A Report by the

MONEY SERVICE BUSINESS FACILITATED-WORKERS' COMPENSATION FRAUD WORK GROUP

A collaboration between the Department of Financial Services, the Florida Attorney General's Office of Statewide Prosecution, the Office of Financial Regulation, the Office of Insurance Regulation, and industry stakeholders

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EXECUTIVE SUMMARY

Workers' compensation premium fraud is a serious problem facing the state of Florida. The effects of this fraud can be felt by every business and its costs are distributed throughout the system in the form of higher insurance rates to all Florida businesses. While workers' compensation fraud can take various shapes, this report is dedicated to a new and highly organized form of premium fraud which employs the use of a check cashing business to cash large checks and to make payments to the workers of uninsured subcontractors. This type of fraud is most prevalent in the construction industry where a high percentage of the labor force is transient. The costs to the system for this type of fraud include unreported payroll taxes, unreported premium taxes, and higher costs to insurance carriers who must process workers' compensation claims from uninsured workers. It is estimated that the costs of this type of fraud could cost the state upwards of $1 billion annually, and places tremendous pressure on law-abiding businesses to absorb the costs of premium avoidance.

In early 2008, the Attorney General impaneled the Eighteenth Statewide Grand Jury (Grand Jury) to look into this issue and other organized criminal enterprises. In March 2008, it published the Second Interim Report of the Statewide Grand Jury entitled "Check Cashers: A Call for Enforcement." During the legislative session in 2008, the Legislature took up and enacted many of the recommendations of the Grand Jury. While these reforms were positive, the legislation unfortunately did not cure the problem of facilitators creating shell companies to purchase and "rent" certificates of insurance to uninsured contractors.

At a Cabinet meeting on August 2, 2011, CFO Jeff Atwater announced his intention to convene a work group to study this issue and make additional recommendations for consideration. Subsequently, the Money Service Business Facilitated – Workers' Compensation Work Group (Work Group) was formed, and comprised representatives from the Department of Financial Services, the Office of the Attorney General, the Office of Financial Regulation, the Office of Insurance Regulation, and varied industry stakeholders.

The Work Group convened four times over a two-month period to analyze this fraud scheme and develop comprehensive reforms. The objectives of the recommendations contained in this report are to enhance the tools available to regulators, law enforcement, and prosecutors in order to more effectively detect, identify and prosecute all parties involved in this type of fraud.

BACKGROUND

Workers' compensation premium fraud is not a new phenomenon in Florida; however, the chosen methods to accomplish this fraud have changed over time. In the past, unscrupulous business owners who wanted to avoid paying lawful premiums did so by either under-reporting payroll or misclassifying employees. While this type of fraud still occurs, a much larger and more organized scheme has emerged which endangers the workers' compensation insurance market and its affected industries.

This new scheme is most commonly found in the construction industry. The individuals perpetrating this scheme are "facilitators" in the sense that they create fake or "shell" companies with no real business operations, labor force, or physical location other than a post office box. Typically, the shell companies use generic names so as not to reveal the type of construction work actually being conducted, which is a critical element to their success.

Facilitators incorporate a shell company usually by using the online incorporation process offered by the Florida Department of State's Division of Corporations. This allows facilitators to unilaterally name the company, as well as its owner and registered agent, without any review or verification process. The facilitator's name will rarely, if ever, be associated with the company, but rather a "nominee" owner, or in many cases, a completely fictitious owner is used. In either case, this person will almost never be located once the scheme is in place, allowing facilitators to use the company for illegal purposes without detection.

Once the operation is active, the facilitator will turn to an insurance agent to obtain a minimal workers' compensation insurance policy. Only sometimes is the insurance agent directly involved and aware of the purpose for setting up the company and obtaining an insurance policy. Often, the agent is duped by the facilitator, who will accompany the nominee owner to the insurance agency and explain that he/she is helping the owner start a company and that the facilitator, and not the owner, will handle much of the paperwork and any required servicing of the policy. There have been instances where facilitators are actually able to get blank insurance policy applications and return them after completing, signing, and notarizing the form.

The insurance application will usually describe the business as a small, two to four person company conducting a low-risk trade, such as drywall installation, brick paver installation, or carpentry work. The insurance agent will then obtain a workers' compensation policy for the shell company, and generate a premium amount. The down payment is usually made in cash at the time of application, and a post office box is routinely given as the address for later bills. The payment of the minimal premium is an investment for the facilitator of the scheme, which can pay off tenfold if the fraud is executed according to plan.

With a registered corporation and an insurance policy, the facilitator will begin to advertise his fraudulent scheme. His marketing strategy will be to let uninsured subcontractors use the newly formed company—for a fee. These uninsured subcontractors are either unwilling, or simply unable, to obtain a real workers' compensation insurance policy that actually covers their employees. Many of these subcontractors who are renting the workers' compensation insurance certificates in fact do so because they are using undocumented laborers. This enables the subcontractor to underbid legitimate subcontractors who are using documented laborers, paying higher wages, purchasing insurance, and paying the required federal and state taxes. Moreover, because these laborers are undocumented, they are less likely to complain to authorities, or at trial will usually be unavailable to testify, either because they cannot be located within the United States because their identities are not known or because they have either voluntarily returned to their

home countries or been deported. However, utilizing the facilitator's shell company will allow an uninsured subcontractor to appear to have coverage when asking general contractors for work. When a general contractor asks for the name of the uninsured subcontractor's company and its insurance policy, the uninsured subcontractor will use the shell company name, and provide the workers' compensation insurance policy's certificate of insurance, which does not include how many employees or what operations the policy actually covers.

Once the uninsured subcontractor completes work under the guise of the shell company, payment will be made to him/her from the general contractor via company check made payable to the shell company. The check cannot be cashed at a bank because most banks will not cash a check made payable to a business or third party, but rather will require that the check be deposited into the payee's bank account. However, money service businesses will allow the cashing of the third-party business-to-business checks by certain "authorized" persons allegedly related to the payee. These "authorized" persons are the facilitator and others designated by the facilitator. Many times, these people have been introduced to the money service business' employees in advance, and limited powers of attorney listing these "authorized" persons are found in the "Know Your Customer" files of the money service business' records.

When checks made payable to the shell company are negotiated at the money service business, two fees are taken out. One, usually between 1.5 percent and 2.0 percent, is taken out for the money service business owner as the fee for cashing the check. The second fee, usually between 6 percent and 8 percent, is taken out for the facilitator as the fee for the use of the shell company name and, more importantly, the workers' compensation insurance policy. The balance of the check is then returned to the uninsured subcontractor, posing as the shell company, in cash.

None of the monies paid are reported to the shell company's insurance carrier, nor are any of the payments considered payroll exposure by the general contractor's insurance carrier. Those perpetrating this fraud do everything in their power to make the transactions appear legitimate on paper. The result, however, is that no workers' compensation premiums are assessed; premium is avoided and workers go without coverage.

The facilitator will duplicate this fraud by soliciting as many uninsured subcontractors as possible, taking a fee for each. Having a generic shell company name assists greatly in this regard, as it helps to avoid detection. Fraud investigators have identified several instances where one shell company name has, in any given week, been used dozens—and maybe hundreds—of times. For example, one shell company alone accounted for $27 million worth of checks in excess of $10,000 over a four-year period.

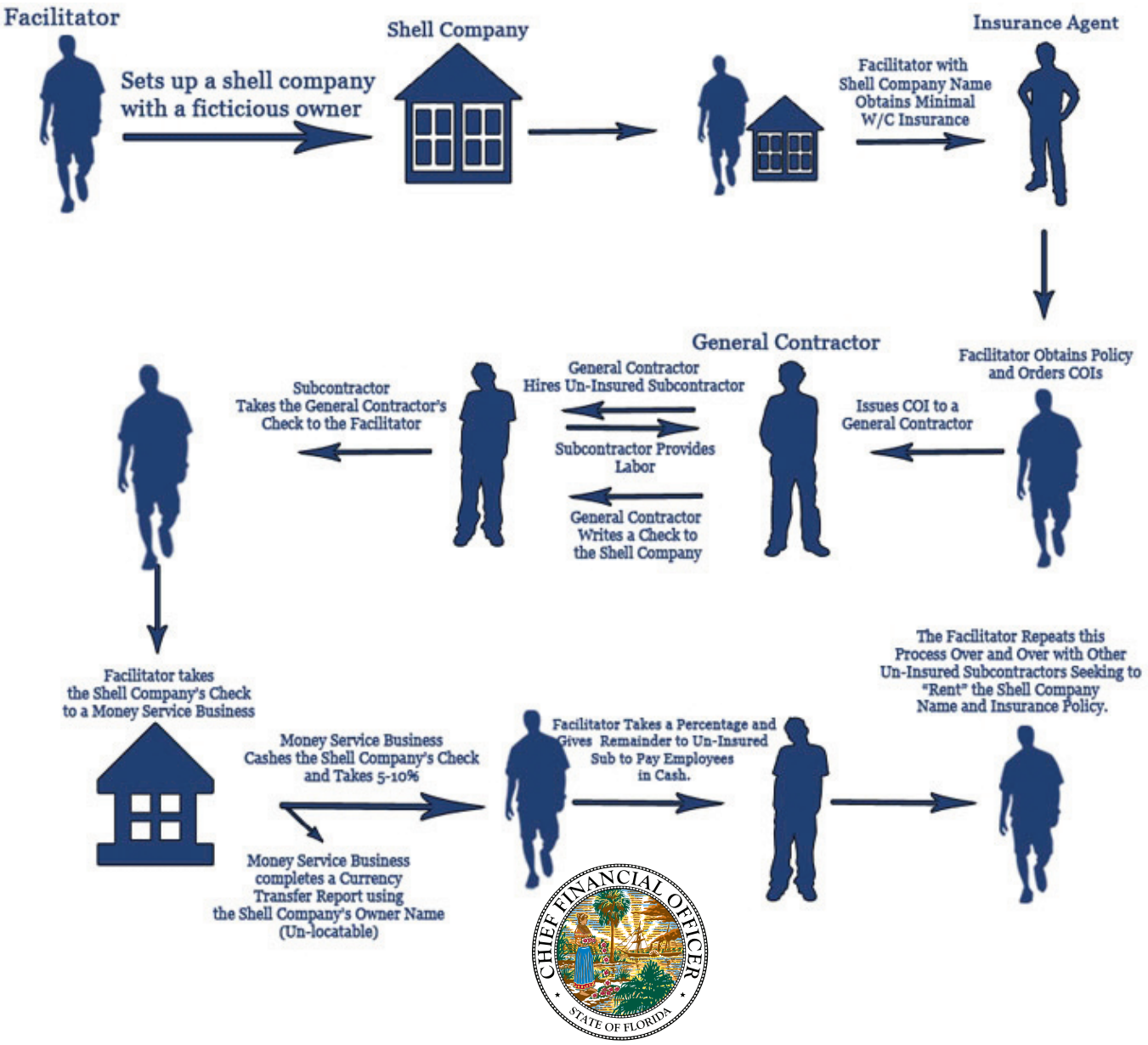
This fraud is particularly financially beneficial for higher risk trades, since workers' compensation premiums are assessed based on a hybrid analysis of employees and the risk level of the work performed. Because higher risk trades are charged higher premiums, the savings can be significant. Further, other overhead can be avoided. For example, a moderate construction industry class code rate is around 20 percent per $100 of payroll, and state and federal payroll taxes are approximately an additional 10 percent. By avoiding these costs and only paying approximately 8 percent to 10 percent in fees to the facilitator and money service business, the fraud offers the uninsured subcontractor a fairly substantial pecuniary benefit.

Some money service businesses are at least tacitly aware of the fraud and their role in its success. Complicit money service businesses falsify required documents regarding the true identity of those persons authorized to conduct the transactions. To do this, they will complete Currency Transaction Reports (CTRs) for transactions in excess of $10,000 in the name of the nominee owner of the company, rather than the facilitator, to protect the latter's identity.

In the end, when a worker employed by an uninsured subcontractor is injured on the job, there is no insurance in effect to cover the cost of his/her injuries. The facilitator instructs those "renting" (i.e. the uninsured subcontractors) his or her certificate of insurance that minor injuries are to be paid for by the uninsured subcontractor, as reporting them to the shell company insurance carrier would reveal that there are other, unreported employees working under the shell company name. Catastrophic injuries cannot be covered by the renter, and when this occurs, the general contractor holds up the certificate of insurance in the name of the shell company and states that the injured worker is an employee of a subcontractor (shell

company). The shell company's insurance carrier, while it may try to defend the claim, will ultimately start processing the claim, because workers' compensation insurance policies do not cover any one specific person, rather, they cover a company's labor force. After further investigation, the insurer may subrogate the claim between the insurance carrier of the shell company and the insurance carrier of the general contractor, depending on where the more clearly defined employer/employee relationship existed. Nonetheless, one carrier may end up paying a claim for a person for whom it has never collected a premium.

Sometimes, the facilitators "burn" one shell company to start a new one, leaving the insurance carrier, and anyone else for that matter, looking for the nominee owner to attempt an audit or get other information about the company and its activities. In many cases, the facilitator simply walks away. In other instances, the facilitator will actually agree to an audit each year by the shell company's insurance carrier, but will create a separate set of books which reflects the same, small, two to four person company, which was described on the application. That will generate a small premium, which the facilitator will pay as an investment in the viability of the scheme. The fraudulent scheme bypasses detection during the audit because the large business-to-business checks, covering thousands—or millions—in labor expense, will never be seen by the insurance carrier, as they are cashed at the money service business, cleared through the money service business bank account, and returned to the subcontractor for his/her "cash" payroll payments to his/her employees.



PAST REFORM EFFORTS

In early 2008, the Attorney General impaneled the Eighteenth Statewide Grand Jury. In March 2008, it published the Second Interim Report of the Statewide Grand Jury entitled "Check Cashers: A Call for Enforcement." The report described this type of workers' compensation premium fraud in detail, and recommended the following solutions to combat insurance fraud and other problems:

Recommendations for the Florida Legislature:

1. Authorize new examiner positions or support personnel or both for Money Transmitter Regulatory Unit (MTRU).
2. Grant MTRU whatever additional authority it requires to utilize 3rd party examiners under 560.118(c), F.S.
3. Authorize MTRU to utilize existing trust funds for increased training for examiners, particularly for forensic training and detection of criminal activity.
4. Cap commercial transactions at a reasonable level.
5. Require photographs of customer, identification and check at time of transaction for all transactions over $5,000.
6. Prohibit under any circumstance the cashing of Medicaid or Medicare checks payable to providers.
7. Require check cashers to establish bank accounts dedicated solely for check cashing functions to ease audit process.
8. Require all checks cashed by check cashers to be deposited into their own bank account.
9. Require licensees to submit Suspicious Activity Reports (SARs).
10. Require licensees to pay actual costs for MTRU exams.
11. Require records to be retained by both MTRU and licensees for 5 years.
12. Amend Chapter 560, F.S., to grant MTRU authority to immediately suspend any licensee that fails to have sufficient records at the time of the exam until that licensee provides such records to MTRU.
13. Require registrations of MSBs to be renewed yearly.
14. Require MTRU to refer possible or suspected criminal activity to appropriate law enforcement agencies in writing.
15. Make such criminal referrals confidential and exempt from the public records law.
16. Require MTRU examiners to independently report suspicious activity directly to law enforcement in writing.
17. Require appropriate security measures for check cashers akin to those found in Florida's Convenience Store Security Act including, at a minimum, security cameras to deter and help solve robberies.
18. Direct DHSMV to undertake a feasibility study of creating an online system for verifying validity of Florida's driver licenses as is done with credit cards.

Recommendations for the Office of Financial Regulation's Money Transmitter Regulatory Unit:

1. Enforce the provisions Chapter 560, F.S., fully.
2. Require licensees to implement approved software programs for check cashing functions to streamline and standardize audit process.
3. Require licensees with multiple locations to network their databases to detect attempts at structuring by their customers and to facilitate MTRU exams.
4. Solicit input from examiners on potential resolutions/penalties including amending exam report to have a section for such input.
5. Utilize third-party contractors for examinations as provided for in s. 560.118(c), F.S.
6. Hire clerical support to free up examiners to do more field examinations.
7. Provide funds for continuing examiner education especially for forensic examinations and the detection of criminal activity. For the latter, take advantage of training opportunities provided by other state agencies such as Division of Insurance

Fraud, Medicaid Fraud Control and Department of Law Enforcement.

8. Promulgate rules detailing additional due diligence required by check cashers to verify identities of their corporate customers commensurate with their check cashing volume including: Copies of articles of incorporation, Verifying incorporation online and updating quarterly, Verifying FEIN, Requiring at least two forms of identification, including one government issued photo ID, business or banking references, site visit or some other verification of customers' corporate existence.
9. Create a standard table of fines for all violations of code.
10. Require check cashers to establish bank account dedicated solely for check cashing functions.
11. Require check cashers to deposit checks in their bank account within 1 business day.
12. Require applicants to have an Anti-Money Laundering program and Bank Secrecy Act manual in place and approved by the agency before issuing a license.
13. Examine all new licensees between 3-6 months after issuance of license.
14. Send 15 day advance notice of exam by certified mail. If the legislature grants authority, include warning that failure to have complete records may result in immediate suspension of license.
15. Schedule follow-up exams for specified infractions of the code between 3-6 months after initial examination.
16. Guidance letters should not be issued without a written policy in place. That policy should emphasize that Guidance Letters should only be issued for the most minor violations and should never be used where violations concerning CTRs' failure to maintain adequate records, or failure to have an effective AML program in place is found.
17. Examinations should be completed and approved in a more timely fashion.
18. Reduce the amount of time Area Financial Managers (AFMs) spend duplicating examiners efforts and require AFMs to approve examination reports in a more timely fashion.
19. Examinations should be tracked from beginning to end and goals for completion should be set for both examiners and AFMs.
20. Make criminal referrals in writing, and track such referrals for annual reporting.

Recommendations for the Division of Insurance Fraud:

1. Require Certificates of Insurance to be issued by insurance companies only, not agents.
2. Require Certificates of Insurance to indicate on their face, in some manner, the amount of coverage purchased.
3. Require contractors relying on Certificates of Insurance provided by subcontractors to verify validity and coverage amounts with the carrier.

Many of these recommendations were incorporated into 2008 legislation, CS/CS/SB 2158 (Ch. 2008-177, LOF). The provisions in that bill were as follows:

General Provisions

- Authorized the Office of Financial Regulation (Office) to immediately suspend a license if a licensee fails to provide requested records pursuant to a written request of the Office.
- Required an applicant to establish an anti-money laundering program as a condition of licensure, which a licensee must maintain and update, as necessary, in accordance with federal regulations. Also, required an applicant to be registered with FinCEN, if applicable.
- Expanded prohibited acts to include violations under 18 U.S.C. section 1957, which pertains to engaging in monetary transactions in property derived from specified unlawful activity. This violation is punishable as a third-degree felony.
- Required an examination of new licensees within the first six months after licensure and requires existing licensees to be examined at least once every five years. Previously, there was no statutorily mandated examination schedule.
- Required licensees to incur the cost of an examination. License and renewal fees were reduced by 25 percent to offset the cost of examinations. License application fees to registered branches/vendors when a change in controlling interest occurs are capped at $20,000.
- Required the Financial Services Commission to adopt by rule disciplinary guidelines applicable to each ground for disciplinary action that may be imposed by the Office.

- Increased the record retention for licensees and the Office from three to five years. The federal Bank Secrecy Act (BSA) requires MSBs registered with the federal government to retain records for five years. Generally, the statute of limitations for financial crimes is five years.
- Authorized the Office to seek restitution on behalf of customers and allows the Office to request the appointment of a receiver.
- Required the Office to make referrals of violations of law that may be a felony to the appropriate criminal investigatory agency having jurisdiction.
- Required the Office to submit an annual report to the Legislature summarizing its activities relating to the regulation of Chapter 560, F.S., entities, including examinations, investigations, referrals and the disposition of such referrals.

Money Transmitter Provisions

- Increased the maximum net worth requirements for a licensee from $500,000 to $2 million. The net worth requirements per location was reduced from $50,000 to $10,000. Net worth requirements had not been adjusted since 1994.
- Increased bonding requirements by raising the cap from $500,000 to $2 million. The amount of the bond will be based on the financial condition, locations, and volume of business. Bonding requirements had not been adjusted since 1994.
- Required all licensees to submit annual financial audit reports, which are used to determine whether net worth and other safety and soundness requirements are met. (Generally, a part II licensee is required to submit annual, audited financial statements unless it is exempt pursuant to s. 560.118(2)(a), F.S. The prior exemption, which was eliminated under the legislation, applied to licensees with 50 or fewer employees and agents and licensees with less than $200,000 in transactions.)
- Required a licensee to place customer assets in a segregated account in a federally insured financial depository institution and maintain separate accounts for operating capital and the clearing of customer funds. The bill required that transmitted funds must be available to the designated recipient within 10 business days after receipt.
- Required certain information to be contained in the licensee's written contract with an authorized agent. These items include the scope and nature of the relationship and responsibilities of the agent. The agent is required to: report to the licensee the theft or loss of currency for a transmission or payment instrument; remit all amounts owed to the licensee for all transmissions accepted and payment instruments sold pursuant to the contractual agreement; consent to an examination or investigation by the Office; hold in trust such money until the time the money is forwarded to the licensee; and adhere to state and federal laws and regulations pertaining to a money services business. The licensee is required to develop and implement written policies and procedures to monitor compliance with applicable state and federal laws by its authorized agents.

Check Casher Provisions

- Required check cashers subject to licensure to submit suspicious activity reports (SARs) to the federal government, if applicable. Previously, check cashers could, but were not required to, submit SARs under federal MSB laws and regulations. There was no requirement under state law for check cashers to file SARs.
- Required check cashers to obtain from its customers acceptable identification, along with a thumbprint, for checks greater than $1,000. Previously, s. 560.309, F.S., allowed a licensee to charge a higher fee if the customer did not provide proof of identification. The bill eliminated the ability of a check casher to charge a higher fee if the customer presenting the check does not provide identification. The federal BSA requires check cashers and other MSBs to verify the identity of their customers. Previously, a check casher could charge up to 5 percent of the face amount of a payment instrument, or 6 percent without the provision of an identification or $5, whichever is greater, if such payment instrument is not the payment of any kind of state public assistance or federal social security benefit payable to the bearer of the payment instrument. For such state or federal payments, the fees are capped at 3 and 4 percent, respectively.

- Required check cashers to maintain copies of the identification and thumbprint for five years.
- Required check cashers to maintain detailed customer files on corporate entities cashing checks exceeding $1,000. This enhanced due diligence assisted the industry in making sure that checks cashed can be traced back to their source, and that the check casher will have records available to law enforcement similar to the records maintained on corporate accounts by traditional financial institutions such as banks.
- Required check cashers to maintain an electronic payment instrument log for checks cashed over $1,000.
- Upon acceptance of a payment instrument that is cashed by the licensee, the payment instrument must be endorsed using the legal name under which the licensee is licensed. Also, a licensee is required to deposit or sell payment instruments within 5 business days after acceptance of the payment instrument.
- Revised the check cashing exemption, which is referred to as the "incidental retail business exemption." The legislation imposed an additional requirement, which provides that in order to qualify for the exemption, the person must not engage in a check cashing transaction that exceeds $2,000 per person per day.
- Required check cashers to be equipped with a security camera system that is capable of recording and retrieving an image in order to assist in identifying and apprehending offenders. The licensee does not have to install a security camera system if the licensee has installed a bulletproof or bullet-resistant partition or enclosure in the area where checks are cashed.

Deferred Presentment Provider Transactions ("Payday Loans")

- Required a deferred presentment provider (DPP) to notify the Office within 15 business days after ceasing operations. Pursuant to s. 560.404, F.S., the Office maintains a database of deferred presentment transactions to ensure that consumers do not have more than one outstanding transaction at any time. The DPP is required to enter certain data regarding a transaction and verify whether any open deferred presentment transactions exist for a particular person. The Office had encountered problems in which the vendor has ceased operations and has failed to reconcile open transactions in the database. The bill authorized the Financial Services Commission to adopt rules regarding the reconciliation of open transactions. If the DPP does not comply with the notice requirement, the Office is authorized to take administrative action to release all open and pending transactions in the database after the Office becomes aware of the closure.

While these reforms were positive in many regards, the legislation unfortunately did not cure the problem of facilitators creating shell companies to purchase and "rent" certificates of insurance to uninsured contractors. This work group, comprising of various and diverse stakeholders, has focused its attention on this distinct problem to evaluate current tools for enforcement and make recommendations for improvement.

WORK GROUP STAKEHOLDERS

Money service business-facilitated workers' compensation fraud affects various governmental agencies, businesses, and other organizations. Below is a representative list of entities participating in the Work Group:

- Department of Financial Services' Division of Insurance Fraud, Division of Workers' Compensation, and Division of Insurance Agents and Agency Services
- Office of the Florida Insurance Consumer Advocate
- Office of Financial Regulation
- Attorney General's Office of the Statewide Prosecutor
- Office of Insurance Regulation
- Department of State's Division of Corporations
- Broward County Sheriff's Office
- Florida Carpenters Council
- Florida Home Builders Association
- Associated Builders & Contractors
- Florida Roofing & Sheet Metal Association
- United Brotherhood of Carpenters and Joiners of America
- Powertech Interiors
- Financial Service Centers of America
- AmScot
- Dollar Financial
- Florida Chamber of Commerce
- Associated Industries of Florida
- Florida United Businesses Association
- National Federation of Independent Businesses
- National Council on Compensation Insurance
- Bridgefield Employers Insurance Company
- FCCI Insurance Company
- Zenith Insurance Company
- FFVA Mutual Insurance Company
- Twin City Fire Insurance Company
- Contego Group
- Florida Association of Insurance Agents
- Professional Insurance Agents of Florida
- Florida Retail Federation
- Publix Supermarkets
- Walmart
- Summit Holdings

RECOMMENDATIONS AND ANALYSIS

Recommendation **– Implement a statewide, real-time database for check cashing transactions above $1,000. In the alternative, provide the Office with the ability to collect specified information on a regular basis.**

Expected Outcome **- Improve the flow of information regarding commercial/ third-party checks between check cashers, the Office of Financial Regulation, the Division of Workers' Compensation and the Division of Insurance Fraud.**

Corporate payment instruments are defined by R. 69V-560.704, F.A.C., as "payment instrument[s] on which the payee named on the face of the payment instrument is not a natural person." Similarly, the rule defines third party payment instruments as "...instrument[s] being negotiated by a party other than the payee named on the face of the payment instrument."

Check casher licensees are statutorily required to keep customer files for those who cash corporate or third-party instruments exceeding $1,000. These files must contain a copy of the customer's personal identification and a thumbprint taken by the licensee. Licensees must also keep payment logs, and maintain all books, account, documents, files, and other information for at least 5 years.

By rule, licensees are also required to affix customer thumbprints to the original of each payment instrument exceeding $1,000, as well as secure and maintain a copy of the original payment instrument, a copy of the customer's personal identification presented at the time of acceptance, and maintain customer files for those cashing corporate and third party payment instruments, which includes documentation from the Secretary of State verifying the corporate registration, Articles of Incorporation, information from DFS' Compliance Proof of Coverage Query Page, and documentation of those authorized to negotiate payment instruments on the corporation of fictitious entity's behalf. Customer files must be updated annually.

Further, Florida rule requires that for payment instruments of $1,000 or more, the check casher shall create and maintain an electronic log of payment instruments accepted, which includes, at a minimum, the following information:

- Transaction date,
- Payor name,
- Payee name,
- Conductor name, if other than the payee,
- Amount of payment instrument,
- Amount of currency provided,
- Type of payment instrument (personal, payroll, government, corporate, third-party, or other),
- Fee charged for the cashing of the payment instrument,
- Branch/location where instrument was accepted,
- Identification type presented by customer, and
- Identification number presented by customer.

This electronic information must be maintained in an electronic format that is "readily retrievable and capable of being exported to most widely available software applications including Microsoft EXCEL." The maintenance of this information was intended to be used in the audit process. While this can be useful, it does not utilize the information in the most proactive

manner. This information, if received and maintained in a "real time" format, could be used to actively identify the perpetrators of the type of workers' compensation fraud addressed by this report.

The Work Group concluded that the efficient and timely flow of information is crucial to the detection of this particular fraud scheme. The shell corporations used as vehicles to commit workers' compensation fraud are only used for a limited time with the perpetrators of this fraud replacing them on a routine schedule. The limited lifecycle of these shell companies keeps the criminals one step ahead of regulators and law enforcement. Routine examinations conducted by the Office show clear data patterns indicative of this type of fraud, but these examinations are generally a forensic look at a single licensee's compliance over the previous year. In this time period, numerous shell companies may be employed and discarded by the facilitators of this scheme and each successive entity may have different nominee owners. Additionally, perpetrators of this scheme may be cashing payment instruments for the same shell company with multiple check cashing licensees to avoid detection by regulators and law enforcement.

A real-time database programmed to collect specified data for checks over $1,000 could be an effective fraud detection tool. Moreover, the Division of Workers' Compensation and the Office of Financial Regulation could work together to develop and implement a data interface between the new check cashing database and existing DFS "Proof of Coverage" database. The information reported by check cashers would include the amount of the check, the entity's workers' compensation policy number and other required information.

This information would be transmitted in real-time to the Office, which through the data interface would instantly be available to the Division of Worker's Compensation. The Division would then match the check amounts, and volume, with the amount of payroll reported to the insurer. This way, if $50,000 worth of checks were cashed by a corporation who has only reported $10,000 in payroll, the Division of Workers'Compensation's Bureau of Compliance would be alerted to investigate, and thus make a compliance visit. Upon detection of a premium avoidance scheme, that investigator would then make a referral to the Division of Insurance Fraud for criminal investigation. This information would then be able to be compared to estimated payroll reported on a policy in order to identify potential premium avoidance schemes almost immediately.

Further, the money service business could also be alerted of any inconsistency, so that the check can be refused at presentment. This information could also be shared with the insurer, which could then initiate an audit or cancel a policy for underwriting inconsistencies. Such a cancellation would be timely reflected on the Proof of Coverage Web site, and would then be reflected as cancelled for future inquiries made to the Proof of Coverage database, which would serve to render that shell company useless statewide for the criminal purpose of committing workers' compensation fraud.

If a real-time database and interface is not possible, then the Office should be given statutory authority to collect similar information on a recurring basis. This will at least enable regulators to detect inconsistencies and illegalities more quickly, so that a referral to law enforcement, when appropriate, can be made. Given that the information is currently in EXCEL, or another easily viewable format, the Legislature could statutorily require that information to be uploaded or exported via encrypted or secure transmission methods to regulators daily or weekly. The Office could share this information with the Division of Insurance Fraud, and/or the Division of Workers' Compensation, which could then aggregate the information and build a program designed to detect similar names or other irregularities that could signal potential fraud.

It is important to note that members of the check cashing industry have also suggested allowing money service businesses to charge a small transaction fee to help cover the costs of collecting this information, if necessary.

Recommendation - DFS' Division of Workers' Compensation should include payroll information on Proof of Coverage Web site.

Expected Outcome – All parties who have a need for this information to make sound business decisions will have the ability to check the database.

Currently, the Division of Workers' Compensation operates a Proof of Coverage Web site, which lists several data points including employer information, coverage history, officer/ owner exemptions and elections, and the like (see below for a representative sample).

Employer Information

Employer Name	ABCXYZ		
Employer Type		NAICS Code	555555

Coverage History

Click here for carrier location information

	Governing Class Code	Effective Date	Cancellation Effective at 12:01 a.m.	Carrier Office	Policy Number	Wrap Up
View Locations	05537	Jan 1 2008	Jan 1 2009	XYZ INSURANCE COMPANY	000AA00A00000	NO

*Represents the Governing Class Code as reported by the insurance carrier

**Carriers were not required to report the Governing Class Code for policies issued prior to October 1, 2009

No Officer Exemption of Coverage Listings

No Owner Election of Coverage Listings

Employer Name History

Employer Name	Name Type	Change Date
ABCXYZ, Inc.	Legal	Dec 31 2007

While payroll information is not presently included, the Division of Workers' Compensation is in the process of developing this functionality, which will go live November 2011, and allow contractors and others utilizing the Web site to evaluate whether the payroll for the policy may be understated in comparison to the number of employees and the type of work being done. In other words, the payroll, class code, and number of employees data would show a discrepancy if a 25-person roofing subcontractor appeared as a 2-person drywall company in the database. Such information would alert a general contractor looking to hire a subcontractor that appropriate coverage is not in effect for that subcontractor.

Requiring contractors to check the database before making a hire could be done; however, it could be difficult in the sense that there are multiple steps to a bidding process. Many times a general contractor will ask for a certificate of insurance for a subcontractor in the pre-bidding process, and that coverage may change before work has actually begun.

However, such a requirement may still lead to inconsistent results. While including payroll information would allow a general contractor to gauge whether the reported payroll is consistent with the subcontractor's workforce, it would not always be a 1:1 comparison. Payroll is reported at the inception of a policy, at renewal, and at the time of audit by an insurer. Therefore, it is very possible that payroll could change mid-term, and that such a change would not be captured or reported by the Web site. The Work Group's general sense was that any such requirement on the contractors would necessitate a degree of precision not currently present in the system.

Thus, while the availability of payroll information through the Web site will help contractors detect glaring discrepancies between reported payroll and actual payroll, it is not likely to report deviations in or close to real-time. Consequently, no requirement should be placed on contractors to report inconsistencies in payroll; rather, contractors should be encouraged to check the Web site to ensure that no significant discrepancies exist.

Moreover, the problem this scheme presents for the construction industry is that honest contractors and subcontractors who purchase coverage for their employees are consistently outbid by those who utilize this premium avoidance scheme. This tool will help the industry self-police, by providing a mechanism by which discrepancies can be detected and authorities can be notified to investigate further.

The addition of the payroll information to the Proof of Coverage database would also allow risk assessments by the Office when compared to data from the recommended check cashing database. The comparison of this data between the two databases would lead to the establishment of red flags and fraud alerts to dispatch examiners and investigators to problem check cashing licensees, construction companies and insurance agents. This enhanced data would also serve to generate fraud alerts to insurance carriers that could prompt immediate audits where potential for fraud has been detected, and to help cancel policies where payroll has been underestimated and fraud is uncovered.

Recommendation **- Require licensed check cashers to provide the workers' compensation policy number, under which a corporate payment instrument is cashed, to the Office of Financial Regulation. The Office will provide this information through a data interface with the Division of Workers' Compensation's Proof of Coverage database.**

Expected Outcome **– Payroll amounts would be tied to the amount of insurance coverage secured by facilitators thereby initiating investigation of suspected fraud.**

As part of improvements in information sharing between the Division of Workers' Compensation and the Office of Financial Regulation, one additional data point should be collected, which is not presently captured. Requiring check cashers to report a payee's workers' compensation policy number, so that the data interface can compare estimated payroll reported on a policy with the amount and number of checks that are cashed for that same policyholder, will enable regulators to more readily identify premium avoidance schemes.

Check cashers would report the amount of the check, as well as the associated workers' compensation policy number. That information would be transmitted—possibly in real-time—to the Office, which through the data interface would instantly be available to the Division of Workers' Compensation. The Division would then match the check amounts, and volume, with the amount of payroll reported to the insurer. This way, if $50,000 worth of checks were cashed by a corporation who has only reported $10,000 in payroll, the Division of Workers' Compensation's Bureau of Compliance would be alerted to investigate, and thus make a compliance visit. Upon detection of a premium avoidance scheme, that investigator would then make a referral to the Division of Insurance Fraud for criminal investigation.

Further, if the data could be updated and shared in real-time, the money service business could also be alerted of any inconsistency, so that the check can be refused at presentment. This information could also be shared with the insurer, which could then initiate an audit or cancel a policy for underwriting inconsistencies. Such a cancellation would be timely reflected on the Proof of Coverage Web site.

Recommendation – Modify check cashing statute to simplify audit trails

Expected Outcome – Allow for efficient examinations of check cashing licensees, and require licensed entities to maintain commercial banking relationships at all times.

When money service businesses do not properly negotiate, endorse, or deposit checks, it is often difficult for the Office to detect illegalities. Sometimes, check cashers who negotiate suspect checks cannot get their financial institution to honor the checks, and in turn, credit their account. This incentivizes some check cashing facilities to sell checks that their financial institution will not honor. However, if check cashing facilities were unable to sell checks and had to keep a bank account at a traditional financial institution, this would dissuade them from negotiating checks that banks refuse to cash.

As such, legislative changes could be made to:

- Require licensees to maintain a depository account for the purpose of negotiating all cashed checks.
- Require the immediate cessation of check cashing activity in the absence of such account.
- Provide for the immediate suspension of licensees for failure to deposit cashed checks.

This would limit a licensee to cashing checks at its financial institution, or risk losing its commercial banking relationship.

Recommendation - Allow the Office of Financial Regulation to focus their efforts more efficiently.

Expected Outcome – Examination resources will be focused on high-risk licensees.

Section 560.109, F.S., requires the Office to examine each money service business at least once every five years. New licensees must be examined within six months of the issuance of the license.

Ensuring that the Office examines new licensees is a worthy goal, but examinations over the past three years have shown that not all licensees pose the same risk for fraud and money laundering. The current requirements give no weight to risk posed by licensees and as a result a large percentage of valuable examination resources are occupied on examinations of low risk licensees. Eliminating the mandatory six-month examinations will allow the Office to focus regulatory resources on high priority cases.

Moreover, allowing the Office to use its examiners in a more targeted way—by freeing them from the six-month cycle but still requiring an examination as soon as is practicable—will remove the ability for licensees to plan illegality around a constricted examination schedule.

A related suggestion from the check cashing industry was to "request that the Legislature allocate additional dollars from [the] licensing trust fund to conduct audits on commercial check cashing transactions and unlicensed activity." The Office has reported , though, that its resources are currently sufficient to

accommodate examinations. At a minimum, the Money Transmitter Regulatory Unit should not sustain any cuts given their critically important role in preventing and detecting fraud.

Recommendation – Allow the Office to make unannounced visits to conduct examinations

Expected Outcome – Examinations will yield better results when they are risk-targeted and unannounced.

Currently, s. 560.109, F.S., prohibits the Office of Financial Regulation from making unannounced visits to money service businesses, and requires the Office to provide the licensee with at least 15 days notice that an exam will be conducted. There is a very limited exception for conducting unannounced exams or investigations if the Office "suspects that the money services business, authorized vendor, or affiliated party has violated or is about to violate any provisions of [Chapter 560] or any criminal laws of [the state of Florida] or of the United States."

The announcement of an exam or investigation allows unscrupulous licensees to hide, destroy, or otherwise tamper with the evidence that the Office may collect in the course of the visit. Other regulated industries, such as insurance agents, insurance companies, and employers required to carry workers' compensation insurance, are subject to unannounced examinations or investigations.

It is reasonable to assume that law-abiding money service businesses would not hide, destroy, or tamper with evidence upon notice that the Office has scheduled an upcoming exam. If that assumption is reasonable, then such money service businesses should not be significantly prejudiced upon an unannounced examination or investigation. Rather, it would be the unscrupulous money service businesses that endeavor to cheat the system that would now face detection in the absence of advance notice.

This recommendation is particularly important given recent developments in insurance fraud investigations that reveal the likelihood that the planning of Office examinations allows critical evidence—later discovered by law enforcement—to be hidden in advance of regulators' arrival. Money service business representatives who participated in the Work Group had no objection and, in fact, were supportive of the increased transparency.

Recommendation - Have the Division of Insurance Fraud run reports from the Department of State's Division of Corporations' Web site to generate lists of common officers/addresses in order to detect shell corporations.

Expected Outcome – Assist the Division of Insurance Fraud in the proactive identification of shell companies so as to more effectively target its law enforcement resources.

The Department of State's Division of Corporations provided some valuable insight to recommendations proposed by Work Group members. In addition to discussing the potential downsides of limiting corporations to bricks and mortar establishments, Work Group members also learned about the functionality of the Division of Corporation's computer systems.

The Division of Corporations reports that it can generate information to detect similarities in officers, directors, addresses/P.O. Boxes, and other corporate identifying information. The Division of Insurance Fraud and the Office of Financial Regulation are encouraged to work with the Division of Corporations to see how that information may be helpful to detect potentially unlawful behavior.

Recommendation (Non-consensus) – Create an endorsement to the money service business' license for commercial check cashing.

Potential Outcome – Provide heightened scrutiny for high-dollar corporate checks.

Some members of the Work Group suggested creating an endorsement to the MSB license for commercial check cashing transactions, which would allow for enhanced scrutiny of the companies engaging in this

type of business. Additionally, certain money service businesses, such as those that cash less than $1,000 to any one person in any one day, would be subject to less regulation, given the lower probability of risk. It is worth noting that 31 C.F.R. 103.11(uu) specifically exempts check cashers that "do not cash checks in an amount greater than $1,000 in currency or monetary or other instruments for any person on any day in one or more transaction" from federal regulation. This distinction is sufficient, as banks are very good at their own brand of regulation for these low-dollar checks; if the checks do not meet a bank's criteria for acceptance, they are rejected. In that way, the check casher is penalized for not having high enough presentment standards.

The Work Group discussed the efficacy of this recommendation. Uniformly, the money service businesses represented were against any deregulation of the industry. If the Office is equipped with the tools necessary to detect potential fraud more quickly, and can strengthen the processes of some of its examinations, this recommendation—the ultimate goal of which is to allow the Office to target its resources on the most risky licensees—may not be necessary.

Recommendation (Non-consensus) – Ban, or implement a monetary threshold, for cashing business-to-business checks.

Potential Outcome – Eliminate the ability for facilitators to easily access cash and thus avoid detection.

Such a recommendation would eliminate the ability to cash checks when the payee is a corporate entity or third-party. In the alternative, a threshold would be set for the dollar amount allowable for such checks to be eligible for cashing.

Law enforcement and some in the construction industry believe that this would go a long way towards solving the problem by forcing people cashing these checks into traditional financial institutions, which would require the deposit of checks into an account. Banks are thought to be in a strong position to monitor, and filter, inappropriate transactions.

However, there were many competing concerns. First, the money service business industry feels that this is too hefty of a burden, particularly on law-abiding licensees, to justify the result. Second, there was a concern that some fraudsters would avoid detection, perhaps by making the check out to cash or to a non-existent first party (using a forged identification).

Given the controversial nature of this issue amongst Work Group members, it cannot be presented as a consensus recommendation.

Recommendation (Non-consensus) – Change how certificates of insurance are issued.

Potential Outcome – Proof of adequate insurance coverage would be centrally stored and, therefore, easier to verify.

A certificate of insurance is a document usually issued by an insurance agent to an insured which serves as proof that insurance coverage exists. Its purpose is to confirm coverage in lieu of an actual copy of the insurance policy.

As is relevant to this type of fraud, certificates of insurance are typically issued by insurance agents to the facilitator, who is posing as an uninsured subcontractor purchasing insurance in advance of a job. Because a certificate of insurance does not include payroll amount or risk classification, a facilitator is able to unlawfully provide this to uninsured subcontractors to use as false "proof" that they have coverage.

While general contractors may know that coverage has been falsified, the lack of information on the certificate can lead to the contractor's own lack of notice that the subcontractor's certificate does not actually cover his/her employees. Further, there is currently no unique or centralized tracking system for certificates issued. Therefore, in some cases, fraud and compliance investigators have found that dozens, if not more, of certificates of insurance have been issued just for one policy. When used fraudulently, more uninsured subcontractors are able to use duplicate certificates—representing just one policy—to repeat the fraud on different construction projects.

Some Work Group members suggest moving towards certificate issuance by either an insurance company or a state entity. In doing so, some suggested that it would be easier to electronically track the issuance of certificates, and validate that information with other data elements, such as payroll amount, address, names of corporate officers, etc. While this recommendation could likely be a very potent cure to the type of fraud found within today's system, many insurance representatives on the Work Group were reluctant to move to such a system. Therefore, it cannot be accurately represented as a consensus recommendation.

CONCLUSION

Throughout 12 hours of meetings and countless additional hours of travel, research, and communications, Work Group members have strived to provide a resource for policymakers who are partners in the fight against fraud. In these challenging economic times, when small businesses are under significant pressure to make ends meet, a fraud as pervasive and as crippling as this type of workers' compensation fraud cannot be excused or tolerated.

Insurance fraud, in any form, inexcusably passes costs onto Florida's law-abiding citizens and businesses. It is the Work Group's hope that this information will be a step forward in the fight against this particularly offensive type of fraud, so that regulators, law enforcement, and prosecutors can better prevent, detect, and punish those who are responsible for unfairly passing costs onto hardworking citizens and businesses.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