Regular Session, 2010

HOUSE BILL NO. 239

BY REPRESENTATIVE KLECKLEY

INSURERS: Requires each authorized insurer and health maintenance organization to produce and maintain an 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 and 572.2, relative to company- produced 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; to provide for certain statistical reports; and to provide for related matters.

Be it enacted by the Legislature of Louisiana:

Section 1. R.S. 22:572.1 and 572.2 are hereby enacted to read as follows:

§572.1. 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 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; fraudulent claims; 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, when 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 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 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 or subpoena except by court order or by request from any law enforcement agency.

§572.2. Anti-fraud statistical report

A. The commissioner of insurance shall prepare a report that summarizes statistical information relating to anti-fraud efforts by each authorized insurer and health maintenance organization in this state. Each report shall include the following information for all authorized insurers and health maintenance organizations in this state combined and separately:

(1) The total number of claims.

(2) The total number of claims referred to the commissioner as suspicious.

(3) The total number of modifications to an anti-fraud plan directed by the commissioner.

(4) The total number of remedial actions required by the commissioner to an anti-fraud plan.

(5) The total number of employees or agents of an insurer or health maintenance organization implicated in fraud based upon the information in the custody of the Department of Insurance.

B. The report required by Subsection A of this Section shall be prepared and available no later than February first of each year and shall be complete for the prior calendar year. The commissioner shall publicly announce the report's availability. The report required by this Section shall be a public record and shall be subject to examination, inspection, and copying or reproduction in accordance with the laws relative to public records.

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 (HMO) to prepare, implement, and maintain an insurance anti-fraud plan for its operations in this state. Requires the commissioner of insurance to prepare a report that summarizes statistical information relating to anti-fraud efforts by each authorized insurer and HMO 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 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 Dept. 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 anti-fraud plan and any summary report be filed with the commissioner on or before April 1 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 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 laws pertaining to public records, shall be company proprietary and business confidential records and not subject to public examination or subpoena except by court order or by request from any law enforcement agency.

Present law (R.S. 44:1 et seq., relative to public records) provides that any person of the age of majority may inspect, copy or reproduce, or obtain a reproduction of any public record. Provides procedures for requesting a record and presentation of the requested record. Provides for enforcement and penalties for violations. Provides exceptions.

Proposed law provides an additional exception for the plans and summary reports prepared pursuant to proposed law.

Proposed law further requires the commissioner of insurance to prepare a report that summarizes statistical information relating to anti-fraud efforts by each authorized insurer and HMO in this state which includes, combined and separately, the (1) total number of claims; (2) total number of claims referred to the commissioner as suspicious; (3) total number of modifications to an anti-fraud plan directed by the commissioner; (4) total number of remedial actions required by the commissioner to an anti-fraud plan; and (5) total number of employees or agents of an insurer or HMO implicated in fraud based upon the information in the custody of the Dept. of Insurance. Requires the report to be prepared and available no later than February 1st of each year and complete for the prior calendar year. Provides that the report is a public record subject to examination, inspection, and copying or reproduction in accordance with the laws relative to public records and requires the commissioner to publicly announce its availability.

Effective Jan. 1, 2011.

(Amends R.S. 44:4.1(B)(10); Adds R.S. 22:572.1 and 572.2)

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.

Committee Amendments Proposed by House Committee on House and Governmental Affairs to the engrossed bill.

1. Removed reference to "written" as requirement of the anti-fraud plan.

2. Removed provision that the commissioner may direct each insurer or HMO as to the data to be reported.

3. Removed provision that the records are not subject to public examination, not discoverable or admissible in any civil litigation, and not subject to subpoena or order of production and provides instead that the records are not subject to public examination or subpoena except by court order or by request from any law enforcement agency.

4. Removed provision specifying proposed law confers no private rights of action upon any person.

5. Added a requirement that the commissioner prepare a report that summarizes statistical information regarding anti-fraud efforts by each insurer and HMO in the state. Provided for the information to be included in such report and provides that the report is a public record.