CLM CLAIMS & LITIGATION MANAGEMENT ALLIANCE™

ADVANCING ETHICS, COOPERATION AND EDUCATION

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Walking the Line: When Fraud Investigation Crosses Over to Bad Faith: How Aggressive is Too Aggressive?

I. Striking A Balance in Fraud Investigations

Keeping Perspective

Insurance Fraud is a costly and prevalent problem for the insurance industry. For those who commit insurance fraud, it is a low-risk, high yield proposition. There is little chance of getting criminally prosecuted and the financial returns are significant. It is much more appealing crime than drug smuggling or auto-theft. Surprisingly, most consumers view insurance fraud as a "victimless crime" and at last count, a whopping 25% of consumers believes that insurance fraud is not a "crime." Of course, this is not true. Most states have laws against insurance fraud, and states at the forefront of the fraud fight, such as Florida and New York, have active Insurance Fraud Bureaus and prosecutors dedicated and trained to enforce these laws.

As insurance professionals we are all aware that insurance fraud causes hundreds of billions of dollars in annual costs and that policyholders eventually subsidize this fraud through increased premiums. There is no question that fraud must be identified and aggressively fought. Yet, each claim must be viewed on its individual facts and determinations must be made to fight fraud intelligently and effectively.

Indeed, insurance companies have a duty to act in "good faith" and to fairly, adequately and timely investigate and pay out on covered losses. This duty arises not only from the common law but from state regulatory and statutory schemes. Thus, there is a delicate balancing act that occurs whenever insurance fraud is suspected in a particular claim and insurance professionals must maintain the correct perspective: fraud must be aggressively fought but the policy holder must receive the benefit of any doubt when claims decisions are being made.

Maintaining Objectivity

If it smells, walks and quacks like a duck, it's likely a duck. Yet, as every claims professional tasked with identifying questionable claims and fighting fraud knows, whether one can prove it's a duck is a whole other question. Sometimes in our quest to prove our case, our objectivity can be challenged. Training of SIU professionals, claims adjusters and underwriting personnel is critical. Fraud investigations must be properly documented and every determination that fraud is at play should withstand evidentiary scrutiny in a court of

law. During examinations under oath and/or sworn statements, questioning should not "suggest" answers. When at all possible independent medical examinations should be conducted to maintain objectivity. Likewise, know when to get other professionals involved in the investigation. At all times, investigations must be thorough and unbiased.

Maintaining Professionalism

As documented in the case summaries discussed below, it is not only easy to lose perspective and objectivity when one is "fighting the good fight" but it is also frighteningly easy to engage in cringe worthy behaviors and conversations. When we get caught up in the "us" vs. "them" mentality necessary to prosecute fraud, we must remember that everything we say and do may one day go before a jury in a court of law. In a bad faith lawsuit attorney client privileges and work product privileges are often waived or no longer applicable. It is thus, imperative that everyone involved in a fraud investigation maintain the utmost professionalism. Individuals should not be identified as "thieves" "crooks" "hoodlums" or the like. People should not be reported as "lying" or "fabricating evidence." Keep to the facts and report inconsistencies. In other words note the weaknesses in acquired testimony but don't ascribe intent to people's actions. Don't say or do anything you wouldn't be able to speak to your 12 year old about without blushing.

II. What Is At Stake When We Cross the Line

Extra-Contractual Exposure

A fraud investigation could easily turn into a bad faith claim. Let's consider some of the typical allegations raised in a bad faith case that could arise from a fraud investigation. Often, in bad faith scenarios insurance companies are accused, for example, of a whole host of "bad acts" which may include: 1) deliberate misinterpretation of records or policy language to avoid coverage; 2) unreasonable delays in making a claims decision; 3) arbitrary or unreasonable demands for proof of loss; 4) abusive investigative tactics; 5) failing to maintain adequate investigative procedures; 6) denying a claim in whole or in part without a "reasonable basis;" 7) targeting of certain individuals based on stereotypes; or 8) targeting of the "usual suspects."

The very need for a fraud investigation is ordinarily based on the identification of "red flags" that make a claim "suspect." Courts have recognized that "[i]nsurers have a right and a duty to other policyholders to contest illegitimate claims…[and] payment of illegitimate claims raises the cost of insurance for all policyholders." *Time Ins. Co., Inc. v. Burger,* 712 So.2 389, 393 (Fla. 1998). Thus, while insurers are obligated to investigate such matters, care must be given to ensure the investigation is kept on track. Investigations should be timely, decisions should be un-biased, well-reasoned and documented. Indeed, in a subsequent bad faith case, and insurer's conduct and motivation are on trial. There must always be a sufficient basis when a policyholder or provider is accused of fraud. If no coverage exists for the claim under the policy, the investigation should stop. Remember, the actual claims decision is not as important as the methodology and basis used to reach that decision. As long as the company can be said to be acting in "good faith" it is allowed to thoroughly conduct its investigation.

Exposure to Libel/Defamation/Tortious Interference Claims

What you say can and will be held against you. Words are powerful and labels should be avoided. When conducting any fraud investigation it is imperative to stick to the facts and allow others to reach conclusions. If there is sufficient probable cause that a crime has been committed, there is no need to identify individuals as "criminals" or "low lifes" or any other libelous terms. While most states offer limited immunity for information that is shared with the State Division's of Insurance Fraud and/or law enforcement, it is critical that such information is strictly factual in nature and supported by evidence. The immunities generally offered are for "good faith" actions free of "malice." Furthermore, make sure that you provide "all the facts" and that no exculpatory evidence is withheld. Finally, it should never appear that claims professionals are pushing law enforcement into accepting or prosecuting a case. This could be misconstrued as extortion in order to avoid paying a particular claim. Provide your best case and fully cooperate with state and or federal officials. Going any further than that, however, may expose one to claims of bias and of skewing reality to fit a particular agenda.

Exposure to Claims of Violations for Unfair Trade Practices

Most states have statutory schemes that describe what constitutes an "unfair insurance trade practice." Not only may an overzealous investigation cross the line of these statutory and regulatory dictates, but, it could expose a company or individual to lawsuits or administrative proceedings based on violations of these statutes. Furthermore, alleged violations of these statutes could form the basis of licensing investigations, disciplinary proceedings or market conduct reviews on the part of state regulators.

III. Case Study Summaries

State Farm Fire & Casualty Company v. Radcliff
987 N.E.2d 121 (Ind. Ct. App. 2013)

- Hail Storm in Central Indiana on April 14, 2006
- State Farm denied roof claims (other insurers in area covered)
- State Farm was subjected to a Market Conduct Examination and a class action lawsuit during this time
- Radcliff offered help to State Farm insureds and started aggressive marketing campaign against State Farm
- State Farm launched a fraud investigation into Radcliff
- Had "proof" that some roof damages were due to "manufactured damage"
- Testimony of former employees
- Engineering Reports
- At State Farm's direction, Radcliff was arrested on 14 felony charges but charges were later dropped
- State Farm sued Radcliff for fraud and racketeering
- Radcliff counter-claimed for defamation
- Jury returned $14.5 M verdict for Radcliff

What went wrong?

- Evidence of Internal State Farm emails re: a "more aggressive" strategy to deal with the bad press created in part by Radcliff

At the time, *not a single report finding vandalism existed*

- Evidence State Farm wanted a "positive story" that exposed questionable practices of certain contractors (Radcliff)
- Asked engineers to "clarify" reports to reflect vandalism
- Told insureds to file vandalism claims and file police reports against Radcliff in order to obtain a new roof
- Reports from engineers hired by insureds/Radcliff finding hail damage and no vandalism were not provided to the NICB
- Some roofs had documented hail damage before Radcliff was ever involved
- State Farm pushed for a criminal indictment
- Cartoon of Radcliff being "raped" in jail

b. Encompass Insurance Company of Massachusetts v. Giampa,
522 F.Supp.2d 300 (U.S. D.C. Mass 2007)

- Encompass sued chiropractors for fraud
- Also issued a press-release entitled "Boston Area Chiropractors named in Million-Dollar Fraud Case"
- Chiropractors counter-claimed for defamation
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What Went Wrong?

The Press Release Implied that They Were Criminals:

Owners and employees of First Spine and Rehab, a Lowell Massachusetts chiropractic clinic, have been named as defendants in a $1.8 million fraud lawsuit—the result of a six-month investigation led by Encompass Insurance Company of Massachusetts. According to court documents, Joseph Giampa, Frederick Giampa and Edward Kennedy are accused of violating the Racketeer Influenced and Corrupt Organizations Act (RICO), the Massachusetts Consumer Protection Act and engaging in common law fraud and civil conspiracy. Encompass filed suit in the U.S. District Court for the District of Massachusetts against the Giampas, Kennedy, as well as Brian Culliney, Jennifer McConnell, the company First Spine and Rehab of Lowell and Future Management Corporation. According to the suit, the Giampas and other chiropractors in the Lowell clinic allegedly "engaged in a scheme to defraud insurance companies, including Encompass Insurance by submitting false, fraudulent and inflated chiropractic invoices containing excessive charges" and "demanding payment for excessive and/or non-existent and/or unwarranted chiropractic treatment through their chiropractic clinic." Court documents say the Giampas are chiropractors who operate First Spine and Rehab in Lowell as well as more than 60 other clinics throughout New England and across the United States, including Florida, Oklahoma, Connecticut, Rhode Island, South Carolina, New Hampshire, Pennsylvania, Illinois and Virginia. ***Since 2001, Allstate companies have received more than $55 million in court judgments. Moran states, "these***

judgments against criminals range from individuals to sophisticated organized crime syndicates." In addition to financial victories, Allstate and Encompass SIU work closely with local, state, and federal authorities for criminal investigation and prosecution—resulting in arrests around the country, ***taking criminals off the street.*** Insurance industry estimates put the overall yearly price tag for fraud at more than $80 billion dollars.
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c. De Leon v. Great American
78 So.3d 585 (Fla. 3d DCA 2011)

- Insured's truck was stolen, when recovered, missing 9 tires
- There was never a legitimate coverage defense
- Great American took an EUO of the insured and focused on an un-related criminal conviction and the insured's living situation
- The insured refused to answer these questions and filed suit to obtain payment of insurance benefits
- Great American paid the claim, but the trial court declined to award attorney's fees, holding that the insured failed to submit to an EUO, and therefore, was not forced to litigate
- Appellate court reversed, finding insured was not required to submit to intrusive and irrelevant questioning
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What went wrong?

The insured was subjected to an Examination Under Oath that was Aborted. The Second EUO, after the insured obtained an attorney lasted 7 hours. Irrelevant lines of questions were pursued and little was asked about the claim itself:

Q: Okay. You mentioned Barbara and the fact that she resided with you in Kentucky. Did anybody else live with you while you were in Kentucky either in Manchester or Lexington?
A: Yes. There were more than 2,000 people in the prison. I lived in a facility.
Q: What's the name of the facility?
A: Federal Correction. Lexington Federal Correction or something like that.
Q: You were serving time for a Federal offense?
A: Correct.
Q: Were you convicted of a crime?
A: Correct.
Q: What crime?
A: Fraud. Cellular phone fraud. Conspiracy for a cellular phone thing, nothing to do, nothing that I did. You see what I'm telling you? What does that have to do with what has to be done. Absolutely nothing.

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Q: Sir, I can't tell you what to do or not do. I'm just here—it's my job to ask you these questions.
A: I know. I know. Correct. But concentrate on what it is, not on what is not. I have the right to keep quiet and not respond to anything. That's what I have. I have the right. I want to

concentrate on what you're going to ask. If not, I have my papers here. You have a copy of my papers, all my receipts, the bills, everything. If you don't want—if you're not going to talk to me about-about what it is, see you next time.
Q: Okay. Sir, I can't tell you what to do but you're more than free to withdraw your claim. In fact, it's your choice.
A: No, I'm not going to withdraw my claim, no. Please. I'm going to look for an attorney and I want to have the attorney talk to you.

I**V. Take Aways**

- Document your files thoroughly and fairly
- Claim files should evidence good faith and fair dealing with insureds and claimants.

Activity logs, correspondence, documentary evidence such as police reports, medicals, peer reviews, indicated that the adjuster is doing their job properly.

- IF IT IS NOT IN WRITING, IT PROBABLY DID NOT HAPPEN
- If a mistake is made, ACKNOWLEDGE IT.
- Ensure that investigations are timely and that any delay due to the insured or claimant is well-documented
- Keep your opinions to your self