A bill to be entitled

An act relating to insurer anti-fraud efforts; reordering and amending s. 626.9891, F.S.; providing and revising definitions; requiring every insurer to designate at least one primary anti-fraud employee for certain purposes; requiring insurers to adopt an anti-fraud plan; revising insurer requirements in providing anti-fraud information to the Department of Financial Services; requiring specified information to be filed annually with the department; revising the information to be provided by insurers who write workers' compensation insurance; requiring each insurer to provide annual anti-fraud education and training; requiring insurers who submit an application for a certificate of authority after a specified date to comply with the section; providing penalties for failure to comply with requirements of the section; requiring rulemaking in certain cases; creating s. 626.9896, F.S.; requiring certain state attorneys to submit data; requiring the Division of Investigative and Forensic Services to provide an annual report to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate; amending s. 641.221, F.S.; requiring a health maintenance organization authorized to exclusively

market, sell, or offer to sell Medicare Advantage plans in this state to meet certain criteria to maintain eligibility for a certificate of authority; authorizing the Office of Insurance Regulation to extend the period of eligibility; amending s. 641.3915, F.S.; deleting obsolete provisions; providing effective dates.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Section 626.9891, Florida Statutes, is reordered and amended to read:

626.9891 Insurer anti-fraud investigative units; reporting requirements; penalties for noncompliance.—

(1)~~(5)~~ As used in ~~For purposes of~~ this section, the term:

(a) "Anti-fraud investigative unit" means the designated anti-fraud unit or division, or contractor authorized under subparagraph (2)(a) 2.

(b) "Designated anti-fraud unit or division" includes a distinct unit or division or a unit or division made up of ~~the assignment of fraud investigation to~~ employees whose principal responsibilities are the investigation and disposition of claims who are also assigned investigation of fraud. ~~If an insurer creates a distinct unit or division, hires additional employees, or contracts with another entity to fulfill the requirements of~~

~~this section, the additional cost incurred must be included as an administrative expense for ratemaking purposes.~~

(2)~~(1)~~ By December 31, 2017, every insurer admitted to do business in this state ~~who in the previous calendar year, at any time during that year, had $10 million or more in direct premiums written~~ shall:

(a)1. Establish and maintain a designated anti-fraud unit or division within the company to investigate and report possible fraudulent insurance acts ~~claims~~ by insureds or by persons making claims for services or repairs against policies held by insureds; or

2.~~(b)~~ Contract with others to investigate and report possible fraudulent insurance acts by insureds or by persons making claims for services or repairs against policies held by insureds.

(b) Adopt an anti-fraud plan.

(c) Designate at least one employee with primary responsibility for implementing the requirements of this section.

(d) Electronically ~~An insurer subject to this subsection shall~~ file with the Division of Investigative and Forensic Services of the department, and annually thereafter ~~on or before July 1, 1996~~, a detailed description of the designated anti-fraud unit or division ~~established pursuant to paragraph (a)~~ or a copy of the contract executed under subparagraph (a)2., as

applicable, a copy of the anti-fraud plan, and the name of the employee designated under paragraph (c) ~~and related documents required by paragraph (b)~~.

An insurer must include the additional cost incurred in creating a distinct unit or division, hiring additional employees, or contracting with another entity to fulfill the requirements of this section, as an administrative expense for ratemaking purposes.

~~(2) Every insurer admitted to do business in this state, which in the previous calendar year had less than $10 million in direct premiums written, must adopt an anti-fraud plan and file it with the Division of Investigative and Forensic Services of the department on or before July 1, 1996. An insurer may, in lieu of adopting and filing an anti-fraud plan, comply with the provisions of subsection (1).~~

(3) Each ~~insurers~~ anti-fraud plan must ~~plans shall~~ include:

(a) An acknowledgement that the insurer has established procedures for detecting and investigating possible fraudulent insurance acts relating to the different types of insurance by that insurer ~~A description of the insurer's procedures for detecting and investigating possible fraudulent insurance acts~~;

(b) An acknowledgment that the insurer has established ~~A description of the insurer's~~ procedures for the mandatory

reporting of possible fraudulent insurance acts to the Division of Investigative and Forensic Services of the department;

(c) An acknowledgement that the insurer provides the ~~A description of the insurer's plan for~~ anti-fraud education and training required by this section to the anti-fraud investigative unit ~~of its claims adjusters or other personnel~~; ~~and~~

(d) A description of the required anti-fraud education and training;

(e) A ~~written~~ description or chart ~~outlining~~ ~~the organizational arrangement~~ of the insurer's anti-fraud investigative unit, including the position titles and descriptions of staffing ~~personnel who are responsible for the investigation and reporting of possible fraudulent insurance acts~~; and

(f) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit which may include objective criteria, such as the number of policies written, the number of claims received on an annual basis, the volume of suspected fraudulent claims detected on an annual basis, an assessment of the optimal caseload that one investigator can handle on an annual basis, and other factors.

(4) By December 31, 2018, each insurer shall provide staff of the anti-fraud investigative unit at least 2 hours of initial anti-fraud training that is designed to assist in identifying

and evaluating instances of suspected fraudulent insurance acts in underwriting or claims activities. Annually thereafter, an insurer shall provide such employees a 1-hour course that addresses detection, referral, investigation, and reporting of possible fraudulent insurance acts for the types of insurance lines written by the insurer.

(5) Each insurer is required to report data related to fraud for each line of insurance written by the insurer during the prior calendar year. The data shall be reported to the department by March 1, 2019, and annually thereafter, and must include, at a minimum:

(a) The number of policies in effect;

(b) The amount of premiums written for policies;

(c) The number of claims received;

(d) The number of claims referred to the anti-fraud investigative unit;

(e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;

(f) The number of claims investigated or accepted by the anti-fraud investigative unit;

(g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;

(h) The number of cases referred to the Division of

Investigative and Forensic Services;

(i) The number of cases referred to other law enforcement agencies;

(j) The number of cases referred to other entities; and

(k) The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.

(6) In addition to providing information required under subsections (2), (4), and (5), each insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1, 2019, and annually thereafter ~~August 1 of each year, on its experience in implementing and maintaining an anti-fraud investigative unit or an anti-fraud plan. The report must include, at a minimum~~:

(a) The estimated dollar amount of losses attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(b) The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(c) The number of cases referred to the Division of Investigative and Forensic Services, delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

~~(a) The dollar amount of recoveries and losses~~

~~attributable to workers' compensation fraud delineated by the type of fraud: claimant, employer, provider, agent, or other.~~

~~(b) The number of referrals to the Bureau of Workers' Compensation Fraud for the prior year.~~

~~(c) A description of the organization of the anti-fraud investigative unit, if applicable, including the position titles and descriptions of staffing.~~

~~(d) The rationale for the level of staffing and resources being provided for the anti-fraud investigative unit, which may include objective criteria such as number of policies written, number of claims received on an annual basis, volume of suspected fraudulent claims currently being detected, other factors, and an assessment of optimal caseload that can be handled by an investigator on an annual basis.~~

~~(e) The inservice education and training provided to underwriting and claims personnel to assist in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities.~~

~~(f) A description of a public awareness program focused on the costs and frequency of insurance fraud and methods by which the public can prevent it~~.

(7)~~(4)~~ An ~~Any~~ insurer who obtains a certificate of authority has 6 ~~after July 1, 1995, shall have 18~~ months in which to comply with subsection (2), and 1 calendar year thereafter, to comply with subsections (4), (5), and (6) ~~the~~

~~requirements of this section~~.

(8)~~(7)~~ If an insurer fails ~~to timely submit a final acceptable anti-fraud plan or anti-fraud investigative unit description, fails to implement the provisions of a plan or an anti-fraud investigative unit description,~~ or otherwise refuses to comply with the provisions of this section, the department, office, or commission may:

(a) Impose an administrative fine of not more than $2,000 per day for such failure ~~by an insurer to submit an acceptable anti-fraud plan or anti-fraud investigative unit description,~~ until the department, office, or commission deems the insurer to be in compliance;

(b) Impose an administrative fine for failure by an insurer to implement or follow the provisions of an anti-fraud plan or anti-fraud investigative unit description; or

(c) Impose the provisions of both paragraphs (a) and (b).

(9)~~(8)~~ The department may adopt rules to administer this section and must adopt rules to administer subsection (5).

Section 2. Effective July 1, 2017, section 626.9896, Florida Statutes, is created to read:

626.9896 Dedicated insurance fraud prosecutors.—

(1) The department shall collect data from each state attorney office that receives an appropriation to fund attorneys and paralegals dedicated solely to the prosecution of insurance fraud cases and report on the use of such funds. The data must

be submitted by the state attorneys to the Division of Investigative and Forensic Services on the last day of each calendar quarter beginning September 30, 2017, and quarterly thereafter. Data must be submitted for each attorney funded by the appropriation and grouped by case type, including Division of Investigative and Forensic Services insurance fraud cases, other insurance fraud cases, and cases not involving insurance fraud. For each type of case, the data must include the number of cases in which an information has been filed; the number of cases pending at pretrial or intake, the number of cases in which the attorney is assisting in the investigation; the number of cases closed or disposed of during the prior quarter; the disposition of the cases closed during the prior quarter; and the number of cases currently pending in a pretrial diversion program.

(2) The Division of Investigative and Forensic Services must report the data collected pursuant to subsection (1) for the year ending June 30, to the Executive Office of the Governor, the Speaker of the House of Representatives, and the President of the Senate by September 1, 2018, and annually thereafter.

Section 3. Section 641.221, Florida Statutes, is amended to read:

641.221 Continued eligibility for certificate of authority.—

(1) In order to maintain its eligibility for a certificate of authority, a health maintenance organization shall continue to meet all conditions required to be met under this part and the rules promulgated thereunder for the initial application for and issuance of its certificate of authority under s. 641.22.

(2) In order to maintain eligibility for a certificate of authority, a health maintenance organization authorized under the Florida Insurance Code to exclusively market, sell, or offer to sell Medicare Advantage plans in this state shall be actively engaged in managed care within 24 months after licensure, shall designate and maintain at least one primary anti-fraud employee, and shall adopt an anti-fraud plan. The Office of Insurance Regulation may extend the period of eligibility upon written request.

Section 4. Section 641.3915, Florida Statutes, is amended to read:

641.3915 Health maintenance organization anti-fraud plans and investigative units.—Each authorized health maintenance organization and applicant for a certificate of authority shall comply with the provisions of ss. 626.989 and 626.9891 as though such organization or applicant were an authorized insurer. ~~For purposes of this section, the reference to the year 1996 in s. 626.9891 means the year 2000 and the reference to the year 1995 means the year 1999.~~

Section 5. Except as otherwise expressly provided in this

act and except for this section, which shall take effect upon this act becoming a law, this act shall take effect September 1, 2017.