

**ANTIFRAUD PLAN GUIDELINE – DRAFT 4**  
**(COMMENTS FROM 9.17.20 CONFERENCE CALL APPLIED)**

**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 believe it's imperative 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 impact 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 departments of insurance and fraud fighting agencies believe it is a best practice for all insurers, whether state mandated or not, to develop an antifraud plan 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 departments of insurance 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, state 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 – DRAFT 24**  
**(COMMENTS FROM 9/3-12/17/20 CONFERENCE CALL APPLIED)**

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**Section 1. Application**

The purpose of this regulation guideline is to establish standards for ~~state fraud bureaus~~, insurance company special investigation units (SIU)s and any other interested parties regarding the preparation of an Antifraud Plan that meets the mandated requirements ~~for submitting a plan of with [insert a state Department of Insurance name].~~ 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.

~~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. “Individual” means a natural person.~~

A

B. “Insurance” means any of the lines of authority in [insert reference to appropriate section of state law] authorized by state law.

CB. “Insurance commissioner” or “commissioner” means the official in any state that is responsible for regulation of the business of insurance.

DC. “Insurer” means a [insert reference to appropriate section of state law] 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.

D. “Material or substantive change” (NAIC) 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.

EE. “National Association of Insurance Commissioners” (NAIC) means the organization of insurance regulators from the fifty (50) states, the District of Columbia and the four (4) U.S. territories.

~~F.~~ “Person” means an individual or a business entity.

GF. “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. ~~within 60 days after determination is made by the insurer that the claims appears to be a fraudulent claim.~~

HG. “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. ~~to a request for information from an authorized agency, not to exceed 30 days from the day on which the duty arose.~~

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

IHH. “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. ~~Creation Of~~ Antifraud Plan ~~Creation / Submission~~

A. An insurer, ~~if required by a Department of Insurance,~~ subject to [insert appropriate state code], shall create an antifraud plan which documents ~~outlining~~ the insurer’s antifraud efforts.

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. ~~submit to the Commissioner [or Fraud Bureau] a detailed description the procedures it will follow when instances of insurance fraud or suspected insurance fraud are brought to its attention, of the company’s antifraud plan. All antifraud plans submitted shall be subject to review by the Commissioner.~~ The Department of Insurance 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] of the change(s) being made. ~~ir antifraud efforts, is amended~~An insurer shall material 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.

#### Section 4. Antifraud Plan Requirements

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

A.

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

C. The following information should be included in the submitted antifraud plan to satisfy this Section:

~~(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;~~

~~(7) A statement as to whether the insurer has implemented a internal or external fraud awareness and [WG1] 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~~

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

~~B. Prevention, Detection and Investigation of Fraud~~

~~(1) A description of the insurer's corporate policies for preventing fraudulent insurance acts (I.E. first [MBR2] or third party claimants, medical or service providers, legal counsel, or any form of agent or internal fraud), 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, vender management [MBR3] standard operation procedures (SOP) 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.~~

- (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 insurer has established criteria that will be used for the investigation of internal fraud and suspected fraud related to the different types of insurance offered.
- (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:
    - (1) An overview of antifraud training provided to new employees.
    - (2) The internal positions the insurer offers regular education and training, such as underwriters, adjusters, claims representatives, appointed agents, attorneys, etc.
    - (3) A description of training topics covered with employees.
    - (4) The method(s) in which training is provided.
    - (5) The frequency and minimum number of training hours provided
    - (6) 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 who, within the organization, 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.).
- (5) 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.
  - (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) An overview of all internal SIU positions / job titles.
      - (1) The overview can be provided in the form of a narrative and/or through the submission of an organizational chart documenting all internal SIU positions.
      - (2) A general overview of each SIU position is required.
        - a. In lieu of a general overview, insurers can provide a copy of all applicable position descriptions to the Department.
  - (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 standard operating procedures (SOP) for investigating suspected insurance fraud.
- (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 insurer shall specify the internal person(s) or position(s) responsible for maintaining contact with the external company(ies) who will serve as the insurer's SIU.
  - (c) The insurer shall provide a description as to 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. number of SIU referrals received, number of investigations opened, outcome of investigations conducted, etc.)

**Drafting Note:** states that do not mandate fraud reporting or have other requirements should revise this section to reflect state requirements.

C. — (9) **Reporting of Fraud**

~~(1)~~—A description of the procedures the insurer has established to ensure suspected insurance fraud is timely reported to [agency / division name] of the insurer's reporting procedures for the mandatory reporting of possible fraudulent insurance acts to the Commissioner/Bureau/Division pursuant to Section [insert reference to state law] [insert applicable State code].

~~— Report in a timely manner.~~

~~— Respond in a timely manner~~

(a) ~~(2)~~—A statement as to which individual(s) or group, within the organization is responsible for reporting suspected fraud on the insurer's behalf.

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

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

(c) ~~(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)

**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

~~10) D. Insurer And Assistance~~ 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. ~~released includes, but is not limited to:~~

(a) ~~(e)~~ For the purpose of this section, the timely release of information means by the deadline provided by the department

**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 specific information, they must not redact or withhold any information that has specifically been requested by the Department.

1. If an insurer has a reasonable belief that specific information cannot legally be provided to the department, 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

#### ~~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.~~

~~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 5.6. Regulatory Compliance**

~~A Department of Insurance has the right to review insurer antifraud plans in order to determine compliance with appropriate state laws. A~~ The Department of Insurance further 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 6.7. 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 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.~~

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*Chronological Summary of Action (all references are to the Proceedings of the NAIC)*

*2011 Proc. 1<sup>st</sup> Quarter, Vol. 1101, 114, 117, 472-477 (adopted).*