§ 409. Fraud prevention plans and special investigations units. (a) Every insurer writing private or commercial automobile insurance, workers' compensation insurance, or individual, group or blanket accident and health insurance policies issued or issued for delivery in this state, except for insurers that write less than three thousand of such policies, issued or issued for delivery in this state annually, and every entity licensed pursuant to article forty-four of the public health law except those entities with an enrolled population of less than sixty thousand persons in the aggregate and, except those entities licensed pursuant to sections forty-four hundred three-a, forty-four hundred three-c, forty-four hundred-d, forty-four hundred three-f and forty-four hundred eight-a of the public health law shall, within one hundred twenty days of the effective date of this amended section to be promulgated by the superintendent to implement this section, file with the superintendent a plan for the detection, investigation and prevention of fraudulent insurance activities in this state and those fraudulent insurance activities affecting policies issued or issued for delivery in this state. The superintendent may accept programs and processes implemented pursuant to section forty-four hundred fourteen of the public health law as satisfying the obligations of this section and regulations promulgated thereunder.

(b) (1) The plan shall provide the time and manner in which such plan shall be implemented, including provisions for a full-time special investigations unit and staffing levels within such unit. Such unit shall be separate from the underwriting or claims functions of an insurer, and shall be responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities pursuant to the plan filed with the superintendent. An insurer shall include in such plan staffing levels and allocations of resources in such full-time special investigations unit as may be necessary and appropriate for the proper implementation of the plan and approval of such plan pursuant to subsection (d) of this section.

(2) In lieu of a special investigations unit, an insurer may contract with a provider of services related to the investigation of information on or cases of suspected fraudulent activities; provided, however, that an insurer which opts for contracting with a separate provider of

services, shall provide to the superintendent a detailed plan therefor, pursuant to requirements set forth in regulation by the superintendent.

(3) Persons employed by special investigations units as investigators or by an independent provider of investigative services under contract with an insurer shall be qualified by education or experience which shall include an associate's or bachelor's degree in criminal justice or related field, or five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies, or seven years of professional investigation experience involving economic or insurance related matters. For the purposes of evaluation of medical related claims insurers may employ or retain duly licensed or authorized medical professionals. Notwithstanding these minimum requirements anyone employed as an investigator in a special investigation unit or by a provider of investigative services under contract to an insurer as of the effective date of this paragraph and who was also so employed on or before September tenth, nineteen hundred ninety-six may continue in such employment provided the insurer identifies such person in writing to the superintendent giving the date such employment began and a description of the person's qualifications, employment history and current job duties.

(c) The plan shall provide for the following:

(1) interface of special investigation unit personnel with law enforcement and prosecutorial agencies and with the financial frauds and consumer protection unit of the department of financial services;

(2) reporting of fraud data to a central organization approved by the superintendent;

(3) in-service education and training for underwriting and claims personnel in identifying and evaluating instances of suspected fraudulent activity in underwriting or claims activities;

(4) coordination with other units of an insurer for the investigation and initiation of civil actions based upon information received by or through the special investigation unit;

(5) public awareness of the cost and frequency of fraudulent activities, and the methods of preventing fraud;

(6) development and use of a fraud detection and procedures manual to assist in the detection and elimination of fraudulent activity; and

(7) the time and manner in which such plan shall be implemented and a

demonstration that the fraud prevention and reduction measures outlined in the plan will be fully implemented.

(d) (1) A fraud detection and prevention plan filed by an insurer with the superintendent pursuant to this section shall be deemed approved by the superintendent if not returned by the superintendent for revision within one hundred twenty days of the date of filing. If the superintendent returns a plan for revision, the superintendent shall state the points of objection with such plan, and any amendments as the superintendent may require consistent with the provisions of this section, including, but not limited to, staffing levels, resource allocation, or other policy or operational considerations. An amended plan reflecting the changes shall be filed with the superintendent within forty-five days from the date of return.

(2) If the superintendent has returned a plan for revision more than one time, the insurer shall be entitled to a hearing pursuant to the provisions of article three of this chapter and regulations promulgated thereunder.

(3) If an insurer fails to submit a final plan within thirty days after a determination of the superintendent after the hearing held pursuant to paragraph two of this subsection, or otherwise fails to submit a plan, or fails to implement the provisions of a plan in a time and manner provided for in such plan, or otherwise refuses to comply with the provisions of this section, the superintendent may: (i) impose a fine of not more than two thousand dollars per day for such failure by an insurer until the superintendent deems the insurer to be in compliance; or (ii) impose upon the insurer a fraud detection and prevention plan deemed to be appropriate by the superintendent which shall be implemented by the insurer; or (iii) impose the provisions of both subparagraphs (i) and (ii) of this paragraph.

(e) Any plan, the information contained therein, or correspondence related thereto, or any other information furnished pursuant to this section shall be deemed to be a confidential communication and shall not be open for review or be subject to a subpoena except by a court order or by request from any law enforcement agency or authority.

(f) For purposes of this section, the term "policies" shall refer to individuals covered if coverage is issued on a group basis.

(g) Every insurer required to file a fraud prevention plan shall

report to the superintendent on an annual basis, no later than March fifteenth, describing the insurer's experience, performance and cost effectiveness in implementing the plan, utilizing such forms as the superintendent may prescribe. Upon consideration of such reports, the superintendent may require amendments to the insurer's fraud prevention plan as deemed necessary.