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Health Care Compliance Association's
Managed Care Compliance Conference

Breakout Session701

Special Investigation Units: The Nuts and Bolts

February 21–23, 2010

Additional Notes – Slide 21

Analysis of Medical Records – Set Standards – Critical

- Medicaid Manual Section 2 – Provider Enrollment and Responsibilities
- Medical Record Documentation Requirements – Plan Provider Manual
- E/M documentation guidelines – 95 or 97

Desirable

- Immunizations are noted as complete or up-to-date
- Personal data includes address, employer, home/work telephone numbers, sex, marital status, and emergency contacts

Mandatory

- Legibility
- Each Page – patient's name and MA number
- Allergies documented
- Correct selection of E/M code
- History and Physical document presenting complaint (CC)
- Services provided clearly document all pertinent information to substantiate the need for the services.
- Diagnostic lab and X-ray results are included in the medical record and abnormal findings or notated with follow up plans.
- Necessary follow-up visits specify time of return by at least the week or month.
- Unresolved problems are noted in the record

Steps to *Informing – Providing the Audit Results*

- Obtain Results using a Score Card
  - Keep it Simple
  - Include the Mandatory Requirements
  - Use Basic Medical Record Documentation Requirements as your audit criteria.

Steps to *Informing – Tallying the Results*

- Use Percentages and Documentation Requirements to obtain Audit Results
- Sample Provided

Where to Begin?

- Use a Percentage Scoring System (number of records divided by the correct records audited)

Example:

- 12 records total audited:
  - Allergies were documented properly 11 out of 12 records =92% accuracy
  - Use this system for each criteria requirement (some may be non-applicable) skip those
  - Total possible score = 800
  - Audit score = 534
  - Coding Compliance = 67%

Steps to *Changing Behavior*

- *Require Coding Accuracy*

- Implement a Coding Accuracy System that will be basis of a Corrective Action Plan
- Sample Corrective Action Plan
  - Agree upon A Coding Accuracy Goal
    - 95%, 90%, 85%
  - Establish a Pass and Fail Scoring System
  - Example:
    - 95-100% Met Accuracy Goal
    - 90-94% Pass
    - 71-89% Satisfactory
    - 60-70% Need Improvement
    - 0-59% Fail
  - Establish a Corrective Action Plan for each score.
  - Example:

- 60-70%-Needs Improvement
- Education Visit Required
- Recoupment
- Re-Review in 1 year

Steps to *Changing Behavior* – *Require a Corrective Action Plan*

- Utilize the Corrective Action Plan to Change Coding Behavior
- Include a space for the Provider to sign and give a date when he/she will implement a Corrective Action for each requirement that needs improvement (a score between 60-70%)
- Give provider a copy
- Follow through with your Corrective Action Plan

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Notes for slide 25:

Case Assessment:

- In addition to the expanded record review, during this phase the SIU would also:
  - Complete the appropriate state referrals;
  - Begin a case tracking search (it is important to review the system for prior cases, related cases or even similar cases which may help unravel the puzzle);
  - Review provider contracts;
  - Review corporate records;
- Complete database records searches, where indicated, that could include information that credentialing might not uncover, such as;
  - Additional Social Security numbers associated with the subject;
  - Former addresses;
  - Real property records;
  - Bankruptcy records;
  - Stock ownership; and,
  - Other information that may become relevant during and extended investigation.
- For budgetary and cost accounting reasons, additional searches should be submitted to management for approval. Other areas in the assessment process to consider are:
  - Financial exposure
  - Location of provider –
  - Specific populations being treated that may be *slightly* outside a stated specialty?

- Is the provider or group using the same billing company as another suspect provider or group?
- Staff expertise – With some plans, lines and coverage certain services provided by auxiliary staff are paid as if they were provided by the contracted provider. Are these ("incident to") services always provided by qualified auxiliary staff?

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Notes for slide 27:

- Does the provider use a billing service? If yes, an investigation of the billing service may be in order.
- Is the provider reassigning benefits to a clinic, hospital or practice? If yes, while the provider's records will still be used to make and support allegations the investigation would be better aimed at the billing entity.
- Are other investigations underway? If yes, resources and information should be shared.
- Does the provider have a history of many denied or down-coded claims, or paybacks? Knowing this could give the investigator valuable information that need not be re-investigated.
- The National Health Care Anti-Fraud Association (NHCAA) maintains a database of providers under investigation by its member organizations.
- The Special Investigation Resource & Intelligence System (SIRIS) is used by member organizations for case input and records searches.
- This is a valuable tool to identify other investigations into a suspect provider.
- By identifying other, ongoing investigations a more efficient utilization of resources can be gained by pooling information. It could also enhance the appeal of a prosecution by revealing that multiple insurance companies have been victimized by the same provider.
- The presence of multiple victims goes a long way toward disputing a provider's defense of "an innocent billing mistake."
- Some facts may be obtained that actually dispute or disprove the allegation. It is important for all participants in the investigation (auditors, administrators, others) to remember that exculpatory evidence is just as important as the facts supporting an allegation because they can persuade the investigator or others to close the investigation and use those resources on other matters.

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Notes for Slide 28:

- Investigating medical specialties – the investigator must understand how each specialty is practiced in order to investigate issues such as equipment necessary (owned or leased), referrals necessary for services, limitations imposed by state law and other issues that may not be caught by claims edits.
- Gathering and using evidence – In a legal context, evidence can be the fact of a particular occurrence or it can be a physical item that documents a particular occurrence. The evidence in a healthcare fraud case might include a broad range of documents – claims, envelopes, bills, statements, prescriptions, contracts, purchase orders and invoices, certificates of medical necessity, patient records and reports, correspondence and/or witness' written statements
- Sources of Evidence – The potential sources of evidence in a healthcare fraud case tend to parallel the investigator's potential sources of information. That is, some sources will lie within the payor organization itself (claims, provider relations, and the mail handling facility) and others will be external, such as the provider's offices and staff members, patients, state disciplinary boards and other licensing and regulatory agencies, court records, etc.
- Nature of the evidence-gathering process – The nature of the source dictates the process, which might be a routine internal function or a highly adversarial activity. Obtaining evidentiary documents from within one's own organization, for example, should represent a routine cooperative process; obtaining documents or statements from patients might be more difficult, but still essentially cooperative, process.
- However, obtaining potential evidence from a provider's office, no matter how civilly it is done, is an inherently adversarial process – even more so when the provider either knows or suspects that he or she might be under investigation. It's vitally important for the investigator to understand how to gather information via legal proceedings without jeopardizing pending legal inquiries.

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Notes for Slide 29

- Establishing and maintaining a chain of custody:
  - Inventorying the evidence
  - Keeping evidence clean and admissible
  - Potentially altered documents
  - Non-original items
  - Packaging the evidence
- Witness statements
- Insurer participation in law-enforcement evidence gathering
- Interviews

- Gathering previously unknown facts
- Developing information regarding matters under investigation or to establish elements of a specific violation
- Gaining leads in developing a case
- Establishing a background of the source of information, including motives for furnishing evidence.

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STATE-BY-STATE
FRAUD PREVENTION PLAN – SIU REQUIREMENTS[1]

SIU Requirement

Arkansas — Insurer Antifraud Initiative — Fraud plan and SIU Requirement — *Section 23-66-510*

(a) Insurers shall have antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Antifraud initiatives may include, but not limited to:

(1) Fraud investigators, who may insurer employees or independent contractors; or

(2) An antifraud plan submitted to the commissioner. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(b) Upon the written request of an insurer, the commissioner may grant an exemption from the requirements of this section if he determines that such an exemption would not be detrimental to the interests of the public.

Arkansas — Antifraud Initiative Requirements - Regulation 66 - Fraud plan and SIU Requirement — *Sec. 6 Antifraud initiative requirements; Sec. 7. Fraud Investigators and independent contractors*

Sec. 6 Antifraud initiative requirements
The antifraud initiative requirements of Arkansas Code Annotated Sec. 23-66-510(a) may be satisfied by an insurer by means of:

(1) Fraud investigators, who may be insurer employees or independent contractors and who are in full compliance with Section (7) of this rule; or

(2) An antifraud plan submitted to, and approved by, the commissioner, and which is in full compliance with Section (8) of this rule; or

(3) An alternative antifraud initiative submitted to, and approved by, the commissioner, under the provisions of Arkansas Code Annotated Sec. 23-66-510(a); or

(4) An exemption from the antifraud initiative requirements granted by the commissioner pursuant to Arkansas Code Annotated Sec. 23-66-510(b).

[1] Correct as of 8/2008

Sec. 7. Fraud Investigators and independent contractors

A. Fraud investigators who are employees of an insurer:
(1) shall be qualified by education, experience or training in the detection, investigation and proper reporting of suspected fraudulent insurance acts, and may be employees whose principal responsibilities are the processing and disposition of claims, if they meet the qualification requirements herein stated; and

(2) shall complete a minimum of three (3) hours of continuing education annually in the detection, investigation and proper reporting of suspected fraudulent insurance acts. The specific curriculum, location and certification of said continuing education courses are not mandated but shall be consistent with industry standards for continuing education for insurance fraud investigators.

California — SIU requirement — *State Insurance Code Section 1875.20; California Code of Regulations Subchapter 9 Insurance Fraud Section 2698.30 et. seq.*

State Insurance Code Section 1875.20 (Fraud unit required); Administrative Code - Title 10 Section 2698.42 (Purpose and objectives of insurer special investigative unit)

Section 1875.20 — Every insurer admitted to do business in this state shall maintain a unit or division to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds.

SPECIAL INVESTIGATIVE UNIT
REGULATIONS
Effective October 7, 2005

California Code of Regulations
Subchapter 9 Insurance Fraud
Article 2 Special Investigative Unit Regulations

Section 2698.30 Definitions

As used in this article, the following definitions shall apply:

(a) "Act" means any violation of California Code of Regulations, Title 10, Chapter 5, Section 2698.30-42, inclusive.

(b) "Authorized governmental agency (agencies)" shall have the same meaning as used in the Insurance Frauds Prevention Act (IFPA).

(c) "Claims handler" means every employee and agent of an insurer whose principal responsibilities include the investigation, adjustment, settlement and resolution of claims.

(d) "Commissioner" means the Insurance Commissioner of the State of California.

(e) "Communication" includes the referral of suspected insurance fraud to the Department of Insurance and providing information and documents requested by the Fraud Division.

(f) "Department" means the California Department of Insurance.

(g) "Fraud Division" means the California Department of Insurance Fraud Division formerly known as the Bureau of Fraudulent Claims.

(h) "Hearing" means an adjudicative proceeding initiated by the Insurance Commissioner pursuant to the provisions of California Insurance Code Section 1875.24(d).

(i) Inadvertent" means unintentional.

(j) "Insurer" means every insurer admitted to do business in this state except the following:

(1) Reinsurers.
(2) Title insurers.
(3) Fraternal fire insurers.
(4) Fraternal benefit societies.
(5) Firemen, policemen, or peace officer benefit and relief associations.
(6) Grant and annuity societies.
(7) Home protection.

(k) "Integral anti-fraud personnel" includes insurer personnel who the insurer has not identified as being directly assigned to its SIU but whose duties may include the processing, investigating, or litigation pertaining to payment or denial of a claim or application for adjudication or claim or application for insurance.. These personnel may include claims handlers, underwriters, policy handlers, call center staff within the claims or policy function, legal staff, and other insurer employee classifications that perform similar duties.

(l) "Reasonable belief" is a level of belief that an act of insurance fraud may have or might be occurring for which there is an objective justification based on articulable fact(s) and rational inferences therefrom.

(m) "Red flag" or "red flag event" means facts, circumstances or events which, singly or in combination, support(s) an inference that insurance fraud may have been committed.

(n) "Regulations" means these regulations, California Code of Regulations, Title 10, Chapter 5,

Subchapter 9, Article 2.

(o) "Special Investigative Unit" (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be comprised of insurer employees or by contracting with other entities for the purpose of complying with applicable sections of the Insurance Frauds Prevention Act (IFPA) for the direct responsibility of performing the functions and activities as set forth in these regulations.

(p) "Suspected insurance fraud" includes any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanations of benefits (EOB), medical evaluations or billings, medical provider notes (commonly known as SOAPE notes); Subjective complaint, Objective findings, Assessment, Plan and Evaluation, Health Care Financing Administration (HCFA) forms, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

(q) "The Insurance Frauds Prevention Act" or "(IFPA)" shall refer to California Insurance Code section 1871-1879.8.

(r) "Willful" means a purpose or willingness to commit the act or make the omission referred to in the California Insurance Code or in these regulations. The Commissioner shall use the factors set forth at California Code of Regulations Section 2591.3(d)(1)(A-E) to determine whether or not an act is willful.

NOTE: Authority: Insurance Code Sections, 1872.4, 1875.24, 1877.3, 1879.5, 1879.6,; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 9080, 10970, 11400, 11520, 11760, 11880, 12400.1, 12743, 12921(a) and 12926

Section 2698.31 Insurer Responsibility

The insurer shall comply with applicable sections of the IFPA and these regulations regarding the establishment, operation and continuous existence of an SIU.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v.

Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.32 SIU Staffing

(a) Adequacy. The adequacy of an insurer's SIU staffing shall be determined by its demonstrated ability to establish, operate and maintain an SIU that is in compliance with these regulations. Factors that may be considered in staffing the SIU include, but not limited to, the number of policies written and individuals insured in California, number of claims received with respect to California insureds on an annual basis, volume of suspected fraudulent California claims currently being detected and other factors relating to the vulnerability of the insurer to insurance fraud.

(b) Knowledge. An SIU shall be composed of employees who have knowledge and/or experience in general claims practices, the analysis of claims for patterns of fraud, and current trends in insurance fraud, education and training in specific red flags, red flag events, and other criteria indicating possible fraud. They shall have the ability to conduct effective investigations of suspected insurance fraud and be familiar with insurance and related law and the use of available insurer related database resources.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.33 SIU Contracted Responsibilities

(a) Any contract entered into by an insurer, or an entity under contract with an insurer as provided under these regulations, shall not relieve the insurer of any obligation under these regulations or the IFPA.

(b) Notwithstanding any other provisions of these regulations, a complete and executed copy of any such agreement, including all attachments, exhibits and amendments thereto, shall be provided to the Fraud Division on execution.

(c) Any contract entered into by an insurer under this section shall:

(1) Specify all SIU duties and functions to be performed by the parties to the contract and how the insurer monitors performance of the contract responsibilities;
(2) Not include provisions that could provide disincentives to the referral and/or investigation of suspected insurance fraud;
(3) Not include provisions that purport to relieve an insurer of any obligation to comply with the

requirements of these regulations and the IFPA.; and
(4) Expressly include a provision to require the contracted entity to comply with all applicable provisions of the IFPA and these regulations.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24,1879.5, 12921(a) and 12926.

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

(a) The insurer and any entity performing the SIU function(s) shall comply with specific sections of the IFPA regarding communication with the Fraud Division and authorized governmental agencies.

(b) On written request by the Fraud Division or an authorized governmental agency, an insurer or its agents, shall release in a timely and complete manner any or all relevant information deemed important that the insurer may possess relating to any specific incident of insurance fraud. Such information shall include:

(1) Insurance policy information;
(2) Applications;
(3) Policy premium payment records;
(4) History of claims;
(5) Information relating to the carrier's investigation, including statements, proof and notice of loss;
(6) Claim file documents;
(7) Claim notes;
(8) Investigation files;
(9) Investigator notes; and
(10) Other information which the Fraud Division or an Authorized Governmental Agency may deem relevant and important.

(c) For the purpose of this section, timely release of information means immediate, but no more than thirty (30) calendar days after the request unless otherwise agreed to by the Fraud Division.

(d) A single written request shall be considered sufficient to compel production of all information deemed relevant by the requesting governmental agency relating to any specific insurance fraud investigation. The single request is applicable throughout the duration of the investigation and is applicable to the requested records of the insurer named in the request and the records of all persons, agents and brokers employed by and conducting business on behalf of the insurer.

NOTE: Authority: Insurance Code Sections 1872.4, 1875.24, 1877.3, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen.

Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1872.3, 1873, 1874.2, 1874.4, 1875.4, 1875.20, 1875.21, 1875.24, 1877.1, 1877.2, 1877.3, 1877.4, 1877.5, 1879.5, 12921(a) and 12926.

Section 2698.35 Detecting Suspected Insurance Fraud.

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures shall include a listing of the red flags to be used to detect suspected insurance fraud for the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against:

(1) Patterns or trends of possible fraud;
(2) Red flags;
(3) Events or circumstances present on a claim;
(4) Behavior or history of person(s) submitting a claim or application; and
(5) Other criteria that may indicate possible fraud.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.36 Investigating Suspected Insurance Fraud.

(a) The SIU shall establish, maintain, distribute and adhere to written procedures for the investigation of possible suspected insurance fraud. An investigation of possible suspected insurance fraud shall include:

(1) A thorough analysis of a claim file, application, or insurance transaction.
(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.
(3) Utilizing industry-recognized databases.
(4) Preservation of documents and other evidence.

(5) Writing a concise and complete summary of the investigation, including the investigator's findings regarding the suspected insurance fraud and the basis for their findings.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.37 Referral of Suspected Insurance Fraud.

(a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and, as required, district attorneys.

(b) Referrals shall be submitted in any insurance transaction where the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

(c) Referrals shall be made within the period specified by statute.

(d) The requirements of this section do not affect the immunity granted under California Insurance Code section 1872.5 or other such similar codes contained in the Insurance Frauds Prevention Act.

(e) The requirements of this section do not diminish statutory requirements contained in the Insurance Frauds Prevention Act regarding the confidentiality of any information provided in connection with an investigation.

NOTE: Authority: California Civil Code Section 1708, Insurance Code Sections 1872.4, 1874.6, 1875.24, 1875.4; 1877.3 1877.5, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1872.5, 1873.2, 1874.2, 1874.4, 1875.20, 1875.21, 1875.24, 1877.3, 1879.5, 12921(a) and 12926.

Section 2698.38 Referral Content

A referral of an act of suspected insurance fraud to the Fraud Division shall be legible and on a form as directed by the Department and contain the information and data to the extent applicable, as provided in the following:

(a) Fraud and referral type

(1) Fraud type
(2) New referral/amended referral indicator

(b) Reporting party information

(1) Reporting party type
(2) Reporting party name
(3) Reporting party California Company number
(4) Reporting self-insured/contracted third party license number, as appropriate
(5) Reporting party address, city, state and zip code
(6) Reporting party email address (generally, contact address)

(c) Alleged victim information, as appropriate

(1) Alleged victim company name
(2) Alleged victim California Company number
(3) Alleged victim self-insured number
(4) Alleged victim address, city, state and zip code

(d) Insurance policy or claim information, as appropriate

(1) Claim number associated with referral
(2) Insurance policy number associated with referral
(3) Date of loss or injury
(4) Geographic location where loss or injury occurred
(5) Insurance premium dollar loss
(6) Total potential loss on claim prior to the identification of fraud
(7) Total claim loss paid to date
(8) Actual suspected fraudulent loss amount paid to date
(9) A complete synopsis of all the facts on which the reasonable belief of the insurance fraud is based.
(10) Disaster claim indicator

(e) Other agency referral information, as appropriate

(1) Names of other authorized governmental agencies receiving this referral
(2) Names of any District Attorney's Office receiving this referral
(3) National Insurance Crime Bureau (NICB) referral indicator
(4) The names of any other agencies receiving this referral

(f) Referral contact information, as appropriate

(1) Referral contact name and phone number

(2) Claim or case file handler and phone number
(3) Name and phone number of person who completed referral
(4) Date referral was completed

(g) Information for each party associated with the referral

(1) Identification of the role of the party to the loss
(2) Phone number
(3) Address, city, state and zip code
(4) Date of birth or age
(5) Social security number
(6) Tax identification number
(7) Drivers license number
(8) State of party's drivers license
(9) Vehicle license plate number
(10) Vehicle license plate state
(11) Vehicle identification number
(12) Other names or identifiers used by the party
(13) Claim of injury indicator

NOTE: Authority: Insurance Code Sections 1872.4, 1874.2, 1875.24, 1877.3, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1877.3, 1879.5, 12921(a) and 12926.

Section 2698.39 Anti-Fraud Training

Requirements for training provided by and for the SIU shall include:

(a) The insurer shall establish and maintain an ongoing anti-fraud training program, planned and conducted to develop and improve the anti-fraud awareness skills of the integral anti-fraud personnel

(b) The insurer shall designate an SIU staff person to be responsible for coordinating the ongoing anti-fraud training program.

(c) The anti-fraud training program shall consist of three (3) levels:

(1) All newly- hired employees shall receive an anti-fraud orientation within ninety (90) days of commencing assigned duties. The orientation shall provide information regarding:

(A) the function and purpose of the SIU;
(B) an overview of fraud detection and referral of suspected insurance fraud to the SIU for investigation;
(C) a review of Fraud Division insurance fraud reporting requirements:
(D) an organization chart depicting the insurer's SIU; and
(E) SIU contact telephone numbers.

(2) Integral anti-fraud personnel shall receive annual anti-fraud in-service training, which shall include:

(A) review of the function and purpose of the SIU;
(B) introduction/review of the written procedures established by the SIU regarding the identification, documentation and referral of incidents of suspected fraud to the SIU;
(C) identification and recognition of red flags or red flag events;
(D) any changes to current procedures for identifying, documenting and referring incidents of suspected insurance fraud to the SIU;
(E) Fraud Division insurance fraud reporting requirements; and
(F) introduction/review of existing and new, emerging insurance fraud trends.

(3) The SIU personnel shall receive continuing anti-fraud training that includes;

(A) investigative techniques;
(B) communication with the Fraud Division and authorized governmental agencies;
(C) fraud indicators;
(D) emerging fraud trends; and
(E) legal and related issues.

(d) Records of the anti-fraud training provided to all staff shall be prepared at the time training is provided and be maintained and available for inspection by the Department on request. The training records shall include the title and date of the anti-fraud training course, name and title and contact information of the instructor(s), description of the course content, length of the training course, and the name and job title(s) of participating personnel.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.40 SIU Annual Report

(a) Each insurer shall file a report as prescribed herein, at the time its initial Certificate of Authority is issued, and annually thereafter. The annual report shall be due no later than 90 days after the

date of mailing of the notification by the Department. The Department shall issue the notification in June of each year.

(b) A complete, accurate and truthful annual report shall be submitted on a form as prescribed by the Department and shall include the following information.

(1) The name(s), title(s) and contact information of the insurer's SIU personnel; or
(2) The name of the organization and organizational contacts with whom the insurer has contracted for the maintenance of the SIU or any function thereof; and
(3) The names of personnel whose duties include communication with the Fraud Division on matters related to the reporting, investigation and prosecution of suspected fraudulent claims or other suspected insurance fraud.
(4) A description of the insurer's methods and written procedures used for detecting, investigating and reporting suspected insurance fraud.
(5) A description of the insurer's plan for initial and on-going fraud education and training for integral anti-fraud personnel pursuant to these regulations.
(6) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of suspected insurance fraud.
(7) A description of how the SIU is adequately staffed to meet the requirements herein and the expertise of the staff.
(8) The number of claims processed by the insurer and the number of claims referred to the SIU, for each reported company, for the past calendar year.
(9) The number of incidents of suspected insurance fraud reported to the Department and to district attorney offices, for each reported company, for the past calendar year.
(10) A description of any significant, anticipated changes to the insurer's structure and operations.
(11) Insurers who enter into contracts for the purpose of compliance with these regulations shall provide a complete copy of the fully executed, existing contract, including all attachments and addendum, to the Department and shall specify the manner in which the contract is monitored.
(12) The number and type of civil actions initiated by each reported company alleging acts of insurance fraud during the preceding calendar year.

(c) A statement signed under penalty of perjury pursuant to the laws of the state of California, must accompany all reports mentioned herein. This statement must be signed by an officer of the holder of or applicant for the Certificate of Authority who attests to the accuracy of the reported information and the signor's personal knowledge of the existence and proper maintenance of an SIU described in this report and these regulations.

(d) The insurer is to maintain a copy of the annual report that will be available for review during examinations as conducted pursuant to section 2698.41 of these regulations or as otherwise requested by the Department.

(e) For the purpose of these regulations, the name(s) of the insurer's personnel who will communicate with the Fraud Division shall not be made part of the public record and shall be

released only pursuant to the provisions of CIC Section 1873.1 applicable to information acquired pursuant to Article 3 of the Insurance Frauds Prevention Act.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.41 Examinations

(a) The commissioner may conduct examinations of an insurer's SIU and related operations, including operations undertaken by entities under contract with the insurer, as deemed necessary to determine compliance with the requirements of this article.

(b) A written report of examination, including identification of violations of these applicable provisions of statute and regulation and required corrective action, if any, will be provided to the insurer on completion of the examination.

(c)(1) Notwithstanding any penalty imposed pursuant to the regulations, within thirty (30) days of receipt of a written report identifying any violation(s) of these regulations, an insurer shall submit to the Department a plan demonstrating how the insurer will correct such violation(s) and achieve compliance. Such plan shall be subject to examination by the Department. If accepted by the Department, the plan shall be submitted as a supplement to any existing annual report and shall be accompanied by a statement of an officer of the insurer as otherwise required for annual reports. Failure to submit a corrective action and compliance plan or to comply with such plan when accepted by the Department shall be considered a violation of these regulations.
(2) Any insurer submitting a written report pursuant to Subsection 2698.41 (c)(1) setting forth a corrective action plan may also submit any of the following information to the Commissioner in conjunction with the report required by Subsection 2698.41 (c)(1):

(A) any written material that may rebut any matters contained in the examination report.

NOTE: Authority: Insurance Code Sections 730 et. seq, 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926 .

Section 2698.42 Penalties

(a) If the Commissioner acts pursuant to the provisions of California Insurance Code Section

1875.24(c) or (d) and finds that the insurer has failed to comply with the provisions of this article, the Commissioner shall impose a monetary penalty in an amount not to exceed $5,000 for each act of non-compliance. Where the Commissioner determines that an insurer has willfully failed to comply with this article, the Commissioner may impose a monetary penalty in an amount not to exceed $ 10,000 for each willful act of non -compliance. The Commissioner shall consider the factors enumerated at California Code of Regulations Title 10 Chapter 5, Subchapter 3,Section 2591.3 (a)-(f) and determine if any of the enumerated factors are applicable to the insurer's conduct in the establishment and operation of its special investigative unit. If the Commissioner finds such factors are applicable to the insurer's conduct, the Commissioner may reduce the amount of the monetary penalty prescribed in subsection 2698.42(a).

(b) If the Commissioner acts pursuant to the provisions of California Insurance Code Section 1875.24(c) or (d) and determines that the acts of non-compliance are inadvertent and are solely relative to the maintenance and operation of the special investigative unit of the insurer, then the Commissioner shall consider such violations to be a single act for the purposes of imposition of a monetary penalty that is no greater than $5,000 for that single act. For all other inadvertent acts, the Commissioner shall impose a penalty in the amount of up to $5,000 per inadvertent act that is not in compliance with this article.

NOTE: Authority: Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926.

Section 2698.43 Hearings

(a) Any hearing conducted pursuant to these regulations shall be governed by the provisions of California Government code Section 11425.10(a).

(b) The Commissioner shall give 30 days written notice of any hearing held pursuant to these regulations.

NOTE: Authority: California Government Code Section 11425.10(a), Insurance Code Sections 1875.24, 1879.5, 1879.6; Calfarm Ins. Co. v. Deukmejian (1989) 48 Cal.3d. 805, 824, 258 Cal. Rptr. 161, 771 P.2d 1247; Credit Ins. Gen. Agents Assn. v. Payne (1976) 16 Cal.3d 651, 656, 128 Cal. Rptr. 881, 547 P.2d 993; Garris v. Carpenter (1939) 33 Cal. App. 2d. 649, 653, 92 P.2d 688.
Reference: California Government Code Section 11425.10(a), Insurance Code Sections 1875.20, 1875.21, 1875.24, 1879.5, 12921(a) and 12926 .

California — SIU requirement — *Section 2698.40 Definitions, Section 2698.42, Section 2698.43 SIU Contracted Responsibilities, Section 2698.43, Section 2698.44 Section 2698.45 Section 2698.46 Section 2698.47 Section 2698.48 Section 2698.49 SIU Training Section 2698.50 SIU Annual Report Section 2698.51 Examinations Section 2698.52 Penalties*

Section 2698.40 Definitions

As used in this article, the following definitions shall apply:

(a) "Authorized governmental agency (agencies)" shall have the same meaning as used in the Insurance Frauds Prevention Act (IFPA).

(b) "Claims handler" means every employee and agent of an insurer whose principal responsibilities include the investigation, adjustment, settlement and resolution of claims.

(c) "Commissioner" means the Insurance Commissioner of the State of California.

(d) "Communication" includes the referral of suspected insurance fraud to the Department of Insurance and providing information and documents requested by the Fraud Division.

(e) "Department" means the California Department of Insurance.

(f) "Fraud Division" means the California Department of Insurance Fraud Division formerly known as the Bureau of Fraudulent Claims.

(g) "Insurer" means every insurer admitted to do business in this state except the following:

(1) Reinsurers.

(2) Title insurers.

(3) Fraternal fire insurers.

(4) Fraternal benefit societies.

(5) Firemen, policemen, or peace officer benefit and relief associations.

(6) Grant and annuity societies.

(7) Home protection

(h) "Integral anti-fraud personnel" includes insurer personnel who the insurer has not identified as being directly assigned to its SIU but whose duties may include the receipt, processing, investigating, or litigation pertaining to payment or denial of a claim or application.

These personnel may include claims handlers, underwriters, agents, policy handlers, call center staff, legal staff, and other insurer employee classifications that perform similar duties.

(i) “Reasonable suspicion” is a level of belief that an act of insurance fraud may have or might be occurring for which there is an objective justification based on articulable fact(s) and rational inferences therefrom.

(j) "Red flag" or "red flag event" means facts, circumstances or events which, singly or in combination, support(s) an inference that insurance fraud may have been committed.

(k) "Regulations" means these regulations, California Code of Regulations, Title 10, Chapter

5, Subchapter 9, Article 2.

(l) "Special Investigative Unit" (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be comprised of insurer employees or by contracting with other entities for the purpose of complying with applicable sections of the Insurance Frauds Prevention Act (IFPA) for the direct responsibility of performing the functions and activities as set forth in these regulations.

(m) “Suspected insurance fraud” includes any misrepresentation of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanation of benefits (EOB), medical evaluations or billings, medical provider notes (commonly known as SOAPE notes; Subjective complaint, Objective findings, Assessment, Plan and Evaluation), Health Care Financing Administration (HCFA) forms, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

(n) “The Insurance Frauds Prevention Act” or “(IFPA)” shall refer to California Insurance

Code section 1871 et seq.

(a) Adequacy. The adequacy of an insurer’s SIU staffing shall be determined by its demonstrated ability to establish, operate and maintain an SIU that is in compliance with these regulations.

(b) Knowledge. An SIU shall be composed of employees who have knowledge and experience in general claims practices, the analysis of claims for patterns of fraud, and current trends in insurance fraud, education and training in specific red flags, red flag events, and other criteria indicating possible fraud. They shall have the ability to conduct effective investigations of suspected insurance

fraud and be familiar with insurance and related law and the use of available insurer related database resources.

Section 2698.43 SIU Contracted Responsibilities

(a) Any contract entered into by an insurer, or an entity under contract with an insurer as provided under these regulations, shall not relieve the insurer of any obligation under these regulations or the IFPA.

(b) Notwithstanding any other provisions of these regulations, a complete and executed copy of any such agreement, including all attachments, exhibits and amendments thereto, shall be provided to the Fraud Division on execution.

(c) Any contract entered into by an insurer under this section shall:

(1) Specify all SIU duties and functions to be performed by the parties to the contract and how the insurer monitors performance of the contract responsibilities.

(2) Not include provisions that could provide disincentives to the referral and/or investigation of suspected insurance fraud.

(3) Not include provisions that purport to relieve an insurer of any obligation to comply with the requirements of these regulations and the IFPA.

(4) Expressly include a provision to require the contracted entity to comply with all applicable provisions of the IFPA and these regulations.

Section 2698.43 SIU Contracted Responsibilities

(a) Any contract entered into by an insurer, or an entity under contract with an insurer as provided under these regulations, shall not relieve the insurer of any obligation under these regulations or the IFPA.

(b) Notwithstanding any other provisions of these regulations, a complete and executed copy of any such agreement, including all attachments, exhibits and amendments thereto, shall be provided to the Fraud Division on execution.

(c) Any contract entered into by an insurer under this section shall:

(1) Specify all SIU duties and functions to be performed by the parties to the contract and how the insurer monitors performance of the contract responsibilities.

(2) Not include provisions that could provide disincentives to the referral and/or investigation of suspected insurance fraud.

(3) Not include provisions that purport to relieve an insurer of any obligation to comply with the requirements of these regulations and the IFPA.

(4) Expressly include a provision to require the contracted entity to comply with all applicable provisions of the IFPA and these regulations.

Section 2698.44 Communication with the Fraud Division and Authorized

Governmental Agencies.

(a) The insurer and any entity performing the SIU function(s) shall comply with specific sections of the IFPA regarding communication with the Fraud Division and authorized

governmental agencies.

(b) On written request by the Fraud Division or an authorized governmental agency, an insurer or its agents, shall release in an timely and complete manner any or all relevant information deemed important that the insurer may possess relating to any specific incident of insurance fraud. Such information shall include:

(1) Insurance policy information.
(2) Applications.
(3) Policy premium payment records.
(4) History of claims.
(5) Information relating to the carrier's investigation, including statements, proof and notice of loss.
(6) Claim file documents.
(7) Claim notes.
(8) Investigation files.
(9) Investigator notes.
(10) Other information which the Fraud Division or an Authorized Governmental Agency may deem relevant and important.

(c) For the purpose of this section, timely release of information means immediate unless otherwise agreed to by the Fraud Division.

(d) A single written request shall be considered sufficient to compel production of all information deemed relevant by the requesting governmental agency relating to any specific insurance fraud investigation at the time the request is made and subsequent to require production of the requested records by the insurer named in the request and all persons, agents and brokers employed by and conducting business on behalf of the insurer.

Section 2698.45 Detecting Suspected Insurance Fraud.

(a) An insurer's integral anti-fraud personnel are responsible for identifying suspected insurance fraud during the handling of insurance transactions and referring it to the SIU as part of their regular duties.

(b) The SIU shall establish, maintain, distribute and monitor written procedures to be used by the integral anti-fraud personnel to detect, identify, document and refer suspected insurance fraud to the SIU. The written procedures will include a listing of the red flags to be used to detect suspected insurance fraud for the insurer.

(c) The procedures for detecting suspected insurance fraud shall provide for comparison of any insurance transaction against:

(1) Patterns or trends of possible fraud
(2) Red flags
(3) Events or circumstances present on a claim
(4) Behavior or history of person(s) submitting a claim or application
(5) Other criteria that may indicate possible fraud

Section 2698.46 Investigating Suspected Insurance Fraud.

(a) The SIU shall establish, maintain, distribute and adhere to written procedures for the investigation of possible suspected insurance fraud. An investigation of possible suspected insurance fraud will include:

(1) A thorough analysis of a claim file, application, or insurance transaction.

(2) Identification and interviews of potential witnesses who may provide information on the accuracy of the claim or application.

(3) Utilizing industry-recognized databases.

(4) Preservation of documents and other evidence.

(5) Writing a concise and complete summary of the investigation, including the investigator's conclusions regarding the suspected insurance fraud and the basis for their conclusions.

Section 2698.47 Referral of Suspected Insurance Fraud.

(a) The SIU shall provide for the referral of acts of suspected insurance fraud to the Fraud Division and, as required, district attorneys.

(b) Referrals shall be submitted when in any insurance transaction the facts and circumstances create a reasonable belief that a person or entity may have committed or is committing insurance fraud.

Section 2698.48 Referral Content

A referral of an act of suspected insurance fraud to the Fraud Division shall be legible and in a format as directed by the Department and contain the information and data to the extent applicable, as provided in the following.

(a) Fraud and referral type

(1) Fraud type
(2) New referral/amended referral indicator

(b) Reporting party information

(1) Reporting party type
(2) Reporting party name
(3) Reporting party California Company number
(4) Reporting self-insured/contracted third party license number, as appropriate
(5) Reporting party address, city, state and zip code
(6) Reporting party email address (generally, contact address)

(c) Alleged victim information, as appropriate

(1) Alleged victim company name
(2) Alleged victim California Company number
(3) Alleged victim self-insured number
(4) Alleged victim address, city, state and zip code

(d) Insurance policy or claim information, as appropriate

(1) Claim number associated with referral
(2) Insurance policy number associated with referral
(3) Date of loss or injury
(4) Geographic location where loss or injury occurred
(5) Insurance premium dollar loss
(6) Total potential loss on claim prior to the identification of fraud
(7) Total claim loss paid to date
(8) Actual suspected fraudulent loss amount paid to date
(9) A complete synopsis of all the facts on which the reasonable suspicion of the insurance fraud is based
(10) Disaster claim indicator

(e) Other agency referral information, as appropriate

(1) Names of other authorized governmental agencies receiving this referral

(2) Names of any District Attorney's Office receiving this referral

(3) National Insurance Crime Bureau (NICB) referral indicator

(4) The names of any other agencies receiving this referral

(f) Referral contact information, as appropriate

(1) Referral contact name and phone number
(2) Claim or case file handler and phone number
(3) Name and phone number of person who completed referral
(4) Date referral was completed

(g) Information for each party associated with the referral

(1) Identification of the role of the party to the loss
(2) Phone number
(3) Address, city, state and zip code
(4) Date of birth or age
(5) Social security number
(6) Tax identification number
(7) Drivers license number
(8) State of party's drivers license
(9) Vehicle license plate number
(10) Vehicle license plate state
(11) Vehicle identification number
(12) Other names or identifiers used by the party
(13) Claim of injury indicator

Section 2698.49 SIU Training

Requirements for training provided by and for the SIU shall include:

(a) The SIU shall establish and maintain an ongoing anti-fraud training program, planned and conducted to develop and improve the anti-fraud awareness skills of the integral anti-fraud personnel.

(b) The insurer shall designate an SIU staff person to be responsible for the ongoing antifraud training program.

(c) The anti-fraud training program shall include instruction on:

(1) The function and purpose of the SIU.

(2) Introduction/review of the written procedures established by the SIU regarding the identification, documentation and referral of incidents of suspected fraud to the SIU.

(3) Identification and recognition of red flags or red flag events.

(4) Any changes to current procedures for identifying, documenting and referring incidents of suspected insurance fraud to the SIU.

(5) Fraud Division insurance fraud reporting requirements.

(6) Introduction and review of existing and new, emerging insurance fraud trends.

(d) In addition to training provided to integral antifraud personnel provided herein, the SIU personnel shall receive anti-fraud training that include investigative techniques, communication with the Fraud Division and authorized governmental agencies, fraud indicators, emerging fraud trends, legal and related issues. This training shall be provided to SIU personnel by qualified and experienced entities in the subject matter being presented.

(e) All insurers shall provide an anti-fraud orientation program to all SIU and integral antifraud personnel within thirty (30) days after hire. Thereafter, insurers shall provide anti-fraud training to SIU and integral antifraud personnel on an annual basis.

(f) Records of the anti-fraud training provided to all staff shall be prepared at the time training is provided and be maintained and available for inspection by the Department on request.

The training records shall include the title and date of the anti-fraud training course, name and title and contact information of the instructor(s), description of the course content, length of the training course, and the name and job title(s) of participating personnel.

Section 2698.50 SIU Annual Report

(a) Every insurer shall, at the time its initial Certificate of Authority is issued and annually on a date prescribed by the Fraud Division on at least sixty (60) days prior to the due date, submit an annual report:

(b) A complete, accurate and truthful annual report shall be submitted in a format as prescribed by the Department and shall include the following information. (1) The name(s), title(s) and contact information of the insurer's SIU personnel, or

(2) The name of the organization and organizational contacts with whom the insurer has contracted for the maintenance of the SIU or any function thereof, and (3) The names of personnel whose duties include communication with the Fraud Division on matters related to the reporting,

investigation and prosecution of suspected fraudulent claims or other suspected insurance fraud.

(4) A description of the insurer's methods and written procedures used for detecting, investigating and reporting suspected insurance fraud.

(5) A description of the insurer's plan for initial and ongoing fraud education and training for integral anti-fraud personnel pursuant to these regulations.

(6) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of suspected insurance fraud.

(7) A description of how the SIU is adequately staffed to meet the requirements herein and the expertise of the staff;

(8) The number of claims processed by the insurer and the number of claims referred to the SIU, for each reported company, for the past calendar year;

(9) The number of suspected insurance fraud reported to the Department and to district attorney offices, for each reported company, for the past calendar year.

(10) A description of any significant, anticipated changes to the insurer's operations.

(11) Insurers who enter into contracts for the purpose of compliance with CIC Section 1875.20

et seq. shall provide a complete copy of the fully executed, existing contract, including all attachments and addendum, to the Department and shall specify the manner in which the contract is monitored.

(12) The number and type of civil actions for each reported company alleging acts of insurance fraud during the preceding calendar year.

(c) A statement signed under penalty of perjury must accompany all reports mentioned herein. This statement must be signed by an officer of the holder of or applicant for the

Certificate of Authority who attests to the accuracy of the reported information and the signor's personal knowledge of the existence and proper maintenance of an SIU as required by CIC

Section1875.20 et seq. and these regulations.

(d) The insurer is to maintain a copy of the annual report that will be available for review.

(e) For the purpose of these regulations, the name(s) of the insurer's personnel who will communicate with the Fraud Division shall not be made part of the public record and shall be

released only pursuant to the provisions of CIC Section 1873.1 applicable to information acquired pursuant to Article 3 of the Insurance Frauds Prevention Act.

Section 2698.51 Examinations

(a) The commissioner may conduct examinations of an insurer's SIU and related operations, including operations undertaken by entities under contract with the insurer, as deemed necessary to determine compliance with the requirements of this article.

(b) A written report of examination, including identification of violations of these applicable provisions of statute and regulation and required corrective action, if any, will be provided to the insurer on completion of the examination.

(c) Notwithstanding any penalty imposed pursuant to the regulations, within thirty (30) days of receipt of a written report identifying any violation(s) of these regulations, an insurer shall submit to the Department a plan demonstrating how the insurer will correct such violation(s) and achieve compliance. Such plan shall be subject to examination by the Department. If accepted by the Department, the plan shall be submitted as a supplement to any existing annual report and shall be accompanied by an statement of an officer of the insurer as otherwise required for annual reports. Failure to submit a corrective action and compliance plan or to comply with such plan when accepted by the Department shall be considered a violation of these regulations.

Section 2698.52 Penalties

(a) On notice and hearing in accordance with Government Code sections 11550 et seq,. the Commissioner may impose sanctions for violation of these regulations and/or Article 5.6 (commencing with section 1875.20) of the California Insurance Code.

(b) Not withstanding any other provisions of law, for each act in violation of these regulations an insurer will be subject to a penalty of not more than $55,000 and/or suspension or revocation of the insurer's Certificate of Authority.

District of Columbia — SIU requirement — *Bulletin 99-FR-001-5/1 Attachment 3*

Recommendations for the Development and Application of the D.C. Insurance Fraud Prevention and Detection Plan

C. Employment of fraud investigators: D.C. Code 22-3825.9 (a)(3)

The anti-fraud plan should contain specific procedures for determining who should conduct or oversee such investigations. You should analyze your options to maintain an in-house staff of investigators or contract with an outside firm.

Florida — SIU requirement — *Section 626.9891; Rule Sections 69D - 2.001-2.005*

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.--

(1) Every insurer admitted to do business in this state who in the previous calendar year, at any time during that year, had $10 million or more in direct premiums written shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or

(b) Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds. __An insurer subject to this subsection shall file with the Division of Insurance Fraud of the department on or before July 1, 1996, a detailed description of the unit or division established pursuant to paragraph (a) or a copy of the contract and related documents required by paragraph (b).

(2) Every insurer admitted to do business in this state, which in the previous calendar year had less than $10 million in direct premiums written, must adopt an anti-fraud plan and file it with the Division of Insurance Fraud of the department on or before July 1, 1996. An insurer may, in lieu of adopting and filing an anti-fraud plan, comply with the provisions of subsection (1).

(3) Each insurers anti-fraud plans shall include:

(a) A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts;

(b) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division of Insurance Fraud of the department;

(c) A description of the insurer's plan for anti-fraud education and training of its claims adjusters or other personnel; and

(d) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.

(4) Any insurer who obtains a certificate of authority after July 1, 1995, shall have 18 months in which to comply with the requirements of this section.

(5) For purposes of this section, the term "unit or division" includes the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.

(6) Each insurer writing workers' compensation insurance shall report to the department, on or before August 1 of each year, on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include, at a minimum:

(a) The dollar amount of recoveries and losses attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.

(b) The number of referrals to the Bureau of Workers' Compensation Fraud for the prior year.

(c) A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.

(d) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being

detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.
(e) The inservice education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.
(f) A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it.
(7) If an insurer fails to timely submit a final acceptable anti-fraud plan or anti-fraud investigative unit description, fails to implement the provisions of a plan or an anti-fraud investigative unit description, or otherwise refuses to comply with the provisions of this section, the department, office, or commission may:
(a) Impose an administrative fine of not more than $2,000 per day for such failure by an insurer to submit an acceptable anti-fraud plan or anti-fraud investigative unit description, until the department, office, or commission deems the insurer to be in compliance;
(a) Impose an administrative fine for failure by an insurer to implement or follow the provisions of an anti-fraud plan or anti-fraud investigative unit description; or
(c) Impose the provisions of both paragraphs (a) and (b).
(8) The department may adopt rules to administer this section.

69D-2.001 Purpose and Scope. The purpose of this rule chapter is to implement the provisions of Section 626.9891, FS., establishing guidelines and reporting requirements for insurer anti-fraud investigative units and anti-fraud plans.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307, FS., 626.9891(8), FS.; History-New.

69D-2.002 Definitions. For the purposes of this rule:
(1) "Division" refers to the Department of Financial Services, Division of Insurance Fraud.
(2) "NAIC" refers to the National Association of Insurance Commissioners.
(3) "Office" refers to the Office of Insurance Regulation.
(4) "SIU" refers to an insurer's internal or contracted anti-fraud investigative unit.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307, FS., 626.9891(8), FS.; History-New.

69D-2.003 Insurer SIUs.
(1) An insurer subject to Section 626.9891(1), FS., shall file with the Division a detailed description of their SIU, and shall submit the following information in the SIU description to satisfy this filing requirement:
(a) The names of all personnel assigned to the SIU, and a description of each person's work responsibilities relating to the SIU's anti-fraud efforts;
(b) An acknowledgment that the SIU has established criteria that will be used to detect suspicious or fraudulent activity during investigations relating to the different types of insurance offered by that insurer;
(c) An acknowledgment that the SIU has established criteria that will be used for the investigation

of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer.
(d) An acknowledgment that the insurer or SIU shall report all suspected fraudulent insurance acts directly to the Division electronically via Form DFS-L1-1691 (Eff._____) "Suspected Fraud Referral Form," or an electronic reporting interface that is linked to such form, as provided on the Division's website at www.fldfs.com/fraud/. Form DFS-L1-1691 (Eff._____) Suspected Fraud Referral Form is hereby adopted and incorporated by reference.
(e) An acknowledgment that all such reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.
(f) An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division;
(g) An acknowledgement that the insurer or SIU shall provide training relating to the detection and investigation of fraudulent insurance acts for all personnel involved in anti-fraud related efforts.
(h) An acknowledgement that the insurer or SIU shall provide on-going training during the reporting period;
(i) The contact information including names, email addresses, and telephone numbers, for personnel designated by the insurer or SIU to be responsible for achieving and maintaining compliance with Section 626.9891(1), FS., and this rule chapter;
(j) The insurer's NAIC individual and group code numbers;
(2) An insurer or SIU subject to Section 626.9891(1), F.S., and this rule chapter, shall submit this SIU description electronically via the Division's website at www.fldfs.com/fraud/. The SIU description shall be submitted electronically on Form DFS-L1-1689 (Eff._____) "SIU Description Form" as provided on the Division's website at www.fldfs.com/fraud/. Form DFS-L1-1689 (Eff._____) SIU Description Form is hereby adopted and incorporated by reference. The insurer's filing of the information required in subsection (1) above shall constitute an adequately detailed description of its SIU as required by Section 626.9891(1), FS.
(3) Nothing in this rule shall require that an SIU utilize all established criteria in every circumstance.
(4) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its SIU, its SIU description, or its SIU policies and procedures.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307,FS., 626.989, FS., 626.9891(1), FS.; History-New.

69D-2.004 Insurer Anti-Fraud Plans.
(1) An insurer subject to Section 626.9891(2), FS., shall file with the Division of Insurance Fraud such anti-fraud plan, and such anti-fraud plan shall include:
(a) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.
(b) A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts. Nothing in this rule shall require that an insurer utilize all established criteria in every circumstance. This description shall include:
1. An acknowledgment that the insurer has established criteria that will be used to detect suspicious

or fraudulent activity during investigations relating to the different types of insurance offered by that insurer;
2. An acknowledgment that the insurer has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer.
(c) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division pursuant to Section 626.989(6), FS. This description shall include:
1. An explanation of the insurer's method for reporting all suspected fraudulent insurance acts directly to the Division electronically on Form DFS-L1-1691, as incorporated and provided for in Rule 69D-2.003(1)(d), F.A.C.
2. An acknowledgment that all such reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.
3. An acknowledgement that the insurer shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division.
(d) A description of the insurer's plan for anti-fraud education and training of its claims adjusters and any other personnel involved in anti-fraud related efforts. This description shall include:
1. A plan that involves training relating to the detection and investigation of fraudulent insurance acts for all employees involved in anti-fraud related efforts.
2. A plan that involves on-going training during the reporting period;
(e) The contact information, including names, e-mail addresses, and telephone numbers, for personnel designated by the insurer to be responsible for achieving and maintaining compliance with Section 626.9891(2), FS., and this rule chapter;
(f) The insurer's NAIC individual and group code numbers;
(2) An insurer subject to Section 626.9891(2), FS., and this rule chapter, shall submit this anti-fraud plan electronically via the Division's website at www.fldfs.com/fraud/. The anti-fraud plan shall be submitted electronically on Form DFS-L1-1690 (Eff._____) "Anti-Fraud Plan Form as provided on the Division's website at www.fldfs.com/fraud/. Form DFS-L1-1690 (Eff._____) Anti-Fraud Plan Form is hereby adopted and incorporated by reference. The insurer's filing of the information required in subsection (1) above shall constitute an acceptable anti-fraud plan as required by Section 626.9891(2), FS.
(3) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its anti-fraud plan or its anti-fraud related policies and procedures.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307,FS., 626.9891(2),(3), FS.; History-New.

69D-2.005 Compliance and Enforcement.
(1) The Division shall review the filings of SIU descriptions and insurer anti-fraud plans and the Office shall conduct audits pursuant to Section 624.3161, FS., to determine compliance with Section 626.9891, FS., and this rule chapter.
(2) If an insurer fails to timely file an anti-fraud plan or SIU description, fails to implement or follow the provisions of their anti-fraud plan or SIU description, or in any other way fails to comply with

the requirements of Section 626.9891, FS., and this rule chapter, the Office shall take appropriate administrative action as provided in Section 626.9891(7), FS., and Section 624.4211, FS.

Kansas — SIU requirement —

See Fraud Plans

Kentucky — SIU requirement — *KRS 304.47-080; 806 KAR 47:030*

KRS 304.47-080 —

(1) Every insurer admitted to do business in the Commonwealth shall maintain a unit to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds.

(2) Insurers may maintain the unit required by subsection (1) of this section, using its employees or by contracting with others for that purpose.

(3) Insurers shall establish the unit required by this section no later than July 15, 1995.

(4) The unit may include the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. If an insurer creates a distinct unit, hires additional employees, or contracts with another entity to fulfill the requirements of this article, the additional cost incurred shall be included as an administrative expense.

806 KAR 47:030 — ... Section 2. All insurers shall implement the following in conjunction with their SIUs:

(1) Systematic and effective methods to detect and investigate suspected fraudulent insurance claims;

(2) Development and implementation of a corporate antifraud strategy to provide for the appropriate disposition of fraudulent insurance claims;

(3) Provisions to educate and train all claims handlers to identify possible insurance fraud;

(4) Policies for the SIU to cooperate with the insurer's claims handlers, the insurer's legal personnel, technical support personnel, and database support personnel;

(5) Procedures to facilitate insurer communications with the Insurance Fraud Unit and compliance with mandatory reporting of suspected fraudulent insurance acts, pursuant to KRS 304.47-050; and

(6) Procedures to encourage, coordinate, and effectuate communications and cooperation between the SIU, the Insurance Fraud Unit and other relevant law enforcement agencies.

Maine — SIU requirement — *24-A MRSA Section 2186 (as enacted by Maine H 1545, Public Law 675, Laws 1998)*

5. Insurer antifraud plans. Within 6 months of the effective date of this Act, every insurer writing direct insurance shall prepare and implement an antifraud plan. This subsection does not apply to any agency, producer or other person acting on behalf of an insurer. The superintendent may review an insurer's antifraud plan to determine if the plan complies with the requirements of this subsection. The antifraud plan must outline specific procedures, appropriate to the lines of insurance the insurer writes in the State, to:

A. Prevent, detect and investigate all forms of insurance fraud;

B. Educate appropriate employees on the antifraud plan and fraud detection;

C. Provide for the hiring of or contracting for fraud investigators; and

D. Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

Nebraska — SIU requirement —

Note: The state does not require insurers to have fraud investigators but requests that insurers send to the state's fraud prevention division a list of current contact responsible for investigating insurance fraud cases.

The purpose of the request is to allow the department to communicate with the appropriate staff and make the gathering of evidence and sharing of information more efficient.

The information should be completed on a form and returned to the department by March1. The form may be submitte with the insurer's premium tax forms.

For more information, contact the fraud division at: fraudprevention@doi.state.ne.us.

New Hampshire — Insurer Antifraud Initiative: Fraud plan and SIU requirement — *Section 417:30*

I. Except for insurance companies writing only credit, home warranty, travel, or title insurance, every insurance company licensed to write direct business in this state shall have antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts, including:

(a) Fraud investigations, who may be insurer employees or independent contractors; or

(b) An antifraud plan submitted to the commissioner.

II. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

New Jersey — SIU requirement — *11:16-6.4 Special Investigations Unit (SIU)-duties, qualifications, and composition;11:16-6.5 Training program and manual for the prevention and detection of fraud;11:16-6.6 Fraud prevention and detection plan;11:16-6.7 Referrals to OIFP;11:16-6.8 Record retention;11:16-6.9 Approval and filing of fraud prevention and detection plans;11:16-6.10 Penalties;11:16-6.11 Transition;11:16-6.12 Confidential records and information*

11:16-6.4 Special Investigations Unit (SIU)-duties, qualifications, and composition
(
a) Except for automobile insurers that insure fewer than 2,500 New Jersey automobile policies, and health insurers that insure fewer than 10,000 lives, the plan in accordance with N.J.A.C. 11:16-6.3 shall establish a full-time Special Investigations Unit ("SIU").

(b) The SIU shall be responsible for the following:

1. Conducting investigations of claims referred by the claim personnel or applications referred by underwriting personnel whenever the adjuster, processor, or underwriter identifies specific facts and circumstances which, upon further SIU investigation, may lead to a reasonable conclusion that a violation of N.J.A.C. 17:33A-4 has occurred;

2. Providing liaison with OIFP, other law enforcement personnel and the DAFC;

3. Providing in-service training to claims personnel, underwriting personnel, and adjusters in accordance with the provisions of N.J.A.C. 1:16-6.5;

4. Maintaining a database of fraudulent claims and application fraud which shall contain, at a minimum, the names, addresses and other identifying information regarding all parties to the investigation referred to in (b) 1 above;

5. Informing insurance underwriters of ineligible risks by reason of prior fraudulent activities from the database in (b)4 above;

6. Identifying persons and organizations that are involved in suspicious claim activity and application fraud, as described in (b)1 above;

7. Referring matters to OIFP in accordance with N.J.A.C. 11:16-6.6(b)
and N.J.A.C. 11:16-6.7 and providing notice of suspicious claims in accordance with N.J.A.C. 11:16-6.6(c); and

8. Ensuring that all evidence on matters referred to the SIU including, but not limited to, checks issued in payment of claims, taped statements, original receipts, and original documents submitted by a person or entity in support of or in opposition of a claim applicant, are identified, collected and

preserved in order to be turned over to OIFP in connection with the referral of cases to OIFP.

(c) The SIU shall have the following composition:

1. SIU investigators and SIU specialists shall be a separate unit from the claims adjusting or underwriting function. For purposes of this paragraph, it shall not violate this provision if the SIU issues a check paying a claim or denies payment of a claim so long as:

i. The SIU personnel are a separate and distinct unit and

ii. When closing the file at the completion of the investigation, the SIU records its findings in writing together with its recommendations to pay or deny the claim with the reasons.

2. Automobile insurers shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for each 30,000 New Jersey automobile policies serviced.

3. Health insurers offering comprehensive benefits contracts shall employ at least one SIU investigator or SIU specialist (when permitted by N.J.A.C. 11:16-6.4(d)2) for every 60,000 insured lives.

4. Health insurers offering limited benefit contracts shall employ at least one SIU or SIU specialist (when permitted by NJAC 11:16-6.4(d)2) for every 250,000 insured lives. Limited benefits contracts shall include, but not be limited to, the following: accident only; credit; disability; long-term care; Medicare supplement; dental only; vision only; insurance issued as a supplement to liability insurance; and any other supplemental hospital indemnity benefits.

(d) Qualifications of SIU investigators and specialists shall be as follows:

1. SIU investigators shall have at least one of the following:

i. A Bachelor's degree;

ii. An Associate's degree plus a minimum of two years experience with insurance related employment;

iii. A minimum of four years of experience with insurance related employment; or

iv. A minimum of five years of law enforcement experience.

2. When approved by the Department in the plan, an insurer shall be permitted to employ a limited number of SIU specialists who shall possess unique qualifications by way of training, technical skill, and/or experience to investigate and identify cases of fraud, but lack the specific educational requirements set forth in (d)1 above, to be SIU investigators.

(e) The plan may provide that the functions of the SIU may be assigned to an outside vendor or third party administrator. In such case, the plan shall provide that the outside vendor or third party administrator shall be also be responsible together with the insurer, for compliance with NJAC 11:16-6.

11:16-6.5 Training program and manual for the prevention and detection of fraud

(a) Except for automobile insurers that insure fewer than 2,500 New Jersey automobile polices and health insurers that insure fewer than 10,000 lives, the plan shall provide anti-fraud education for SIU investigators, SIU specialists, claims adjusters and underwriters that shall include a detailed and comprehensive program of insurance fraud awareness and education to prepare claims adjusting and underwriting personnel for insurance fraud prevention and detection.

1. The training program, which shall include Basic Entry level Training and Continuing Education Training for all adjusters, claims processors, underwriters, SIU investigators and SIU specialists, shall be submitted to and approved by the Department by August 5, 2000. The instructions format may be classroom instruction, self-guided instruction, videotape, seminar, computer based or by any other means.

2. The training programs referred to in (a)1 above shall be provided as follows:

i. In the case of automobile insurers, training shall include, but no be limited to, the following areas as appropriate: automobile theft investigations, automobile property damage and fire investigations, personal injury protection investigations, bodily injury liability claim investigation, statutory requirements for fraud referrals, techniques for the identification of fraudulent applications for coverage, insurance rate making practices, tier rating plans used by the insurer, PIP medical expense benefits and medical treatment protocols and precertification plans, and current indicators of fraud.

ii. In the case of health insurers, training shall include, but not be limited to, the following areas as appropriate: overcharging and overpayment detection, claims processing guidelines, medical coding, duplicate bills, excessive charges, unnecessary services or supplies, over-utilization, services never rendered, miscoded or misleading claim information, hospital inpatient or outpatient billing abuse or inappropriate commitment or confinement, abusive or fraudulent referrals, statutory requirements dealing with fraud referrals, techniques for the identification of fraudulent applications for coverage, the type, methods of service and operating procedures of various health insurers, and current indicators of fraud.

iii. The Basic Entry Level Training shall be no less than nine hours of classroom instruction. The Continuing Education Training shall be no less than nine hours of training per year for SIU personnel and four hours per year for claims and underwriting personnel. Basic Entry Level training shall be given to all employees within 180 days from the commencement of their employment at each of these positions: underwriters, adjusters, claims processors, SIU investigators, or SIU specialists. The four hour continuous education training provided to non-SIU personnel shall emphasize the

responsibility of all employees to identify and report indications of internal and external fraud to the proper authority. Persons currently employed in these positions as of February 7, 2000 shall be exempt from entry level training requirements.

(b) Except for insurers which insurer fewer than 2,500 New Jersey automobile policies, or health insurers fewer than 10,000 lives, the plan shall provide a Fraud Prevention and Detection Procedures Manual and disseminate it to, or make it available to, as appropriate, all SIU, claims adjusters, and underwriting personnel. The Fraud Prevention and Detection Procedures Manual shall include, at a minimum, the following:

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

2. The process to be employed for reporting to OIFP when specific facts and circumstances are identified, in connection with a claim or application, which upon further SIU investigation leads to a reasonable conclusion that a violation of N.J.S.A. 17:33A-4 has occurred;

3. For automobile insurers, the "fraud indicators" used for automobile theft, automobile physical damage fraud, personal injury claims fraud, bodily injury claims fraud, and application fraud;

4. For health insurers, "fraud factors" or "indicators" for health fraud, application fraud, and claims fraud;

5. The duties and functions of the SIU;

6. The procedure for referral of a claim or application to the SIU;

7. The post-referral procedure for communication between the claims unit and/or the underwriting unit and the SIU; and

8. An update page indicating that the manual has been updated and kept current.

11:16-6.6 Fraud prevention and detection plan
(a) The plan shall provide for underwriting inquiry to verify that the insured is an eligible person and the policy is properly rated within 60 days of receipt of the application. These underwriting inquiries shall verify the insured's residency provided by the insured on his or her application for insurance. The plan may provide that these inquires are generally done "in-house" by telephone and by using information from the New Jersey Division of Motor Vehicle Services (or similar agencies in other states) and prior insurers.

(b) The following concern referral of application and claims:

1.The plan shall provide that an application or claim shall be referred as a case to OIFP, for further OIFP investigation or other appropriate action, on the prescribed Referral Form (OIFP-1A for Claim Fraud Referral, OIFP-1B for Application Fraud Referral, OIFP-2 for Suspicious Claim/Application Notification, OIFP-3A for Health Claim Fraud Referral, OIFP-3B for Health Application Fraud Referral, and OIFP-4 for Suspicious Health Claim/Application notification incorporated herein by reference in the subchapter Appendix), with all other information required by the form, when the investigation complies with the requirements set forth in N.J.A.C. 11:16-6.7.

2. The plan shall provide that all applications and claims, which meet the standard for referral set forth in N.J.A.C. 11:16-6.7, shall be referred to OIFP by the SIU as soon as practicable, but in no case later than 30 days from when the investigation is complete.

3. The plan shall provide criteria and levels of economic impact for the referral of insurance claims and application fraud in accordance with the requirements of NJAC 11:16-6.7.

(c) The plan shall provide that after completion of an SIU investigation, or after identification by an SIU of a pattern of applications or claims, the insurer shall provide notice to OIFP on Notification Form OIFP-2 and for Health insurance Notification on OIFP-4 (incorporated herein by reference in the subchapter Appendix), unless this form is superseded by an electronic reporting form, of instances in which a violation of N.J.S.A. 17:33A-4 is suspected on the basis of fraud factors or indicators, but where sufficient evidence to support a case referral pursuant to N.J.A.C. 11:16-6.7 has not been developed.

(d) The plan shall provide that all referrals of application and claims fraud and notifications of suspected application or claims fraud by the insurer to OIFP shall be made by personnel in the insurer's SIU or other personnel designated in the plan so long as records are kept of all referrals and notifications and the appropriate form is used.

(e) Where an insurer contracts any of its SIU functions to an outside vendor or third party administrator in accordance with NJAC 11:16-6.4(e), the plan shall provide the name and address of the outside vendor or third party administrator used by the insurer to conduct investigations or perform SIU functions together with a copy of the contract between the insurer and the outside vendor or third party administrator.

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

11:16-6.7 Referrals to OIFP

(a) The plan shall provide that upon completion of its investigation, as described in (d) below, an SIU shall refer cases, on form OIFP-1A, OIFP-1B, OIFP-3A or OIFP-3B which meet the following standard to OIFP:

1. Any application or claim where the facts and circumstances crate a reasonable suspicion that a person or entity has violated N.J.S.A. 17:33A-4: and;

2. There is sufficient independent evidence corroborating the reasonable suspicion described in (a)1 above, from which a person could reasonably conclude that the person or entity has violated N.J.S.A. 17:33A-4.

(b) The facts and circumstances referred to in (a)1 above can include, but are not limited to, "fraud indicators" contained in an insurer's approved plan, and such other facts and circumstances as would lead a reasonable person to suspect that a violation of N.J.S.A. 17:33A-4 has occurred.

(c) As referred to in (a)2 above, independent evidence corroborating the reasonable suspicion that a person has violated N.J.S.A. 17:33A-4 includes, but is not limited to:

1. A statement from a witness;

2. Documentary evidence that directly negates a material element of the claim or directly establishes the falsity of a material element of an insurance application;

3. A report of an expert; or

4. Additional apparent misrepresentations tending to negate a possibility that the misrepresentation was merely an error.

(d) An investigation shall be complete for purposes of referral to OIFP when all reasonable and appropriate investigative leads and opportunities have been exhausted. When an investigation has identified a pattern of possible violations of N.J.S.A. 17:33A-4, the investigation will be deemed complete for purposes of referral as a case to OIFP when one or more violations included in the identified pattern have been sufficiently investigated and corroborated, in accordance with (a) above for referral to OIFP.

11:16-6.8 Record retention

(a) Insurers shall maintain up-to-date and accurate records on their fraud prevention and detection plan, which shall at minimum include those necessary to prepare the report required in (b) below.

(b) As of January 1 of each year, insurers shall submit an annual report for the prior calendar year to the Commissioner on DAFC From #1 found in this Appendix.

1. The report referred to in (b) above shall be filed with the Department on or before February 1 of each year and sent to the following address:

New Jersey Department of Banking and Insurance
Division of Anti-Fraud Compliance
PO Box 324
Trenton, N.J. 08625-0324

2. Insurers shall submit the report referred to in (b) above in written copy and on an MS-DOS formatted disk. The disk shall be a 3.5 inch 1.44 MB disk. The information shall be provided in an Access Database provided by DAFC. Insurers may submit a disk, together with a self-addressed stamped diskette mailer to the DAFC. The DAFC will properly format the disk and return to the insurer to facilitate compliance.

3. As an alternative to the filings described in (1) and (2) above, insurers may submit this annual informational filing to the Department at the following e-mail address: DAFC@DOBI.STATE.NJ.US. Insurers can acquire the required Access Database format from the Department by directing a request for the "annual filing template" to the DAFC e-mail address referenced here.

11:16-6.9 Approval and filing of fraud prevention and detection plans

(a) An insurer's fraud prevention and detection plan shall be deemed approved by the Commissioner if not affirmatively approved or disapproved by the Commissioner within 90 days of the date of filing.

(b) The Commissioner may request such amendments to the plan as he or she deems necessary.

(c) An insurer must submit amendments to its plan when necessary to achieve compliance with these rules. Any amendments to a plan filed with the Commissioner shall be deemed approved by the Commissioner if not affirmatively approved or disapproved within 90 days of the date of filing.

(d) The insurer shall permit the DAFC access to its offices upon reasonable notice and at reasonable hours to conduct an audit of the insurer's compliance with its fraud prevention plan. Nothing in this section shall be construed as to preclude the DAFC from conducting reviews of an insurer's compliance with its fraud prevention and detection plan at the office of the DAFC when determined to be necessary by the DAFC.

(e) In those instances in which an insurer uses an outside agent, third party administrator or contractor to perform SIU functions or claims investigations, the Plan and contract with the outside vendor or third party administrator shall provide the Department shall be permitted to audit the records, books and documents maintained by the outside contractor or third party administrator in the same manner and fashion as it would be able to examine the books and records in accordance with N.J.S.A. 17:33A-15 and N.J.S.A. 17:23-22.

(f) All information included in an insurer's plan submitted to the DAFC pursuant to this subchapter or any other information including training programs submitted to DAFC pursuant to this subchapter shall be confidential and not subject to public disclosure or inspection.

11:16-6.10 Penalties
Failure to comply with the provisions of this subchapter shall subject the insurer to penalties as prescribed by law.

11:16-6.11 Transition
No later than 120 days following the adoption of this subchapter, all insurers shall file with the Department a new fraud prevention and detection plan and manual in conformance with these rules.

11:16-6.12 Confidential records and information
(a) All information and materials in the possession of the Office of Insurance Fraud Prosecutor concerning the existence or occurrence of insurance fraud or related criminal activities are confidential and privileged against disclosure, and shall not be deemed public records, so as to protect the public interest in the prosecution of insurance fraud, including protecting witness security, the State's relationship with informants and witnesses, the privacy interests of persons investigated by OIFP where no fraud has been proven and other confidential relationships.

(b) The confidentiality which extends to information and materials possessed by the Office of Insurance Fraud Prosecutor with respect to the existence or occurrence of insurance fraud or related criminal activities extends to all papers, documents, reports, evidence and databases, such as investigative reports, referrals, reports or notifications of suspicious claims or applications or suspected insurance fraud, computer maintained databases of such investigative information, and such other materials and information as the Insurance Fraud Prosecutor, on the basis of his experience and exercise of judgment, believes must be kept confidential in order to ensure the orderly investigation and prosecution of insurance fraud.
c. Confidentiality of the information and materials in the possession of OIFP shall not preclude OIFP from fulfilling its statutory obligations of working with other law enforcement agencies, the Department of Health and Senior Services, the Department of Human Services, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police and such local government units as may be necessary or practicable and of coordinating and providing information to and among referring entities on pending cases of suspected insurance fraud, where such action would serve the public interest n facilitating the investigation or prosecution of insurance fraud.

New Mexico — SIU requirement —

A. Within six months of the effective date of the Insurance Fraud Act and by July 1 of each succeeding year every insurer who in the previous calendar year reported ten million dollars ($10,000,000) or more in direct written premiums in New Mexico shall establish, prepare, implement and submit to the superintendent an anti-fraud plan that is reasonably calculated to detect, prosecute and prevent insurance fraud. Any subsequent amendments to the plan shall be submitted to the superintendent at the time they are adopted.

B. Each insurer's anti-fraud plan shall outline, at a minimum, specific procedures, appropriate to the type of insurance the insurer writes, to:

(1) prevent, detect and investigate all forms of insurance fraud;

(2) educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(3) provide for the hiring or contracting of fraud investigators;

Tennessee — Fraud plan/SIU Requirement - Workers Compensation only — *Section 56-47-112*

Section 56-47-112 requires insurers to prepare, implement, maintain and submit anti-fraud plans to the Department of Commerce and Insurance.

"Each insurer's antifraud plan shall outline specific procedures to:

(A) prevent, detect and investigate all forms of insurance fraud, including fraud involving the insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies, claims fraud; and security of the insurer's data processing system;

(B) educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(C) provide for the hiring of or contracting for fraud investigators;

(D) report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud; and

(E) pursue restitution for financial loss caused by insurance fraud where appropriate."

Fraud Plan Requirement

Arkansas — Insurer Antifraud Initiative — Fraud plan and SIU Requirement — *Section 23-66-510*

(a) Insurers shall have antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent insurance acts.

Antifraud initiatives may include, but not limited to:

(1) Fraud investigators, who may insurer employees or independent contractors; or

(2) An antifraud plan submitted to the commissioner. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

(b) Upon the written request of an insurer, the commissioner may grant an exemption from the

requirements of this section if he determines that such an exemption would not be detrimental to the interests of the public.

Arkansas — Antifraud Initiative Requirements - Regulation 66 - Fraud plan and SIU Requirement — *Sec. 6 Antifraud initiative requirements; Sec. 7. Fraud Investigators and independent contractors*

Sec. 6 Antifraud initiative requirements
The antifraud initiative requirements of Arkansas Code Annotated Sec. 23-66-510(a) may be satisfied by an insurer by means of:

(1) Fraud investigators, who may be insurer employees or independent contractors and who are in full compliance with Section (7) of this rule; or

(2) An antifraud plan submitted to, and approved by, the commissioner, and which is in full compliance with Section (8) of this rule; or

(3) An alternative antifraud initiative submitted to, and approved by, the commissioner, under the provisions of Arkansas Code Annotated Sec. 23-66-510(a); or

(4) An exemption from the antifraud initiative requirements granted by the commissioner pursuant to Arkansas Code Annotated Sec. 23-66-510(b).

Sec. 7. Fraud Investigators and independent contractors

A. Fraud investigators who are employees of an insurer:
(1) shall be qualified by education, experience or training in the detection, investigation and proper reporting of suspected fraudulent insurance acts, and may be employees whose principal responsibilities are the processing and disposition of claims, if they meet the qualification requirements herein stated; and

(2) shall complete a minimum of three (3) hours of continuing education annually in the detection, investigation and proper reporting of suspected fraudulent insurance acts. The specific curriculum, location and certification of said continuing education courses are not mandated but shall be consistent with industry standards for continuing education for insurance fraud investigators.

California — Fraud plan — *Insurance Code Sections 1875.20, 1875.21, 1875.22 and 1875.23*

(b) Within ninety days of the effective date of these regulations, every insurer shall submit to the Fraud Division a written report setting forth the manner in which the insurer is complying with Insurance Code Sections 1875.20, 1875.21, 1875.22 and 1875.23 and setting forth how the insurer is meeting the objectives specified in Section 2698.42 of these Regulations.

Colorado — Fraud plan — *Section 10-1-128*

(5)(a) Every licensed insurance company doing business in Colorado shall prepare, implement, and maintain an insurance anti-fraud plan; except that this subsection (5) shall not apply to entities whose principal business is the assumption of reinsurance, reinsurance agreements, or reinsurance claims transactions. Insurance companies approved by the commissioner under article 5 of this title may be required, as a condition of such approval, to maintain an insurance anti-fraud plan. Each anti-fraud plan shall outline specific procedures, appropriate to the type of insurance provided by the insurance company in Colorado, to:

(I) Prevent, detect, and investigate all forms of insurance fraud, including fraud by the insurance company's employees and agents, fraud resulting from false representations or omissions of material fact in the application for insurance, renewal documents, or rating of insurance policies, claims fraud, and security of the insurance company's data processing systems;

(II) Educate appropriate employees about fraud detection and the company's anti-fraud plan;

(III) Provide for the hiring of or contracting for one or more fraud investigators;

(IV) Report suspected or actual insurance fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of insurance fraud.

(b) The commissioner of insurance may review a licensed insurance company's anti-fraud plan in connection with a market conduct examination to determine whether such plan complies with the requirements of paragraph (a) of this subsection (5).

(c) Every licensed insurance company doing business in this state shall include, as part of its annual report as required in section 10-3-109, a summary of its anti-fraud efforts as described in paragraph (a) of this subsection (5).

(d) The anti-fraud plan of an insurance company and the summary of anti-fraud efforts prepared as required in paragraph (c) of this subsection (5) are not public records and are exempted from article 72 of title 24, C.R.S.; are proprietary and not subject to public examination; and are not discoverable or admissible under the Colorado rules of civil procedure in any civil litigation.

District of Columbia — Fraud plan — *Section 22-3225.9 (Section 125I of Enrolled D.C. Act 12-595); Section 125I. Insurance fraud prevention and detection.*

Section 22-3225.9 (Section 125I of Enrolled D.C. Act 12-595)

Section 125I. Insurance fraud prevention and detection.

(a) Within 6 months of the effective date of this act [October 27, 1999], every insurer licensed in the District shall submit to the Department of Insurance and Securities Regulation, an insurance fraud prevention and detection plan ("plan"). The plan shall indicate specific procedures for the accomplishment of the following:

(1) Prevention, detection, and investigation of insurance fraud;

(2) Orientation of employees on insurance fraud prevention and detection;

(3) Employment of fraud investigators;

(4) Reporting of insurance fraud to the appropriate authorities; and

(5) Collection of restitution for financial loss caused by insurance fraud.

(b) The Commissioner may review the plan for compliance with this section and may order reasonable modification or request a summary of the plan. The Commissioner may establish by regulation a fine for an insurer failing to comply with the plan. The plan shall not be deemed a public record for the purposes of any public records or Title II of the District of Columbia Administrative Procedure Act, effective March 25, 1977 (D.C. Law 1-96); D.C. Code Sec. 1-1521 et seq.).

(c) Notwithstanding any other provisions of law, an insurer who fails to submit an insurance fraud prevention and detection plan, or the warning provision required by subsection (d) of this section shall be subject to a fine of $500 per day, not to exceed $25,000.
New Insurers: Within six months of the effective date of the issuance date of your Certificate of Authority, you shall submit to the Department of Insurance and Securities Regulation, an insurance fraud prevention and detection plan.

Bulletin 99-FR-001-5/1 Attachment 3
Recommendations for the Development and Application of the D.C. Insurance Fraud Prevention and Detection Plan

I. Anti-fraud Plan Components:

A. Prevention, Detection, and Investigation: D.C. Code 22-3825.9(a)(1)

The anti-fraud plan should contain specific procedures for the prevention, detection and investigation of all areas of insurance fraud. Such procedures should be prepared, published, and maintained to assist your Special Investigation Unit (hereinafter referred to as "SIU") or your point

of contact.

B. Orientation and education of employees on insurance fraud prevention and detection: D.C. Code 22-3825.9 (a)(2)
The anti-fraud plan should contain specific procedures for an orientation, education, and training program for your employees. It is imperative that your employees have the skills to recognize and investigate all insurance fraud. To increase understanding of insurance fraud, your new and existing employees should undergo an ongoing training program on the multi-dimensional nature of insurance fraud. The program should include a minimum of 2-hour sessions on a continuing education basis.

Florida — Fraud plan — *69D-2*

69D-2.001 Purpose and Scope. The purpose of this rule chapter is to implement the provisions of Section 626.9891, FS., establishing guidelines and reporting requirements for insurer anti-fraud investigative units and anti-fraud plans.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307, FS., 626.9891(8), FS.; History-New.

69D-2.002 Definitions. For the purposes of this rule:
(1) "Division" refers to the Department of Financial Services, Division of Insurance Fraud.
(2) "NAIC" refers to the National Association of Insurance Commissioners.
(3) "Office" refers to the Office of Insurance Regulation.
(4) "SIU" refers to an insurer's internal or contracted anti-fraud investigative unit.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307, FS., 626.9891(8), FS.; History-New.

69D-2.003 Insurer SIUs.
(1) An insurer subject to Section 626.9891(1), FS., shall file with the Division a detailed description of their SIU, and shall submit the following information in the SIU description to satisfy this filing requirement:
(a) The names of all personnel assigned to the SIU, and a description of each person's work responsibilities relating to the SIU's anti-fraud efforts;
(b) An acknowledgment that the SIU has established criteria that will be used to detect suspicious or fraudulent activity during investigations relating to the different types of insurance offered by that insurer;
(c) An acknowledgment that the SIU has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer.
(d) An acknowledgment that the insurer or SIU shall report all suspected fraudulent insurance acts directly to the Division electronically via Form DFS-L1-1691 (Eff._____) "Suspected Fraud Referral Form," or an electronic reporting interface that is linked to such form, as provided on the Division's website at www.fldfs.com/fraud/. Form DFS-L1-1691 (Eff._____) Suspected Fraud Referral Form is hereby adopted and incorporated by reference.

(e) An acknowledgment that all such reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.
(f) An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division;
(g) An acknowledgement that the insurer or SIU shall provide training relating to the detection and investigation of fraudulent insurance acts for all personnel involved in anti-fraud related efforts.
(h) An acknowledgement that the insurer or SIU shall provide on-going training during the reporting period;
(i) The contact information including names, email addresses, and telephone numbers, for personnel designated by the insurer or SIU to be responsible for achieving and maintaining compliance with Section 626.9891(1), FS., and this rule chapter;
(j) The insurer's NAIC individual and group code numbers;
(2) An insurer or SIU subject to Section 626.9891(1), F.S., and this rule chapter, shall submit this SIU description electronically via the Division's website at www.fldfs.com/fraud/. The SIU description shall be submitted electronically on Form DFS-L1-1689 (Eff._____) "SIU Description Form" as provided on the Division's website at www.fldfs.com/fraud/. Form DFS-L1-1689 (Eff._____) SIU Description Form is hereby adopted and incorporated by reference. The insurer's filing of the information required in subsection (1) above shall constitute an adequately detailed description of its SIU as required by Section 626.9891(1), FS.
(3) Nothing in this rule shall require that an SIU utilize all established criteria in every circumstance.
(4) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its SIU, its SIU description, or its SIU policies and procedures.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307,FS., 626.989, FS., 626.9891(1), FS.; History-New.

69D-2.004 Insurer Anti-Fraud Plans.
(1) An insurer subject to Section 626.9891(2), FS., shall file with the Division of Insurance Fraud such anti-fraud plan, and such anti-fraud plan shall include:
(a) A written description or chart outlining the organizational arrangement of the insurer's anti-fraud personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts.
(b) A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts. Nothing in this rule shall require that an insurer utilize all established criteria in every circumstance. This description shall include:
1. An acknowledgment that the insurer has established criteria that will be used to detect suspicious or fraudulent activity during investigations relating to the different types of insurance offered by that insurer;
2. An acknowledgment that the insurer has established criteria that will be used for the investigation of acts of suspected insurance fraud relating to the different types of insurance offered by that insurer.
(c) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the Division pursuant to Section 626.989(6), FS. This description shall include:

1. An explanation of the insurer's method for reporting all suspected fraudulent insurance acts directly to the Division electronically on Form DFS-L1-1691, as incorporated and provided for in Rule 69D-2.003(1)(d), F.A.C.
2. An acknowledgment that all such reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.
3. An acknowledgement that the insurer shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division.
(d) A description of the insurer's plan for anti-fraud education and training of its claims adjusters and any other personnel involved in anti-fraud related efforts. This description shall include:
1. A plan that involves training relating to the detection and investigation of fraudulent insurance acts for all employees involved in anti-fraud related efforts.
2. A plan that involves on-going training during the reporting period;
(e) The contact information, including names, e-mail addresses, and telephone numbers, for personnel designated by the insurer to be responsible for achieving and maintaining compliance with Section 626.9891(2), FS., and this rule chapter;
(f) The insurer's NAIC individual and group code numbers;
(2) An insurer subject to Section 626.9891(2), FS., and this rule chapter, shall submit this anti-fraud plan electronically via the Division's website at www.fldfs.com/fraud/. The anti-fraud plan shall be submitted electronically on Form DFS-L1-1690 (Eff._____) "Anti-Fraud Plan Form as provided on the Division's website at www.fldfs.com/fraud/. Form DFS-L1-1690 (Eff._____) Anti-Fraud Plan Form is hereby adopted and incorporated by reference. The insurer's filing of the information required in subsection (1) above shall constitute an acceptable anti-fraud plan as required by Section 626.9891(2), FS.
(3) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its anti-fraud plan or its anti-fraud related policies and procedures.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307,FS., 626.9891(2),(3), FS.; History-New.

69D-2.005 Compliance and Enforcement.
(1) The Division shall review the filings of SIU descriptions and insurer anti-fraud plans and the Office shall conduct audits pursuant to Section 624.3161, FS., to determine compliance with Section 626.9891, FS., and this rule chapter.
(2) If an insurer fails to timely file an anti-fraud plan or SIU description, fails to implement or follow the provisions of their anti-fraud plan or SIU description, or in any other way fails to comply with the requirements of Section 626.9891, FS., and this rule chapter, the Office shall take appropriate administrative action as provided in Section 626.9891(7), FS., and Section 624.4211, FS.
Specific Authority: 624.308, FS., 626.9891, FS., 626.9891(8), FS.; Law Implemented: 624.307, FS., 626.9891(7), FS.; History-New.

Kansas — Fraud plan — *KSA 40-2,118(d)*

(d)(1) Each insurer shall have antifraud initiatives reasonably calculated to detect fraudulent insurance acts. Antifraud initiatives may include: fraud investigators, who may be insurer employees or independent contractors; or an antifraud plan submitted to the commissioner no later than July 1, 2007. Each insurer that submits an antifraud plan shall notify the commissioner of any material change in the information contained in the antifraud plan within 30 days after such change occurs. Such insurer shall submit to the commissioner in writing the amended antifraud plan.
The requirement for submitting any antifraud plan, or any amendment thereof, to the commissioner shall expire on the date specified in paragraph (2) of this subsection unless the legislatue reviews and reenacts the provisions of paragraph (2) pursuant to K.S.A. 45-229 and amendments thereto.
(2) Any antifraud plan, or any amendment thereof, submitted to the commissioner for informational purposes only shall be confidential and not be a public record and shall not be subject to discovery or subpoena ina civil action unless following an in camera review, the court determines that the antifraud plan is relevant and otherwise admissable under the rules of evidence set forth in article 4, chapter 60 of the Kansas Statutes Annotated, and amendments thereto. The provisions of this paragraph shall expire on July 1, 2011, unless the legislatiure reviews and reenacts this provision pursuant to K.S.A. 45-229, and amendments thereto, prior to July 1, 2011.

Kentucky — Fraud plan — *Section 3*

... Section 3 (1) Within ninety (90) days of the effective date of this administrative regulation, every insurer shall submit to the Insurance Fraud Unit a written report setting forth the manner in which the insurer is complying with Section (2) of this administrative regulation.

(2) The above report shall also include the following:

(a) If the insurer formed the SIU in house and solely governs it, the year that the SIU was formed;

(b) If the insurer has contracted SIU services through another company, the following shall be reported:
1. The identity of the company providing SIU services;
2. The initial year of the contract between the insured and the company providing SIU services;
3. A copy of the contract between the insurer and the company providing SIU services.

(c) The total number of the SIU investigative staff;

(d) The total number of SIU investigative staff investigating cases for multiple jurisdictions including Kentucky; and

(e) The total number of SIU investigative staff limited to investigating cases in Kentucky.

Section 4. Within thirty (30) days of a material change of the information provided in the above report, the insurer shall amend the written report and refile the report in accordance with this section.

Maine — Fraud plan — *24-A MRSA Section 2186 (as enacted by Maine H 1545, Public Law 675, Laws 1998)*

5. Insurer antifraud plans. Within 6 months of the effective date of this Act, every insurer writing direct insurance shall prepare and implement an antifraud plan. This subsection does not apply to any agency, producer or other person acting on behalf of an insurer. The superintendent may review an insurer's antifraud plan to determine if the plan complies with the requirements of this subsection. The antifraud plan must outline specific procedures, appropriate to the lines of insurance the insurer writes in the State, to:

A. Prevent, detect and investigate all forms of insurance fraud;

B. Educate appropriate employees on the antifraud plan and fraud detection;

C. Provide for the hiring of or contracting for fraud investigators; and

D. Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.

Maryland — Fraud plan (Regulations) — *09.31.17.04 - Procedures and Requirements; 09.31.17.0.5 - Plan Components*

09.31.17

.04 - Procedures and Requirements

A. Antifraud Plan

(1) An insurer authorized to write insurance business in this State shall institute, implement, and maintain an insurance antifraud plan.

B. Contents of Antifraud Plan

An antifraud plan shall:

(1) Contain provisions for educating and training an insurer's employees in the detection of insurance fraud;

(2) Provide for methods and procedures concerning the investigation of suspicious claims; and

(3) Apply to but not limited to:
(a) Claims fraud,
(b) Application fraud,
(c) Agent fraud,

(d) Broker fraud;
(e) Third party administrator fraud, and
(f) Internal fraud.

0.5 - Plan Components
A. Education/Training.

(1) An antifraud plan shall contain procedures for the provision of education or training, or both, to the insurer's employees regarding the detection of insurance fraud.

(2) Training in the recognition and referral of suspicious claims shall be:

(a) required of new and existing claim personnel, underwriters, auditors, agents, and consumer service personnel; and

(b) offered to independent agents or brokers who have appointments with the company.

(3) At a minimum, the educational components an antifraud plans shall address the following:

(a) courses of instruction shall be:

(i) designed to address specific aspects of fraud associated with a company's product line, and

(ii) at least 2 hours in duration.

(b) Personnel shall be presented with updated material at the entrance level and at least once every 2 years in conjunction with continuing education standards or as a company policy;

(c) A new employee shall receive the regulated education and training regarding the detection of fraud within 6 months of the effective date of employment; and

(d) Training programs may be developed and conducted either by internal personnel or by outside contractors.

B. Detection

(1) An antifraud plan shall have provisions regarding the early detection of all areas of fraud including, but not limited to:

(a) Embezzlement and internal theft;

(b) Underwriting and application fraud;

(c) Theft and misappropriation of premiums by agents;

(d) Claims fraud; and

(e) Application fraud.

(2) The antifraud plan shall delineate the methods or approaches, or both, that will be utilized in detecting fraud.

(3) An authorized insurer shall:

(a) designate an individual or individuals, or a specific unit, either
in-house or outside, to be responsible for coordinating the detection, referral, and investigation of suspected fraudulent activity;

(b) include the designation in the antifraud plan; and

(c) submit amendments to the designation to the Administration.

(4) Fraud detection guides shall be prepared, published, and maintained to assist claim personnel, underwriters, and agents in the identification, detection, and handling of suspicious claims.

C. Investigation

(1) An antifraud plan shall contain:

(a) procedures for handling fraud complaints;

(b) procedures that are to be followed when instances of suspected fraud have been detect, evaluated, and found to warrant a full investigation;

(c) the requirement that the company representative responsible for the conduct and oversight of fraud investigations assign the matter for investigation;

(d) the designation of the individuals responsible for conducting investigations on behalf of the insurer including the individuals responsible for providing the notifications required by Sec. C(1)(g) of this regulation;

(e) guidelines and procedures for conducting investigations and cooperating with the Insurance Fraud Division or other law enforcement agency which is conducting a criminal investigation if in-house staff is utilized;

(f) written considerations as to work product and court room testimony; and

(g) guidelines and procedures for notifying the appropriate law enforcement agency, including the

Insurance Fraud Division of the Administration.

(2) Investigators

(a) a company may maintain an in-house staff of investigators or contract with an outside firm.

(b) if an outside firm is used, the firm shall comply with all Maryland licensing laws and regulations to the extent that they are applicable.

(D) Auditing

(1) An antifraud plan shall contain procedures regarding the auditing of agents by the company.

(2) The auditing procedures shall provide for both routine auditing and random audits.

(3) If an irregularity is discovered during an audit, the antifraud plan shall require that the duly authorized company representative who conducts or oversees investigations be notified immediately.

Minnesota — Fraud plan — *General Insurance Powers Statutes Section 60A.954*

Section 60A.954 - Antifraud plan — Subdivision 1. Establishment. An insurer shall institute, implement, and maintain an antifraud plan. For the purpose of this section, the term insurer does not include reinsurers, self-insurers, and excess insurers. Within 30 days after instituting or modifying an antifraud plan, the insurer shall notify the commissioner in writing. The notice must include the name of the person responsible for administering the plan. An anti-fraud plan shall establish procedures to:

(1) prevent insurance fraud, include: internal fraud involving the insurer's officers, employees or agents; fraud resulting from misrepresentations on applications for insurance; and claims fraud;

(2) report insurance fraud to appropriate law enforcement authorities; and

(3) cooperate with the prosecution of insurance fraud cases.

Subdivision 2. Review. The commissioner may review each insurer's antifraud plan to determine whether it complies with the requirements of this section....

New Hampshire — Insurer Antifraud Initiative: Fraud plan and SIU requirement — *Section 417:30*

I. Except for insurance companies writing only credit, home warranty, travel, or title insurance, every insurance company licensed to write direct business in this state shall have antifraud initiatives reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts,

including:

(a) Fraud investigations, who may be insurer employees or independent contractors; or

(b) An antifraud plan submitted to the commissioner.

II. Antifraud plans submitted to the commissioner shall be privileged and confidential and shall not be a public record and shall not be subject to discovery or subpoena in a civil or criminal action.

New Jersey — Fraud plan — *11:16-6.1 Purpose and scope; 11:16-6.2 Definitions; N.J.A.C. 11:4-16.7, 11:20-4.1 and 11:21-6.1; 17:30A-1 et seq.; 17:48D-1 et seq.;11:16-6.3 General requirements and filing format*

17:33A-15. Filing of plan for prevention, detection of fraudulent health, auto insurance claims

1. a. Every insurer writing health insurance or private passenger automobile insurance in this State shall file with the commissioner a plan for the prevention and detection of fraudulent insurance applications and claims. The plan shall be deemed approved by the commissioner if not affirmatively approved or disapproved by the commissioner within 90 days of the date of filing. The commissioner may call upon the expertise of the director in his review of plans filed pursuant to this subsection. The commissioner may request such amendments to the plan as he deems necessary. Any subsequent amendments to a plan filed with and approved by the commissioner shall be submitted for filing and deemed approved if not affirmatively approved or disapproved within 90 days from the filing date.

b. The implementation of plans filed and approved pursuant to subsection a. of this section shall be monitored by the division. The division shall promptly notify the Attorney General of any evidence of criminal activity encountered in the course of monitoring the implementation and execution of the plans. Each insurer writing health insurance or private passenger automobile insurance in this State shall report to the director on an annual basis, on January 1st of each year, on the experience in implementing its fraud prevention plan.

11:16-6.1 Purpose and scope

(a) This subchapter sets forth the standards for plan for the prevention and detection of fraudulent insurance applications and claims filed for approval pursuant to N.J.S.A. 17:33A-15 by insurers which transact the business of private passenger automobile insurance or health insurance this State. These provisions apply to all insurers that transact the business of private passenger automobile insurance in New Jersey, including both personal and commercial coverage; and to all insurers transacting the business of health insurance as sets forth in N.J.S.A. 17:33A-3 and N.J.A.C. 11:16-6.2.

(b) The subchapter also sets forth the reporting standards and forms necessary to refer insurance

fraud matters to the Office of Insurance Fraud Prosecutor ("OIFP"). These provisions apply to all insurers as defined by N.J.S.A. 17:33A-3 and N.J.A.C. 11:16-6.2 including those with PAIP and CAIP assignments.

11:16-6.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Application" means any document that contains the minimum information necessary as set forth at N.J.A.C. 11:3-44.3(a) to determine whether an applicant is an eligible person or is used in any way by the insurer to rate or underwrite a policy, including the coverage of selection form and renewal questionnaire as provided at N.J.A.C. 11:3-15.7 and 11:3-8 and, if requested, a copy of the applicant's driver's license, a copy of the motor vehicle registration of the principal vehicle to be insured and any additional proof of New Jersey residency.
The term "application" shall also mean those signed forms, data, reports, analysis and other documents supplied in support of an application when requested by an insurer or by any other person, and/or supplied by the insured/applicant, or other person(s), seeking coverage under a policy or plan of health insurance that is provided to or used by an insurer in assessing the risk, or premium, or which is relied upon by the insurer in agreeing to provide coverage under the policy or plan, including but not limited to that information submitted in accordance with

N.J.A.C. 11:4-16.7, 11:20-4.1 and 11:21-6.1.

"Commissioner" means the Commissioner of the New Jersey Department of Banking and Insurance.

"DAFC" means the Division of Anti-Fraud Compliance in the Department of Banking and Insurance.

"Department" means the New Jersey Department of Banking and Insurance.

"Eligible person" means an individual who meets the qualifications set forth in N.J.A.C. 11:3-34.

"Fraud and misrepresentation" means the knowing misrepresentation of any material fact in a claim or application or the knowing failure to disclose any material fact in a claim or application which, if properly revealed or disclosed, would change the premium; either would affect the placement or underwriting of the risk, the assignment in the insurer's rating plan, or affect the payment of a claim.

"Fraud and prevention detection plan" or "plan" means an insurer's plan for the prevention and detection of fraudulent insurance applications and claims.

"Health insurance" means a contract or agreement whereby an insurer is obligated to pay or allow a benefit of pecuniary value with respect to the bodily injury, disablement, sickness, death by accident or accidental means of a human being, or because of any expense relating thereto, or

because of any expense incurred in prevention of sickness, and includes every risk pertaining to any of the enumerated risks. Health insurance does not include any administrative services only (ASO) contracts, workers' compensation coverage, or stop-loss coverage.

"Insured lives" means the actual number of New Jersey residents entitled to receive benefits under a contract delivered or issued for delivery in this State.

"Insurer" means any person or entity authorized to transact the business of private passenger automobile insurance in New Jersey, whether in accordance with a personal lines or commercial lines rating system, and includes a group of affiliated companies, and the Property-Liability Insurance Guaranty Association established pursuant to N.J.S.A.

17:30A-1 et seq. when performing its statutory function.
"Insurer" pursuant to N.J.S.A. 17:33A-3 (health insurance) also means:

1. Any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to N.J.S.A. 17:17-1 et seq. or 17B:17-1 et seq.);

2. Any medical service corporation operating pursuant to N.J.S.A. 17:48A-1 et seq.;

3. Any hospital service corporation operating pursuant to N.J.S.A. 17:48-1 et seq.;

4. Any health service corporation operating pursuant to N.J.S.A. 17:48E-1 et seq.;

5. Any dental service corporation operating pursuant to N.J.S.A. 17:48C-1 et seq.;

6. Any dental plan organization operating pursuant to N.J.S.A.

17:48D-1 et seq.;
"OIFP" means the Office of the Insurance Fraud Prosecutor in the Division of Criminal Justice in the Department of Law and Public Safety.
"Special Investigations Unit" or "SIU" means the functional group established by an insurer to carry out the duties set forth in N.J.A.C. 11:16-6.4(a).
"Stop-loss or excess risk insurance" means insurance designed to reimburse a self-funded arrangement for catastrophic and unexpected expenses exceeding specified per person retention limits and/or aggregate retention limit, wherein neither employees nor other individuals are third party beneficiaries under the policy, contract or plan.

11:16-6.3 General requirements and filing format

(a) All insurers shall file for approval a fraud prevention and detection plan ("plan") in accordance with N.J.S.A. 17:33A-15 and this subchapter. No insurer shall use or implement any plan that is not filed and approved.

(b) Insurers shall submit their plan on 8 1/2 by 11-inch paper. The first page shall show the filer's company name, the filer's identifying number for this filing, National Association of Insurance Commissioners ("NAIC") company number(s), and NAIC group number.

(c) Insurers shall file their plan with the Department at the following address:
Fraud Prevention and Detection Plan
New Jersey Department of Banking and Insurance
Division of Anti-Fraud Compliance
P.O. Box 324
Trenton, N.J. 08625-0324

New Mexico — Fraud plan — *Section 10 - H 141, enacted 1998 session, effective July 1, 1998*

Section 10 - H 141, enacted 1998 session, effective July 1, 1998.

A. Within six months of the effective date of the Insurance Fraud Act and by July 1 of each succeeding year every insurer who in the previous calendar year reported ten million dollars ($10,000,000) or more in direct written premiums in New Mexico shall establish, prepare, implement and submit to the superintendent an anti-fraud plan that is reasonably calculated to detect, prosecute and prevent insurance fraud. Any subsequent amendments to the plan shall be submitted to the superintendent at the time they are adopted.

B. Each insurer's anti-fraud plan shall outline, at a minimum, specific procedures, appropriate to the type of insurance the insurer writes, to:

(1) prevent, detect and investigate all forms of insurance fraud;

(2) educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(3) provide for the hiring or contracting of fraud investigators;

(4) report insurance fraud to appropriate law enforcement and regulatory authorities; and

(5) pursue restitution, where appropriate, for financial loss caused by insurance fraud.

C. The superintendent may review each insurer's anti-fraud plan to determine if it adequately complies with the requirements of this section. The superintendent may examine the insurer to assure its compliance with anti-fraud plans submitted to the superintendent. The superintendent may require reasonable modifications to the insurer's anti-fraud plan or may require other reasonable remedial action if the review or examination reveals substantial noncompliance with the plan.

New Mexico — Fraud plan — *Section 10 - H 141, enacted 1998 session, effective July 1, 1998*

A. Within six months of the effective date of the Insurance Fraud Act and by July 1 of each succeeding year every insurer who in the previous calendar year reported ten million dollars ($10,000,000) or more in direct written premiums in New Mexico shall establish, prepare, implement and submit to the superintendent an anti-fraud plan that is reasonably calculated to detect, prosecute and prevent insurance fraud. Any subsequent amendments to the plan shall be submitted to the superintendent at the time they are adopted.

B. Each insurer's anti-fraud plan shall outline, at a minimum, specific procedures, appropriate to the type of insurance the insurer writes, to:

(1) prevent, detect and investigate all forms of insurance fraud;

(2) educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(3) provide for the hiring or contracting of fraud investigators;

(4) report insurance fraud to appropriate law enforcement and regulatory authorities; and

(5) pursue restitution, where appropriate, for financial loss caused by insurance fraud.

C. The superintendent may review each insurer's anti-fraud plan to determine if it adequately complies with the requirements of this section. The superintendent may examine the insurer to assure its compliance with anti-fraud plans submitted to the superintendent. The superintendent may require reasonable modifications to the insurer's anti-fraud plan or may require other reasonable remedial action if the review or examination reveals substantial noncompliance with the plan.

New York — Fraud plan — *Section 409 (c)*

Section 409 (c) "The plan (anti-fraud plan) shall provide for the following:

(1) interface of special investigation unit personnel with law enforcement and prosecutorial agencies, including the insurance frauds bureau of the state insurance department;

(2) reporting of fraud data to a central organization approved by the superintendent;

(3) in-service education and training for underwriting and claims personnel in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities;

(4) coordination with other units of an insurer for the investigation and initiation of civil actions based upon information received by or through the special investigation unit;

(5) public awareness of the cost and frequency of fraudulent activities, and the methods of preventing fraud;

(6) development and use of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity; and

(7) the time and manner in which such plan shall be implemented and a demonstration that the fraud prevention and reduction measures outlined in the plan will be fully implemented."

Section 409 (d) sets out the procedures for the review and approval by the superintendent, and for the revision of any plan as ordered by the superintendent.

New York — Fraud plan - Regulations — *Section 86.6 - Fraud prevention plans and special investigation units*

Section 86.6 - Fraud prevention plans and special investigation units.

(a) Every insurer writing private or commercial automobile insurance, worker's compensation insurance, or individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, which writes three thousand or more such policies in any given year, shall develop and file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state.

(b) The plan shall include the following provisions:

(1) Establishment of a full time Special Investigation Unit separate from the underwriting or claims functions of the insurer, which shall be responsible for investigation of cases of suspected fraudulent activity and for implementation of the insurer's fraud prevention and reduction activities under the Fraud Prevention Plan. In the alternative the insurer may contract with a provider of services to perform all or part of this function, but shall remain primarily responsible for the development and implementation of its Fraud Prevention Plan. The agreement under which such services are provided shall be filed with the Insurance Frauds Bureau as part of the Fraud Prevention Plan, and must provide for specific levels of staffing devoted to the investigation of suspected fraudulent claims. In the event that investigators employed by a provider of services will be working for more than one insurer or on cases in states other than New York, the plan must apportion the percentage of the investigator's efforts which will be devoted to working for the insurer on its New York cases. The agreement shall also require that the provider of services cooperate fully with the Department of Insurance in any examination of the implementation of the Fraud Prevention Plan, and provide any and all assistance requested by the Insurance Frauds Bureau, any other law enforcement agency or any prosecutorial agency in the investigation and prosecution of insurance fraud and related crimes.

(2) A description of the organization of the Special Investigation Unit, including the titles and job descriptions of the various investigators and investigative supervisors, the minimum qualifications for employment in these positions in addition to those required by this regulation, the geographical location and assigned territory of each investigator and investigative supervisor, the support staff

and other physical resources, including database access available to the Unit and the supervisory and reporting structure within the Unit and between the Unit and the general management of the insurer. If investigators employed by the Unit will be responsible for investigating cases in more than one State, the plan must apportion that percentage of the investigators' efforts which will be devoted to New York cases.

(3) The rationale for the level of staffing and resources being provided for the Special Investigations Unit including objective criteria such as number of policies written and individuals insured in New York, number of claims received with respect to New York insureds on an annual basis, volume of suspected fraudulent New York claims currently being detected, other factors relating to the vulnerability of the insurer to fraud, and an assessment of optimal caseload which can be handled by an investigator on an annual basis.

(4) A description of the relationship between the Special Investigation Unit and the claims and underwriting functions of the insurer, including procedures for detecting possible fraud, criteria for referral of a case to the Unit for evaluation, and the designation of the individuals authorized to make such a referral; and a description of the relationship between the Unit and the Insurance Frauds Bureau, other law enforcement agencies and prosecutors, including procedures for case investigation, detection of patterns of repetitive fraud involving one or more insurers, criteria for referral of a case to the Insurance Frauds Bureau, designation of the individuals authorized to make such referrals, and a policy to avoid duplication of effort due to concurrent referrals by the Unit to more than one law enforcement agency.

(5) Provision for the reporting of fraud data to a data collection firm to be designated by the superintendent.

(6) Provision for in-service training programs for investigative, underwriting and claims personnel in identifying and evaluating instances of suspected insurance fraud, including an introductory training session and periodic refresher sessions. This description shall include course descriptions, the approximate number of hours to be devoted to these sessions and their frequency.

(7) Provision for the coordination with other units of the insurer to further fraud investigations, including a periodic review of claims and underwriting procedures and forms for the purpose of enhancing the ability of the insurer to detect fraud to increase the likelihood of its successful prosecution, and for initiation of civil actions where appropriate.

(8) Development of a public awareness program focused on the cost and frequency of insurance fraud, and methods by which the public can prevent it.

(9) Development of a fraud detection and procedures manual for use by underwriting, claims and investigative personnel.

(10) Timetable for the implementation of the Fraud Prevention Plan.

(c) Persons employed by the Special Investigations Units as investigators or by an independent provider of investigative services under contract with an insurer shall be qualified by education and/or experience which shall include a bachelor's degree or either four years of claims investigation experience or five years of professional investigation experiences involving economic or insurance related matters. Notwithstanding these minimum requirements anyone employed as an investigator in a special investigation unit as of the effective date of this provision may continue in such employment provided the insurer identifies such person in writing to the superintendent giving the date such employment began and a description of the person's qualifications, employment history and current job duties.

(d) Every insurer required to file a fraud prevention plan shall file an annual report with the Insurance Frauds Bureau no later than January 15 of each year on a form approved by the superintendent, describing the insurer's experience, performance and cost effectiveness in implementing the plan and its proposals for modifications to the plan to amend its operations, to improve performance or to remedy observed deficiencies. The report shall be reviewed and signed by the chief executive officer of the insurer.

Ohio — Fraud plan — *Section 3999.41*

(A) Except as provided in Division (D) of this section, every insurer, as defined in Division (A) of Section 3999.36 of the revised code, shall adopt an antifraud program and shall specify in a written plan the procedures it will follow when instances of insurance fraud or suspected insurance fraud are brought to its attention. The insurer shall identify in the written plan the person or persons responsible for the insurer's antifraud program.

(B)(1) An insurer shall develop a written plan required by Division (A) of this section within ninety days after obtaining its license to transact business within this state or within ninety days after beginning to engage in the business of insurance within this state and shall thereafter maintain such a written plan.

(2) An insurer engaged in the business of insurance within this state on the effective date of this section shall develop a written plan required by Division (A) required by Division (A) of this section within ninety days after the effective date of this section and shall thereafter maintain such a written plan.

(C) If an insurer modifies the procedures it follows for instances of insurance fraud or suspected insurance fraud, or if there is a change in the person or persons responsible for the insurer's antifraud program, the insurer shall modify the written plan it maintains pursuant to this section.

(D) The requirements of this section are not applicable to any
insurer identified in Division (A) of this section that is not engaged in writing direct insurance in this state.

Pennsylvania — Fraud plan — *Title 75 Sections 1811-1816*

Title 75 Sections 1811-1816 (Motor Vehicle Insurance Fraud)
Section 1811 — Each insurer licensed to write motor vehicle insurance in this Commonwealth shall institute and maintain a motor vehicle insurance antifraud plan.... All insurers licensed ... shall file within six months of licensure. All changes to the antifraud plan shall be filed with the department within 30 days after it has been modified.

Section 1812 — The antifraud plans of each insurer shall establish specific procedures:

(1) To prevent insurance fraud, including internal fraud involving employees or company representatives, fraud resulting from misrepresentation on applications for insurance coverage, and claims fraud.

(2) To review claims in order to detect evidence of possible insurance fraud and to investigate claims where fraud is suspected.

(3) To report fraud to appropriate law enforcement agencies and to cooperate with such agencies in their prosecution of fraud cases.

(4) To undertake civil actions against persons who have engaged in fraudulent activities.

(5) To report fraud-related data to a comprehensive database system.

(6) To ensure that costs incurred as a result of insurance fraud are not included in any rate base affecting the premiums of motor vehicle insurance consumers.

Section 1813 — "Review by commission
Antifraud plans shall be filed with the department . . ."

Tennessee — Fraud warning/Fraud plan — *56-53-111*

Chapter No. 356 – Enacted 2001 Legislative Session
Section 12 (b)

(1)(A) No later than six (6) months after the effective date of this act, all applications for insurance, and all claim forms regardless of the form of transmission provided and required by an insurer or required by law as a condition of payment of a claim, shall contain a statement, permanently affixed to the application or claim form, that clearly states in substance the following, or words to that effect:
"It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits."

(1)(B) The lack of a statement required in this subsection does not constitute a defense in any criminal prosecution under Section 3 nor in any civil action under Section 3 or 4.

(2) The warning required by this subsection shall not be required on forms relating to reinsurance.

Fraud Plan/SIU Requirement
Chapter No. 356 – Enacted 2001 Legislative Session
Section 12 (a) Anti-Fraud Plans
Within six months of the effective date of this legislation, every insurer with direct written premiums exceeding ten million dollars ($10,000,000) shall prepare, implement, and maintain an insurance anti-fraud plan. Each insurer's anti-fraud plan shall outline specific procedures, appropriate to the type of insurance the insurer writes in the state, to:

(1) Prevent, detect and investigate all forms of insurance fraud, including fraud involving the insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies; claims fraud; and security of the insurer's data processing system;

(2) Educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(3) Provide for the hiring of or contracting for fraud investigators;

(4) Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud; and

(5) Pursue restitution for financial loss caused by insurance fraud, where appropriate.

Tennessee — Fraud plan/SIU Requirement - Workers Compensation only — *Section 56-47-112*

Section 56-47-112 requires insurers to prepare, implement, maintain and submit anti-fraud plans to the Department of Commerce and Insurance.

"Each insurer's antifraud plan shall outline specific procedures to:

(A) prevent, detect and investigate all forms of insurance fraud, including fraud involving the insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal or rating of insurance policies, claims fraud; and security of the insurer's data processing system;

(B) educate appropriate employees on fraud detection and the insurer's anti-fraud plan;

(C) provide for the hiring of or contracting for fraud investigators;

(D) report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud; and

(E) pursue restitution for financial loss caused by insurance fraud where appropriate."

Vermont — Fraud plan — *Chapter 130 Section 4750*

CHAPTER 130. INSURANCE FRAUD
§ 4750. INSURER ANTI-FRAUD PLANS
(a) Every insurer with direct written premiums shall prepare, implement, and maintain an insurance anti-fraud plan. Each insurer's anti-fraud plan shall outline specific procedures, appropriate to the type of insurance the insurer writes in this state, to:
(1) Prevent, detect, and investigate all forms of insurance fraud, including fraud involving the insurer's employees or agents; fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies; claims fraud; and security of the insurer's data processing systems.
(2) Educate appropriate employees on fraud detection and the insurer's anti-fraud plan.
(3) Provide for the hiring of or contracting for fraud investigators.
(4) Report insurance fraud to appropriate law enforcement and regulatory authorities in the investigation and prosecution of insurance fraud.
(5) Where appropriate, pursue restitution for financial loss caused by insurance fraud.
(6) Ensure that applicable state and federal privacy laws are complied with and that the confidential personal and financial information of consumers and insureds is protected.
(7) Comply with such other procedures as the commissioner may require by rule.
b) The commissioner may require an insurer to file annually its anti-fraud plan with the department and an annual summary of the insurer's anti-fraud activities and results, including misclassification and miscoding. A workers' compensation insurer shall file an anti-fraud plan with the department of labor, including information about fraud investigations, referrals, or prosecutions involving Vermont workers' compensation claims, misclassifications, and miscoding, if requested by the commissioner of labor. Information regarding fraud investigations and referrals shall not be public unless the commissioner of labor or the attorney general commences administrative or criminal proceedings.
(c) This section confers no private rights of action. This section does not affect private rights of action conferred under other laws or court decisions.
(d) Enforcement. Notwithstanding any other provision of this title, the following are the exclusive monetary penalties for violation of this section. Insurers that fail to prepare, implement, maintain, or submit to the department of banking, insurance, securities, and health care administration an insurance anti-fraud plan are subject to a penalty of $500.00 per day, not to exceed $10,000.00.
Sec. 3. 1 V.S.A. § 317(c)(36) is added to read:
(36) anti-fraud plans and summaries submitted by insurers to the department of banking, insurance, securities, and health care administration for the purposes of complying with 8 V.S.A. § 4750.

Washington — Fraud plan — *Chapter 285, Laws of 1995 - Sections 8 - 11*

Section 9 — Each insurer licensed to write direct insurance in this state shall institute and maintain an insurance antifraud plan. An insurer licensed on the effective date of this act shall file its antifraud plan with the insurance commissioner no later than December 31, 1995. An insurer licensed after the effective date of this act shall file its antifraud plan within six months of licensure. An insurer shall file any change to the antifraud plan with the insurance commissioner within thirty days after the plan has been modified.

Section 10 — An insurer's antifraud plan must establish specific procedures to:

(1) Prevent insurance fraud, including internal fraud involving employees or company representatives, fraud resulting from misrepresentation on applications for insurance coverage, and claims fraud;

(2) Review claims in order to detect evidence of possible insurance fraud and to investigate claims where fraud is suspected;

(3) Report fraud to appropriate law enforcement agencies and cooperate with those agencies in their prosecution of fraud cases;

(4) Undertake civil actions against persons who have engaged in fraudulent activities;

(5) Train company employees and agents in the detection and prevention of fraud."

Section 11 — If after review of an insurer's antifraud plan, the commissioner finds that the plan does not comply with section 10 of this act, the commissioner may disapprove the antifraud plan . . .

Note: In 1997, HB 1002 exempted life and health insurers from anti-fraud plan requirements.