Third Party Administrators (TPA)

Effective October 1, 2009, TPAs were added to the list of entities required to file antifraud plans with the Insurance Fraud Division of the Maryland Insurance Administration. See Insurance Article §8-321.1, mandating that a Third Party Administrator shall comply with §27-803.

Pursuant to the authority in §27-803(g), the Commissioner has promulgated Regulations – found at COMAR 31.04.15 - which not only detail what is required to be included in an antifraud plan, but also mandate the filing of an annual Fraud Related Data Report. This requirement as well became applicable to TPAs as of October 1, 2009. This report is due to be filed with MIA's Insurance Fraud Division by March 31st every year, for the previous year.

As part of this packet, see attached copies of §§8-321.1 and 27-803, COMAR 31.04.15 and the Guidelines for Developing an Antifraud Plan.

Please call if you have any questions.

Compliance Officer
Maryland Insurance Administration
Insurance Fraud Division
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202
Phone 410-468-3968
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For Antifraud Plans: fraud_plans.mia@maryland.gov
For Annual Fraud Data Reports: data_reports.mia@maryland.gov

*** Statutes current through the 2013 General Assembly Regular Session with updates for sections effective through July 1, 2013 ***

INSURANCE
TITLE 27. UNFAIR TRADE PRACTICES AND OTHER PROHIBITED PRACTICES
SUBTITLE 8. REPORTING AND PREVENTING INSURANCE FRAUD

Md. INSURANCE Code Ann. § 27-801 (2013)

§ 27-801. Definitions

(a) In general. -- In this subtitle the following words have the meanings indicated.

(b) Fraud Division. -- "Fraud Division" means the Insurance Fraud Division in the Administration.

(c) Insurance fraud. -- "Insurance fraud" means:

(1) a violation of Subtitle 4 of this title;

(2) theft, as set out in §§ 7-101 through 7-104 of the Criminal Law Article:

(i) from a person regulated under this article; or

(ii) by a person regulated under this article or an officer, director, agent, or employee of a person regulated under this article; or

(3) any other fraudulent activity that is committed by or against a person regulated under this article and is a violation of:

(i) Title 1, Subtitle 3 of the Agriculture Article;

(ii) Title 19, Subtitle 2 or Subtitle 3 of the Business Regulation Article;

(iii) Title 14, Subtitle 29, § 11-810 or § 14-1317 of the Commercial Law Article;

(iv) the Criminal Law Article other than Title 8, Subtitle 2, Part II or § 10-614;

(v) Title 12, Subtitle 9 of the Financial Institutions Article;

(vi) § 14-127 of the Real Property Article;

(vii) Article 2B, Title 22 of the Code;

(viii) § 109 of the Code of Public Local Laws of Caroline County;

(ix) § 4-103 of the Code of Public Local Laws of Carroll County; or

(x) § 8A-1 of the Code of Public Local Laws of Talbot County.

HISTORY: An. Code 1957, art. 48A, § 233A; 1997, ch. 35, § 2; 2002, ch. 213, § 6; 2004, ch. 25; 2005, ch. 574, § 2.

Md. INSURANCE Code Ann. § 27-802 (2013)

§ 27-802. Reporting suspected insurance fraud

(a) In general. --

(1) An authorized insurer, its employees, fund producers, insurance producers, a viatical settlement provider, or a viatical settlement broker who in good faith has cause to believe that insurance fraud has been or is being committed shall report the suspected insurance fraud in writing to the Commissioner, the Fraud Division, or the appropriate federal, State, or local law enforcement authorities.

(2) An independent insurance producer shall meet the reporting requirement of this subsection by reporting the suspected insurance fraud in writing to the Fraud Division.

(3) A registered premium finance company shall meet the requirement of this subsection by reporting suspected insurance fraud in writing to the Fraud Division.

(b) Information not subject to public inspection. -- In addition to any protection provided under § 10-618 of the State Government Article, any information, documentation, or other evidence provided under this section by an insurer, its employees, fund producers, or insurance producers, a viatical settlement provider, a viatical settlement broker, an independent insurance producer, or a registered premium finance company to the Commissioner, the Fraud Division, or a federal, State, or local law enforcement authority in connection with an investigation of suspected insurance fraud is not subject to public inspection for as long as the Commissioner, Fraud Division, or law enforcement authority considers the withholding to be necessary to complete an investigation of the suspected fraud or to protect the person investigated from unwarranted injury.

(c) Civil liability. -- A person is not subject to civil liability for a cause of action by virtue of reporting suspected insurance fraud, or furnishing or receiving information relating to suspected, anticipated, or completed fraudulent insurance acts, if:

(1) the report was made, or the information was furnished to or received from:

(i) the Commissioner, Fraud Division, or an appropriate federal, State, or local law enforcement authority;

(ii) the National Association of Insurance Commissioners or its agent, employee, or designee;

(iii) a not-for-profit organization established to detect and prevent fraudulent insurance acts or its agent, employee, or designee;

(iv) a person that contracts to provide special investigative unit services to an insurer; or

(v) a provider of a recognized comprehensive database system that the Commissioner approves to monitor activities involving insurance fraud or an employee of the provider; and

(2) the person that reported the suspected insurance fraud, or furnished or received the information, acted in good faith when making the report or furnishing or receiving the

information.

HISTORY: An. Code 1957, art. 48A, § 233B; 1997, ch. 35, § 2; 2001, ch. 731, §§ 1, 9; 2002, ch. 19, § 5; 2004, ch. 275; 2005, ch. 369; 2012, chs. 590, 591.

Md. INSURANCE Code Ann. § 27-803 (2013)

§ 27-803. Insurance antifraud plan

(a) In general. --

(1) Each authorized insurer shall institute and maintain an insurance antifraud plan.

(2) Within 30 days after instituting or modifying an antifraud plan, the authorized insurer shall notify the Commissioner in writing.

(b) Requirements for plan. -- Each antifraud plan shall establish specific procedures to:

(1) prevent insurance fraud, including:

(i) internal fraud that involves the authorized insurer's employees or insurance producers;

(ii) fraud that results from misrepresentations on insurance applications; and

(iii) claims fraud;

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

(3) cooperate with the prosecution of insurance fraud cases; and

(4) report fraud-related data to the Commissioner and Fraud Division.

(c) Filing required; review by Commissioner; deemed approval. --

(1) Each authorized insurer shall file its antifraud plan with the Commissioner.

(2) The Commissioner may review each antifraud plan to determine whether it complies with the requirements of this section.

(3) An antifraud plan is deemed approved unless disapproved by the Commissioner within 30 days after the date of filing.

(d) Disapproval by Commissioner. --

(1) If the Commissioner finds that an antifraud plan does not comply with the requirements of this section, the Commissioner shall disapprove the antifraud plan and send a notice of disapproval, including the reasons for disapproval, to the authorized insurer.

(2) If the Commissioner disapproves an antifraud plan, the authorized insurer shall submit

a new antifraud plan to the Commissioner within 60 days after the date of disapproval.

(e) Examination to determine compliance with antifraud plan. -- During an examination under § 2-205 of this article, the Commissioner shall examine the authorized insurer's procedures to determine whether the authorized insurer is complying with its antifraud plan.

(f) Public inspection of plan. -- The Commissioner may withhold from public inspection any part of an antifraud plan for as long as the Commissioner considers the withholding to be in the public interest.

(g) Written affirmation of benefits. --

(1) As part of an antifraud plan, an authorized insurer may require in writing that an individual who is receiving benefits under a disability insurance policy must affirm on a periodic basis that the individual:

(i) remains entitled to the benefits; and

(ii) has had no change in the condition entitling the individual to the benefits.

(2) An authorized insurer that requires the affirmation permitted under paragraph (1) of this subsection shall disclose to the individual who is receiving benefits that if the individual knowingly and willfully provides false information or knowingly and willfully fails to provide material information in connection with the individual's eligibility or continued eligibility for benefits under a disability insurance policy, the individual is guilty of a crime and may be subject to a fine and imprisonment.

(h) Regulations. -- The Commissioner shall adopt regulations that establish minimum standards for antifraud plans required to be filed under this section.

(i) Violations of subtitle. -- It is a violation of this subtitle if the Commissioner finds that an authorized insurer has failed to:

(1) file an antifraud plan;

(2) file a revised antifraud plan after disapproval by the Commissioner of the initial antifraud plan; or

(3) comply with the antifraud plan filed by the authorized insurer.

HISTORY: An. Code 1957, art. 48A, § 233B; 1997, ch. 35, § 2; 2001, ch. 731, § 9; 2002, ch. 19, § 5; 2009, ch. 372.

Md. INSURANCE Code Ann. § 27-804 (2013)

§ 27-804. Antifraud plans for viatical settlement providers

(a) Required. -- Each viatical settlement provider shall have in place an antifraud plan reasonably calculated to detect, prosecute, and prevent fraudulent viatical settlement acts.

(b) Notice to Commissioner. -- Within 30 days after instituting or modifying an antifraud plan, the viatical settlement provider shall notify the Commissioner in writing.

(c) Contents. -- Each antifraud plan shall include:

(1) the use of fraud investigators;

(2) a description of the procedures for detecting and investigating possible fraudulent viatical settlement acts and procedures for resolving material inconsistencies between medical records and insurance applications;

(3) a description of the procedures for reporting possible fraudulent viatical settlement acts to the Commissioner;

(4) a description of the plan for antifraud education and training of underwriters, and other personnel; and

(5) a description or chart outlining the organizational arrangement of the 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.

(d) Confidentiality. -- An antifraud plan 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.

(e) Filing with Commissioner. --

(1) Each viatical settlement provider shall file its antifraud plan with the Commissioner.

(2) The Commissioner may review each antifraud plan to determine whether it complies with the requirements of this section.

(3) An antifraud plan is deemed approved unless disapproved by the Commissioner within 30 days after the date of filing.

(f) Disapproval; refiling. --

(1) If the Commissioner finds that an antifraud plan does not comply with the requirements of this section, the Commissioner shall disapprove the antifraud plan and send a notice of disapproval, including the reasons for disapproval, to the viatical settlement provider.

(2) If the Commissioner disapproves an antifraud plan, the viatical settlement provider shall submit a new antifraud plan to the Commissioner within 60 days after the date of disapproval.

(g) Violations. -- It is a violation of this subtitle if the Commissioner finds that a viatical settlement provider has failed to:

(1) file an antifraud plan;

(2) file a revised antifraud plan after disapproval by the Commissioner of the initial antifraud plan; or

(3) comply with the antifraud plan filed by the viatical settlement provider.

HISTORY: 2004, ch. 275.

Md. INSURANCE Code Ann. § 27-805 (2013)

§ 27-805. Required disclosure statements.

(a) "Claim form" defined. -- In this section, "claim form" means any document supplied by an insurer to a claimant that a claimant is required to complete and submit in support of a claim for benefits.

(b) In general. --

(1) Except as provided in subsection (c) of this section, all applications for insurance and all claim forms, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

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

(2) The lack of the statement required by paragraph (1) of this subsection does not constitute a defense in any legal proceeding.

(c) Exceptions. -- Subsection (b)(1) of this section does not apply to:

(1) reinsurance applications or claim forms; or

(2) the uniform claims form for reimbursement of hospital services or the uniform claims form for reimbursement of health care practitioners services adopted by the Commissioner under § 15-1003 of this article.

HISTORY: 2008, ch. 271, § 2; 2012, ch. 120.

Md. INSURANCE Code Ann. § 27-806 (2013)

§ 27-806. Penalty

The penalty for a violation of this subtitle is as provided in §§ 4-113 and 4-114 of this article.

HISTORY: An. Code 1957, art. 48A, § 233B; 1997, ch. 35, § 2; 2004, ch. 275; 2008, ch. 271, § 1.

31.04.15.00

Title 31 MARYLAND INSURANCE ADMINISTRATION

Subtitle 04 INSURERS

Chapter 15 Antifraud Plans

Authority: Health-General Article, §19-706(v); Insurance Article, §§2-109, 8-321.1, and 27-803; Annotated Code of Maryland

.01 Purpose.

The purpose of this chapter is to establish minimum standards for antifraud plans as required by Insurance Article, §27-803, Annotated Code of Maryland.

.02 Applicability.

This chapter is applicable to every authorized insurer that conducts business and writes contracts of insurance in Maryland.

03 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Administration" means the Maryland Insurance Administration.

(2) "Antifraud plan" means antifraud plans as provided for in Insurance Article, §27-803, Annotated Code of Maryland.

(3) "Commissioner" means the Insurance Commissioner of Maryland.

(4) Insurer.

(a) "Insurer" means authorized insurers and includes dental plans, fraternal benefit societies, the Maryland Automobile Insurance Fund, health maintenance organizations, nonprofit health service plans, third party administrators, and the Injured Workers' Insurance Fund.

(b) "Insurer" does not include reinsurers.

31.04.15.04

.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.

(2) This section does not apply to an insurer that has filed an antifraud plan with the Administration, and the plan has been approved by the Commissioner.

(3) An insurer beginning business in this State after the effective date of these regulations shall submit an antifraud plan within 90 days of the insurer's receipt of a certificate of authority to conduct the business of insurance.

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 be limited to:

(a) Claims fraud,

(b) Application fraud,

(c) Insurance producer fraud,

(d) Third-party administrator fraud, and

(e) Internal fraud.

C. Amendments to Antifraud Plans. Within 30 days after modifying or amending an antifraud plan, an insurer shall:

(1) Notify the Commissioner in writing; and

(2) Provide a copy of the revised antifraud plan showing the amendments.

D. Approval of Antifraud Plans and Amendments.

(1) The Commissioner shall review each insurer's antifraud plan and any subsequent amendments to determine compliance with:

(a) The requirements of Insurance Article, §27-803, Annotated Code of Maryland; and

(b) This chapter.

(2) If the Commissioner has not disapproved an antifraud plan or amendment within 30 days of its filing, the plan shall be deemed approved.

(3) Under §D(1) of this regulation, if the Commissioner determines that an insurer's antifraud plan and any subsequent amendment is not in compliance, the Commissioner shall disapprove the plan or amendment and send a written notice of disapproval with the reasons for disapproval to the insurer.

(4) If the insurer's antifraud plan is disapproved by the Commissioner, the insurer shall submit a new plan to the Commissioner within 60 days after the date the plan was disapproved.

E. This regulation does not apply to third party administrators (TPAs) that only participate in federal programs and are therefore required to file a federal antifraud plan provided that:

(1) Such a federal antifraud plan has been filed with the Centers for Medicare & Medicaid Services;

(2) The TPA provides the federal antifraud plan at the Commissioner's request; and

(3) The TPA files a written attestation stating:

(a) The name of the TPA;

(b) The name and title of the employee attesting who has authority to bind the TPA;

(c) That the TPA is required to file an antifraud plan with the federal government; and

(d) The date the TPA filed the antifraud plan with the federal government.

31.04.15.05

.05 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 claims personnel, underwriters, auditors, insurance producers, and consumer service personnel; and

(b) Offered to independent insurance producers who have appointments with the company.

(3) At a minimum, the educational components of 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 insurance producers;

(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 claims personnel, underwriters, and insurance producers 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 detected, 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 §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 courtroom 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 insurance producers 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.

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.

(3) The written policy shall be open for inspection by market conduct examiners of the Maryland Insurance

Administration.

.06 Reporting of Fraud-Related Data.

A. An insurer shall maintain appropriate records for the Commissioner to determine the effectiveness of its antifraud plan.

B. A report shall be developed and provided to the Administration.on an annual basis regarding the plan's effectiveness and the effectiveness of the investigative and prosecutorial efforts.

C. The report shall be filed with the Administration by March 31 of each year, reporting the previous year's statistics. The report shall be limited to Maryland data. The following information shall be reported:

(1) Number of policies in force;

(2) Number of claims;

(3) Number of suspected fraud cases;

(4) Number of suspected fraud cases in which a claim was denied;

(5) Number of suspected fraud cases reported to the authorities;

(6) Number of suspected fraud cases by product line;

(7) Number of suspected fraud cases in which a claim was denied, by product line;

(8) Number of cases prosecuted by criminal authorities; and

(9) Breakdown by perpetrator, as follows:

(a) Insured,

(b) Claimant,

(c) Insurance producer/employee,

(d) Noninsurance professional, by category, and

(e) Other.

31.04.15.9999

Administrative History

Effective date:

Regulations .01—.06 adopted as an emergency provision effective October 1, 1996 (23:21 Md. R. 1465); adopted permanently effective December 30, 1996 (23:26 Md. R. 1859)

Chapter recodified from COMAR 09.31.17 to COMAR 31.04.15, July 1998

Regulation .03B amended effective March 21, 2011 (38:6 Md. R. 397)

Regulation .04 amended effective March 21, 2011 (38:6 Md. R. 397)

Regulation .04A, B amended effective January 15, 2007 (34:1 Md. R. 33)

Regulation .05A, B, D amended effective January 15, 2007 (34:1 Md. R. 33)

Regulation .06C amended effective January 15, 2007 (34:1 Md. R. 33)

MARYLAND INSURANCE ADMINISTRATION
INSURANCE FRAUD DIVISION

GUIDELINES FOR DEVELOPING AN ANTIFRAUD PLAN

I. PREAMBLE

This document was developed by the Maryland Insurance Administration ("MIA") in concert with industry experts, to serve as a guide in the development of your antifraud plan pursuant to The Annotated Code of Maryland, Insurance, Section 27-803, "Insurance Antifraud Plan" and COMAR 31.04.15.05 and.06. To further assist you, we have developed a Checklist, which is also on the MIA website, which tracks each of the requisite Plan components set forth in COMAR.

The Administration intends that these guidelines be flexible so that each company's needs can be met, depending on the product lines/services of each unique entity required to file a Plan (authorized insurers, TPA's and HMO's).

It is also important to bear in mind that your Plan must address all types of potential insurance fraud, not just claims fraud. Those other types of fraud include, but are not limited to, application fraud, underwriting fraud, agent/producer fraud and misappropriation, false certificates of insurance, and internal fraud and embezzlement.

Please bear in mind as well that the education and training requirements set forth in COMAR apply to all employee groups referenced in the regulation, namely: claims personnel, underwriters, auditors, producers (both employed directly and with appointments) and consumer service personnel.

II. PLAN COMPONENTS

A. EDUCATION

Incidents of insurance fraud can be decreased once potential perpetrators realize that insurance personnel have the skills and commitment to recognize, investigate, and refer for investigation any suspected insurance fraud. To increase understanding of insurance fraud, it is necessary for insurance personnel to undergo training on the multi-dimensional nature of fraudulent insurance acts. This training is an ongoing process; it will increase employee awareness of suspicious activity and assist in deterring the commission of fraud. All new and existing personnel should be trained in the recognition and referral of suspected fraud. Those to be trained should include but not be limited to:

- agents and producers
- claims personnel
- underwriters

- auditors
- consumer service personnel

1. Courses of instruction should be designed which address specific aspects of fraud associated with a company's product line.
2. Courses should be designed to address the educational needs of the target personnel.
3. In order to adequately cover the necessary subject matter, courses of instruction should be two (2) hours in duration.
4. Personnel should be presented with updated material at the entrance level and at least once every two years, in conjunction with continuing education standards or as a company policy.
5. Training programs may be developed and conducted either by internal personnel or by outside contractors.
6. Training programs may include but not be limited to the following modalities:
   a. fraud indicators
   b. actual case scenarios
   c. videos and slides
   d. updates of schemes and trends
   e. professional and/or in-house newsletters dealing with fraud
   f. items placed on the company intranet

B. DETECTION

Once trained, company employees must accept responsibility for the early detection of suspicious or fraudulent acts. Once the proper training is provided to entrance level and in-service personnel, the detection of suspicious acts will become routine. All companies shall designate a person or persons or a specific unit to be responsible for coordinating the detection, referral and investigation of suspected fraudulent activity. Designations and amendments shall be submitted to the Maryland Insurance Fraud Division.

Fraud detection guides/manuals should be prepared, published and maintained to assist personnel in the identification, detection and handling of suspicious claims and other fraudulent insurance acts.

Referrals to the company point of contact (POC) or special investigation unit (SIU) may be generated by the following detection methods:

1. Calls from policyholders, subscribers, beneficiaries and other providers received on a toll free or local inquiry line.

2. Suspicions raised by claims personnel.

3. Suspicions raised by field agents and adjusters.

4. Suspicions raised by service representatives.

5. Referrals/complaints from policyholders.

6. Information obtained in conjunction with special surveys, studies and audits conducted by the company.

7. Referrals from law enforcement agencies, i.e., the Insurance Fraud Division, the F.B.I., State and local police departments; the NICB or the NAIC; professional licensing boards and regulators; the Attorney General's Office, Medicaid Fraud Control Unit, and U.S. Postal Inspectors, to name a few.

C. INVESTIGATION

Once suspicious activity has been detected, evaluated, and found to warrant a full investigation, it should be assigned to the duly authorized company representative who conducts or oversees such investigations. In considering this aspect of the plan, the company should analyze its options to maintain an in-house staff of investigators or contract with an outside firm. If you opt to contract with an outside firm, bear in mind they must conform to all applicable State licensing requirements.

In-house vs. outside contractors

A determination as to who will conduct investigations on behalf of an insurer must be made. In most cases, the volume of suspicious acts resulting in investigations will be one of the deciding factors. Companies who conduct large volumes of investigations may opt to retain an internal investigative unit. Those companies who deal with a somewhat reduced volume of investigations may find it more cost effective to contract out the work to a qualified investigative firm. If you opt to contract with an outside firm, bear in mind that it must conform to all applicable State licensing requirements.

Once the company has determined who will conduct its fraud investigations, the following should be developed:

1. Guidelines and procedures for the conduct of potential criminal investigations if in-house staff is utilized, i.e., investigations that may lead to prosecution.

2. Written considerations as to work product, court room testimony, if necessary, and liability assumption.
3. Guidelines and procedures for cooperation with law enforcement

Companies shall establish guidelines and procedures for detecting fraud relating but not limited to the following:

1 Embezzlement/internal theft;
2 Underwriting/application fraud;
3. Theft/misappropriation of premiums by agents;
4. Claims fraud

Appropriate records shall be maintained to determine the effectiveness of the company's fraud plan.

The Maryland Insurance Division has developed an Annual Report of Fraud Related Data that is to be submitted by March 31 of each year. Our website is www.mdinsurance.state.md.us

D. AUDITING

An effective antifraud plan should contain procedures regarding the auditing of agents. Any auditing protocol should provide for both routine auditing and random audits. This would aid in the early detection of inappropriate and/or fraudulent practices of agents. Such procedures would protect both the company and its customers from unscrupulous business practices being undertaken by agents and the misappropriation of premiums. If any irregularities are discovered during an audit, the duly authorized company representative who conducts or oversees investigations should be notified immediately.

E. PROSECUTION/RECOVERY

If an insurer, TPA or HMO, in good faith, has cause to believe that insurance fraud has been or is being committed, that insurer must report such fraud to the Insurance Fraud Division or to the appropriate federal, State, or local law enforcement authority.

In addition to referral for possible prosecution, the matter should be submitted to the company legal department for a decision on whether to deny payment of a claim, whether to seek restitution, whether to deny coverage, what personnel actions to take, etc. This policy should be in writing and maintained in the offices of the company point of contact for fraud. Upon request, the written policy shall

be open for inspection by market conduct examiners of the Maryland Insurance Administration.

F. ANNUAL STATISTICAL REPORTING

Concurrent with the implementation of the operational fraud plan components, companies should develop a method to capture data associated with fraud statistics reporting, as set forth below:

I. POLICY/CLAIM DATA

- a. number of policies in force in Maryland
- b. number of claims submitted by Maryland residents

II. SUSPECTED FRAUDS

- a. Total number of suspected frauds
  1. number of suspected fraudulent applications
  2. number of suspected fraudulent claims
  3. number of suspected internal fraud (employee and/or agent)
- b. Total number of suspected fraudulent claims in which the claim was denied
- c. Total number of suspected frauds reported to the authorities
  1. number reported to the Insurance Fraud Division

Effective January 1, 2014, all entities required to file Annual Fraud Data Reports (see COMAR 31.04.15.06 and Insurance Art. §27-803(b)(4)) with the Commissioner (Insurance Fraud Division) may do so online between January 1 and March 31 (for the previous calendar year). In the past, the only mechanism for completing and filing said Reports was manually, but for calendar year 2013 (due on or before March 31, 2014), our website (http://www.mdinsurance.state.md.us) will provide for it to be done electronically. All affected entities are strongly encouraged to utilize this capability, as opposed to the old manual submission. These reports must be filed annually.

A separate Report must be filed for each entity; it will no longer be acceptable to file a single Report covering several related companies (i.e., by Group). Additionally, in completing the form online, the statistics being reported will be verified automatically as they are entered, so that totals match before submission.

PLEASE COMPLETE THIS FORM
AND E-MAIL IT TO THE MARYLAND INSURANCE ADMINISTRATION's FRAUD DIVISION
(data_reports.mia@maryland.gov)

ANNUAL REPORT OF FRAUD RELATED DATA – Due each year by 3/31
(COMAR 31.04.15.06)

COMPANY NAME: _____ NAIC #: _____

I. POLICY/CLAIM DATA

a. Total # of policies in force in Maryland . . . . . ____
b. Total # of claims submitted by Maryland residents . . . . . ____

II. SUSPECTED FRAUDS

a. Total # of suspected frauds . . . . . ____
(1) # of suspected fraudulent applications . . . . . ____
(2) # of suspected fraudulent claims . . . . . ____
(3) # of suspected internal frauds (employee and agent). . . . ____

b. Total # of suspected fraudulent claims in which the claim was denied . . . . . ____

c. Total # of suspected frauds reported to authorities . . . . . ____
(1) # reported to Maryland Insurance Fraud Division . . . . . ____

_____
Name, title, telephone number and email address of person completing form

PLEASE MAINTAIN A HARD COPY OF COMPLETED FORM IN YOUR RECORDS FOR AUDIT PURPOSES

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