CONTROLLING THE COST OF INSURANCE FRAUD: A LEGISLATIVE APPROACH

A Capstone Seminar Paper for
PAD 595-20: Seminar in Public Administration
Presented To
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Department of Political Science and Public Administration
Sage Graduate School

In Partial Fulfillment
of the Requirements for the Degree of
Master of Science in Public Service

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December, 1996

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CHAPTER 1

Problem Statement

Each and every citizen within the state of New York who purchases insurance in order to protect his or her exposure to certain risks is paying from ten to twenty-five percent more in order to cover the costs of insurance fraud. The New York State Insurance Department has provided estimates of at least 3.5 billion dollars being paid annually for fraudulent claims. The problem is staggering when one takes into account that we New Yorkers pay upwards of $240 in additional premium for auto insurance itself. This figure does not take into account the additional premium dollars we spend for other lines of insurance such as property and casualty lines and the health insurances that most residents chose to purchase. According the National Insurance Crime Bureau, auto insurance premiums were inflated an estimated 16.44 percent to cover fraud last year on a national basis. This figure translates into approximately 1.18 billions dollars a year for the New York State insurance policy holder (NICB Spotlight, 1992, p. 1).

The New York State legislature has become increasingly aware of this problem through both their constituency and personal experiences with the ever increasing high costs of obtaining their respective insurance policies. The legislature's

involvement has resulted in the drafting of legislation to include the requirement for the mandatory formation of Special Investigation Units within the individual insurance companies for the purpose of effectively and efficiently detecting and preventing insurance fraud as well as providing them with the necessary state law to prosecute those being found to have committed the crime of insurance fraud.

My research problem is to determine if the New York State legislature's activity in the area of insurance fraud will serve to reduce the fraud and thereby enable the insurance companies to lower their premiums for the policy holders. I will explore the legislature's role in protecting the public interests as it relates to the citizen's payment of inflated insurance premiums as a result of fraud. This paper will examine and focus on the legislative history and actions relating to the legislature's ultimate adoption of recently signed legislation and conclude with an evaluation as to whether their activity will provide premium relief to the policy holders of this state.

CHAPTER 2

Literature Review

The availability of literature focusing on insurance fraud was found to be somewhat limited and primarily found within the periodicals serving the insurance industry. A major source of information proved to be the National Insurance Crime Bureau (NICB) which is an organization supported by member individual insurance companies providing them with assistance in training and the identification and subsequent prosecution of insurance fraud. NICB was founded in 1992 and brought together the National Automobile Theft Bureau and the Insurance Crime Prevention Institute. The NICB contributes most of its resources to organized criminal activity involving rings of professionals such as doctors and attorneys, fraudulent accident stagers, and vehicle theft gangs.

Placing the overall problem in perspective, the crimes of insurance fraud and income tax evasion run second only to drug crime activity according to the Federal Bureau of Investigation Uniform Crime Report for 1995. The frequency and amount of insurance fraud tends to suggest the high public tolerance for this type of crime. Public perception, combined with the feeling that the insurance industry is not taking enough action to detect fraudulent insurance activity, exacerbates the problem of ever

increasing premium costs to the consumer (Insurance Marketing Insider, 1992). A public opinion survey which had been conducted by the All Industry Research Advisory Council revealed that a surprising number of the public agreed that "claim padding" is acceptable to cover deductibles and twenty-five percent agreed that claim padding is acceptable to make up for insurance premiums paid when a person had no claim. The results indicate that at least one in four members of the public admits to being willing to commit a crime of insurance fraud (Roper, 1992, Poll Study). The public attitude will continue to play as an important factor in the detection and prevention of insurance fraud in the future. Mooney and Salvatore (1990) found that there was no national agenda involving legislators, law enforcement and the insurance industry in the fight against insurance fraud. They further stated that although a more intense interest in combating the fraud was evident, the efforts were not cohesive and needed more education, training and communication among all the parties involved in order to be more effective.

The Random House Dictionary defines fraud as "deceit or trickery used to gain unfair or dishonest advantage". The definition of insurance fraud would accordingly apply this description to the insurance process. The concept of insurance fraud can be further described as being either "inside" or "outside". The inside insurance fraud usually refers to that activity committed by persons within the industry itself such as

the issuance of fake insurance policies by an agent or the theft of monies by an accounting executive within the company. The outside fraud usually refers to that activity committed by the policy holders, lawyers, or doctors against the company. The fraud element is often further broken down into "non-professional" and "professional" or "hardcore". The non-professional insurance fraud is exemplified in the activity which includes the so called padding of claims, the lying about one's address on an auto application in order to obtain a lower rate, or exaggerating an injury to induce a greater payment. The so called non-professional frauds usually involve relatively small amounts of money which collectively, however, add up to billions of dollars to the industry. The hardcore or professional fraud generally indicates a carefully choreographed scheme which may include either an individual or groups of professional people such as lawyers and doctors who conspire to offer false information in order to pursue a claim or claims (Mooney, S., Salvatore, J., 1990).

Insurance fraud has also been described as being either opportunistic or fictitious. The opportunity for fraud describes a situation involving a legitimate claim where the claimant takes that opportunity to inflate or add to the actual loss. The fictitious loss describes the situation which the claimant or claimants stage or fabricate a claim in misrepresenting the circumstances of such.

The seriousness of the fraud problem is highlighted in the findings of Conning and Company research findings (1996) that estimated fraud costing the nation's insurance companies 120 billion dollars in 1995 which was a thirty-three percent increase from 1990 figures. The Conning study was titled "Insurance Fraud: the quiet catastrophe". The fraud losses were further broken down indicating that ninety-five billion dollars came from the health care sector, twenty billion dollars from the property and casualty sector, and five billion dollars from the life and disability sector. The study further estimates that the property and casualty insurers discovered only approximately twenty percent of their fraud claims with the life/disability insurers approximately ten percent and the health care insurers a small one percent. Formulated projections reveal that a typical property and casualty insurance company could bring its average return on investment up to eighteen percent if the fraud was closely dealt with (Conning and Company, 1996).

The total amount of fraud which is present is extremely difficult to measure due to its subjective nature and ability to escape detection. Criminologists, statisticians and forensic auditors have developed methods for estimating the frequency and severity of fraudulent claims which do help in establishing programs and a basis upon which to channel energies in detecting the problem (Finnegan, D., Simpson, G., 1992, p. 58).

Most sources agree that any fight against insurance fraud

needs to be waged with a multifaceted attack from the insurance companies, the policy holders, law enforcement, and the respective state legislators. A concerted effort by all of the above mentioned factors is the efficient path to take in order to successfully reduce this massive problem. Individual efforts naturally will help but only serve in the short term. The New York State legislature's attempt to assist with this fight is certainly a positive step in helping all to control this growing problem.

The same consumer who finds the exorbitant premium being assessed for coverages unconscionable is that same person who believes it is acceptable to pad insurance claims to make up for the premiums paid in past years. General public attitudes regarding the acceptability of insurance fraud have not basically changed during the past decade. A compounding contributing factor in the willingness of policy holders to commit insurance fraud is the low risk nature of the crime and the ease in which to steal from the insurers without being detected. An additional impediment to establishing positive attitudes against insurance fraud lies in the fact that once a person is detected, the sanctions and consequences are modest to non existent (Foppert, D., 1994, p. 46). Insurance fraud is often perceived as a "victimless crime" which often does not rate highly on the federal and state level prosecutorial staffs saddled with adjudicating these offenses. Consequently, few insurance fraud prosecutions are highlighted and brought to the attention of the

general public. This lack of legal publicity further serves to hide this major problem and also serves to blunt any public outcry over this issue.

Cooperation among the regulators, insurance companies, and the consumer, can serve to dramatically decrease the fraud problem to more manageable levels. Industry experts predict that a reduction in fraud by twenty percent would put enough money back in the pockets of the consumer so that they would change their attitude toward insurance fraud from passive acceptance to disdain (Foppert, D., 1994, p. 46).

The multifaceted approach to controlling and reducing fraud requires a close coalition of all involved with the insurance process. States such as New Jersey attribute much of their anti-fraud success to anti-fraud legislation and regulation "with some teeth in it". This coalition serves to belie the traditional thought process of the insurance industry which felt that fighting fraud was viewed as being anti-consumer. Laws and regulations alone will not serve to effectively combat insurance fraud but will serve to assist the coalition of factors with the overall problem. The insurance industry on its own would tend to somewhat ignore the incidence of fraud if they felt that it did not affect their bottom line. The state of New Jersey found that many insurers in their state initially resisted the state mandated fraud division and the passage of anti-fraud legislation by viewing it merely as an additional expense. These companies

exhibited an inclination to collect the premium, pay the fraudulent claims and seek higher rates, creating a vicious cycle. New Jersey further noted that since enactment of their strong legislative anti-fraud measures, the companies became "pleasantly surprised by the results and are finally getting in the same boat with the same oars on this problem" (Foppert, 1994, p. 49).

Public attitude was cited as being an important factor contributing to the general lack of concern over the fraud problem. The Insurance Information Institute fraud research sought out media opinions regarding their perception of the industry's commitment to the problem since they appear to play a role in the formation of the existing attitudes. The research found that media representatives believe the insurance industry efforts against fraud to be minimal relative to the size of the problem. Anti-fraud efforts by the insurance industry were described as "window dressing persisting because of a passiveness and indifference within the industry". It was also the opinion of reporters that the industry used fraud as a whipping boy when looking for rate increases with their efforts to counter fraud as being disproportionate to its rhetoric recommending that they develop a reputation as having a serious strong effort to fight fraud before their message will be credible (Mooney, S., Salvatore, J., 1990). These media perceptions of the so called passiveness of the insurance industry was somewhat supported by a study conducted on behalf of Fraud Control Services PTY, Limited,

Sidney, Australia. This particular study appeared to be significant in that it involved seventeen private insurance organizations within North America reporting that they have experienced a rising level of fraudulent claims over the prior three years preceding 1992. Two thirds of these companies reported a low level of confidence in detecting or uncovering the bulk of fraudulent claims being submitted to them citing automobile personal injury, automobile theft and third party medical claims as those with the greatest potential for fraud. Many of these organizations employed their own investigators to look into fraudulent claims but other than those specialized units, there appears to be no common structure for fraud control within the companies surveyed. High turnover of claims staff, lack of commitment to fraud control and a lack of standardization were often noted as weaknesses in existing anti-fraud programs (Merry, K., 1991).

A review of New York State's laws and statutes reveal several which deal specifically with insurance fraud. It is interesting to note that the mere presence of these statutes, laws, and regulations appears to have demonstrated little effect in bringing down the fraud inflated costs of insurance policies.

Article 4 of the New York State Insurance Law was titled as the "Insurance Frauds Prevention Act". The legislative purpose of this act was to equip the Insurance Department to better utilize their personnel to investigate fraudulent activity and

receive assistance from the state and federal law enforcement agencies to prosecute persons responsible for same. The article established a formal Insurance Frauds Bureau and designated employees as peace officers in order to enforce the provisions of the article. A major feature of this law was the provision calling for the mandatory reporting by the insurance companies conducting business within the state to report any suspicion of fraudulent activity to them for potential investigation. It is noted that the act specified suspicion as opposed to actual evidence of fraudulent activity. The act further demanded that all automobile policies contain language which would warn of the penalties which would be incurred if the policy holder engaged in fraudulent insurance claims. Provisions for a civil penalty not to exceed five thousand dollars in addition to the value of the motor vehicle was also included. A highlight of the entire article was the extension of immunity to the companies to share information with both law enforcement and other involved companies without being subjected to bad faith suits which have traditionally cost them millions of dollars and serve to chill the anti-fraud fighting emphasis of the companies. The lack of immunity was perceived to be a reason that the companies failed to take an aggressive stance in pursuing the investigation of fraudulent claims (Appendix A).

The New York State Insurance Law is augmented in statute by Article 176 of the New York State Penal Law. Section 176.05 of the article defines insurance fraud as:

> "A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer or purported insurer, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to: (i) contains materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading, information concerning any fact material thereto."

The above definition establishes the parameters of activity which would constitute the elements of five degrees of insurance fraud, the lowest of which is a class A Misdemeanor and the highest, insurance fraud in the first degree designated as a class B Felony. The incremental value of the gains from the fraudulent act is the determining factor as to the degree of crime charged (Appendix B).

On September 10, 1996, New York State Governor George Pataki signed into law a bill intended to "effect a comprehensive reform of the workers' compensation law, and related statutes, so as to restore the integrity of the workers' compensation system and

satisfy the workers' compensation law's mission of protecting the interests of injured workers". This bill, combining Senate 7951 with Assembly 11331, appeared to serve as a lightening rod and attracted intense scrutiny since it was tied to the passage of the state's upcoming budget. "The political dance that has continued to hold hostage the signing of the state budget and the bill reforming the workers' compensation system has finally ended - more than five months into the fiscal year" (Precious, T., 1996).

The subsequent passage of this law initiates a movement for the insurance carriers doing business within New York State toward taking a more proactive role in controlling insurance fraud by mandating the establishment of fraud prevention plans and Special Investigative Units. The provision relating to the anti-fraud plan and establishment of Special Investigation Units is nestled within the above described workers' compensation reform bill and reads, in part, as follows:

> Section 409. Fraud prevention plans and special investigation units. (a) Every insurer writing private or commercial automobile insurance, workers' compensation insurance or individual, group or blanket accident and health insurance policies issued or issued for delivery in the state, except for insurers that write less than three thousand of such policies, issued or issued for delivery in this state annually, shall, within one hundred eighty days

of the effective date of the regulation to be promulgated by the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state.

(b) (1) The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigations unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims functions of an insurer, and shall be responsible for investigating information on or cases prevention and reduction activities pursuant to the plan filed with the superintendent.

This section within the reform bill continues to specifically outline the requirements for these Special Investigation Units (SIU) along with their duties within their respective companies. The law further mandates that the individual companies monitor the activities of their units and plans and report their findings annually for further study.

The inclusion of the special investigation unit provision is primarily the result stemming from the efforts of the New York State Assembly through the sponsorship of Assemblyman Alexander B. Pete Grannis during his memberships on both the rules and insurance standing committees. It is noted that Assemblyman

Grannis is currently the chairperson of the Assembly's Insurance Committee. Assemblyman Ivan C. Lafayette of the insurance committee provided additional support attributed to his knowledge of the auto repair business and its relationship to and with the insurance industry.

The genesis of the special investigation unit provision within the final bill noted is rooted in hearings which were held in March of 1993 by the Assembly Insurance Committee specifically dealing with automobile insurance fraud. Information obtained from these hearings revealed that reported fraudulent claims through The State Insurance Department increased by one hundred and sixty-six percent over the prior six years. Testimony received at this hearing further revealed that Special Investigation Units in the state of New Jersey were saving their state's insurance companies and policy holders money (New York State Assembly, 1993, Memorandum In Support Of Legislation).

The purpose of their early legislation was to decrease insurance premiums for policy holders by requiring insurance companies to take a proactive approach in dealing with insurance fraud. The justification section of the memorandum attributed a major contribution to the problem as being the industry's failure to aggressively fight fraud due to their unique ability to merely pass on the additional expenses to the policy holder. A review of the early correspondence from Assemblyman Grannis to Senator Guy Villella revealed that it failed to muster any requested

Senate support in mounting a joint effort in passage of Assembly sponsored anti-fraud legislation. An editorial in the Albany Times Union specifically noted the traditional lack of support by the Senate in combining with the spirit of the Assembly in drafting legislation which would reduce auto insurance premiums for New Yorkers. The editorial further stated that by helping with this type of legislation, the Senate could possibly help the state's driving population with monetary relief of up to $240 per policy (Coryell, H., 1996).

The 1993 Assembly hearings proved to be an unique forum for industry executives, regulators, law enforcement, and policy holders to explain their roles within the process. Fraud bureau personnel from the state of New Jersey drew much attention since their recently enacted anti-fraud legislation served as a model for the Assembly's initial legislation (A8289-A).

The New Jersey statute is a strong anti-fraud measure which sets specific requirements for companies which included the establishment of Special Investigation Units based upon the number of auto policies in force as well as set out duties which would be closely monitored by their insurance department. The New Jersey law additionally mandates formal training outlines for the SIUs for presentment to adjusters, claims processors and other investigators (Appendix C).

Assembly Bill 8289-A contained language which subsequently

proved to be a major stumbling block in attracting support from both the New York State Senate and the insurance carriers. The "A" version of the bill changed the original language that Special Investigation Units would be required to consist of one investigator for every twenty thousand policies in force to twenty-five thousand policies in force. The Assembly Bill 8913 introduced and dated 10/19/93 contained an amendment which in fact mandated the SIUs and attempted to place one investigator per company claim office with an additional person for each twenty-five thousand policies in force. The bill also required that the Special Investigation Units perform other functions such as in service training to insurance industry personnel along with the initiating of civil or criminal actions based upon their investigations as authorized by the respective insurer. A key provision for this and subsequent bills was the ability for The New York State Insurance Department superintendent to monitor the insurers anti-fraud activity and demand their reporting of same by specified format.

The summer of 1994 saw the reintroduction of Assembly Bill 8913 along with Assemblyman Grannis' request for Senator Guy Villella to join him in working out a joint approach in pursuing anti-fraud legislation. In his letter to Senator Villella dated June 10, 1994, Assemblyman Grannis announced a press conference with the State Attorney General G. Oliver Koppell to promote the passage of the bill and asked that the insurance industry increase its efforts in fraud fighting. Assemblyman Grannis

stated that "judging by the reports to The State Insurance Department and our own analysis, the overall industry response historically has been anemic, bordering on scandalous". Assemblyman Grannis further pointed out the fact that millions of dollars in excessive premiums were being paid each year due to the lack of such legislation (Grannis, A., June, 1994).

The year 1995 saw a flurry of activity from the New York State Assembly to promote their anti-fraud legislation efforts by offering two bills for consideration. Ms. Chris Ollie, Legislative Aide to Assemblyman Pete Grannis, described these bills as "running on parallel tracks". Bill A7630 was presented as a "standalone" and Bill 8269-A was described as being linked with efforts to extend existing laws. The Assembly Bill 8269A dated 6/23/95 required one special investigation unit investigator per thirty thousand policies in force, an increase of five thousand policies over previous bills and added that workers' compensation insurers have one special investigation unit investigator for each ten thousand workers covered along with the provision which allowed the superintendent of insurance to reduce the required number of investigators based upon the submission by carriers of proof of effectiveness of their programs. Justification in their support memorandums was based on similar findings offered in previous memos noted. The standalone bill 7630 dated 5/8/95 basically mirrored prior bills with regard to the establishment of Special Investigation Units.

The Governor's Program Bill #2, dated 5/17/95 was introduced at the end of the 1995 legislative session and offered an amended amendment providing an assessment of insurance company activities in regard to detecting, investigating and reporting fraudulent activities, including a list of companies which maintain Special Investigative Units for the sole purpose of detecting, investigating and reporting fraudulent activities, and the number of investigators assigned to such units per every thirty thousand policies in force. It required them to report to the superintendent of insurance that information required. It is noted that the Governor's Program Bill did not specifically mandate the establishment of such investigative units.

In 1996, the Assembly continued to press for special investigation unit staffing based upon ratios to policies in force. Three bills, A7630-B, A10856 and the Assembly's Companion Workers' Compensation Bill designated A8820, all contained mandates for Special Investigation Units. The workers' compensation version, however, was specific to workers' compensation policies. The Senate version identified as S7618-A provided for the implementation of Special Investigation Units but left the question of staffing entirely up to the individual insurance carriers.

The final version of the legislative bills which were signed into law by Governor Pataki was the combination and melding of Assembly Bill A11331 with Senate Bill S7951 which ultimately kept

the provision for mandatory Special Investigation Units without requiring minimum staffing based upon policies in force. The correspondence in response to the special investigation unit requirement within the bill indicated a general opposition by insurers to having fixed staffing legislated. Opposition to the special investigation unit mandate was additionally voiced through lobbying efforts directed at elements of the entire workers' compensation reform bill. The Albany Times Union reported in their October 18, 1996 issue that dozens of groups from insurance companies to manufacturers to trial lawyers and unions spent money on workers' compensation which made the bill "one of the most divisive issues of the session" (Staff, Albany Times Union, 1996, October). The portion of this bill which requires Special Investigation Units did not attract all of the lobbying efforts but did receive enough attention to somewhat dilute the provision dealing with staffing levels.

An examination of the contents of the Governor's Bill Jacket regarding this legislation reveals one letter from the Alliance of American Insurers in which they expressed concern over certain aspects of the fraud staffing provisions. The remainder of the correspondence within this bill jacket dealt primarily with the workers' compensation reform issues and does not specifically refer to the special investigation unit provisions. Correspondence received by Assemblyman Grannis generated by his sponsorship of anti-fraud measures provides a more incisive look into the sentiments of industry personnel towards the special

investigation unit mandate.

The State Farm Insurance Companies reacted negatively to the original legislative efforts and their staffing provisions. State Farm vociferously opposed the requirement for staffing linked directly to number of policies in force and accused the legislature of attempting to micro manage their business by dictating the exact number of positions they would be required to staff. Their concern was subsequently lessened in 1995 with the understanding that the superintendent of insurance could modify the required numbers sought based upon a reasonable justification on behalf of the company.

The American Insurance Association (AIA) also disagreed with the required staffing aspect of the SIUs. Their beliefs outlined in a letter dated 6/26/95, were that the provision may have been well intentioned but was impractical in that it could be counterproductive to the goal of lower insurance costs. The AIA professed to be deeply committed to the anti-fraud movement and promised to help with the development of any effective measures with the exception of the requiring the specific number of investigators. The basis for their opposition appeared to be their belief that this requirement would impose an administrative burden without any benefit of a cost benefit justification. AIA stated that demanding investigators on the basis on the number of policies was inherently flawed because it did not take the risk of fraud or the return on fraud investigation into account.

Similar opposition was voiced by The National Association of Independent Insurers in their correspondence of June 6, 1995, advising that Legislative Bill A7630 would promote the fraud it purportedly seeks to prevent. This group felt that the specification of numbers of investigators would be overly burdensome on small to medium size companies. It was further stated that the financial burden would be great since there was no evidence that this requirement would reduce fraud with any corresponding savings. It was additionally pointed out that several companies already voluntarily complied with sufficient staffing plans to achieve this goal. Although it is agreed that the establishment of full-time SIUs would enhance or improve the current investigative procedures, the group in its letter described the policy ratio to investigator formula as being based upon a capricious estimate of fraudulent claim frequency and the amount of personnel needed to investigate. It was reiterated that mandatory Special Investigation Units would impose realistic financial and administrative burdens on the companies without any guarantee that fraudulent conduct would be prosecuted.

Eagle Insurance and Progressive Insurance Companies in letters dated 6/13/95 and 6/28/95 respectively both offered support of the Assembly bills. Eagle Insurance's letter contained unconditional support of the enactment of mandatory Special Investigation Units along with the mandatory submission of fraud plans. Progressive Insurance Company, however,

qualified their support of the Assembly bill by stating that while they felt that the state mandates for company staffing to achieve good business outcomes were unnecessary, their current staffing of special investigation unit personnel was well in excess of the minimum requirements in this legislation.

The legislative aide to Assemblyman Pete Grannis, Ms. Chris Ollie, was hesitant to attribute the Assembly's strong involvement with the anti-fraud bill to any one factor but did suggest that much of it was a result of constituency outcry for lower premium cost. Ms. Ollie further offered that constituency demand for lower insurance costs was expected and that Assemblyman Grannis was attentive to their request since it effected all of the insurance buying public as well as members of the legislature. The law maker's ability to better analyze the underlying factors contributing to the continually rising costs, led them to a closer examination of the insurance carriers' activities with respect to controlling fraud and found fraud to be one of the largest reasons for the increasing costs cycle. The general insurance industry attitude was found to be somewhat passive and not displaying a proactive stance in an attempt to combat the fraud dilemma. The anti-fraud provision to establish Special Investigation Units will serve as a positive message for the industry to take measures in controlling the premium costs by passing the savings along to the policy holder.

Mooney and Salvatore (1990) and Best's Review (1994) studies

and findings regarding the control of insurance fraud reveal a general consensus that a cooperative effort is required to combat and reduce the ever growing problem. The insurance industry, law making bodies, law enforcement agencies, prosecutorial agencies, and the policy holder all have an important contribution to make in this direction. The available literature often suggests that the industry has to assume more responsibility in controlling this situation by encouraging a more aggressive stance in the identification and prevention of fraud. An important step in this direction, is the establishment of Special Investigation Units within the individual companies as being mandated by the bill enactment of the New York State legislature. The SIUs will consist of trained investigators who will assist with:

1. Fraud awareness training to both employees and policy holders;
2. Investigation to determine the legitimacy of claims and/or policies; and
3. Liaison with other carriers, individual state fraud bureaus and law enforcement.

A theme throughout a recent chartered property and casualty's underwriters annual meeting held in San Francisco in 1992 was that the insurance industry is its own worst enemy when it comes to battling fraud. This statement was illustrated by the explanation that fraud will become self perpetuating in nature as long as the industry continues to reward low level

fraudulent injury claims in the spirit of cost effectiveness. A company's willingness to accept a "win" upon the settlement of a claim out of court for less than what is would have cost to fight it will certainly impact on the long term costs of letting small scale the fraud continue in this manner. It appears that the largest factor in allowing the continual payment of fraudulent claims is a company's strong desire to maintain a high level of service to their policy holder which equates to the rapid processing of each claim with diminished vigilance as to the legitimacy of same (Wastler, A., 1992).

The establishment of special investigations units can reduce the above described situation by serving to assist and augment the existing claim force to identify, investigate and collect evidence to properly and legally deny the fraudulent claims. The claims adjuster does not have the experience, time or skills required to deal with complex, unusual or organized ring activity in addition to their need to process and manage their regular claim cases. The SIU will also serve as a training resource in helping the adjuster to learn to identify indicators of insurance fraud and serve to monitor the company's vulnerability to determine if the indicators are being detected and the claim investigated. This vigilance would include not only the large dollar claims but also the smaller minor claims which eventually will accumulate and impact upon the carrier's profits. With the exception of one lobbying group, not one source suggested that the SIUs were ineffective or not cost effective, yet carriers are

still not at a point where they embrace their worth or openly encourage their growth.

CHAPTER 3

Analysis and Evaluation

The law establishing mandatory Special Investigation Units within each of the insurance carriers conducting business within New York State will provide some form of premium relief for the policy holder. It is difficult to predict what the savings will be since no current figures exist to actually state the cost attributable to fraud. The figures that have been made available to the state and industry personnel indicate a potential savings figure of $240 for each auto policy when the units and their associated plans are put into effect sometime during late 1997.

The companies can not rely solely upon external agencies to handle the fraudulent activity since someone has to first become aware of the situation within the company. Dollar loss will be better controlled through the detection and successful denial of fraudulent claims which will naturally become more frequent when SIUs are specifically dedicated to performing this function. The detection of fraud will be accomplished without the company's perceived impairment of service standards or the fair claim practice statutes which are both suspected as being a major reason for the lack of industry self imposed fraud fighting.

It is not unrealistic to project that the presence of

Special Investigation Units could initially reduce fraud by a minimum of twenty percent which would generate a substantial savings to the respective companies and would be passed on to the policy holders in the form of lower rates. This accomplishment would further serve to encourage policy holders to demand closer scrutiny of their claims if it would, in fact, result in their paying lower premiums for their auto insurance.

My evaluation as to the legislative action contributing to the premium relief is further bolstered by the fact that neighboring New Jersey found that the implementation of mandatory SIUs coupled with other similar provisions as present in New York was credited with a reduction in the auto theft rate of twenty-one percent in the first six months of 1993 which translated into their companies saving over 150 million dollars in claims (Foppert, 1994, p. 49).

The inherent reduction in fraud attributed to Special Investigation Units will most likely lead to a competitive advantage owing to their ability to offer lower premiums to their customers. The personnel assigned to the SIUs have generally attracted from the field of law enforcement accompanied by their investigative skills and training in the collection of evidence in order to support the proper denial of a fraudulent claim which otherwise may have been cleared by an adjuster without the time or inclination to fully investigate the suspicious circumstances surrounding a particular claim.

The existence of Special Investigation Units in New York State is not a relatively new phenomena although adoption and function have little consistency within different companies. There is a substantial variation from unit to unit depending on the functions that the respective companies chose for their SIUs to perform. One auto insurance carrier which has had an SIU in New York State since 1976 has estimated that they save seven dollars for every dollar spent in operating their program (New York State Assembly, 1993, Memorandum In Support Of Legislation). It is highly improbable that any unit would not represent at least a minimal amount of similar savings when utilized properly.

It is suggested that most companies could maintain a comprehensive program utilizing Special Investigation Units for less than one percent of their premium intake. Depending on the role that the individual company chose for their SIU to play, cost benefit analysis would indicate the fraud control program savings to cost ratios ranging from 2:1 to more than 100:1. This projection suggests my contention that the state legislatures requirement for insurance carriers to establish Special Investigation Units will result in some form of premium relief.

CHAPTER 4

Summary and Conclusions

The passage of the Worker's Compensation Reform Bill which will mandate Special Investigation Units to be established within each insurance company will contribute to a greater awareness of the fraud problem and result in savings when fraudulent claims are identified and properly denied based upon effective investigations. These legitimate claim denials will translate into savings which would then enable the respective carriers to lower the cost of the product. The New York State legislature has stepped in to encourage the companies to fight fraud which they found to have been traditionally resisted because of the perception of it hurting customer relations, being costly and not effective.

Passage of the legislation will now require each carrier to monitor the results of their fraud fighting efforts and formally report the results back to the State Insurance Department for continuing evaluation. The oversight function of the Insurance Department will eliminate any ability of the companies now employing special investigators to utilize them as "Window Dressing" and will hold them accountable for the effectiveness.

This provision in its current form appears relatively weak

owing to its being substantially diluted through political compromise in order to gain passage. Lobbyists representing the insurance industry played a key role in keeping the Senate from lending much support to the Assembly since this portion would specify staffing without any guarantee that their expenses would be recoverable. Because of the resulting dilution, the legislative intent to save policy holders premium dollar will be realized incrementally as expected amendments will be necessary in order to achieve the full savings potential sought.

The legislature must continue to strengthen the provisions and requirements for SIU involvement in order to compel the carriers to promote positive fraud fighting programs attributed to substantial savings which can be applied to the mission of lowering premiums. Recommendations to improve the existing SIU provision include:

1. Specifically require that a percentage of the actual savings attributed to fraud investigation be applied toward lowering policy premiums.
2. Develop and require guidelines to measure the amount of reported savings to achieve uniformity in determining SIU effectiveness.
3. Establish incentives for the insurance carriers to maintain their commitment possibly through a program of tax relief or similar benefit linked to performance.

4. Require that the special investigators provide specialized fraud training for the adjusters to assist them in identifying indicators within the claims they are responsible to administer.
5. Maintain an aggressive monitoring of carrier compliance and assess civil penalties to those not meeting basic requirements.
6. Establish a dedicated fund made up of civil penalties to be placed in a common premium rebate plan for distribution to all New York State automobile policy holders.
7. Develop a public relations campaign aimed at informing the consumer how the existence of ignored insurance fraud impacts the increasing cost of their coverage.

New York State has both criminal and civil anti-fraud laws with which the insurance industry can work to combat fraud and protect the consumer from ever increasing premiums. The industry has consistently been able to merely pass the cost of fraud along to the consumer rather than take a firm stance to deny those claims that are found to be not legitimate. The new legislation supports a cooperative effort in forming a partnership comprised of the industry, government and the policy holder to better control and reduce the incidence of fraud.

The New York State anti-fraud legislation's provision to

create mandatory Special Investigation Units has resulted in a welcome foundation block upon which to further build. The intended partnership formed to control costs will return excessive premium dollars generated by fraud back to the residents who are required by the same legislature to carry minimum amounts of coverage before they are allowed to register and use their vehicles.

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Appendix "A"

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Article 4

INSURANCE FRAUDS PREVENTION

(1991, chgd. by chap. 371; 1993, chgd. by chap. 729. eff. 12/27/93.)

Sec.

§401. Title; legislative declaration and purpose.

This article shall be known and may be cited as the "insurance frauds prevention act".

(a) The legislature finds and declares that the business of insurance directly and indirectly affects all sectors of the public, business and government. It furthers finds that the business of insurance, including organization and licensing, the issuance of policies, and the adjustment and payment of claims and losses, involve many transactions which have potential for abuse and illegal activities.

(b) The superintendent and the department have broad authority under this chapter to investigate activities which may be fraudulent and to develop evidence thereon. This article is intended to permit the full utilization of the expertise of the superintendent and the department so that they may more effectively investigate and discover insurance frauds, halt fraudulent activities and assist and receive assistance from federal and state law enforcement agencies in the prosecution of persons who are parties to insurance frauds.

(c) Arson for insurance fraud is a particularly damaging crime against society, destroying lives, property and neighborhoods. Insurance losses resulting from arson are reflected in higher premiums charged to residents of this state.

(d) This article establishes a framework within which the superintendent and the department can more effectively assist in the elimination of arson for insurance fraud. That increased capacity, together with a more effective monitoring of fire loss claims and payments by the insurance industry through centralized reporting and oversight, is intended to make it more difficult to perpetrate the crime of insurance fraud by arson.

(1991, chgd. by chap. 371; 1993 chgd. by chap. 729, eff. 12/27/93.)

§402. Insurance frauds bureau.

(a) The insurance frauds bureau in the department under the supervision of the superintendent shall be continued. It shall be a qualified agency, as defined in section eight hundered thirty-five of the executive law, to enforce the provisions of this article.

(b) The superintendent shall have the power to designate employees of the bureau as peace officers as defined in section 2.10 of the criminal procedure law.

(1991, chgd. by chap. 371; 1993, chgd. by chap. 729, eff. 12/27/93.)

§403. Prohibitions

(a) In this article, "fraudulent insurance act" means an insurance fraud as defined in section 176.05 of the penal law; and the terms "personal insurance" and "commercial insurance" shall have the same meaning ascribed to them by section 176.00 of such law.

(b) For the purpose of section one hundred nine of this chapter, it is a violation of this chapter for any individual, firm, association or corporation subject to the provisions of this chapter to commit a fraudulent insurance act.

(c) In addition to any criminal liability arising under the provisions of this section, the superintendent shall be empowered to levy a civil penalty not exceeding five thousand dollars and the amount of the claim for each violation upon any person, including those persons and their employees licensed pursuant to this chapter, who is found to

§155.30 Grand larceny in the fourth degree.

A person is guilty of grand larceny in the fourth degree when he steals property and when:

1. The value of the property exceeds one thousand dollars; or

2. The property consists of a public record, writing or instrument kept, filed or deposited according to law with or in the keeping of any public office or public servant; or

3. The property consists of secret scientific material; or

4. The property consists of a credit card or debit card; or

5. The property, regardless of its nature and value, is taken from the person of another; or

6. The property, regardless of its nature and value, is obtained by extortion; or

7. The property consists of one or more firearms, rifles or shotguns, as such terms are defined in section 265.00 of this chapter; or

8. The value of the property exceeds one hundred dollars and the property consists of a motor vehicle, as defined in section one hundred twenty-five of the vehicle and traffic law, other than a motorcycle, as defined in section one hundred twenty-three of such law; or

9. The property consists of a scroll, religious vestment, vessel or other item of property having a value of at least one hundred dollars kept for or used in connection with religious worship in any building or structure used as a place of religious worship by a religious corporation, as incorporated under the religious corporations law or the education law.

10. The property consists of an access device which the person intends to use unlawfully to obtain telephone service.

Grand larceny in the fourth degree is a class E felony.

§155.35 Grand larceny in the third degree.

A person is guilty of grand larceny in the third degree when he steals property and when the value of the property exceeds three thousand dollars.

Grand larceny in the third degree is a class D felony.

§155.40 Grand larceny in the second degree.

A person is guilty of grand larceny in the second degree when he steals property and when:

1. The value of the property exceeds fifty thousand dollars; or

2. The property, regardless of its nature and value, is obtained by extortion committed by instilling in the victim a fear that the actor or another person will (a) cause physical injury to some person in the future, or (b) cause damage to property, or (c) use or abuse his position as a public servant by engaging in conduct within or related to his official duties, or by failing or refusing to perform an official duty, in such manner as to affect some person adversely.

Grand larceny in the second degree is a class C felony.

§155.42 Grand larceny in the first degree.

A person is guilty of grand larceny in the first degree when he steals property and when the value of the property exceeds one million dollars.

Grand larceny in the first degree is a class B felony.

§155.45 Larceny; pleading and proof.

1. Where it is an element of the crime charged that property was taken from the person or obtained by extortion, an indictment for larceny must so specify. In all other cases, an indictment, information or complaint for larceny is sufficient if it alleges that the defendant stole property of the nature or value required for the commission of the crime charged without designating the particular way or manner in which said property was stolen or the particular theory of larceny involved.

2. Proof that the defendant engaged in any conduct constituting larceny as defined in section 155.05 is sufficient to support any indictment, information or complaint for larceny other than one charging larceny by extortion. An indictment charging larceny by extortion must be supported by proof establishing larceny by extortion.

have committed a fraudulent insurance act or otherwise violates the pvosisions of this section. *(1992, added by chap. 480; 1993, chgd. by chap. 729, eff. 12/27/93.)*

(d) All applications for commercial insurance, individual, group or blanket accident and health insurance and all claims forms, except as provided for in subsection (e) of this section, shall contain a notice in a form approved by the superintendent that clearly states in substance by the superintendent that clearly states in substance the following: *(1993, chgd. by chap. 729, eff. 12/27/93.)*

"Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation."

1992, relettered and chgd. by chap. 480, eff. 1/13/93.)

(e) All applications for automobile insurance and all claim forms shall contain a notice, in a form approved by the superintendent, that clearly states in substance the following:

"Any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or stated claim for each violation."

(1992, added by chap. 480, eff. 1/13/93.)
1991, chgd. by chap. 371; 1993, chgd. by chap. 729, eff. 12/27/93.)

4. Procedures

(a) If the insurance frauds bureau has reason to believe that a person has engaged in, or is engaging in, an act defined in section 155.05 of the penal law, with respect to personal or commercial insurance transactions or section 176.05 of such law, the superintendent may make such investigation within or without this state as he deems necessary to aid in the enforcement of this chapter or to determine whether any person has violated or is about to violate any such provision of the penal law.

(b) A person having material located outside the state and requested by the superintendent may make it available to the superintendent or his representative to be examined at the place where it is located. The superintendent may designate representatives, including officials of the state in which the material is located, to inspect the material on his behalf, and he may respond to similar requests from officials of other states.

(1991, chgd. by chap. 371; 1993, chgd. by chap. 729, eff. 12/27/93.)

§405. Reports.

(a)Any person licensed pursuant to the provisions of this chapter, and any person engaged in the business of insurance in this state who is exempted from compliance with the licensing requirements of this chapter. including the state insurance fund of this state, who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent insurance transaction is about to take place, or has taken place shall, within thirty days after determination by such person that the transactions appears to be fraudulent, send to the insurance frauds bureau on a form prescribed by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require.

(b) The insurance frauds bureau shall review each report and undertake such further investigation as it deems necessary and proper to determine the validity of the allegations.

(c) Whenever the superintendent is satisfied that a material fraud, deceit, or intentional misrepresentation has been committed in an insurance transaction or purported insurance transaction, he shall report any such violation of law to the appropriate licensing agency, the district attorney of the county in which such acts were committed, when authorized by law, to the attorney general, and where appropriate, to the person who submitted the report of fraudulent activity, as provided by the provisions of this article. Within one hundred twenty days of receipt of the superintendent's report, the attorney general or the district attorney concerned shall inform the superintendent as to the status of the reported violations.

(d) No later than January fifteenth of each year, beginning in nineteen hundred ninety-four, the superintendent shall furnish to the governor, the speaker of the assembly and the president pro tem of the senate a report containing:

(1) a comprehensive summary and assessment of the frauds bureau's efforts in discovering, estigating and halting fraudulent activities and assisting in the prosecution of persons who are parties to insurance fraud;

(2) the number of reports received from any person or persons engaged in the business of insurance, the number of investigations undertaken by the bureau pursuant to any reports received, the number of investigations undertaken not as a result of reports received, the number of investigations that resulted in a referral to a licensing agency, a local prosecutor or the attorney general, the number of such referrals pursued by a licensing agency, a local prosecutor or the attorney general, and the disposition of such cases;

(3) a delineation of the number of reported and investigated cases by line of insurance;

(4) a comparison of the frauds bureau's experience, with regard to paragraphs two and three of this subdivision, to the bureau's experience of years past;

(5) the total number of employees assigned to frauds bureau delineated by title and location of bureau assigned;

(6) an assessment of insurance company activities in regard to detecting, investigating and reporting fraudulent activities, including a list of companies which maintain special investigative units for the sole purpose of detecting, investigating and reporting fraudulent activities and the number of investigators assigned to such units per every thirty thousand policies in force with such company;

(7) the amount of technical and monetary assistance requested and received by the frauds bureau from any insurance company or companies or any organization funded by insurance companies;

(8) the amount of money returned by the frauds bureau to insurance companies pursuant to any fraudulent claims that were recouped by the bureau;

(9) the number and amount of civil penalties levied by the frauds bureau pursuant to chapter four hundred eighty of the laws of nineteen hundred ninety-two; and

(10) recommendations for further statutory or ad- ministrative changes designed to meet the objectives of this article.

(1993, repealed and added by chap. 57, eff. 4/1/93.) (1993, chgd. by chap. 371; 1993 chgd. by chap. 729, eff. 12/27/93.)

§406. Immunity.

In the absence of fraud or bad faith, no person subject to the provisions of this chapter, or the employees or agents of such person, shall be subject to civil liability, and no civil cause of action of any nature shall arise against such person(i) for any information relating to suspected fraudulent insurance transactions furnished to law enforcement officials, their agents and employees; and (ii) for any information relating to suspected fraudulent insurance transactions furnished to other persons subject to the provisions of this chapter; and (iii) for any such information furnished in reports to the insurance frauds bureau, its agents or employees. Nor shall the superintendent or any employee of the insurance frauds bureau, in the absence of fraud or bad faith, be subject to civil liability and no civil cause of action of any nature shall arise against

'em by virtue of the publication of any report or bulletin related to the official activities of the insurance frauds bureau. Nothing herein is intended to abrogate or modify in any way any common law privilege of immunity heretofore enjoyed by any person. *(1991, chgd. by chap. 371; 1993, chgd. by chap. 729, eff. 12/27/93.)*

§407. Other law enforcement authority, powers and duties not affected or impaired.

This article shall not:

(a) Preempt the authority or relieve the duty of other law enforcement agencies to investigate and prosecute suspected violations of law.

(b) Prevent or prohibit a person from voluntarily disclosing any information concerning violations of this article to any law enforcement agency.

(c) Limit any of the powers granted elsewhere in this chapter and other laws to the superintendent or the department to investigate possible violations of this chapter and take appropriate action against wrongdoers.

1991, chgd. by chap. 371; 1993, chgd. by chap. 729, eff. 12/27/93.)

§408. Expiration of article.

The provisions of this article shall cease to be of any force or effect January first, nineteen hundred ninety-seven. *(1991, chgd. by chap. 371; 1993, chgd. by chap. 729, eff. 12/27/93.* Article 4 no longer expires due to provisions of L.1993, chap. 729(17-b). Legislature failed to provide for repeal of this section.)

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APPENDIX
B

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ARTICLE 176 - INSURANCE FRAUD

Section

§176.00 Insurance fraud; definition of terms.

The following definitions are applicable to this article:

1. "Insurance policy" has the meaning assigned to insurance contract by subsection (a) of section one thousand one hundred one of the insurance law except it shall include reinsurance contracts, purported insurance policies and purported reinsurance contracts.

2. "Statement" includes, but is not limited to, any notice, proof of loss, bill of lading, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, x-ray, test result, and other evidence of loss, injury or expense.

3. "Person" includes any individual, firm association or corporation.

4. "Personal insurance" means a policy of insurance insuring a natural person against any of the following contingencies:

(a) loss of or damage to real property used predominantly for residential purposes and which consists of not more than four dwelling units, other than hotels, motels and rooming houses;

(b) loss of or damage to personal property which is not used in the conduct of a business;

(c) losses or liabilities arising out of the ownership, operation, or use of a motor vehicles, predominantly used for non-business purposes;

(d) other liabilities for loss of, damage to, or injury to persons or property, not arising from the conduct of a business;

(e) death, including death by personal injury, or the continuation of life, or personal injury by accident, or sickness; disease or ailment, excluding insurance providing disability benefits pursuant to article nine of the workers' compensation law.

A policy of insurance which insures any of the contingencies listed in paragraphs (a) through (e) of this subdivision as well as other contingencies shall be personal insurance if that portion of the annual premium attributable to the listed contingencies exceeds that portion attributable to other contingencies.

5. "Commercial insurance" means insurance other than personal insurance.

§176.05 Insurance fraud; defined.

A fraudulent insurance act is committed by any person who, knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer or purported insurer, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which he knows to: (I) contain materially false information concerning any fact material thereto; or (ii) conceal, for the purpose of misleading, information concerning any fact material thereto.

§176.10 Insurance fraud in the fifth degree.

A person is guilty of insurance fraud in the fifth degree when he commits a fraudulent insurance act.

Insurance fraud in the fifth degree is a class A misdemeanor.

§176.15 Insurance fraud in the fourth degree.

A person is guilty of insurance fraud in the fourth degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of one thousand dollars.

Insurance fraud in the fourth degree is a class E felony.

§176.20 Insurance fraud in the third degree.

A person is guilty of insurance fraud in the third degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of three thousand dollars.

Insurance fraud in the third degree is a class D felony.

§176.25 Insurance fraud in the second degree.

A person is guilty of insurance fraud in the second degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of fifty thousand dollars.

Insurance fraud in the second degree is a class C felony.

§176.30 Insurance in the first degree.

A person is guilty of insurance fraud in the first degree when he commits a fraudulent insurance act and thereby wrongfully takes, obtains or withholds, or attempts to wrongfully take, obtain or withhold property with a value in excess of one million dollars.

Insurance fraud in the first degree is a class B felony.

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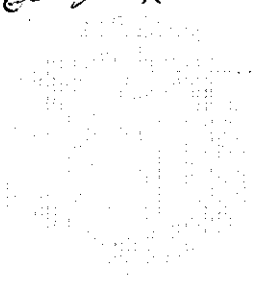
APPENDIX C



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enforcement investigation experience involving economic crimes.

(b) Except for insurers which insure less than 1,000 New Jersey automobiles, the plan shall provide fraud education for claims personnel which shall contain a detailed and comprehensive program of insurance fraud awareness and education to prepare claims personnel for fraud detection.

1. The program shall consist of formal, specialized training for adjustors, claims processors and investigators.

2. Training shall be provided in the following specialties: automobile theft investigations, automobile property damage and fire investigations, personal injury protection investigations, and bodily injury liability claim investigation.

(c) Except for insurers which insure less than 1,000 New Jersey automobiles, the Plan shall provide a Fraud Detection Procedures Manual and disseminate it to all claims personnel for the handling of suspicious automobile insurance claims. The Fraud Detection and Procedures Manual shall include, at a minimum, the following:

1. Information for claims personnel and SIU investigators regarding general investigation guidelines; unfair claims practices; conducting interviews; report writing; information disclosure; law enforcement relations; and the New Jersey Fraud Prevention Act;

2. The process to be employed when a suspicious claim is identified;

3. The "fraud profiles" or indicators for automobile theft, automobile physical damage and bodily injury claims fraud;

4. The duties and functions of the SIU;

5. The procedure for referral of a claim to the SIU; and

6. The post-referral procedure for communication between the claims unit and the SIU.

(d) The plan shall provide for underwriting investigations to verify that the insured is an eligible person and is properly rated within 60 days of receipt of the application. These underwriting investigations

shall verify the insured's residency provided by the insured on his or her application for insurance. The plan may provide that these investigations are generally done "in-house" by telephone and by using information from the New Jersey Division of Motor Vehicle Services (or similar agencies in other states) and prior insurers.

1. The Plan shall provide that the insurer shall notify the IFD of an ineligible insured based on residency pursuant to N.J.S.A. 17:33A-9a of the Fraud Prevention Act.

(e) The plan shall provide that all suspicious claims be referred to the IFD as soon as practical on the prescribed reporting form (as set forth in Appendix A, incorporated herein by reference), and thereafter cooperate with the IFD investigation. The IFD will assist insurers by providing necessary information, such as fraud profiles or indicators.

(f) The insurer shall permit the IFD access to its offices upon reasonable notice and at reasonable hours to conduct on site review of the insurer's compliance with its fraud prevention plan.

(g) The plan may include such other items as the insurer may wish to provide.

HISTORY R.1992 d.190, eff. 4/20/92.

PUBLISHERS NOTE Appendix A is set out separately. See NJAC 11:16-4.4 Appendix A.

CROSS REFERENCE 17:33A-9

DATE NEW 1992

SUBJECT CATEGORY 140 - Automobile insurance / insurers
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