



**CALIFORNIA DEPARTMENT
OF INSURANCE**

**ADVISORY TASK FORCE
ON INSURANCE FRAUD**

***Reducing Insurance Fraud
in California***

**Steve Poizner
Insurance Commissioner**

MAY 2008



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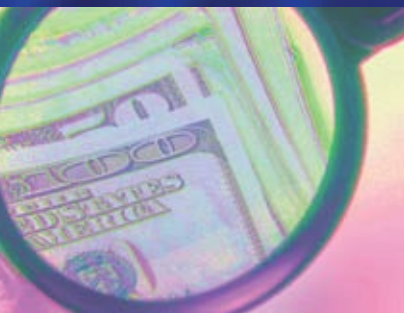
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INTRODUCTION: COMBATTING INSURANCE FRAUD

As consumers, we all need insurance to protect us from the consequences of both minor and catastrophic losses. In some cases, such as automobile insurance, we are required by law to buy insurance. We are also required by mortgage lenders to buy homeowner's insurance. All California employers are required by law to buy workers' compensation insurance, and many employers are required by union contracts to provide health insurance to their workers. Californians pay tens of billions of dollars a year for insurance.

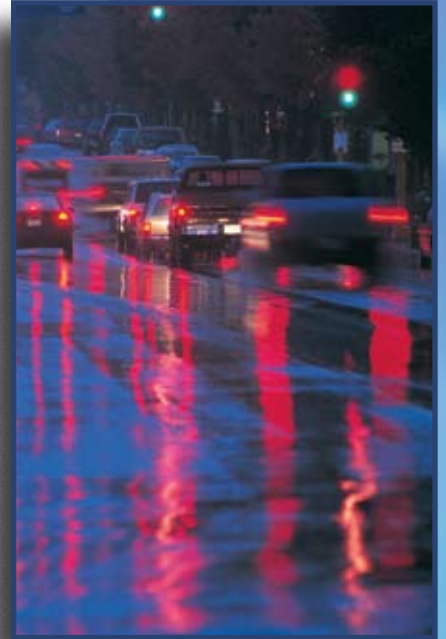
State law defines insurance as "a contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event."¹ Insurance is a mechanism to protect against unanticipated events that might lead to financial losses. An insurance policy allows consumers and businesses to protect their assets and manage risks. For example, health insurance is a necessity to protect a consumer from unexpected medical costs that could lead to bankruptcy. Automobile insurance protects the consumer against losses resulting

Staged Auto Accidents

Staged crashes are one of the more abusive and potentially dangerous scams in insurance fraud. One 1997 case involved the deaths of three family members in a staged traffic collision on the 710 Freeway in the Los Angeles area. The victims' vehicle was crushed between two large trucks when one of the trucks, carrying gravel, was unable to stop in time due to the staged collision. All three occupants of the family vehicle, including a two-year-old child, were burned to death in the ensuing car fire.

from a collision or other accident. An insurance company spreads the risk by charging customers a fee (a "premium") for the insurance contract.

Our insurance system works fairly well, but it is burdened by people who cheat and commit insurance fraud. Insurance fraud is a growing problem in our society. Most people believe that it is a "victimless crime" that does not affect them. This is simply not true. Insurance fraud affects everyone. It is a crime that costs lives and also funds criminal enterprises such as organized crime and terrorism, and contributes to higher premium costs.



1 California Insurance Code, Section 22, available online at www.leginfo.ca.gov/calaw.html.



With the threat of an economic recession and a multi-billion dollar state budget deficit, the time has come to change the public's perception about insurance fraud, to energize anti-fraud efforts, and to find new and innovative ways to end this drain on California's economy.

The Effects of Fraud

Although the incidents of insurance fraud are frequent and far-reaching, its effect on our lives and economic well-being is rarely recognized.

➤ Insurance fraud in California totals over \$15 billion each year, costing each resident an average of more than \$500 per year.² This cost results in higher insurance premiums, higher taxes, higher prices, and lower levels of government services.

➤ According to the National Insurance Crime Bureau (NICB), insurance fraud is the second most costly crime in our country, with tax evasion being the most costly. In California, the losses from insurance fraud even exceed the estimated losses from tax evasion.³

Life Insurance Scams Lead to Death

People have been murdered to obtain proceeds from life insurance policies. For example, a nine-year-old boy was kidnapped and strangled to death in connection with a life insurance scheme in 1992. One of the perpetrators in this gang was later found to have obtained life insurance policies on six individuals without their knowledge.

➤ There is no stereotype or profile of people who perpetrate insurance fraud. The perpetrator could be a neighbor, a co-worker, an entrepreneur, or a certified/licensed individual or institution. People involved in insurance fraud can be recruited by ringleaders to participate in large-scale fraud rings, or they can be opportunists who try to bluff their way around the system.

➤ Fraud is committed in many forms by individuals, businesses, and criminal organizations. For instance, medical fraud may be perpetrated by medical professionals, clinic staff, or medical equipment suppliers to the detriment of a consumer, an employer, an insurance company, and/or a government benefit program.

² California Department of Insurance estimated calculation.

³ State income tax evasion is estimated at \$6.5 billion, according to the Franchise Tax Board. See www.mercurynews.com/localnewsheadlines/ci_8228577.

- Insurance fraud can directly affect innocent, law-abiding people, dramatically changing their lives forever. For example, fraud perpetrators have staged collisions resulting in loss of life, have driven companies out of business by damaging their bottom line and their hard-earned reputation, and have performed inappropriate medical treatments on defenseless victims. Vulnerable groups such as seniors, recent immigrants, or small businesses may be special targets of sophisticated swindlers.
- Many Californians do not think about the personal, moral, and economic threat that fraud poses to their lives and standard of living. This leads to a growing tolerance of insurance fraud.

Current Fraud-Prevention Efforts

There have been efforts to combat fraud within specific lines of insurance. However, fraudulent practices overlap lines of insurance and need to be addressed wherever they occur. For example, a medical provider could bill a workers' compensation insurer, a health insurer, and an automobile insurer for the same unnecessary or even fictitious medical services. A stronger and more coordinated effort within and among regulatory and enforcement agencies is needed to address the various types of insurance fraud.

Medical Mills

- * In 2004, two outpatient surgery centers in Orange County performed unnecessary surgeries in order to bill insurance companies for services. Two of the perpetrators, a brother and sister, recruited patients from various states and arranged for transportation to Orange County for the surgery. Little or no follow-up care was given to the patients. The two surgery centers were responsible for over 120 million dollars in fraudulent billings. Seventeen arrests were made as a result of this investigation, including three doctors. So far three defendants have pled guilty and are awaiting sentencing; three have received prison terms ranging from 5–12 years. The remaining individuals are in various stages of the court process.
- * In 2007, three Southern California doctors (an obstetrician-gynecologist, a general surgeon, and a gastroenterologist) were arrested and accused of participating in a \$96 million billing scheme. The fraud involved recruiting 2,000 healthy people from all over the country to receive unnecessary surgeries in exchange for money or low-cost cosmetic surgery. The recruiters targeted employees from businesses in over 32 states. More than 1,600 employers had employees who were involved in this scheme.



The California Department of Insurance (CDI) regulates more than \$123 billion of insurance business annually.⁴ The major areas of insurance overseen in 2006 were:

- ◆ \$22.6 billion in automobile insurance
- ◆ \$11.5 billion in workers' compensation
- ◆ \$64.4 billion in life, accident, and health (not including HMOs)
- ◆ \$22.8 billion in property and casualty
- ◆ \$2.6 billion in title insurance

The Fraud Division is a law enforcement agency within CDI. The mission of the Fraud Division is to protect the public from economic loss and distress by actively investigating and arresting those who commit insurance fraud. The Fraud Division investigators are sworn peace officers with statewide authority whose primary duty is to enforce California Penal Code Section 550.

The Fraud Division has four anti-fraud programs: Automobile; Property/Casualty and Life; Disability and Healthcare; and Workers' Compensation.⁵ The Fraud Division is also responsible for administering and coordinating grant awards to various district attorneys' offices throughout California for dedicated insurance fraud prosecution units. Fraud Division investigators conduct proactive and reactive criminal investigations and field enforcement operations, and also work closely with other federal, state, and local law enforcement agencies and insurer Special Investigative Units (SIUs).

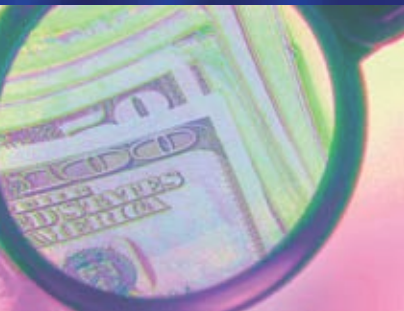
Insurance fraud is a felony in California (California Penal Code, Sections 548-550). The Legislature has designated the CDI Fraud Division as the primary agency for insurance-related anti-fraud programs in California.

Workers' Compensation Premium Fraud

In 2007, a Reedley woman was arrested on four counts of workers' compensation insurance premium fraud and nine felony counts of failure to remit withheld payroll taxes. The woman, who was the owner and president of a farm labor service company, allegedly failed to report and/or misclassified approximately \$4 million in employee payroll assessments to the State Compensation Insurance Fund (SCIF) and the state Employment Development Department (EDD). This resulted in losses of \$900,000 to SCIF and approximately \$500,000 to EDD.

4 Based on Market Share Reports for Property & Casualty and for Life & Annuity, at www.insurance.ca.gov/0400-news/0200-studies-reports/0100-market-share/.

5 For more information, see the "2006 Annual Report of the Commissioner," California Department of Insurance, at www.insurance.ca.gov/0400-news/0200-studies-reports/0700-commissioner-report. The Fraud Division Annual Report appears on pp. 64-80.



Homeless Men Killed in Life Insurance Scam

In 2005, two women, 75 and 73 years old, were charged by the Los Angeles County District Attorney with masterminding the deaths of homeless men to collect on their insurance policies. The women befriended the men by helping them obtain housing and food. In some cases, the men signed multiple life insurance policies listing the women as beneficiaries, while in other cases the women forged the signatures. So far, \$2.7 million has been paid by insurance companies to these defendants. In one incident, two men killed in hit and run accidents had life insurance policies listing the two women as beneficiaries. It is suspected that this scam had been going on for several years.

As such, the CDI requires all insurance carriers licensed in California to report all suspected fraudulent claims.

The Fraud Division also receives suspected criminal referrals from government agencies, allied law enforcement agencies, and consumer interest groups.

According to the law, the crime of insurance fraud can be prosecuted when:

- ◆ The suspect had the intent to defraud. Insurance fraud is a “specific” intent crime, which means the prosecutor must prove that the person involved knowingly committed an act to defraud.
- ◆ An act is completed. Simply making a misrepresentation (written or oral) to an insurer with knowledge that it is untrue is sufficient.
- ◆ The act and intent must come together. One without the other is not a crime.
- ◆ Actual loss is not needed as long as the suspect has committed an act and had the intent to commit the crime. No money necessarily has to be lost by a victim.

The true cost of insurance fraud is poorly understood because it has been inadequately studied. More research is needed.

Insurance fraud losses often become a “cost of doing business” that is passed on to every consumer in the State. In some cases, it is cheaper for an insurance company to pass along the cost of fraud to policyholders than to invest in fighting fraud. In other cases, it is beyond the resources of any one company to fight fraud, so industry groups and municipal and state governments must





take up the fight. Consumers and businesses must also join this effort. With all stakeholders involved and committed, insurance fraud can be reduced.

Cutting the cost of fraud makes economic sense for California. The return on investment justifies increased resources for combating fraud, even in this time of fiscal emergency. If Californians could reduce the rate of insurance fraud by only ten percent, it could save us nearly \$1.5 billion per year.

This report recommends steps to reduce insurance fraud and thereby strengthen the State's economy. The effort will require commitment on the part of everyone, and we all stand to benefit.

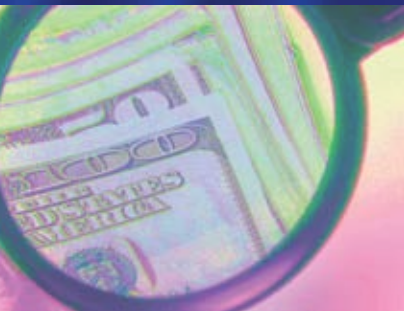
ORIGIN AND SCOPE OF THIS REPORT

This report responds to the request of Insurance Commissioner Steve Poizner for guidance and advice on reducing insurance fraud in California.

On May 31, 2007, the Commissioner convened an Advisory Task Force on Insurance Fraud, consisting of a Blue Ribbon Review Committee and a Working Committee. The Working Committee then subdivided into Expert Working Groups for particular topics. The Task Force and its committees were charged with identifying issues and making recommendations to CDI on how to reduce the incidence of insurance fraud in California.

This report will focus on the problem of insurance fraud as outlined in the California Insurance Code, Chapter 12, Section 1871-1879.8, the Insurance Frauds Prevention Act. The Act is primarily concerned with fraudulent claims.

However, of equal importance is fraud committed by insurers, agents, brokers, and others in the insurance industry, including deceptive sales practices, theft of premiums, kickbacks, collusion with contractors, and fraudulent claims adjustment practices. These activities not only increase costs for insurance, but also may lead to financial ruin for a consumer when the promised protection is not forthcoming. It is recommended that another advisory task force with the appropriate expertise be convened to address these consumer protection concerns, including point-of-sale conduct and other fraudulent practices involving licensees and unauthorized entities.



The goals of the Advisory Task Force on Insurance Fraud were to:

- ◆ Review the efficiency of the California Department of Insurance Fraud Division.
- ◆ Review the insurance industry's anti-fraud programs and efforts.
- ◆ Review the current anti-fraud statutes and regulations.
- ◆ Review and identify emerging technology for the investigatory process.
- ◆ Recommend new outreach for the CDI Fraud Division.

Members of the Advisory Task Force included leaders from the judiciary, law enforcement, insurance industry, consumer protection organizations, and government.

The Working Committee included experts from the following lines of insurance:

- ◆ Automobile
- ◆ Disability, Life, and Healthcare
- ◆ Property and Casualty
- ◆ Workers' Compensation

Members of the Working Committee of the Advisory Task Force facilitated meetings with various subject matter experts. Emerging issues and trends were identified, which resulted in the final recommendations presented in this report.

California Department of Insurance staff contributed invaluable guidance and technical support at all stages of the process. While this report is the product of the independent Advisory Task Force on Insurance Fraud, it would not exist without the contributions of these individuals.

See the *Acknowledgments* on page ii for individuals who participated in this process.



RECOMMENDATIONS OF THE ADVISORY TASK FORCE

A. Organization and Efficiency of the CDI Fraud Division

The primary responsibility of the Fraud Division is to receive, review, and investigate suspected insurance fraud claims. In general, the primary duty of district attorneys is to review completed investigations and prosecute offenders. In California, the district attorneys and CDI work closely together by adhering to vertical prosecution strategies which allows both governmental entities to combine investigative resources. This system has been productive in terms of the number of successful prosecutions when compared to other states. We do not recommend any fundamental redesign of this division of responsibilities, nor do we recommend any change to the system of providing state funds to assist local investigators and prosecutors. We do recommend an increased emphasis by CDI on the functions that require a statewide perspective. The foremost of those functions involves funding issues, which include setting priorities, acquiring funds, and distributing funds.

Recommendation 1

Establish a research program to evaluate and monitor the cost of all types of insurance fraud.

Discussion: Decisions should be based on factual information, not anecdote or speculation. Without reliable measurement of the extent and cost of fraud, it is difficult to make the case for adequate funding to fight fraud or to allocate the available funds intelligently. With meaningful measurements over time, the success of various fraud programs may be evaluated and the return on investment may be demonstrated.

Recommendation 2

Establish flexible criteria for allocating funds that take into consideration the extent of fraud being addressed by each program or project, and the expected impact of the program or project in reducing that fraud.

Discussion: The Fraud Division is restricted on how specific program resources are utilized. For example, workers' compensation fraud program funds cannot be used to investigate automobile insurance fraud crimes. There has been an imbalance of resources and funding for the insurance fraud problem in California. Suspected automobile fraud claims outnumber suspected fraudulent workers' compensation claims three-to-one. All insurance fraud crimes affect California's economy and every

person. The CDI should work with the Legislature and the Department of Finance in finding a solution to allow the Commissioner to have more flexibility in utilizing current resources and personnel to lower insurance fraud in California.

Recommendation 3

Obtain additional funding sources for fraud investigations from assessments on policies. When research becomes available, adjust revenue streams to make revenue proportional to the scope of the fraud problem in various lines of insurance.

Discussion: The Property & Casualty Expert Working Group recommended combining the revenue streams into a single budget that the CDI could allocate flexibly. The Blue Ribbon Review Committee has concerns about that recommendation because it raises problems of fairness among lines of insurance that are more or less heavily assessed, that experience greater or lesser fraud losses, and that receive greater or lesser investigative support. (Also see Recommendation 13.)

Recommendation 4

Extend the funding cycle for the District Attorney Local Assistance Grants to three years for all anti-fraud programs.

Discussion: The Fraud Division is responsible for administering the District Attorney Local Assistance grant funding as set forth in California Insurance Code Sections 1872.8 (Automobile), 1872.83 (Workers' Compensation), 1874.8 (Organized Automobile Insurance Fraud Activity Interdiction Program, commonly referred as Urban Auto), and 1872.85 (Disability/Healthcare). The funding is to be strictly used for the investigation and prosecution of insurance fraud. The Fraud Division audits all programs for financial accountability and performance. The grant application and approval process is a thorough process with built-in accountability and performance measurements with the emphasis on a good return on investment (ROI). Currently, all programs are funded annually except for the Urban Auto, which is three years. The Urban Auto Program has been successful because it allows district attorneys to focus on complex prosecutions, such as organized crime, medical/legal operations, cappers, etc., which are cost drivers within the system. Most high dollar or multiple suspect prosecutions take years to litigate, should the defendants



decide not to plead out. If all the programs are increased to a three-year funding cycle, district attorneys will be able to focus on complex cases, retain experienced prosecutors, reduce administrative time, and provide continuity and a higher ROI to the anti-fraud program.

Recommendation 5

Assign CDI investigators to specialize in one area of insurance fraud for at least three years.

Discussion: The investigation of the numerous lines of insurance requires specialized training and years of experience in order for an investigator to become effective. If resources are available, assignments should be focused on specific areas as to maximize investigative efforts and develop expertise.

Recommendation 6

Adopt more aggressive recruiting and retention practices, including pay upgrades, so that CDI can recruit and retain qualified investigators.

Discussion: The Fraud Division loses experienced investigators to agencies that offer better pay. There is an overall shortage of entry-level applicants in law enforcement. The Property & Casualty Expert Working Group made the most detailed recommendations in this area, which are highlighted here:

- ◆ Institute internet/on-line testing to expedite the hiring process.
- ◆ Waive the written exam for qualified peace officer personnel from outside State service.
- ◆ Change the minimum qualifications to allow Bachelor's degrees, not solely Criminal Justice degrees.
- ◆ Establish recruitment incentives, such as the California Highway Patrol's 40 hours additional vacation time for an officer who recruits a candidate who is selected and graduates from the academy.
- ◆ Conduct a job analysis to ensure appropriate personnel classification that is comparable to other agencies.
- ◆ Align CDI Fraud Division salaries with the Department of Justice pay scale.

- ◆ Adopt additional retention incentives, such as educational incentives and task force commander incentives. (Steps have already begun in this area.)

B. Industry Role in Fighting Fraud

Recommendation 7

Insurer Special Investigative Units (SIUs) must be trained to provide better quality referrals, and the Fraud Division should provide more feedback on the referrals received.

Discussion: Insurance companies are required to have SIUs and to report suspected fraudulent claims to the Fraud Division. The four Expert Working Groups were unanimous in urging better communication of the criteria for reporting and the standards for what should be in a report. The Disability, Life, and Healthcare Expert Working Group prepared a particularly complete set of recommendations for training seminars. We recommend that approach. Another Expert Working Group suggested company-by-company roundtables to review each company's referrals.

Recommendation 8

The Fraud Division should communicate to insurance companies what to expect after a referral has been submitted for review.

Discussion: A common complaint is the lack of follow-up from CDI after a company submits a referral. Companies should be informed of the restrictions on disclosing criminal investigations, and should be informed of what to expect and whom to contact for information. Companies should be instructed how to report updated information after the initial reports.

Recommendation 9

A forum should be created to allow insurance companies to share information about fraud patterns, rings, and trends.

Discussion: Cooperation among companies is currently discouraged by the threat of defamation or other civil liability, and by concerns of anti-trust violations. (See the discussion of immunity in Recommendation 12. This concern also may be addressed by the recommendation in Section E for a centralized database housed in CDI.)



Recommendation 10

Recognize companies that go beyond compliance with minimum SIU requirements for their greater commitment to fighting fraud.

Discussion: All insurance carriers licensed to conduct business in California must file an annual SIU Compliance Report with the Fraud Division. The report details how the SIU is organized in the company, the name of the director, training received and provided to applicable personnel about fraud, reporting procedures, and internal protocols. Some insurance carriers excel in their SIU activity. Others just meet the minimum requirements of the laws and regulations governing the SIU mandates for California. The CDI should consider creating a formal recognition program for those insurance companies that excel in fraud prevention, recognition, reporting, and reducing premiums for policyholders due to an efficient and effective anti-insurance fraud program.

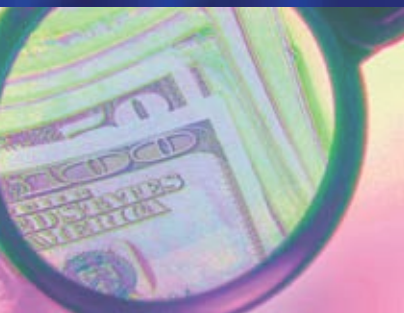
C. Public Role in Fighting Fraud

Recommendation 11

Conduct a statewide campaign to educate the public about the cost of fraud, its consequences, how to prevent it, and how to recognize and report it.

Discussion: Such a campaign was unanimously supported by the Expert Working Groups as a vehicle to change attitudes and reverse the trend of growing tolerance for insurance fraud. The groups noted various features of a possible campaign:

- ◆ The message should be that fraud is wrong, is costly to everyone, should be prevented, and should be reported.
- ◆ Billboards and broadcast public service announcements are among the vehicles that could carry the message.
- ◆ As part of the campaign, training should be conducted for employers, workers, and professionals.
- ◆ An effective, coordinated campaign requires professional management and “branding.”



- The Property & Casualty Expert Working Group recommends the work of the Coalition Against Insurance Fraud and the book, “United We Brand.”
- The Disability, Life, and Healthcare Expert Working Group recommends designating a person experienced with public awareness campaigns.
- The Automobile Expert Working Group recommends developing educational materials in collaboration with other agencies and organizations.
- ◆ The results of the campaign must be measured. Public tolerance for insurance fraud must be reduced demonstrably, and willingness to act to prevent fraud must be increased.
- ◆ Funding for the campaign must be continual and directed toward producing results.

D. Fraud Statutes and Regulations

Certain themes and recommendations involving legislation were repeated among the Expert Working Groups, or stand out as having general impact. They are included in this report.

Recommendation 12

Strengthen the immunity provisions for companies that report suspected fraud and cooperate in investigations in accordance with the National Association of Insurance Commissioners (NAIC) Insurance Fraud Prevention Model Act.

Discussion: The NAIC Insurance Fraud Prevention Model Act has been substantially updated since a predecessor version was enacted in California. The updated Act provides greater civil immunity for insurers sharing fraud information. The need for immunity was raised repeatedly in the Expert Working Groups, and the NAIC Model Act was discussed in detail in the Disability, Life, and Healthcare group’s recommendations. (See *Coalition Against Insurance Fraud paper, “Civil Immunity Laws Governing Anti-Fraud Activities,”* listed in Bibliography.)



Recommendation 13

Increase revenue from policy assessments for CDI to administer and conduct investigations and for grants to District Attorneys.

Discussion: Some lines of insurance have insufficient policy assessments to support anti-fraud efforts. In the long term, assessments on various policy lines should be made in proportion to the magnitude of the problem in each line. Until the magnitude is accurately determined by research, immediate attention should be given to legislation to change the assessment on life policies to annual instead of one-time-only, and establish an assessment on homeowners' policies. Further attention should be given to identifying other lines of insurance that do not currently generate revenue sufficient to carry their share of the cost of combating fraud. (Also see Recommendation 3.)

Other legislative and/or regulation recommendations from the Expert Working Groups:

Automobile

- Remove the sunset on Assembly Bill 1183 (Vargas) – Organized Automobile Fraud Interdiction Program. The program mandates that the Fraud Division, the California Highway Patrol, and various district attorneys throughout California work together in a task force setting to investigate organized automobile insurance fraud rings. The program is scheduled to sunset on January 1, 2010. This program has been very successful in the identification, investigation, and prosecution of organized insurance fraud rings in California.
- Extend statute of limitations for certain crimes as proposed in Senate Bill 610 (Corbett). The extension of the statute of limitation for a felony will assist prosecutors in the most complex organized ring cases. Senate Bill 620 passed the State Senate in January 2008 and is currently pending in the State Assembly.
- Explore and identify strategies to aggressively deter fraudulent behavior and penalize crimes associated with but not limited to: fake automobile insurance identification, staged accidents, undisclosed drivers, and false damage and injury claims.

Disability, Life, and Healthcare

- Amend Insurance Code Section 10127.17(a) to require a fee of up to \$1.00 per policy to be collected annually instead of once in the life of the policy.
- Amend Penal Code 550 to make fraudulent misrepresentation in an application for health or disability insurance a crime, as it already is in an application for workers' compensation insurance.
- Review industry practices and statutes on rescission policies and evaluate potential need for amendments to prevent abuse.
- Require fraud warning notices on checks for payment of disability insurance benefits, as already required for workers' compensation temporary disability checks.

Property and Casualty

- Allow insurers who bring action under Insurance Code Section 1871.7 to retain a larger percentage of the civil recovery, and authorize CDI to assist insurers in such actions, as an incentive for greater use of the "whistleblower" statute to prosecute frauds.

Workers' Compensation

- Require employers to publicly disclose their workers' compensation coverage, to improve compliance with Labor Code Section 3700, which requires this insurance.
- Require the Commissioner to publish the workers' compensation coverage of every employer (as do 29 other states), to improve compliance with Labor Code Section 3700, which requires this insurance.
- Increase civil and criminal penalties for premium fraud, including misclassification of payroll as well as under-reporting of payroll.



- Increase civil and criminal penalties for willful failure to carry insurance. Existing law allows under-reporting to be punished as a felony, while going completely uninsured is only a misdemeanor. The law should allow willful lack of insurance to be charged either as a misdemeanor or as a felony.
- Review the cost benefit of requiring carriers, Third Party Administrators, and self-insured entities to send a statement of benefits document to patients to verify that services were actually rendered, the extent of those services and to include information on where and how to report suspected fraud.
- Conduct additional research on: (1) the misuse of “independent contractor” designation, (2) coverage fraud in temporary help and professional employment agencies, (3) medical billing practices, and (4) methods to require greater disclosure of employer coverage information.

E. Technologies

Recommendation 14

CDI should acquire the software and hardware to implement a statewide investigative review program to store, analyze, and extract evidence obtained from seized digital records and documents.

Discussion: Various regional forensic laboratories use systems to manage evidence similar to the model described in the recommendations of the Disability, Life, and Healthcare Expert Working Group.

Recommendation 15

Create a centralized case management database that allows participating law enforcement agencies to coordinate efforts and share evidence. Find trends, patterns, and evidence by data mining within that database and by associating the data with available public and commercial databases.

Discussion: Investigators in different jurisdictions may work on different aspects of the same problem, sometimes unaware of one another or of the relationships between their cases. In addition, the persons or entities involved in one case may turn up in others, and relationships that appear to be insignificant in one case may become patterns when seen

in multiple cases. Persons who appear to be unremarkable in one case may turn out to be other than they appear when viewed in the context of commercial or public data (e.g., licensing, criminal histories, claims histories, business experience).

Recommendation 16

Provide a central point within CDI for reporting and recording suspected fraud, including a tip hotline, with direct forwarding to interested agencies.

Discussion: One Expert Working Group suggested that suspected fraud reports in all lines of insurance should be filed with the local District Attorney (DA) as well as the CDI, as they currently are in workers' compensation. The Workers' Compensation Expert Working Group, however, indicated that multiple reporting is confusing and that all reports should go to a central point for redistribution. It may not be so difficult for some SIUs to determine which DA has jurisdiction, but individuals making a report do not know where to turn. The Workers' Compensation group suggested that the CDI could relay suspected fraud reports to the appropriate DA. Additionally, CDI could electronically forward the reports to multiple jurisdictions and link them to related cases or related reports, adding value to the initial report of suspected fraud. The relay could occur automatically as soon as the data entry is completed at the Fraud Division, eliminating the problem of DAs not being timely informed of issues within their jurisdictions.

Recommendation 17

Create a Forensic Information Technology Center within the Fraud Division to support and improve the efficiency of the anti-fraud programs in California.

Discussion: This is essentially a wrap-around for Recommendations 14, 15, and 16, and a recognition of the need to provide IT support to the many functions performed by the Fraud Division and the local agencies involved in fighting fraud. Among other things, a Technology Center could house a hotline and an e-mail tip database which would be promoted by the public education outreach program as discussed in Recommendation 11.



Recommendation 18

Adopt a revised FD-1 (intake) form customized for the unique requirements of reporting suspected healthcare fraud.

Discussion: Healthcare insurers organize and track individual claims differently than automobile, workers' compensation, and property/casualty carriers. There are differences in patient file numbers and other unique numbers attached to the claim. The current FD-1 reporting form does not allow the healthcare carriers to easily submit a suspected fraudulent claim.

Conclusion

The California Insurance Commissioner's Advisory Task Force on Insurance Fraud is the first of its kind in the nation. The Task Force produced several positive recommendations for the Insurance Commissioner and the stakeholders of the anti-fraud programs in California to consider and implement in order to aggressively reduce fraud. The Task Force examined the mandated legislative requirements, enforcement operations, grant coordination and distribution, and enforcement operations administered daily by the Fraud Division.

Communication, collaboration and commitment are the critical keys to successfully reduce insurance fraud throughout the State. Some of the recommendations contained in this report will require legislative and regulatory changes. With the collaborative efforts of the insurance industry, the California Department of Insurance (CDI), and district attorneys throughout the State, we can increase the return on our investment while protecting the consumers of California from being victimized by the crime of insurance fraud.

The Task Force stands ready to assist CDI staff in the implementation of these recommendations. The communication and collaboration between the insurance industry, specifically, the special investigative units and consumer protection groups, has never been stronger. By raising the bar for success, we can turn the corner in the fight against insurance fraud in California.

Communication, collaboration and commitment are the critical keys to successfully reduce insurance fraud throughout the State.

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