



Georgia Department of Audits and Accounts Performance Audit Operations

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Why we did this review

This audit was conducted in response to a request from the House Appropriations Committee. We assessed the Program's overall efficiency and effectiveness; reviewed the Program's goals and objectives; and evaluated the Program's formula for determining the amount of the special fraud assessment collected from insurance companies. We also identified alternative strategies the Program should consider implementing in an effort to reduce the incidence of insurance fraud in the state.

Who we are

The Performance Audit Operations Division was established in 1971 to conduct in-depth reviews of state programs. The purpose of these reviews is to determine if programs are meeting their goals and objectives; provide measurements of program results and effectiveness; identify other means of meeting goals; evaluate the efficiency of resource allocation; and assess compliance with laws and regulations.

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Georgia Department of Insurance Special Fraud Program

Relatively few cases of suspected fraud are reported to the Program by insurance companies each year, only a small percentage of reported cases are subsequently investigated in a timely manner, and ultimately very few cases are prosecuted.

What we found

The 1995 statute that created the Program stated that "proper investigation of fraudulent insurance acts, followed by vigorous prosecution of insurance fraud" would result in lower premiums. Our review, however, found that relatively few cases of suspected fraud are reported by insurance companies each year (in fiscal year 2006, only 86 cases were reported by 38 of the 1,504 insurance companies doing business in Georgia) and only a small percentage of reported cases are subsequently investigated in a timely manner (of the 203 cases that were resolved in 2006, 68% were closed because the statute of limitations had expired). Only 17 cases were referred for criminal prosecution in fiscal year 2006.

Our review of other states' insurance fraud programs identified other strategies that the Department should consider implementing in its efforts to combat insurance fraud. These strategies include monitoring the activities of insurance companies' anti-fraud units, identifying fraud trends, and targeting organized fraud rings and repeat offenders.

As a result of our review, we also recommend that the Department consider reevaluating the extent to which the Regulatory Services Division and the Examinations Section

contribute to the Department's overall effort to curtail insurance fraud in the state. In fiscal year 2006 the Department used \$1.2 million (43%) of the Program's appropriation of \$2.8 million to offset some of the cost of its Regulatory Services Division and its Examinations Section which, per the Department, are involved in the investigation and identification of financial statement fraud. Our review found, however, that in fiscal year 2006 the Regulatory Services Division and Examinations Section did not report any cases of suspected fraud to the Fraud Unit. Similarly, based on information provided by personnel in these units, we found that they were directly involved in investigating only one case of fraudulent financial reporting during fiscal year 2006.

The Department should also consider revising the formula it uses for computing the special fraud assessment paid by insurance companies to fund the Special Fraud Program. Under the current formula, the amount paid by the companies is not proportional to their premium volume. For fiscal year 2007, companies with no premium volume in Georgia were assessed \$82; companies that had more than \$40 million in annual premiums were assessed amounts ranging from 1.2¢ per \$1,000 of written premiums to 34.7¢ per \$1,000 of written premiums.

In its written response to this report, the Department noted that *[b]ased on the amount of restitution ordered, indictments obtained, and the limited occurrence of financial reporting fraud since inception, the Program has been successful and has provided a valuable service to the citizens of this state.*

Table of Contents

Background

Audit Purpose	1
Program Background	1
Audit Scope and Methodology	5

Findings and Recommendations

Action should be taken to improve the overall effectiveness of the Special Fraud Unit in combating insurance fraud in Georgia.	6
The Program should consider developing additional strategies that could be employed to help reduce the incidence of insurance fraud in Georgia.	7
The Department should establish formal goals, objectives, and performance standards for monitoring the Program's efficiency and effectiveness.	7
Action should be taken to ensure that insurance companies comply with state law and report all suspected cases of insurance fraud to the Department.	8
The Program should take steps to ensure that all cases of suspected fraud that are assigned for investigation are resolved in a timely manner.	9
A system should be established for prioritizing suspected fraud cases to help investigators focus on cases with the greatest potential impact.	10
Action should be taken to ensure that cases referred for prosecution are subsequently prosecuted in a timely manner.	11
Procedures should be established for notifying persons and firms of the receipt of their suspected fraud case and of the subsequent disposition of the case.	12
The Department should take steps to ensure that it is making the most effective use of the Special Fraud Program's annual appropriation.	12
The dollar amount charged to the Special Fraud Unit each year should accurately reflect the actual direct and indirect costs of operating the Unit.	13
The formula for determining the special fraud assessment paid by insurance companies should be revised to make it more equitable and to simplify the collection process.	13

Appendix: Cases Referred for Prosecution in Fiscal Year 2006	15
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Audit Purpose

This audit was conducted in response to a request from the House Appropriations Committee.

Program Background

Legislation enacted in 1995 created the Special Insurance Fraud Fund “for the purpose of funding the investigation and prosecution of insurance fraud” by the Insurance Department. As noted in the 1995 statute, the legislation was enacted based on the General Assembly’s finding that “proper investigation of fraudulent insurance acts, followed by vigorous prosecution of insurance fraud, will bring about lower insurance rates for the citizens of the state.”

Insurance fraud may be committed by consumers who submit fraudulent claims or by insurance companies and agents who issue fake policies, misuse insurance premium payments, or sell insurance coverage without authorization. The Coalition Against Insurance Fraud, a national alliance of consumer groups, insurance companies, and government anti-fraud agencies, estimates that insurance fraud losses in the United States totaled about \$80 billion in 1997 (the most recent year studied).

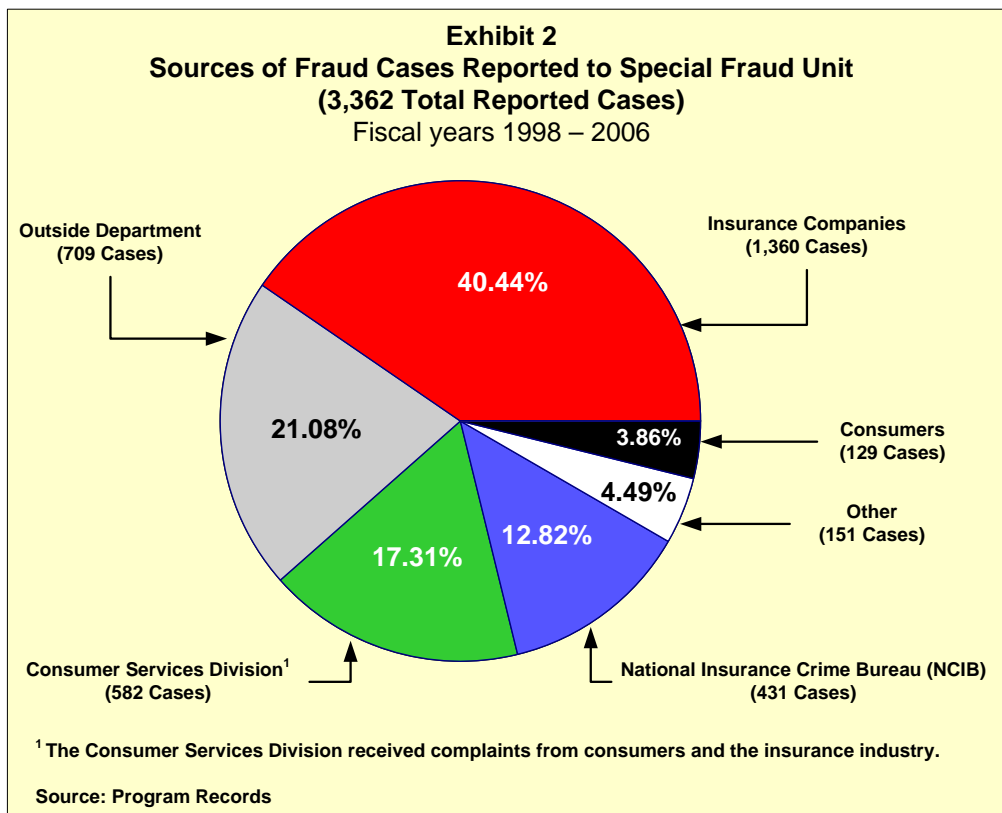
The Department’s Special Fraud Unit, established pursuant to the 1995 legislation, became operational in 1998. The Unit investigates various types of consumer fraud as well as fraud committed by insurance companies and agents. A specialized program within the State Board of Workers’ Compensation investigates workers’ compensation fraud. The Fraud Unit is currently staffed with six investigators, an administrative assistant, and a chief of investigations (who also oversees the Department’s Arson Unit).

Overview of the Investigative Process

State law requires that all insurers and agents report suspected fraud to the Department of Insurance. The Department’s Special Fraud Unit also receives case referrals from consumers, the National Insurance Crime Bureau (NICB), the Department’s Consumer Services Division, and other agencies outside of the Department (e.g., law enforcement, other state agencies, etc). As shown in **Exhibit 1** on the next page, a total of 3,362 fraud cases were referred to the Special Fraud Unit in fiscal years 1998 through 2006. Over 40% of the 3,362 cases were reported by insurance companies and agents.

The Fraud Unit’s administrative assistant reviews each referral to determine if the case meets the Unit’s criteria for opening an investigation. Cases that have been assigned to another law enforcement agency, cases involving potential losses that fall below a minimum threshold (\$10,000), and cases where evidence has been destroyed or altered are usually not assigned to an investigator and are only entered into the Program’s database for informational purposes. In recent years, the Unit’s administrative assistant has begun handling cases that are not thought to warrant assignment to an investigator by sending out form letters to individuals notifying them that a complaint has been filed against them. Of the 197 cases referred to the

Unit in fiscal year 2006, 58 cases were declined for investigation, 65 cases were handled by the administrative assistant, and 74 cases were assigned to investigators.



The investigator assigned to a case is responsible for determining the amount of work necessary to resolve the case. In some instances, the reporting insurance company may have already conducted an extensive internal investigation. Other situations may require more investigative work, such as interviewing the parties involved, collecting evidence, and executing search warrants. Cases are closed when the investigator determines that no action is necessary, evidence is not sufficient to prosecute, or the case is referred to another division or agency. Investigations are also automatically closed if they exceed the four-year statute of limitations, which starts with the time the crime is discovered. Cases that are deemed appropriate for prosecution are submitted to a local district attorney (DA). In fiscal year 2006, the Program closed 203 cases and referred 19 cases for prosecution (17 of the 19 were referred for criminal prosecution and 2 were referred for administrative action). Of the 186 cases closed without prosecution, 139 were closed when they exceeded the statute of limitations, while 47 were closed for other reasons.

A DA may decline to prosecute a case referred by the Unit due to having higher priority cases, a lack of sufficient resources to handle the case, or for other reasons. Many of the cases that are prosecuted result in plea agreements. If a case goes to trial, the investigator may assist with the prosecution by attending hearings and testifying when necessary. Of the 17 cases the Unit referred for criminal prosecution in fiscal year 2006, 9 had resulted in a conviction at the time of our review; the remaining 8 cases had not yet been resolved (See Appendix on page 16).

The Department can also take administrative actions (i.e., revoke or suspend an agent's license, impose a fine, etc) against agents who commit fraud. Administrative actions are usually taken when an investigator determines that the case does not rise to the level of a criminal charge or when a DA is unwilling to prosecute; however, in some cases, administrative action is taken in conjunction with a criminal prosecution. In fiscal year 2006, two investigations resulted in agents surrendering their licenses, and six cases were referred by the Fraud Unit to the Department's Legal Division for administrative action.¹

Program Funding and the Special Fraud Assessment

State law requires that all insurance companies doing business in Georgia pay an annual special fraud assessment that is remitted to the state's general fund. By law, the total assessment is not to exceed the amount appropriated by the General Assembly to the Insurance Department for its activities to investigate and prosecute insurance fraud. State law also specifies that the funding appropriated to the Insurance Department can only be used for investigating insurance fraud or for reimbursing some or all of the costs of retaining assistant prosecuting attorneys to prosecute insurance fraud cases.

The Department is responsible for developing a formula for determining the amount of the assessment charged insurance companies. The formula for fiscal year 2007 divided companies into four groups (or tiers) according to their written premium volume. Three groups were assessed fixed amounts: companies with written premiums of less than \$1 million were assessed \$82; companies with written premiums between \$40 million and <\$100 million were assessed \$13,962; and companies with written premiums of \$100 million or more were assessed \$23,270. The assessment for the remaining group (with \$1 million to <\$40 million in written premiums) was calculated on a pro-rata basis of premiums to provide the additional funding required to equal the Program's total anticipated expenditures and ranged from \$84 to \$3,266.

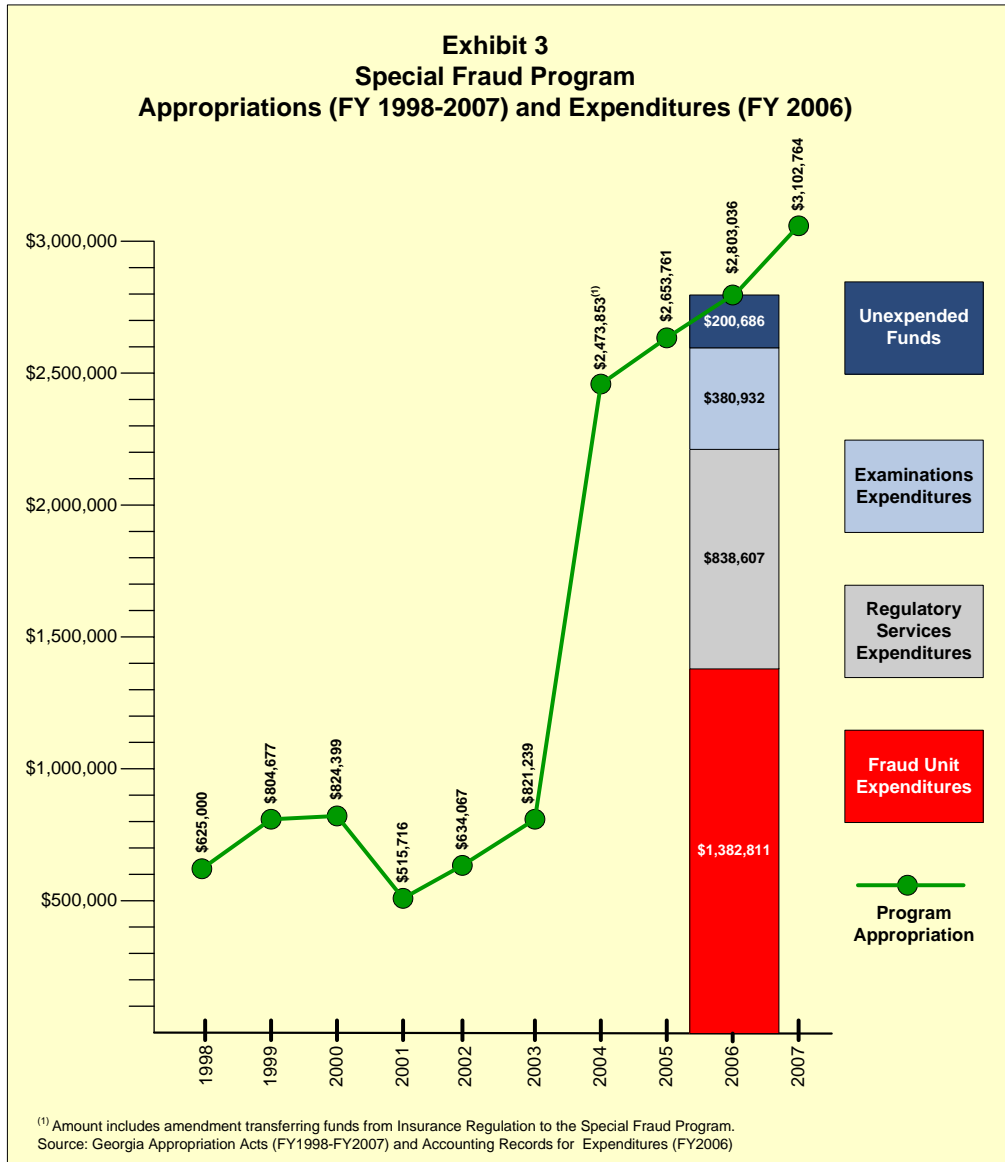
Exhibit 2		
Fraud Assessment Formula		
Fiscal Year 2007		
Written Premiums	Assessment Calculation	\$ Amount (Per Company)
Less than \$1 million	Fixed Amount	\$82
\$1 million - <\$40 million	Pro-rata basis	\$84 - \$3,266
\$40 million - <\$100 million	Fixed Amount	\$13,962
\$100 million or more	Fixed Amount	\$23,270

Source: Program Records

The Program was initially appropriated \$625,000 in fiscal year 1998 to fund the Special Fraud Unit (see Exhibit 3). When legislation was enacted in 2003 to expand the definition of insurance fraud to include fraudulent financial reporting, the Department requested increased funding of \$2.47 million for fiscal year 2004 to pay for some of the costs incurred by its Regulatory Services Division and Examinations

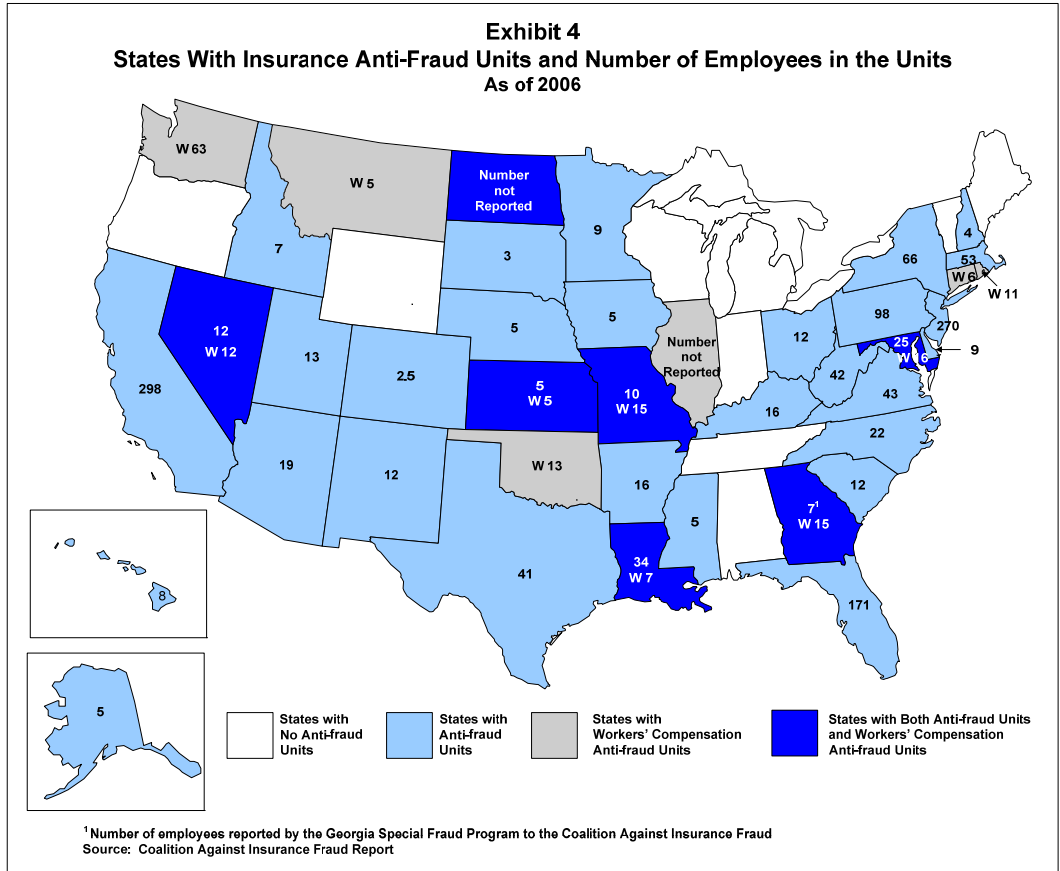
¹ Administrative action may also have been taken in the cases that were criminally prosecuted.

Section. In fiscal year 2006, the Program was appropriated \$2.8 million, of which about \$1.4 million was associated with the Special Fraud Unit, about \$800,000 with its Regulatory Services Division, and almost \$400,000 with its Examinations Section. The Program was appropriated \$3.1 million for fiscal year 2007.



Other States' Anti-Fraud Efforts

As shown in Exhibit 4 on the next page, 41 of the 50 states have implemented some type of insurance anti-fraud program. Most states have one program that investigates all insurance fraud cases, but seven states (including Georgia) have a separate program for Workers' Compensation cases. A study issued by the Coalition Against Insurance Fraud reported that in 2006 the budgets for state insurance anti-fraud programs ranged from \$216,243 to \$36.7 million; the staffing ranged from 2.5 to 298 full-time equivalent employees.



Audit Scope and Methodology

This audit was conducted in accordance with generally accepted government auditing standards for performance audits. The audit team evaluated the extent to which the Special Fraud Program aggressively investigates and prosecutes insurance fraud; reviewed the Program’s goals and objectives; and evaluated the Program’s methodology for determining the amount of the special fraud assessment charged insurance companies.

In conducting this project, the audit team researched applicable laws and regulations and interviewed key personnel with the Special Fraud Unit and other units within the Department of Insurance. We also reviewed a sample of case files and analyzed activity data regarding case referrals, investigations, and case outcomes. In addition, we contacted three other states with the largest and most aggressive anti-fraud programs in the United States (California, Florida, and New Jersey) regarding the funding and operations of their programs.

This report has been discussed with appropriate personnel representing the Department of Insurance. A draft copy was provided for their review and they were invited to provide a written response, including any areas in which they plan to take corrective action. Pertinent responses from the Department have been included in this report as appropriate.

Findings and Recommendations

Action should be taken to improve the overall effectiveness of the Special Fraud Unit in combating insurance fraud in Georgia.

The 1995 statute that created the Program stated that “proper investigation of fraudulent insurance acts, followed by vigorous prosecution of insurance fraud” would result in lower premiums. Our review, however, found that relatively few cases of suspected fraud are reported to the Program by insurance companies each year, only a small percentage of reported cases are subsequently investigated in a timely manner, and ultimately very few cases are prosecuted. In fiscal year 2006, the Program expended \$2.6 million and referred only 17 cases for criminal prosecution (See Appendix on page 16). Areas in which the Program could improve its overall effectiveness are briefly discussed below and are addressed more fully in the remainder of this report.

- Action has not been taken to require insurance companies to report suspected fraud cases to the Department as required by state law. In fiscal year 2006, only 38 of the 1,504 insurance companies doing business in Georgia reported any cases of suspected fraud to the Fraud Unit.
- Procedures have not been implemented to ensure that suspected fraud cases are investigated in a timely manner. Of 457 cases assigned to investigators in fiscal years 2003 through 2006, 161 (35%) had not been resolved (closed or referred for prosecution) as of November 2006.
- While the Program is not investigating all of the assigned cases in a timely manner, action has not been taken to ensure that investigators focus their efforts on the most significant cases.
- Program funds have never been used to reimburse prosecuting attorneys to prosecute insurance fraud cases (as provided for in the Program’s enabling legislation). Our review found that some fraud cases are not being prosecuted by district attorneys because of their focus on higher priority cases or for other reasons.
- In fiscal year 2006 the Department used \$1.2 million (43%) of the Program’s appropriation of \$2.8 million to offset some of the cost of its Regulatory Services Division and its Examinations Section which, per the Department, are involved in the investigation and identification of financial statement fraud. In fiscal year 2006, however, the Regulatory Services Division and Examinations Section did not report any cases of suspected fraud to the Special Fraud Unit.

Action should be taken to enable the Program to better fulfill its statutory purpose of reducing consumers’ insurance premiums through the “proper investigation...[and] vigorous prosecution of insurance fraud.” Consideration should also be given to developing additional strategies for combating insurance fraud in the state (as discussed in the following finding).

The Program should consider developing additional strategies that could be employed to help reduce the incidence of insurance fraud in Georgia.

Currently, the Program tends to focus its efforts on investigating the cases that it receives from insurance companies, consumers, and other sources and on attempting to identify potential fraud during its financial examination of insurers. Our review of other states' insurance fraud programs identified other strategies that could be used in combating insurance fraud. These strategies include monitoring the activities of insurance companies' anti-fraud units, identifying fraud trends, and targeting organized fraud rings and repeat offenders.

- **Monitoring the anti-fraud activities of insurance companies** – We found that 29 other states have activities to ensure that insurance companies are investigating fraudulent claims (and not simply paying fraudulent claims and passing the costs on to policyholders through higher premiums). For example, we found that the three states we identified with aggressive anti-fraud programs (California, Florida, and New Jersey) all require insurance companies to submit their plans for preventing, detecting, and investigating fraudulent claims to the state for review.
- **Identifying and analyzing fraud trends** – The aggressive anti-fraud programs in California, Florida and New Jersey analyze trend data to measure the scope of fraudulent activity in their states, and to identify specific areas of focus. For example, California's anti-fraud program is implementing an effort to measure the extent and nature of insurance fraud and to identify the types of fraud that are most responsible for higher insurance premiums. New Jersey has a specialized unit that is responsible for analyzing fraud trends.
- **Targeting organized fraud rings and repeat offenders** – The anti-fraud program in California focuses on organized automobile fraud rings that operate in urban centers. Similarly, Florida's program works with its Department of Highway Safety and Motor Vehicles to analyze traffic reports in order to identify crime rings that stage traffic accidents.

In addition to investigating individual cases, the Program should consider developing other strategies for reducing insurance fraud in the state. Implementation of other strategies, however, may require legislative action since the activities related to the new strategies may exceed the Program's current statutory authority for "investigating" insurance fraud.

In its response to this finding, the Department of Insurance noted that the aggressive programs in California, Florida, and New Jersey had considerably larger budgets than Georgia's Program. However, the Department also indicated that it would consider how the techniques identified in the finding might be implemented in view of currently available resources.

The Department should establish formal goals, objectives, and performance standards for monitoring the Program's efficiency and effectiveness.

Although the Program's overall purpose is to "bring about lower insurance rates," Program officials have not established specific goals or objectives for measuring the Program's impact on insurance rates. Similarly, the Program does not have goals or

objectives for determining if the Program is having any impact on the incidence of insurance fraud in Georgia (i.e., if the Program's investigative activities are resulting in fewer fraud cases). The agency's strategic planning documents for fiscal year 2007 indicate that the Program's goal is *[t]o identify and investigate instances of insurance fraud in cooperation with federal, state, and local government agencies and to take enforcement actions where appropriate to protect consumers from financial loss due to fraudulent activities.*

Our review also found that the Program does not have sufficient performance standards for monitoring its overall efficiency in investigating fraud cases. Currently, for example, the Program does not have any performance standards regarding the percentage of cases that are investigated within a certain time period (e.g., within 90 days of receipt) or the productivity of the Unit's investigators (e.g., number of cases closed and referred for prosecution). The Program's results measures for its overall goal (cited above) only quantify the Program's basic activities by measuring funds recovered, number of open cases, number of arrests, and the amount involved in indicted fraud cases.

By developing more focused formal goals and objectives and specific performance standards, Program personnel could monitor the Program's efficiency and effectiveness on an ongoing basis. The need to better monitor the Program's timeliness in conducting investigations is further discussed on page 9. Once the Program develops specific goals and objectives, it can determine whether its funding is sufficient or if additional funding is needed. It should be noted that while the General Assembly approves the Department's budget, the Department's Commissioner has the authority to assess insurance companies for funding that is sufficient to support the Program's objectives.

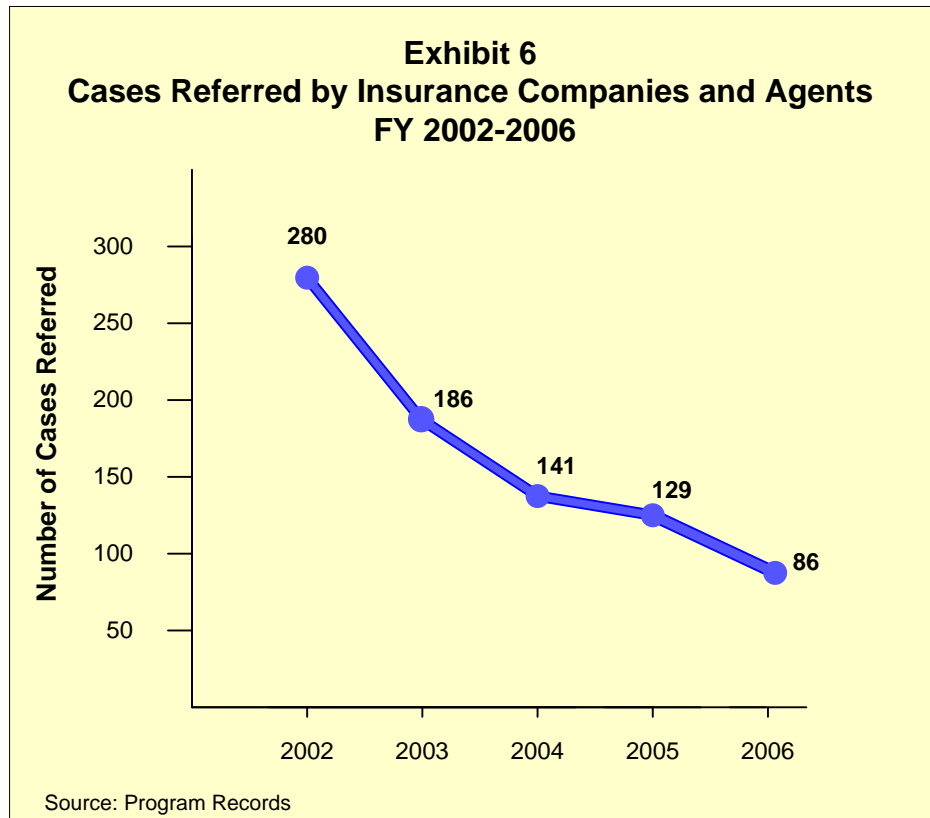
In its written response to this finding, the Department indicated that it would reevaluate its policies and procedures to determine what, if any, enhancements could be made in view of its currently available resources. The Department also noted that it thought that the nature and complexity of white collar criminal investigations make it difficult to form valid judgments by simply utilizing quantitative measures for a specified time period.

Action should be taken to ensure that insurance companies comply with state law and report all suspected cases of insurance fraud to the Department.

Although legislation enacted in 1990 requires insurance companies and agents to report cases of suspected fraud to the Department, we found that only a few of the state's insurance companies are reporting any suspected fraud cases. Of the 1,504 companies doing business in Georgia, only 38 (less than 3%) reported one or more fraud cases to the Fraud Unit in fiscal year 2006. Of the 18 largest companies (those with more than \$200 million in premium volume), 10 did not report any suspected fraud cases during fiscal year 2006. As shown in **Exhibit 6** on the next page, the number of fraud cases referred to the Fraud Unit by insurance companies and agents has steadily declined since fiscal year 2002.

While the actual number of fraud cases that should have been reported cannot be determined, we found that the number of cases reported to the Fraud Unit is disproportionately low compared to other states that monitor requirements for reporting suspected insurance fraud. The three states that we identified as having

aggressive anti-fraud programs (California, Florida and New Jersey) all periodically audit insurance companies' investigation units to verify that all suspected fraud cases are being reported to the state program as required. For these states, the number of reported fraud cases per \$1 billion of premiums written in the state ranged from 42 to 157 (from 10 to 38 times more than the 4 cases per \$1 billion in premiums that were reported by Georgia companies in fiscal year 2006).



The Program should take steps to enforce the statutory provisions requiring insurers to report cases of suspected fraud. Implementation of this recommendation would enable the Program to have more information to analyze fraud activity, identify repeat offenders and fraud rings, or ensure that the most significant cases are selected for investigation and prosecution.

In its written response, the Department noted that it was developing an on-line fraud reporting system that would be database supported. It was thought that this system would make it easier for third parties to report suspected fraud to the Department and would enable statistical information to be compiled that, assuming the availability of sufficient resources, could be analyzed in the future to identify fraud trends and potential repeat offenders.

The Program should take steps to ensure that all cases of suspected fraud that are assigned for investigation are resolved in a timely manner.

Currently, suspected fraud cases are not being resolved in a timely manner. A review of all the cases assigned to investigators since the inception of the Program

found that 752 (37%) of the cases were not resolved and were closed due to the expiration of the four-year statute of limitations. Of the 457 cases assigned for investigation in fiscal years 2003 through 2006, 161 (35%) had not been resolved (i.e., closed or referred for prosecution) as of November 2006. The 221 cases that were assigned to investigators at the start of fiscal year 2007 included 129 cases (58%) that had been assigned to investigators prior to fiscal year 2005. Specific areas in which the Program should implement corrective action are discussed below.

- The Program does not have policies and procedures or productivity standards to help ensure that fraud investigations are completed in an efficient manner. Program staff indicated that because each case is unique, there is less value in developing procedures and standards for conducting investigations. While the circumstances of each case may vary, the Program could benefit from implementing general procedures and standards that outline a strategic approach to conducting the investigations and that provide a baseline to measure performance.
- Program management does not adequately monitor investigators' activities or productivity. Although investigators list their activities in weekly status reports, our review found that these reports do not provide adequate information on the progress of each case. In addition, the Program's current database does not maintain sufficient information for management to assess the progress of the investigations or the productivity of investigators. Program personnel have indicated that they expect that a new case tracking database with improved management tools will be implemented.
- The Program does not always reassign cases when an investigator leaves employment, which may result in significant cases never being investigated. A review of cases that were open at the beginning of fiscal year 2006 identified 102 cases that had not been reassigned after the initial investigator left the Department. More than half (59) of these were subsequently closed when they exceeded the four-year statute of limitations.

The Program should develop policies and procedures to help ensure that cases are investigated and closed in a timely manner. In addition, the Program should continue its efforts to implement a case tracking database to help management better monitor the progress of investigations.

In its response to this finding the Department noted that it thought that the best control for efficient investigation of insurance fraud was management supervision. The Department also noted that it thought that it would need additional financial resources to hire and retain supervisory and investigative staff to provide for more management supervision in order to ensure the achievement of the desired goal of more efficient investigations.

A system should be established for prioritizing suspected fraud cases to help investigators focus on cases with the greatest potential impact

As long as investigators are not able to resolve all their assigned cases in a timely manner, it is important that they prioritize their efforts in order to ensure that the most significant cases are investigated and resolved first. Program management reported that agent fraud cases are prioritized over claims fraud cases because agent

fraud has a greater potential for impacting an entire community. Aside from this general provision, each investigator usually has the discretion to decide which cases to pursue. During interviews, investigators indicated that because of time and resource constraints, they often prioritize their efforts to focus on cases in which the most evidence is already provided and less additional work is necessary.

Without prioritization criteria, significant cases assigned to investigators may not be worked while time is spent on other less significant cases. For example, the audit team reviewed a sample of 27 cases closed in fiscal year 2006 due to the expiration of the statute of limitations and identified 11 potentially significant cases in which little or no work was performed. One case involved an organized ring accused of staging automobile accidents. Another case involved a fraudulent claim in which the suspect had backdated insurance paperwork that resulted in a \$200,000 payout. In contrast, only 3 of the 17 cases submitted for criminal prosecution in fiscal year 2006 appeared to be highly significant cases (See **Appendix** on page 16). Less significant cases that were prosecuted included two cases of claims fraud with estimated losses of less than \$10,000 and one case involving an agent who used an unlicensed person to solicit insurance applications.

We also found that the cases the Program refers for prosecution are not resulting in the recovery of significant amounts of restitution, which might be another indication that the Program is not focusing its efforts on the most significant cases. The Program reported that for fiscal years 2003 through 2006 the amount of restitution ordered ranged from \$6,704 to \$431,791, with an average of \$284,607. A study of state anti-fraud programs by the Coalition Against Insurance Fraud reported that the average restitution ordered by 31 state anti-fraud programs in 2005 was more than double their operational costs. Based on this average, Georgia's Program might be expected to have resulted in restitution amounts totaling at least \$5.2 million in fiscal year 2006 (twice the \$2.6 million expended by the Program).

The Program should develop a case prioritization system that is aligned with its purpose and objectives. Requiring investigators to prioritize their efforts could help the Program ensure that the most effective use is made of its resources.

In its written response, the Department noted that it prioritizes its efforts to focus on financial statement fraud, on agent fraud cases, and on other types of cases which most efficiently utilize the time of its investigators.

Action should be taken to ensure that cases referred for prosecution are subsequently prosecuted in a timely manner.

Interviews with Program officials indicated that some cases are never prosecuted because the local district attorneys consider them to be low priority or because the DAs lack expertise in insurance fraud. At the time of our review, we identified 40 cases that had been referred to local district attorneys for prosecution. Of these cases, 20 had been referred for prosecution two or more years earlier. The older the case the more difficult it is to prosecute and it is likely that some of the older cases will never be prosecuted.

It should be noted that state law requires that prosecuting attorneys inform the Department of the reasons for lack of prosecution when prosecution is not begun

within 90 days of when a case is submitted. However, Program staff indicated that they do not normally receive any notifications. While Program staff reported that they periodically check on the status of cases referred for prosecution, they could not be certain of the status of each case, when a case would be prosecuted, or whether a case would ever be prosecuted. It should also be noted that state law authorizes the Program to use assessment funds for the prosecution of insurance fraud; however, the Program has never utilized this provision despite the previously discussed problems with timely prosecutions. As described below, our review found examples of how other states' fraud programs have used state funds to pursue prosecutions of insurance fraud cases.

- **Dedicated Prosecutors** – Twenty-four states reported having at least one dedicated prosecutor who works exclusively on insurance fraud cases.
- **Grants for Prosecution**– The fraud program in California provides grant funding to district attorneys to support the prosecution of insurance fraud cases.
- **Training and Coordination** - New Jersey's anti-fraud program has a County Prosecutor Liaison who conducts training for local prosecutors. In addition, the liaison also coordinates referrals between the fraud program and the county prosecutors' offices and meets regularly with local prosecutors.

The Program should consider using special fraud assessment funds to facilitate the prosecution of insurance fraud (as authorized by the Program's enabling legislation). The Program should also consider developing additional techniques for facilitating fraud prosecutions which may require legislative changes since current state law only authorizes reimbursing prosecuting attorneys for the costs of retaining assistant prosecuting attorneys.

The Department noted that its ability to resolve this finding was limited since prosecutors make the determination of when to prosecute a case. The Program's fraud investigators work to facilitate this process by providing assistance when requested. The Department also noted that at the current level of appropriations, it did not believe that funding prosecutors would be the most effective use of the fraud budget.

Procedures should be established for notifying persons and firms of the receipt of their suspected fraud case and of the subsequent disposition of the case.

Currently, companies and firms that refer suspected fraud cases are notified when cases are assigned to investigators and may be informally notified when cases are submitted for prosecution. However, the receipt of cases that are not assigned to investigators is not acknowledged and complainants are not notified about the outcome of investigations that do not result in prosecutions. During fiscal year 2006, 74 cases (38%) were assigned to investigators and 123 cases (62%) were not assigned. Since the inception of the Program, only about 9% of the cases that were assigned to investigators resulted in prosecutions.

In its written response, the Department noted that it agreed that better notification procedures were needed. The Department indicated that it would develop uniform procedures to acknowledge receipt of suspected fraud cases.

The Department should take steps to ensure that it is making the most effective use of the Special Fraud Program's annual appropriation.

In fiscal year 2006 the Department used \$1.2 million (43%) of the Program's appropriation of \$2.8 million to offset some of the cost of its Regulatory Services Division and its Examinations Section. The funds are used for these units because the Department believes that the financial examinations of insurance companies conducted by these units are directly related to the identification/investigation of financial statement fraud. (Legislation enacted in 2003 expanded the definition of insurance fraud to include fraudulent financial reporting.)

Our review found, however, that in fiscal year 2006, the Regulatory Services Division and Examinations Section did not report any cases of suspected fraud to the Fraud Unit. Similarly, based on information provided by personnel in these units, we found that they were directly involved in investigating only one case of fraudulent financial reporting during fiscal year 2006.

The Department should consider reevaluating the extent to which Special Fraud funds are used for the Regulatory Services Division and the Examinations Section given their limited contribution to the Department's overall effort to curtail insurance fraud in the state.

In its response to this finding the Department indicated that it felt that the amounts allocated from the Special Fraud Program to support the operations of the Insurance Regulation Program were consistent with the intent of the legislature. The Department specifically noted that it thought that "[i]t is clear that the legislative intent, in recognition of the expanded definition of insurance fraud, was to have part of the costs of the Insurance Regulation Program funded by the insurance industry through the special fraud assessment." The Department also noted that while the investigation of only one case of fraudulent reporting appeared negative, the results were consistent with its expectations that the occurrence of financial reporting fraud should be low as a result of its financial surveillance efforts.

The dollar amount charged to the Special Fraud Unit each year should accurately reflect the actual direct and indirect costs of operating the Unit.

In fiscal year 2006, a total of \$499,088 in operating expenses, travel, and per diem and fees and contracts that were primarily incurred by other programs and units within the Department were charged to the Special Fraud Program to cover the Program's share of these expenses. Our review found that the amount charged to the Program may have been overstated by as much as \$208,081.

- A total of \$343,063 in operating expenses (supplies and materials, motor vehicles, computer charges, telecommunications, real estate, etc.) was charged to the Fraud Program. This charge was about 18% of the Department's total operating costs. Based on the Program's size, however, (28 employees of the Department's 250 full-time equivalent employees), an allocation of 11.4% of the salaries and benefits would appear to be more reasonable indicating that these expenses may have been overstated by \$125,352.

- Approximately \$86,369 in travel expenses was charged to the Special Fraud Program. We found that \$68,699 of this amount did not appear to be related to individuals whose salaries were charged to the Special Fraud Program.
- A total of \$69,656 in per diem and fees and contract expenses was charged to the Program. Based on our review of invoices and on the relative size of the Program, we determined that \$14,030 of this amount did not appear to be related to the activities of the Special Fraud Program.

The Department should take steps to ensure that the indirect costs charged to the Special Fraud Program more accurately reflect the actual costs associated with the Program's operations.

The agency's response to this finding indicated that the dollar amounts reflected in this section of the report were obtained from the State's accounting system which the agency thought was "generally inaccurate". The agency thought that the unsupported amounts that it provided to the audit team should have been used in this report.

The formula for determining the special fraud assessment paid by insurance companies should be revised to make it more equitable and to simplify the collection process.

Under the Department's current four-tier formula (shown in Exhibit 7), only those companies whose premium volume ranges from \$1 million to less than \$40 million are assessed a proportional amount. Companies in each of the other three tiers are assessed a fixed amount. In addition to being inequitable, this formula results in the Department collecting annual assessment payments as small as \$82.

Exhibit 7								
Special Fraud Assessments Paid by Insurance Companies								
Fiscal Year 2007								
	<\$1Million		\$1Million-<\$40Million		\$40Million-<\$100 Million		\$100 Million or More	
Assessment Calculation	Fixed		Variable		Fixed		Fixed	
Number of Companies	685		681		80		58	
Assessment Per Company	\$82		\$84	\$3,266	\$13,962		\$23,271	
Written Premium Range	(\$1,880,333)	\$995,811	\$1,012,173	\$39,301,760	\$40,249,961	\$99,480,050	\$101,331,070	\$1,861,927,003
Assessment Per \$1,000 of Written Premium	NA	8.2¢	8.3¢	8.3¢	34.7¢	14.0¢	23.0¢	1.2¢
Source: Program Records								

Specific problems with the current formula are discussed below.

- Companies with no written premiums are assessed even though there is little chance that fraud cases related to their operations will need to be investigated or prosecuted. Of the 685 companies assessed the minimum amount (\$82) in fiscal year 2007, 336 companies reported zero or negative written premiums. According to Program staff, these companies are assessed because state law requires that all insurance companies "doing business in the state" must pay the fraud assessment and the Program considers all licensed companies to be doing business in the state. It should be noted that "doing business in state" is not defined in state law relevant to

the special fraud assessment and might also be interpreted as companies having written premium volume (as is the case with premium taxes that are also collected by the Department).

- The formula's mixture of fixed and variable assessment tiers results in companies paying significantly different assessment rates. For example, as shown in Exhibit 7, all the companies in the variable tier paid an assessment rate of 8.3¢ per \$1,000 of written premiums; however, companies in the two fixed tiers with more than \$40 million of written premiums paid from 1.2¢ to 34.7¢ per \$1,000 of written premiums.
- The audit team also noted that the special fraud assessment is collected on an annual basis. State law (O.C.G.A. 33-1-17c), however, specifies that the assessment should be paid quarterly.

Action should be taken to revise the assessment formula so that the amount collected from the insurance companies is proportional to their premium volume. Companies with little or no premium volume (for example, companies whose assessment amount is less than \$100) should not be assessed. Consideration should also be given to revising current state law regarding the premium taxes paid by insurance companies to include an additional component to cover the cost of the Special Fraud Program. Implementation of this recommendation would provide for an assessment that is directly related to a company's premium volume and would minimize collection efforts.

In its response to this finding the Department noted that it thought that zero or negative premiums was not an indication that an opportunity for fraud activity did not exist or that fraud had not been committed. The Department also indicated that it believed that the current assessment formula was appropriate and in accordance with state law and that allowing companies to make one annual payment (instead of quarterly payments) streamlined the assessment and collection process. It thought that including the special fraud fee with premium tax payments would add processing time, would require additional forms (or revisions to current forms), and would result in overlapping fiscal years for processing and accounting (since insurance companies are required to file quarterly and annual returns on a calendar year basis for premium taxes.

Appendix					
Cases Referred for Prosecution in Fiscal Year 2006					
	Investigator	Date Assigned	Description	Outcome	Restitution
1	1	5/24/05	Agent did not forward premiums to carriers.	Warrant Issued 8/11/05	In Court system
2	2	3/2/06	Individual generated fake certificates of insurance.	Warrant Requested 6/21/06	In Court system
3	2	10/27/04	Unlicensed agent did not forward premiums to carrier.	Convicted 4/07	Unknown
4	2	6/9/04	Contractor purchased 4 fake certificates of insurance from a flea market vendor.	Convicted 8/18/05	\$0
5	2	5/17/05	Agent did not forward premiums to carriers. <i>(Estimated amount \$39,973)</i>	Indicted 3/14/07	In Court system
6	2	9/9/05	Agent did not forward premiums to carrier and created fake proof of motor vehicle coverage.	Convicted 2/4/06	\$0
7	2	1/6/06	Claims adjuster submitted fraudulent claims.	Warrant Issued 6/21/06	In Court system
8	3	8/5/05	Several City of Atlanta employees filed fraudulent disability claims.	Warrant Issued 11/3/05	In Court system
9	3	3/29/04	Auto sales dealer sold warranty contracts that were not backed by insurance.	Indicted 3/22/06	In Court system
10	3	4/29/02	Chiropractor billed insurance for services not rendered.	Convicted 3/13/06	\$0
11	3	8/21/00	Dentist billed insurance for services not rendered.	Convicted 3/23/06	\$406,500
12	4	1/24/03	Contractor created fake certificate of insurance.	Warrant Issued 10/04/05	In Court system
13	4	11/25/02	Agent used an unlicensed person to solicit insurance applications that turned out to be fake. <i>(Agent returned commissions when problem discovered.)</i>	Warrant Issued 1/31/06	In Court system
14	4	4/27/05	Same medical insurance claims submitted multiple times.	Convicted 8/31/06	\$8,300
15	4	7/21/04	Agent did not forward premiums to carriers. <i>(Known amount \$90; however noted that other victims involved.) The agent was arrested for insurance fraud in two counties. He has been convicted in one county but is currently awaiting indictment in the other county.</i>	Convicted 8/2/06	\$0
16	6	2/27/04	Chiropractor practicing and billing insurance without a license.	Convicted 9/22/05	\$13,167
17	6	12/20/04	Excessive disability income insurance claim.	Convicted 7/13/06	\$3,081

Source: Program Records

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