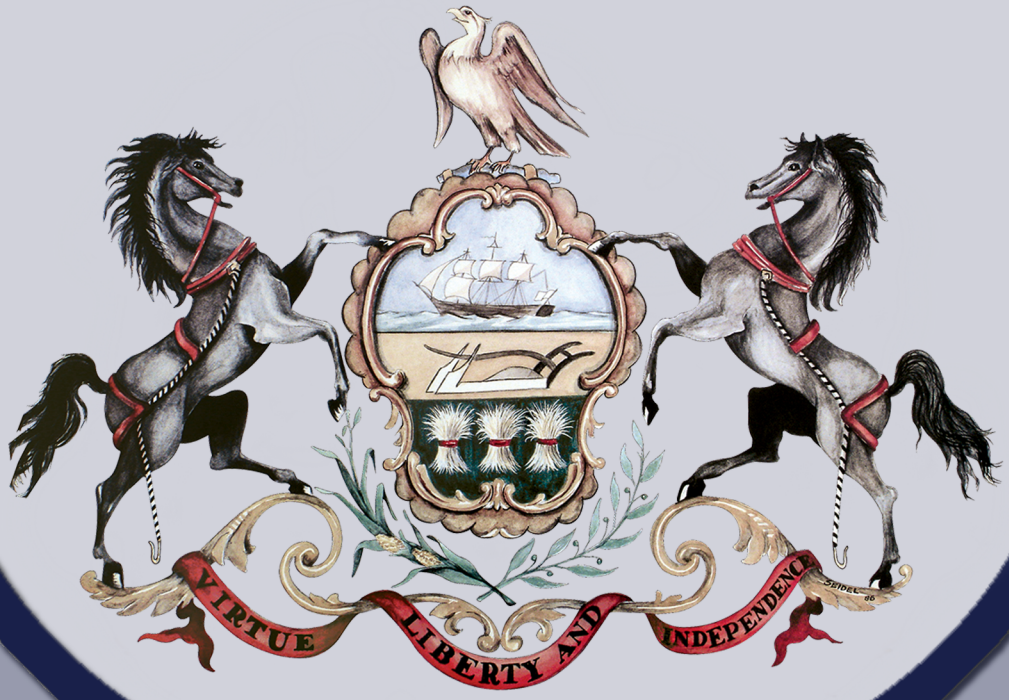
PENNSYLVANIA

OFFICE OF ATTORNEY GENERAL

CRIMINAL LAW DIVISION

INSURANCE FRAUD SECTION



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The Insurance Fraud Section (IFS) of the Office of Attorney General investigates and prosecutes those who commit insurance fraud.

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PENNSYLVANIA'S BATTLE AGAINST INSURANCE FRAUD

For years insurance fraud was tolerated as an unfortunate but somewhat inevitable "cost of doing business" in Pennsylvania. But as insurance rates continued to rise, Pennsylvanians decided that enough was enough. The General Assembly passed tough new anti-fraud legislation.

In 1990 the legislature made insurance fraud a serious crime in Pennsylvania, punishable by heavy fines and stiff prison sentences. It is hoped that strict enforcement of these laws, along with greater public awareness of insurance fraud, will help curb fraud and ultimately hold down Pennsylvania insurance rates.

Americans pay $308 billion a year due to insurance fraud, according to the National Insurance Crime Bureau.

- Rising insurance rates force us to pay higher premiums, thereby reducing our net income.
- The cost of workers' compensation, property-casualty and health insurance exact a heavy price on businesses, particularly small businesses. This financial burden can ultimately result in lost jobs.
- As businesses pass along the higher costs of insurance, consumer prices continue to rise.
- As fraudulent claims drive up the cost of automobile insurance, more and more drivers do not have insurance.

FUNDING THE FIGHT

NO TAXPAYER DOLLARS are used to fund the efforts of the Attorney General's Insurance Fraud Section!

Every two years the Insurance Fraud Section applies for an operating grant from the Pennsylvania Insurance Fraud Prevention Authority (IFPA). Established by state law in 1994, the IFPA assesses and administers monies paid by the insurance industry in Pennsylvania. The funds are awarded by the IFPA in the form of grants to law enforcement units throughout the Commonwealth.

ATTORNEY GENERAL'S ROLE IN COMBATTING FRAUD

The Office of Attorney General's Insurance Fraud Section is the largest law enforcement entity in PA vested with specific authority to investigate and prosecute insurance fraud.

The Insurance Fraud Section was officially launched by then Acting Attorney General Tom Corbett in March, 1996. Since its inception the Section has continued to aggressively investigate and prosecute all types of insurance fraud in Pennsylvania. Cases include all lines of insurance: Auto, Homeowners, Health, Life, Disability and Workers' Compensation.

Most of the investigations conducted by the Insurance Fraud Section are initiated by referrals from insurance companies. The IFS also receives referrals from state agencies, employers and private citizens. (For more information on how to refer a case to the Insurance Fraud Section, please see the "Fraud Referrals" section in this booklet.)

When the IFS determines that a referral warrants criminal investigation, an investigator and an attorney are assigned to the case. The investigator gathers information and conducts interviews in order to obtain the pertinent facts of the case. Based upon the findings, the investigator and the attorney determine whether the evidence is sufficient to warrant the filing of criminal charges, or whether the case should be closed without further action. In either case, the referring company, agency or individual will be notified by the Insurance Fraud Section.

Once criminal charges are filed, the assigned Deputy Attorney General represents the Commonwealth in the prosecution of the defendant. That prosecution takes place in the county where charges were filed.

Many insurance fraud cases are resolved through guilty pleas or other appropriate pre-trial dispositions. A smaller percentage of the cases go to trial. If a defendant is convicted of one or more charges, a Common Pleas Court Judge determines an appropriate sentence based upon a variety of factors, including the severity of the applicable offense(s), the defendant's prior criminal record (if any) and any recommendations the prosecuting attorney makes.

The Judge may sentence the defendant to a term of probation, house arrest or incarceration. Many sentencing orders require the defendant to perform some community service and/or pay a fine. If the defendant received insurance proceeds or other monies as a direct result of his/her fraudulent conduct, the Judge will order the defendant to make monetary restitution to the victim.

§4117. Insurance Fraud.

(a) Offense defined.—A person commits an offense if the person does any of the following:

(1) Knowingly and with the intent to defraud a State or local government agency files, presents or causes to be filed with or presented to the government agency a document that contains false, incomplete or misleading information concerning any fact or thing material to the agency's determination in approving or disapproving a motor vehicle insurance rate filing, a motor vehicle insurance transaction or other motor vehicle insurance action which is required or filed in response to an agency's request.

(2) Knowingly and with the intent to defraud any insurer or self-insured, presents or causes to be presented to any insurer or self-insured any statement forming a part of, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim.

(3) Knowingly and with the intent to defraud any insurer or self-insured, assists, abets, solicits or conspires with another to prepare or make any statement that is intended to be presented to any insurer or self-insured in connection with, or in support of, a claim that contains any false, incomplete or misleading information concerning any fact or thing material to the claim, including information which documents or supports an amount claimed in excess of the actual loss sustained by the claimant.

(4) Engages in unlicensed agent, broker or unauthorized insurer activity as defined by the act of May 17,1921 (P.L. 789, No. 285), known as The Insurance Department Act of one thousand nine hundred and twenty-one, [FN1] knowingly and with the intent to defraud an insurer, a self-insured or the public.

(5) Knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy or urging of any person.

(6) Is the owner, administrator or employe of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section.

(7) Borrows or uses another person's financial responsibility or other insurance identification card or permits his financial responsibility or other insurance identification card to be used by another, knowingly and with intent to present a fraudulent claim to an insurer.

(8) If, for pecuniary gain for himself or another, he directly or indirectly solicits any person to engage, employ or retain either himself or any other person to manage, adjust or prosecute any claim or cause of action against any person for damages for negligence or for pecuniary gain for himself or another, directly or indirectly solicits other persons to bring causes of action to recover damages for personal injuries or death, provided, however, that this paragraph shall not apply to any conduct otherwise permitted by law or by rule of the Supreme Court.

(b) Additional offenses defined.—

[Former Section (b)(1) was declared unconstitutional by the Pennsylvania Supreme Court in Commonwealth v. Stern. Pa., 701 A.2d 568 (1997).]

(2) With respect to an insurance benefit or claim covered by this section, a health care provider may not compensate or give anything of value to a person to recommend or secure the provider's service to or employment by a patient or as a reward for having made a recommendation resulting in the provider's service to or employment by a patient; except that the provider may pay the reasonable cost of advertising or written communication as permitted by rules of professional conduct. Upon a conviction of an offense provided for by this paragraph, the prosecutor shall certify such conviction to the appropriate licensing board in the Department of State which shall suspend or revoke the health care provider's license.

(3) A lawyer or health care provider may not compensate or give anything of value to a person for providing names, addresses, telephone numbers or other identifying information of individuals seeking or receiving medical or rehabilitative care for accident, sickness or disease, except to the extent a referral and receipt of compensation is permitted under applicable professional rules of conduct A person may not knowingly transmit such referral information to a lawyer or health care professional for the purpose of receiving compensation or anything of value. Attempts to circumvent this paragraph through use of any other person, including, but not limited to, employes, agents or servants, shall also be prohibited.

(4) A person may not knowingly and with intent to defraud any insurance company, self-insured or other person file an application for insurance containing any false information, or conceal for the purpose of misleading information concerning any fact material thereto.

(c) Electronic claims submission.—If a claim is made by means of computer billing tapes or other electronic means, it shall be a rebuttable presumption that the person knowingly made the claim if the person has advised the insurer in writing that claims will be submitted by use of computer billing tapes or other electronic means.

(d) Grading.-An offense under subsection (a)(1) through (8) is a felony of the third degree. An offense under subsection (b) is a misdemeanor of the first degree.

(e) Restitution.—The court may, in addition to any other sentence authorized by law, sentence a person convicted of violating this section to make restitution.

(f) Immunity.—An insurer, and any agent, servant or employe thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral

information to any entity duly authorized to receive such information by Federal or State law, or by Insurance Department regulations.

(g) Civil action.—An insurer damaged as a result of a violation of this section may sue therefor in any court of competent jurisdiction to recover compensatory damages, which may include reasonable investigation expenses, costs of suit and attorney fees. An insurer may recover treble damages if the court determines that the defendant has engaged in a pattern of violating this section.

(h) Criminal action.—

(1) The district attorneys of the several counties shall have authority to investigate and to institute criminal proceedings for any violation of this section.

(2) In addition to the authority conferred upon the Attorney General by the act of October 15,1980 (P.L. 950, No. 164), known as the Commonwealth Attorneys Act, [FN2] the Attorney General shall have the authority to investigate and to institute criminal proceedings for any violation of this section or any series of such violations involving more than one county of the Commonwealth or involving any county of the Commonwealth and another state. No person charged with a violation of this section by the Attorney General shall have standing to challenge the authority of the Attorney General to investigate or prosecute the case, and, if any such challenge is made, the challenge shall be dismissed and no relief shall be available in the courts of the Commonwealth to the person making the challenge.

(i) Regulatory and investigative powers additional to those now existing.—Nothing contained in this section shall be construed to limit the regulatory or investigative authority of any department or agency of the Commonwealth whose functions might relate to persons, enterprises or matters falling within the scope of this section.

(j) Violations, penalties, etc.—

(1) If a person is found by court of competent jurisdiction, pursuant to a claim initiated by a prosecuting authority, to have violated any provision of this section, the person shall be subject to civil penalties of not more than $5,000 for the first violation, $10,000 for the second violation and $15,000 for each subsequent violation. The penalty shall be paid to the prosecuting authority to be used to defray the operating expenses of investigating and prosecuting insurance fraud. The court may also award court costs and reasonable attorney fees to the prosecuting authority.

(2) Nothing in this subsection shall be construed to prohibit a prosecuting authority and the person accused of violating this section from entering into a written agreement in which that person does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding, but notification thereof shall be made to the licensing authority if the person is licensed by a licensing authority of the Commonwealth so that the licensing authority may take appropriate administrative action. Penalties paid under this section shall be deposited into the Insurance Fraud Prevention Fund created under the Insurance Fraud Prevention Act.

(3) The imposition of any fine or other remedy under this section shall not preclude prosecution for a violation of the criminal laws of this Commonwealth.

(k) Insurance forms and verification of services.—

(1) All applications for insurance and all claim forms shall contain or have attached thereto the following notice: "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 subjects such person to criminal and civil penalties."

(2) Repealed. 1995, July 6, P.L. 242, No. 28, § 2, effective in 60 days.

(l) Definitions.—As used in this section, the following words and phrases shall have themeanings given to them in this subsection:

"Insurance policy." A document setting forth the terms and conditions of a contract of insurance or agreement for the coverage of health or hospital services.

"Insurer." A company, association or exchange defined by section 101 of the act of May 17,1921 (P.L. 682, No. 284), known as The Insurance Company Law of 1921; [FN3] an unincorporated association of underwriting members; a hospital plan corporation; a professional health services plan corporation; a health maintenance organization; a fraternal benefit society; and a self-insured health care entity under the act of October 15,1975 (P.L. 390, No. 111), known as the Health Care Services Malpractice Act. [FN4]

"Person." An individual, corporation, partnership, association, joint-stock company, trust or unincorporated organization. The term includes any individual, corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society, beneficial association and any other legal entity engaged or proposing to become engaged, either directly or indirectly, in the business of insurance, including agents, brokers, adjusters and health care plans as defined in 40 Pa.C.S. Chs. 61 (relating to hospital plan corporations), 63 (relating to professional health services plan corporations), 65 (relating to fraternal benefit societies) and 67 (relating to beneficial societies) and the act of December 29,1972 (P.L. 1701, No. 364), known as the Health Maintenance Organization Act. [FN5] For purposes of this section, health care plans, fraternal benefit societies and beneficial societies shall be deemed to be engaged in the business of insurance.

"Self-insured." Any person who is self-insured for any risk by reason of any filing, qualification process, approval or exception granted, certified or ordered by any department or agency of the Commonwealth.

"Statement" Any oral or written presentation or other evidence of loss, injury or expense, including, but not limited to, any notice, statement, proof of loss, bill of landing, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X-ray, test result or computer-generated documents.

[FN1] 40 P.S. § 1 et seq.
[FN2] 71 P.S. §732-101 et seq.
[FN3] 40 P.S. §361.
[FN4] 40 P.S. § 1301.101 et seq.
[FN5] 40 P.S. § 1551 et seq.

INSURANCE FRAUD STATUTE IN PLAIN LANGUAGE

BASIC ELEMENTS

1. Makes or presents a statement in support of an insurance claim;
2. The statement contains false information;
3. The statement is material; and
4. The statement is made with the intent to defraud an insurer.

PROHIBITED ACTS

1. Filing a fraudulent claim with a state or local agency relative to motor vehicle insurance matters.
2. Filing a fraudulent claim with an insurer.
3. Assisting (as an accomplice) and / or conspiring (as a co-conspirator) with another to file a fraudulent claim.
4. Engaging in unlicensed agent, broker or unauthorized insurer activity with the intent to defraud.
5. Knowingly receiving proceeds from insurance fraud.
6. Using a health care facility to perpetrate insurance fraud.
7. Using another person's financial responsibility / identification card to commit insurance fraud.
8. Being part of a "personal injury mill" based on fraudulent insurance claims.
9. Compensation by a health care provider to another for referring patients.
10. Health care provider compensates others for providing information of individuals securing medical treatment.
11. Filing an application for insurance containing false material information.

DEFINITION OF "STATEMENT"

Any oral or written presentation or other evidence of loss, injury or expense, including, but not limited to, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X-ray, test results or computer generated documents.

TYPES OF INSURANCE FRAUD

The following is a list of the more commonly perpetrated acts or schemes of insurance fraud:

Auto

1. False or inflated repair billing
2. Theft or "give up" (false stolen car report to police)
3. Inflated theft claim
4. "Jump in" (someone not in vehicle at time of accident)
5. Staged accident
6. Vandalism / intentional damage to vehicle
7. Falsifying the date of an accident to get coverage on a newly acquired policy
8. Arson
9. Altered or false documents of financial responsibility
10. Rate evasion

Property

1. False or inflated repair billing
2. False burglary and theft report to police
3. Inflated theft claim
4. Arson
5. Vandalism / intentional damage

Personal Injury

1. Bogus slip and fall
2. Fraudulent pain and suffering claim
3. Fraudulent continued disability claim

Health Care Fraud

1. Fee for service
   a. Billing for services not provided
   b. Billing for a more expensive service than what was actually provided
   c. Providing and billing for unnecessary services while representing that the services were necessary
   d. Paying kickbacks for referrals, including self-referrals
   e. Billing for services or supplies not covered
   f. Double billing
   g. Fraudulent pharmacy claims
2. Managed care (capitation reimbursement).
   a. Submission of false cost data
   b. Registration of fictitious enrollees
   c. Underprovision of necessary care or services
   d. Corruption in organizing and monitoring the groups of providers and in enrolling patients with provider groups

Agent / Industry Misconduct

1. Theft of premiums
2. Accomplice / co-conspirator liability for the acts of the insured
3. Unlicensed activity
4. "Churning" — Using the cash value of an existing policy to buy a new, usually more expensive policy. The unscrupulous agent / broker / company earns a commission on the new policy and the insured loses the cash value of the old policy, often without realizing it.

SOME "TYPICAL" INSURANCE FRAUD SCENARIOS

Just as there are many types of insurance (auto, residential, business, personal property, life insurance, etc.), there are many forms of insurance fraud. Here are a few common examples:

Fraudulent auto damage claim

While rushing to work one morning, a driver fails to properly negotiate a sharp curve and scrapes the fender of his 5 year old car against a guardrail. Cursing himself for having recently dropped collision coverage from his auto policy, the man realizes that his insurer is not obligated to fix his car. After taking a moment to consider his predicament, the man calls the insurance company and asks to have his collision coverage reinstated. He deliberately says nothing about the accident or the damage to his car. The man waits two days after the collision coverage takes effect, then files a vehicle accident claim. Instead of reporting the true accident date, the man tells the insurer that "it just happened this morning".

Inflated homeowner claim

During an overnight storm, several tree branches snap off and crush a section of rain gutter attached to the roof of Mr. Smith's home. Mr. Smith calls his insurance agent the next morning to report the damage. In addition to the gutter damage, Mr. Smith tells the insurer that the storm blew about eight shingles off his roof. Mr. Smith knows that the shingles were missing when he bought the house 2 years ago. In fact, he had recently spoken with a local contractor about replacing them.

Vehicle "give up"

A few months after making the down payment on a new SUV, George decides that his monthly vehicle loan payment is more than he can handle. Instead of selling the vehicle or trading it in for a less-expensive model, George decides to take a friend up on his offer to make George's SUV "disappear". The friend tells George to park the SUV behind a certain store at the local mall on a particular night, and to leave the keys in the ignition. George does so. He then spends an hour walking through the mall stores before checking on his SUV. Finding it gone, George immediately calls his insurance company and files a theft claim.

Vehicle "Jump in"

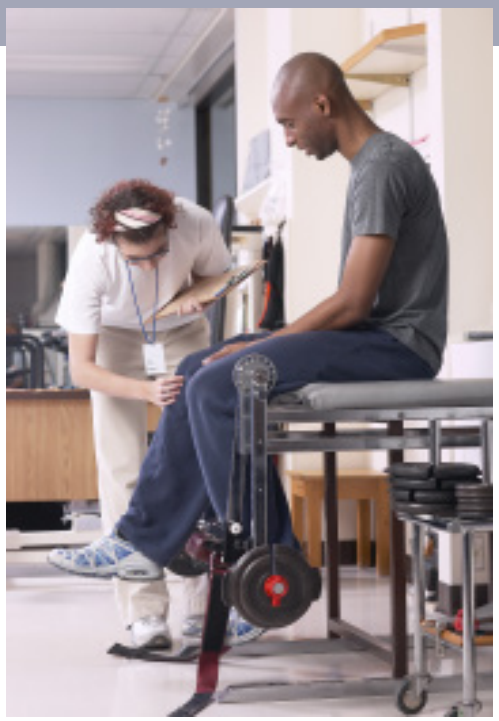
While approaching a city intersection, Sally notices that the traffic light is yellow. She is late for an appointment, so Sally punches the accelerator in an effort to get through the intersection before the light turns red. At that same moment, Bill is approaching the same intersection from the cross street. Seeing his traffic signal light turn "green", Bill continues to drive his truck into the intersection. Suddenly Sally's car shoots in front of Bill's truck, which collides with the rear driver's side of Sally's car. Neither driver is hurt but both vehicles are damaged. They exchange insurance information and wait for police. Several weeks later Bill's insurance company receives correspondence from Sally's attorney. The letter states that Sally, her mother, father and brother all required medical treatment for injuries they "sustained in the vehicle accident" and therefore will be filing personal injury claims against Bill's insurer. When the insurer notifies Bill, he swears that Sally was alone in her vehicle when the accident occurred.

Insurance Rate Evasion

George lives and works in New York City where auto insurance premiums are extremely expensive. George's mother owns a home in a rural area of Pennsylvania. On a Saturday, George drives from New York to Pennsylvania for an appointment to meet with an insurance agent. George tells the agent that he has recently moved to Pennsylvania and would like to insure his Cadillac in Pa. While completing the application paperwork George lists his mother's address as his Pennsylvania "residence". By falsely claiming Pennsylvania residency, George obtains auto insurance at a lower rate than he paid in New York.

Fraudulent Disability Claims

Terry takes out a long-term disability insurance policy which, under specific conditions, will pay him most of his current monthly wages if he becomes disabled. One weekend while Terry is cleaning leaves out of the roof gutters at his home, he slips and falls off the ladder. As a result of his injuries, Terry is disabled and cannot work. He files a disability claim and begins to receive biweekly checks from the insurer. The insurer requires Terry to complete and submit a form each month in order to continue receiving benefits. A portion of the form is to be completed by Terry's treating physician. After several months of medical treatment and physical therapy, Terry is cleared by his doctor to return to work. Rather than inform the insurance company, Terry falsifies a form for continuing disability benefits and submits it to the insurer. The physician's portion of the form (which Terry completed and forged his doctor's signature) falsely certifies that Terry remains unable to return to work due to his injuries.



Multi-Person Insurance Scams

A group of eight adult family members decide that they can make some "easy money" by staging "accidents" and filing fraudulent insurance claims. Per the plan several family members go to the local grocery where one of the women "accidentally" slips and falls. The other family members tell the grocery store manager that they witnessed the "accident", which they say occurred when their mother slipped on a wet spot on the floor. The "injured" woman tells the manager that she heard her ankle "snap" when she slipped and that she is in severe pain. The woman files a false claim against the grocery store's insurance policy for medical expenses and lost wages. Several weeks later, a different family member has a similar "accident" when he trips over a basket at a local Laundromat. Supported by "witnesses" who are in on the scheme, the man files a claim against the Laundromat's insurance company. Later he brags to a cousin about the scam and encourages him to stage a slip and fall accident at a local tavern parking lot.

Health Care Fraud

An unscrupulous chiropractor orchestrates a complex scheme to bilk medical insurers out of thousands of dollars. The doctor pays several acquaintances to recruit "patients" for his practice. These "patients" are paid by the recruiters to come to the chiropractic clinic for treatment. The recruiters tell each "patient" to claim that his or her condition or "injury" was caused by a car wreck, a fall, or other type of accident. Some patients have no actual injuries. Others have pre-existing conditions. At the chiropractor's office each patient provides his or her health insurance information to the staff and signs paperwork enabling the office to directly bill the patient's health insurer. A doctor or other clinician then meets briefly with each patient and takes notes. Some patients are given cursory examinations. Some are scheduled for repeat visits. The doctor and his associates falsify patient diagnostic and medical records to make it appear as though the patients received elaborate or extensive treatment. In some cases, the records falsely indicate that special equipment was used, or that certain patients suffer from chronic conditions requiring ongoing treatment. The chiropractor and his associates then submit bills (supported by the fraudulent documentation) to the patients' health insurers.

CRIMINAL PENALTIES FOR FRAUD OFFENSES

Most insurance fraud offenses are graded as third degree felonies. Insurance application fraud is graded as a first degree misdemeanor.

The **maximum** penalty for a single third degree felony offense is seven (7) years in prison and/or a $15,000 fine.

The **maximum** penalty for a single first degree misdemeanor is five (5) years in prison and/or a $10,000 fine.

STATUTE OF LIMITATIONS – FIVE YEARS

The crime of insurance fraud carries a five (5) year statute of limitations. In other words, law enforcement authorities have just 5 years from the date of the offense to file criminal charges against the perpetrator.

WORKERS' COMPENSATION INSURANCE FRAUD

Another very important category of fraud crimes pertains specifically to the area of Workers' Compensation. These offenses are defined in the Pennsylvania Workmen's Compensation Act, Title 77 of PA Statutes (Purdons), Section 1039.2.

While most workers' compensation claims are legitimate, industry observers estimate that workers' compensation and disability insurance fraud has become pervasive in recent years. Besides the loss in productivity, the most obvious economic impact is felt by the insurers and state agencies which pay the fraudulent claims. But it does not stop there. Insurers and state agencies are forced to pass much of the cost on to policyholders in the form of increased premiums.

Pennsylvania businesses must pay higher rates for workers' compensation coverage, which makes them less competitive in regional and national marketplaces. Higher workers' compensation premium rates discourage new businesses from locating to Pennsylvania, thereby limiting new job opportunities. Fraud hurts everyone.

When former Governor Ridge signed Act 57 into law (the Worker's Compensation Reform Act of 1996), a major loophole affecting anti-fraud enforcement was closed. Now a workers' compensation insurer can ask any employee who is receiving benefits to submit, in writing, any change in the status of his or her employment, wages or physical condition. The employee is obligated to cooperate with the insurer and must respond within 30 days or face the possible suspension of compensation. If the employee lies on the form, proof of a "material misrepresentation" can be more easily established. Many insurance companies require claimants to complete a questionnaire for verification of continuing eligibility every six months.

Act 57 criminalized the following:

Failure to report a change in employment, wages or physical condition.

Working while receiving total disability.

Drawing partial disability and wages greater than a pre-injury wage.

§1039.2. Offenses

A person, including, but not limited to, the employer, the employe, the health care provider, the attorney, the insurer, the State Workmen's Insurance Fund and self-insureds, commits an offense if the person does any of the following:

(1) Knowingly and with the intent to defraud a State or local government agency files, presents or causes to be filed with or presented to the government agency a document that contains false, incomplete or misleading information concerning any fact or thing material to the agency's determination in approving or disapproving a workers' compensation insurance rate filing, a workers' compensation transaction or other workers' compensation insurance action which is required or filed in response to an agency's request.

(2) Knowingly and with intent to defraud any insurer presents or causes to be presented to any insurer any statement forming a part of or in support of a workers' compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.

(3) Knowingly and with the intent to defraud any insurer assists, abets, solicits or conspires with another to prepare or make any statement that is intended to be presented to any insurer in connection with or in support of a workers' compensation insurance claim that contains any false, incomplete or misleading information concerning any fact or thing material to the workers' compensation insurance claim.

(4) Engages in unlicensed agent or broker activity as defined by the act of May 17,1921 (P.L. 789, No. 285), [FN1] known as "The Insurance Department Act of 1921," knowingly and with the intent to defraud an insurer or the public.

(5) Knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this section due to the assistance, conspiracy or urging of any person.

(6) Is the owner, administrator or employe of any health care facility and knowingly allows the use of such facility by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this section.

(7) Knowingly and with the intent to defraud assists, abets, solicits or conspires with any person who engages in an unlawful act under this section.

(8) Makes or causes to be made any knowingly false or fraudulent statement with regard to entitlement to benefits with the intent to discourage an injured worker from claiming benefits or pursuing a claim.

(9) Knowingly and with the intent to defraud makes any false statement for the purpose of avoiding or diminishing the amount of the payment in premiums to an insurer or self-insurance fund.

(10) Knowingly and with intent to defraud, fails to make the report required under Section 311.1. [FN2]

(11) Knowingly and with intent to defraud, receives total disability benefits under this act while employed or receiving wages.

(12) Knowingly and with intent to defraud, receives partial disability benefits in excess of the amount permitted with respect to the wages received.

[FN1] 40 P.S. §l, et seq.
[FN2] 77 P.S. §631.1.

WORKERS' COMPENSATION FRAUD STATUTE IN PLAIN LANGUAGE

PROHIBITED ACTS

The initial provisions of this statute closely mirror their counterparts in the Insurance Fraud Statute (18 PA C.S.A. § 4117). However, because Section 1039.2 is limited to the realm of workers' compensation insurance, this statute contains additional provisions:

1. Knowingly and intentionally assists, recruits or conspires with anyone committing workers' compensation fraud.
2. Knowingly makes or causes a false or deceptive statement to be made pertaining to entitlement benefits, with the intention of discouraging an injured worker from claiming or pursuing benefits.
3. Knowingly and intentionally makes a false statement with the purpose of avoiding or reducing the amount of workers' compensation premium payments.
4. Knowingly and intentionally fails to comply with reporting requirements.
5. Knowingly and intentionally receives total disability benefits while working or receiving wages.
6. Knowingly and intentionally receives partial disability benefits amounting to more than is permitted by law.

Types of Workers' Compensation Insurance Fraud

1. Claimant fraud
   a. Unreported wages, income, employment and / or change of status
   b. Fraudulent pain and suffering claim

2. Premium fraud
   a. Underreporting payroll and/or employee compensation; excluding employees and paying in cash; insuring only a portion of the company
   b. Intentionally misclassifying employees' job codes
   c. Misrepresenting company experience by providing false history of losses; new or different company ownership; listing different geographic location of company on policy application

CRIMINAL PENALTIES FOR FRAUD OFFENSES

Typically crimes under the Workers' Compensation Insurance Fraud statute are graded as third degree felonies.

The **maximum** penalty for a single **third degree felony** workers' compensation fraud offense is seven (7) years in prison and/or a fine of up to $50,000 or twice the monetary value of the fraud.

STATUTE OF LIMITATIONS – FIVE YEARS

The crime of workers' compensation insurance fraud carries a five (5) year statute of limitations. In other words, law enforcement authorities have just 5 years from the date of the offense to file criminal charges against the perpetrator.

Failure to Carry Workers' Compensation Insurance

In addition to prosecuting workers' compensation insurance fraud, the Attorney General's Insurance Fraud Section also investigates and prosecutes PA employers who fail to carry workers' compensation insurance. Unless an employer is self-insured, Section 305 of the PA Workers' Compensation Act (77 P.S. §501) requires the employer to have workers' compensation insurance. The statute enables law enforcement to charge the employer with a separate offense for each day that the employer operates without workers' compensation insurance.

Any employer convicted of failing to carry workers' compensation insurance is guilty of a third degree misdemeanor. If the employer is convicted of intentionally failing to carry the required insurance, that employer is guilty of a third degree felony.

Any employer convicted of a misdemeanor under the Act may be ordered to spend up to a year in jail and pay a fine of up to $2500.00. In the case of a felony conviction, the employer will face the possibility of up to seven years in prison and/or a fine of up to $15,000.00.

Finally, a judge may order the convicted employer to pay restitution to an employee, if the employee was injured on the job during the time period in which the employer operated without workers' compensation insurance.

STATUTES RELATING TO IMMUNITY

18 Pa. C.S.A. § 4117(f) (Crimes Code)
Insurance fraud

Immunity.—An insurer, and any agent, servant or employe thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any entity duly authorized to receive such information by Federal or State law, or by Insurance Department regulations.

40 P.S. § 325.47 (Insurance)
Immunity

(a) General rule.—In the absence of malice, persons or organizations providing information to or otherwise cooperating with the section, its employes, agents or designees shall not be subject to civil or criminal liability for supplying the information.

(b) Civil and criminal liability.—
(1) In the absence of malice, persons or organizations shall not be subject to civil or criminal liability for complying with an order issued by a court of competent jurisdiction acting in response to a request by the section.

40 P.S. § 474.1 (Insurance)
Immunity from liability

(a) In the absence of fraud or bad faith, no person or his employes or agents shall be subject to civil liability and no civil cause of action shall arise against any of them for any of the following:

(1) Information relating to suspected fraudulent insurance acts or persons suspected of engaging in such acts furnished by them to or received from Federal, State or local law enforcement officials, their agents and employes and designees.

(2) Information relating to suspected fraudulent insurance acts or persons suspected of engaging in such acts furnished by them to or received from other persons subject to the provisions of this act.

(3) Information furnished by them or received from a Federal, State or local agency, the National Association of Insurance Commissioners or another organization established to detect and prevent fraudulent insurance acts, their agents, employes or designees or a recognized comprehensive database system approved by the Insurance Department.

(a.1) In the absence of fraud or bad faith, the immunity granted in subsection (a) shall also apply to persons identified as designated employes of insurers, self-insurers or insurance licensees whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent insurance acts when sharing information on such acts or persons suspected of engaging in such acts with other designated employes of the same or other insurers, self-insurers or insurance licensees whose responsibilities include the investigation or disposition of claims relating to suspected fraudulent insurance acts.

(b) State agencies and their employes and designees, in the absence of fraud or bad faith, shall not be subject to civil liability for sharing information identified in subsection (a). No civil cause of action shall arise against any of them by virtue of the publication of a report or bulletin related to the official activities of the State agency.

75 Pa. C.S.A. § 1818 (Motor Vehicle)

Civil immunity
No person shall be subject to civil liability for libel, violation of privacy, or otherwise by virtue of the filing of reports or furnishing of other information, in good faith and without malice, required by this sub-chapter.

77 P.S. §1039.7 (Workers' Compensation)

Immunity from liability for supplying information in connection with allegations of fraud.
An insurer and any agent, servant or employe thereof acting in the course and scope of his employment shall be immune from civil or criminal liability arising from the supply or release of written or oral information to any entity duly authorized to receive such information by Federal or State law or by Insurance Department regulations only if the information is supplied to the agency in connection with an allegation of fraudulent conduct on the part of any person relating to a violation of this article and the insurer, agent, servant or employe has reason to believe that the information supplied is related to the allegation of fraud.

Other Statutes

40 P.S. § 325.44 (Duty to Cooperate)

Every insurer, every employe of an insurer and every licensed agent or broker shall cooperate fully with the section.

40 P.S. § 325.46 (Refusal to Cooperate)

It is unlawful for any person to...otherwise interfere with section investigators in the duties imposed upon them by this article or by any other applicable law.

FRAUD REFERRALS

Typically, a case is referred to the IFS by the insurance industry, a business, an employee or a concerned citizen. If you suspect someone is committing insurance fraud, you are encouraged to contact the Pennsylvania Office of Attorney General's Insurance Fraud Section and request a fraud referral form. The form contains instructions on how to complete and submit the necessary information.

To request an insurance fraud referral form, please contact:

PA Office of Attorney General
Insurance Fraud Section
Commonwealth Tower
303 Walnut Street, 8th Floor

(717) 787-0272 (phone)
(717) 705-0741 (fax)

OR…

www.attorneygeneral.gov

If you prefer to use the internet, simply type the aforementioned web address into your internet browser. Once you arrive at the Attorney General's homepage, put your mouse cursor on the heading entitled "Crime". A drop-down menu will appear. Put your cursor on the menu link for "insurance fraud" and an "Online Referral" link will appear. Clicking on that link will allow you to access, complete and submit your referral electronically! If you prefer, you can select a "Printable Referral Form".

All referrals are initially received at the IFS headquarters in Harrisburg. The referral is given a reference number and forwarded to the appropriate regional IFS office for review. An acknowledgement letter is sent to the individual who submitted the referral.

At the regional IFS office the referral is reviewed by an attorney who will ascertain whether the matter alleged warrants opening a criminal investigation. At this point additional information may be requested from the individual who made the referral.

If the referral does not appear to warrant further investigation, a declination letter is sent. If an investigation is opened, a specific agent and attorney are assigned to the case until it is resolved.

IMPORTANT TIPS FOR BETTER FRAUD REFERRALS

Although the Insurance Fraud Section carefully reviews every insurance fraud referral it receives, not every referral results in the opening of a criminal investigation. Some referrals must be rejected because they do not contain essential information or because the material does not present a clear picture of the allegations. In an effort to help you avoid these and other common problems, the Insurance Fraud Section offers the following tips:

- **Provide a Clear, Concise Summary of Case**
  Please provide a brief summary of the essential facts of the case and the specific fraudulent conduct alleged (ex: claimant made false verbal/written statements in support of an auto accident claim; "disabled" worker found to be employed at another job while continuing to receive workers' compensation benefits, etc.)

- **Include ALL Statements Made by the Target**
  Be sure to include documentation of every statement made by the target. (ex: recorded interviews, civil deposition testimony, claim or SIU notes which summarize interviews, phone conversations, etc.)

- **Include ALL Claim & SIU Notes**
  Even if you do not think that some of the notes are important, please send ALL the claim notes and file documents with your referral.

- **Organize Claim & SIU Files**
  Disorganized or incomplete claim and investigative files tend to confuse and frustrate anyone who is unfamiliar with the material. Please take the time to organize the files in a clear, logical fashion. When possible, please include a "table of contents" cover sheet.

- **Include All Evidence of Fraud**
  Be sure to include a copy of all relevant documents, recorded statements and other evidence of the fraud alleged. (ex: copy of recorded interview of claimant making material false statement to insurance company representative; surveillance video of disability recipient working at a job site and copy of wage statements, etc.)

- **Ask: Is this REALLY Insurance Fraud?**
  Sometimes a case may appear to involve insurance fraud, but actually lacks an essential element of the offense. (ex: The claimant makes a false statement to an insurer, but the claim would have been paid regardless. The claimant's false statement may not have been material.) Please clearly state how the false statement is material or important to the claim.

TIPS FOR HANDLING FRAUD INVESTIGATIONS AND PROSECUTIONS

- When examining a claimant under oath, do not promise him/her immunity from prosecution in exchange for an admission of wrongdoing. Such a promise could pose problems if a prosecution is eventually initiated.

- If a claimant's financial circumstance becomes an issue during an investigation, please gather all relevant financial information. This information could be useful in a subsequent fraud prosecution.

- Once a case has been referred to the Insurance Fraud Section, please cooperate fully with IFS investigators and prosecutors.

- If IFS investigators or prosecutors request a claim file, please provide EVERYTHING in the file, including ALL claim / SIU diary notes.

- Please promptly notify IFS investigators and prosecutors of any additional information relative to a referral, including any changes in the status of a claim and any additional documentation.

- Please be available to confer with IFS investigators and prosecutors on all matters relating to an investigation/prosecution, including preparing for court appearances.