Guidelines for Industry for Reporting Suspicious Claims or Activity to State Fraud Bureaus
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NAIC Antifraud Task Force
External Claims/Fraud Working Group (ECFWG)
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The NAIC Antifraud Task Force has assigned the following charge to the External Claims/Fraud Working Group. The ECFWG hereby reports back in the form of guidelines, the purpose of which is to delineate the issues and provide information and assistance in developing this area further.

TASK FORCE CHARGE 5: Consider developing guidelines for industry reporting of suspicious claims or activity.

COMMENT ON THE CHARGE: Developing guidelines to provide assistance to the insurance industry in determining when a suspicious claim or activity should be reported to a state fraud bureau proves to be a complex task. The very nature of working with so many different states creates a hurdle in providing some uniformity in establishing what information states want, the form in which they want it and the very definition of a suspicious claim or activity. It may be best to detail each of these areas separately and provide a broad approach which would apply in one manner or the other to all states.

DEFINITION OF SUSPICIOUS CLAIM OR ACTIVITY:

The NAIC Antifraud Task Force has defined a suspicious insurance claim or activity as any claim where there is reason to believe, based upon evidence, may contain one or more material misrepresentations (per NAIC Suspected Insurance Fraud Reporting Form).

We have adopted the following definition of a suspicious claim or activity to be used in our information and concepts.

A claim or activity can be deemed suspicious if it meets standards developed by an individual, entity or company containing or exhibiting any of the red flags enumerated by the industry or experiences of claims representatives or other relevant insurance company personnel.

Issues that can be considered would include, but not be limited to, evidence of doctoring, changing or destroying forms, receipts, estimates, Explanation of Benefits—(EOBs), medical evaluations or billings, electronic medical records—(SOAP Notes), High Risk Money Laundering and Related Financial Crimes Areas—(HIFCA), forms, use of another person’s medical records, alteration of medical records, unusual policy activity, falsified or untruthful application for insurance, or police and/or investigative reports. Also, determining that there are relevant discrepancies in written or oral statements, examinations under oath—EUOs), or
contacts with claims representatives or adjusters can raise a claim or act to the level of suspicious.

Finally, an identifiable pattern in a person’s claims or policy activity or policy purchasing history may suggest that the claim, policy activity or purchase should be further evaluated and could give rise to the possibility that the mere fact that this person has submitted numerous claims, or has had unusual policy activity or has purchased numerous policies in a manner that seems to be out of the norm constitutes suspicion

DEFINITION OF EVIDENCE

For the purposes of these guidelines, evidence will be broadly defined as anything sent by the reporting individual, entity or company, to a fraud bureau to include, but not be limited to, claims file, including notes, claims form, insurance policy applications, statements, EUOs, electronic data or recordings, and other relevant or supporting information.

GUIDE TO SUBMISSION OF SUSPICIOUS CLAIMS OR ACTIVITY:

REPORTING FORM

There are currently numerous reporting forms required for use in reporting fraud to state fraud bureaus throughout the United States. Each state not currently using the NAIC Model Reporting Form has developed a specific form tailored to their needs and require reported fraud to be submitted on that specific form. A concerted effort should be made in convincing states to adopt, at the very least and at a minimum, a uniform one-page form containing that basic information required by the state, and allowing an individual, entity or company to meet the mandatory reporting standard.

The form should include, at minimum, the name, date of birth, Social Security Number, address and telephone number of the suspected violator. It would also include the name of any individual, entity or company reporting said suspicious claim or activity, associated claim number(s), amount of loss, amount in reserve and contact information for said reporting individual, entity or company. The form should include a brief synopsis of the activity, giving rise to the suspicious claim or activity. This information would allow fraud bureaus to maintain a database of valuable information and provide them with enough information to evaluate the report for further action or to utilize said data in analyzing other claims or activities which may involve the suspected person.

To assist those states which require additional information for statistical, or legislative mandated purposes, to meet those obligations the information could be provided in the form of attachments, specifically designed and provided by those states. This would allow individuals, entities, or companies to use the basic form in all states and limit the supplemental forms for use only as required. This could greatly reduce time and paper work and make for more effective reporting to those states only requiring the basic form.
REPORTING REQUIREMENTS

Fraud bureaus differ in the manner in which they handle the receiving and assigning of reported suspicious claims or acts. Some may require the entire case file (evidence), or a portion thereof be sent when a case is originally submitted. Some may use a one-page reporting format as a means to evaluating whether or not the remainder of the file (evidence) is required to make any determination concerning investigating that case. This makes it difficult to set standards that would apply to all of the states.

The NAIC Antifraud Task Force developed and adopted the State Insurance Department Antifraud Resources Report 2000–2001. This report enumerates and provides information about states insurance fraud bureaus, including fraud statute cites, types of fraud investigated, reporting requirements and related civil immunity provisions. This Report provides a single source from which state requirements can be obtained. By combining the use of the NAIC Antifraud Resources Report and standardizing a reporting form used in conjunction with any supplemental report requirements by individual states, we can move towards uniformity in the fraud reporting process.

RECOMMENDATION

The External Claims/Fraud Working Group should update the State Insurance Department Antifraud Resource Report 2000–2001 on a biannual basis. The Antifraud (G) Task Force should develop a new section in the report entitled MANDATORY REPORTING REQUIREMENTS. This section would define what each state requires when a case is submitted to a fraud bureau.

It is imperative that a basic reporting form, not only be developed and adopted, but be USED by all states. The form should be developed with a concept which would allow for those states requiring only basic information to comply with their reporting laws to utilize a one-page format and yet further provide those states requiring additional information to add a supplemental section requesting the information pertinent to that state. The mandatory one-page report can be included in the guide including detailing which states require additional information and the location in which that form can be obtained. This could be managed in publications, or on–line which will lend itself to the time when on–line reporting becomes a common option. Special Note: A one–page format is suggested as a guide and may include but should not exceed two pages.

Implementing these recommendations may require legislation, regulation or procedural changes in each state and therefore should be developed as soon as possible. The Gramm–Leach–Bliley Act requires state insurance regulators to streamline the regulatory process and provide uniform operational standards. Standardized fraud reporting guidelines and procedures would be supportive of the states efforts to comply with Gram–Leach–Bliley. The NAIC should commit its resources to assisting any state needing to make legislative changes in order to accomplish this task.
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The NAIC serves the needs of consumers and the industry, with an overriding objective of supporting state insurance regulators as they protect consumers and maintain the financial stability of the insurance marketplace.

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