

ENGROSSED HOUSE
BILL NO. 1495

By: Cox and Widener of the
House

and

Hendrick of the Senate

An Act relating to insurance; creating the Anti-Fraud Division; providing for hiring of employees; stating exclusion; defining terms; declaring certain acts to be unlawful and to constitute insurance fraud; clarifying conditions under which person is deemed to have made claim, defense, statement or representation and to have known that such was false; defining term; requiring certain information be provided to third party payor; allowing third party payor to request independent medical examination for certain purposes; requiring all claims and answers to claims include certain statement and declaring persons signing statement and knowing such to be false, guilty of perjury; providing penalties; repealing 21 O.S. 1991, Section 1662, which relates to insurance fraud; providing for codification; providing an effective date; and declaring an emergency.

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1231.1 of Title 36, unless there is created a duplication in numbering, reads as follows:

There is hereby created within the Insurance Department and under the control and direction of the Insurance Commissioner, a division designated as the "Anti-Fraud Division". The Commissioner may hire such additional employees as authorized by the Legislature as needed in the administration and enforcement of this act. This act shall not apply to workers' compensation insurance or benefits.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1231.2 of Title 36, unless there is created a duplication in numbering, reads as follows:

There is hereby created the "Insurance Department Anti-Fraud Revolving Fund". This fund shall consist of all monies, other than appropriated monies, received by the Insurance Department from fees collected from insurers transacting the business of insurance in Oklahoma. Each such insurer shall, on or before July 1 of each year, pay to the Insurance Department a fee based on premiums collected by said insurer during the preceding calendar year, as follows:

<u>Premiums</u>	<u>Fee</u>
up to \$1,000,000.00	\$50.00
5,000,000.00	250.00
10,000,000.00	500.00
20,000,000.00	1,000.00
50,000,000.00	2,500.00
100,000,000.00	5,000.00

The fund shall be a continuing fund not subject to fiscal year limitations and shall be subject to the administrative direction of the Insurance Department. Expenditures from the fund shall be made upon warrants issued by the Oklahoma State Treasurer against claims made to the Director of State Finance. Monies in said fund may be

expended for salaries and operating expenses of the Insurance Department and shall be made pursuant to the laws of this state.

SECTION 3. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1231.3 of Title 36, unless there is created a duplication in numbering, reads as follows:

As used in this act:

1. "Agent" means a person authorized by another person to act for that person;

2. "Bribe" means any money, goods, right in action, property, thing of value or advantage, present or prospective, or any promise or understanding, asked, given or accepted, with a corrupt intent to influence unlawfully the person to whom it is given, in action taken by that person;

3. "Claimant" means any individual claiming entitlement to benefits under an insurance contract or a benefit plan, or any firm, corporation, professional association, partnership, limited liability company, organization or other legal entity which is entitled to make a related claim for reimbursements for goods, items or services rendered to the claimant;

4. "Kickback" means the giving of money or any other thing of value either directly or indirectly by or on behalf of any person, or the agent of any person, for furnishing goods or services of any kind to any purchaser of the goods or services, or the agent of any purchaser; and

5. "Records" means, but is not limited to, all medical, professional or business records or documents relating to the treatment or care of any recipient or potential recipient of benefits, all documents provided in support of a claim, and all records necessary to allow an insurer or other benefit provider or self-insured to determine the appropriate settlement; provided, however, that any privilege granted pursuant to Article V of the

Oklahoma Evidence Code, Section 2502 of Title 12 of the Oklahoma Statutes, shall be held inviolate.

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1231.4 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. The Insurance Commissioner and designated employees of the Insurance Commissioner shall determine the extent, if any, to which any violation has occurred of any statute or administrative rule of this state pertaining to insurance fraud and may initiate any necessary investigation, civil action, criminal action, referral to a district attorney or referral to any appropriate official of this or any other state or federal government. The Insurance Commissioner and the Insurance Department, the Attorney General and the Office of the Attorney General, every district attorney and every law enforcement agency shall cooperate and coordinate efforts for the investigation and prosecution of suspected insurance fraud.

B. It shall be unlawful and constitute insurance fraud for any person to willfully and knowingly:

1. Make or cause to be made a claim or defense knowing the claim or defense to be false, in whole or in part, by commission or omission;

2. Misrepresent or fail to disclose a material fact to an insurance carrier or agent or other benefit provider or self-insured which may deny payment, cause an insurer or other benefit provider or self-insured to cease payment or alter the amount of payment of benefits;

3. Make or cause to be made a statement or representation for use by another in obtaining a good or a service knowing the statement or representation to be false, in whole or in part, by commission or omission;

4. Misrepresent any fact or fail to disclose a material fact in order to obtain payment from another insurance or benefit provider;

5. Solicit, offer, deliver, receive or accept any benefit, including pecuniary benefit, kickback or bribe in connection with goods, services or benefits paid or claimed to be payable;

6. Misrepresent or fail to disclose a material fact to any individual who is a claimant or such claimant's attorney, which may tend to increase such claimant's or his attorney's entitlement to payment or have an effect which will benefit the claimant or his attorney on a claim or alter or increase the amount of payment of benefits;

7. Make or cause to be made a statement or representation for use by another in terminating, delaying or limiting goods or services pursuant to the claim for benefits, knowing the statement or representation to be false, in whole or in part, by commission or omission;

8. Misrepresent any fact or fail to disclose a material fact in order to avoid or delay payment to any claimant or his attorney;

9. Solicit, offer, deliver, receive or accept any benefit, including pecuniary benefit, kickback or bribe in connection with defending or attempting to avoid, delay or limit the delivery of goods or the rendering of services or the payment of benefits;

10. Misrepresent or fail to disclose to any claimant or the claimant's attorney that there has been any change of fact which would affect adversely or positively the payment or receipt of any benefits;

11. Act as an insurance agent in the solicitation, sale or issuance of a policy of insurance without being duly licensed as such by the Insurance Department or specifically exempted therefrom by law; or

12. Act as an insurer in the solicitation, sale or issuance of a policy of insurance in the State of Oklahoma without being duly licensed as such by the Insurance Department, or specifically exempted therefrom by law.

C. For the purposes of this section, a person shall be deemed to have made or caused to be made a claim, statement or representation if the person:

1. Had the authority or responsibility to make the claim, statement or representation; and

2. Exercised such authority or responsibility or failed to exercise such authority or responsibility and as a direct or indirect result, the false claim, statement or representation was made.

D. For the purposes of this section, a person shall be deemed to have known that a claim, statement or representation was false if the person knew, or by virtue of position, authority or responsibility had reason to know, of the falsity of the claim, statement or representation.

E. For the purposes of this section, "material fact" means:

1. A fact which, if communicated to the insurer or other benefit provider or self-insured, may induce the insurer, other benefit provider, or self-insured either to decline, alter or cease or proceed to cease payment of benefits;

2. A fact which, if communicated to any claimant or attorney for a claimant, might induce the claimant or attorney to seek, claim or attempt to obtain payment or receipt of benefits; or

3. A fact which has a tendency to make the validity of the claim of a claimant or attorney of the claimant or of anyone providing medical treatment to such claimant more likely than it would have been without the fact.

F. 1. Upon request of any third party payor from which payment is requested, any health care provider, claimant or claimant's agent shall provide the payor with a copy of the diagnosis, prognosis and plan of treatment for the patient.

2. Upon request, but not more than once every thirty (30) days after treatment has begun, any health care provider, claimant or

claimant's agent shall provide the third party payor with records and progress of the patient for whom the third party payor may be liable. At the expense of the third party payor, the payor may require an independent medical examination to determine the necessity for continued treatment.

3. Nothing in this section shall restrict a third party payor from requesting an independent medical examination to determine the necessity of treatment or to determine when treatment can reasonably be expected to be concluded.

SECTION 5. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1231.5 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. All claims filed for benefits shall contain an affidavit that all matters stated therein are true and accurate, and shall be signed by the claimant and the agent of the claimant, if any. Any person who signs this affidavit or causes another to sign said affidavit knowing the statement to be false shall be guilty of perjury. An individual who signs on behalf of a claimant may be presumed to have the authorization of the claimant and to be acting at the direction of the claimant.

B. All answers and defenses to claims or to documents filed on behalf of a respondent or the respondent's insurer shall contain an affidavit that all matters stated therein are true and accurate, and shall be signed by the respondent, the insurer or their respective agents, if any. Any person who signs such an affidavit or causes another to sign such affidavit, knowing the statement to be false, shall be guilty of perjury. An individual who signs on behalf of a respondent, its insurer, or its agent may be presumed to have the authorization of the respondent, its insurer and agent and to be acting at their direction.

SECTION 6. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1231.6 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. Any person committing insurance fraud where the aggregate amount of payments illegally claimed or received is Two Thousand Five Hundred Dollars (\$2,500.00) or more, upon conviction, shall be guilty of a felony punishable by the imposition of a fine of not more than three times the amount of payments illegally claimed or received or Ten Thousand Dollars (\$10,000.00), whichever is greater, or by imprisonment in the State Penitentiary for not more than ten (10) years, or by both such fine and imprisonment.

B. Any person committing insurance fraud where the aggregate amount of payments illegally claimed or received is less than Two Thousand Five Hundred Dollars (\$2,500.00), upon conviction, shall be guilty of a misdemeanor punishable by the imposition of a fine of not more than three times the amount of payments illegally claimed or received or Two Thousand Dollars (\$2,000.00), whichever is greater, or by imprisonment in the county jail for not more than one (1) year, or by both such fine and imprisonment.

C. Any person committing insurance fraud in any other manner not related to the aggregate amount of payments illegally claimed or received, upon conviction, shall be guilty of a felony punishable by a fine of not more than Three Thousand Dollars (\$3,000.00) or by imprisonment in the State Penitentiary for not more than three (3) years, or by both such fine and imprisonment.

D. Any person who reports insurance fraud as set out in Section 4 of this bill is immune from civil liability for doing so, unless the person making the report knows it to be false, and the person or entity alleged to have committed the fraud shall not retaliate against a person who reports insurance fraud for providing such report, unless the person making the report knows it to be false.

SECTION 7. REPEALER 21 O.S. 1991, Section 1662, is hereby repealed.

SECTION 8. This act shall become effective July 1, 1995.

SECTION 9. It being immediately necessary for the preservation of the public peace, health and safety, an emergency is hereby declared to exist, by reason whereof this act shall take effect and be in full force from and after its passage and approval.

Passed the House of Representatives the 6th day of March, 1995.

Speaker of the House of
Representatives

Passed the Senate the ____ day of _____, 1995.

President of the Senate