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THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE BILL

No. 1750 Session of 2009

INTRODUCED BY BARBIN, DeLUCA, CARROLL, D. COSTA, FABRIZIO, KORTZ, KOTIK, MANDERINO, MELIO, MENSCH, PASHINSKI, READSHAW, SWANGER, R. TAYLOR, WALKO, BURNS AND HORNAMAN, JUNE 22, 2009

AS REPORTED FROM COMMITTEE ON INSURANCE, HOUSE OF REPRESENTATIVES, AS AMENDED, MARCH 23, 2010

AN ACT

Amending Titles 18 (Crimes and Offenses) and 40 (Insurance) of the Pennsylvania Consolidated Statutes, further providing for insurance fraud; consolidating Article XI of The Insurance Department Act of 1921, further providing for purpose, for definitions, for Insurance Fraud Prevention Trust Fund, for powers and duties and for duties of insurance licensees and their employees; and making a repeal.

The General Assembly of the Commonwealth of Pennsylvania hereby enacts as follows:

Section 1. Section 4117(a)(1), (2), (3), (4) and (7), (b)(4), (f) and (k)(1) of Title 18 of the Pennsylvania Consolidated Statutes are amended to read:

§ 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] an insurance rate filing[, a motor vehicle insurance transaction] or other [motor vehicle insurance] action requiring insurance 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, insurance licensee, person or the public, presents or causes to be presented [to any insurer or self-insured] any statement forming a part of, or in support of, [a claim] an insurance transaction that contains any false, incomplete or misleading information concerning any fact or thing material to [the claim.] any of the following:

(i) Issue by an insurer or self-insured of an insurance policy, rider, endorsement or a certificate of insurance.

(ii) Determination of insurance premium.

(iii) Payment of any commission, benefit, claim or other funds, under a policy of insurance or a certificate of insurance.

(3) Knowingly and with the intent to defraud any insurer [or], self-insured, insurance licensee, person or the public, 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] an insurance transaction 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.] any of

the following:

(i) Issue by an insurer or self-insured of an insurance policy, rider, endorsement or a certificate of insurance.

(ii) Determination of insurance premium.

(iii) Payment of any commission, benefit, claim or other funds under a policy of insurance or a certificate of insurance.

(4) Engages in unlicensed [agent, broker] or unauthorized [insurer] insurance 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, knowingly and with the intent to defraud an insurer, a self-insured, an insurance licensee or the public.

* * *

(7) [Borrows] Makes, solicits, negotiates, sells, distributes, possesses false insurance documents 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] documents, knowingly and with intent to [present a fraudulent claim to an] defraud any insurer, self-insured, insurance licensee, person or the public.

* * *

(b) Additional offenses defined.--

* * *

[(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.]

* * *

(f) **[**Immunity.--~~[~~An~~]~~ ~~Any~~ insurer, ~~self-insured, insurance licensee or person,~~ and any agent, servant or employee thereof acting in the course and scope of ~~[~~this~~]~~ 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**]** (RESERVED).

* * *

(k) Insurance forms and verification of services.--

(1) All applications for insurance and all claim forms shall contain or have attached thereto a notice substantially similar to the following notice:

> Any person who knowingly and with intent to defraud any [insurance company or other] insurer, self-insured, insurance licensee, person or the public 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.

* * *

Section 2. Part II heading of Title 40 is amended to read:

PART II

REGULATION OF INSURERS AND RELATED PERSONS GENERALLY

[(Reserved)]

Section 3. Title 40 is amended by adding an article to read:

ARTICLE A

INSURANCE FRAUD

Chapter

11. Insurance Fraud Prevention Authority

CHAPTER 11

INSURANCE FRAUD PREVENTION AUTHORITY

Subchapter

A. Preliminary Provisions

B. Insurance Fraud Prevention Authority

C. Section of Insurance Fraud

D. Antifraud Plans and Reporting

E. Penalties

F. Miscellaneous Provisions

SUBCHAPTER A

PRELIMINARY PROVISIONS

Sec.

1101. Scope of chapter.

1102. Purpose.

1103. Definitions.

§ 1101. Scope of chapter.

This chapter deals with insurance fraud prevention.

§ 1102. Purpose.

The purpose of this chapter is to do all of the following:

(1) Establish, coordinate and fund activities in this Commonwealth to prevent, combat and reduce insurance fraud.

(2) To require insurers to implement antifraud plans increasing the prevention, detection, investigation and reporting of insurance fraud.

(3) To require insurers to annually certify antifraud plans and report activity under those plans to the

commissioner.

(4) To improve and support insurance fraud law enforcement and administration.

(5) To improve and support insurance fraud prosecution.

§ 1103. Definitions.

The following words and phrases when used in this chapter shall have the meanings given to them in this section unless the context clearly indicates otherwise:

"Antifraud plan" or "plan." The written procedures of an insurer for preventing, detecting, investigating and reporting insurance fraud.

"Authority." The Insurance Fraud Prevention Authority.

"Board." The board of directors of the Insurance Fraud Prevention Authority.

"Commissioner." The Insurance Commissioner of the Commonwealth.

"Department." The Insurance Department of the Commonwealth.

"Fund." The Insurance Fraud Prevention Trust Fund.

"Identified fraud cost." The dollar amount of loss caused by insurance fraud as admitted by a fraud suspect, alleged by an insurer in civil or criminal legal proceedings or found by a court of law, including insurer losses associated with insurance premium, commission, policy benefits, claim payments or policyholder or insurer funds.

"Insurance fraud." An activity defined as an offense under 18 Pa.C.S. § 4117 (relating to insurance fraud).

"Insurance licensee." A person holding a license to engage in the business of insurance.

"Insurance producer." A person that sells, solicits or negotiates contracts of insurance.

"Insurer." An insurance company, association, exchange, interinsurance exchange, health maintenance organization, preferred provider organization, a hospital plan corporation subject to Chapter 61 (relating to hospital plan corporations), professional health services plan corporation subject to Chapter 63 (relating to professional health services plan corporations), fraternal benefits society, beneficial association, Lloyd's insurer or health plan corporation.

"Section of Insurance Fraud." The Section of Insurance Fraud in the Office of Attorney General.

SUBCHAPTER B

INSURANCE FRAUD PREVENTION AUTHORITY

Sec.

§ 1121. Establishment of authority.

(a) Establishment.--There is established a body corporate and politic to be known as the Insurance Fraud Prevention Authority. The purposes, powers and duties of the authority shall be vested in and exercised by a board of directors.

(b) Composition.--The board of the authority shall consist of the following members composed and appointed in accordance with the following:

(1) The Attorney General or his designee.

(2) A representative of the Philadelphia Federal Insurance Fraud Task Force.

(3) Four representatives of insurers, one of whom shall be appointed by the President pro tempore of the Senate, one

of whom shall be appointed by the Minority Leader of the Senate, one of whom shall be appointed by the Speaker of the House of Representatives and one of whom shall be appointed by the Minority Leader of the House of Representatives. Each of the four members shall be, respectively, a representative of an insurer writing workers compensation, accident and health, automobile or general commercial liability insurance in this Commonwealth.

(4) One representative of purchasers of insurance in this Commonwealth who is not employed by or connected with the business of insurance and is appointed by the Governor.

(c) Terms.--With the exception of the Attorney General and the representative of the Philadelphia Federal Insurance Fraud Task Force, members of the board shall serve for terms of four years. No appointed member shall be eligible to serve more than two full consecutive terms.

(d) Compensation.--Members of the board shall serve without compensation but shall receive reimbursement for all reasonable and necessary expenses incurred in connection with their duties in accordance with the rules of the executive board.

(e) Quorum.--A majority of the members of the board shall constitute a quorum for the transaction of business at a meeting or the exercise of a power or function of the authority. Notwithstanding any other provision of law, action may be taken by the board at a meeting upon a vote of the majority of its members present in person or through the use of amplified telephonic equipment if authorized by the bylaws of the board. The board shall meet at the call of the chairperson or as may be provided in the bylaws of the board. The board shall meet at least quarterly. Meetings of the board may be held anywhere

within this Commonwealth. The board shall elect its own chairperson.

§ 1122. Powers and duties.

The authority shall have the powers necessary and convenient to carry out and effectuate the purposes and provisions of this chapter and the purposes of the authority and the powers delegated by other laws, including:

(1) Employ administrative, professional, clerical and other personnel as may be required and organize the staff as may be appropriate to effectuate the purposes of this chapter.

(2) Have a seal and alter the same at pleasure, have perpetual succession, make, execute and deliver contracts, conveyances and other instruments necessary or convenient to the exercise of its powers and make and amend bylaws.

(3) Procure insurance against any loss in connection with its property, assets or activities.

(4) Apply for, solicit, receive, establish priorities for, allocate, disburse, contract for, administer and spend funds in the fund and other funds that are made available to the authority from any source consistent with the purposes of this chapter.

(5) Make grants to and provide financial support for the Section of Insurance Fraud, the Unit for Insurance Fraud in the Philadelphia District Attorney's Office, other county district attorneys' offices, other government agencies, community, consumer and business organizations consistent with the purposes of this chapter and consider the extent of the insurance fraud problem in each county of this Commonwealth.

(6) Advise the State Treasurer in relation to the investment of any money held in the fund and any funds held in reserve or sinking funds and any money not required for immediate use or disbursement and to advise the State Treasurer in relation to the use of depositories for money of the fund.

(7) Assess the scope of the problem of insurance fraud, including areas of this Commonwealth where the problem is greatest, and review State and local criminal justice policies, programs and plans dealing with insurance fraud.

(8) Develop and sponsor the implementation of Statewide plans, programs and strategies to combat insurance fraud, improve the administration of the insurance fraud laws and provide a forum for identification of critical problems for those persons dealing with insurance fraud.

(9) Coordinate the development, adoption and implementation of plans, programs and strategies relating to interagency and intergovernmental cooperation with respect to insurance fraud law enforcement.

(10) Promulgate rules or regulations related to the expenditure of money held in the fund in order to assist and support those agencies, units of government, county district attorneys' offices and other organizations charged with the responsibility of reducing insurance fraud or interested and involved in achieving this goal.

(11) Audit at its discretion the plans and programs that it has funded in whole or in part in order to evaluate the effectiveness of the plans and programs and withdraw funding should the authority determine that a plan or program is ineffective or is no longer in need of further financial

support from the fund.

(12) Report annually on or before the first day of April to the Governor and the General Assembly on the authority's activities in the preceding period of operation.

(13) Meet with the Section of Insurance Fraud on at least a quarterly basis in order to advise and assist it in implementing its statutory mandate.

(14) Advise the General Assembly on matters relating to insurance fraud and recommend to the General Assembly on an annual basis any changes to the operation of the Section of Insurance Fraud. The report shall be available for public inspection.

(15) Establish, either alone or in cooperation with authorized insurance companies and licensed agents and producers, a fund to reward persons not connected with the insurance industry who provide information or furnish evidence leading to the arrest and conviction of persons responsible for insurance fraud.

(16) Require as a condition of every application and request for financial support, including every application for ongoing renewal of a multiyear grant under section 1123(f) (relating to Insurance Fraud Prevention Trust Fund), that the applicant described both the nature of and the amount of funding for the activities, if any, devoted to the investigation and prosecution of insurance fraud at the time of the application or request.

(17) Require as a condition of every application and request for financial support that every recipient of funding report annually within four months of the close of each funding cycle to the authority on the use of the funds

obtained from the authority during the previous year, including a description of programs implemented and results obtained. The authority shall include this information on the use of funds by grantees in its annual report under paragraph (12) and send a copy specifically to the chairman and the minority chairman of the standing committees of the Senate and the chairman and the minority chairman of the standing committees of the House of Representatives with jurisdiction over insurance matters.

§ 1123. Insurance Fraud Prevention Trust Fund.

(a) Establishment.--There is established a separate account in the State Treasury to be known as the Insurance Fraud Prevention Trust Fund. This fund shall be administered by the State Treasurer with the advice of the authority. All interest earned from the investment or deposit of money accumulated in the fund shall be deposited in the fund for the same use.

(b) Funds.--All money deposited into the fund shall be held in trust and shall not be considered general revenue of the Commonwealth but shall be used only to effectuate the purposes of this chapter as determined by the authority and shall be subject to audit by the Auditor General.

~~(c) Assessment.--~~

~~(1) Annually on or before the first day of April, each insurer engaged in the writing of the insurance listed under paragraph (2), as a condition of its authorization to transact business in this Commonwealth, shall pay into the fund in trust an amount equal to the product obtained by multiplying $8,000,000 by a fraction, the numerator of which is the direct premium written for those types of insurance listed under paragraph (2) by that insurer in this~~

~~Commonwealth during the preceding calendar year and the denominator of which is the direct premium written on the insurance in this Commonwealth by all insurers in the same period.~~

~~(2) All Commonwealth property, casualty, life, accident and health, and title insurance written by insurers, except premiums written for federally mandated health insurance, excess insurance, reinsurance and surplus lines insurance, as listed in annual statutory financial statements filed with the department or the National Association of Insurance Commissioners, shall be considered in determining assessments. Assessments made under this section shall not be considered burdens and prohibitions under section 212 of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921.~~

~~(3) Assessments for health plan corporations, professional health services plan corporations and health insurers not licensed as property, casualty or life insurers, if added together, shall not be more than 10% of the total assessment authorized under this subsection. If the total assessment for these organizations is more than 10%, the organizations shall share the assessment up to the 10% limit among themselves in the same proportion as they would otherwise have shared their calculated assessment absent this limit. Any deficiency in the total assessment caused by the application of this limit will be shared by all other entities being assessed in the same proportions as they are sharing the rest of the assessment.~~

~~(4) Assessments for insurers licensed as life insurers if added together shall not be more than 10% of the total~~

~~assessment authorized under this subsection. If the total assessment for these organizations is more than 10%, the organizations shall share the assessment up to the 10% limit among themselves in the same proportion as they would otherwise have shared their calculated assessment absent this limit. Any deficiency in the total assessment caused by the application of this limit will be shared by all other entities being assessed in the same proportions as they are sharing the rest of the assessment.~~

(C) ASSESSMENT.--

(1) ANNUALLY ON OR BEFORE THE FIRST DAY OF APRIL, EACH INSURER ENGAGED IN THE WRITING OF THE INSURANCE COVERAGES LISTED BELOW, AS A CONDITION OF ITS AUTHORIZATION TO TRANSACT BUSINESS IN THIS COMMONWEALTH, SHALL PAY INTO THE FUND IN TRUST AN AMOUNT EQUAL TO THE PRODUCT OBTAINED BY MULTIPLYING $8,000,000 BY A FRACTION, THE NUMERATOR OF WHICH IS THE DIRECT PREMIUM COLLECTED FOR THOSE COVERAGES LISTED BELOW BY THAT INSURER IN THIS COMMONWEALTH DURING THE PRECEDING CALENDAR YEAR AND THE DENOMINATOR OF WHICH IS THE DIRECT PREMIUM WRITTEN ON SUCH COVERAGES IN THIS COMMONWEALTH BY ALL INSURERS IN THE SAME PERIOD.

(2) THE FOLLOWING COVERAGES, AS LISTED IN THE ANNUAL STATISTICAL REPORT OF THE INSURANCE DEPARTMENT, SHALL BE CONSIDERED IN DETERMINING ASSESSMENTS: ALL FIRE AND CASUALTY DIRECT BUSINESS WRITTEN AND ACCIDENT AND HEALTH AND CREDIT ACCIDENT AND HEALTH WRITTEN UNDER LIFE/ANNUITY/ACCIDENT AND HEALTH DIRECT BUSINESS WRITTEN. ASSESSMENTS MADE UNDER THIS SECTION SHALL NOT BE CONSIDERED BURDENS AND PROHIBITIONS UNDER SECTION 212.

(3) ASSESSMENTS FOR HEALTH PLAN CORPORATIONS AND

PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS WHEN ADDED TOGETHER SHALL NOT BE MORE THAN 10% OF THE TOTAL ASSESSMENT AUTHORIZED BY THIS SUBSECTION. IF THE TOTAL ASSESSMENT FOR THESE ORGANIZATIONS IS MORE THAN 10%, SUCH ORGANIZATIONS WILL SHARE THE ASSESSMENT UP TO THE 10% LIMIT AMONG THEMSELVES IN THE SAME PROPORTION AS THEY WOULD OTHERWISE HAVE SHARED THEIR CALCULATED ASSESSMENT ABSENT THIS LIMIT. ANY DEFICIENCY IN THE TOTAL ASSESSMENT CAUSED BY THE APPLICATION OF THIS LIMIT WILL BE SHARED BY ALL OTHER ENTITIES BEING ASSESSED IN THE SAME PROPORTIONS AS THEY ARE SHARING THE REST OF THE ASSESSMENT.

(d) Base amount.--In succeeding years, the authority may vary the base amount of $8,000,000, except that any increase which on an annual basis exceeds the increase in the Consumer Price Index for this Commonwealth must be approved by three of the four insurance representatives on the board.

(e) Expenditures.--Money in the fund may be expended by the authority for the following purposes:

(1) Effectuate the powers, duties and responsibilities of the authority as set forth under this chapter.

(2) Pay the costs of administration and operation of the Section of Insurance Fraud and the Unit for Insurance Fraud in the Philadelphia District Attorney's Office.

(3) Provide financial support to law enforcement, correctional agencies and county district attorneys' offices for programs designed to reduce insurance fraud and to improve the administration of insurance fraud laws.

(4) Provide financial support for other governmental agencies, community, consumer and business organizations for programs designed to reduce insurance fraud and to improve

the administration of insurance fraud laws.

(5) Provide financial support to programs designed to inform insurance consumers about the costs of insurance fraud to individuals and to society and to suggest methods for preventing insurance fraud.

(6) Provide financial support for reward programs leading to the arrest and conviction of persons and organizations engaged in insurance fraud.

(7) Provide financial support for other plans, programs and strategies consistent with the purposes of this chapter.

(f) Multiyear grants.--In funding the Section of Insurance Fraud, the Unit for Insurance Fraud in the Philadelphia District Attorney's Office and in funding grant requests, the authority may consider and approve requests for multiyear grants of not more than four years in length, although extensions of the multiyear commitments may be renewed from year to year. No funding reduction under subsection (d) may be imposed by the authority in any given year which would operate to reduce funding for any multiyear approved program for which persons have been hired for full-time positions to a funding level where the positions must be terminated unless the organization employing the persons certifies either that other equivalent positions are available or that the positions with the antifraud program can be funded from other sources.

(g) Dissolution.--If the trust fund is discontinued or the authority is dissolved by operation of law, any balance remaining in the fund, after deducting administrative costs for liquidation, shall be returned to insurers in proportion to their financial contributions to the fund in the preceding calendar year.

§ 1124. Immunity.

In the absence of malice, no board member and no employee of the authority may be subject to any civil or criminal liability for receiving or disclosing information related to insurance fraud or the activities of the authority. In the absence of malice, persons or organizations shall not be subject to civil or criminal liability for providing information relating to insurance fraud to the authority, its employees, agents or designees. This section shall not abrogate or modify in any way any common law or statutory privilege or immunity heretofore enjoyed by any person.

SUBCHAPTER C

SECTION OF INSURANCE FRAUD

Sec.

§ 1141. Establishment.

(a) Establishment.--There is established within the Office of Attorney General a Section of Insurance Fraud to investigate and prosecute insurance fraud in accordance with jurisdictional mandates as specified under the act of October 15, 1980 (P.L.950, No.164), known as the Commonwealth Attorneys Act, and 18 Pa.C.S. § 4117 (relating to insurance fraud).

(b) Funding.--All costs of administration and operation of the Section of Insurance Fraud shall be borne by the fund. Any

money or other property awarded to the Section of Insurance Fraud as costs of investigation or as a fine shall be credited to the fund.

§ 1142. Powers and duties.

The Section of Insurance Fraud shall have the powers necessary and convenient to carry out and effectuate the purposes and provisions of this chapter and the powers delegated under other laws, including the power:

(1) To employ administrative, professional, clerical and other personnel as may be required and organize the staff as may be appropriate to effectuate the purposes of this chapter.

(2) To initiate inquiries and conduct investigations if the Section of Insurance Fraud has reason to believe that insurance fraud may have been or is being committed.

(3) To respond to notifications or complaints of suspected insurance fraud generated by State and local police, other law enforcement authorities, governmental units, including the Federal Government, and the general public.

(4) To review notices and reports of insurance fraud and to select those incidents of suspected fraud as, in its judgment, require further investigation, undertake the investigation and issue subpoena for records and testimony relating to insurance fraud.

(5) To conduct independent examination of insurance fraud, conduct studies to determine the extent of insurance fraud, deceit or intentional misrepresentation of any kind in the insurance process and publish information and reports on the examinations or studies.

(6) To prosecute, both on its own and in conjunction with other sections and divisions within the Office of Attorney General, any incidents of insurance fraud involving more than one county of this Commonwealth or involving any county of this Commonwealth and another state disclosed by its investigations and to assemble evidence, prepare charges, bring charges or, upon request of any other prosecutorial authority, otherwise assist that prosecutory authority having jurisdiction over the incidents.

(7) To report incidents of insurance fraud disclosed by its investigations to any other appropriate law enforcement, administrative, regulatory or licensing agency.

(8) To pay over all civil and criminal fines and penalties collected for violations and acts subject to investigation and prosecution into the fund.

(9) To undertake programs to investigate insurance fraud and to meet, at least on a quarterly basis, with the Insurance Fraud Prevention Authority.

(10) To employ investigators trained in accordance with 53 Pa.C.S. Ch. 21 Subch. D (relating to municipal police education and training). The laws applicable to law enforcement officers of this Commonwealth shall be applicable to the investigators. Investigators of the Section of Insurance Fraud shall have the following additional powers:

(i) To make arrests in accordance with existing jurisdictional rules for criminal violations established as a result of their investigations.

(ii) To execute arrest and search warrants in accordance with existing jurisdictional rules for the same criminal violations.

(11) To designate, if evidence, documentation and related materials sought are located outside of this Commonwealth, representatives, including officials of the state where the matter is located, to secure the matter or inspect the matter on its behalf. The person so requested shall either make the matter available to the Section of Insurance Fraud or shall make the matter available for inspection or examination by a designated representative of the Section of Insurance Fraud.

§ 1143. Document confidentiality ~~and immunity from subpoena~~.

~~(a) General rule.--~~Papers, records, documents, reports, materials or other evidence relative to the subject of an insurance fraud investigation shall remain confidential and shall not be subject to public inspection ~~for so long as the Section of Insurance Fraud deems it reasonably necessary to complete its investigation or for so long as the Section of Insurance Fraud deems it reasonably necessary to protect the privacy of the person investigated, to protect the person furnishing the matter or to be in the public interest.~~

~~(b) Subpoena.--~~

~~(1) Papers, records, documents, reports, materials or other evidence relative to the subject of an insurance fraud investigation shall not be subject to subpoena until opened for public inspection by the Section of Insurance Fraud unless the Office of Attorney General consents or until, after notice to the Section of Insurance Fraud and a hearing, a court of record determines that the Section of Insurance Fraud will not be unnecessarily hindered by compliance with a subpoena.~~

~~(2) Investigators employed by the Section of Insurance~~

~~Fraud shall not be subject to subpoena in civil actions by any court in this Commonwealth to testify concerning any matter of which they have knowledge under a pending or continuing insurance fraud investigation being conducted by the Section of Insurance Fraud unless the Office of Attorney General consents or until, after notice to the Office of Attorney General and a hearing, a court of record determines that the investigation will not be hindered by the appearance.~~

§ 1144. Duties of insurance licensees and their employees.

Every insurer, every employee of an insurer, every producer and its employees and any other insurance licensee and its employees shall cooperate fully with the Section of Insurance Fraud. If an insurer, producer, any other insurance licensee or employee of an insurer or insurance licensee who believes that an insurance fraud has been or is being committed notifies the Section of Insurance Fraud, the notification shall toll any applicable time period in the act of July 22, 1974 (P.L.589, No.205), known as the Unfair Insurance Practices Act, or any other law or regulation.

§ 1145. Persons not connected with insurance industry.

Any person having knowledge of or who believes that an insurance fraud is being or has been committed may send to the Section of Insurance Fraud a report or information pertinent to the knowledge and belief.

§ 1146. Refusal to cooperate with investigation.

It is unlawful for any person to resist an arrest authorized under this chapter or in any manner to interfere either by abetting or assisting the resistance or otherwise interfere with Section of Insurance Fraud investigators in the duties imposed

upon them under this chapter or under any other applicable law.

~~§ 1147. Immunity.~~

~~(a) General rule.--In the absence of malice, persons or organizations providing information to or otherwise cooperating with the Section of Insurance Fraud, its employees, 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 of Insurance Fraud.~~

~~(2) In the absence of malice, the Attorney General and any employee, agent or designee of the Office of Attorney General and the Section of Insurance Fraud shall not be subject to civil or criminal liability for the execution of official activities or duties of the Section of Insurance Fraud by virtue of the publication of any report or bulletin related to the official activities or duties of the Section of Insurance Fraud.~~

~~(c) Construction of section.--This section shall not abrogate or modify any common law or statutory privilege or immunity enjoyed by any person before December 6, 2002.~~

~~SUBCHAPTER D~~

~~ANTIFRAUD PLANS AND REPORTING~~

~~Sec.~~

~~1151. Scope.~~

~~1152. Purpose.~~

~~1153. Antifraud plans.~~

~~1154. Antifraud certification and statistical reporting.~~

~~1155. Information sharing.~~

~~1156. Rate inclusion or exclusion.~~

~~1157. Fraud investigation resources.~~

~~1158. Fraud warning notice.~~

~~1159. Reporting of insurance fraud.~~

~~1160. Cooperation.~~

~~1161. Immunity.~~

~~1162. Confidentiality.~~

~~§ 1151. Scope.~~

~~This subchapter provides for implementation of antifraud plans by insurers and reporting of insurance fraud by insurance licensees and their employees. Excess insurers, reinsurers, surplus lines insurers, self-insurers and nonrisk assuming health plans shall be exempt from the provisions of this subchapter.~~

~~§ 1152. Purpose.~~

~~The purpose of this subchapter is to require the development of antifraud plans by insurers and reporting of insurance fraud by all insurers, insurance licensees and their respective employees and to encourage the prevention, detection, investigation and reporting of insurance fraud.~~

~~§ 1153. Antifraud plans.~~

~~(a) Written procedures.--An insurer licensed for and conducting an insurance business in this Commonwealth shall, by itself or as part of a group of affiliated insurers, implement and maintain written procedures to prevent, detect, investigate and report suspected insurance fraud. The conducting of the business of insurance shall be considered to include the sale, solicitation, negotiating or writing of new business, the~~

renewal of existing business, the collection of premium, the appointment of producers, the payment of commissions, the processing of claims or the settlement of claims made against policies insuring risks located in or residing in this Commonwealth.

(b) Contents of procedures.--The written antifraud procedures of each insurer or group of affiliated insurers shall at a minimum provide for the:

(1) Education of the insurer's officers, employees, insurance producers, policyholders and business partners as to the insurer's Commonwealth antifraud effort and requirements.

(2) Detection of insurance fraud or other criminal acts occurring within or affecting the insurer's underwriting, premium collection, agency, commission payment, policyholder services, vendor relations, provider relations, claims or claim payment areas.

(3) Reporting of underwriting and claims information to insurance industry database systems permitting access to such information by insurers and law enforcement.

(4) Establishment of fraud investigation units, employing or contracting with persons qualified by education and experience to do the insurer's investigation of insurance fraud.

(5) Reporting of insurance fraud to Federal, State or local criminal law enforcement authorities for consideration of investigation and prosecution.

(6) Insurer's cooperation with Federal, State or local criminal law enforcement agencies in investigation and prosecution of insurance fraud.

(7) Release to Federal, State or local criminal law enforcement agencies upon their request all information relating to reported insurance fraud.

(8) Pursuit of civil recovery of fraud-related costs and expenses.

(9) Removal of identified fraud costs from ratemaking and thereby the insurance premiums charged to insurance consumers in this Commonwealth.

(c) Filing.--By the first business day of April, an insurer shall annually file with the commissioner a certification of antifraud procedures or a certification of no business in this Commonwealth. Where an insurer participates in an antifraud plan of a group of affiliated insurers, the parent company of the group shall make a separate certification for each member of its group.

(d) Statistical reporting.--By the first business day of April, an insurer shall file with the commissioner an annual statistical report of antifraud activity for the preceding calendar year. Where an insurer participates in an antifraud plan of a group of affiliated insurers, the parent company of the group may make a consolidated statistical reporting that separately identifies each member of its group.

§ 1154. Antifraud certification and statistical reporting.

(a) Forms.--The department shall annually, by December 31, make available to insurers annual certification and statistical reporting forms.

(b) Mandatory information.--The annual statistical reporting of each insurer or group of insurers for the previous calendar year shall include the following:

(1) The identity of each certifying and reporting

~~insurer, listing each insurer's full company name, National Association of Insurance Commissioners' (NAIC) company code and NAIC group code.~~

~~(2) The name, title, address, telephone and e-mail address of the individual responsible for the insurer's or group's Commonwealth insurance fraud matters.~~

~~(3) The total dollar amount cost of the insurer's or group of insurers' Commonwealth antifraud effort.~~

~~(4) The name, address, telephone and e-mail address of the fraud investigators employed or contracted with for implementation of the insurer's or group of insurers' Commonwealth antifraud plan.~~

~~(5) The total dollar amount of fraud identified only within reports of insurance fraud made to criminal law enforcement agencies. Identified fraud shall include:~~

~~(i) For application or premium fraud, the dollar amount of premium which would have been charged by the insurer had the true nature of the risk been known to the insurer less the amount charged without knowledge of the true nature of the risk.~~

~~(ii) For attempted application or premium fraud, the dollar amount of premium which would have been charged by the insurer had the true nature of the risk been known to the insurer less the amount that would have been charged without knowledge of the true nature of the risk.~~

~~(iii) For theft of premium, commission or other funds, the dollar amount of such funds unlawfully obtained by the fraud suspect.~~

~~(iv) For attempted theft of premium, commission or other funds, the dollar amount which would have been~~

~~obtained by the fraud suspect had the theft not been detected.~~

~~(v) For claim fraud where a specific dollar amount was demanded by or obtained by a fraud suspect, that dollar amount.~~

~~(vi) For claim fraud where a specific dollar amount was not demanded or obtained by the fraud suspect, the policy limits for coverages subject to the claim.~~

~~(6) The dollar amount of restitution ordered and the dollar amount of restitution received from civil and criminal prosecutions of insurance fraud involving Commonwealth business.~~

~~(7) Summary of investigations:~~

~~(i) For false insurance applications made to defraud an insurer or another person, or attempts thereof, the number of investigations by line of business opened, investigations closed and investigations referred to criminal law enforcement agencies.~~

~~(ii) For theft or embezzlement of premium, commission or other funds of the company, or attempts thereof, the number of investigations by line of business opened, investigations closed and investigations referred to criminal law enforcement agencies.~~

~~(iii) For false claims, or attempts thereof, made to defraud an insurer or other person, the number of investigations by line of business opened, investigations closed and investigations referred to criminal law enforcement agencies.~~

~~(8) A summary of the insurer's or group's Commonwealth fraud concerns, including the identification and proposal of~~

remedies for any fraud scheme or method detected.

§ 1155. Information sharing.

(a) Duties.--Each insurer or group of affiliated insurers subject to the antifraud plan provisions of this subchapter shall do one of the following:

(1) Obtain and maintain membership in one or more database systems supporting the insurance industry for the purpose of indexing, querying, retrieval or sharing of insurance information with other insurers and law enforcement.

(2) Maintain its own database of insurance information upon which other insurers and law enforcement may inquire and be provided information.

(b) Cooperation.--Each insurer and group of affiliated insurers subject to the antifraud plan provisions of this subchapter shall cooperate fully with other insurers and law enforcement in the exchange of information relating to investigation of suspected insurance fraud or other criminal offenses.

§ 1156. Rate inclusion or exclusion.

(a) Prohibition.--An insurer shall not pay and knowingly pass on identified fraud costs to its policyholders, subscribers or certificate holders.

(b) Exclusion.--An insurer shall exclude all identified fraud cost from its ratemaking or the ratemaking of any rating organization to which it subscribes.

(c) Requirement.--An amount included in ratemaking by an insurer prior to recognition of the amount as an identified fraud cost shall have a like amount excluded from the insurer's current ratemaking.

(d) Cost of antifraud plan.--Any expense or cost incurred by an insurer in implementing its Commonwealth antifraud plan may be included in its ratemaking.

§ 1157. Fraud investigation resources.

(a) Units.--An insurer or group of affiliated insurers shall maintain one or more Commonwealth fraud investigation units to implement its Commonwealth antifraud plan.

(b) Qualifications of investigators.--Persons employed or contracted with by the insurer or group of insurers as fraud investigators shall be qualified by reason of experience and training to do fraud awareness training, the investigation of insurance fraud and the communication of insurance fraud to criminal law enforcement authorities.

(c) Limitation.--Unless an insurer has obtained the written approval of the commissioner, persons employed or contracted with or by the insurer or group of insurers as fraud investigators shall do only the insurer's fraud investigation.

(d) Continuing education requirement.--Persons employed as fraud investigators shall have or obtain within one year of employment a professional fraud investigation designation having an annual continuing education requirement through an organization or association offering such designation.

§ 1158. Fraud warning notice.

(a) Notice requirements.--Insurers shall use with all insurance applications, on the face of each new or renewed policy or certificate of insurance and on all claim documents asking or requiring information of a claimant, a fraud warning notice as required by 18 Pa.C.S. § 4117(k)(1) (relating to insurance fraud).

(b) Information requested.--An insurance application shall

include any written, electronic or oral information requested by an insurer of an applicant or enrollee for insurance for issue or amendment of a policy or certificate of insurance.

(c) Claims.--An insurance claim includes any written, electronic or oral information requested of a person seeking compensation, a service or payment of a benefit under a policy of insurance.

(d) Satisfaction.--Insurers may satisfy the requirements of this subchapter, as to oral communications with applicants and claimants, by reading or providing a copy of the required fraud warning notice to the applicant or claimant.

§ 1159. Reporting of insurance fraud.

(a) Written report requirement.--All insurers and insurance licensees and their officers, employees and agents, having credible evidence that insurance fraud or other criminal offense involving insurance has occurred, is occurring or will occur, shall make a written report of that belief to a Federal, State or local criminal law enforcement agency having jurisdiction over the matter within 30 days of receiving the evidence. Reports of insurance fraud or other criminal offenses to a criminal law enforcement agency by officers, employees or agents of an insurer or insurance licensee may be made through the insurer or insurance licensee.

(b) Copy of report.--For any report of insurance fraud or other criminal offense involving insurance made to a criminal law enforcement agency, the insurer or insurance licensee shall concurrently provide a copy of the report to the department.

§ 1160. Cooperation.

An insurer making a report of suspected insurance fraud or other criminal offense involving insurance to a criminal law

enforcement agency shall, upon the written request of that agency, release to that agency all documentation or information relating to alleged crime or crimes and cooperate fully in the subsequent production of any requested evidence or testimony deemed by that agency as necessary for prosecution.

§ 1161. Immunity.

Insurers and insurance licensees and their officers and employees shall be exempt from both civil and criminal liability for requesting or providing information required by this subchapter to other insurers, to other insurance licensees, to any criminal law enforcement authority, to the authority, to any grantee or designee of the authority, to the department, to the National Association of Insurance Commissioners, to any industry database system utilized by an insurer in compliance with this chapter or to any other entity authorized by Federal, State or local law or insurance regulation to receive such information.

§ 1162. Confidentiality.

Antifraud plan certifications and reports filed with the department and any reports or materials related to such reports shall be given confidential treatment and are not subject to subpoena and may not be made public by the department or any other person. The information shall be exempt from disclosure under the act of February 14, 2008 (P.L.6, No.3), known as the Right-to-Know Law.

SUBCHAPTER E

PENALTIES

Sec.

1171. Violations.

1172. Other violations.

§ 1171. Violations.

~~Insurers violating any provision of this chapter shall, in addition to any penalty that may be imposed under any other law, be subject to all of the following:~~

~~(1) Payment of a penalty of $10,000 per violation for failing to implement or maintain a Commonwealth antifraud plan, for failing to make or making a false antifraud certification or annual antifraud statistical report, for failing to make a required report of insurance fraud to a criminal law enforcement authority or for failing to remove identified fraud costs from ratemaking.~~

~~(2) Upon notice by the commissioner of violation of this chapter, payment of a penalty of $500 per day, for each day of continuing violation.~~

~~§ 1172. Other violations.~~

~~Insurance licensees other than insurers violating any provision of this chapter shall, in addition to any penalty that may be imposed under any other law, be subject to:~~

~~(1) payment of a penalty of $5,000 per violation for failing to make a required report of insurance fraud to a criminal law enforcement authority; and~~

~~(2) upon notice by the commissioner of violation of this chapter, payment of a penalty of $500 per day, for each day of continuing violation.~~

SUBCHAPTER D

ANTIFRAUD PLANS

SEC.

1151. SCOPE.

1151.1. DEFINITION.

1152. FILING OF PLANS.

1153. CONTENT OF PLANS.

1154. REVIEW BY DEPARTMENT.
1155. REPORT ON ANTIFRAUD ACTIVITIES.
1156. PENALTIES.
1157. CONFIDENTIALITY OF PLANS AND REPORTS.
1158. REPORTING OF INSURANCE FRAUD.
1159. CIVIL IMMUNITY.

§ 1151. SCOPE.

THIS SUBCHAPTER PROVIDES FOR IMPLEMENTATION OF ANTIFRAUD PLANS BY INSURERS NOT PRESENTLY REQUIRED TO DEVELOP ANTIFRAUD PLANS.

§ 1151.1. DEFINITION.

THE FOLLOWING WORDS AND PHRASES WHEN USED IN THIS SUBCHAPTER SHALL HAVE THE MEANINGS GIVEN TO THEM IN THIS SECTION UNLESS THE CONTEXT CLEARLY INDICATES OTHERWISE:

"INSURER." A COMPANY OR HEALTH INSURANCE ENTITY LICENSED IN THIS COMMONWEALTH TO ISSUE AN INDIVIDUAL OR GROUP HEALTH, SICKNESS OR ACCIDENT POLICY OR SUBSCRIBER CONTRACT OR CERTIFICATE OR PLAN THAT PROVIDES MEDICAL OR HEALTH CARE COVERAGE BY A HEALTH CARE FACILITY OR LICENSED HEALTH CARE PROVIDER THAT IS OFFERED OR GOVERNED UNDER THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921, OR ANY OF THE FOLLOWING:

(1) THE ACT OF DECEMBER 29, 1972 (P.L.1701, NO.364), KNOWN AS THE HEALTH MAINTENANCE ORGANIZATION ACT.

(2) THE ACT OF MAY 18, 1976 (P.L.123, NO.54), KNOWN AS THE INDIVIDUAL ACCIDENT AND SICKNESS INSURANCE MINIMUM STANDARDS ACT.

(3) CHAPTER 61 (RELATING TO HOSPITAL PLAN CORPORATIONS) OR 63 (RELATING TO PROFESSIONAL HEALTH SERVICES PLAN CORPORATIONS).

(4) ARTICLE XXIV OF THE INSURANCE COMPANY LAW OF 1921.

§ 1152. FILING OF PLANS.

EACH INSURER SHALL INSTITUTE AND MAINTAIN AN INSURANCE ANTIFRAUD PLAN. THE ANTIFRAUD PLAN OF INSURERS LICENSED ON THE EFFECTIVE DATE OF THIS SUBCHAPTER SHALL BE FILED WITH THE DEPARTMENT ON OR BEFORE DECEMBER 31, 2011. INSURERS LICENSED AFTER THE EFFECTIVE DATE OF THIS SUBCHAPTER SHALL FILE WITHIN SIX MONTHS OF LICENSURE. CHANGES TO THE ANTIFRAUD PLAN SHALL BE FILED WITH THE DEPARTMENT WITHIN 30 DAYS AFTER IT HAS BEEN MODIFIED.

§ 1153. CONTENT OF PLANS.

THE ANTIFRAUD PLANS OF EACH INSURER SHALL ESTABLISH SPECIFIC PROCEDURES:

(1) TO PREVENT INSURANCE FRAUD, INCLUDING INTERNAL FRAUD INVOLVING EMPLOYEES OR COMPANY REPRESENTATIVES, FRAUD RESULTING FROM MISREPRESENTATION ON APPLICATIONS FOR INSURANCE COVERAGE AND CLAIMS FRAUD.

(2) TO REVIEW CLAIMS IN ORDER TO DETECT EVIDENCE OF POSSIBLE INSURANCE FRAUD AND TO INVESTIGATE CLAIMS WHERE FRAUD IS SUSPECTED.

(3) TO REPORT FRAUD TO APPROPRIATE LAW ENFORCEMENT AGENCIES AND TO COOPERATE WITH THE AGENCIES IN THEIR PROSECUTION OF FRAUD CASES.

(4) TO UNDERTAKE CIVIL ACTIONS AGAINST PERSONS WHO HAVE ENGAGED IN FRAUDULENT ACTIVITIES.

(5) TO REPORT FRAUD-RELATED DATA TO COMPREHENSIVE DATABASED SYSTEMS APPROVED BY THE DEPARTMENT.

(6) TO ENSURE THAT COSTS INCURRED AS A RESULT OF DETECTED INSURANCE FRAUD ARE NOT INCLUDED IN A RATE BASE AFFECTING THE PREMIUMS OF POLICYHOLDERS, SUBSCRIBERS AND

CERTIFICATE HOLDERS.

§ 1154. REVIEW BY DEPARTMENT.

ANTIFRAUD PLANS SHALL BE FILED WITH THE DEPARTMENT. IF, AFTER REVIEW, THE DEPARTMENT FINDS THAT THE ANTIFRAUD PLAN DOES NOT COMPLY WITH SECTION 1153 (RELATING TO CONTENT OF PLANS), THE ANTIFRAUD PLAN MAY BE DISAPPROVED. NOTICE OF DISAPPROVAL SHALL INCLUDE A STATEMENT OF THE SPECIFIC REASONS FOR THE DISAPPROVAL. A PLAN DISAPPROVED BY THE DEPARTMENT MUST BE REFILED WITHIN 60 DAYS OF THE DATE OF THE NOTICE OF DISAPPROVAL. THE DEPARTMENT MAY AUDIT INSURERS TO ENSURE COMPLIANCE WITH ANTIFRAUD PLANS AS A PART OF THE EXAMINATIONS PERFORMED UNDER SECTIONS 213, 214 AND 216 OF THE ACT OF MAY 17, 1921 (P.L.789, NO.285), KNOWN AS THE INSURANCE DEPARTMENT ACT OF 1921.

§ 1155. REPORT ON ANTIFRAUD ACTIVITIES.

INSURERS SHALL ANNUALLY PROVIDE TO THE DEPARTMENT A SUMMARY REPORT ON ACTIONS TAKEN UNDER THE PLAN TO PREVENT AND COMBAT INSURANCE FRAUD, INCLUDING, BUT NOT LIMITED TO, MEASURES TAKEN TO PROTECT AND ENSURE THE INTEGRITY OF ELECTRONIC DATA-PROCESSING-GENERATED DATA AND MANUALLY COMPILED DATA, STATISTICAL DATA ON THE AMOUNT OF RESOURCES COMMITTED TO COMBATING FRAUD AND THE AMOUNT OF FRAUD IDENTIFIED AND RECOVERED DURING THE REPORTING PERIOD.

§ 1156. PENALTIES.

INSURERS THAT FAIL TO FILE TIMELY ANTIFRAUD PLANS AS REQUIRED BY SECTIONS 1152 (RELATING TO FILING OF PLANS) AND 1154 (RELATING TO REVIEW BY DEPARTMENT) ARE SUBJECT TO THE PENALTY PROVISIONS OF SECTION 320 OF THE ACT OF MAY 17, 1921 (P.L.682, NO.284), KNOWN AS THE INSURANCE COMPANY LAW OF 1921. INSURERS THAT DO NOT MAKE A GOOD FAITH ATTEMPT TO FILE AN ANTIFRAUD PLAN WHICH COMPLIES WITH SECTION 1153 (RELATING TO CONTENT OF PLANS)

SHALL ALSO BE SUBJECT TO THE PENALTY PROVISIONS OF SECTION 320 OF THE INSURANCE COMPANY LAW OF 1921, PROVIDED THAT NO PENALTY MAY BE IMPOSED FOR THE FIRST FILING MADE BY AN INSURER UNDER THIS SUBCHAPTER. INSURERS THAT FAIL TO FOLLOW THE ANTIFRAUD PLAN SHALL BE SUBJECT TO A CIVIL PENALTY FOR EACH VIOLATION, NOT TO EXCEED $10,000, AT THE DISCRETION OF THE COMMISSIONER AFTER CONSIDERATION OF RELEVANT FACTORS, INCLUDING THE WILLFULNESS OF A VIOLATION.

§ 1157. CONFIDENTIALITY OF PLANS AND REPORTS.

THE ANTIFRAUD PLANS AND REPORTS WHICH INSURERS FILE WITH THE DEPARTMENT AND REPORTS OR MATERIALS RELATED TO THE REPORTS ARE NOT PUBLIC RECORDS AND SHALL NOT BE SUBJECT TO PUBLIC INSPECTION.

§ 1158. REPORTING OF INSURANCE FRAUD.

INSURERS, EMPLOYEES OF INSURERS AND PROVIDERS WHO HAVE A REASONABLE BASIS TO BELIEVE INSURANCE FRAUD HAS OCCURRED SHALL BE REQUIRED TO REPORT THE INCIDENCE OF SUSPECTED INSURANCE FRAUD TO FEDERAL, STATE OR LOCAL CRIMINAL LAW ENFORCEMENT AUTHORITIES. LICENSED INSURANCE PROVIDERS MAY ELECT TO REPORT SUSPECTED FRAUD THROUGH THE AFFECTED INSURER WITH WHICH THEY HAVE A CONTRACTUAL RELATIONSHIP. REPORTS OF INSURANCE FRAUD TO LAW ENFORCEMENT AUTHORITIES SHALL BE MADE IN WRITING.

§ 1159. 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 SUBCHAPTER.

SUBCHAPTER E

(RESERVED)

SUBCHAPTER F

MISCELLANEOUS PROVISIONS

Sec.

1181. Other law enforcement authority.

§ 1181. Other law enforcement authority.

This chapter shall not:

(1) Preempt the authority of or relieve the duty of any other law enforcement agencies to investigate and prosecute suspected violations of law.

(2) Prevent or prohibit a person from voluntarily disclosing any information concerning insurance fraud to any law enforcement agency other than the Section of Insurance Fraud.

(3) Limit any of the powers granted to the commissioner to investigate possible violations of law and to take appropriate action against wrongdoers.

Section 4. Repeals are as follows:

(1) The General Assembly declares that the repeal under paragraph (2) is necessary to effectuate the addition of 40 Pa.C.S. Ch. 11, Subchs. A, B, C and F.

(2) Article XI of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921, is repealed.

Section 5. 40 Pa.C.S. Ch. 11, Subchs. A, B, C and F is a continuation of Article XI of the act of May 17, 1921 (P.L.789, No.285), known as The Insurance Department Act of 1921. The following apply:

(1) Except as otherwise provided under 40 Pa.C.S. Ch. 11, Subchs. A, B, C and F, all activities initiated under Article XI of The Insurance Department Act of 1921, shall continue and remain in full force and effect and may be

completed under 40 Pa.C.S. Ch. 11, Subchs. A, B, C and F. Orders, regulations, rules and decisions which were made under Article XI of The Insurance Department Act of 1921 and which are in effect on the effective date of this section shall remain in full force and effect until revoked, vacated or modified under 40 Pa.C.S. Ch. 11, Subchs. A, B, C and F. Contracts, obligations and collective bargaining agreements entered into under Article XI of The Insurance Department Act of 1921 are not affected nor impaired by the repeal of Article XI of The Insurance Department Act of 1921.

(2) Except as set forth in paragraph (3), any difference in language between 40 Pa.C.S. Ch. 11, Subchs. A, B, C and F and the Article XI of The Insurance Department Act of 1921 is intended only to conform to the style of the Pennsylvania Consolidated Statutes and is not intended to change or affect the legislative intent, judicial construction or administration and implementation of Article XI of The Insurance Department Act of 1921.

(3) Paragraph (2) does not apply to the addition of the following:

(i) 40 Pa.C.S. § 1102.

(ii) 40 Pa.C.S. § 1103, except for the definition of "authority."

(iii) 40 Pa.C.S. § 1123(c) and (d).

(iv) 40 Pa.C.S. § 1142(4).

(v) 40 Pa.C.S. § 1144.

Section 6. This act shall take effect in 60 days.