STATE OF CALIFORNIA
DEPARTMENT OF INSURANCE
300 CAPITOL MALL, 17TH FLOOR
SACRAMENTO, CA 95814

INITIAL STATEMENT OF REASONS

SPECIAL INVESTIGATIVE UNIT

July 19, 2019 **REG-2018-00023**

INTRODUCTION

The California Department of Insurance (the "Department") proposes to adopt amendments to Title 10, California Code of Regulations ("CCR"), Chapter 5, Subchapter 9, Article 2, sections 2698.30 and 2698.33-2698.41 pursuant to the authority granted by Insurance Code ("Ins. Code") sections 730, 1872.4, 1874.2, 1874.6, 1875.24, 1875.4, 1877.3, 1877.5, 1879.5, and 1879.6. The date, time, and location for the public hearing, as well as applicable contact information, are set forth in the Notice of Proposed Action for this rulemaking.

STATEMENT OF THE PROBLEM

Insurance Code section 1875.20 requires every insurer admitted to do business in California to provide for the continuous operation of a unit or division, commonly known as a Special Investigative Unit ("SIU"), to investigate possible fraudulent claims. The Department's current SIU regulations, found at 10 CCR section 2698.30 et seq., provide definitions and procedures for detecting, investigating, and referring suspected insurance fraud; establish training requirements; specify the information insurers are required to report to the Department; and provide guidelines regarding the Commissioner's examination of an insurer's SIU. The SIU regulations became effective October 7, 2005 and have not been amended since.

Since the regulations first went into effect, it has become apparent that additional clarification and guidance is necessary to ensure that fraud is being adequately investigated by insurers and to update the regulations to address changing practices in insurers' fraud investigations. The most frequently occurring problems under the current regulations include (1) issues related to fraud referrals received by the Department; (2) compliance issues related to the lack of information necessary to determine adequacy of the SIU; (3) compliance issues specifically related to subcontractors; and (4) lack of clarity causing confusion and undue burden for the Department and insurers.

(1) Referral Issues: The Fraud Division routinely receives a high quantity of referrals from insurers that are incomplete, superficial, or sent prematurely. Many referrals omit entire sections or key data fields, including the suspected loss amount. This information is essential to the Fraud Division's intake process. These incomplete referrals result in a significant waste of CDI

resources, because the Fraud Division is forced to devote its limited resources to processing incomplete referrals lacking vital information.

(2) General Compliance Issues: Due to lack of specificity in the current regulations, the SIU Compliance Unit routinely encounters difficulties ensuring that insurers are actively engaging in fighting fraud. Stronger regulations are required to ensure that insurers identify to CDI the structure of their SIU/Anti-fraud personnel and how they specifically operate to meet the regulatory requirements. This includes ensuring that insurers appropriately identify and respond to "red flags" or other criteria that may indicate fraud. It also includes ensuring that insurers train their SIU personnel effectively.

(3) Compliance Issues Related to Subcontracted Anti-Fraud Entities: Regulations are needed to ensure that insurers who contract out their SIUs or fraud detection functions are monitoring subcontracted anti-fraud personnel effectively. In many cases where SIU contractors subcontract out certain anti-fraud personnel duties, the insurers are not able to identify to the Department which company is performing which anti-fraud function. This information is essential for effective compliance monitoring.

(**4) Clarity Issues:** A lack of clarity in some of the SIU regulations has led to confusion and inefficiencies for insurers and the Department alike. For example, clarification is required to make explicit that, while an insurer must refer an investigation within a statutorily mandated timeline, it does not necessarily need to complete the entire investigations within this timeline. Instead, it must complete as much as of the investigation as is reasonable and identify if further investigation is needed. Clarification is also necessary to address the problem of potentially burdensome and duplicative requirements being placed on insurers in the context of the SIU Annual Report and other reporting requirements.

OVERALL PURPOSE AND ANTICIPATED BENEFITS

The regulations will facilitate the detection of insurance fraud in this state, by increasing the overall effectiveness of insurer fraud investigations. The regulations will result in more, higher-quality insurer fraud referrals to the Department, and reduce the number of low-quality referrals, which will lead to efficiencies in fraud investigations for state and local governments. These efficiencies are expected to reduce the incidence of fraud, thus promoting an insurance market better able to serve consumers.

SPECIFIC PURPOSE AND REASONABLE NECESSITY OF ADOPTING REGULATIONS

[Amended] Article 2. Special Investigative Unit
Title. Updates the title of the Article to remove the word "[r]egulations" and to make the word "unit" singular. This amendment is reasonably necessary to remove redundant language.

[Amended] Section 2698.30. Definitions.
2698.30(f). Defines "contracted entity" to mean any entity that an insurer contracts with to perform SIU or integral anti-fraud personnel duties or functions, and includes subcontracts and

sub-subcontractors. This is a new term used in revised section 2698.33 and a definition is reasonably necessary to assist the reader in understanding the regulations and to make clear to what entities the regulations refer.

2698.30(g). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(h). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(i). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(j). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(k). Corrects a typographical error and changes "or" to "of." An application for adjudication of claim is a form that an employee fills out if they have a disagreement with the employer or insurance company and would like the Workers' Compensation Appeals Board to resolve the matter. The change from "adjudication or claim" to "adjudication of claim" is reasonably necessary to clarify that the reference is to the form used in Workers' Compensation claims. Otherwise, the definition could be read as an application for adjudication or an application for claim. Also adjusts the section lettering due to the addition of subdivision (f), which is a non-substantive change.

2698.30(l). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(m). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(n). Further defines the term "red flags." Incorporates the categories that were previously listed in section 2698.35(c). The original definition caused confusion because the categories listed in section 2698.35(c) were also considered red flags but were not included in the definition. This amendment is reasonably necessary to further define and clarify the term in order to assist the reader in understanding the regulations, and to ensure consistency in the use of the term throughout the regulations. Also adjusts the section lettering due to the addition of subdivision (f), which is a non-substantive change.

2698.30(o). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(p). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

2698.30(q). Makes punctuation changes. This is reasonably necessary to clarify that what

follows SOAPE is the definition of the acronym. Also adjusts the section lettering due to the addition of subdivision (f), which is a non-substantive change.

2698.30(r). Adds an "s" to the word "section" since there are multiple sections being referred to in this definition. Also adjusts the section lettering due to the addition of subdivision (f), which is a non-substantive change.

2698.30(s). Adjusts the section lettering due to the addition of subdivision (f) and is a non-substantive change.

[Amended] Section 2698.33 SIU and Integral Anti-Fraud Personnel Contracted Responsibilities.

Title. Clarifies that this section applies to contracts for integral anti-fraud personnel as well as SIU personnel. When this rulemaking was first promulgated, integral anti-fraud functions were generally not contracted out and were performed by the insurer's employees. Insurers are now contracting out both SIU and integral anti-fraud functions, and the proposed amendment is reasonably necessary to clarify that the scope of this section includes SIU and integral anti-fraud personnel contracted responsibilities.

2698.33(a). Specifies that this section is limited to contracts with an insurer "for the performance of SIU or integral anti-fraud personnel duties or functions." Without that clarification, some insurers have interpreted this section as applying to contracts entered into for any SIU-adjacent function, including tasks such as surveillance, database searches, or other non-substantive investigative tasks. This amendment is reasonably necessary to clarify that intent of this section is to capture contracts where the insurer is using a third party for substantive SIU or integral anti-fraud personnel functions and not merely administrative or ministerial tasks.

2698.33(b). Changes when the insurer is required to provide the Department with a copy of the executed contract. The existing regulations require the insurer to provide a copy of the executed contract upon execution. The Department does not wish to receive a copy of the contract each time an insurer enters into an agreement with another entity for SIU and integral anti-fraud personnel duties and functions because this could result in the Department receiving duplicative materials. Insurers already submit executed contracts with their Annual Reports, and this is usually sufficient. However, the Department would like to receive the contract before submission with the Annual Report upon request. The change from "upon execution" to "upon request" is reasonably necessary to avoid duplicate submissions of contracts.

2698.33(c)(3). Reconciles punctuation and grammar issues resulting from the addition of subdivision (c)(5) and is a non-substantive change.

2698.33(c)(4). Removes redundant language and clarifies that "these regulations" means Article 2. This is reasonably necessary to remove duplicative language and for clarity.

2698.33(c)(5). Requires contracted entities that the insurer contracts with to include provisions in their contracts with subcontractors to ensure that subcontractors are bound by the same requirements as the contractor. The requirements of subdivision (c) under the previous language

required only that the contracted entity comply with the applicable provisions of the Insurance Frauds Prevention Act ("IFPA") and Article 2. This amendment is reasonably necessary to ensure that the requirements of subdivision (c) apply equally to all entities performing SIU and integral anti-fraud personnel functions, regardless of the level of contracting involved.

2698.33(c)(5)(A). Requires a subcontractor to provide its contract to the Department upon request and requires the contractor to include that requirement in its contract with the subcontractor. This is reasonably necessary to enable the Department to understand the contractual relationship between the entities and conduct compliance audits based on that information.

2698.33(c)(5)(B). Requires the subcontractor to be bound by the same requirements as the contractor. This is reasonably necessary to ensure that obligations under this section remain enforceable and cannot be contracted away.

2698.33(c)(5)(C). Added to impose the same requirements on the sub-subcontractor as the contractor, and to limit the level of subcontracting for SIU and integral anti-fraud personnel duties and functions to three levels of contracting from the original contract with the insurer. The Department has begun to see multiple levels of subcontracting where insurers contract SIU and integral anti-fraud personnel duties and functions. A pattern has emerged where the more subcontractors there are, the less compliant the insurer is. Section 2698.33(c)(5)(C)(1) requires the sub-subcontractor to be bound by the same requirements as the subcontractor. Section 2698.33(c)(5)(C)(2) requires the sub-subcontractor to provide its contract with the subcontractor to the Department. Section 2698.33(c)(5)(C)(3) limits the sub-subcontractor from contracting out SIU or integral anti-fraud personnel duties or functions further. This is reasonably necessary to ensure that the requirements of subdivision (c) apply equally to all entities performing SIU and integral anti-fraud personnel functions, to enable the Department to understand the contractual relationship between the entities and conduct compliance audits based on that information, and to hold responsible entities who contract away certain investigative functions.

[Amended] Section 2698.34. Communication with the Fraud Division and Authorized Governmental Agencies.

2698.34(b). Corrects a punctuation error, which is a non-substantive change. Clarifies that the "information" referenced is "the information released pursuant to this subdivision (b)."

2698.34(b)(10). Sets the phrase "authorized governmental agency" in all lowercase font instead of in initial caps. This change is reasonably necessary to keep the regulation's use of the term consistent with the term as used in the Insurance Code (see, e.g., Ins. Code section 1873.3(b)).

2698.34(c). Reconciles the timeframes set forth in the regulations with the timeframes set forth in statute for the different types of insurance fraud. Ins. Code section 1877.3, which deals with workers' compensation fraud, was amended after these regulations were enacted to require an insurer providing information to an authorized governmental agency to provide the information within a reasonable time, but not exceeding 60 days from the day on which the duty arose. All other types of fraud require an insurer providing information to an authorized agency to provide the information within a reasonable time, but not to exceed 30 days from the day on which the

duty arose. The amendment is reasonably necessary to reconcile the different requirements between workers' compensation fraud and other types of insurance fraud.

Additionally, this subdivision is being amended to permit an authorized governmental agency making a request under this section to agree to a different timeframe for the release of information. This is reasonably necessary because this section applies to written requests by both the Department and an authorized governmental agency and there is a need to clarify that an authorized governmental agency has the power to agree to a different timeframe.

2698.34(d). Adds methods by which the requested information may be submitted. Sections 2698.34(d)(1)-(3) add the most commonly used methods of transmission. However, for electronic files the Department has experienced difficulty with insurers who submit the requested information with an encryption or password protection. There is no universal encryption method used by insurers, so the Department has had to purchase numerous software programs to access encrypted files. Further, files with password protection often have expiring passwords that prevent the Department from accessing the information once the Department is ready to review the submission. Section 2698.34(d)(3)(A)-(B) add requirements to address these issues. This is reasonably necessary to specify the manner in which the information should be submitted in order to establish consistency among insurers and provide the Department with access to the information in a timely manner. This will allow CDI to review and potentially to open more referrals.

2698.34(e). Adjusts the section lettering due to the addition of subdivision (d) and is a non-substantive change.

[Amended] Section 2698.35. Detecting Suspected Insurance Fraud.

2698.35(b). Clarifies that there must be a listing of red flags for all insurance lines and products offered by insurers. The detection of insurance fraud varies by line of insurance and product offered; as such, red flags will differ. This amendment is reasonably necessary to provide clarity and guidance as to what is required in the insurer's written procedures and to ensure procedures are completed across all lines and products. When the Department's auditors conduct exams they compare the activities conducted by the insurer with the written procedures. If the proper procedure is not identified for the specific line of insurance or insurance product, the auditor is unable to determine whether the insurer is compliant since the red flags may differ among each line or product.

2698.35(c). Reconciles this section with the revised definition of "red flags." The enumerated items in sections 2698.35(c)(1)-(5) are red flags. It is now unnecessary to enumerate these red flags individually since the definition of "red flags" was amended to include those items. This reconciliation is reasonably necessary for clarity purposes and to avoid confusion.

Additionally, this amendment expands the criteria for conducting comparisons of insurance transactions to include other criteria that may indicate possible fraud. There may be other criteria unique to each case and limiting the comparison to just red flags could prevent beneficial criteria from being used to detect fraud.

[Amended] Section 2698.36. Investigating Suspected Insurance Fraud.

2698.36(a)(1). Clarifies that analysis of the claim should include fraud indicators. Sometimes an insurer uses SIU personnel to conduct work on non-fraud cases, and it is difficult for the Department to distinguish between fraud and non-fraud cases. Determining the proportion of fraud and non-fraud cases the SIU worked assists the Department in assessing the adequacy of the SIU. This amendment is a way to gather additional information about the legitimacy of the investigation as well as to determine whether the case was related to fraud. This is reasonably necessary for compliance purposes to ensure that the Department has the necessary information to determine adequacy of the SIU.

2698.36(a)(2). Clarifies that all potential witnesses should be identified and interviewed. This is reasonably necessary for clarity purposes and to leave no doubt as to which witnesses should be identified and interviewed.

2698.36(a)(3). Requires the use of one or more industry-recognized database identified by the SIU for use in fraud investigations. This is reasonably necessary to ensure that insurers use a relevant database in their investigations and thus that investigations are conducted effectively.
2698.36(a)(4). Clarifies that documents and other evidence obtained during an investigation must be preserved. This is reasonably necessary for clarity purposes and to avoid confusion over what documents or evidence must be preserved.

2698.36(a)(5). Clarifies what is required in the summary. The detail and quality of summaries vary among insurers, and some insurers submit an analysis that has already been completed for the claim file, an analysis of a combination of different claim files, or other documents in lieu of a summary of the investigation. The amendment requires a summary of the entire investigation, a summary that is specific to the investigation of suspected fraud and one that is separate from any other document prepared in connection with the investigation. This is reasonably necessary to specify the requirements of the summary.

Additionally, the amendment requires answers to specific questions to be included the summary. These questions are considered foundational to any investigation of suspected insurance fraud. In many cases, the Department cannot determine the adequacy of the investigation because the investigative summary is minimal. The Department would like to know what was considered by the SIU internally in determining whether a referral to the Department was warranted, or if the claim was not referred whether it should have been. The questions in section 2698.36(a)(5)(A)-(E) specify the information that should be sought when investigating suspected insurance fraud. This is reasonably necessary to increase the quality of investigations.

2698.36(b). Specifies that the procedures identified in section 2698.36(a) must be performed. This is reasonably necessary to clarify that it is not sufficient for insurers to merely establish written procedures that include the requirements in section 2698.36(a); insurers must also follow those procedures to the extent applicable.

2698.36(c). Requires an insurer to investigate each credible referral of insurance fraud it receives from its anti-fraud personnel. If an SIU is inadequately staffed, credible referrals may not be investigated. The lack of investigation of credible referrals is a factor the Department considers

when determining adequacy of an SIU. This is reasonably necessary to ensure credible referrals are investigated and to assist the Department in determining whether the SIU is adequately staffed.

[Amended] Section 2698.37. Referral of Suspected Insurance Fraud.

2698.37(d). Requires the SIU to complete as much of the investigation as is reasonable prior to referral to the Department. Clarifies what is considered reasonable, and also requires that each referral indicate the status of the investigation. Also clarifies that SIU staff must prioritize fraud investigation over other tasks. The Department receives many insufficient referrals from insurers who do not conduct adequate investigations. Some insurers refer cases to the Department at the same time they refer those cases to their own SIU, prior to undertaking any investigation whatsoever. Cases should be referred to the Department in instances where the facts and circumstances create reasonable belief of fraud, which necessarily requires an investigation by the SIU. The Department reviews every referral, and the volume of premature submissions the Department receives results in a significant waste of Department resources. The inclusion of the status of the investigation assists the Department in determining whether follow-up is required. This amendment provides clearer direction to insurers while being consistent with existing law that mandates the timing of referrals. This is reasonably necessary to increase the quality of referrals to the Department and to clarify that the insurer should be conducting as thorough an investigation as possible prior to referral.

2698.37(e). Adjusts the section lettering due to the addition of subdivision (d) and is a non-substantive change.

2698.37(f). Adjusts the section lettering due to the addition of subdivision (d) and is a non-substantive change.

[Amended] Section 2698.38. Referral Content.

2698.38(b)(1). Clarifies the party code. This is reasonably necessary to ensure that the insurer understands which codes are referenced and to provide consistency among insurer reporting.

2698.38(b)(3). Clarifies that the company number is the certificate of authority number issued by the Department. This is reasonably necessary to clarify that term since company number could also refer to the insurer's National Association of Insurance Commissioners ("NAIC") number.

2698.38(b)(4). Adds the word "party" to be consistent with the other provisions in this section and replaces the "/" with "or." This is reasonably necessary for consistency and clarity.

2698.38(b)(7). Adds additional data that a reporting party must provide. The Federal Employer Identification Number is used to distinguish between insurers with similar names. This is reasonably necessary to ensure proper identification of the reporting party.

2698.38(c)(2). Clarifies that the company number is the certificate of authority number issued by the Department. This is reasonably necessary to clarify that term since company number could also refer to the insurer's NAIC number.

2698.38(c)(3). Allows alleged victims to be identified by contracted third-party license number, in addition to by self-insured license number. This is reasonably necessary to ensure the victim is properly identified.

2698.38(d)(9). Requires the same information that was prepared under section 2698.36(a)(6). Also changes the requirement from a synopsis, which is often understood as a short explanation of the claim, to a summary, which is more detailed than a synopsis. In many cases, the Department cannot determine the adequacy of the investigation because the investigative summary is minimal. The Department would like to know what the SIU considered internally in determining whether a referral to the Department was warranted. If the claim was not referred, the Department would like to know whether it should have been. This is reasonably necessary for consistency among the sections and to provide the Department with sufficient information to identify whether the insurer conducted a thorough investigation and whether a referral to the Department was warranted.

Additionally, this amendment adds section 2698.38(d)(9)(B) to include the same information as required in 3698.37(d). This is reasonably necessary for consistency among the sections and to provide the Department with sufficient information to determine the status of the investigation and whether additional investigation is warranted.

2698.38(f)(1). Requires a reporting party to provide the title of the referral contact. This is reasonably necessary to ensure that the referral is being made from the correct department and to ensure accurate contact information.

2698.38(f)(4). Makes an exception to allow omitting the date of the referral if the referral was submitted electronically. This is reasonably necessary for clarity and to remove duplicative information since referrals submitted electronically will already include date the referral was completed.

2698.38(g)(1). Requires the name of the party associated with the referral. This is reasonably necessary to clarify confusion when there are multiple parties associated with a referral.

2698.38(g)(7). Corrects a punctuation error and is a non-substantive change.

2698.38(g)(8). Corrects a punctuation error and is a non-substantive change.

[Amended] Section 2698.39. Anti-Fraud Training.
2698.39(a). Corrects a punctuation error and is a non-substantive change.

2698.39(c)(1)(C). Corrects grammar and punctuation errors and is a non-substantive change.

2698.39(c)(1)(E). Adds the requirement for an email address. This amendment is reasonably necessary given the frequent use of email as a primary method of communication.

2698.39(c)(2). Adds a title to this subdivision and adjusts section lettering due to the addition of subdivision (2)(B), which is a non-substantive change.

2698.39(c)(2)(A)(1). Adjusts the section lettering due to the addition of subdivision (2)(B) and is a non-substantive change.

2698.39(c)(2)(A)(2). Adjusts the section lettering due to the addition of subdivision (2)(B) and is a non-substantive change.

2698.39(c)(2)(A)(3). Adjusts the section lettering due to the addition of subdivision (2)(B) and is a non-substantive change.

2698.39(c)(2)(A)(4). Adjusts the section lettering due to the addition of subdivision (2)(B) and is a non-substantive change.

2698.39(c)(2)(A)(5). Adjusts the section lettering due to the addition of subdivision (2)(B) and is a non-substantive change. Additionally, this subdivision is being amended to correct grammar, which is a non-substantive change.

2698.39(c)(2)(A)(6). Adjusts the section lettering due to the addition of subdivision (2)(B) and is a non-substantive change.

2698.39(c)(2)(B). Clarifies that experts or consultants on medical, technical, or scientific topics who do not participate in the claims handling or decision-making function of the insurer are not required to meet the training requirements stated in subdivision (c)(2)(A). For example, a doctor hired to provide a medical opinion does not need to receive anti-fraud training in order to provide his or her medical opinion based on his or her professional training. This amendment is reasonably necessary to makes clear for insurers that the training requirements apply only to those contractors who participate in claims handling or decision-making on behalf of the insurer.

2698.39(c)(3). Requires at least five hours of continuing anti-fraud training for SIU personnel per calendar year, and requires instruction in one or more of the enumerated topics. Five hours is a reasonable requirement and well within the realm of what is required in other similar contexts. For example, New Jersey requires nine hours of training for SIU staff, and Florida requires two hours of initial training for SIU staff and an additional one-hour course annually thereafter. The International Association of Special Investigation Units ("IASIU") has a certification for Certified Insurance Fraud Representatives who possess specialized skills to detect fraud and conduct preliminary claims investigations, much like SIU personnel. The recertification requires 15 hours of continuing education units over a three-year period (which averages to five hours per year). Thus, the five-hour minimum falls between the hours that New Jersey and Florida require and approximates the IASIU requirements. Most insurers already satisfy the five-hour minimum, and the five-hour minimum strikes a balance between costs to insurers and the need to fight fraud. This is reasonably necessary to clarify the training requirements, to ensure that the training requirements are effective, and to provide an objective method for the Department to determine compliance.

2698.39(d). Clarifies the types of activities that count towards the training requirement. This is reasonably necessary to further define and clarify what training would satisfy the requirement in 2698.39(c)(3).

2698.39(e). Reconciles this subdivision with changes in this section and with current practices. The amendment clarifies that records of anti-fraud training are to be prepared and maintained for all training, not just training provided to all staff since trainings can differ by staff member and there may be trainings that are not provided to all staff. Additionally, the amendment modifies the requirements of the training records to the information that is applicable to the training. Not all trainings will have each of the listed descriptors. This is reasonably necessary to provide clarity to insurers as to what type of training records to maintain.

[Amended] Section 2698.40. SIU Annual Report.

2698.40(a). Permits the primary reporting insurer who is actually performing the SIU functions on behalf of the insurer to report the information after the initial report filed by the insurer at the time its initial Certificate of Authority is issued. This is reasonably necessary to clarify that the insurer may satisfy its duties by reporting the information through a primary reporting insurer that conducts the insurer's SIU operations.

2698.40(b)(1). Requires the insurer's California Certificate of Authority number, the lines of insurance, and information of the primary reporting insurer given the revisions in section 2698.40(a). Some primary reporting insurers perform work for multiple subsidiaries of an insurer. The existing language was interpreted to require every insurer to file a report. For example, if an insurer has 30 subsidiaries then the insurer would be required to submit 30 reports, even if all 30 reports were completed by the same primary reporting insurer. The amendment is reasonably necessary to streamline the reporting process, remove duplicative reports, and permit the primary reporting insurer to submit one report on behalf of all insurers it is conducting work for to ensure efficient reporting. This is also reasonably necessary to save Department resources. In the example above, instead of reviewing 30 reports the Department could review one report that contains the same information in the 30 separate reports.

2698.40(b)(2). Specifies that the information requested is for fraud work related to California. This is reasonably necessary to clarify the requirement and limit the information to SIU personnel or contracted entities working on California fraud investigations, and provides the most accurate contact should there be an investigation pursued by the Department.

2698.40(b)(4). Requires copies of written procedures used by the insurer or its contracted entities, and specifies the minimum information required under this section. Sections 2698.40(b)(4)(A)-(C) require descriptions of specific aspects of the insurer's fraud detection, investigation, and referral procedures that the Department may use in audits to determine compliance. This is reasonably necessary for the Department to complete its audit functions and understand the insurer's methodologies, and to enable the Department to easily access pertinent information without wasting time and resources filtering through copies of the written procedures to find that information.

2698.40(b)(5). Requires copies of the insurer's plan as well as plans of any contracted entities, and specifies what is to be included in the description. This is reasonably necessary to provide a snapshot to the Department for ease of review in determining compliance, and to be consistent with the requirements under section 2698.39.

2698.40(b)(6). Requires the insurer to provide to the Department the organizational arrangement of the SIU and integral anti-fraud personnel in California, including that of contracted entities. This is reasonably necessary to ensure the Department is receiving all relevant contact information and to understand the relationship between the insurer and its contracted entities. This increases insurer accountability and improves CDI's ability to enforce compliance by requiring insurers to identify and track who they subcontract with and who those subcontractors further subcontract out SIU investigative functions to. Additionally, it limits the information required to those who are responsible for working on suspected fraud that occurred in California. This is reasonably necessary to remove unnecessary information from the report.

2698.40(b)(7). Specifies the requirements in describing how an SIU is adequately staffed. The Department compares insurers with similarly situated insurers in the same line of business and compares the resources being allocated to its SIU function. This assists the Department in determining adequacy of the SIU under section 2698.32. It is reasonably necessary for clarity and consistency among insurers, and to ensure both internal and external staffing resources are reported to the Department so that the department may measure the adequacy of the SIU.

2698.40(b)(8). Clarifies what each reported company must report on. Specifies that the reporting is specific to California claims. Clarifies that the timeframe is for the last calendar year, instead of the past calendar year. This is necessary for clarity purposes. The amendment also includes the number of claims and other transactions. This is reasonably necessary for the Department to receive accurate information as referrals also go to SIUs for application fraud and not just claims fraud. The amendment also requires referred claims that resulted in the SIU opening an investigation. This is reasonably necessary to enable the Department to conduct analyses and comparisons of claims referred to investigations opened. The additional information being requested in this section is to enable the Department to determine whether the insurer is allocating adequate SIU resources for fraud in California and to evaluate the adequacy of the SIU.

2698.40(b)(9). Specifies that the information required is for each reported company, limits the reporting to fraud in California, and clarifies the timeframe for the reporting. This is reasonably necessary for the Department to be able to use this information as a measure of effectiveness of the SIU's investigation and referrals.

2698.40(b)(10). Requires a description of changes impacting SIU operations that have already occurred in addition to anticipated changes, and requires a description of the impact of the changes. Operational changes of an insurer is a factor the Department considers in determining whether the quality of the SIU will change as well. This information also assists the Department in planning field exams. If the Department is aware of the changes it can either defer the exam to a more appropriate time, or the changes may be incorporated into its analysis. This amendment narrows the insurer's reporting obligation to the information that the Department finds useful and decreases the burden on insurers. This is reasonably necessary to determine the adequacy of the SIU and to assist the Department in planning field exams.

2698.40(b)(11). Adds a requirement to list all lines of insurance and the number of active policies for each line, as well as a description of each product or program offered for each line of

insurance. The description of the products and lines helps the Department get a sense of what products are being sold since different products have different fraud risks. This enables the Department to better understand the insurer's exposure to fraud. That information is then used by the Department to assess what the insurer is doing in relation to training and investigations and to ensure that there is a proper connection between the two. This is reasonably necessary to provide statistical information needed for the Department to evaluate the adequacy of the SIU, and to determine insurer compliance with training and investigation requirements.

2698.40(b)(12). Specifies that the requirements of this subsection apply to each contract, and adds requirements to include a listing of all entities contracted with, description of services, and description of each entity's SIU. Not all contracts are being reported in the Annual Report, and the contracting structure can be unclear to the Department. The additional information required is reasonably necessary to help the Department better understand the SIU structure of the insurer and the contracted entities the insurer is working with, and to ensure the Department receives full and accurate information.

2698.40(b)(13). Limits the information requested to California, and requires specific information related to the civil actions. This information is necessary for the Department to find and track civil cases, and to determine whether a criminal fraud referral has also been made. At times, an insurer will file a civil action but not a criminal action, even though a criminal action may be warranted. This amendment is reasonably necessary for the Department to verify that the insurer has met its reporting requirements and to verify compliance.

2698.40(e). Replaces the acronym "CIC" with the phrase "Insurance Code." This amendment is reasonably necessary to clarify that the body of law referenced is the Insurance Code.

[Amended] Section 2698.41. Examinations.

2698.41(b). Distinguishes the steps taken by the Department when an insurer is found to be in compliance versus in noncompliance. This is reasonably necessary to clarify that no additional steps are necessary if the insurer is found to be in compliance. The amendment also specifies that in the event of noncompliance, the Department will issue a draft written report. This is reasonably necessary to provide consistency with Ins. Code section 1875.24, which requires the Department to issue a notice of noncompliance, and the draft written report serves as that notice.

2698.41(c). Provides an explanatory title to section (c). This is reasonably necessary for clarity.

2698.41(c)(1). Amended to clarify the procedures for submitting a corrective action and compliance plan and to eliminate confusion between the draft written report and final written report. This is reasonably necessary to reconcile the regulations with the procedures required in Ins. Code section 1875.24, and to provide clear guidance to insurers. The amendment also specifies that the report may identify violations of the regulations or underlying statute. This is reasonably necessary for clarity purposes since a violation of the underlying statute may result in noncompliance. This amendment also specifies that the corrective action and compliance plan must be submitted pursuant to section (c)(1). This is reasonably necessary for clarity purposes since section (c)(1) sets out specific steps and timeframes.

2698.41(c)(2). Amended to reconcile the language with the other subdivisions in this section, to clarify confusion, and to restructure this section into a more readable format. The written report is what is being issued by the Department, and the corrective action and compliance plan is what is submitted by the insurer. This amendment is reasonably necessary to make the language consistent throughout section 2698.41 and to avoid confusion.

2698.41(d). Clarifies that the Department will issue a final report after review of the insurer's corrective action and compliance plan. This is reasonably necessary to reconcile the regulations with Ins. Code section 1875.24.

ECONOMIC IMPACT ASSESSMENT

Economic Overview of the Proposed Regulation

The economic value of suspected fraudulent losses was $963 million for Fiscal Year 2016-17.[1] Fraudulent claims result in losses to insurers and drive up the cost of all insurance products. To combat fraud, insurers are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to their internal Special Investigative Unit (SIU) for additional review. If the SIU reasonably believes that fraud has occurred, they will refer their findings to the Department for an official investigation. This regulation would increase the overall effectiveness of insurer fraud investigations, and help the Department and local district attorneys better investigate and prosecute insurer fraud referrals. However, the recovery of additional fraudulent claims payments through the courts is just one of many anticipated benefits of the regulation. The Department believes that better fraud documentation and the ability to complete more cases will help to identify and investigate more large fraud rings. Another important benefit of the regulation is that uncovering more instances of well-documented, pervasive fraud, would likely create a greater deterrent for individuals considering committing fraud in the future. The calculation of a monetary benefit due to an added fraud deterrent or an increase in the conviction rate includes many variables, some of which are outside the scope of the regulation and outside the regulatory control of the Department. As a result, these benefits are discussed, but the monetary value of those benefits is not included due to the unpredictability of the variables needed to create an accurate estimation.

Establishing a Baseline

Fraud referrals and investigations are important to ensure vibrant insurance markets and protect businesses. As shown in Table 1, over the prior four fiscal years the Department received more than 116,000 fraud referrals. To establish an annual baseline, the Department averaged the last three fiscal years of data. Over the last three years, the Department has received an annual average of nearly 28,000 fraud referrals. Some of those referrals are incomplete and are unable to be investigated by the Department. By improving the quality of all insurer SIU fraud investigations, the Department anticipates that the total number of referrals will decrease and the

[1] Suspected fraudulent losses are defined as the amount paid that is suspected as being fraudulently claimed. Data is from the 2017 Annual Report of the Commissioner: Table O: Economic Value of Fraud Reported by Type, pg. 44. https://www.insurance.ca.gov/0400-news/0200-studies-reports/0700-commissioner-report/upload/2017-Annual-Report-of-the-Commissioner.pdf

number of cases opened will increase. The data collected by the Department is at the umbrella, or primary, company level and includes data for all referrals that were investigated by insurers and referred to the Department. For the purposes of this economic impact analysis, it is assumed that all benefits and costs accruing to subsidiaries and third-party administrators would flow through the umbrella company.

Table 1. Historical Referral and Case Data

Fiscal Year	Total Referrals	Total Cases Opened	Total Cases Closed	Cases: More than 40 hours to Close	Total Referrals Closed
2017/18	25,159	1,236	990	453	22,998
2016/17	29,552	1,482	1,183	556	26,789
2015/16	29,156	1,327	1,177	541	28,372
2014/15	32,267	1,733	1,477	677	31,303
3-Year Average	**27,956**	**1,348**	**1,117**	**517**	**26,053**

Costs Anticipated from the Proposed Regulation

SIU functions were previously performed primarily by the insurer's employees and were not contracted out to third parties. However, current industry practice has insurers subcontracting more regularly for SIU functions. This change has led to inconsistent and sometimes inadequate SIU reporting. Additionally, some insurers have submitted initial reports indicating suspected fraud, without first completing their own internal investigations and reaching the standard of "reasonable belief" that fraud has occurred.[2] This leads to a large number of SIU reports that were submitted prematurely and could not be properly investigated. The initial review of numerous incomplete SIU reports creates unnecessary work for the Department.

This regulation sets standards for what needs to be included in an insurer SIU report that gets submitted to the Department, with the goal of improving efficiency and investigation outcomes. The Department expects to receive more referrals of a higher quality, while simultaneously seeing a decrease in the total number of referrals. However, the higher quality standards will result in an additional workload for insurers and their subcontractors. The Department evaluated the current quality of referrals received and the tasks required by the proposed regulation to calculate the average number of additional hours that insurers would need to fully complete the required tasks and improve SIU referral quality.

[2] Reasonable belief is a higher standard than just suspecting fraud and includes an objective justification based on articulable facts.

Table 2. Analysis of Tasks Required to Generate High Quality SIU Referrals

Section	Added Insurer SIU Task	Referral will need more of the new required material	Referral will need some of the new required material
2698.36(a)(1)	Identification of insurance fraud factors	0.5	0
2698.36(a)(5)	Concise investigation summary	3.5	1.5
2698.38(d)(9)	Synopsis of facts	1.5	1
Total Increased Hours per Referral		**5.5**	**2.5**

Table 2 above shows the anticipated increase in the average number of hours for tasks required by the proposed regulation that are needed to generate a high-quality referral, given the current quality of a referral. Some referrals that the Department receives are already high quality and would need no additional material to be compliant with the regulation. Many of the referrals received are currently adequate but would need some of the new material listed in the regulation, requiring an average of two and a half hours of additional work. Finally, referrals that are currently incomplete would require an estimated five and a half additional hours to include the new material required by the regulation. The Department assumes that the three referral quality categories approximate a bell curve distribution, with most of the referrals clustered in the middle (50 percent) and fewer arrayed along each of the extremes (25 percent each). In Table 3 below, the cost estimate includes the post-regulation estimate for referrals that includes both the elimination of low-quality referrals and the addition of previously unworked referrals.[3]

Table 3. Total Cost of Improving SIU Referral Quality

Insurer SIU Referrals	Percent of Referrals	Number of Referrals	Average Increase in Hours	Total Cost Increase to Insurers
Referral will need most of the required material	25%	5,858	5.5	$1,106,950
Referral will need some of the required material	50%	11,715	2.5	$1,006,319
Currently achieves high-quality standard	25%	5,858	0	$0
Total	**100%**	**23,430**	**2.625**	**$2,113,269**

Section 2698.36(c) specifies that the SIU shall investigate each credible referral of suspected insurance fraud it receives from the insurer's integral anti-fraud personnel. In calendar year 2017, Department records show that SIUs received approximately 121,000 referrals, of which the SIU referred 27,000 to the Department. This means that 94,000 referrals were deemed to be not credible by the insurer SIU. The Department estimates that five percent of those referrals should have been fully investigated. As a result, the Department anticipates 4,700 additional referrals. These represent new cases that were previously unworked by insurers. Since the additional time to complete each investigation was already accounted for by including these new referrals in Table 3, the remaining cost impact is from the time it currently takes insurer SIUs to investigate. The Department estimates that prior to the proposed regulation each insurer SIU

[3] More detail on the post-regulation total referral estimate can be found in Table 4. Estimated Total Referrals Post Regulation in the **Benefits Anticipated from the Proposed Regulation** section.

investigation took an average of 25 hours to complete. Therefore, the cost impact of requiring the insurers' SIU to investigate each new anticipated credible referral is $4.0 million (4,700 referrals x 25 hours x $34.36).[4] The hourly cost estimates in Table 3 and throughout the *Costs Anticipated from the Proposed Regulation* section utilize the 2018 1st quarter median hourly wage estimate for Claims Adjusters, Examiners, and Investigators of $34.36, published by the Employment Development Department's Labor Market Information Division.

The total cost to insurers of conducting additional SIU investigations of credible fraud referrals and submitting high quality SIU referrals in accordance with the proposed regulation is estimated to be $6.1 million ($2.1 million + $4.0 million).

Additionally, Section 2698.39(c)(3), requires SIU personnel to receive a minimum of five hours of continuing anti-fraud training per calendar year. The regulations currently require insurers to provide anti-fraud training and the proposed regulatory change only specifies the minimum number of training hours required. Many insurers take fraud prevention seriously and already meet the prescribed training requirements. Department records indicate that there are approximately 3,300 SIU personnel that would potentially be impacted. Based on attendance at SIU Roundtable discussions and knowledge of existing training programs, the Department estimates that about 50 percent of SIU staff would already meet the new anti-fraud training requirements. Therefore, the total cost impact to insurers of requiring a minimum of 5 anti-fraud training hours for SIU staff is estimated to be $283,000 ($34.36 x 3,300 x 5 x 50% = $283,470).

Therefore, the total estimated cost to insurers of completing an increased number of detailed SIU referrals and providing increased anti-fraud training as required by the regulation is $6.4 million (6.1 million +.283 million).

Benefits Anticipated from the Proposed Regulation

As discussed above, the expected result of the regulation is that the Department will receive more referrals of a higher quality, while simultaneously seeing a decrease in the total number of referrals. By conducting full SIU investigations, either in-house or contracted out, it is anticipated that insurers will no longer submit SIU referrals that do not meet the standard of "reasonable belief" that fraud has occurred. Requiring insurers to reasonably complete SIU investigations in a manner consistent with the regulations will eliminate some lower quality referrals that do not reach the standard of "reasonable belief" that fraud has occurred. The Department estimates that a third of all SIU referrals, or 9,225 referrals, will be eliminated. Then, to estimate the total number of referrals post regulation, the 4,700 previously unworked referrals have to be added back in.

[4] California Employment Development Department Labor Market Information Division, Employment and Wages Data Table for the State of California in the First Quarter of 2018, Median Hourly Wage for "Claims Adjusters, Examiners, and Investigators" (SOC Code 13-1031), available online at http://www.labormarketinfo.edd.ca.gov/data/oes-employment-and-wages.html. Data accessed May 8, 2019.

Table 4. Estimated Total Referrals Post Regulation

	Totals Referrals
Pre-Regulation Baseline	27,956
Elimination of low-quality referrals	-9,225
Previously unworked referrals	4,700
Post-Regulation estimate	23,430

In addition to the elimination of 9,225 lower quality referrals and the increase of 4,700 previously unworked referrals, the regulation is also expected to increase the number of complete referrals with well-documented evidence. This is expected to lead to an increased rate at which cases are opened as a percentage of total referrals, as fraud cases that previously would have been closed for having insufficient evidence can now be investigated. By eliminating 9,225 incomplete referrals, the rate at which cases are opened relative to total referrals increases from 4.8 percent (1,348 / 27,956) to 7.2 percent [1,348 / (27,956-9225)]. Applying the new rate cases are opened relative to total referrals to 4,700 previously unworked referrals results in an estimated 338 (4,700 x 7.2 %) additional cases per year for the Department to open, as shown in Table 5.

Table 5. Changes from Pre-Regulation Baseline

	Totals Referrals	Cases Opened	Cases: More than 40 hours to Close	Total Referrals Closed
Pre-Regulation Baseline (detailed in Table 1)	27,956	1,348	591	26,553
Result of eliminating of low-quality referrals	18,730	1,348	591	17,791
Increase from including previously unworked referrals	4,700	338	148	4,362
Post-Regulation Baseline Estimate (adjusted for the elimination of low-quality referrals and previously unworked referrals)	23,430	1,687	739	22,152
Total Change from Pre-Regulation Baseline	**-4,525**	**338**	**148**	**-4,620**

The Department estimates that of those 338 new cases, it is anticipated that an additional 148 cases requiring more than 40 working hours would be completed. It is necessary to separate out the cases that take more than 40 hours to close because these are the cases where the efficiencies due to the regulation will accumulate. Over the past four years, the Department has completed 2,227 cases where the investigation took more than 40 hours. At an average of 242 hours per case, these intensive investigations account for approximately 95 percent of the time spent by investigators on all fraud cases. Department investigations can still be completed beneath the 40 hour threshold for reasons including, but not limited to, abrupt conviction by a district attorney or redirection to a master case, but the efficiencies in investigations and cost savings to the Department will be concentrated in the most time intensive cases.

While higher quality SIU referrals could potentially lead to an increase in the percentage of cases that lead to a conviction (and more benefits from this regulation), this analysis conservatively assumes that the percentage of cases ending in conviction will remain constant. At this time, the Department has no reliable data to estimate how much the regulation might increase the different conviction rates of local district attorneys throughout the state. Restitution is how the Department calculated the monetary benefit of increased fraud detection and better SIU investigations. For fiscal year 2015-2016 there was $32.4 million in court-ordered restitution and $16.3 million in restitution collected. For the same fiscal year, there were 58 cases (4.4%) that lead to a conviction, 402 cases (30.4%) that were closed for various reasons, and 869 cases (65.4%) with ongoing investigations.[5] Those restitution payments can then be prorated on a per case basis, resulting in an average of $558,600 ($32.4 million / 58 cases) of restitution ordered and $281,000 ($16.3 million / 58 cases) of restitution collected. To better estimate the future restitution that will be collected due to the regulation, both the restitution ordered and collected amounts for fiscal year 2015-16 were adjusted for inflation to $585,900 and $294,700, respectively.[6]

The better quality of SIU referrals is anticipated to increase the total number of cases the Department can work by 338. This is projected to result in an additional 15 cases (4.4% x 338) leading to conviction and $8.8 million (15 cases x $585,900) in court-ordered restitution. However, it will probably only save insurers an additional $4.4 million (15 cases x $294,700), the amount of restitution that is likely to be collected. The recovery of additional fraudulent claims payments through the courts is not the only benefit of the regulation. Better fraud documentation and the ability to complete more cases will help to identify and investigate more fraud rings. Another important benefit is creating a greater deterrent for individuals considering committing fraud in the future.

Fiscal Impacts on Federal, State, and Local Government

Fiscal Impact on Federal Government

On occasion, the Department will refer a fraud case to federal law enforcement authorities. However, it is not anticipated that the regulation will result in a fiscal impact on the Federal Government. During fiscal year 2017-2018, the Department only referred 1 fraud case to the Office of the United States Attorney. It is not expected that the regulation will significantly impact the rate or total number of cases that get referred to federal authorities.

Fiscal Impact on State Government

This regulation will likely impact the State Compensation Insurance Fund (SCIF). Department records show that in 2017 SCIF had 127 SIU investigations that were referred to the Department of Insurance. The Department assumes that SCIF's total SIU referrals would be reduced by 33

[5] Data is from the 2016 Annual Report of the Commissioner: Table M: The Status of the Assigned Suspected Fraudulent Claims, pg. 44. https://www.insurance.ca.gov/0400-news/0200-studies-reports/0700-commissioner-report/upload/2016-Annual-Report.pdf

[6] The amounts were adjusted upwards using the June 2016 end date of the 2015/16 Fiscal Year to February 2019, the most current month available, using the CPI inflation calculator on the Bureau of Labor Statistics website. https://www.bls.gov/data/inflation_calculator.htm

percent, due to the elimination of low-quality referrals, to 84 referrals. This is similar to the estimate for all insurers because of the requirement in the regulation to conduct a more thorough investigation. Additionally, SCIF would experience the same 5 percent increase of previously unworked referrals, or 21 referrals, bringing the estimated total for SCIF SIU referrals to 105. Assuming SCIF SIU referrals adhere to the same bell curve distribution shown in Table 3 above, the result would be a fiscal impact to SCIF of nearly $9,500 due to increased investigative steps as shown in Table 6.

Table 6. Fiscal Impact on the State Compensation Insurance Fund

SCIF SIU Referrals	Percent of Referrals	Number of Referrals	Average Increase in Hours	Total Cost Increase to SCIF
Referral will need most of the required material	25%	26	5.5	$4,964
Referral will need some of the required material	50%	53	2.5	$4,513
Currently achieves high-quality standard	25%	26	0	$0
Total	**100%**	**105**	**2.625**	**$9,478**

Each of the 21 previously unworked referrals will also incur the costs of the entire investigation. As before, the Department estimates that prior to the proposed regulation each insurer SIU investigation took an average of 25 hours to complete. Therefore, the cost impact of requiring SCIFs' SIU to investigate each new anticipated credible referral is $18,000 (21 referrals x 25 hours x $34.36). The Department assumes that SCIF will continue their current practice of attending the SIU roundtable discussions and will not incur any additional costs due to the new training requirements in the regulation. As a result, the total anticipated fiscal impact on SCIF is estimated to be $27,500.

Fiscal Impact on the Department

Each SIU referral gets an initial review to determine the appropriate course of action. These initial intake reviews only average 15 minutes, but eliminating a net of 4,525 (add 4,700, subtract 9,225) referrals will save the Department 1,031 hours.

It is also expected that better documentation of fraud will save the Department's investigators time on each case that is opened. The main time savings will accrue on cases requiring a minimum of 40 hours to complete. Currently, these cases average 242 hours of staff time. Based on its experience working cases, the Department estimates that insurers submitting more developed SIU reports in accordance with the regulation will save investigators an average of 10 percent of their time, or 24 hours per case. Multiplying the time savings per case by the baseline number of cases requiring 40 hours to complete, results in a savings of 12,408 hours to the Department (24 hours x 517 cases). Adding the aggregated savings per case to the savings gained from fewer initial referral intake reviews results in a total savings of 13,539 hours (12,408 + 1,031) to the Department. Since the new average time to complete a case is estimated to be 218 (242 - 24) hours, efficiency achieved through the regulation will allow the Department to work 62 new cases (13,539 / 218). That still leaves an additional 86 cases (148 – 62) that the Department anticipates opening because of insurers conducting additional SIU investigations of credible fraud referrals and submitting high quality SIU referrals. Assuming that the 86

anticipated cases have the same completion time of 218 hours results in an additional 18,700 hours of work for the Department.

The Department assumes that time savings from cases taking less than 40 hours to complete would be minimal, as there are not many hours to cut, but there would be more of them. These remaining 190 cases (338 - 148), to be closed in less than 40 hours, are projected to average around 10 hours per case resulting in 1,900 additional hours of investigator time.

The total impact of the regulation on the Department's workload is estimated to be 20,600 hours. Using 1,778 hours for a person year, the Department will need to add the equivalent of 11.5 full-time positions. These 11.5 positions will be split between 2 Supervising Fraud Investigator I's and 9.5 Investigators, resulting in an initial fiscal impact to the Department of $2,697,000 and ongoing annual costs of $1,721,000.

Fiscal Impact on Local Government

The Department works closely with local government district attorneys to ensure that fraud cases are fully investigated and prosecuted. This is especially true with workers' compensation insurance, where insurers are required by law to submit SIU referrals to both the Department and the local district attorney.

Table 7. Counties with the Largest Projected Fiscal Impact

County	Population	Cost Impact
Los Angeles	10,283,729	$271,755
San Diego	3,337,456	$88,195
Orange	3,221,103	$85,120
Riverside	2,415,955	$63,843
San Bernardino	2,174,938	$57,474
Santa Clara	1,956,598	$51,705
Alameda	1,660,202	$43,872
Sacramento	1,529,501	$40,418
Contra Costa	1,149,363	$30,373
Fresno	1,007,229	$26,617
California Total	**39,809,693**	**$1,052,000**

The Department anticipates that the most likely outcome is that local government district attorneys will experience a workload increase similar to the Department. Specifically, better documentation from insurers upfront will lead to efficiencies in investigations, allowing for more cases to be worked with existing resources. However, not every case referred to a local district attorney makes it to court. As noted above, 30 percent of cases were closed for various reasons. As such the Department assumes that local governments will experience an increase in workload equivalent to about 70 percent of the total increase in hours estimated for the Department, or 14,400 hours (20,600 x 70%). At the median annual wage for Lawyers of $73.06, the increase in

workload is equivalent to a projected $1.1 million cost impact.[7] Table 7 projects which counties would have the largest cost impact, based on population.[8]

Results of the Economic Impact Assessment

Below is a summary of the results of the Economic Impact Assessment pursuant to Government Code sections 11346.3(b)(1)(A) through (D). A detailed analysis of the results follows.

A. The proposed regulations will likely have a minimal effect, a net gain of 2.4 jobs, on overall employment within the State of California. The regulation is expected to affect less than one ten-thousandth of a percent of the total nonfarm employment in California (i.e., 2.4 / 17,549,645 = 0.00001%).
B. Insurers are very large financial companies often operating in multiple states. Given that the average cost impact to an insurer is estimated to be $27,800 ($6.4 million / 230 firms[9]), and the average insurer has an estimated benefit of $19,100 ($4.4 million / 230 firms), it is not expected that the proposed regulation will have a significant impact on the creation of new businesses or the elimination of existing businesses in California.
C. Insurers are very large financial companies often operating in multiple states. Given that the average cost impact to an insurer is estimated to be $27,800 ($6.4 million / 230 firms), and the average insurer has an estimated benefit of $19,100 ($4.4 million / 230 firms), it is not anticipated that the proposed regulation will have an impact on the ability of businesses in California to expand. Additionally, the estimated net loss to total economic output of $12.2 million suggests that the regulation will have a very small impact on the California economy as a whole.
D. The proposed regulation will benefit the health and welfare of California's consumers and businesses. Streamlining the investigative process, eliminating incomplete SIU referrals, and recovering additional restitution payments will lead to a more efficient insurance market that can better serve consumers.

The Economic Impact on Jobs, Businesses, and the State Economy

The Department evaluated the potential changes in economic variables, including output and employment, which could result from the proposed regulation. Insurance industry employment and total output effects were assessed using the Regional Input-Output Modeling System (RIMS II) multipliers.[10]

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[7] California Employment Development Department Labor Market Information Division, Employment and Wages Data Table for the State of California in the First Quarter of 2018, Median Hourly Wage for "Lawyers" (SOC Code 25-1011), available online at http://www.labormarketinfo.edd.ca.gov/data/oes-employment-and-wages.html. Data accessed May 8, 2019.

[8] Department of Finance county population estimates, accessed on April 19, 2019: http://www.dof.ca.gov/Forecasting/Demographics/Estimates/E-1/documents/E-1_2018_InternetVersion.xls

[9] While provisions of this regulation may impact up to 700 insurance companies, subsidiaries, and third party administrators, many of the provisions are not likely to result in a measurable economic impact. In 2017, approximately 230 insurers referred SIU investigations to the Department. This is the subset of insurers who are most likely to experience cost impacts because of increased work on SIU investigations and the added five hour training requirement.

[10] U.S. Department of Commerce, Bureau of Economic Analysis: Table 1.5 Regional Input-Output Modeling System (RIMS II) Multipliers (2007/2016). RIMS II multipliers calculate how changes in economic activity result in

Creation or Elimination of Jobs within the State

The job impact estimates are based on aggregated data presented as full-time equivalents, not necessarily full-time jobs. There are three entities likely to experience job impacts. First, the job impacts for insurers were calculated using the RIMS II multipliers for insurance carriers. The RIMS II multiplier for insurers is a ratio of 8.6023 jobs lost throughout the economy for every one million dollars in added costs. The ratio multiplied by the estimated direct cost of the regulation ($6.4 million), equals the projected number of jobs lost, which is 55.1 (8.6023 x $6.4).

While standard RIMS modeling projects a loss of some insurance company jobs, there is an offset because the benefit is assumed to accrue to insurers where restitution is collected for fraudulent claims that were already paid out. The same RIMS multiplier of 8.6023 jobs for every one million dollars added was used to estimate the offsetting positive job impacts. Given the projected benefit of $4.4 million, the expected number of jobs gained would be 37.9 ($4.4 million x 8.6023). As a result, the regulation is projected to result in a net loss of 17.2 insurance industry jobs in California (37.9 – 55.1). However, this job impact projection could vary somewhat as most of the cost to insurers is expected to come in the form of hiring additional SIU investigative staff that may not be sufficiently captured by the RIMS multipliers.

As stated above, the Department estimated a workload increase of 20,600 hours. Using 1,778 hours for a person year results in the addition of 11.5 state government jobs. Likewise, adding an estimated 14,400 hours to the workload of local government district attorneys will result in the addition of the equivalent of 8.1 full-time jobs (14,400 / 1,778) throughout the state. Since the cost impacts on state and local governments are assumed to be the result of hiring additional employees, the use of RIMS multipliers was considered inappropriate for this part of the analysis. As a result, this analysis doesn't include any indirect or induced job gains resulting from the estimated additional state and local government jobs.

The proposed regulation is projected to result in a net increase of 2.4 jobs (11.5 + 8.1 -17.2) and have a minimal effect on total statewide employment. According to the California Department of Finance, the projected total nonfarm employment for 2020, when the regulation is likely to be effective, is 17.5 million.[11] When dividing the projected number of net jobs gained by the number of people employed in nonfarm jobs in California, the result is that the proposed regulations would not affect even one ten-thousandth of a percent of the total nonfarm employment in California (i.e., 2.4 / 17,549,645 = 0.00001%).

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new rounds of spending. For example, building a new road requires increased production of asphalt and concrete, causing an increase in mining. Workers who benefit from increased hours will spend more, perhaps by eating out or seeing a movie. RIMS estimates a new $1 million road creates 9.9 new jobs throughout the economy and increases output by $2 million. Similarly, a decrease in economic activity will lead to a decrease in jobs and total output.

[11] http://www.dof.ca.gov/Forecasting/Economics/Eco_Forecasts_Us_Ca/index.html. The Department of Finance economic forecast data was accessed on April 9, 2019.

Creation of New Businesses or the Elimination of Existing Businesses, and the Expansion of Businesses

To address Government Code sections 11346.3(b)(1)(B) and (C) and determine the effect of the proposed regulation on the creation of new businesses or the expansion of existing businesses within the state, the Department uses a broad approach. Factors affecting the creation and expansion of businesses are intertwined and very similar, so they are analyzed together.

The Department also calculated the effect of the regulation on California's economic output. Output measures the total market value, including the value of all intermediary goods and services, used in the production of a final good or service.

The RIMS II multiplier for output of 1.9129 represents a $1.91 million total economic impact (accounting for all direct, indirect, and induced costs/benefits) for every one million dollars of direct impact on insurers. Multiplying the direct cost of the regulation by the RIMS output multiplier results in an estimated loss to economic output of $12.2 million (1.9129 x $6.4 million). There is also an offsetting benefit to total economic output because of the estimated $4.4 million in direct benefits to insurers through additional restitution collected. Applying the RIMS output multiplier to the estimated direct benefit results in a gain to economic output of $8.4 million (1.9129 x $4.4 million), resulting in a net loss of $3.8 million ($8.4 - $12.2 million) to total economic output.

There is also the direct impacts on local government district attorneys and the Department to consider. RIMS only has one multiplier for "Other government enterprises", that adds $2.2191 million to output for every $1 million spent. Adding the $1.1 million spent by local government district attorneys to the $2.7 million initially spent by the Department results in the total first year cost to state and local governments due to the regulation. Then multiplying the cost to government by the RIMS output multiplier for other government enterprises results in an estimated loss to economic output of $8.4 million (2.2191 x $3.8 million). As a result, the regulation is anticipated to result in a net loss to output of $12.2 million in the first year.

The calculated impact on total output represents a very small share of California's total output. There are also only a small number of relatively large businesses that are expected to be directly impacted by this regulation, this suggests that the regulation will have very little impact on insurers and the California economy as a whole. The regulation is not likely to lead to a measurable impact on the creation or elimination of existing businesses, or the ability of existing businesses to expand.

Health and Welfare Effects, the Impact on Worker Safety and Environmental Effects

The Department also assessed whether, and to what extent, the proposed regulation affects the other criteria set forth in Government Code sections 11346.3(b)(1)(D).

Worker Safety and Environmental Effects

Compliance with the proposed regulation does not change the job responsibilities of employees in the affected industries in a way that would impact their safety. Thus, the proposed regulation will neither increase nor decrease worker safety. The Department also concludes that there will be no measurable effect on the state's environment.

Health and Welfare Effects

The proposed regulation will benefit the health and welfare of California's consumers and businesses. Gaining efficiency in the investigative process and eliminating or recovering fraudulent claims payments is expected to lead to reduced fraud and an insurance market that can better serve consumers.

Adverse Impact on Small Business

The proposed regulation will have a minimal adverse direct impact on insurers as discussed in the foregoing analysis, but by law they are not considered small businesses (Government Code § 11342.610(b)(2)).

Analysis of Alternatives to the Proposed Regulation

Alternative 1: Require 16 hours of anti-fraud training for SIU personnel, annually.

The Department considered requiring insurers to provide 16 hours of anti-fraud training for SIU personnel, annually. This alternative was considered because 16 hours is used as a requirement for other programs in the Department and requiring 16 hours of anti-fraud training would ensure that all SIU personnel would be superbly trained.

Reasons for rejecting Alternative #1

There were already five training categories specified in the regulation that insurers were required to cover. The Department believes that these categories are nearly sufficient to ensure that SIU personnel remain well trained. Additionally, those topics are already covered in SIU roundtable meetings hosted by the Department. It was determined that even though 16 hours was a standard for training in other areas of the Department, it was excessive for SIU personnel when compared to what other states require. This alternative would have imposed additional costs on insurers, without providing any additional benefits.

Alternative 2: Require the insurer SIU to complete its investigation prior to the time the referral is made to Fraud Division.

The Department considered requiring insurers to complete their investigation prior to submitting the referral to Fraud Division. This alternative was meant to stop the Department from receiving inadequate referrals resulting from incomplete investigations.

Reasons for rejecting Alternative #2

Feedback provided to the Department at the prenotice public discussion indicated that this was not feasible. The statute dictates the time frame for when fraud referrals must be made to the Department. While it is imperative to complete a substantial portion of the investigation and establish a reasonable belief fraud has occurred, the Department concurs that it is not always possible to complete the entire investigation prior to making the referral to Fraud Division. This alternative would have imposed additional costs on insurers.

Alternative 3: Specify that information submitted in fraud referrals to the Department be unredacted.

The Department considered specifying that information submitted pursuant to section 2698.34(b) must be unredacted. In some instances, the Department received fraud referrals that redacted relevant information. This alternative was meant to ensure that the Department would receive all relevant information and prevent insurers from submitting heavily-redacted documents that could hide potentially relevant facts.

Reasons for rejecting Alternative #3

This alternative was rejected because it duplicates existing law; Insurance Code section 1873 already requires insurers to release information requested by the Department in full and does not permit redactions. Insurance Code section 1873.1 requires that the information in fraud referrals provided to the Department shall not be a part of any public record until the time its release is required in connection with a criminal or civil proceeding. Since the content of this alternative is already adequately covered by current law it was not expected to result in any additional costs, or provide any additional benefits.

ANALYSIS OF ALTERNATIVES TO THE PROPOSED REGULATION

Alternative 1: Require 16 hours of anti-fraud training for SIU personnel, annually.
The Department considered requiring insurers to provide 16 hours of anti-fraud training for SIU personnel, annually. This alternative was considered because 16 hours is used as a requirement for other programs in the Department, and requiring 16 hours of anti-fraud training would ensure that SIU personnel would be superbly trained.

Reasons for rejecting Alternative #1

There were already five training categories specified in the regulation that insurers were required to cover. The Department believes that these categories are nearly sufficient to ensure that SIU personnel remain well trained. Additionally, those topics are already covered in SIU roundtable meetings hosted by the Department. It was determined that even though 16 hours was a standard for training in other areas of the Department, it was excessive for SIU personnel when compared to what other states require. This alternative would have imposed additional costs on insurers.

Alternative 2: Require the insurer SIU to complete its investigation prior to the time the referral is made to Fraud Division.

The Department considered requiring an insurer to complete its investigation prior to submitting the referral to Fraud Division. The purpose of this alternative would be to stop insurers from submitting inadequate referrals resulting from incomplete investigations.

Reasons for rejecting Alternative #2

Feedback provided to the Department at the pre-notice public discussion indicated that this alternative was not feasible. The statute dictates the time frame for when fraud referrals must be made to the Department. While it is imperative to complete a substantial portion of the investigation and establish a reasonable belief fraud has occurred, the Department concurs that it may not be possible to complete the entire investigation prior to making the referral to Fraud Division. This alternative would have imposed additional costs on insurers.

Alternative 3: Require information released pursuant to section 2698.34(b) to be unredacted.

The Department considered specifying that information submitted pursuant to section 2698.34(b) must be unredacted. In some instances, the Department has received fraud referrals that redacted relevant information. This alternative was meant to ensure that the Department would receive all relevant information and prevent insurers from submitting heavily-redacted documents that could hide potentially relevant facts.

Reasons for rejecting Alternative #3

This alternative was rejected because it duplicates existing law; Insurance Code section 1873 already requires insurers to release information requested by the Department in full and does not permit redactions. Insurance Code section 1873.1 requires that the information in fraud referrals provided to the Department shall not be a part of any public record until the time its release is required in connection with a criminal or civil proceeding. Since the content of this alternative is already adequately covered by current law, it was not expected to result in any additional costs or provide any additional benefits.

IDENTIFICATION OF STUDIES, REPORTS, DOCUMENTS

- 2016 Annual Report of the Commissioner (California Department of Insurance)
- 2017 Annual Report of the Commissioner (California Department of Insurance)
- Occupational Employment & Wage Data (California Employment Development Department)
- Population Estimates for Cities, Counties, and State (California Department of Finance)
- California Economic Forecast (California Department of Finance)
- RIMS Multipliers

SPECIFIC ACTIONS AND PROCEDURES PRESCRIBED

Performance standards were considered but were rejected as inappropriate for regulations that are designed to improve the minimum standard of insurer SIU fraud referrals. The proposed regulation prescribes specific actions and procedures. For instance, the regulation requires the SIU to establish, maintain, distribute, and adhere to specified procedures for the investigation of suspected insurance fraud, and to investigate each credible referral of suspected insurance fraud that it receives from the insurer's integral anti-fraud personnel. The Department considered a performance standard in the form of an alternative rule that would allow an insurer to refrain from reporting a certain number, or a certain percentage, of instances of suspected insurance fraud, each year, as long as all other instances were properly referred to the Department. However, this approach was rejected because it would fail of the Consistency Standard of the Administrative Procedure Act. The Insurance Code requires insurers to refer to the Department each instance of suspected insurance fraud in connection with which the insurer forms a reasonable belief that a fraudulent claim is being made or, in cases of workers' compensation insurance, the insurer forms a reasonable belief as to the identity of a person or entity the insurer has reason to believe has committed fraud. (Ins. Code §§ 1872.4(a); 1877.3(b)(1).) Thus, a standard that would accept any level of performance short of full compliance with the Insurance Code would be untenable in the area of insurance fraud reporting. The Insurance Code requires insurers to report suspected insurance fraud whenever the reasonable belief standard is met, and the commissioner cannot, by rule or otherwise, legally waive this requirement to any degree. "The commissioner shall require from every insurer a full compliance with all the provisions of this Code." (Ins. Code § 12926.)

PRE-NOTICE DISCUSSIONS

The Commissioner conducted prenotice public discussions pursuant to Government Code section 11346.45(a) on March 20, 2019. Interested and affected parties were given an opportunity to present statements or comments with respect to the proposed amendments. The Commissioner considered these statements and comments in drafting the proposed amendments.