: claims fraud, applications fraud, and fraud committed by employees in the insurance industry including agents, adjusters, brokers or persons claiming to be in the business of insurance. Any comprehensive insurance fraud act should address all three categories. Then, strict enforcement will help restrain prices and keep the insurance system financially sound. Also, enforcement brings fairness to the system so honest consumers don't subsidize, through unnecessarily high premiums, those who cheat the system.

Overview

This legislation establishes insurance fraud as a specific crime and as a felony in most cases. It attacks insurance fraud at the source and can be used as a framework for additional laws, such as creating an insurance fraud bureau. The model will help reduce fraudulent claims paid by insurers. Since the model also covers fraud committed by insurers and those who purport to be insurers, it would curtail fraud committed against consumers and lessen financial disruption of the insurance industry.

Specifically, the model includes a cohesive attack on fraud with both civil and criminal penalties for committing what's defined as either a fraudulent insurance act or an unlawful insurance act. The model addresses all forms of insurance fraud, including claims fraud, underwriting fraud, deceptive sales practices and scams by insurance operators.

The fraudulent act is an act based on an intent to defraud someone, whether an insurance company or a consumer. The unlawful insurance act requires a lower standard of proof and is designed to attack scams such as medical mills and fraud rings in which the leaders often are able to shield themselves from prosecution under current laws.

The model significantly expands the definition of insurance fraud that currently exists in state laws and other models, as well as the remedies available to both the consumer and insurer when defrauded. The bill affords the consumer an additional level of protection particularly when it comes to shutting down bogus insurance operations. The bill also sets strict penalties for licensed practitioners who are found in violation of the fraud act.

The legislation puts insurers on the front line in the fight against fraud. Insurers would be required to cooperate with law enforcement in cases of suspected fraud. In return, the model contains the broadest civil immunity for anyone who shares information about suspected fraud. The model also requires insurers to draft anti-fraud plans and to place fraud warnings on applications and claims forms, but avoids micro-management of anti-fraud efforts by insurance regulators.

RATIONALE OF THE PROVISIONS

Section 1. Definitions

This section defines terms used in the legislation, including "insurance transaction" and "insurer." The term "insurer" includes anyone purported to be in the business of insurance as well as those authorized to do business in that state.

The bill also defines "practitioner" as any individual who is, or is required to be, a licensee of the state and whose services are compensated in whole or part by insurance proceeds. This includes medical providers, lawyers, agents, building contractors, adjusters and automotive repair shops.

These definitions are written to cover all forms of insurance fraud, as discussed above, as well as those who are most likely to commit fraud, and are designed to establish greater consistency from state to state.

Section 2. Fraudulent Insurance Act

A fraudulent insurance act is defined as an act committed by anyone who, knowingly and with intent, defrauds another person for gain. A fraudulent act includes claims fraud and application fraud. The legislation contains a separate provision dealing with insurer fraud. Individuals who conspire, aid and/or abet a fraudulent act also are covered by the definition. As in all criminal cases, a conviction under these provisions must meet the burden of proof beyond a reasonable doubt.

Among the actions that fall under the fraudulent act is the preparation and presentation of false information affecting:

- the application for any insurance policy;
- an insurance claim pursuant to any policy;
- any payments made pursuant to any insurance policy.

The actions that would fall under the insurer fraud elements of the fraudulent act include:

- the solicitation for sale of any policy or purported policy;
- an application for certificate of authority;
- misrepresentation of the financial condition of any insurer.

This section makes all forms of insurance fraud, as well as attempts to commit fraud, a specific crime. Without definite language targeting attempts, conspiracies, and aiding or abetting fraud, an insurer often must pay false claims before a crime can be said to be committed; even then, others involved in the fraud may go free. Many existing statutes lack this kind of provision. This section also protects consumers from unscrupulous operators by expanding the definition of fraud to include schemes perpetrated by insurers or those who claim to be in the insurance business.

Section 3. Unlawful Insurance Act

An unlawful insurance act is an act committed by anyone who commits or allows to be committed an act with "an intent to induce reliance." Unlike the fraudulent insurance act, those who bring actions need not prove that a defendant knowingly and with intent committed fraud. Convictions under this section must

meet the lower civil standard of proof, which requires a preponderance of evidence.

The legislation separates the definition for unlawful insurance actions affecting claims and applications fraud from fraud committed by insurers. Actions falling under the claims/applications fraud portion of the unlawful act include:

- the application for any insurance policy;
- an insurance claim pursuant to any policy;
- payments made in accordance with the terms of any policy.

Actions falling under the insurer fraud portion of the unlawful act include:

- an application for certificate of authority;
- misrepresentation of the financial condition of an insurer;
- the solicitation for sale of any policy or purported policy.

This section expands the legal scope of insurance fraud into an entirely new arena. Those who have shielded themselves from the actual act of fraud — signing a false claim form, for example —can be charged through this civil remedy, which requires a lower standard of proof. This provision is designed to punish individuals who create a fraudulent scheme, such as a medical mill, but have underlings execute it. Like the provisions against fraudulent acts, this section also protects consumers from unscrupulous operators by expanding the scope of what constitute a fraud.

Section 4. Criminal Penalties

The criminal penalties only apply to those persons charged with committing a fraudulent insurance act. The penalties use a stepladder approach and increase based on actual damages and/or by previous convictions for fraud. The penalties would allow the courts and the prosecution to segregate or aggregate the economic loss suffered by the persons defrauded. The highest felony charge includes those charged with committing a fraudulent insurance act where the offense places anyone at risk of death or serious bodily injury.

Criminal sanctions must be severe enough to deter rather than be treated by perpetrators as a cost of doing business. The commonly used stepladder approach deters repeat offenders as well as particularly egregious forms of fraud. States are left free to define those levels as legislatures sees fit.

Section 5. Restitution

Anyone convicted of a fraudulent act would be required to make monetary restitution for any financial loss due to the violation. The legislation grants the court the ability to order restitution to be paid in a lump sum or installments. Restitution for victims is codified both for the purpose of providing justice and as a way to seize perpetrators' ill-gotten gains.

Section 6. Administrative Penalties for Practitioners

The legislation requires notification of appropriate state licensing authority if any practitioner is found guilty of a fraudulent insurance act. The licensing authority would be required to hold a hearing to consider whether administrative sanctions (including license revocation) are in order.

Appropriate sanctions against licensed practitioners are included because depriving them of their livelihood is a powerful deterrent, especially against repeat offenses.

Section 7. Civil Remedies

Individuals charged with an unlawful insurance act face these provisions. Anyone defrauded by an unlawful insurance act can recover the payment lost as a result of the violation, plus reasonable attorney fees not to exceed $5,000.

These provisions also can be used against those charged with a fraudulent insurance act. The state attorney general or any appropriate prosecuting agency would have the authority to conduct civil proceedings on behalf of the state insurance department and victims. A $5,000 fine for each violation can be assessed. Victims can recover profits or payments lost from the fraud and reasonable attorney fees, and all other economic damages resulting from the violation. The legislation also allows victims to recover treble damages if there's clear evidence the offense was part of a pattern or practice of violations of the fraudulent insurance act.

In addition to criminal remedies, civil remedies may be sought in cases where it's difficult to prove charges beyond a reasonable doubt. Attorney and legal fees in these cases are limited to $5,000 to eliminate any profit motive, which should deter frivolous suits. This provision also encourages prosecutors to bring actions against anyone who commits a fraudulent act.

Section 8. Exclusivity of Remedies

The legislation restricts the civil remedies provisions so they may not be used in conjunction with, or in addition to, any other remedies available under law to collect for the same damages.

Section 9. Cooperation

Insurers are required to disclose information about suspected insurance fraud to any court, law enforcement agency or insurance department. The bill allows a disclosing insurer to have the right to receive case-related information from the agency to which the insurer submitted material. The legislation would protect any information that is privileged. Also, under this provision, any person or insurer who fails to cooperate will not be eligible to receive restitution. To assist insurers in their in-house attempts to curtail fraud, government agencies in turn would have to disclose relevant information about reported cases.

Section 10. Immunity

The bill grants broad civil immunity to anyone who, in the absence of actual malice, furnishes information about insurance fraud. The bill allows exchange of information among insurers and any other organization for the purpose of detecting and deterring fraud. The section further allows for recovery of reasonable legal fees if any action is brought against any person found to be immune from liability.

This section encourages cooperation with law enforcement and helps to facilitate detection and prosecution. It allows anyone who has that information to report it without fear of being sued for defamation, libel, slander or similar offenses, which has had a chilling effect in many cases. Also, many frauds especially organized rings, are uncovered only when insurers discover the same or similar claims are filed with multiple insurers. This provision protects insurers who share information among themselves as long as the infor-

mation is used exclusively for the prevention, detection and prosecution of fraud.

Section 11. Regulatory Requirements

All insurers have six months after the law's effective date to prepare, implement and maintain an anti-fraud plan. The legislation establishes a framework for the plan that includes procedures to:

- prevent and detect all forms of fraud;
- educate appropriate employees on detection and the anti-fraud plan;
- hire or contract for fraud investigators;
- report fraud to the appropriate authorities for investigation and prosecution.

The anti-fraud plan may be reviewed by the insurance commissioner who may examine the insurer's compliance with its anti-fraud plan. The anti-fraud plans that are submitted to the insurance department would be exempt from the state's public records act. Insurers also are required to print or attach fraud warnings on all applications and claims forms no later than six months after the effective date of the law. Insurers face a fine for failing to prepare, implement, maintain and submit an anti-fraud plan to the insurance department.

There's considerable evidence showing that insurers who invest in an active fight against fraud receive a substantial return on the investment. However, not all insurers fight fraud voluntarily; their customers bear that cost. By requiring all insurers to have a plan to fight fraud, and then ensuring they comply with that plan, the playing field is leveled. All insured consumers will benefit. Also, printed fraud warnings are a reminder against illegal acts and will help deter claims fraud.

March 1995

MODEL INSURANCE FRAUD ACT

(Adopted March 2, 1995; amended September 20, 1995)

Model Language

COALITION AGAINST INSURANCE FRAUD

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF _____

The legislature finds that insurance fraud is pervasive and expensive, costing consumers and the business community of this state millions of dollars each year. Each family spends in excess of several hundreds of dollars each year in direct and indirect costs attributable to insurance fraud. Insurance fraud increases premiums, places businesses at risk and is a leading cause of insurance company insolvencies. Insurance fraud reduces consumers ability to raise their standard of living and decreases the economic vitality of this state.

Therefore, the legislature believes that the state of _____ must aggressively confront the problem of insurance fraud by facilitating the detection, reducing the occurrence through stricter enforcement and deterrence, requiring restitution and increasing the partnership among consumers, the insurance industry and the state in coordinating efforts to combat insurance fraud by enacting the following Act.

Table of Contents

Section 1. Definitions

As used in this act, unless the context requires otherwise, the following terms have the meaning ascribed to them in this section.

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

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

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

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

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

Insurer. "Insurer" means any Person purporting to engage in the business of insurance or authorized to do business in the state or subject to regulation by the state, who undertakes to indemnify another against loss, damage or liability arising from a contingent or unknown event. "Insurer" includes, but is not limited to, an insurance company; self-insurer; reinsurer; reciprocal exchange; interinsurer; risk retention group; Lloyd's insurer; fraternal benefit society; surety; medical service, dental, optometric or any other similar health service plan; and any other legal entity engaged or purportedly engaged in the business of insurance, including any Person or entity which falls within the definition of "Insurer" found within the _____ Insurance Code §_____.

Pattern or practice. "Pattern or practice" means repeated, routine or generalized in nature, and not merely isolated or sporadic.

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

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

Premium. "Premium" means consideration paid or payable for coverage under an Insurance Policy. "Premium" includes any payments, whether due within the Insurance Policy term or otherwise, and deductible payments whether advanced by the Insurer or Insurance Professional and subject to reimbursement by the insured or otherwise, any self insured retention or payments, whether advanced by the Insurer or Insurance Professional and subject to reimbursement by the insured or otherwise, and any collateral or security to be provided to collateralize obligations to pay any of the above.

Premium Finance Company. "Premium Finance Company" means a Person engaged or purporting to engage in the business of advancing money, directly or indirectly, to an Insurer or producer at the request of an insured pursuant to the terms of a premium finance agreement, including but not limited to loan contracts,

notes, agreements or obligations, wherein the insured has assigned the unearned Premiums, accrued dividends, or loss payments as security for such advancement in payment of Premiums on Insurance Policies only, and does not include the financing of insurance Premiums purchased in connection with the financing of goods and services.

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

Reckless. "Reckless" means without reasonable belief of the truth, or, for the purposes of Section 3(c), with a high degree of awareness of probable insolvency.

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

Section 2. Fraudulent Insurance Act

Any Person who, knowingly and with intent to defraud, and for the purpose of depriving another of property or for pecuniary gain, commits, participates in or aids, abets, or conspires to commit or solicits another Person to commit, or permits its employees or its agents to commit any of the following acts, has committed a Fraudulent Insurance Act:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact concerning any of the following:

(1) The application for, rating of, or renewal of, any Insurance Policy;

(2) A claim for payment or benefit pursuant to any Insurance Policy;

(3) Payments made in accordance with the terms of any Insurance Policy;

(4) The application used in any Premium Finance Transaction;

(b) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which contains false representations as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) The solicitation for sale of any Insurance Policy or purported Insurance Policy;

(2) An application for certificate of authority;

(3) The financial condition of any Insurer;

(4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;

(c) Solicits or accepts new or renewal insurance risks by or for an insolvent Insurer.

(d) Removes the assets or records of assets, transactions and affairs or such material part thereof, from the home office or other place of business of the Insurer, or from the place of safekeeping of the Insurer, or destroys or sequesters the same from the Department of Insurance.

(e) Diverts, misappropriates, converts or embezzles funds of an Insurer, an insured, claimant or applicant for insurance in connection with:

(1) An Insurance Transaction;

(2) The conduct of business activities by an Insurer or Insurance Professional;

(3) The acquisition, formation, merger, affiliation or dissolution of any Insurer.

It shall be unlawful for any Person to commit, or to attempt to commit, or aid, assist, abet or solicit another to commit, or to conspire to commit a Fraudulent Insurance Act.

Section 3. Unlawful Insurance Act

Any Person who commits, participates in, or aids, abets, or conspires to commit, or solicits another Person to commit, or permits its employees or its agents to commit any of the following acts with an intent to induce reliance, has committed an Unlawful Insurance Act:

(a) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, by or on behalf of an insured, claimant or applicant to an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which the Person knows to contain false representations, or representations the falsity of which the Person has Recklessly disregarded, as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) The application for, rating of, or renewal of, any Insurance Policy;

(2) A claim for payment or benefit pursuant to any Insurance Policy;

(3) Payments made in accordance with the terms of any Insurance Policy;

(4) The application for the financing of any insurance Premium;

(b) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an Insurer, Insurance Professional or a Premium Finance Company in connection with an Insurance Transaction or Premium Finance Transaction, any information which the Person knows to contain false representations, or representations the falsity of which the Person has Recklessly disregarded, as to any material fact, or which Withholds or Conceals a material fact, concerning any of the following:

(1) The solicitation for sale of any Insurance Policy or purported Insurance Policy;

(2) An application for certificate of authority;

(3) The financial condition of any Insurer;

(4) The acquisition, formation, merger, affiliation or dissolution of any Insurer;

(c) Solicits or accepts new or renewal insurance risks by or for an Insurer which the Person knows was insolvent or the insolvency of which the Person Recklessly disregards.

It shall be unlawful for any Person to commit, or to attempt to commit, or aid, assist, abet or solicit another to commit, or to conspire to commit an Unlawful Insurance Act.

Section 4. Criminal Penalties

A Person who violates Section 2 of this Act is guilty of:

(a) A Class A misdemeanor if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____;

(b) A Class B misdemeanor if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____, and the defendant has been previously convicted of any class or degree of insurance fraud in any jurisdiction;

(c) A Class C misdemeanor if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____;

(d) A felony in the third degree if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____, and the defendant has been previously convicted two or more times of any class or degree of insurance fraud in any jurisdiction;

(e) A felony in the second degree if the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____

(f) A felony in the first degree if:

(1) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is _____ or more but less than _____; or

(2) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____ and the defendant has been previously convicted two or more times of any degree of felony insurance fraud in any juris-

diction; or

(3) the greater of (i) the value of property, services or other benefit he wrongfully obtained, or attempted to obtain, or (ii) the segregate or aggregate economic loss suffered by any Person or Persons as a result of his violation of Section 2, is less than _____ and his violation of Section 2 of this Act placed any Person at risk of death or serious bodily injury.

Section 5. Restitution

A Person convicted of a violation of Section 2 of this Act shall be ordered to make monetary restitution for any financial loss or damages sustained by any other Person as a result of the violation. Financial loss or damage shall include, but is not necessarily limited to, loss of earnings, out-of-pocket and other expenses, paid deductible amounts under an Insurance Policy, Insurer claim payments, cost reasonably attributed to investigations and recovery efforts by owners, Insurers, Insurance Professionals, law enforcement and other public authorities, and cost of prosecution.

When restitution is ordered, the court shall determine its extent and methods. Restitution may be imposed in addition to a fine and, if ordered, any other penalty, but not in lieu thereof. The court shall determine whether restitution, if ordered, shall be paid in a single payment or installments and shall fix a period of time, not in excess of _____, within which payment of restitution is to be made in full.

Section 6. Administrative Penalties for Practitioners

Any Practitioner determined by the Court to have violated Section 2 shall be deemed to have committed an act involving moral turpitude that is inimical to the public well being. The court or prosecutor shall notify the appropriate licensing authority in this state of the judgment for appropriate disciplinary action, including revocation of any such professional license(s), and may notify appropriate licensing authorities in any other jurisdictions where the Practitioner is licensed. Any victim may notify the appropriate licensing authorities in this State and any other jurisdiction where the Practitioner is licensed, of the conviction. This State's appropriate licensing authority shall hold an administrative hearing, or take other appropriate administrative action authorized by state law, to consider the imposition of the administrative sanctions as provided by law against the Practitioner. Where the Practitioner has been convicted of a felony violation of Section 2 of this Act, this state's appropriate licensing authority shall hold an administrative hearing, or take other appropriate administrative action authorized by state law, and shall summarily and permanently revoke the license and it is hereby recommended by the legislature that the Supreme Court shall summarily and permanently disbar any attorney found guilty of such felony. All such referrals to the appropriate licensing or other agencies, and all dispositive actions thereof, shall be a matter of public record.

Section 7. Civil Remedies

(a) Any Person injured in his business or property by reason of a violation of Section 3 may recover therefor from the Person[s] violating Section 3, in any appropriate _____ Court the following:

(1) Return of any profit, benefit, compensation or payment received by the Person violating Section 3 directly resulting from said violation;

(2) Reasonable attorneys fees, related legal expenses, including internal legal expenses and court costs, not to exceed $5,000;

An action maintained under this subparagraph may neither be certified as a class action nor be made part

of a class action.

(b) Any Person injured in his business or property by reason of a violation of Section 2 may recover therefor from the Person[s] violating Section 2, in any appropriate _____ Court the following:

(1) Return of any profit, benefit, compensation or payment received by the Person violating Section 2 directly resulting from said violation;

(2) Reasonable attorneys fees, related legal expenses, including internal legal expenses and court costs;

(3) All other economic damages directly resulting from the violation of Section 2;

(4) Reasonable investigative fees based on a reasonable estimate of the time and expense incurred in the investigation of the violation(s) of Section 2 proved at trial:

(5) A penalty of no less than $_____ and no greater than $_____.

An action maintained under this subparagraph may neither be certified as a class action nor be made part of a class action.

(c) Any Person injured in his or her business or property by a Person violating Section 2, upon a showing of clear and convincing evidence that such violation was part of a Pattern or Practice of such violations, shall be entitled to recover threefold the injured Person's economic damages. An action for treble damages must be brought within _____ year(s) of such violation. One third of the treble damages awarded shall be payable to the state to be used solely for the purpose of investigation and prosecution of violations of this Act or other fraudulent behavior relating to Insurance Transactions, and/or for public education relating to insurance fraud. An action maintained under this subparagraph may neither be certified as class action nor be made part of a class action, unless the violations of Section 2 giving rise to the action resulted in criminal conviction of the violator[s] under Section 4.

(d) The State Attorney General, District Attorney or prosecutorial agency shall have authority to maintain Civil proceedings on behalf of the State Insurance Department and any victims of violations of Section 2. In any such action, the court shall proceed as soon as practicable to the hearing and determination thereof. Pending final determination thereof, the court may at any time enter such restraining orders or prohibitions, or take such other actions, including the acceptance of satisfactory performance bonds, as it shall deem proper.

(1) The _____ Courts of the state shall have jurisdiction to prevent and restrain violations of Section 2 of this Chapter by issuing appropriate orders.

(2) In any action commenced under this subparagraph (d), the Court, upon finding that any Person has violated Section 2, shall levy a fine of up to $5,000 for each violation.

Any court in which a prosecution for violation of Section 2 is pending shall have authority to stay or limit proceedings in any civil action regarding the same or related conduct. Any court in which is pending a civil action brought pursuant to subparagraph (d) of this Section 7 may stay or limit proceedings in actions brought pursuant to subparagraphs (a)-(c) regarding the same or related conduct or may transfer such actions or consolidate them before itself or allow the plaintiffs in such actions to participate in the action brought pursuant to subparagraph (d), as it shall prescribe.

Any cause of action under this section for violation of Section 2 or Section 3 must be brought within _____

years of the commission of the acts constituting such violation, or within _____ years of the time the plaintiff discovered (or with reasonable diligence could have discovered) such acts, whichever is later.

An insurer shall not pay damages awarded under this Section 7, or provide a defense or money for a defense, on behalf of an insured under a contract of insurance or indemnification. A third party who has asserted a claim against an insured shall have no cause of action under this Section against the Insurer of the insured arising out of the Insurer's processing or settlement of the third party's claim. An obligee under a surety bond shall not have a cause of action under this section against the surety arising out of the surety's processing or settlement of the obligee's claim against the bond.

Any Person injured in his business or property by reason of a violation of Section 2 or Section 3 of this Chapter may recover under only one of the subparagraphs in this Section.

Section 8. Exclusivity of Remedies

The remedies expressly provided in Section 7 shall be the only private remedies for violations of this Act and no additional remedies shall be implied. The remedies available under Section 7 shall not be used in conjunction with or in addition to any other remedies available at law or in equity to duplicate recovery for the same element of economic damage. Further, in any civil action pleading both exemplary damages and the treble damages available in Section 7(c), plaintiff shall elect one or the other remedy, but not both, at the conclusion of the evidentiary phase of the trial.

However, nothing in this Act shall limit or abrogate any right of action which would have existed in the absence of this Act, but no action based on such a right shall rely on this Act to establish a standard of conduct or for any other purpose.

Section 9. Cooperation

(a) When any law enforcement official or authority, any insurance department, state division of insurance fraud, or state or federal regulatory or licensing authority requests information from an Insurer or Insurance Professional for the purpose of detecting, prosecuting or preventing insurance fraud, the Insurer or Insurance Professional shall take all reasonable actions to provide the information requested, subject to any legal privilege protecting such information.

(b) Any Insurer or Insurance Professional that has reasonable belief that an act violating Sections 2 or 3 will be, is being, or has been committed shall furnish and disclose any information in its possession concerning such act to the appropriate law enforcement official or authority, insurance department, state division of insurance fraud, or state or federal regulatory or licensing authority, subject to any legal privilege protecting such information.

(c) An Insurer or Insurance Professional providing information to any law enforcement, regulatory, licensing or other governmental agency under subparagraphs (a) or (b) of this section, shall have the right to request information in the possession or control of the agency relating to the suspected violation or to a pattern of related activity, except information which was privileged or confidential under the laws of this state prior to its submission to the agency. In instances where disclosure would not jeopardize an ongoing investigation or prosecution, the agency shall provide the requested information to the Insurer or Insurance Professional. The agency may request that the Insurer or Insurance Professional keep the disclosed information confidential.

(d) Any Person that has a reasonable belief that an act violating this Chapter will be, is being, or has been committed; or any Person who collects, reviews or analyzes information concerning insurance fraud may furnish and disclose any information in its possession concerning such act to an authorized representative of an Insurer that requests the information for the purpose of detecting, prosecuting or preventing insurance fraud.

(e) Failure to cooperate with a request for information from an appropriate local, state or federal governmental authority shall bar a Person's eligibility for restitution from any proceeds resulting from such governmental investigation and prosecution.

Section 10. Immunity

In the absence of Actual Malice, no Person furnishing, disclosing or requesting information pursuant to Section 9 shall be subject to civil liability for libel, slander, or any other cause of action arising from the furnishing, disclosing or requesting of such information. No Person providing information pursuant to Section 9(a) shall be subject to civil liability for any cause of action arising from the Person's provision of requested information. Any Person against whom any action is brought who is found to be immune from liability under this section, shall be entitled to recover reasonable attorney's fees and costs from the Person or party who brought the action. This section does not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any Person.

Section 11. Regulatory Requirements

Insurers solely writing _____shall be excepted from the requirements of this Section.

(a) Anti-Fraud Plans

Within six months of the effective date of this legislation, every Insurer shall prepare, implement, maintain and submit to the department of insurance an insurance anti-fraud plan.

Each Insurer's anti-fraud plan shall outline specific procedures, appropriate to the type of insurance the Insurer writes in this state, to:

(1) prevent, detect and investigate all forms of insurance fraud, including fraud involving the Insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies; claims fraud; and security of the Insurer's data processing systems.

(2) educate appropriate employees on fraud detection and the Insurer's anti-fraud plan.

(3) provide for the hiring of or contracting for fraud investigators.

(4) report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

(5) pursue restitution for financial loss caused by insurance fraud, where appropriate.

The Commissioner may review each Insurer's anti-fraud plan to determine if it complies with the requirements of this subparagraph.

It shall be the responsibility of the Commissioner to assure Insurer compliance with anti-fraud plans submitted to the Commissioner. The Commissioner may require reasonable modification of the Insurer's anti-

fraud plan, or may require other reasonable remedial action if the review or examination reveals substantial non-compliance with the terms of the Insurer's own anti-fraud plan.

The Commissioner may require each Insurer to file a summary of the Insurer's anti-fraud activities and results. The anti-fraud plans and the summary of the Insurer's anti-fraud activities and results are not public records and are exempt from the _____ public records act, and shall be proprietary and not subject to public examination, and shall not be discoverable or admissible in civil litigation.

This section confers no private rights of action.

(b) Fraud Warnings

No later than six months after the effective date of this Act, all applications for insurance, and all claim forms regardless of the form of transmission provided and required by an Insurer or required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following:

> *"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company: Penalties include imprisonment, fines and denial of insurance benefits."*

The lack of a statement required in this subparagraph does not constitute a defense in any criminal prosecution under Section 2 nor in any civil action under Sections 2 or 3.

Drafting note: It is not the intent of the drafters to require reinsurers to meet the provisions of Section 11(b).

(c) Enforcement

Notwithstanding any other provision of the Insurance Code, the following are the exclusive monetary penalties for violation of this Section. Insurers that fail to prepare, implement, maintain and submit to the department of insurance an insurance anti-fraud plan are subject to a penalty of $500 per day, not to exceed $25,000.

ATTACHMENT F

DRAFT LEGISLATION

LR #
Sponsor: Commission to Study Insurance Fraud pursuant to Resolves 1997, c.77
Drafted by: Colleen McCarthy Reid/CMM
Date: January 16, 1998
Doc. Name: G:\OPLAGEA\COMMTTEE\BAN\STUDIES\INSFRAUD\DRFTLEG2.DOC

Title: An Act to Implement the Recommendations of the Commission to Study Insurance Fraud

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

Sec. 1. **24-A MRSA § 2183** is repealed.

Sec. 2. **24-A MRSA § 2183-A** is enacted to read:

§ 2183-A. Insurance Fraud Prevention

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

A. "Fraudulent insurance act" means any of the following acts or omissions when committed knowingly and with intent to defraud:

(1) Presenting, causing to be presented or preparing false information with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to an insurer, insurance producer or other person engaged in the business of insurance. False information is information that contains false representations as to a material fact relating to 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) Presenting, causing to be presented or preparing false information with knowledge or belief that the information will be presented to or by an insurer, insurance producer or other person engaged in the business of insurance. False information is information that contains false representations as to a material fact relating to 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) Soliciting or accepting 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) Removing , concealing, altering or destroying the assets or records of an insurer or other person engaged in the business of insurance;

(5) Embezzling, abstracting, purloining or converting monies, funds, premiums, credits or other property of an insurer or other person engaged in the business of insurance;

(6) Transacting 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) Attempting to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions described in this subsection.

B. "Insurer" means a 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. For the purposes of this section, "insurer" also means the State Medicaid program.

2. Fraudulent insurance acts prohibited. A person may not commit a fraudulent insurance act.

3. 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 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 subsection 1 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. The statement required in subsection 1 must be included in all applications and claim forms filed and approved for use by the superintendent on or after January 1, 1999.

4. Reporting of fraudulent insurance acts. Fraudulent insurance acts must be reported in accordance with the following.

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 which the insurer had knowledge of or had a reasonable belief that a fraudulent insurance act was being 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 individuals. The superintendent shall adopt rules necessary to define the information that must be reported related to fraudulent insurance acts. Rules adopted pursuant to this subsection are major substantive rules as defined in Title 5, chapter 375, subchapter II-A. The rules must be provisionally adopted and forwarded to the Legislature for review in the First Regular Session of the 119th Legislature. The initial reporting date is the first full calendar year following adoption of the rules by the superintendent.

B. On the July 1st following the filing of the initial reports required by paragraph A and annually thereafter, 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.

5. Insurer anti-fraud plans. Within six months of the effective date of this Act, every insurer shall prepare and implement an anti-fraud plan. The superintendent may review an insurer's anti-fraud plan to determine if the plan complies with the requirements of this subsection. The anti-fraud 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 anti-fraud 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.

6. Civil penalties. Any violation of this section is subject to civil penalties and other remedies as provided in section 12-A. Notwithstanding section 2165-A, subsection 1, the superintendent may issue emergency cease and desist order on the basis of conduct involving fraudulent insurance acts.

7. 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.

Sec. 3. 24-A MRSA § 2183-B is enacted to read:

§ 2183-B. 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) Attorney General;

(2) District attorney responsible for prosecution in the municipality where the fraud occurred;

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

(4) State Fire Marshal;

(5) Superintendent of Insurance;

(6) Superintendent of Banking;

(7) 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;

(8) State Police and local law enforcement officials; or

(9) The National Association of Insurance Commissioners.

C. "Immune" means that in the absence of fraud, malice or bad faith, no insurer, or person acting on its behalf, or authorized agency who furnished information concerning suspected, anticipated or completed insurance fraud if the information is provided to or received from an authorized agency is liable for damages in any civil action for furnishing information pursuant to this chapter.

2. Information disclosed. An authorized agency or insurer may release or provide that information to any other authorized agency or insurer with an interest in the insurance fraud under investigation.

3. Exchange of information. Any authorized agency investigating insurance fraud may, in writing, require the insurance company at interest to release to the requesting agency any or all relevant information or evidence deemed important to the authorized agency, which the company may have in its possession relating to the insurance fraud in question. This information includes, but is not limited to:

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

D. Policy premium payment records.

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

5. Immunity. Any insurer, or person acting on its behalf, or authorized agency which releases information pursuant to this section, is immune from civil liability.

6. Confidentiality. Any authorized agency or insurer which receives any information pursuant to this section shall hold it in confidence and not release the information, except to another authorized agency, until its release is required for a criminal or civil proceeding.

Summary

This bill implements recommendations of the Commission to Study Insurance Fraud. The bill does the following.

1. It prohibits fraudulent insurance acts and makes violations subject to civil penalties.
2. It requires insurers to include warnings on all claim forms and insurance applications.
3. It clarifies the immunity provisions to allow sharing of information related to fraudulent insurance acts between law enforcement agencies and insurers.
4. It requires insurers to report fraudulent insurance acts on an annual basis to the Superintendent.
5. It requires insurers to prepare and implement anti-fraud plans.

LR #
Sponsor: Commission to Study Insurance Fraud pursuant to Resolves 1997, c. 77
Drafted by: Colleen McCarthy Reid/CMM
Date: January 16, 1998
Doc. Name: G:\OPLAGEA\COMMTTEE\BAN\STUDIES\INSFRAUD\DRFTLEG.DOC

Title: An Act to Create the Crime of Insurance Fraud and Require Reporting of Convictions to Licensing Authorities

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

Sec. 1. **17-A MRSA c. 16** is enacted to read:

Chapter 16
INSURANCE FRAUD

§ 371. Insurance Fraud

1. A person is guilty of insurance fraud if the person commits knowingly and with intent to defraud a fraudulent insurance act defined in subsection 2.

2. "Fraudulent insurance act" means any of the following acts or omissions when committed knowingly and with intent to defraud:

A. Presenting, causing to be presented or preparing false information with knowledge or belief that the information will be presented by or on behalf of an insured, claimant or applicant to an insurer, insurance producer or other person engaged in the business of insurance. False information is information that contains false representations as to a material fact relating to any of the following:

(1) An application for the issuance or renewal of an insurance policy;
(2) The rating of an insurance policy;
(3) A claim for payment or benefit pursuant to an insurance policy;
(4) Payments made in accordance with an insurance policy;
or
(5) Premiums paid on an insurance policy;

B. Presenting, causing to be presented or preparing false information with knowledge or belief that the information will be presented to or by an insurer, insurance producer or other person engaged in the business of insurance. False information is information that contains false representations as to a material fact relating to any of the following:

(1) A document filed with the superintendent or the insurance regulatory official or agency of another jurisdiction;
(2) The financial condition of an insurer;
(3) 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;
(4) The issuance of written evidence of insurance; or
(5) The reinstatement of an insurance policy;

C. Soliciting or accepting 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;

D. Removing, concealing, altering or destroying the assets or records of an insurer or other person engaged in the business of insurance;

E. Embezzling, abstracting, purloining or converting monies, funds, premiums, credits or other property of an insurer or other person engaged in the business of insurance;

F. Transacting 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

G. Attempting to commit, aiding or abetting in the commission of, or conspiracy to commit the acts or omissions described in this subsection.

§ 372. Classification of insurance fraud offenses.

1. All violations of this chapter are classified, for sentencing purposes, according to this section. The facts set forth in this section upon which the classification depends must be proved by the State beyond a reasonable doubt.

2. Insurance fraud is a Class B crime if:

A. The value of the property, services or benefits wrongfully obtained is more than $10,000; or

B. The insurance fraud is a violation defined in section 371, subsection 2, paragraphs C, D, E or F.

3. Insurance fraud is a Class C crime if the value of the property, services or benefits wrongfully obtained is more than $2,000 but not more than $10,000.

4. Insurance fraud is a Class C crime if the actor has 2 prior Maine convictions for insurance fraud or any violation of chapter 15, any violation of section 453, 651, 702, 703 or 708, or any violation of section 401 in which the crime intended to be committed inside the structure is theft, or any attempts thereat. For purposes of this subsection, the dates of both of the prior convictions must precede the commission of the offense being enhanced by no more than 10 years, although both prior convictions may have occurred on the same day. This subsection does not apply if the commission of the 2 prior offenses occurred within a 3-day period. The date of a conviction is deemed to be the date that sentence is imposed, even though an appeal was taken. The date of a commission of prior offenses is presumed to be that stated in the complaint, information or indictment, notwithstanding the use of the words "on or about" or the equivalent.

5. Insurance fraud is a Class D crime if the value of the property, services or benefits wrongfully obtained is more than $1,000 but not more than $2,000.

6. Insurance fraud is a Class E crime if the value of the property, services or benefits wrongfully obtained is less than $1,000.

§ 373. Reporting of insurance fraud convictions

If a person who is licensed or registered under the laws of this State to engage in a profession is convicted of or pleads guilty to insurance fraud as prohibited by this chapter, the court shall forward upon conviction a copy of the conviction or plea to the Office of Licensing and Registration within the Department of Professional and Financial Regulation or to the agency, board or organization that licensed or registered the person. Upon receipt of notice of a conviction for insurance fraud, the Office of Licensing and Registration shall refer the notice to the appropriate licensing board charged with regulating the profession of the person convicted. The court shall also order a person convicted of insurance fraud to notify the appropriate licensing authority of the conviction. A victim of insurance fraud may notify the Office of Licensing and Registration or the appropriate licensing authority of a person's conviction for insurance fraud

Summary

This bill implements a recommendation of the Commission to Study Insurance Fraud and creates the crime of insurance fraud. It also requires that the court notify the appropriate licensing authority of a conviction for insurance fraud against a person licensed or registered under the laws of this State.