

Anti-Fraud Plan Filing, Reporting and Compliance

Please note that, as a courtesy, the following information is provided as general guidance and a brief summary of the Commonwealth's antifraud plan filing, reporting and compliance requirements. You should consult the actual statutes and regulations for a complete understanding of all requirements associated with antifraud plans, filings, reporting and compliance.

Antifraud Plan Filing

Each insurer licensed to write motor vehicle, workers' compensation or viatical insurance in this Commonwealth shall institute and maintain an antifraud plan in accordance with 75 Pa.C.S. § 1811 (motor vehicle insurance), 77 P.S. § 1040.3 (worker's compensation insurance) or 40 P.S. § 626.10 (viaticals). Since a substantial number insurers actively write multiple lines of insurance, the Department encourages insurers to merge anti-fraud plans.

Motor Vehicle Insurers: An antifraud plan shall be filed 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 (75 Pa.C.S. § 1811).

Insurers that fail to file timely antifraud plans are subject to the penalty provisions of section 320 of the Act of May 17, 1921 (P.L.682, No.284) (40 P.S. § 443), known as The Insurance Companies Law of 1921. Insurers that do not make a good faith attempt to file an antifraud plan which complies with section 1812 (relating to content of plans) shall also be subject to the penalty provisions of section 320 of The Insurance Companies Law of 1921, provided that no penalty may be imposed for the first filing made by an insurer under this subchapter. Insurers that fail to follow the antifraud plan shall be subject to a civil penalty for each violation, not to exceed \$10,000, at the discretion of the Insurance Commissioner after consideration of all relevant factors, including the willfulness of any violation (75 Pa.C.S. § 1815).

Viatical Settlement Providers: Viatical settlement providers shall within 60 days of licensure and annually by March 31 of each year thereafter certify to the department implementation of antifraud initiatives reasonably calculated to detect, investigate, prevent and report fraudulent viatical settlement acts (40 P.S. § 626.10(g)). Antifraud initiatives shall include:

- (i) Hiring of individuals qualified by experience and education for the investigation of fraudulent viatical settlement acts, including the viatical settlement provider's criteria and rationale for securing the services of such individuals.
- (ii) An antifraud plan that includes:
 - A. A description of the procedures for detecting and investigating actual or possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications.
 - B. A description of the procedures for reporting possible fraudulent viatical settlement acts to the department and any appropriate law enforcement agency.
 - C. Procedures to prevent fraudulent viatical settlement acts, including fraud awareness, detection and antifraud education and training of underwriters and other personnel.
 - D. A description of the viatical settlement provider's organizational structure and key personnel, including antifraud personnel who are responsible for the investigation

and reporting of possible fraudulent viatical settlement acts and investigating unresolved material inconsistencies between medical records and insurance applications.

Workers' Compensation Insurers: Insurers shall institute and maintain an insurance antifraud plan within 4 months of commencing to write business (77 P. S. § 1040.3). An insurer newly licensed and writing coverage, shall certify in writing within 4 months of commencement of writing coverage that it has instituted and maintains an anti-fraud plan. (31 Pa.Code CSA § 119.23). Maintenance of the anti-fraud plan includes its ongoing implementation and operation by insurers (31 Pa.Code § 119.22).

The Department's regulations provide the minimum requirements for a workers' compensation insurance carrier's antifraud plan, including the following policies and procedures to prevent, detect, investigate and report fraud, (31 Pa.Code § 119.22):

- (1) The policies and procedures must seek to prevent workers' compensation insurance fraud, and should cover all aspects of the insurer's operation and recognize the wide variety of potential fraudulent activity. Procedures should address internal fraud, fraud involving the integrity and security of company data including electronic data processed information, fraud involving employees or company representatives, and fraud resulting from misrepresentation on applications and renewals for insurance coverage and claims fraud. Detailed information should be provided describing existing procedure manuals, internal policies, guidelines and employee training programs implemented by the insurer to prevent fraud. It is recommended that specific policies and procedures be either included in the antifraud plan or, if the policies and procedures are voluminous, appropriately summarized.
- (2) Policies and procedures must seek to detect and investigate possible insurance fraud in the claims process. Reference should be made to specific procedure manuals, internal policies, guidelines and training initiatives designed to detect fraud in the claims process.
- (3) Policies and procedures must seek to report workers' compensation insurance fraud to appropriate criminal law enforcement agencies, including procedures to cooperate with and monitor progress of the agencies in their fraud cases.

Pursuant to 31 Pa.Code § 119.22, and in order to facilitate the Department's understanding of insurers' administration of their antifraud procedures, insurers are encouraged to address the following areas in their antifraud plans:

- (1) Organizational components involved in or affected by the policies and procedures, including key positions involved.
- (2) Roles and interrelationships of components as they relate to the policies and the procedures described.
- (3) Personnel resources involved and budget allocations to implement the antifraud policies and procedures.
- (4) Extra-company relationships with central claims data bases and criminal law enforcement authorities as they relate to the policies and procedures implemented for antifraud plans.

Reporting

Motor Vehicle Insurers: All insurers shall annually provide to the Department a summary report on actions taken under the antifraud plan to prevent and combat motor vehicle insurance fraud, including, but not limited to, measures taken to protect and ensure the integrity of electronic data-processing-generated data and manually compiled data, statistical data on the amount of resources committed to combating fraud, and the amount of fraud identified and recovered during the reporting period (75 Pa.C.S. § 1814).

Viatical Settlement Providers: A statistical reporting on the number of viatical settlement applications, viatical settlement contracts and actual or potential viatical settlement fraudulent acts that relate to the business of viatical settlements occurring within this Commonwealth. This statistical reporting shall accompany the initial and annual antifraud initiative certification submitted to the department. (40 P.S. § 626.10(g)).

Workers' Compensation Insurers: All workers' compensation insurers shall annually provide to the Department a summary report on actions taken under an antifraud plan to prevent and combat insurance fraud, including, but not limited to, measures taken to protect and ensure the integrity of electronic data processing-generated data and manually compiled data, statistical data on the amount of resources committed to combating fraud and the amount of fraud identified and recovered during the reporting period (77 P.S. § 1040.4).

Further, in accordance with 31 Pa.Code § 119.24, reports are to be filed by March 31 of each year and cover the previous calendar year's antifraud activities. The annual report should provide detailed information on the following:

- (1) Specific actions taken by the insurer during the year to prevent and combat workers' compensation insurance fraud. The actions should be thoroughly described in the annual report and should contain statistical information relating to the number of cases of detected fraud, including the status of disposition of those cases, the number of personnel and other resources committed to detecting and combating fraud, the total dollar cost of fraud and the savings attributed to detected fraud or otherwise recovered by the insurer.
- (2) Measures implemented throughout the year to provide for the integrity and security of fraud related data and information collected and maintained. The measures apply to data collected and maintained in a manual or automated environment.
- (3) Originating sources of the information on the fraudulent activity—for example, an agent, adjuster, employee, policyholder or citizen.

The annual reports should be submitted to the Department in a standard report format, including a table of contents, summary, subdivisions of information in the report, including tables and graphs necessary to clearly illustrate the statistical information. Additionally, insurers should identify the person responsible for preparing and filing the annual report. The Department may require that the insurer clarify items addressed in the report or provide additional information relative to the annual report.

Workers' compensation insurers which also write motor vehicle insurance may file a single annual report for both motor vehicle and workers' compensation insurance anti-fraud activities. The combined report shall segregate the information reported for both motor vehicle insurance and workers' compensation insurance lines of business.

Monitoring and Review

Motor Vehicle Insurers: Antifraud plans shall be filed with the Department. If, after review, the Insurance Commissioner finds that the antifraud plan does not comply with section 1812 (relating to content of plans), the antifraud plan may be disapproved. Notice of disapproval shall include a statement of the specific reasons for such disapproval. Any plan disapproved by the Insurance Commissioner must be refiled within 60 days of the date of the notice of disapproval. The Insurance Commissioner may audit insurers to ensure compliance with antifraud requirements as a part of the examinations performed under the Insurance Department Act of 1921, (P.L.789, No.285) (40 P.S. §§ 323.1-323.8).

Workers' Compensation Insurers: The Department will audit insurers to determine compliance with the antifraud requirements as part of financial and market conduct examinations performed under the Insurance Department Act of 1921, (P.L.789, No.285) (40 P.S. §§ 323.1-323.8)

Submission

Annual reporting is completed online through our website. Beginning in 2019 (reporting for calendar year 2018), there is only one survey. It will be released in January and is due on or before March 31st.

Insurers are responsible for meeting the reporting requirements in a timely manner as set forth above. Insurance companies failing to file or timely file statements or reports are subject to the penalty provisions of Section 320(e)(1) (40 P.S. §443) of The Insurance Company Law.

Extensions to the filing deadline may be considered at the discretion of the Division Chief. Any request for an extension must be submitted via mail or email no later than 10 business days prior to the filing deadline. Extensions will be considered on a case-by-case basis.

In an effort to go paperless, insurers are encouraged to submit plans, updates, and filing extension requests via email to RA-IN-Fraud@pa.gov.

For further information, please contact RA-IN-Fraud@pa.gov.