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.