By the Committee on Banking and Insurance; and Senator Kurth

311-2093B-98

A bill to be entitled

An act relating to insurance fraud; amending s. 626.989, F.S.; applying the requirements of this section to health maintenance organizations, which requirements relate to insurance fraud and the Division of Insurance Fraud of the Department of Insurance; specifying designated employees who are immune from civil liability for certain actions; amending s. 626.9891, F.S.; requiring insurers to provide for investigation of fraudulent claims; requiring insurers to adopt an anti-fraud plan; providing criteria and procedures; requiring insurers to file an anti-fraud report with the department; specifying contents; authorizing the department to adopt rules; creating s. 626.9892, F.S.; establishing the Anti-Fraud Reward Program in the department; providing for awarding rewards under certain circumstances; exempting certain department actions from Florida Administrative Code requirements; creating s. 641.3915, F.S.; requiring certain health maintenance organizations to provide for investigation of fraudulent claims; requiring health maintenance organizations to adopt an anti-fraud plan; providing criteria and procedures; requiring health maintenance organizations to file an anti-fraud report with the department; specifying contents; authorizing the department to adopt rules; amending s. 817.234, F.S.;

specifying a schedule of criminal penalties for committing insurance fraud or insurance solicitation; providing definitions; providing a period of limitations for undertaking certain proceedings; applying the provisions of the section to health maintenance organizations; providing an appropriation; providing an effective date.

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

Section 1. Section 626.989, Florida Statutes, is amended to read:

626.989 Division of Insurance Fraud; definition; investigative, subpoena powers; protection from civil liability; reports to division; division investigator's power to execute warrants and make arrests.--

(1) For the purposes of this section, a person commits a "fraudulent insurance act" if the person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, self-insurer, self-insurance fund, servicing corporation, purported insurer, broker, or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or a claim for payment or other benefit pursuant to any insurance policy, which the person knows to contain materially false information concerning any fact material thereto or if the person conceals, for the purpose of misleading another, information concerning any fact material thereto. <u>For the purposes of this section, the term "insurer"</u>

also includes any health maintenance organization, and the term "insurance policy" also includes a health maintenance organization subscriber contract.

(2) If, by its own inquiries or as a result of complaints, the department or its Division of Insurance Fraud has reason to believe that a person has engaged in, or is engaging in, a fraudulent insurance act, an act or practice that violates s. 626.9541 or s. 817.234, or an act or practice punishable under s. 624.15, it may administer oaths and affirmations, request the attendance of witnesses or proffering of matter, and collect evidence. The department shall not compel the attendance of any person or matter in any such investigation except pursuant to subsection (4).

(3) If matter that the department or its division seeks to obtain by request is located outside the state, the person so requested may make it available to the division or its representative to examine the matter at the place where it is located. The division may designate representatives, including officials of the state in which the matter is located, to inspect the matter on its behalf, and it may respond to similar requests from officials of other states.

(4)(a) The department or its division may request that an individual who refuses to comply with any such request be ordered by the circuit court to provide the testimony or matter. The court shall not order such compliance unless the department or its division has demonstrated to the satisfaction of the court that the testimony of the witness or the matter under request has a direct bearing on the commission of a fraudulent insurance act, on a violation of s. 626.9541 or s. 817.234, or on an act or practice punishable

under s. 624.15 or is pertinent and necessary to further such investigation.

(b) Except in a prosecution for perjury, an individual who complies with a court order to provide testimony or matter after asserting a privilege against self-incrimination to which the individual is entitled by law may not be subjected to a criminal proceeding or to a civil penalty with respect to the act concerning which the individual is required to testify or produce relevant matter.

(c) In the absence of fraud or bad faith, a person is not subject to civil liability for libel, slander, or any other relevant tort by virtue of filing reports, without malice, or furnishing other information, without malice, required by this section or required by the department or division under the authority granted in this section, and no civil cause of action of any nature shall arise against such person:

1. For any information relating to suspected fraudulent insurance acts furnished to or received from law enforcement officials, their agents, or employees;

2. For any information relating to suspected fraudulent insurance acts furnished to or received from other persons subject to the provisions of this chapter; or

3. For any such information furnished in reports to the department, division, the National Insurance Crime Bureau, or the National Association of Insurance Commissioners.

(d) In addition to the immunity granted in paragraph (c), persons identified as designated employees whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent insurance acts may share information relating to persons suspected of committing

fraudulent insurance acts with other designated employees employed by the same or other insurers whose responsibilities include the investigation and disposition of claims relating to fraudulent insurance acts, provided the department has been given written notice of the names and job titles of such designated employees prior to such designated employees sharing information. As used in this paragraph, the term "designated employees of an insurer" includes employees of another entity or person with whom the insurer contracts in accordance with s. 626.9891 or otherwise to investigate possible fraudulent claims or suspected fraudulent insurance acts.Unless the designated employees of the insurer or of such third party act in bad faith or in reckless disregard for the rights of any insured, ~~neither~~ the insurer, such third party, and their ~~nor its~~ designated employees are not civilly liable for libel, slander, or any other relevant tort, and a civil action does not arise against the insurer, such third party,or their ~~its~~ designated employees:

1. For any information related to suspected fraudulent insurance acts provided to an insurer; or

2. For any information relating to suspected fraudulent insurance acts provided to the National Insurance Crime Bureau or the National Association of Insurance Commissioners.

Provided, however, that the qualified immunity against civil liability conferred on any insurer or its designated employees shall be forfeited with respect to the exchange or publication of any defamatory information with third persons not expressly authorized by this paragraph to share in such information.

(e) The Insurance Commissioner and any employee or agent of the department or division, when acting without malice and in the absence of fraud or bad faith, is not subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature exists against such person by virtue of the execution of official activities or duties of the department under this section or by virtue of the publication of any report or bulletin related to the official activities or duties of the department or division under this section.

(f) This section does not abrogate or modify in any way any common-law or statutory privilege or immunity heretofore enjoyed by any person.

(5) The department's papers, documents, reports, or evidence relative to the subject of an investigation under this section are confidential and exempt from the provisions of s. 119.07(1) until such investigation is completed or ceases to be active. For purposes of this subsection, an investigation is considered "active" while the investigation is being conducted by the department with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings. An investigation does not cease to be active if the department is proceeding with reasonable dispatch and has a good faith belief that action could be initiated by the department or other administrative or law enforcement agency. After an investigation is completed or ceases to be active, portions of records relating to the investigation shall remain exempt from the provisions of s. 119.07(1) if disclosure would:

(a) Jeopardize the integrity of another active investigation;

(b) Impair the safety and soundness of an insurer;

(c) Reveal personal financial information;

(d) Reveal the identity of a confidential source;

(e) Defame or cause unwarranted damage to the good name or reputation of an individual or jeopardize the safety of an individual; or

(f) Reveal investigative techniques or procedures.

Further, such papers, documents, reports, or evidence relative to the subject of an investigation under this section shall not be subject to discovery until the investigation is completed or ceases to be active. Department or division investigators shall not be subject to subpoena in civil actions by any court of this state to testify concerning any matter of which they have knowledge pursuant to a pending insurance fraud investigation by the division.

(6) Any person, other than an insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed may send to the Division of Insurance Fraud a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may request. Any professional practitioner licensed or regulated by the Department of Business and Professional Regulation, except as otherwise provided by law, any medical review committee as defined in s. 766.101, any private medical review committee, and any insurer, agent, or other person licensed under the code, or an employee thereof, having knowledge or who believes that a fraudulent insurance act or any other act or practice which,

upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being or has been committed shall send to the Division of Insurance Fraud a report or information pertinent to such knowledge or belief and such additional information relative thereto as the department may require. The Division of Insurance Fraud shall review such information or reports and select such information or reports as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such information or report to be made to determine the extent, if any, to which a fraudulent insurance act or any other act or practice which, upon conviction, constitutes a felony or a misdemeanor under the code, or under s. 817.234, is being committed. The Division of Insurance Fraud shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency and state attorney or other prosecuting agency having jurisdiction with respect to any such violation, as provided in s. 624.310. If prosecution by the state attorney or other prosecuting agency having jurisdiction with respect to such violation is not begun within 60 days of the division's report, the state attorney or other prosecuting agency having jurisdiction with respect to such violation shall inform the division of the reasons for the lack of prosecution.

(7) Division investigators shall have the power to make arrests for criminal violations established as a result of investigations only. The general laws applicable to arrests by law enforcement officers of this state shall also be applicable to such investigators. Such investigators shall have the power to execute arrest warrants and search warrants for the same criminal violations; to serve subpoenas issued

for the examination, investigation, and trial of all offenses determined by their investigations; and to arrest upon probable cause without warrant any person found in the act of violating any of the provisions of applicable laws. Investigators empowered to make arrests under this section shall be empowered to bear arms in the performance of their duties. In such a situation, the investigator must be certified in compliance with the provisions of s. 943.1395 or must meet the temporary employment or appointment exemption requirements of s. 943.131 until certified.

(8) It is unlawful for any person to resist an arrest authorized by this section or in any manner to interfere, either by abetting or assisting such resistance or otherwise interfering, with division investigators in the duties imposed upon them by law or department rule.

Section 2. Section 626.9891, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 626.9891, F.S., for present text.)

626.9891 Insurer anti-fraud plans, reports, and investigative units.--

(1) Each authorized insurer that had $10 million or more in direct premiums written during the previous calendar year shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by insureds or by persons making claims for services or repairs against policies held by insureds; or

(b) Contract with others to investigate possible fraudulent claims for services or repairs against policies held by insureds.

For purposes of this section, the term "unit or division" includes the assignment of fraud investigation to employees whose principal responsibilities are the investigation and disposition of claims. 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)(a) Each authorized insurer writing direct insurance shall adopt an anti-fraud plan, which shall be filed with the department prior to January 1, 1999.

(b) Any insurer that previously filed an anti-fraud plan with the department shall amend the plan to comply with the requirements of subsection (3) and shall file all plan amendments with the department prior to January 1, 1999.

(c) Any insurer that files an application for a certificate of authority with the department prior to January 1, 1999, shall, if the certificate is not issued as of that date, comply with the requirements of this section within 90 days after the issuance of a certificate of authority.

(d) Any insurer that files an application for a certificate of authority with the department on or after January 1, 1999, shall comply with the requirements of this section when the application is filed.

(3) Each insurer's anti-fraud plan shall include:

(a) A description of the unit or division established, or a copy of the contract and related documents required under subsection (1), if applicable.

(b) A description of the insurer's policies and procedures that facilitate the detection and investigation of

possible fraudulent insurance acts, including specific policy provisions and investigative procedures intended to combat complex instances of fraud with respect to each of the following coverages: health, property, casualty, and workers' compensation and employer's liability.

(c) A description of the insurer's procedures for the mandatory reporting of possible fraudulent insurance acts to the department.

(d) A description of the insurer's procedures for auditing workers' compensation insureds to verify covered employees and to ensure proper classification, loss experience reporting, and premium collection practices.

(e) A description of the insurer's anti-fraud education and training program for claims adjusters or other personnel.

(f) A description or chart that includes the organizational arrangement of the insurer's anti-fraud personnel and the education, training, and claims adjusting, law enforcement, or other investigative experience of such personnel responsible for the investigation of possible fraudulent insurance acts.

(4) Each insurer shall file an anti-fraud report with the department prior to March 1, 2000, and annually thereafter, which shall include, for the previous calendar year:

(a) Material changes or amendments to personnel, policies, or procedures in the insurer's anti-fraud plan.

(b) A summary of significant actions taken by the insurer to combat or prosecute cases of insurance fraud and cases of workers' compensation insurance premium fraud.

(c) A statement of the insurer's total number of referrals of suspected fraud made to the division by line of coverage and monetary category, and the increase or decrease in these referrals compared to previous calendar years. The monetary categories shall be:

1. Suspected cases of fraud totaling less than $20,000;

2. Suspected cases of fraud totaling $20,000 or more, but less than $100,000; and

3. Suspected fraud totaling $100,000 or more.

(d) The amount of direct premiums written, by line of coverage, in the previous calendar year and the number of fraud referrals, by line of coverage, made by the insurer to the department during the reporting period.

(5) The department may recommend changes or amendments to an insurer's anti-fraud plan.

(6) Every authorized insurer shall describe, through its anti-fraud plan required in subsection (3) and its anti-fraud report required in subsection (4), the amount of resources allocated to identify and combat fraud.

Section 3. Section 626.9892, Florida Statutes, is created to read:

626.9892 Anti-Fraud Reward Program; reporting of insurance fraud.--

(1) The Anti-Fraud Reward Program is hereby established within the department, to be funded from the Insurance Commissioner's Regulatory Trust Fund.

(2) The department may, at its discretion, pay rewards of up to $25,000 to persons responsible for providing information leading to the arrest and conviction of persons committing complex and organized crimes, investigated by the

Division of Insurance Fraud, arising from violations of the insurance code, s. 440.105, or s. 817.234.

(3) Only a single reward amount may be awarded for each case, regardless of the number of persons arrested and convicted in connection with the case and regardless of how many persons submit claims for the reward.

(4) The department shall establish procedures to implement and administer the Anti-Fraud Reward Program. Applications for rewards authorized by this section must be made pursuant to the procedures established by the department.

(5) The decision of the department whether to make an award under this section, or the decision of the department with respect to the amount of a reward, is not a decision that affects substantial interests for purposes of chapter 120.

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

641.3915 Health maintenance organization anti-fraud plans, reports, and investigative units.--

(1) Each authorized health maintenance organization that had $10 million or more in revenues during the previous calendar year shall:

(a) Establish and maintain a unit or division within the company to investigate possible fraudulent claims by subscribers or by persons making claims for services against policies held by subscribers; or

(b) Contract with others to investigate possible fraudulent claims for services against policies held by subscribers.

For purposes of this section, the term "unit or division" includes the assignment of fraud investigation to employees

whose principal responsibilities are the investigation and disposition of claims. If a health maintenance organization 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 shall be included as an administrative expense for ratemaking purposes.

(2)(a) Each authorized health maintenance organization must adopt an anti-fraud plan and file it with the department before January 1, 1999.

(b) Any health maintenance organization that has filed an application for a certificate of authority with the department prior to January 1, 1999, shall, if the certificate is not issued as of that date, comply with the requirements of this section within 90 days after the issuance of the certificate of authority.

(c) Any health maintenance organization that files an application for a certificate of authority with the department on or after January 1, 1999, shall comply with the requirements of this section when the application is filed.

(3) Each health maintenance organization's anti-fraud plan shall include:

(a) A description of the unit or division established, or a copy of the contract and related documents required under subsection (1), if applicable.

(b) A description of the health maintenance organization's policies and procedures that facilitate the detection and investigation of possible fraudulent insurance acts.

(c) A description of the health maintenance organization's procedures for the mandatory reporting of possible fraudulent insurance acts to the department.

(d) A description of the health maintenance organization's anti-fraud education and training program for claims adjusters or other personnel.

(e) A description or chart that includes the organizational arrangement of the health maintenance organization's anti-fraud personnel and the education, training, and claims adjusting, law enforcement, or other investigative experience of such personnel responsible for the investigation of fraudulent insurance acts.

(4) Each health maintenance organization shall file an anti-fraud report with the department before March 1, 2000, and annually thereafter, which shall include, for the previous calendar year:

(a) Material changes or amendments to personnel, policies, or procedures in the health maintenance organization's anti-fraud plan.

(b) A summary of significant actions taken by the health maintenance organization to combat or prosecute cases of insurance fraud.

(c) A statement of the health maintenance organization's total number of referrals of suspected fraud made to the division by line of coverage and monetary category, and the increase or decrease in these referrals compared to previous calendar years. The monetary categories shall be:

1. Suspected cases of fraud totaling less than $20,000;

2. Suspected cases of fraud totaling $20,000 or more, but less than $100,000; and

3. Suspected fraud totaling $100,000 or more.

(d) The number of fraud referrals made by the health maintenance organization to the department during the reporting period.

(5) The department may recommend changes or amendments to a health maintenance organization's anti-fraud plan.

(6) Every authorized health maintenance organization shall describe, through its anti-fraud plan required in subsection (3) and its anti-fraud report required in subsection (4), the amount of resources allocated to identify and combat fraud.

(7) Failure to comply with the requirements of this section or authorized rules constitutes grounds for sanctions or penalties pursuant to s. 641.25.

Section 5. Subsections (1), (2), (3), (4), (8), (9), and (10) of section 817.234, Florida Statutes, are amended, and subsections (11), (12), and (13) are added to that section, to read:

817.234 False and fraudulent insurance claims.--

(1)(a) Any person who, with the intent to injure, defraud, or deceive any insurer:

1. Presents or causes to be presented any written or oral statement as part of, or in support of, a claim for payment or other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim;

2. Prepares or makes any written or oral statement that is intended to be presented to any insurer in connection

with, or in support of, any claim for payment or other benefit pursuant to an insurance policy, knowing that such statement contains any false, incomplete, or misleading information concerning any fact or thing material to such claim; or

3. Knowingly presents, causes to be presented, or prepares or makes with knowledge or belief that it will be presented to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any employee or agent thereof, any false, incomplete, or misleading information or written or oral statement as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, or who conceals information concerning any fact material to such application,

commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~.

(b) All claims and application forms shall contain a statement that is approved by the Department of Insurance that clearly states in substance the following: "Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree." The changes in this paragraph relating to applications shall take effect on March 1, 1996. This paragraph does not apply to reinsurance contracts, reinsurance agreements, or reinsurance claims transactions.

(2) Any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractor licensed under chapter 460, or other practitioner licensed

under the laws of this state who knowingly and willfully assists, conspires with, or urges any insured party to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging by said physician, osteopathic physician, chiropractor, or practitioner, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud ~~is guilty of a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~. In the event that a physician, osteopathic physician, chiropractor, or practitioner is adjudicated guilty of a violation of this section, the Board of Medicine as set forth in chapter 458, the Board of Osteopathic Medicine as set forth in chapter 459, the Board of Chiropractic as set forth in chapter 460, or other appropriate licensing authority shall hold an administrative hearing to consider the imposition of administrative sanctions as provided by law against said physician, osteopathic physician, chiropractor, or practitioner.

(3) Any attorney who knowingly and willfully assists, conspires with, or urges any claimant to fraudulently violate any of the provisions of this section or part XI of chapter 627, or any person who, due to such assistance, conspiracy, or urging on such attorney's part, knowingly and willfully benefits from the proceeds derived from the use of such fraud, commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~.

(4) Any ~~No~~ person or governmental unit licensed under chapter 395 to maintain or operate a hospital, and any ~~no~~

administrator or employee of any such hospital, who ~~shall~~ knowingly and willfully allows ~~allow~~ the use of the facilities of said hospital by an insured party in a scheme or conspiracy to fraudulently violate any of the provisions of this section or part XI of chapter 627~~. Any hospital administrator or employee who violates this subsection~~ commits insurance fraud ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~. Any adjudication of guilt for a violation of this subsection, or the use of business practices demonstrating a pattern indicating that the spirit of the law set forth in this section or part XI of chapter 627 is not being followed, shall be grounds for suspension or revocation of the license to operate the hospital or the imposition of an administrative penalty of up to $5,000 by the licensing agency, as set forth in chapter 395.

(8) It is unlawful for any person, in his or her individual capacity or in his or her capacity as a public or private employee, or for any firm, corporation, partnership, or association, to solicit any business in or about city receiving hospitals, city and county receiving hospitals, county hospitals, justice courts, or municipal courts; in any public institution; in any public place; upon any public street or highway; in or about private hospitals, sanitariums, or any private institution; or upon private property of any character whatsoever for the purpose of making motor vehicle tort claims or claims for personal injury protection benefits required by s. 627.736. Any person who violates the provisions of this subsection commits insurance solicitation ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~.

(9) It is unlawful for any attorney to solicit any business relating to the representation of persons injured in a motor vehicle accident for the purpose of filing a motor vehicle tort claim or a claim for personal injury protection benefits required by s. 627.736. The solicitation by advertising of any business by an attorney relating to the representation of a person injured in a specific motor vehicle accident is prohibited by this section. Any attorney who violates the provisions of this subsection commits insurance solicitation ~~a felony of the third degree~~, punishable as provided in subsection (11)~~s. 775.082, s. 775.083, or s. 775.084~~. Whenever any circuit or special grievance committee acting under the jurisdiction of the Supreme Court finds probable cause to believe that an attorney is guilty of a violation of this section, such committee shall forward to the appropriate state attorney a copy of the finding of probable cause and the report being filed in the matter. This section shall not be interpreted to prohibit advertising by attorneys which does not entail a solicitation as described in this subsection and which is permitted by the rules regulating The Florida Bar as promulgated by the Florida Supreme Court.

(10) As used in this section, the term "insurer" means any insurer, health maintenance organization,self-insurer, self-insurance fund, or other similar entity or person regulated under chapter 440 or by the Department of Insurance under the Florida Insurance Code, and the term "insurance policy" includes a health maintenance organization subscriber contract.

(11) If the value of any property involved in violation of this section:

(a) Is less than $20,000, the offender commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) Is $20,000 or more, but less than $100,000, the offender commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) Is $100,000 or more, the offender commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(12) As used in this section:

(a) "Property" means property as defined in s. 812.012.

(b) "Value" means value as defined in s. 812.012.

(13) Notwithstanding any other provision of law, a proceeding under this section may be commenced at any time within 5 years after the cause of action accrues; however, in such proceeding, the period of limitation is tolled whenever the defendant is continuously absent from this state or is without a reasonably ascertainable place of residence or work within this state, but not to extend such period of limitation by more than 1 year. If a criminal prosecution, action, or other proceeding is brought, or intervened in, to punish, prevent, or restrain any violation of this section, the running of the period of limitation prescribed by this section, which is based in whole or in part upon any matter complained of in any such prosecution, action, or proceeding, shall be tolled during the pendency of the prosecution, action, or proceeding and for 2 years following the termination of such prosecution, action, or proceeding.

Section 6. The sum of $250,000 is hereby appropriated from the Insurance Commissioner's Regulatory Trust Fund in a

nonoperating category to implement the purpose and provisions of funding the anti-fraud reward program established by this act.

Section 7. This act shall take effect upon becoming a law.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bill 1640

Removes provisions allowing the Department of Insurance to impose sanctions against insurers and Health Maintenance Organizations (HMOs) for not allocating "sufficient resources to identify and eliminate fraud."

Deletes the provision relating to Judges of Compensation Claims and administrative law judges. Removes the revisions to criminal penalties imposed for workers' compensation insurance fraud and statute of limitations provisions and deletes the provision expanding the jurisdiction of the Division of Insurance Fraud to include violations of workers' compensation insurance laws.

For purposes of immunity from civil liability, the term "designated employees of insurers" would be expanded to include employees of the entity with whom an insurer contracts to investigate insurance fraud.

Expands the jurisdiction of the Division of Insurance Fraud to include all criminal violations of HMO fraud. Provides that criminal prohibitions against false and fraudulent insurance claims and applications would include HMOs.