Regular Session, 2010

HOUSE BILL NO. 239

BY REPRESENTATIVE KLECKLEY

INSURERS: Requires each authorized insurer and health maintenance organization to produce and maintain a written insurance anti-fraud plan

AN ACT

To amend and reenact R.S. 44:4.1(B)(10) and to enact R.S. 22:572.1, relative to company-produced written insurance anti-fraud plans; to require each authorized insurer and health maintenance organization to produce and maintain such a plan; to provide for minimum requirements of such plans; to provide for the authority of the commissioner of insurance to review, investigate, and order modification of such plans; to authorize summary reports; to provide for confidentiality; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:572.1 is hereby enacted to read as follows:

§572.1. Written insurance anti-fraud plan

A. Each authorized insurer and each health maintenance organization licensed to operate in this state shall prepare, implement, and maintain an insurance anti-fraud plan for the insurer's or health maintenance organization's operations in this state.

B. The insurance anti-fraud plan utilized by each authorized insurer and each health maintenance organization in this state shall be filed with the commissioner of insurance and shall outline specific procedures, actions, and safeguards that are applicable, relevant, and appropriate to the type of insurance the authorized insurer writes or the type of coverage offered by the health maintenance organization in this state and shall include but not be limited to how the authorized insurer or health maintenance organization will:

(1) Detect, investigate, and prevent all forms of insurance fraud, including fraud involving the insurer's or health maintenance organization's employees or agents;

fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies; claims fraud; and security of the insurer's or health maintenance organization's data processing systems.

(2) Educate appropriate employees on fraud detection and the insurer's or health maintenance organization's anti-fraud plan.

(3) Provide for fraud investigations, whether through the use of internal fraud investigators or third-party contractors.

(4) Report a suspected fraudulent insurance act, as defined by R.S. 22:1923(1), to the Department of Insurance as well as appropriate law enforcement and other regulatory authorities engaged in the investigation and prosecution of insurance fraud.

(5) Pursue restitution for financial loss caused by insurance fraud, where applicable, relevant, and appropriate.

C. The commissioner shall review the insurance anti-fraud plan submitted by each authorized insurer and each health maintenance organization to determine compliance with the requirements of this Section.

D. The commissioner shall have the authority to investigate and examine the records and operations of each authorized insurer and each health maintenance organization to determine if the insurer or health maintenance organization has implemented and maintained compliance with the insurance anti-fraud plan.

E. The commissioner is authorized to direct any authorized insurer or health maintenance organization to make any modification to the insurer's or health maintenance organization's insurance anti-fraud plan necessary to obtain and maintain compliance with the requirements of this Section, and the commissioner may require any other reasonable remedial action to the insurer's or health maintenance organization's insurance anti-fraud plan if the investigation and examination reveals substantial noncompliance by the insurer or health maintenance organization with the terms of the insurer's or health maintenance organization's insurance anti-fraud plan.

F. The written anti-fraud plan and any summary report shall be filed with the commissioner on or before April first of each calendar year. Either on a calendar year

basis or on whatever other interval he deems appropriate, the commissioner is authorized to require that each authorized insurer and each health maintenance organization file a summary report of any material change to the insurance anti-fraud plan, including the total number of claims and the number of claims referred to the commissioner as suspicious, and the commissioner is authorized to direct each insurer and each health maintenance organization as to the data to be reported and the format of the summary report.

G. The insurance anti-fraud plan submitted to the department, as well as the summary report of the insurer's or health maintenance organization's insurance anti-fraud activities and results, are not public records and are exempt pursuant to R.S. 44:1 et seq., and specifically R.S. 44:4.1(B)(10), shall be and are hereby declared to be company proprietary and business confidential records and not subject to public examination, shall not be discoverable or admissible in any civil litigation, and shall not be subject to subpoena or order of production.

H. This Section confers no private rights of action upon any person.

Section 2. R.S. 44:4.1(B)(10) is hereby amended and reenacted to read as follows:

§4.1. Exceptions

* * *

B. The legislature further recognizes that there exist exceptions, exemptions, and limitations to the laws pertaining to public records throughout the revised statutes and codes of this state. Therefore, the following exceptions, exemptions, and limitations are hereby continued in effect by incorporation into this Chapter by citation:

* * *

(10) R.S. 22:2, 14, 42.1, 88, 244, 461, 572, 572.1, 574, 618, 706, 732, 752, 1203, 1460, 1466, 1546, 1644, 1656, 1723, 1929, 1983, 2036, 2303

* * *

Section 3. The provisions of this Act shall become effective on January 1, 2011.

DIGEST

The digest printed below was prepared by House Legislative Services. It constitutes no part of the legislative instrument. The keyword, one-liner, abstract, and digest do not constitute part of the law or proof or indicia of legislative intent. [R.S. 1:13(B) and 24:177(E)]

Kleckley HB No. 239

Abstract: Requires each authorized insurer and health maintenance organization to prepare, implement, and maintain a written insurance anti-fraud plan for its operations in this state.

Proposed law requires each authorized insurer and each health maintenance organization (HMO) licensed to operate in this state to prepare, implement, and maintain an insurance anti-fraud plan for its operations in this state.

Proposed law requires that such a plan be filed with the commissioner of insurance and outline specific procedures, actions, and safeguards that are applicable, relevant, and appropriate to the type of insurance the authorized insurer writes or the type of coverage offered by the HMO in this state and shall include but not be limited to how these entities will:

(1) Detect, investigate, and prevent all forms of insurance fraud, including fraud involving the entity's employees or agents; fraud resulting from misrepresentations in the application, renewal, or rating of insurance policies; claims fraud; and security of the entity's data processing systems.

(2) Educate appropriate employees on fraud detection and the entity's anti-fraud plan.

(3) Provide for fraud investigations, whether through the use of internal fraud investigators or third-party contractors.

(4) Report a suspected fraudulent insurance act, as defined by present law, to the Department of Insurance as well as appropriate law enforcement and other regulatory authorities engaged in the investigation and prosecution of insurance fraud.

(5) Pursue restitution for financial loss caused by insurance fraud, where applicable, relevant, and appropriate.

Proposed law authorizes the commissioner to review the insurance anti-fraud plan submitted by each entity to determine compliance with the requirements of proposed law. Further authorizes the commissioner to investigate and examine the records and operations of each such entity to determine if it has implemented and maintained compliance with the insurance anti-fraud plan. Additionally authorizes the commissioner to direct each such entity to make any modification to its insurance anti-fraud plan necessary to obtain and maintain compliance with the requirements of proposed law. Provides that the commissioner may require any other reasonable remedial action to the entity's insurance anti-fraud plan if the investigation and examination reveals substantial noncompliance by the entity with the terms of its anti-fraud plan.

Proposed law requires that the written anti-fraud plan and any summary report be filed with the commissioner on or before April 1st of each calendar year. Authorizes the commissioner to periodically require that each such entity file any material change to a summary report of the insurance anti-fraud plan, including the total number of claims and the number of claims referred to the commissioner as suspicious, and to direct each such entity as to the data to be reported and the format of the summary report.

Proposed law provides that the insurance anti-fraud plan submitted to the department, as well as the summary report of the entity's insurance anti-fraud activities and results, are not public records, are exempt from the Public Records Act, shall be company proprietary and business confidential records and not subject to public examination, shall not be discoverable or admissible in any civil litigation, and shall not be subject to subpoena or order of production.

Proposed law provides that it confers no private rights of action upon any person.

Present law, the Public Records Act, provides for specific exceptions from present law.

Proposed law makes proposed law one of these exceptions.

Effective Jan. 1, 2011.

(Amends R.S. 44:4.1(B)(10); Adds R.S. 22:572.1)

Summary of Amendments Adopted by House

Committee Amendments Proposed by House Committee on Insurance to the original bill.

1. Deleted requirement that the anti-fraud plan include how the insurer or HMO provides for the hiring of or contracting for fraud investigators. Instead requires that it include how such an entity provides for fraud investigations, whether through the use of internal fraud investigators or third-party contractors.

2. Added requirement that the written anti-fraud plan and any summary report shall be filed with the commissioner on or before April 1st of each calendar year.

3. Deleted provision that authorizes the commissioner to periodically require that each such entity file a summary report of the insurance anti-fraud activities and results. Instead authorizes the commissioner to periodically require that each such entity file any material change to a summary report of the insurance anti-fraud plan, including the total number of claims and the number of claims referred to the commissioner as suspicious.

4. Added effective date of Jan. 1, 2011.