No-Fault Insurance Fraud in New York State is Ramping Up Premiums

Fraud is driving up the cost of auto insurance for New York State drivers, particularly those who live in New York City?s five boroughs and its neighboring suburbs. As a result, some people are paying four times more for no-fault auto insurance than the state average and seven times more than drivers in Albany, which has fewer cases of fraud.

Investigations by insurers and law enforcement agencies show that a small number of dishonest and unscrupulous medical service providers are filing inflated and often bogus medical claims with the state?s auto insurers. They are aided and abetted by equally unscrupulous lawyers who sue insurers that dare to challenge these fraudulent claims and by street level criminals who work on their behalf. In 2009 policyholders paid the equivalent of a $229 million tax on their auto insurance policies due to these unethical and often fraudulent activities.

Sadly and ironically, it is the New York State auto insurance system itself that is contributing to the problem. If the system?s flaws and weaknesses are not addressed with meaningful reform, the cost of inaction in 2010 alone will approach a quarter of a billion dollars.

New York?s Auto Insurance System

New York?s auto insurance system is the fourth largest in the nation, with some nine million cars insured. More than 300 auto insurance companies compete vigorously for the state?s $10 billion in auto insurance premiums.

No-Fault: New York adopted its no-fault system in 1974, at a time when auto insurance costs were rising rapidly and auto insurance disputes were clogging the courts, causing long delays in the payment of compensation to accident victims. The concept behind no-fault was simple. Taking disputes over small claims out of the courts and transferring the payment of compensation to the policyholder?s own insurance company, regardless of who was at fault in the accident, results in a system that is more cost effective and that fairly and promptly compensates auto accident victims for their injuries.

New York is one of 12 states and Puerto Rico that has what insurers refer to as a ?true? no-fault system, one that provides for the payment of injury claims by the victim?s own insurance company but, to offset more generous benefits, imposes restrictions on filing a lawsuit for noneconomic damages, such as emotional suffering. (Economic damages are for tangible and computable losses ? medical care costs and funeral expenses, for example.) All true no-fault states have thresholds that dictate at what point a policyholder may go to court to claim for noneconomic damages.

Thresholds and Personal Injury Protection (PIP): Some states, like New York, have a verbal threshold for filing a lawsuit for pain and suffering that describes the severity of the accident, such as serious

disfigurement or death. Others have a monetary threshold based on a certain dollar amount of medical bills. Policyholders in no-fault states are entitled to a certain dollar amount of medical and other benefits ? $50,000 in New York ? under the no-fault coverage part of a policy known as personal injury protection or PIP. When medical bills exceed this figure, victims may take their case to court to recover medical care costs and other economic damages in excess of that amount as well as noneconomic damages.

The Cost of Inaction

Fifty thousand dollars offers medical care providers intent on defrauding the system a significant sum to work with. In the last few years, a very small subset of the medical community, working with a small group of attorneys specializing in the collection of unpaid medical bills, has found a way to manipulate the system to their advantage. They inundate insurers with so much paperwork for so many medical treatments and procedures that it is impossible for claims investigators scrutinize each claim to determine its validity before the deadline for payment. If claims are denied, they sue the insurer for insubstantial errors made in the rush to meet deadline requirements.

Consider the price consumers are paying for these fraudulent activities:

- Based on the amount fraud costs add to each claim, no-fault fraud and abuse in New York State cost consumers and insurers about $229 million in 2009, according to Insurance Information Institute estimates.
- The cumulative cost of no-fault fraud and abuse in New York State since 2005, when claim costs started to rise again after a lull following an earlier crisis, is at least $617 million.
- If nothing is done to contain runaway no-fault auto insurance costs, the price tag will rise to an estimated $241 million in 2010, for a total of $858 million since 2005. In the absence of meaningful reforms, cumulative costs will exceed $1 billion by early 2011.
- Fraud and abuse push up the total cost of claims. When these extra costs are averaged out over all the claims filed in 2009, the additional cost comes to approximately $1,561, or 22 percent of each claim. When claim costs rise due to fraud, policyholders are forced to pay for it through higher premiums.
- This so-called no-fault fraud tax ? the extra cost fraud is adding to the system ? will rise to an estimated $1,644 per claim, or 22.4 percent of the cost, in 2010 if no reforms are enacted.
- By the third quarter of 2009, the average cost of a no-fault auto insurance claim in New York State had soared to $8,690, up $3,075, or 55 percent, from $5,615 at the end of 2004.
- No-fault claim costs, as of the third quarter 2009, were close to hitting a record. The average claim peaked at $9,235 in the first quarter of 2002, due to the earlier crisis when an influx of organized criminals began to prey on the no-fault pot of gold.
- New York?s average claim cost, at $8,690, is the third highest in the United States. Only Michigan and New Jersey, have higher costs.
- The average cost of a no-fault claim in New York State is now 64 percent higher than the U.S. median of $5,289.
- Medical care costs in the United States rose 21.1 percent between 2004 and 2009, according to the Consumer Price Index, but the average no-fault (PIP) claim, which mainly reimburses for medical care costs, rose an amazing 47.7 percent during that same period.
- No-fault fraud is a lucrative business, earning unethical medical providers and their accomplices an average of nearly $628,000 per day in 2009.

No-Fault Fraud is Rampant

At a New York Senate hearing on no-fault fraud held in Albany in February 2010, a New York insurance department official testified that 85 percent of the rate changes being filed with the department were for increases in no-fault (PIP) rates, the coverage that provides medical care benefits to a policyholder filing a claim for auto accident injuries. The requested increases were averaging 6.5 percent. The official said this

situation is likely to continue, based on the dramatic increase in referrals to the department?s fraud bureau.

Rise in suspected claims: No-fault cases reported to the bureau rose by an alarming 22 percent from 2006 to 2008. Suspected no-fault claims totaled 13,433 in 2009, an increase of almost 9 percent from 2008, and accounted for 54 percent of all fraud reports received during 2009, according to the New York Insurance Department?s fraud bureau. More than 100 cases against perpetrators were opened. Interestingly, reflecting the nature of the cases, no-fault fraud has been transferred from the fraud bureau?s auto unit to its medical unit.

Insurers can also report questionable claims to the National Insurance Crime Bureau (NICB), which acts as a bridge between the insurance industry and law enforcement agencies. Statistics from the NICB show that fraud is still a major problem, despite changes in Regulation 68, which implements the no-fault law, and arrests each year by law enforcement authorities. The changes to Regulation 68, which went into effect in 2002, were intended to make fraud more difficult to perpetrate.

Analysis of claims: In an analysis of suspected claims submitted in 2009 up to the end of November 2009, the NICB found 4,776 out of the 6,351, or 75 percent, were for personal auto claims. Further analysis revealed that among the top 10 reasons for referral to the bureau were faked/exaggerated injury; staged/caused accident; lack of cooperation from the insured; excessive treatment; billings for services not rendered; and faked damage. Faked/exaggerated injury reports were mentioned in 1,235 submissions to the NICB, or 26 percent of questionable no-fault claims. Moreover, 44 percent of all reasons for referring New York personal auto insurance claims in 2009 fell into a medical investigation category.

NICB investigators have found that patterns of no-fault fraud fall into four categories: staged accidents, where a vehicle is used to perpetrate fraud; illegal corporate structures, where lay persons rather than licensed medical practitioners are opening and operating medical clinics ,or ?medical mills?; scripted, regimented treatment and medical procedures that are ordered for all patients, irrespective of their individual injuries or the severity of those injuries; and egregious, purposeful misuse of durable medical equipment, where unscrupulous providers sell these devices at highly inflated prices and often without regard to a patient?s specific needs.

Staged accidents: Staged accidents are aimed at creating an accident scenario from which costly and fraudulently contrived medical claims can be created to obtain payments from auto insurers.

Typically, owners and managers of medical mills pay ?runners,? or recruiters, to arrange minor auto accidents and send individuals supposedly injured in the accidents to the clinics for treatment. The runners recruit drivers to cause the accident and passengers to ride in the cars. Being a runner is a lucrative business, with each ?referral? earning the runner a large fee paid by the attorney associated with the medical mill or the clinic itself. Usually, two to four passengers are recruited to maximize the profit per accident. Insurers have also reported that the same vehicle is sometimes used in several staged accidents. When the alleged accidents are investigated, frequently none of the cars involved can be found, and none of the ?injured? parties will talk.

Although staged accidents are intended to cause no real injuries to the defendant driver or passengers, the accidents are reported to police so that a record can be created to support the fraudulent insurance claims. Some claimants, despite the absence of any apparent injuries, insist on being transported to a hospital by ambulance in order to establish the legitimacy of their claims for medical treatment. Runners then direct them to clinics for bogus medical treatment, often driving the ?passengers? there themselves. The clinics then submit claims under the insurance policy of the runner or another ring member who had insured the car.

Medical bills often reach $10,000 to $20,000 per passenger and can go as high as $50,000 per passenger under the New York no-fault law. A single staged accident with multiple claimants generally results in billings for hundreds or even thousands of treatments.

How Should the System Be Changed?

The no-fault system is in need of fundamental reform. In response to the last fraud crisis in 2002, the timeframe for the submission of claims was shortened to reduce the opportunity to fabricate massive numbers of medical care claims. That change brought about a brief respite, reducing claim costs for a couple of years. But medical mills soon learned how to game the system under the new rules and are once again burdening New York State drivers with inflated claim costs.

The New York no-fault law and Regulation 68 contain many provisions designed to protect insurance consumers and claimants and improve the system. Ironically, some of these provisions are enabling those who commit fraud greater opportunities for enrichment. So that consumers are not forced to transfer a substantial portion of their hard-earned wages to criminals, lawmakers and regulators must review all aspects of the law that facilitate abuse.

The 30-day rule: For example, to protect claimants from unwarranted delay in the payment of claims, the New York no-fault law requires that insurers pay claims for PIP benefits, or deny these benefits, within 30 days of the receipt of the claim and that they pay interest to the claimant on the benefit amount if they fail to meet those requirements.

In 1997 a New York Court of Appeals ruling in Presbyterian Hospital v. Maryland Casualty Company added another penalty: an insurer is precluded from denying a claim or asserting any defense of its nonpayment if it has violated the 30-day rule. The Presbyterian decision opened the door for unscrupulous individuals to take advantage of this strict 30-day timeframe. Just the sheer volume of bills submitted makes it difficult to check and evaluate each claim for possible fraud within that time period. In an effort to stay within the law?s confines, claims may be paid for excessive amounts or for services that were billed but never actually provided.

One proposal would modify the Presbyterian decision by making payment of interest the only penalty when an insurer fails to issue a timely payment or denial within the 30-day period. Denial of a claim or defense of nonpayment for cause, such as lack of coverage or fraud, would not be precluded from consideration. In some cases, a timely denial is issued but is invalidated by non-substantive errors. If this change were implemented, the penalty for failure to pay or deny claims within the 30-day period would be retained, but insurers would have the opportunity to defend against payment of claims that were not medically necessary or were fraudulent.

Assignment of benefits: An assignment of benefits is common in all types of medical claims. Patients/claimants regularly sign documents authorizing their medical care provider to submit charges to an insurer for payment; provide information to support the claim; and receive benefits directly from the insurer on the patient?s behalf. The authorization does not give the medical care provider the right to sue the insurer directly for nonpayment ? that right remains with the patient/claimant ? but the provider does have the right to seek payment from the patient or from the proceeds of any successful lawsuit against the insurer.

However, the assignment process in no-fault claims differs substantially from the one commonly used for typical visits to the doctor?s office. Consumers may not be aware that it assigns ?all rights and privileges and

remedies? to the provider to pursue benefits under the no-fault law, meaning that the medical care provider ?assignee? has the right to contest everything from policy coverage and duties to comply with policy conditions to claimants? attendance at independent medical examinations or examinations under oath. The result is a huge amount of litigation instigated by providers/assignees with little or no involvement from the injured party.

One solution to the assignment of benefits problem would require amendments to the statute so that the right to contest denial of claims involving insurance policy issues belongs to the claimant only.

Burden of proof: A third proposal concerns the burden of proof required for a plaintiff to prevail in a no-fault case. Normally, in a civil action it is the plaintiff who must prove the basic elements of his or her case in order to prevail. Over the years no-fault case law has shifted that burden of proof to the insurer so that medical providers as assignees need only to provide a bill to establish their claim for benefits. The burden is on the insurer to request information to ?verify? that the services billed for were medically necessary and in accordance with the no-fault law.

Frequently, a lengthy exchange of paperwork ensues, with a myriad of requirements for second requests and follow-ups, providing more opportunities to generate the kind of non-substantial technical errors that have little bearing on the merits of the claim presented but that serve as a basis to deny any defense to it.

The problem of the burden of proof could be addressed by amending the statute to require the assignee to present admissible evidence that the services billed for were medically necessary and provided by a properly licensed practitioner. Furthermore, the statute should require that claims for no-fault benefits have been properly assigned to the provider and that they are billed for according to the applicable fee schedule and all applicable regulations.

Other proposed solutions:

- Require claimants and providers to provide additional information to help ensure that treatments being claimed for are medically necessary and require providers to sign treatment forms rather than use a signature stamp for billings.
- Raise the burden of proof to receive no-fault benefits by requiring the plaintiff to produce a witness with personal knowledge of the facts alleged in the complaint.
- Strengthen the penalty for acting as a runner to a felony. The crime is currently a misdemeanor. Runners are now using different scams from in the past that are easier for them and more difficult to detect, such as recruiting patients in hospitals with injuries not caused by an auto accident and employing them to submit fraudulent claims.
- Simplify the procedures required for insurers to suspend payment of claims to a medical clinic while an investigation of the clinic?s licensing status is underway.
- Decertify no-fault medical care providers that have engaged in fraudulent activities, make the information publicly available and authorize civil penalties of up to $50,000.
- Require disputes to be resolved by arbitration to speed up the resolution of claims and avoid the costs and uncertainty of a trial. There should be special arbiters for no-fault dispute resolution since the proceedings are often highly technical. The proceedings could be streamlined to allow the parties to submit their evidence on paper, saving time and money for both providers and insurers. Although the no-fault system was created to reduce the number of cases going to trial, court dockets in New York are currently clogged with auto insurance cases. In New York City, trial dates in some jurisdictions are already being set for well into 2011.
- Permit those with claims for less than $5,000 to submit proof based on a doctor?s sworn affidavit. Under the current system, doctors must appear in court in person.
- Allow insurers to bundle bills for the same claim or from the same provider and process these as a single claim.

- Require clinics to be owned and staffed by healthcare professionals and available for inspection.
- Create treatment guidelines similar to those that have been developed for workers compensation insurance in New York and other states.
- Create a no-fault plan with several levels of PIP coverage, based on policyholders? needs. Some consumers may prefer a lower level of PIP benefits in return for a lower premium.
- Create a policy with non-emergency medical care sublimits. For example, keep total PIP benefits at $50,000 but limit routine medical care treatments to $5,000.

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