ANTIFRAUD PLAN GUIDELINE

Narrative

As insurance fraud costs insurers and consumers billions of dollars annually, and no line of insurance is immune to fraud, state departments of insurance (DOIs) believe it’s imperative that insurers make the detection, investigation and reporting of suspected fraud a priority in its overall operations. Failure to dedicate resources towards the fight against insurance fraud can tremendously affect an insurer’s financial stability, as well as rates charged to consumers. In light of the aforementioned, insurers are encouraged to proactively take measures to minimize the cost of fraud.

To encourage insurers to take a proactive approach to fighting fraud, and minimize organizational risk, many states require the preparation and/or submission of an antifraud plan. Such plans are often audited and inspected for compliance purposes and/or are reviewed in conjunction with market conduct and financial examinations conducted.

While the development and submission of an antifraud plan is currently not mandated in all states, most state DOIs and fraud fighting agencies believe it is a best practice for all insurers, whether state mandated or not, to develop an antifraud plan that which documents the antifraud efforts an insurer has put in place to prevent, detect investigate and report fraud. As such, this guideline is intended to serve as a guide for insurance company special investigation units (SIU) and other interested parties in the preparation of antifraud plans that meet state mandates.

In the spirit of promoting uniformity amongst the states, and providing insurers with added insight regarding key elements that should be considered when developing an antifraud plan, state fraud bureaus are encouraged to utilize this guideline to introduce new antifraud plan legislation or revise existing antifraud plan laws in their states.

To further uniformity in this area, and assist both insurers and state DOIs with compliance efforts, the NAIC Antifraud Task Force intends to utilize this revised guideline as a basis for developing an antifraud plan submission repository / system that will streamline insurer antifraud plan compliance nationwide. Until such a system is developed and implemented, insurers are encouraged to utilize this guideline, and incorporate all information outlined within the document when developing and/or updating company antifraud plans.

Important Note: Unless this guideline is adopted by a state, this guideline does not preempt existing state laws.
ANTIFRAUD PLAN GUIDELINE

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Section 1. Application

The purpose of this guideline is to establish standards for state fraud bureaus, insurance company Special Investigation Units (SIU) and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements for submitting a plan with a state Department of Insurance. Currently, twenty states require that fraud plans be prepared for inspection by the state Departments of Insurance. The concept of mandating the submission of an insurer fraud plan was developed to encourage those insurers with direct written premiums to fight insurance fraud proactively by drafting a plan to fight fraud. This plan, along with audits, inspections, or in conjunction with a market conduct examinations, ensure the insurer is following its submitted antifraud plan of [insert Department of Insurance (DOI) name].

These guidelines are primarily intended for state fraud bureaus as a guide in the preparation of new antifraud plan legislation, revision of existing mandated antifraud plans and for insurer SIUs in the preparation of its antifraud plans. The intention of this guideline is to collate the current twenty states’ antifraud plan requirements into a guide for those states researching what should go into a plan. Most national fraud fighting agencies believe it is a good practice for all insurers, whether it is state mandated or not, to develop an internal insurance antifraud plan. Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meets state compliance standards.

This guideline does not preempt other state laws. This guideline is not intended to preempt or amend any guidance previously published by the NAIC Antifraud Task Force or in the NAIC Fraud Prevention Law Model Act. This document is intended to provide a road map for state fraud bureaus, insurers’ SIUs or contracted SIU vendors for preparation of an antifraud plan.

Drafting Note: In lieu of an agency name, states may amend this statement to incorporate a reference to a state law / rule.

Section 2. Definitions reserved for state specific information

A. “Insurance” means any of the lines of authority authorized by state law.

B. “Insurance commissioner” or “commissioner” means the insurance commissioner of this state.

C. “Insurer” means a company required to be licensed under the laws of this state to provide insurance products.

D. “Material or substantive change” means any change, modification or alteration of the operations, standards, methods, staffing or outsourcing utilized by the insurer to detect, investigate and report suspected insurance fraud.

E. “National Association of Insurance Commissioners” (NAIC) means the organization of state insurance regulators from the fifty (50) states, the District of Columbia and all participating U.S. territories.

F. “Report in a timely manner” means in accordance with all applicable laws and rules of the state.

Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.

G. “Respond in a reasonable time” means to respond in accordance with all applicable laws and rules of the state.
Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.

H. “Special Investigation Unit” (SIU) means an insurer's unit or division that is established to investigate suspected insurance fraud. The SIU may be made up of insurer employees or by contracting with other entities.

I. "Suspected Insurance Fraud” means any misrepresentation of fact or omission of fact pertaining to a transaction of insurance including claims, premium and application fraud. These facts may include but are not limited to evidence of doctoring, altering or destroying forms, prior history of the claimant, policy holder, applicant or provider, receipts, estimates, explanations of benefits (EOB), medical evaluations or billings, medical provider notes, police and/or investigative reports, relevant discrepancies in written or oral statements and examinations under oath (EUO), unusual policy activity and falsified or untruthful application for insurance. An identifiable pattern in a claim history may also suggest the possibility of suspected fraudulent claims activity. A claim may contain evidence of suspected insurance fraud regardless of the payment status.

Drafting Note: States can insert, modify or delete definitions as needed and/or insert references to state law if necessary.

Section 3. Antifraud Plan Creation/Submission Requirement

A. An insurer, if required by a Department of Insurance, subject to [insert appropriate state code], shall submit to the Commissioner [or Fraud Bureau] a detailed description of the company's create an antifraud plan. All that documents the insurer’s antifraud efforts plans submitted shall be subject to review by the Commissioner.

B. An insurer shall develop a written plan within [insert number of days based upon state law] days after obtaining its license to transact business within this state or within [insert number of days] days after beginning to engage in the business of insurance.

C. The DOI has the right to review an insurer’s antifraud plan in order to determine compliance with appropriate state laws.

D. An insurer shall submit their antifraud plan in accordance with all state laws, regulations and requirements.

Drafting Note: States are able to insert a reference to a state law / rule if they feel it is necessary.

E. If an insurer makes a material / substantive change in the manner in which they detect, investigate and/or report suspected insurance fraud, or there is a change in the person(s) responsible for the insurer’s antifraud efforts, the insurer will be required to amend [and submit] their antifraud plan within [insert number of days] days of the change(s) being made.

Drafting Note: States without mandatory submission requirements should adjust this section appropriately.

Section 4. Antifraud Plan Requirements

A. The following information should be included in the submitted [An antifraud plan to satisfy this Section. The plan is an acknowledgment that the insurer and its SIU has established criteria that will be used to overview of the insurer’s efforts to prevent, detect suspicious or fraudulent, investigate and report all aspects of suspected insurance activity related to fraud related to the different types of insurance offered by that insurer. All antifraud plans submitted shall be subject to review by the Commissioner.

B. One SIU antifraud plan may cover several insurer entities if one SIU has the fraud investigation mission for all entities.

The plan should include:

A. General Requirements

C. The following information should be included in the submitted antifraud plan to satisfy this Section:
(1) The insurer’s name and NAIC individual and group code numbers;

(a) A description of the insurer’s approved lines of authority.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility of the above noted information auto-populating based upon NAIC carrier data maintained by individual / group codes.

(2) An acknowledgment that the SIU of the insurer has established criteria that will be used for the investigation of acts of internal fraud and suspected insurance fraud relating to the different types of insurance offered by that insurer.

(2) An acknowledgement that the insurer or SIU shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud were sent directly to the Fraud Bureau/Department within a specific time frame.

(3) A provision stating whether the SIU is an internal unit or an external or third party unit.

(3) A statement as to whether the insurer has implemented an internal and/or external fraud awareness and/or outreach program in order to educate employees, applicants, policy holders and/or members of the general public about insurance fraud.

(a) A description of the insurer’s external fraud awareness or outreach program(s) geared towards applicants, policy holders and members of the general public.

(b) A description of the insurer’s internal awareness / antifraud education and training initiatives of any personnel involved in antifraud related efforts. The description shall include:

(i) An overview of antifraud training provided to new employees.

(ii) The internal positions the insurer offers regular education and training to, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.

(iii) A description of training topics covered with employees.

(iv) The method(s) in which training is provided.

(v) The frequency and minimum number of training hours provided

(vi) The method(s) in which employees, policyholders and members of the general public can report suspected fraud.

(4) A description of the insurer’s corporate policies for preventing, detecting and investigating suspected internal fraud committed by company employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.

(a) The insurer shall include a description of their internal fraud reporting policy.

(b) The insurer shall identify the person and/or position within the organization who is ultimately responsible for the investigation of internal fraud.

(c) A description of the insurer’s standard operating procedures (SOP) for investigating internal fraud.

(d) The insurer shall include a description of the reporting procedures it will follow upon a criminal and/or insurance law violation being identified as the result of an internal
investigation conducted (i.e. agent misconduct, referral to Fraud Unit or law enforcement, etc.).

(45) If the SIU is an internal unit, provide a description of whether the unit is part of the insurer's claims or underwriting departments, or whether it is separate from such departments. A description of the insurer’s corporate policies for preventing fraudulent insurance acts committed by first- or third-party claimants, medical or service providers, attorneys, or any other party associated with a claim.

(a) A description of the technology and/or detection procedures the insurer has put in place to identify suspected fraud.

(b) The criteria used to report suspicious claims of insurance fraud for investigation to an insurer’s SIU.

(5) A written description or chart outlining the organizational arrangement of the insurer’s antifraud positions responsible for the investigation and reporting of possible fraudulent insurance acts.

(a) If SIU is an internal unit, the insurer shall provide general contact information for the company’s SIU.

(b) If SIU is an external unit, the insurer shall provide (1) the name of the company or companies used; (2) contact information for the company; and (3) a company organizational chart. The insurer shall specify the person or position at the insurer responsible for maintaining contact with the external SIU Company.

(c) If an external SIU is employed for purposes of surveillance, the insurer shall include a description of the policies and procedures implemented.

(6) A provision where the insurer provides the NAIC individual and group code numbers;

(6) A statement as to whether the insurer has established an internal SIU to investigate suspected insurance fraud.

(a) A description as to whether the unit is part of any other department within the organization.

(b) A description or chart outlining the organizational arrangement of all internal SIU positions/job titles.

(i) A general overview of each SIU position is required. In lieu of a general overview, insurers can provide a copy of all applicable position descriptions to the DOI.

Drafting Note: Upon exploring the creation of an electronic fraud plan submission system, the working group will explore the possibility insurers having the ability to upload an organization chart / list of SIU employees / position descriptions, etc

(c) General contact information for the company’s SIU as well as contact information for the person/position(s) responsible for overseeing the insurer’s antifraud efforts.

(d) A description of the insurer’s SOPs for investigating suspected insurance fraud.

(7) A statement as to whether the insurer has implemented a fraud awareness or outreach program. If insurer has an awareness or outreach program, a brief description of the program shall be included;

(8) If the SIU is a third party unit, a description of the insurer’s policies and procedures for ensuring that the third party unit fulfills its contractual obligations to the insurer and a copy of the contract with the third party vendor.
(7) A statement as to whether the insurer utilizes an external/third party as their SIU or in conjunction with their internal SIU.

(a) If an external/third party is used to substantially perform the insurer’s SIU function, the insurer shall provide the name of the company(ies) used and contact information for the company(ies).

(b) The insurance shall specify the internal persons or position responsible for maintaining contact with the external company(ies) which will serve as the insurer’s SIU. The insurer shall provide a description how they will monitor and/or gauge the external/third party’s compliance with insurer antifraud mandates.

Drafting Note: If a state requires the disclosure of specific and/or all vendors for investigative activities conducted, this section can be modified accordingly.

(8) A description of the method(s) used to document SIU referrals received and investigations conducted.

(a) An overview of any case management system and/or computer program used to memorialize SIU referrals received and investigations conducted.

(b) The manner in which the insurer tracks SIU/investigative information for compliance purposes; i.e., the number of SIU referrals received, the number of investigations opened, the outcome of investigations conducted, etc.

Drafting Note: States that do not mandate fraud reporting should revise or remove inapplicable or have other requirements from this section to reflect state requirements.

B. Prevention, Detection and Investigation of Fraud

(1) A description of the insurer’s corporate policies for preventing fraudulent insurance acts by its policy holders.

(2) A description of the insurer’s established fraud detection procedures (I.E. technology and other detection procedures).

(3) A description of the internal referral criteria used in reporting suspicious claims of insurance fraud for investigation by SIU.

(4) A description of SIU investigation program (I.E by business line, external form claims adjustment, vendor management SOPs)

(5) A description of the insurer’s policies and procedures for referring suspicious or fraudulent activity from the claims or underwriting departments to the SIU.

C. Reporting of Fraud

(1) A description of the insurer’s reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the Commissioner/Bureau/Division pursuant to Section [Insert applicable State code].

(2) A description of the insurer’s criteria or threshold for reporting fraud to the Commissioner.

(3) A description of insurer’s means of submission of suspected fraud reports to the Commissioner (e.g. NAIC OFRS, NICB, NHCAA, electronic state system, or other)

(9) A description of the procedures the insurer has established to ensure that suspected insurance fraud is timely reported to [agency/division name] pursuant to [insert reference to state law].
(a) A statement as to which individual(s) or group, within the organization is responsible for reporting suspected fraud on the insurer’s behalf.

(i) When composing such a statement, companies may cite specific position descriptions in lieu of employee names.

(ii) A description of the insurer’s criteria or threshold for reporting fraud to the Commissioner.

(iii) A description of insurer’s means of submission of suspected fraud reports to the Commissioner (e.g. Online Fraud Reporting System (OFRS), National Insurance Crime Bureau (NICB), National Health Care Anti-Fraud Association (NHCAA), electronic state system, or other).

**Drafting Note:** States that do not mandate fraud reporting should revise or remove inapplicable requirements from this section.

**Drafting Note:** If a state has a mandatory reporting method, this section should be adjusted to reflect an acknowledgment of the reporting method.

**D. Education and Training**

(1) If applicable, a description of the insurer’s plan for antifraud education and training initiatives of any personnel involved in antifraud related efforts. This description shall include:

(a) The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointment agents, attorneys, etc.

(b) If the training will be internal and/or external.

(c) Number of hours expected per year.

(d) If training includes ethics, false claims or other legal-related issues.

**E. Internal Fraud Detection and Prevention**

(1) A description of insurer’s internal fraud detection policy for employees, consultants or others, such as underwriters, claims representatives, appointed agents, etc.

(2) A description of insurer’s internal fraud reporting system.

(10) An insurer shall incorporate within its antifraud plan the steps it will take to ensure all information they, or a contracted party possess with regard to a specific claim or incident of suspected insurance fraud is provided in a timely and complete manner when a formal written request from the [insert agency/division name] has been received.

(a) For the purpose of this section, the timely release of information means by the deadline provided by the DOI.

**Drafting Note:** States who have a specific time period in which carriers must provide information can determine if a reference to a state statute or rule is warranted.

(b) Unless an insurer is able to cite legal grounds for withholding information, they must notredact or withhold any information that has been requested by the DOI.

(i) If an insurer has a reasonable belief that information cannot legally be provided to the DOI, the insurer will be required to provide, in writing, a description of any information being withheld, and cite the legal grounds for withholding such information.
Section 5.  18 USC 1033 & 1034 Compliance

The insurer shall include a description of its policies and procedures for candidates for employment and existing employees for compliance with 18 USC 1033 & 1034 [insert applicable State code if appropriate].

Section 65.  Regulatory Compliance

A Department of Insurance has the right to review insurer antifraud plans in order to determine compliance with appropriate state laws. A Department further The DOI has the right, in accordance with Section [insert specific state code], to take appropriate administrative action against an insurer if it fails to comply with the mandated requirements and/or state laws.

Section 76.  Confidentiality of Antifraud Plan

The submission of required information is not intended to constitute a waiver of an insurer’s privilege, trade secret, confidentiality or any proprietary interest in its antifraud plan or its antifraud related policies and procedures. The Commissioner shall maintain the antifraud plan as confidential. Submitted plans shall not be subject to the Freedom of Information Act (FOIA) if submitted properly under the state statutes or regulations which would afford protection of these materials [insert applicable state code].

Drafting Note: State will need to cite state specific privacy and protection authority.

Section 8.  Required Antifraud Plan Submission

An insurer, if required by a Department of Insurance, shall submit its antifraud plan within ninety days of receiving a certificate of authority. Plans shall be submitted every 5 years thereafter. An insurer shall submit revisions to its plans within thirty days of a material change being made.

Drafting Note: States without mandatory submission requirements should adjust this section appropriately.
Project History

ANTIFRAUD PLAN GUIDELINE

1. **Description of the Project, Issues Addressed, etc.**

   In 2020, the Antifraud (D) Task Force discussed implementation of the revised *Antifraud Plan Guideline* (#1690). Currently, 23 states require their insurers to file an Antifraud Plan with their insurance commissioner. The purpose of an Antifraud Plan is to describe in detail how the company detects, addresses and prevents insurance fraud.

2. **Name of Group Responsible for Drafting the Model and States Participating**

   The Antifraud Technology (D) Working Group of the Antifraud (D) Task Force.

   Chair: Utah. Participating states: Arizona, Arkansas, California, Florida, Louisiana, New Mexico, Ohio, Texas and Virginia.

3. **Project Authorized by What Charge and Date First Given to the Group**

   On Dec. 10, 2019, the Antifraud Technology (D) Working Group was given the charge to “[r]eview and provide recommendations for the development of an Antifraud Plan Repository to be used by insurers to centrally file their antifraud plan to all states/jurisdictions.” The revision of Guideline #1690 was determined to be the first step in completing this charge. The Working Group continues to discuss potential recommendations for an Antifraud Plan Repository.

4. **A General Description of the Drafting Process (e.g., drafted by a subgroup, interested parties, the full group, etc). Include any parties outside the members that participated.**

   The Antifraud Technology (D) Working Group initially sent a request for comments on Nov. 25, 2019, to the Antifraud (D) Task Force, interested state insurance regulators, and interested parties. The Working Group chair and the Ohio Working Group member drafted the initial revisions to Guideline #1690 that was exposed for comment in March 2020.

   The Working Group met again Sept. 17, 2020, to discuss additional comments received and review proposed revisions. The Working Group exposed a second draft for comment following the September call.

   The Working Group met Oct. 14, 2020, to review the final draft and Oct. 29, 2020, to adopt the revised Guideline #1690.

   Working Group members, state insurance regulators, and interested parties provided comments, and they were invited to participate in all Working Group calls. Revised drafts were released for comment following each Working Group call. The drafts were circulated via email and posted to the Task Force web page on the NAIC home page.

   Written comments were received by the following groups:

   **Interested State Insurance Regulators**

   Minnesota, Ohio and Utah.

   **Interested Parties**

   The Center for Economic Justice (CEJ), the Coalition Against Insurance Fraud (CAIF), the National Association of Mutual Insurance Companies (NAMIC), and the National Insurance Crime Bureau (NICB).
5. **A General Description of the Due Process (e.g., exposure periods, public hearings, or any other means by which widespread input from industry, consumers and legislators was solicited)**

The initial draft of Guideline #1690 was exposed in December 2019. Comments were received until Dec. 31, 2019. The Antifraud Technology (D) Working Group met in March 2020 to discuss the comments received.

A second draft was distributed following the call in March. Due to the COVID-19 pandemic, the activity of the Working Group was temporarily delayed, and the comment period was extended until September. The Working Group met in September and October to finalize and adopt the revisions to Guideline #1690.

In October 2020, the Antifraud (D) Task Force exposed the revised draft for comment. No comments were received on the revised draft. The Task Force met Nov. 16, 2020, to discuss the proposed revisions and adopt the revised Guideline #1690.

The Market Regulation and Consumer Affairs (D) Committee adopted the revised Guideline #1690 during the 2020 Fall National Meeting.

6. **A Discussion of the Significant Issues (items of some controversy raised during the due process and the group’s response)**

The purpose of Guideline #1690 is to bring greater uniformity among the states in antifraud plan requirements and to be used as a template in creating the Antifraud Plan Repository. This Antifraud Plan Repository is intended to streamline the process used by industry to submit their Antifraud Plans to all appropriate insurance departments and streamline the process for state review.

Ohio suggested incorporating a comprehensive narrative at the beginning of Guideline #1690 to explain its purpose as a best practice because not all states mandate the reporting of Antifraud Plans. Antifraud Technology (D) Working Group members, state insurance regulators, and industry representatives unanimously agreed that the language suggested by Ohio was not necessary. The Working Group decided to reorganize the structure of the existing Guideline #1690 and keep the existing language.

The Working Group added and changed definitions within Guideline #1690. The Antifraud (D) Task Force decided to modify these changes by using certain definitions from existing NAIC model laws.

The first definition added was “insurance commissioner” or “commissioner.” The Working Group incorporated the definition used in the Insurance Data Security Model Law (#668).

The next definition added was for “insurer.” In the initial draft, the Working Group defined “insurer” as a business entity who is in the process of obtaining or has obtained a certificate of authority to enter into arrangements of contracts of insurance or reinsurance and who agrees to: 1) pay or indemnify another as to loss from certain contingencies called “risks,” including through reinsurance; 2) pay or grant a specified amount or determinable benefit to another in connection with ascertainable risk contingencies; 3) pay an annuity to another; or 4) act as surety. Except for using the language “including annuities,” the Task Force decided to use language found in the Suitability in Annuity Transactions Model Regulation (#275) definition for “insurer.” This language states that an “insurer is a company required to be licensed under the laws of this state to provide insurance products, including annuities.”

The last definition added to was for the “NAIC” stating, “the NAIC is the organization of insurance regulators from 50 states, the District of Columbia and all participating U.S. territories.”

The Task Force members, state insurance regulators, and interested parties unanimously agreed that Guideline #1690 should not be considered a regulation but rather a guideline to assist states that currently require the submission of an Antifraud Plan and encourage the remaining jurisdictions to adopt a requirement for insurers’ submission of an Antifraud Plan.
7. Any Other Important Information (e.g., amending an accreditation standard).

None.