American Property Casualty Insurance Association
INSURING AMERICA apci.org

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Greg Welker
Antifraud & Producer Licensing Program Manager
National Association of Insurance Commissioners
1100 Walnut Street
Kansas City, MO 64106-2197

Submitted Via E-Mail

Re: NAIC Anti-Fraud Plan Guidelines Revisions 8-3-20 Draft

Dear Mr. Welker,

The American Property Casualty Insurance Association (APCIA) is the primary national trade association for home, auto, and business insurers. APCIA promotes and protects the viability of private competition for the benefit of consumers and insurers, with a legacy dating back 150 years. APCIA members represent all sizes, structures, and regions-protecting families, communities, and businesses in the U.S. and across the globe. Together, APCIA members write nearly 60 percent of the property and casualty insurance in the United States, representing over $439 billion in direct written premium and assumed reinsurance premium.

APCIA and its predecessor organizations have long supported the support the objectives of this NAIC initiative around common requirements and formatting for anti-fraud plans, along with a central location for filing. We agree that a standardized fraud plan streamlines and adds consistency to our submissions and will make the review/update/submission of the plans simpler and more efficient. In support of those objectives, APCIA offers the following comments on the NAIC Anti-fraud Task Force Technology Working Group's draft update of NAIC's Anti- Fraud Plan Guidelines.

The draft includes some important clarifications, such as allowing submission of one plan for multiple insurer entities that share the same mission and avoiding refiling plans that have not materially changed. The draft also raises some questions that we will address section by section:

Section One- Application

While we have no concerns with the text removed from this section, we suggest that the second paragraph be revised to reflect the goal of increasing uniformity of state anti-fraud plan requirements, and that most "national and state" fraud fighting agencies agree on the importance of a written anti-fraud plan.

We are often asked by our members what happens to anti-fraud plans and reports once they are submitted? In our previous comments we suggested that the guidelines the review include some reference to the importance of the fraud fighting entity sharing aggregated results or best practices with the industry without identifying individual insurers. Perhaps this section could include such a reference or recommendation as a drafting note?

Section Two- Definitions

The revised draft provides specific definitions for terms, while the prior version "reserved" the section for state definitions. Providing specific definitions clearly supports uniformity, but the suggested language does raise some issues.

- "Suspected Insurance Fraud", is a defined broadly as a misrepresentation or omission of facts in an insurance transaction that "may include" a lengthy list of items. We suggest that the definition be

revised to read “These facts may include but are not limited to” since there certainly could be other pertinent facts that give rise to suspicions of fraud.

- The definition appears to contain a typographical error (“means includes”).

- The definition of “person” includes an “individual or business entity”. The term “person” is mentioned only five times in the document, so replacing “person” with “individual or business entity” would seem clearer.

Section Three- Anti-Fraud Plan ‘Creation and Submission”

- The draft requires a plan that “fully documents” the insurers anti-fraud efforts. The term “fully” is vague, simply requiring that the plan “documents” the insurers effort provides clarity.

- The draft removes the current requirement that the plan be submitted every 5 years, a positive change. However, the new language requires the plan to be submitted in accordance with state law and refiled within a specified number of days if the insurer “amends” its practices. It is not unusual for an insurer to make minor adjustments without making a material changes to the plan. We suggest that the “amends” be replaced with “makes a material change”.

Section Four – Anti-Fraud Plan Requirements

- This section defines the plan as a “comprehensive” overview of the insurers anti-fraud efforts. Consistent with our earlier comment on the use of the term “fully”, we would suggest that the preamble to this section read that “<u>An anti-fraud plan documents the insurers efforts to…</u>”

- The document retains the provision that a plan may cover multiple insurer entities if the insurer has “the same SIU mission” for all the ensures entities that share the same mission. This is an important provision that avoids duplication of effort by insurers and the fraud fighting entities reviewing the plans.

- Section 4 C. of the draft that revises the specific items to be addressed in the plan that raises some questions/ suggestions for revisions:

    - (2)(b) and (c) require an insurer to provide annual premium and claim volume, data points that not only change from year to year but that are reported in other required reports. We suggest that both sections be deleted to avoid duplicative reporting.

    - (4)(b)(5) requires the “frequency and number” of training hours provided. This may vary based on the needs of the individual; therefore, we suggest that this be revised to require the “frequency and minimum number” of training hours provided.

    - (4)(b)(6) requires a description of methods for employees, policyholders, and the public to report suspected fraud. This seems misplaced in this section and would be more appropriately included in (6) that references reporting procedures for suspected fraud.

    - (5) references procedures to investigate when internal fraud is suspected. We suggest that references in this section be clarified that they apply to “suspected internal fraud”.

    - (7) requires a “written description or chart outlining the organizational arrangement of all internal personnel responsible for the investigation and reporting of possible fraudulent insurance acts”. This could be interpreted as requiring submission of a new plan when ever there is any change in personnel. We do not believe that is the drafters’ intent, so we suggest revising this requirement to a “written description”.

    - (8)(a) references external/third parties used for investigative functions. The intent of this section appears to be addressing situations where an insurer uses a third party to substantially perform the SIU function, rather than vendors used for individual investigative

tasks. We suggest that this section be revised to reflect the intended distinction.

- (10)(a) requires a statement identifying "who" is responsible for reporting suspected fraud on the insurer's behalf. We suggest that this be revised to "the individuals or group within the organization…" so that a single change in personnel does not trigger an obligation to file a new report.

- (11) requires insurers to incorporate a plan to provide information to the fraud agency in a timely manner, going on to provide an extensive list of materials. The intent of the section appears to be ensuring that the insurer has a plan for timely responses to requests for information, rather than specifying what materials be requested. We suggest the list of materials be removed for clarity.

- (11) (1) defines timely release of information requested by the fraud agency as "immediate" then defines that as a specific number of days. The use of the term immediate is vague, consistent with our earlier comments, we recommend that the guidelines specify 30, 60 or 90 days.

- (11)(2) and (3) appear to be in conflict, forbidding an insurer from reacting or withholding information, then explaining why it has done so? We suggest that these sections be combined to require an insurers response to be complete but provide a description of and reason for withholding any information not provided as requested.

- Not every state provides statutory immunity from criminal or civil liability for an insurer that is reporting suspected fraud or providing information in response to the requests referenced by this section. To address such cases, we suggest a drafting note be added that the insurer should have the option of requesting the information be requested by subpoena or if the carrier is an NICB member company request transmission of the documentation via the National Insurance Crime Bureau (NICB).

Thank you for the opportunity to comment on the draft guidelines. As always, please do not hesitate to contact me with any questions, or if we can be of any assistance.

Sincerely,

Robert Passmore