

House of Representatives, April 8, 1998. The Committee on Judiciary reported through REP. LAWLOR, 99th DIST., Chairman of the Committee on the part of the House, that the substitute bill ought to pass.

AN ACT CONCERNING HEALTH CARE FRAUD.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

1 Section 1. Section 53-440 of the general
2 statutes is repealed and the following is
3 substituted in lieu thereof:

4 Sections 53-440 to [53-443] 53-445,
5 inclusive, AS AMENDED BY THIS ACT, AND SECTIONS 7
6 TO 9, INCLUSIVE, OF THIS ACT, shall be known and
7 may be cited as the "Health [Insurance] CARE Fraud
8 Act".

9 Sec. 2. Section 53-441 of the general
10 statutes is repealed and the following is
11 substituted in lieu thereof:

12 As used in sections 53-440 to [53-443]
13 53-445, inclusive, AS AMENDED BY THIS ACT, AND
14 SECTIONS 7 TO 9, INCLUSIVE, OF THIS ACT:

15 [(a)] (1) "Statement" includes but is not
16 limited to any notice, statement, PROOF OF LOSS,
17 BILL OF LADING, RECEIPT FOR PAYMENT, invoice,
18 account, bill for services, explanation of
19 services, medical opinion, test result, DIAGNOSIS,
20 PRESCRIPTION, RECORD OF A HOSPITAL OR PROVIDER OF
21 HEALTH CARE SERVICES, X-RAY, computer generated
22 document, electronic transmission or other
23 evidence of loss, injury or expense;

24 [(b)] (2) "Person" means any individual,
25 corporation, limited liability company,
26 partnership, association or any other legal
27 entity, INCLUDING BUT NOT LIMITED TO ANY PUBLIC
28 AGENCY;

29 [(c)] (3) "Insurer" means (A) any insurance
30 company, health care center, corporation, Lloyd's
31 insurer, fraternal benefit society or any other
32 legal entity authorized to provide health care
33 benefits in this state, including, BUT NOT LIMITED
34 TO, benefits provided under health insurance,
35 disability insurance, workers' compensation and
36 automobile insurance; or (B) ANY PRIVATE
37 INDIVIDUAL, ENTITY OR STATE AGENCY WHICH PAYS
38 DIRECTLY OR INDIRECTLY FOR HEALTH CARE SERVICES,
39 INCLUDING BUT NOT LIMITED TO any person [,
40 partnership, association or legal entity] which is
41 self-insured and provides health care benefits to
42 ITSELF OR its employees, or [governmental entity]
43 ANY STATE AGENCY, INCLUDING THE DEPARTMENT OF
44 SOCIAL SERVICES, which provides [medical benefits
45 to Medicare or Medicaid recipients] PAYMENT FOR
46 HEALTH CARE SERVICES;

47 (4) "HEALTH CARE SERVICES" MEANS ANY MEDICAL
48 BENEFIT, ITEM OR SERVICE, INCLUDING BUT NOT
49 LIMITED TO, ANY MEDICAL SERVICES, MEDICAL GOODS
50 AND MEDICAL TRANSPORTATION SERVICES;

51 (5) "KICKBACK" MEANS ANY TRANSACTION
52 PROHIBITED BY SECTIONS 53a-161c AND 53a-161d OR 42
53 USC SECTION 1320a-7b(b).

54 Sec. 3. Section 53-442 of the general
55 statutes is repealed and the following is
56 substituted in lieu thereof:

57 (a) A person [is guilty of] COMMITS health
58 [insurance] CARE fraud when he, KNOWINGLY AND with
59 the intent to defraud or deceive any insurer: [,]

60 (1) [presents] PRESENTS or causes to be
61 presented to any insurer or any agent thereof any
62 written or oral statement as part of or in support
63 of [an] THE FOLLOWING: (A) AN application for any
64 policy of insurance RELATING TO PAYMENT FOR HEALTH
65 CARE SERVICES; (B) AN APPLICATION TO BECOME A
66 PROVIDER OR PREFERRED PROVIDER IN ANY PLAN
67 ESTABLISHED BY AN INSURER; (C) A COST REPORT
68 REQUIRED TO BE PROVIDED TO AN INSURER IN ORDER TO
69 ESTABLISH RATES OF PAYMENTS; or (D) claim for
70 payment or other benefit from [a plan providing
71 health care benefits] AN INSURER, whether for

120 penalties for THE APPROPRIATE larceny under
121 [sections] SECTION 53a-122 [to 53a-125b,
122 inclusive] OR 53a-123. Each act shall be
123 considered a separate offense. In addition to any
124 fine or term of imprisonment imposed, including
125 any order of probation, any such person shall make
126 restitution to an aggrieved insurer, including
127 reasonable attorneys' fees and investigation
128 costs. THE PENALTIES PROVIDED UNDER THIS SECTION
129 ARE NOT EXCLUSIVE AND SHALL NOT PRECLUDE ANY OTHER
130 CRIMINAL OR CIVIL PENALTIES.

131 Sec. 5. Section 53-444 of the general
132 statutes is repealed and the following is
133 substituted in lieu thereof:

134 Any PERSON, INCLUDING AN insurer, as defined
135 in [subsection (c)] SUBDIVISION (3) of section
136 53-441, AS AMENDED BY SECTION 2 OF THIS ACT,
137 [that] WHO is aggrieved as a result of an act of
138 [insurance] HEALTH CARE fraud, OR ANY PERSON FROM
139 WHOM PAYMENT FOR HEALTH CARE SERVICES IS SOLICITED
140 OR DEMANDED EVEN IF SUCH PERSON IS NOT LEGALLY
141 RESPONSIBLE FOR MAKING SUCH PAYMENT, may institute
142 [an] A CIVIL action against the perpetrator of
143 such fraud to recover all damages resulting from
144 the fraud.

145 Sec. 6. Section 53-445 of the general
146 statutes is repealed and the following is
147 substituted in lieu thereof:

148 (a) Any person, including an insurer, as
149 defined in [subsection (c)] SUBDIVISION (3) of
150 section 53-441, AS AMENDED BY SECTION 2 OF THIS
151 ACT, who has knowledge of or has reason to believe
152 that health [insurance] CARE fraud, as defined in
153 section 53-442, AS AMENDED BY SECTION 3 OF THIS
154 ACT, has occurred, shall provide any [additional]
155 information and documentation in his or its
156 possession relative to the suspected fraud as the
157 Insurance Commissioner may require.

158 (b) ANY PERSON, INCLUDING AN INSURER, AS
159 DEFINED IN SUBDIVISION (3) OF SECTION 53-441, AS
160 AMENDED BY SECTION 2 OF THIS ACT, WHO IS AGGRIEVED
161 AS A RESULT OF AN ACT OF HEALTH CARE FRAUD MAY
162 FILE A COMPLAINT WITH THE INSURANCE COMMISSIONER
163 REQUESTING THAT THE INSURANCE COMMISSIONER CONDUCT
164 AN INVESTIGATION AND MAKE SUCH REFERRAL OR
165 REFERRALS AS HE DEEMS APPROPRIATE, IN ACCORDANCE
166 WITH SUBSECTION (c) OF THIS SECTION. ANY STATE
167 AGENCY THAT IS AN INSURER, AS DEFINED IN

168 SUBDIVISION (3) OF SECTION 53-441, AS AMENDED BY
169 SECTION 2 OF THIS ACT, THAT IS AGGRIEVED AS A
170 RESULT OF AN ACT OF HEALTH CARE FRAUD, MAY REQUEST
171 THAT THE ATTORNEY GENERAL INSTITUTE A CIVIL ACTION
172 ON SUCH STATE AGENCY'S BEHALF WITHOUT FIRST MAKING
173 A REFERRAL TO THE INSURANCE COMMISSIONER.

174 [(b)] (c) The [commissioner] INSURANCE
175 COMMISSIONER shall review and investigate any
176 COMPLAINT, reports of, or information received [by
177 any person regarding insurance] REGARDING HEALTH
178 CARE fraud [; he] AND shall conduct an independent
179 investigation of the suspected [insurance fraud;
180 and when he] HEALTH CARE FRAUD. THE INSURANCE
181 COMMISSIONER SHALL HAVE SUCH AUTHORITY TO CONDUCT
182 INVESTIGATIONS AS SET FORTH IN SECTION 38a-16. IF
183 THE INSURANCE COMMISSIONER reasonably believes,
184 AFTER CONDUCTING SUCH INVESTIGATION, that [a
185 violation] HEALTH CARE FRAUD has occurred, he
186 shall refer such investigation to the [appropriate
187 state agency] OFFICE OF THE CHIEF STATE'S ATTORNEY
188 for criminal prosecution, THE ATTORNEY GENERAL FOR
189 civil enforcement or THE APPROPRIATE STATE AGENCY
190 FOR disciplinary action. [During the
191 commissioner's investigation and prior to the
192 referral of such investigation, the investigation
193 and record thereof shall be confidential.] ANY
194 ACTION REFERRED TO THE ATTORNEY GENERAL FOR CIVIL
195 ENFORCEMENT SHALL BE PURSUED IN ACCORDANCE WITH
196 SECTION 7 OF THIS ACT.

197 [(c)] (d) Any person, including an insurer,
198 as defined in [subsection (c)] SUBDIVISION (3) of
199 section 53-441, AS AMENDED BY SECTION 2 OF THIS
200 ACT, or a not-for-profit organization established
201 to detect and prevent insurance fraud or his or
202 its agents or employees may disclose otherwise
203 personal or privileged information as defined in
204 section 38a-976, orally or in writing to another
205 person concerning any alleged, suspected or
206 anticipated [insurance] HEALTH CARE fraud as
207 defined in section 53-442, AS AMENDED BY SECTION 3
208 OF THIS ACT, when such disclosure is limited to
209 that which is reasonably necessary to detect,
210 investigate, PROSECUTE CIVILLY OR CRIMINALLY, or
211 prevent criminal activity, HEALTH CARE fraud,
212 material misrepresentation or material
213 nondisclosure. SUCH PERSONAL OR PRIVILEGED
214 INFORMATION SHALL NOT BE DISCLOSED FURTHER EXCEPT
215 AS PROVIDED IN THIS SUBSECTION.

216 [(d)] (e) No person, INCLUDING AN INSURER, AS
217 DEFINED IN SUBDIVISION (3) OF SECTION 53-441, AS
218 AMENDED BY SECTION 2 OF THIS ACT, shall be subject
219 to liability for libel, slander or any other civil
220 liability in connection with the filing of reports
221 or documents WITH ANY STATE OR FEDERAL LAW
222 ENFORCEMENT AGENCY, INCLUDING BUT NOT LIMITED TO
223 THE INSURANCE COMMISSIONER, THE CHIEF STATE'S
224 ATTORNEY AND THE ATTORNEY GENERAL, OR WITH ANY
225 OTHER INSURER, AS DEFINED IN SUBDIVISION (3) OF
226 SECTION 53-441, AS AMENDED BY SECTION 2 OF THIS
227 ACT, or furnishing orally or in writing
228 information concerning any suspected, anticipated
229 or alleged [insurance] HEALTH CARE fraud TO ANY
230 SUCH LAW ENFORCEMENT AGENCY OR INSURER, AS DEFINED
231 IN SUBDIVISION (3) OF SECTION 53-441, AS AMENDED
232 BY SECTION 2 OF THIS ACT, when the reports,
233 documents or information are provided or received
234 in accordance with the provisions of [subsection
235 (a) or (c) of this section] SECTIONS 53-440 TO
236 53-445, INCLUSIVE, AS AMENDED BY THIS ACT, AND
237 SECTIONS 7 TO 9, INCLUSIVE, OF THIS ACT or in
238 accordance with an order issued by a court of
239 competent jurisdiction to provide testimony or
240 evidence, unless such person disclosed false
241 information with malice or wilful intent to injure
242 any person.

243 (f) FOR THE PURPOSES OF SECTIONS 53-440 TO
244 53-445, INCLUSIVE, AS AMENDED BY THIS ACT, AND
245 SECTIONS 7 TO 9, INCLUSIVE, OF THIS ACT, "LAW
246 ENFORCEMENT AGENCY", AS THAT TERM IS USED IN
247 SUBDIVISION (3) OF SUBSECTION (b) OF SECTION 1-19,
248 INCLUDES THE INSURANCE COMMISSIONER, THE ATTORNEY
249 GENERAL, AND ANY STATE AGENCY THAT IS AN INSURER,
250 AS DEFINED IN SUBDIVISION (3) OF SECTION 53-441,
251 AS AMENDED BY SECTION 2 OF THIS ACT.

252 Sec. 7. (NEW) (a) Upon receipt of a referral
253 from the Insurance Commissioner in accordance with
254 subsection (c) of section 53-445 of the general
255 statutes, as amended by section 6 of this act, or
256 a request from a state agency requesting the
257 Attorney General to institute a civil action on
258 the state agency's behalf in accordance with
259 section 53-445 of the general statutes, as amended
260 by section 6 of this act, the Attorney General may
261 conduct any further investigation necessary to
262 determine whether commencement of a civil action
263 is appropriate. The Attorney General shall have

264 such authority to conduct investigations as is set
265 forth in section 35-42 of the general statutes.

266 (b) If the Attorney General determines that
267 institution of a civil action is appropriate, he
268 may commence a civil action as (1) *parens patriae*
269 for insurers, as defined in subdivision (3) of
270 section 53-441 of the general statutes, as amended
271 by section 2 of this act, residing or doing
272 business in the state with respect to damages
273 sustained by such insurers; or (2) *parens patriae*
274 with respect to damages to the general economy of
275 the state or any political subdivision thereof.
276 Such action may be commenced in the superior court
277 for the judicial district of Hartford, or in the
278 superior court for the judicial district in which
279 the defendant resides or has his principal place
280 of business.

281 (c) In any action brought by the Attorney
282 General under this section, the court may award
283 one or more of the following: (1) Actual damages;
284 (2) treble damages; (3) civil penalty not to
285 exceed five thousand dollars for each violation;
286 (4) injunctive relief, both temporary or
287 permanent, against threatened loss or damage to
288 the property of any insurer, as defined in
289 subdivision (3) of section 53-441 of the general
290 statutes, as amended by section 2 of this act, by
291 any violation of chapter 949e of the general
292 statutes; or (5) reasonable attorney's fees and
293 costs.

294 (d) The cause of action and remedies provided
295 under this section are not exclusive and shall not
296 preclude the use of any other civil or criminal
297 causes of action or remedies.

298 (e) Upon notice to any state agency by the
299 Attorney General that any sums are due from any
300 person to be paid pursuant to a judgment issued by
301 a court of competent jurisdiction under this
302 section or order of restitution pursuant to
303 section 53-443 of the general statutes, as amended
304 by section 4 of this act, the state agency shall
305 withhold any order for payment of any amount
306 payable by the state to such person unless the
307 amount so payable is reduced by the amount of such
308 judgment or order of restitution, provided any
309 such amount payable by the state shall not be so
310 reduced if: (1) Such amount payable is a payment
311 of salary or wages, or any payment in lieu of or

312 in addition to such salary or wages, to a state
313 employee; or (2) an appeal from such judgment or
314 order of restitution is pending, or the time for
315 taking such an appeal has not yet expired.

316 Sec. 8. (NEW) A finding by a court of
317 competent jurisdiction that a person who is
318 licensed to provide health care services by the
319 state, or a person who is enrolled as a provider
320 in a medical assistance program, has committed
321 health care fraud shall be grounds for one or more
322 of the following: (1) Disciplinary action against
323 such person's license; or (2) suspension or
324 termination of such person's medical assistance
325 program provider agreement. As used in this
326 section, "medical assistance program" means any
327 program administered or funded by any state agency
328 for the purpose of providing health care services.

329 Sec. 9. (NEW) No action with respect to any
330 claim arising from health care fraud shall be
331 commenced but within four years from the date when
332 the health care fraud is discovered or in the
333 exercise of reasonable care should have been
334 discovered.

335 JUD COMMITTEE VOTE: YEA 38 NAY 1 JFS

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"THE FOLLOWING FISCAL IMPACT STATEMENT AND BILL ANALYSIS ARE PREPARED FOR THE BENEFIT OF MEMBERS OF THE GENERAL ASSEMBLY, SOLELY FOR PURPOSES OF INFORMATION, SUMMARIZATION AND EXPLANATION AND DO NOT REPRESENT THE INTENT OF THE GENERAL ASSEMBLY OR EITHER HOUSE THEREOF FOR ANY PURPOSE."

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FISCAL IMPACT STATEMENT - BILL NUMBER SHB 5546

STATE IMPACT Indeterminate Savings (General Fund), Workload Increase (Insurance Fund), see explanation below

MUNICIPAL IMPACT None

STATE AGENCY(S) Department of Social Services, Department of Insurance, Office of the Attorney General

EXPLANATION OF ESTIMATES:

STATE IMPACT: The bill redefines health care fraud to include a person who:

- 1) commits health care fraud when he or she knowingly provides an application to an insurer or health care provider when he knows or should have known that the information provided is false;
- 2) Offers, accepts, demands or solicits payments for health care services beyond which is allowed by law or required;
- 3) Obstructs or misleads the communication of information; or
- 4) Assists, abets, solicits or conspires with another to do any of the acts or omissions set forth in sections 1 and 2 of the bill.

The bill allows any person, including an insurer, aggrieved as a result of health care fraud to institute a civil action.

An individual may also file a complaint with the insurance commissioner requesting that he conduct an investigation and make referrals as he deems appropriate. After he conducts an investigation, the insurance commissioner can refer an investigation to the Chief State's Attorney for criminal prosecution, the Attorney General for civil enforcement or the appropriate state agency for disciplinary action.

The budget bill (sHB 5021) transfers \$90,000 from the Department of Social Services to the Department of Insurance for the investigation of health care fraud complaints. With these funds, it is expected that the department can handle this investigative responsibility.

The Department of Social Services (DSS) currently spends approximately \$2 billion a year on health related services through the Medicaid and Husky programs. To the extent that this bill has the effect of reducing health care fraud, indeterminate savings to DSS could result through reduced costs in these programs.

While the bill strengthens the Attorney General's authority to investigate and commence civil action against health care fraud, it is not anticipated to have any fiscal impact on the agency's budget.

It is anticipated that any impact to criminal justice agencies and to the Judicial Department can be absorbed within the budgeting resources of these agencies.

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OLR BILL ANALYSIS

sHB 5546

AN ACT CONCERNING HEALTH CARE FRAUD

SUMMARY: This bill renames the Health Insurance Fraud Act the Health Care Fraud Act and broadens existing health fraud laws by expanding the definitions of insurer and person, extending coverage to transactions involving health care services rather than health insurance benefits, and specifying additional methods by which fraud may be committed.

Under current law, health insurance fraud is limited to false, misleading or deceptive statements or omissions made in connection with applications for health insurance policies and claims for benefits. The bill creates four new categories of health care fraud: (1) making fraudulent statements in an application to become a health care service provider or preferred provider in any insurer's plan; (2) making fraudulent statements in the Medicare or Medicaid cost reports that are used to establish reimbursement rates for entities such as hospitals, nursing homes, and home health agencies; (3) offering, accepting, demanding, or soliciting kickbacks or other unlawful payments; and (4) obstructing, misleading, or delaying the communication of information or records in furtherance of an act of health care fraud. It also extends to these claims the existing prohibitions against any person aiding, abetting, soliciting or conspiring to commit health care fraud.

The bill specifies that any act of health care fraud is felony larceny, punishable by imprisonment for up to 20 years, a fine of up to \$10,000, or both and continues the present requirement that those convicted make restitution to the injured insurer, including reasonable attorneys' fees and investigation costs. It also allows claims of health care fraud to be pursued under other civil and criminal theories in addition to those enumerated in the bill.

The bill creates an administrative complaint procedure and increases the authority of the insurance commissioner to investigate such complaints. It establishes that a court judgment of health care fraud is grounds for disciplining state licensed health care service providers and for suspending or terminating a service provider's contract in any medical assistance program administered or funded by the state.

It also authorizes the attorney general to investigate complaints referred by the insurance commission or brought to him directly by a state agency insurer. He may file suit on behalf of all injured insurers, including the state, or because of injuries to the state economy. The bill enhances the remedies that may be awarded in such actions including (1) actual damages, (2) treble damages, (3) a civil penalty of up to \$5,000 per violation, (4) temporary and permanent

injunctive relief, and (5) reasonable attorney's fees and costs. The bill also extends existing confidentiality protections and civil immunity for witnesses under some circumstances.

EFFECTIVE DATE: October 1, 1998

FURTHER EXPLANATION

Intent Requirement Modified

The bill requires that a fraudulent statement be presented to the insurer knowingly and with the intent to defraud, rather than merely with the intent to defraud. But it extends liability to statements about a material fact that a person should know or have known, rather than actually know, were false, deceptive, or misleading. The bill eliminates liability for making incomplete statements.

Expansion of Existing Anti-Fraud Definitions

This bill expands the definition of insurer to include private individuals, entities, and state agencies such as the Department of Social Services that pay directly or indirectly for health care services. It broadly defines health care services as any medical benefit, item, or service, including but not limited to any medical services, medical goods, and medical transportation services. Current law covers only government entities that provide health care benefits or medical benefits to Medicare or Medicaid recipients, legal entities authorized to provide health care benefits in this state, and self-insured employee benefit plans.

The bill also adds public agencies to the definition of "person," which currently includes individuals, associations, and various business entities.

Additional Documents

The bill also specifies the following categories of falsified documents that, if intentionally submitted to an insurer, may give rise to liability for health care fraud: proofs of loss, bills of lading, receipts for payment, diagnoses, prescriptions, records of a hospital or provider of health care services and

x-rays. The law currently includes, but is not limited to, statements, invoices, accounts, bills for services, explanations of services, medical opinions, test results, computer generated documents, electronic transmissions and other evidence of loss, injury, or expense.

Misrepresentations

The law currently prohibits, but is not limited to false representations that goods or services were medically necessary in accordance with professionally accepted standards. The bill also prohibits falsely representing that goods or services were medically necessary as defined in a health care services contract or health insurance contract with a state agency.

Kickbacks and Other Fraudulent Payments

The bill incorporates the existing statutory definitions of "receiving" and "paying kickbacks," which are limited to transactions involving government contracts. It also reaches influence-peddling in the private sector, by prohibiting the offering, accepting, demanding, or soliciting of payments from any source that exceed that to which a person is legally entitled. In all instances, liability attaches whether or not a payment is actually made.

The bill provides exceptions to the anti-kickback provisions for certain types of financial arrangements among health care service providers, insurers, and other entities that have been approved under federal Medicare regulations, such as equipment and space rentals and manufacturer warranties.

Criminal Penalties

The bill specifies that health care fraud is larceny in either the first or the second degree. It eliminates specific reference to lesser penalties for fraudulent conduct involving non-governmental services valued at less than \$5,000. But it specifies that its penalties are not exclusive and do not preclude any other criminal or civil claims.

Insurance Commission Investigations

The bill allows anyone, including an insurer, who has been injured by an act of health care fraud to file a complaint with the insurance commissioner. It requires him to conduct an investigation and permits him to administer oaths, issue subpoenas for document production or witness testimony, hold hearings, and obtain court orders to compel compliance with his orders. Currently there is no formal complaint procedure, but the commissioner must investigate reports or information that he receives about health care fraud.

As under existing law, the bill requires him to refer cases when he reasonably believes, after investigation, that fraud has been committed. It specifies that such referrals must be made to one or more of the following:

(1) the chief state's attorney for criminal prosecution, (2) the attorney general for civil enforcement, or (3) the appropriate state agency for disciplinary action on a provider's license or for suspension or termination of a medical assistance provider's contract.

The bill allows state agencies such as the Department of Social Services that pay for health care services to bypass the insurance commissioner's complaint procedure and request the attorney general to file a civil lawsuit on their behalf.

Attorney General Investigations and Civil Actions

The bill authorizes the attorney general to further investigate cases referred to him by the insurance department and cases brought directly to him by state agencies in order to determine whether civil litigation is appropriate. It allows him to subpoena documents and witness testimony, to issue written interrogatories, and to get court orders to compel compliance. The court may issue sanctions of up to \$500 for non-compliance. There are currently no specific provisions for the attorney general to conduct fraud investigations before initiating litigation.

The bill authorizes the attorney general to file suit on behalf of Connecticut insurers or insurers doing business in the state or on behalf of the state or local economy. It authorizes the court to award actual damages, treble damages, a civil penalty up to \$5,000

per offense, temporary and permanent injunctions, and reasonable attorney's fees and costs.

The bill authorizes the attorney general to require that state funds owed to a person against whom a money judgment or order of restitution has been entered be first applied to satisfy the judgment or order. This action cannot be taken while an appeal is pending or before the time limit for filing an appeal has run. The bill also exempts wages owed to state employees or payments in lieu of or in addition to such wages from being encumbered by the attorney general.

Private Lawsuits

The bill also allows any injured person, rather than insurers only, to bring a civil action to recover actual damages. It also authorizes individuals from whom payment for health care services was fraudulently sought, but who were not legally responsible for making such payments, to sue.

Confidentiality and Civil Immunity

The bill extends to civil and criminal prosecutions existing privacy law exceptions that permit insurers, non-profit fraud investigation agencies, and other persons to disclose personal and privileged information that is reasonably necessary to detect and prevent health care fraud. But it prohibits further disclosure and makes confidential the investigatory records of the insurance commissioner, the attorney general, the chief state's attorney, and any state agency that pays for health care services.

The bill also extends existing civil immunity to individuals, including insurers, who file reports, provide documents, or make statements to the insurance commissioner, the chief state's attorney, the attorney general, or other insurers during a health care fraud investigation or prosecution. Under the bill as under current law, a person cannot be sued for libel or slander if he makes false statements about health care fraud without malice or an intent to injure.

Statute of Limitations

The bill requires that all actions be brought within

four years of the date on which the fraud was discovered or reasonably should have been discovered. Current law does not specify a statute of limitations.

COMMITTEE ACTION

Judiciary Committee

Joint Favorable Substitute
Yea 38 Nay 1