**RÉSUMÉ DIGEST**

**ACT 614 (HB 399)** **2024 Regular Session** **Henry**

Existing law requires each risk-bearing entity to annually disclose to the commissioner of insurance (commissioner) the accurate information of the name, address, phone number, and electronic mail address of the contact person responsible for each of the following:

(1) Receipt of and response to consumer complaints.

(2) Receipt of rules, regulations, and directives from the commissioner.

(3) Receipt and filing of inquiries into the financial state of the entity.

(4) Receipt and filing of tax payments.

(5) Any other duty or function the commissioner deems necessary.

New law changes "function" to "information" and makes other technical changes.

New law requires every person licensed by the commissioner to annually disclose to the commissioner the accurate information of the name, mailing address, phone number, and electronic mail address of the contact person responsible for each of the following:

(1) Receipt of and response to consumer complaints.

(2) Receipt of rules, regulations, and directives from the commissioner.

(3) Any other information the commissioner deems necessary.

Existing law requires a risk-bearing entity to notify the commissioner within 30 days of any change in information required for submission in existing law.

New law extends the notification requirement to persons licensed by the commissioner.

Existing law requires authorized insurers and health maintenance organizations (HMOs) licensed in the state of La. to prepare, implement, and maintain an insurance anti-fraud plan for operations.

Existing law requires an insurer or HMO to annually file its insurance anti-fraud plan and any summary report with the commissioner on or before April 1st. Authorizes the commissioner to periodically require each entity to file any material change to a summary report of the anti-fraud plan, including the total number of claims and the number of claims referred to the commissioner as suspicious.

New law requires insurers and HMOs to submit the following additional information:

(1) The number of policies in effect.

(2) The amount of premiums written for policies.

(3) The number of claims received.

(4) The number of claims referred for investigation to the insurer's fraud investigators.

(5) The number of claims investigated or accepted by the insurer's fraud investigators.

(6) The number of insurance fraud matters investigated or accepted by the insurer's fraud investigators that were not claim related.

(7) The number of cases referred to the La. Dept. of Insurance.

(8) The estimated dollar amount of losses attributable to fraudulent insurance acts, organized by type of fraud, including claimant, employer, provider, agent, and other types.

(9) The estimated dollar amount of recoveries attributable to fraudulent insurance acts, organized by type of fraud, including claimant, employer, provider, agent, and other types.

(10) The dollar amount of claims denied or not paid based on fraud investigation organized by product line.

(11) Quantification of the resources committed to investigating insurance fraud, organized by line of business, for the prior year.

Effective August 1, 2024.

(Amends R.S. 22:41.2 and 572.1(F))