Guidelines for Drafting State Anti-Fraud Regulations

- FRAUD PLANS
- FRAUD WARNINGS
- REPORTING REQUIREMENTS

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Introduction

The Coalition Against Insurance Fraud established a regulatory guidelines task force with the responsibility to 1) review existing regulatory requirements and 2) produce a document that can guide state legislators and regulators in the development of anti-fraud regulations that are effective, consistent and fair.

The guidelines are intended to encourage standardization among all jurisdictions in the insurance anti-fraud effort. While recognizing state interests in preserving the current state-by-state scheme for insurance regulation, the coalition believes that it is in the best interest of consumers, regulators and insurers to establish uniformity in standards. The power to effectively fight fraud comes from the concentration of resources and unity of effort that would result from a generally uniform set of rules that would deter, detect and help prosecute fraud in any jurisdiction.

The cost effectiveness and efficiency of standardization also will provide greater incentives for insurers to fight fraud, while reducing regulatory burdens that otherwise distract them. Coincidentally, uniformity among the states in anti-fraud requirements would improve the measurement of insurer fraud fighting performance which would give a better state-by-state comparison of fraud fighting techniques.

Ultimately, a uniform regulatory approach will help reduce the effect of fraud on the cost of insurance borne by consumers.

The guidelines provide recommendations for uniform regulations for three common requirements:

— Fraud Warnings,
— Fraud Plans
— Mandatory Reporting of Suspected Fraud.

Each by itself has shown to be an effective anti-fraud tool. Yet, state mandates vary in how they regulate insurers on each of these issues.

The guidelines will serve as a resource for regulators and insurers to obtain current information on insurance fraud regulatory requirements. The objective of this venture is to reduce insurance fraud. When taken with the information from the NAIC or other sources, these guidelines will assist state agencies in drafting anti-fraud regulations.
The Coalition Against Insurance Fraud plans to update the guidelines regularly to include new laws and regulations as they are implemented in the states. This will allow the guidelines to continue to be used as a resource by legislators, regulators and insurers.

1) Fraud Warnings

A total of 25 states currently require some type of insurance fraud warnings on claims and/or application forms stating that it is a crime to provide information to an insurer with an intent to defraud.

The coalition’s model insurance fraud act contains a requirement for fraud warnings on claims and application forms, as does the model act drafted by the National Association of Insurance Commissioners. The coalition model also would exempt reinsurance insurers from the fraud warning requirement since the warning is intended to the insurance consumer and thus reinsurers do not usually interact directly with consumers.

Both the coalition and NAIC model acts permit insurers to use substantially similar language than what is written in their respective acts. The coalition agrees that insurers should be given the flexibility to utilize “substantially similar” language to facilitate timely implementation and reduce costs in producing the warning, since most insurers could craft a single warning that would be suitable in multiple states.

However, not all state fraud warning requirements allow insurers to use “substantially similar” language. Six states require warnings to be exactly as stated in the statute. One state, Colorado, has added extraneous information that is not required in any other state fraud warning.

Recommendation

To assure a cost-effective and enforceable requirement for fraud warnings, the coalition recommends the following general guidelines for creating related laws and regulations:

1. Exact content of fraud warnings should be discretionary based on a standard of language “substantially similar” to what is contained in the statute or “language reasonably appropriate to effectuate the purposes of the law.”

2. Prior approval of language by the appropriate regulator based on an expedited approval process that facilitates timely, cost effective implementation.

3. Time permitted for implementation should be six-months after effective date of the act or regulation with the discretion to exhaust current forms
inventories or to allow the insurer to attach or stamp warnings until the current inventories are exhausted.

**Conclusion**

The desired result of any anti-fraud effort is to reduce the effect of fraud on the cost of insurance. It is incumbent on government not to increase those costs inadvertently. Allowing insurers to use “substantially similar” language will help achieve this desired result.

**Recommended Fraud Warnings**

*Coalition Model Act Language on Fraud Warnings*

Fraud Warnings

(1)(A) No later than six 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:

“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.”

(B) The lack of a statement required in this subparagraph does not constitute a defense in any criminal prosecution under Section 2 nor in any civil action under Sections 2 or 3.

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

*NAIC Model Act Language on Fraud Warnings*

A. Claim forms and applications for insurance, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

“All persons who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.”
B. The lack of a statement as required in Subsection A of this section does not constitute a defense in any prosecution for a fraudulent insurance act.

See Appendix A for specific state language on fraud warnings.

2) Fraud Plans

Considerable evidence shows that insurers that invest in an active fight against fraud receive substantial return on their investment. However, not all insurers fight fraud voluntarily. By requiring insurers with direct written premiums to draft a plan to fight fraud, and then ensuring they comply with that plan, the playing field is leveled for all. This precept is a driving force in the coalition’s belief that developing a fraud plan is a fundamental obligation and a small price for insurers to pay in the continuing effort to fight fraud. If spending one dollar can save some insurers two, five, or even ten dollars, then it is well worth the effort to extend this effort to all insurers. Not only will the insurer benefit but all insured consumers will benefit.

Currently fewer than twenty states require insurers to write and maintain fraud plans, some with very stringent regulations, others giving a framework for the insurer.

The National Association of Insurance Commissioners model act recognizes the need for insurers to be proactive in the fight against fraud. However, the NAIC model does not call for mandatory fraud plans but includes a section simply stating the insurer shall have anti-fraud initiatives without spelling out what those initiatives should entail. If states are going to enact the NAIC model bill, they should look toward the coalition’s model bill as a guideline for drafting the necessary regulations meeting the anti-fraud initiatives directives.

Recommendation

The coalition advocates that legislation or regulation mandating fraud plans should be viewed as a framework on which the insurer may build, rather than a micromanaged package presented to insurers to follow.

1. The fraud plan requirement should be viewed as a skeleton to which the insurer can add the necessary meat to develop a fraud plan best suited for its lines of business, management structure and geographic market.

2. Give insurers the flexibility to design a fraud plan to meet its individual needs while meeting the general requirements of the law or regulation.
3. Plans should not be static; an insurer should regularly review its own plan and amend it to meet the changing types of frauds the insurer is facing.

4. The insurer’s plan and any subsequent changes should be submitted to regulators. And in order to facilitate interaction between regulators and insurers, the plan should identify a specific contact person for regulators to deal with when discussing an insurer’s fraud plan.

**Conclusion**

Micromanagement of insurers anti-fraud efforts will not in the long run achieve the best cost-effective fraud fighting tools. Giving insurers the flexibility to design a fraud plan to meet its individual needs while meeting the general requirements of the state law or regulation maximizes the anti-fraud partnership between government and insurers; thus benefiting the insured consumers.

Any regulation should seek a balance between the desires of regulators with the needs of the insurers. For instance, regulators should have the ability to police compliance – assuring insurers are meeting the state requirements for fraud plans and the insurer’s compliance with its own plan. This would include the ability to apply appropriate sanctions on insurers for failure to meet compliance.

**Recommended Fraud Plans**

**Coalition Model Act Language on Fraud Plans**

(a) Anti-Fraud Plans

Within six months of the effective date of this legislation, every Insurer with direct written premiums shall prepare, implement, maintain and submit to the department of insurance 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) pursue restitution for financial loss caused by insurance fraud, where appropriate.

The Commissioner may review each Insurer’s anti-fraud plan to determine if it complies with the requirements of this subparagraph.

It shall be the responsibility of the Commissioner to assure Insurer compliance with anti-fraud plans submitted to the Commissioner. The Commissioner may require reasonable modification of the Insurer’s anti-fraud plan, or may require other reasonable remedial action if the review or examination reveals substantial non-compliance with the terms of the Insurer’s own anti-fraud plan.

The Commissioner may require each Insurer to file a summary of the Insurer’s anti-fraud activities and results. The anti-fraud plans and the summary of the Insurer’s anti-fraud activities and results are not public records and are exempt from the _______ public records act, and shall be proprietary and not subject to public examination, and shall not be discoverable or admissible in civil litigation.

This section confers no private rights of action.

**NAIC Model Language on Antifraud Initiatives**

Insurers shall have antifraud initiatives reasonably calculated to detect, prosecute and prevent fraudulent insurance acts. Antifraud initiatives may include:

A. Fraud investigators, who may be insurers employees or independent contractors; or

B. 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.

See Appendix B for examples of state laws and regulations dealing with fraud plans.

**3) Mandatory Reporting**

Mandatory fraud reporting is the requirement that insurers must report suspected fraudulent cases to law enforcement or to the state fraud unit. How and what the insurer
goes about reporting varies from state-to-state. Currently, 30 states require a form of mandatory reporting of suspected fraud.

The National Association of Insurance Commissioner’s Antifraud Task Force has worked extensively on the issue of fraud reporting. The task force approved a model reporting form based on the state of California form. The NAIC recommends all states use the same form for accepting fraud reports from insurers. It is clear that uniformity of reporting will aid in quantifying the amount of fraud and allow comparisons from state-to-state.

The NAIC’s Antifraud Task Force is working to develop standards developing a uniform definition of suspicious claim. Standardized definitions will assist insurers in selecting which cases should or should not be referred to the state’s insurance fraud unit. This project, when it is completed, will help resolve one of the ongoing tensions that exist between insurers and regulators, and will enhance the anti-fraud efforts of both groups.

Several states also have working agreements with the National Insurance Crime Bureau allowing for the reporting of suspected fraud to the NICB which then reports the suspicion to the appropriate fraud bureau. Such agreements between states and NICB to meet the requirements of mandatory reporting does achieve the goals of the reporting requirement.

**Recommendation**

1. Insurers should report suspicious claims to fraud bureaus, regardless of whether the insurer reports the suspicion to a local prosecutor, police department or other law enforcement agency. It is important that a referral be made to the fraud bureau. Also, the reporting should be in a reasonable time frame soon after the insurer discovers the suspicious activity.

2. Mandatory reporting goes hand-in-hand with strong insurance fraud immunity laws giving the insurer civil immunity for the reporting of the suspected fraud if the reporting is done without malice or bad faith. The breadth and exceptions to immunity varies from state-to-state. The coalition advocates broad civil immunity for both regulatory reporting and exchange of fraud-related information among carriers. The coalition further believes that the only exception should be in instances of actual malice.

3. Confidentiality of the information is also an important ingredient of this mix. Insurers should not fear that information supplied to fraud units will be made public or open to discovery by other parties. The information reported is highly sensitive and personally identifiable. As with law...
enforcement records, fraud reports should not be made public, nor be open to discovery.

Conclusion

Mandatory reporting with strong insurance civil immunity is the backbone for the partnership between insurers and government in the fight against insurance fraud. States should seek the strongest partnership available in the effort to reduce the effect of fraud on the insurance consumers of the states.

Recommended Mandatory Reporting

See Appendix C for examples of state language for mandatory reporting.

Appendix A — Fraud Warnings

States with fraud warnings allowing insurers to have a "substantially similar" warning

A R I Z O N A

Arizona Revised Statutes Section 20-466.03
Notice of penalty for false or fraudulent claims; claim forms
The forms provided by an insurer to an insured or any other person for filing a notice or making a claim in connection with a policy or contract issued by the insurer shall include in substance the following statement in at least twelve point type:

"For your protection Arizona law requires the following statement to appear on this form, any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties."

A R K A N S A S

Section 23-66-503

(a) Claim forms, proofs of loss, or any similar documents, however designated, seeking payment or benefit pursuant to an insurance policy, and applications for insurance, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

(b) The lack of a statement as required in subsection (a) of this section does not constitute a defense in any prosecution for a fraudulent insurance act.
(c) Policies issued by unauthorized insurers shall contain a statement disclosing the status of the insurer to do business in the state where the policy is delivered or issued for delivery or the state where coverage is in force.

(d) All persons to whom this section applies shall have six (6) months from the effective date of this section to comply with the requirements thereof.

(e) The requirements of this section shall not apply to reinsurance proofs of loss or applications.

COLORADO
Colorado House Bill 1149, enacted 4/96, amended 5/97
Section 10-1-127

7(a) On and after January 1, 1997, each insurance company shall provide on all printed applications for insurance, or on all insurance policies, or on all claim forms provided and required by an insurance company, or required by an insurance company, or required by law, whether printed or electronically transmitted, a statement, in conspicuous nature, permanently affixed to the application, insurance policy, or claim form substantially the same as the following:

“It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.”

Section 7b

“This subsection (7) shall not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.”

FLORIDA
Fraud warning
All Claim Forms - Sec. 817.234(1b)
All Workers Compensation Claim Forms - Sec. 440.37(2)(a)
Underwriting - Workers Compensation Informational Brochures - Sec. 440.185(4)

“Any person who knowingly and with intent to injure, defraud or deceive any insurance company files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony of the third degree.”

Section 440.37(2)(a)

“Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.”
Section 440.185(4)
Same as above (Sec. 440.37(2)(a)) except for phrase at end "guilty of a felony ... " reads as
"commits a felony ..."

IDAHO

Fraud warning
All Claim Forms - Sec. 41-1331
Section 41-1331
“Any person who knowingly, and with intent to defraud or deceive any insurance company,
files a statement containing any false, incomplete, or misleading information is guilty of a
felony.”
The section also states that lack of a warning does not constitute a defense against
prosecution.

INDIANA

Fraud warning
All preprinted claims forms - Sec. 27-2-16-3(a)
Section 27-2-16-3(a)
“Any person who knowingly, and with intent to defraud an insurer, files a statement of
claim containing false, incomplete or misleading information commits a felony.”
Section 27-2-16-3(b) - the absence of a warning statement is not a defense against prosecution
for insurance fraud.

KENTUCKY

Fraud warning
All insurance applications - Sec. 304.47-030(1)
All claim forms - Sec. 304.47-030(2)
Section 304.47-030(1)
“Any person who knowingly and with intent to defraud any insurance company or other
person files an application for insurance containing any materially false information or
conceals, for the purpose of misleading, information concerning any fact material thereto
commits a fraudulent insurance act, which is a crime.”
Section 304.47-030(2)
“Any person who knowingly and with intent to defraud any insurance company or other
person files a statement of claim containing any materially false information or conceals, for
the purpose of misleading, information any fact material thereto commits a fraudulent
insurance act, which is a crime.”

MAINE

Fraud Warning
24-A M R S A Section 2186 (as enacted by Maine H 1545, Public Law 675, Laws 1998)
3. Fraud warning required. Fraud warnings are required in accordance with the following.
A. All applications and claim forms for insurance used by insurers in this State, regardless of form of transmission, must contain the following statement or a substantially similar statement permanently affixed to the application or claim forms: “It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.”

B. The lack or omission of the statement required in paragraph A does not constitute a defense in any criminal prosecution or civil action for a fraudulent insurance act.

C. This subsection applies to all insurers except reinsurers. The statement required in paragraph A must be included in all applications and claim forms filed and approved for use by the superintendent on or after January 1, 1999.

MINNESOTA

Fraud warning
All application forms - Sec. 60A.955
All claim forms - Sec. 60A.955
Section 60A.955
“A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.”
Section also states that the absence of a fraud warning on claims forms is not a defense to prosecution.

NEW HAMPSHIRE

Fraud warning
All claim forms - Sec. 402:82
Section 402:82
“All person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud as provided in R.S.A. 638.20.”
Section also states that the absence of the warning is not a defense against prosecution for insurance fraud.

NEW JERSEY

Fraud warning
Applications forms for motor vehicle insurance - Sec. 17:33(A-6)
All claim forms - Sec. 17:33(A-6)
Section 17:33(A-6) - motor vehicle insurance; must be approved by the Insurance Commissioner

“Any person who knowingly makes an application for motor vehicle insurance coverage containing any statement that the applicant resides or is domiciled in this State when, in fact that applicant resides or is domiciled in a state other than this State, is subject to criminal and civil penalties.”

Section 17:33(A-6) - all claims forms - Language must be approved by the Insurance Commissioner

“Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.”

NEW MEXICO

Fraud Warning

Section 8, H. 141, enacted 1998 session, effective July 1, 1998.

Within six months of the effective date of the Insurance Fraud Act all claim forms and applications for insurance shall contain a statement permanently affixed to the application or claim form which states substantially as follows:

“Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.”

The failure to include that statement shall not constitute a defense against prosecution for commission of insurance fraud.

NEW YORK

Fraud warning

Application forms - Section 403
All claim forms - Section 403

Section 403 - All applications and claims forms

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.”

Fraud warning - Regulations

Section 86.4
(a) All applications provided to applicants for commercial insurance and all claim forms for insurance, except personal automobile insurance, delivered to any person residing or located in this State on and after February 2, 1994 in connection with commercial insurance policies to be issued or issued for delivery in this State shall contain the following statement:

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.”

(b) All claim forms for personal automobile insurance delivered to any person residing or located in this state on and after February 2, 1994 in connection with policies of personal
automobile insurance and claims arising under policies of such insurance shall contain the following statement:

“Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, and any person who knowingly makes or knowingly assists, abets, solicits or conspires with another to make a false report of the theft, destruction, damage or conversion of any motor vehicle to a law enforcement agency, the department of motor vehicles or an insurance company commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the value of the subject motor vehicle or state claim for each such violation.”

(c) Self insurers may adopt one or both of the required warning statements set forth in (a) or (b)
(d) Location of warning statements and type size.

(1) The warning statements required by subdivisions (a), (b) and (d) of this section shall be placed immediately above the space provided for the signature of the person executing the application or claim form and shall be printed in type which will produce a warning statement of conspicuous size. On claim forms which require execution by a person other than a claimant, or in addition to the claimant, the warning statements required by subdivisions (a), (b) and (d) of this section shall be placed at the top of the first page of the claim form or on the page containing instructions, either in print, by stamp or by attachment and shall be in type size which will produce a warning statement of conspicuous size.

(2) Notwithstanding the provisions of paragraph (1) of this subdivision, insurers may affix the warning statements required by this Part to all applications and claim forms by means of labels and/or stamps or by attachment during the period February 2, 1994 to July 31, 1994.

(e) Notwithstanding the provisions of subdivisions (a) or (b) of this section, insurers may use substantially similar warning statements provided such warning statements are submitted to the Insurance Frauds Bureau for prior approval.

OHIO

Fraud warning
All application forms - Sec. 3999.21
All claim forms - Sec. 3999.21
Section 3999.21 - statement must be approved by Insurance Department

“Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.”

The section also states that the absence of a warning is not a defense against prosecution for insurance fraud.
OKLAHOMA

Fraud warning
All claim forms - Section 3613.1

“WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.”

The section also states that the absence of a warning is not a defense against prosecution for insurance fraud.

VIRGINIA

Fraud Warning
Section 52-40(B) - of S. 421, Chapter 590, Laws 1998

B. All applications for insurance and all claim forms 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, or included as a part of the application or claim form, that clearly states in substance the following:

“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.”

The lack of a statement required in this subsection does not constitute a defense in any criminal prosecution. The statement required by this subsection shall not be required on applications and forms relating to reinsurance.
Appendix B — Fraud Plans

States with provisions dealing with fraud plans

ARKANSAS

Insurer Antifraud initiative

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 be 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.

Antifraud Initiative Requirements — Regulation 66

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).

COLORADO

Section 10-1-127 of the Colorado Revised Statutes as amended by HB 96-1149 Section 1 (6)(a) requires all insurance companies doing business in the state, except for reinsurers, to prepare, implement and maintain anti-fraud plans.

Each anti-fraud plan shall outline specific procedures, appropriate to the type of insurance provided by the insurance company in Colorado, to:

(l) 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.

FLORIDA
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 insurer's anti-fraud plan 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.

KENTUCKY
806 KAR 47:030 - 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) In 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.

MARYLAND
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.

MINNESOTA
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
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.

OHIO
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
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

Section 56-_-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."

WASHINGTON

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.

M A I N E 24-A M RSA 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.
Appendix C — Mandatory Reporting

A R I Z O N A
An insurer that believes a fraudulent claim is being made shall send to the director, on a form prescribed by the director, information relative to the claim and the parties claiming loss or damage as a result of an accident and any other information the fraud unit may require.

A R K A N S A S
Regulation 67, Section 6
(a) The reporting requirement of Arkansas Code Annotated Sec. 23-66-505(a) may be satisfied by filing a completed fraud referral form with the Insurance Fraud Investigation Division of the Arkansas Insurance Department. The form shall be as prescribed by the commissioner and may be obtained from the Insurance Fraud Investigation Division.
(b) A reporting form containing substantially similar language and providing all the information requested in the fraud referral form prescribed by the commissioner may be used, if previously approved by the commissioner.

C A L I F O R N I A
Insurance Code 1872.4
"Any company licensed to write insurance in this state that believes that a fraudulent claim is being made shall, within 60 days after determination by the insurer that the claim appears to be a fraudulent claim, send to the Bureau of Fraudulent Claims, on a form prescribed by the Department, the information requested by the form and any additional information relative to the factual circumstances of the claim and parties claiming loss or damages that the commissioner may require."

C O L O R A D O
Revised Statutes 10-4-1003
"Any insurer or person that has reason to believe that ... any insurance claim may be fraudulent may furnish and disclose any relevant information in its possession concerning such loss or claim to any authorized agency, as defined in Section 10-4-1002 (1), for the purpose of detecting, prosecuting, or preventing fraudulent insurance claims."

D E L A W A R E
Insurance Code Section 2408
"Any insurer which has a reasonable belief that an act of insurance fraud is being, or has been, committed shall send to the Bureau, on a form prescribed by the Bureau, any and all information and such additional information relating to such act as the Bureau may require."

F L O R I D A
Insurance Code Section 626.989 (6)
"... any insurer, agent, or other person licensed under the code, or an employee thereof, having
knowledge or who believes that a fraudulent insurance act or any other act or practice which,
upon conviction, constitutes a felony or a misdemeanor under the code ... is being or has been
committed shall send to the Division of Insurance Fraud a report or information pertinent to
such knowledge or belief and such additional information relative thereto as the department
may require...."

GEORGIA
Section 33-1-16 (f)
"... any insurer, agent, or other person licensed under the code, or an employee thereof, having
knowledge or who believes that a fraudulent insurance act or any other act or practice which,
upon conviction, constitutes a felony or a misdemeanor under the code ... is being or has been
committed shall send to the Division of Insurance Fraud a report or information pertinent to
such knowledge or belief and such additional information relative thereto as the department
may require...."

IDAHO
Section 41-290
"Any insurer which has facts to support a belief that a fraudulent claim is being or has been
made shall, within sixty (60) days of the receipt of such notice, send to the director of
insurance, on a form prescribed by the director, the information requested and such additional
information relative to the claim and the parties claiming loss or damages as the director may
require."*

IOWA
"An insurer which believes that a claim is being made which is a violation of section 507E.3
shall provide, within sixty days of the receipt of such claim, written notification to the bureau
of the claim on a form prescribed by the bureau, including any additional information requested
by the bureau related to the claim or the party making the claim. The fraud bureau shall
review each notification and determine whether further investigation is warranted. If the
bureau determines that further investigation is warranted, the bureau shall conduct an
independent investigation of the facts surrounding the claim to determine the extent, if any, to
which fraud occurred in the submission of the claim. The bureau shall report any alleged
violation of law disclosed by the investigation to the appropriate licensing agency or
prosecuting authority having jurisdiction with respect to such violation."*

KENTUCKY
"The following individuals having knowledge or believing that a fraudulent insurance act or any other act or
practice which may constitute a felony or misdemeanor under this subtitle is being or has been committed shall
send to the Insurance Fraud Unit a report or information pertinent to the knowledge or belief and additional
relevant information that the commissioner or his employees or agents may require:

(a) Any professional practitioner licensed or regulated by the Commonwealth ...

(d) Any insurer, agent, or other person licensed under this chapter ...."

LOUISIANA
"Any person, company, or other legal entity engaged in the business of insurance, including agents, brokers, and adjusters, which believes that a fraudulent claim is being made, shall within sixty days of the receipt of such notice, send to the section of insurance fraud, on a form prescribed by the section, the information requested and such additional information relative to the claim and the parties claiming loss or damages because of an occurrence and or accident as the section may require."

**MARYLAND**

(E) Referral for Prosecution

(1) If an insurer, in good faith, has cause to believe that insurance fraud has been or is being committed, the insurer shall report the suspected fraud to the Insurance Fraud Division or to the appropriate federal, State, or local law enforcement authority.

(2) The reporting policy shall be in writing and maintained in the offices of the company point of contact for fraud.

**MASSACHUSETTS**

"Any insurer ... having reason to believe that an insurance transaction may be fraudulent, or having knowledge that a fraudulent insurance transaction is about to take place, or has taken place, shall within thirty days after determination that the transaction may be fraudulent, send to said insurance fraud bureau, on a form prescribed by the executive director, the information requested by the form and such additional information relative to the transaction and the parties involved as the executive director may require."

**MICHIGAN**

"If an insurer knows or reasonably believes it knows the identity of a person who it has reason to believe committed a fraudulent insurance act or has knowledge of a suspected fraudulent insurance act that is reasonably believed not to have been reported to an authorized agency, then for the purpose of notification and investigation, the insurer or an agent authorized by an insurer to act on its behalf may notify an authorized agency of the knowledge or believe and provide any additional information in accordance with subsection (1)."

**MINNESOTA**

Statutes Sec. 60A.951

Apprehension, the Commerce Commissioner, the Attorney General or a federal criminal investigative agency. Notice to one authorized person is deemed notice to all.

**MISSOURI**

Any company which believes that a fraudulent claim is being made shall, within sixty days of the receipt of such notice, send to the department of insurance, on a form prescribed by the department, the information requested and such additional information relative to the claim and the parties claiming loss or damages because of the accident as the department may require....

**NEW JERSEY**

Statutes - Section 17:33A-9
"Any person who believes that a violation of this act has been or is being made shall notify the division immediately after discovery of the alleged violation of this act and shall send to the division, on a form and in a manner prescribed by the commissioner, the information requested and such additional information relative to the alleged violation as the division may require."

**NEW YORK**

"Any person licensed ... who has reason to believe that an insurance transaction may be fraudulent, or has knowledge that a fraudulent insurance transaction is about to take place, or has taken place shall, within thirty days after determination by such person that the transaction appears to be fraudulent, send to the insurance frauds bureau on a form prescribed Insurers shall notify an authorized person of a suspected fraudulent insurance act. An authorized person includes the county attorney, sheriff or chief of police, Bureau of Criminal by the superintendent, the information requested by the form and such additional information relative to the factual circumstances of the transaction and the parties involved as the superintendent may require."

**NORTH CAROLINA**

Whenever any insurance company, or employee or representative of such company, or any other person licensed or registered under ... this Chapter knows or has reasonable cause to believe that any other person has violated G.S. 58-2-161, 58-2-162, 58-2-180, 58-8-1, or 58-24-180(e), ... it is the duty of such person, upon acquiring such knowledge, to notify the Commissioner and provide the Commissioner with a complete statement of all of the relevant facts and circumstances.

**OHIO**

Administrative Code Rule 3901-1-54 (Bulletin 93-3)

If an insurer reasonably believes, based upon information obtained and documented within the claim file, that a claimant has fraudulently caused or contributed to the loss represented by a properly executed and documented proof of loss, such information shall be presented to the Fraud Division of the Department within sixty days of receipt of the proof of loss. Any person making such report shall be afforded such immunity and the information submitted will be confidential as provided in Sections 3901.44 and 3999.01 of the Revised Code.

**PENNSYLVANIA**

Title 75 Section 1817 — Reporting Requirements (Motor Vehicle Insurance Fraud)

"Every insurer licensed to do business in this Commonwealth, and its employees, agents, brokers, motor vehicle physical damage appraisers and public adjusters, or public adjuster solicitors, who has a reasonable basis to believe insurance fraud has occurred shall be required to report the incidence of suspected insurance fraud to Federal, state or local criminal law enforcement authorities. Licensed insurance agents and physical damage appraisers may elect to report suspected fraud through the affected insurer with which they have a contractual relationship. All reports of insurance fraud shall be made in writing. Where insurance fraud involves agents, brokers, motor vehicle physical damage appraisers, public adjusters or public adjuster solicitors, a copy of the report shall also be sent to the department."

**SOUTH CAROLINA**

"Any person, insurer, or authorized agency having reason to believe that another has made a false statement or misrepresentation or has knowledge of a suspected false statement or misrepresentation shall, for purposes of reporting and investigation, notify the Insurance Fraud Division of the Office of the Attorney General of the knowledge or belief and provide any additional information within his possession relative thereto."

Coalition Against Insurance Fraud 25 Guidelines on Drafting State Regulations
TEXAS

"If a person determines that a fraudulent insurance act has been committed, or is about to be committed, the person shall report the information to the commissioner or board or to an authorized governmental agency in writing not later than the 30th day after the date of the determination."

VIRGINIA

A. If any insurer, any employee thereof, or any insurance professional has knowledge of, or has reason to believe that a violation of Section 18.2-178 will be, is being, or has been committed, that person shall furnish and disclose any information in his possession concerning the fraudulent act to the Department, (Department of State Police) subject to any legal privilege protecting such information.
THE COALITION AGAINST INSURANCE FRAUD is a national alliance dedicated to fighting insurance fraud through public advocacy and public education.

Our mission is to combine the influence and resources of consumers, government organizations and insurers to combat fraud as a means to restrain insurance costs for consumers and insurers by reducing the financial impact of fraud.

Our objectives are:

➤ Enact new laws and regulations that directly and indirectly prevent, deter or help detect insurance fraud, and seek appropriate remedies, including restitution and license revocation, against those who commit fraud. Such initiatives must be cost effective and practical.

➤ Communicate the scope of the fraud problem and potential solutions to all major audiences to increase awareness, provide deterrence, change attitudes and build support for the Coalition’s initiatives.

➤ Serve as a clearinghouse of insurance fraud information; conducting research to help the coalition and policymakers make informed decisions on how to combat insurance fraud effectively and efficiently.

For membership information, please contact Dennis Jay, executive director, 1010 Vermont Ave, Washington, D.C. 20005. Telephone 202-393-7330. E-mail: DJay@InsuranceFraud.org

Current members include:

Allstate Insurance Company
American Council on Consumer Interests
American Insurance Association
American International Group
Atlantic Mutual Companies
Center for Consumer Affairs—University of Wisconsin-Milwaukee
CGU Insurance
CNA Insurance Companies
Consumer Action
Consumer Federation of America
Consumer Fraud Watch
Fireman’s Fund Insurance
General Reinsurance Corporation
International Association of Insurance Fraud Agencies
The Hartford
Liberty Mutual
Mass Mutual
National Association of Consumer Agency Administrators
National Association of Insurance Commissioners
National Conference of Insurance Legislators
National Criminal Justice Association
National District Attorneys Association
National Insurance Crime Bureau
National Urban League
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