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Firm Submissions
On Handling Fraud Claims

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ALABAMA

Alabama Law on Fraudulent Claims
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I. Fraudulent Claims Involving Insurance

Alabama is one of the few states in the nation that has not passed an insurance-fraud bill in their penal code. Attempts were made in 2003 by the Alabama Legislature to pass HB271/SB137, but they were unsuccessful. The Alabama statutes that do address fraud perpetrated by the insured will seem rather soft compared to other states. For example Ala. Code § 27-14-7 which prohibits misrepresentations by an insured in the application for a policy states:

(a) All statements and descriptions in any application for an insurance policy or annuity contract, or in negotiations therefor, by, or in behalf of, the insured or annuitant shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy or contract unless either:
(1) Fraudulent;
(2) Material either to the acceptance of the risk or to the hazard assumed by the insurer; or
(3) The insurer in good faith would either not have issued the policy or contract, or would not have issued a policy or contract at the premium rate as applied for, or would not have issued a policy or contract in as large an amount or would not have provided coverage with respect to the hazard resulting in the loss if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

(b) No plea of misrepresentation or fraud in connection with the issuance of a life insurance policy or annuity contract shall be filed unless accompanied by a payment into court of all premiums paid on the policy or contract.

Another example is § 27-14-28 which deals with the effect of misrepresentations in a proof of loss:
No misrepresentation in any proof of loss under any insurance policy shall defeat or void the policy unless such misrepresentation is made with actual intent to deceive as to a matter material to the insured's rights under the policy.

An insurer would have to prove actual intent to deceive on behalf of the insured in order to avoid coverage. This section should be read as a clear statutory expression of the public policy of this state that, where an insured materially misrepresents to an insurer the proof of his loss with an intent to deceive, the insurer need not honor, and pay pursuant to, the contract of insurance. The statute, as worded, cannot be construed as a mere limitation on the enforceability of fraud and false swearing provisions that may appear in contracts of insurance. Ex parte State Farm Fire and Cas. Co., 523 So.2d 119 (Ala.1988), on remand 523 So.2d 121.

II. Fraudulent Claims Not Involving Insurance
Of course, Alabama has a statute prohibiting misrepresentation in general. § 6-5-101 provides:
Misrepresentations of a material fact made willfully to deceive, or recklessly without knowledge, and acted on by the opposite party, or if made by mistake and innocently and acted on by the opposite party, constitute legal fraud.

A party injured by a misrepresentation is certainly able to recover from a person who misrepresents a claim. See International Resorts, Inc. v. Lambert, 350 So.2d 391 (Ala. 1977) (Regardless of whether the representations were made willfully, recklessly or mistakenly, it has been held that there must be: (1) a false representation; (2) the false representation must concern a material existing fact; (3) the plaintiff must rely upon that false representation, and (4) the plaintiff must be damaged as a proximate result.)
In handling a claim that is suspect, one should strike a delicate balance (while papering your file and conducting an extensive investigation) so as to not incite unnecessary litigation on the one hand, while not paying illegitimate claims on the other. In the end, though, a defense to a claim is available under Alabama law if a claimant misrepresents a claim to the detriment of the payer of that claim.

ARIZONA

Insurance Fraud Statutes
Like most states, Arizona has enacted legislation against insurance fraud. A.R.S. § 20-463 makes it a fraudulent and unlawful practice to knowingly present an insurance claim that misrepresents a material fact. It is also a fraudulent practice to assist in the presentation of a misrepresentative insurance claim or to act as an enabler for fraudulent insurance claims.

Violating A.R.S. § 20-463 is a Class 6 felony. Because of this, insurers may find it advantageous to report suspected fraudulent claims to law enforcement personnel. The insurer should, however, seek counsel on the possibility of reporting suspected fraudulent claims leading to liability for insurer bad faith.

Remedies for Fraudulent Claims
If an insurer has already paid out on a fraudulent claim, it has two options under Arizona law. First, an insurer can always pursue a claim for common law fraud against an insured. The downside of this is that fraud requires a higher standard of proof than other claims. Second, an action for breach of contract or breach of the covenant of good faith and fair dealing may be maintained against an insured.

If an insurer is litigating with its insured over coverage and suspects a fraudulent claim, this can form an effective defense under Arizona law. In this situation, a defending insurer need not carry its burden by clear and convincing evidence, but rather the fraudulent claim defense undercuts the insured’s claims to coverage.

Bad Faith Practices
Under recent Arizona court opinions, an insurer may be liable for bad faith in handling a first party claim even though the insured was not entitled to coverage. It is unclear just what behavior presently constitutes bad faith under Arizona law; the guidance from the courts is that insurers must "play fair" when handling first party claims. Because of this, an insurer should be cautious when reporting a suspected fraudulent claim to law enforcement or otherwise acting against the insured.

ARKANSAS

I. Insurance Fraud:
Similar to other states, insurance fraud in the state of Arkansas is based in the Arkansas statutory law, rather than the common law. Case law concerning insurance fraud is limited in Arkansas; therefore, the majority of the rules and requirements included herein are found within the Arkansas Code Annotated.

A person shall not commit a fraudulent insurance act in the state of Arkansas. Ark. Code Ann. §23-66-502(a). A "fraudulent insurance act" is defined as follows:

"Fraudulent insurance act" means an act or omission committed by a person who, knowingly and with intent to defraud, deceive, conceal, or misrepresent:

(A) Presents, causes to be presented, or prepares with knowledge or belief that it will be presented to an insurer, a reinsurer, broker or its agent, or by a broker or agent, false information as part of, in support of, or concerning a fact material to one (1) or more of the following:
(i) An application for the issuance or renewal of an insurance policy or reinsurance contract;
(ii) The rating of an insurance policy or reinsurance contract;
(iii) A claim for payment or benefit pursuant to an insurance policy or reinsurance contract;
(iv) Premiums paid on an insurance policy or reinsurance contract;
(v) Payments made in accordance with the terms of an insurance policy or reinsurance contract;
(vi) A document filed with the commissioner or the chief insurance regulatory official of another jurisdiction;
(vii) The financial condition of an insurer or reinsurer;
(viii) The formation, acquisition, merger, reconsolidation, dissolution, or withdrawal from one (1) or more lines of insurance or reinsurance in all or part of this state by an insurer or reinsurer;
(ix) The issuance of written evidence of insurance; or
(x) The reinstatement of an insurance policy;

(B) Solicits or accepts new or renewal insurance risks on behalf of an insurer, reinsurer, or other person engaged in the business of insurance by a person who knows or should know that the insurer or other person responsible for the risk is insolvent at the time of the transaction;

(C) Removes, conceals, alters, or destroys the assets or records of an insurer, reinsurer, or other person engaged in the business of insurance;

(D) Embezzles, abstracts, purloins, or converts moneys, funds, premiums, credits, or other property of an insurer, reinsurer, or person engaged in the business of insurance;

(E) Transacts the business of insurance in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of insurance;

(F) Attempts to commit, aids or abets the commission of, or conspires to commit the acts or omissions specified in this subsection;

(G) Issues false, fake, or counterfeit insurance policies, certificates of insurance, insurance

identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance;

(H) Possesses or possesses in order to distribute, solicit, sell, negotiate or effectuate false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance to consumers, lienholders or loss payees, insurance agents or producers, or other persons or entities; or

(I) Possesses any device, software, or printing supplies utilized to manufacture false, fake, or counterfeit insurance policies, certificates of insurance, insurance identification cards, policy declaration pages or policy covers, or insurance binders or other temporary contracts of insurance[.]

Ark. Code Ann. §23-66-501(4).

It is a crime to commit insurance fraud in Arkansas, and "[a]ny person who files any statement, application, form, or other document required to be filed by the Arkansas Insurance Code knowing the statement or information contained in the document to be false or misleading in any material respect shall be guilty of a Class D felony." Ark. Code Ann. §23-60-109; see also *Hale v. State*, 343 Ark. 62, 31 S.W.3d 850 (Ark. 2000). Further, a person committing a fraudulent insurance act may suffer a civil penalty of up to ten thousand ($10,000) dollars for each violation, and be forced to pay restitution to the aggrieved party. Ark. Code Ann. §23-66-512.

Additionally, it has been well-established that "the burden is on [the insurer] to establish fraud by proving affirmatively the falsity, materiality and bad faith in the representations made by the insured…" *American Republic Life Ins. Co. v. Edenfield*, 228 Ark. 93, 97, 306 S.W.2d 321, 324 (Ark. 1957); (Quoting *Aetna Life Insurance Co. v. Mahaffy*, 215 Ark. 892, 224 S.W.2d 21 (Ark. 1949)).

II. Remedies for the Insurer:

As stated above, restitution may be awarded to an aggrieved party when there has been insurance fraud. See Ark. Code Ann. §23-66-512. Additionally, "an insurance company may retroactively rescind a policy because of fraud or misrepresentation of the insured." *Neill v. Nationwide Mut. Fire Ins. Co.*, 355 Ark. 474, 479, 139 S.W.3d 484, 487 (Ark. 2003). Further, it is important to recognize that the "[r]escission of a contract and cancellation of a contract are two distinct remedies based on different grounds." *Ferrell v. Columbia Mut. Ins. Casualty Co.*, 306 Ark. 533, 537, 816 S.W.2d 593, 595 (Ark. 1991). Cancellation will only have prospective effect, while rescission avoids the contract *ab initio*. *Id.*

However, "the insurer cannot, on the ground of fraud or misrepresentation, retroactively avoid coverage under a compulsory insurance or financial responsibility law." *Id*. at 538, 596. In particular, "an insurer shall not be able to rescind bodily injury or property damage liability coverage under an insurance policy for fraud or misrepresentation with respect to any injury to a third party when suffered as a result of the insured's negligent operation of a motor vehicle." Ark. Code Ann. §23-89-303(d)(1). Courts have held that "when an innocent third party has suffered damages as a result of an insured's negligent operation of an insured vehicle, there is no right of retroactive rescission," with the same being abrogated and the only remedy remaining being prospective cancellation in accordance with the terms of the statute. *Ferrell,* 816 S.W.2d at 595. However, these rules are not intended to negate an insurer's right to rescind other coverages in the insurance policy purchased by the insured when such policy has been procured through fraud. See Ark. Code Ann. §23-89-303(d)(2).

III. Duties of Insurers:

The state of Arkansas does place some duties and requirements upon insurers that are designed to help prevent insurance fraud. In particular, there is a mandatory reporting requirement for any insurer that has knowledge or a reasonable belief that a fraudulent insurance act is being, will be, or has been committed to the Insurance Commissioner. See Ark. Code Ann. §23-66-505(a). Further, any insurer who fails to report such a fraudulent act, after obtaining knowledge of the same, shall be guilty of a Class A misdemeanor. See Ark. Code. Ann. §23-66-505(b).

Arkansas insurers shall also have antifraud initiatives in place that are "reasonably calculated to detect, prosecute, and prevent fraudulent insurance acts." Ark. Code Ann. §23-66-510(a). Such initiatives could include the use of fraud investigators or the submission of an antifraud plan to the Insurance Commissioner. *Id.* However, upon written request from the insurer, the Insurance Commissioner may grant an exemption from this requirement if the Commissioner determines that such an exemption would not be detrimental to the interests of the public. Ark. Code Ann. §23-66-501(b).

Additionally, insurers must provide a fraud warning to its insured on "[c]laim forms, proofs of loss, or any similar documents, however designated, seeking payment or benefit pursuant to an insurance policy, and applications for insurance, regardless of the form of transmission…" Ark. Code Ann. §23-66-503(a). The warning shall state, or be substantially similar to, the following:

"Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Id.

Lastly, the Insurance Commissioner in the state of Arkansas has the authority to investigate suspected fraudulent insurance acts and persons engaged in the business of insurance, if the same is deemed necessary by him or her. Ark. Code Ann. §23-66-504.

CALIFORNIA

Attacking insurance fraud in California is statutorily required – the California Department of Insurance, Fraud Division was established to investigate suspected fraudulent claims. The statutes are replete with stated legislative intent to crack down on fraudulent claims in a multitude of ways, including mandatory insurer reporting of suspected fraudulent claims to law enforcement for investigation and criminal sanctions, civil claims for deceit/fraud, declaratory judgments to deem insurance policies void, rescission of the policy, and private whistleblower qui tam actions.

Reporting Requirements and Civil Immunity

In order for law enforcement to investigate, an insurer or licensed rating organization who knows or reasonably believes someone has committed a fraudulent act relating to an insurance claim or policy shall report the suspected fraudulent activity and identities of those suspected on the forms established for this purpose, found at www.insurance.ca.gov. The State has earmarked funds specifically for insurance fraud investigation and prosecution. Automobile insurance-related fraud (in both third-party as well as first-party claims) and workers' compensation fraud have historically been the main focus of law enforcement investigation, but health care fraud is also policed by the California Department of Insurance. The California Attorney General has jurisdiction over Medi-Cal fraud. The FBI and other federal agencies also have an interest in quashing insurance fraud across state/national lines.

If an authorized governmental agency (this includes NICB) requests any relevant information, the insurer or licensed rating organization shall release that requested information. The relevant information will certainly include the claim file and contents, which may include medical information. The responding party (insurer, adjuster, attorney, self-insured) is immune from civil liability for turning over this information to an authorized governmental agency, including the Department of Motor Vehicles or other licensing agency, when acting in good faith. Ins. Code sections 1872.5, 1873.2, and 1877.5. The information turned over in response to the request from the agency – as well as the fact of the inquiry/response – is confidential and not public record. Ins. Code section 1873.1 and 1877.4.

Investigation by Insurer

California Insurance Code Section 1871.1 provides insurers and their agents, while they are investigating suspected insurance fraud claims, with the right to access all relevant public records that are required to be open for inspection under California's Public Records Act ("CPRA"). The CPRA is found at California

Government Code Section 6250-6270. The purpose of California Insurance Code Section 1871.1 is to ensure that insurers have unrestricted access to open public records in order to effectively work to identify and eliminate fraudulent claims.

The term “public records” is broadly defined at California Government Code Section 6252(e) as "any writing containing information relating to the conduct of the public's business prepared, owned, used or retained by any state or local agency regardless of physical form or characteristics." The categories of records and public agencies available for inspection are listed in the statute, as well as a number of exemptions listed in section 6254, including the investigative reports of any state or local police agencies. However, if there is no belief that disclosure of witnesses’ names and statements would endanger their safety, that information may be disclosed upon proper application.
Criminal Sanctions

Automobile, Health Care, All Insurance Claims
Penal Code section 550(a) makes it unlawful to do any of the following, or to aid, abet, solicit, or conspire with any person to do the following: knowingly present a false or fraudulent claim for payment of a loss or injury under a contract of insurance, to essentially stage a motor vehicle collision, to make any writing intended for use in support of a fraudulent claim for a health care benefit, workers’ compensation benefit or any other insurance benefit. Penal Code section 550 goes on to expressly prohibit another person to knowingly give a written or oral statement in support of someone making such a fraudulent claim.

Penal Code section 548(a) makes it a felony to willfully injure, destroy, secrete, abandon, or dispose of property insured against loss or damage by theft, embezzlement, or any casualty with intent to defraud the insurer. This section specifically excludes arson to defraud, which is covered in Penal Code section 451(d). Section 548(a) is used against false reports of auto theft, as happens frequently in areas near an international border, and many other types of claims of theft or destruction of property.

Penal Code section 551 deals specifically with automobile repair dealers, prohibiting kickbacks from repair shops to insurance agents, adjusters or brokers in exchange for referrals, and prohibiting offers to offset the amount of the insurance deductible in any repair bill before the deductible is established or the repair is done.

Workers’ Compensation Insurance and Other Benefits
In addition to Penal Code section 550, the Insurance Fraud Prevention Act (California Insurance Code sections 1871-1879.8) specifically reiterates what is criminally punishable conduct within the workers’ compensation system. The Insurance Code expressly prohibits fraudulent conduct by insurers, agents, brokers and service providers within the workers’ compensation system.

Insurance Code section 1871.4 prohibits anyone from knowingly submitting a false or fraudulent statement or misrepresentation for the purpose of obtaining workers’ compensation benefits, or discouraging someone from obtaining workers’ compensation benefits or filing a claim, and section 1871.5 makes one who is convicted of violating 1871.4 ineligible to keep the compensation (defined as any medical, indemnity or other workers’ compensation benefit) he or she received: a statutory method of immediate restitution. Cf. Tensfeldt v. Workers Comp App. Bd. (1998) 66 Cal.App.4th 116, 123-124.
Labor Code sections 3820 – 3823 make it unlawful for an employer to willfully misrepresent any fact in order to obtain workers’ compensation insurance. Labor Code section 3700.5 makes it a crime for employers to knowingly fail to secure workers compensation insurance.

California Welfare & Institutions Code section 14107 prohibits the intentional presentation of a false or fraudulent claim for payment of a Medi-Cal claim. People v. Gregory, 217 Cal.App.3d 665, 678. Similarly, section 14014 prohibits false statements as to Medi-Cal eligibility. California Unemployment Insurance Code sections 2101, 2116 and 2122 prohibit making a false statement or knowingly conceal a material fact in order to obtain the payment of California Unemployment Insurance benefits.

Other Charges
In the appropriate cases, perjury (Penal Code section 118) or grand theft (Penal Code section 487) may be charged as well as, or instead of, those sections listed above.
Civil Remedies

Private Whistleblower
Penal Code section 549 prohibits soliciting, accepting or referring business from an individual or entity knowing that they intend to violate Penal Code section 550 (all types of insurance fraud) or Insurance Code Section 1871.4 (workers' compensation insurance fraud). Insurance Code Section 1871.7(a) makes it unlawful to knowingly employ a runner or "capper" in workers' compensation system, i.e., paying a sum of money per capita to someone who refers or brings clients or patients to the worker's compensation lawyer or medical provider.

Insurance Code 1871.7(b) imposes a civil penalty of $5,000 - $10,000 per violation of subdivision (a) or Penal Code section 549, 550 or 551. Insurance Code section 1871.7(d) allows any interested person or insurer to bring a civil case in the name of the State of California, to seek assessment of those civil penalties. Judgments against the service providers can be and have been in the millions of dollars.

Declaratory Relief – denial of coverage for fraud
Insurance Code section 550 requires an insured to present an accurate proof of loss. If the proof of loss is insufficient, the insurer is obligated to reject it. The required proof depends on the circumstances of the particular case. Culley v. New York Life Insurance Co., 27 Cal.2d 187 (1945). If the insurer does not object to the proof of loss, it may waive its right to challenge any defects in it. Ins. Code section 553. Willful misstatements in a proof of loss will generally prevent recovery on an insurance policy. In other words, a policy may be deemed void if an insured submits a false and fraudulent claim for payment. Zemelman v. Boston Ins. Co., 4 Cal.App.3d (1970).

An insurer may rescind a policy when the insured has misrepresented or concealed material information in connection with obtaining insurance. Nieto v. Blue Shield of California Life and Health Ins. Co., 181 Cal.App.4th 60 (2010); TIG Ins. Co. of Michigan v. Homestore, Inc. (2006) 137 Cal.App.4th 749, 755-756. Insurance Code sections 331 and 359 authorize insurers to rescind and/or reform a policy if the application is based on fraud and/or misrepresentation. Mitchell v. United Nations Ins. Co. (2005) 127 Cal.App.4th 457, 468.

In the right case, then, an insurer may file for declaratory relief regarding denial of coverage, and to ask the Court to declare the contract void for fraud. The insurer carries the burden of proof of the false/fraudulent claim, and of course, caution must be exercised, as counterclaims of extra-contractual liability may be drawn.

Common Law Civil Claim
Finally, California law still provides for the civil tort claim for "deceit" or "fraud" – which includes misrepresentation or concealment with intent to defraud. Civil Code sections 1572, 1709 and 1710. Engalla v. Permanente Medical Group, Inc. (1997) 15 Cal.4th 951, 974. The civil claim requires a showing of measureable damages caused by the fraud.

COLORADO

According to Colorado Revised Statute § 10-1-128, "a fraudulent insurance act is committed if a person knowingly and with intent to defraud presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, a purported insurer, or any producer thereof any written statement as part of in support of an application for the issuance or the rating of an insurance policy or a claim for payment or other benefit pursuant to an insurance policy that he or she knows to contain false information concerning any fact material thereto or if he or she knowingly and with intent to defraud or mislead conceals information concerning any fact material thereto."

As part of enacting this statute in 2002, the General Assembly in Colorado found and declared that "insurance fraud is expensive; that it increases premiums and places businesses at risk; and that it reduced consumers' ability to raise their standards of living and decreases the economic vitality of this state." The General Assembly further found that the State of Colorado "must aggressively confront the problem of insurance fraud by facilitating the detection of and reducing the occurrence of fraud through stricter enforcement and deterrence and by encouraging greater cooperation among consumers, the insurance industry, and the state in coordinating efforts to combat insurance fraud."

Colorado enacted various statutes in order to further their legislative intent to stop insurance fraud from occurring so frequently. Under C.R.S. § 10-1-128(5)(a), "every licensed insurance company doing business in Colorado shall prepare, implement, and maintain an insurance anti-fraud plan . . . Each anti-fraud plan shall outline specific procedures, appropriate to the type of insurance provided by the insurance company in Colorado, to:

1) Prevent, detect, and investigate all forms of insurance fraud . . .;
2) Educate appropriate employees about fraud detection and the company's anti-fraud plan . . .;
3) Provide for the hiring [of] . . . fraud investigators . . .;
4) Report suspected or actual insurance fraud to the appropriate law enforcement and regulatory entities . . ."

Any insurance company that has committed a fraudulent insurance act, as defined above, will be subjected to disciplinary action by the commissioner of insurance. Penalties for fraud may include imprisonment, fines, denial of insurance, and civil damages. C.R.S. § 10-1-128(6)(a).

The general statute of limitations for fraud is three years. C.R.S. § 13-80-101. But, the limitations period is tolled until the aggrieved party learns of the fraud or should have discovered it by the exercise of reasonable diligence. *Hackbart v. Holmes*, 675 F.2d 1114 (10th Cir. 1982).

When fraud is pleaded, it is incumbent upon plaintiff to prove that defendant made the false representation with knowledge of its falsity or with utter disregard for its truth and falsity. *Caldwell v. Kats*, 555 P.2d 190 (Colo. App. 1976).

Although there is no specific crime of fraud, fraud is an element in a number of criminal statutes, including Forgery under C.R.S. 18-5-102, which is a Class 5 Felony.

CONNECTICUT

A. Criminal Liability for Insurance Fraud

A person is guilty of insurance fraud under Connecticut law when she knowingly submits a statement related to an insurance claim containing false, incomplete or misleading information regarding anything material to the claim, with the intent to injure, defraud or deceive an insurance company. A statement includes any written, oral or computer-generated information in an insurance application, claim for payment, claim for other benefits, or other supporting documentation. A person is guilty whether she submits the false or misleading statement herself, causes another to submit the statement, or assists, solicits or conspires with another to submit the statement. Conn. Gen. Stat. § 53a-215. Insurance fraud is punishable by one to five years imprisonment. Conn Gen. Stat. § 53a-35a; Conn. Gen. Stat. § 53a-215. There are also separate statutes that address specific types of insurance fraud. See, e.g., Conn. Gen. Stat. § 38a-287 (accident or life insurance fraud); § 53-440 et seq. (health insurance fraud).

Insurance fraud can also form the basis for a charge of larceny. State v. Nosik, 715 A.2d 673, 679, 245 Conn. 196, 207 (1997). A person is guilty of larceny when she knowingly makes a statement with the intent to permanently deprive an owner of something of value and thereby obtains something of value without compensation. Conn. Gen. Stat. § 53a-119. The degree of

the larceny involved depends on the amount of insurance proceeds or benefits fraudulently obtained.

B. Voiding an Insurance Policy

Under common law, an insurer can void an insurance policy if it can show that the insured knowingly included false information on the insurance application. See Middlesex Mut. Assurance Co. v. Walsh, 590 A.2d 957, 963-964, 218 Conn. 681, 691-692 (1991). Failure by an insured to disclose material information during the course of an investigation can also relieve an insurer of its obligations under the policy if the insured's conduct violates the policy's cooperation clause. Double G.G. Leasing, LLC. V. Underwriters at Lloyd's, 978 A.2d 83, 92-93, 116 Conn. App. 417-432-433 (2009).

Misrepresentations or concealment of information by an insured before or after a loss renders a fire insurance policiy void if the insurer proves that the insured willfully misrepresented statements of material fact. Conn. Gen. Stat. § 38a-307; Rego v. Conn. Ins. Placement Facility, 593 A.2d 491, 495, 219 Conn. 339, 346-347 (1991). Standard contract law may yield the same result for other insurance policies if a voidability provision is included in the contract. See, e.g., Hernandez v. Vt. Mut. Ins. Co., 2008 Conn. Super. LEXIS 844, at *12-*25 (Super. Ct., Judicial District of Hartford at Hartford, April 4, 2008).

C. Recovery of Payments Made for False Claims

In addition to common law causes of action for breach of contract, unjust enrichment, conversion, or fraud, a statutory cause of action allows defrauded insurers to seek damages caused. Conn. Gen. Stat. § 53-444. In addition, the Connecticut Unfair Insurance Practices Act ("CUIPA") prohibits certain enumerated unfair insurance practices. Conn. Gen. Stat. § 38a-815. This includes, among other things, making false or fraudulent statements in insurance applications. Conn. Gen. Stat. § 38a-816(8). Where a CUIPA violation is alleged, the Insurance Commissioner will conduct a hearing, and upon a determination that a violation has occurred, the commissioner may impose monetary penalties, suspend licenses or order restitution to an injured party. Conn. Gen. Stat. § 38-817. It is not clear whether a CUIPA violation creates a private right of action. McCulloch v. Hartford Life & Accident Ins. Co., 363 F. Supp. 2d 169, 181 (D. Conn. 2005). However, the Connecticut Supreme Court has allowed a private cause of action based on CUIPA violations to proceed under the private right of action created in the Connecticut Unfair Trade Practices Act (Conn. Gen. Stat. § 42-110a et seq.). Macomber v. Travelers Prop. & Cas. Corp., 804 A.2d 180, 196, 261 Conn. 620, 645 (2002).

Finally, it is noteworthy that where a fraud meets the elements of a larceny, the owner of the stolen property may seek treble damages for civil theft. See generally Conn. Gen. Stat. § 52-564; Sullivan v. Delisa, , 923 A.2d 760, 771, 101 Conn. App. 605, 619-620, cert. denied 928 A.2d 540, 283 Conn. 908 (2007).

D. Defamation

A person is liable for defamation if he publishes to a third party a defamatory statement that identifies another person, and that person's reputation is injured as a result. Cweklinsky v. Mobil Chem. Co., 837 A.2d 759, 763-764, 267 Conn. 210, 217 (2003). To be actionable, the defamatory statement must express a fact, not an opinion. Daley v. Aetna Life & Cas. Co., 734 A.2d 112, 129, 249 Conn. 766, 795 (1999). Where a statement charges a person with a crime punishable by imprisonment, such as insurance fraud, the statement is actionable per se, and a plaintiff need not prove special damages to recover. See Moriary v. Lippe, 294 A.2d 326, 332-333, 162 Conn. 371, 382-383 (1972); Wilcox v. Webster Ins., Inc., 2009 Conn. Super. LEXIS 2123, at *11-*12 (Super. Ct., Judicial District of New Haven at New Haven, August 6, 2009).

There are, however, statutory protections from civil liability for persons disclosing information necessary to conduct insurance fraud investigations. See, e.g., Conn. Gen. Stat. § 38a-318(c) (fire insurance); § 38a-356 (motor vehicle insurance); § 53-445(d) (health insurance). Additionally, where the alleged defamation stems from a defendant's action in the bona fide

discharge of a public or private duty, a common law qualified privilege exists that can protect the defendant unless the statement was made with malice or bad faith. Miles v. Perry, 529 A.2d 199, 205 n.8, 11 Conn. App. 584, 594 n.8 (1987).

E. Insurance Fraud Unit
The Connecticut Insurance Department has an Insurance Fraud Unit that promotes insurance fraud prevention, detection and reporting. The Insurance Fraud Unit collects data; coordinates investigations between different state agencies and private entities; and educates the public about reporting and preventing insurance fraud. It does not receive or process claims of insurance fraud itself.

DELAWARE

In Delaware insurance fraud can result in criminal charges and civil administrative fines. Likewise, allegations of insurance fraud can trigger a criminal investigation and/or an investigation conbducted by the Delaware Department of Insurance.

Criminal
On the criminal side, 11 *Del. C.* 913, ("the Criminal Statute") makes it a crime to intentionally injure, defraud, or deceive an insurer. A conviction is a class G felony, which carries a sentence of up to 2 years in prison. A person commits insurance fraud when they knowingly make false, incomplete or misleading written or oral statements[1] to obtain insurance payments or other benefits under an insurance policy; or, they assist or conspire with another to make such a claim.

In Delaware, pursuant to the Criminal Statute, all insurance claim forms must include the language:

"Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony."

The Delaware Supreme Court has upheld the statute and ruled that the list contained in foot note one is a non-exhaustive list of what constitutes a statement. 800 *Minus v. State,* A.2d 811 (Delaware 2004). In *Minus*, the defendant was a state court employee who falsely claimed she was bumped by a court security officer when she passed through a metal detector and injured. She also reported the incident to her supervisor who filled out a report and submitted a claim to the State's Worker's Compensation insurance carrier. The Supreme Court upheld her convictions on two counts of insurance fraud, one for falsely reporting the incident to her supervisor and one for the claim filed by the supervisor with the Worker's Compensation carrier.

Administrative Proceedings
The state has also empowered the Delaware Insurance Department to enforce a civil statute, 18 *Del. C.* § 2401 *et seq.* ("the Insurance Statute"). The Insurance Statute gives the Insurance Department the power to require the restitution of fraudulently obtained insurance benefits § 2411(e) and to levy administrative fines up to $10,000 for parties found to have violated the statute, § 2411(b). While the language of the Insurance Statute parallels the language of the Criminal Statute, it goes further.

[1] As noted in the statute:
"[S]tatement" includes, but is not limited to, a police report, any notice, statement, proof of loss, bill of lading, receipt for payment, invoice, account, estimate of property damages, bill for services, diagnosis, prescription, hospital or doctor records, X rays, test result or other evidence of loss, injury or expense; "insurer" shall include, but is not limited to, a health service corporation or health maintenance organization; and "insurance policy" shall include, but is not limited to, the subscriber and members contracts of health service corporations and health maintenance organizations. 11 *Del. C.* §913 (c).

Under the Insurance Statute, insurance fraud is defined as knowingly by act or omission with intent to injure, defraud, or deceive an insurance company by giving false information on an insurance application, giving false information in a claim for money or a benefit from an insurance policy, or to assist another in giving such information. The Insurance Statute goes further than the Criminal Statute in that it gives the insurance department authority to levy administrative fines against insurance agents and insurance companies who likewise are found to have engaged in fraudulent behavior.

The Insurance Statute also imposes a duty on insurance carriers to report to the Insurance Fraud Prevention Bureau any act of insurance fraud it reasonably believes is being committed. Those parties providing such information are given immunity from civil liability, provided the information is not given in bad faith.

The Insurance Fraud Prevention Bureau is charged with investigating insurance fraud and the Insurance Department holds hearings into the allegations. The Hearing officer then issues findings of fact and conclusions of law. The findings can be appealed to the Superior Court, Delaware's trial court. Ultimately the findings can also be appealed to the Delaware Supreme Court.

Like most civil cases in Delaware, finding someone guilty of insurance fraud under the Insurance Statute takes a lower legal standard that must be met than the Criminal Statute. All crime in Delaware must be proven by guilt beyond a reasonable doubt; while the standard for proving fraud under the Insurance Statute is by a preponderance of the evidence. *See State v. Limprum,* WL 1079004 at *4 (Del. Super. 2001) and *Bryant-Harris v. Delaware Department of Insurance*, WL 2106946 at *2 (Del. Super. 2012).

FLORIDA

I. What Rights Does an Insurer Have if Claimant is Suspected of Fraud?

The filing of a fraudulent insurance claim is a crime and, as such, subjects the guilty party to criminal prosecution pursuant to § 817.234, Fla. Stat. (2006). This statute outlines the type of conduct which would create criminal liability for fraudulent insurance practices. Complimenting the criminal repercussions of such conduct, Florida's Division of Insurance Fraud, pursuant to § 626.989, Fla. Stat. (2004), has extensive power to investigate, grant immunity or arrest individuals or entities involved in fraudulent insurance claims practices. Further, depending on the dollar value of premiums written by a given insurer, the insurer may or may not be required to create an internal fraud investigation unit within their organization and share their fraud "plan" with Florida's Division of Insurance Fraud. § 626.9891, Fla. Stat. (2006).

If an insurance investigative unit suspects a fraudulent claim, their best remedy is to report the individual or entity to the Division of Insurance Fraud. Not only could this potentially merit a monetary reward (See § 626.9892) if the person is found to have been guilty of such conduct, but the Division of Insurance Fraud has tort immunity pursuant to § 626.989, and has investigative powers a private company simply does not have, including the ability to arrest culpable individuals.

II. What is the Standard for Dismissing a Case for Fraud After the Commencement of Litigation?

The trial court and the circuit court have the inherent authority to dismiss actions based on fraud and collusion, within the exercise of sound judicial discretion. The court's power to dismiss a case where a fraud has been perpetrated on the court derives from the court's inherent authority to prevent an abuse of its processes. When reviewing a case for fraud, the court should consider the proper mix of factors and carefully balance a policy favoring adjudication on the merits with competing policies to maintain the integrity of the judicial system; because dismissal sounds the death knell of the lawsuit, courts must reserve such strong medicine for instances where the defaulting party's misconduct is correspondingly egregious.

Courts should use dismissal upon the most blatant showing of fraud, collusion, or other similar wrongdoing. A court acting on a motion to dismiss for a fraud on the court should carefully adhere to rules of procedure, established due process, adversarial practice, and evidentiary rules in conducting an inquiry

into such charges. Where a party perpetrates a fraud on the court which permeates the entire proceedings, dismissal of the entire case is proper. Unless it appears that the process of trial has itself been subverted, factual inconsistencies or even false statements are well managed through the use of impeachment at trial or other traditional discovery sanctions, not through dismissal of a possibly meritorious claim on grounds that a fraud has been perpetrated on the court.

In recognition of the state constitutional provision that the courts will be available to every person for redress of injury, a party alleging fraudulent behavior as grounds for dismissal must, accordingly, prove its position by clear and convincing evidence. Thus, the requisite fraud on the court occurs where it can be demonstrated, clearly and convincingly, that a party has sentiently set in motion some unconscionable scheme calculated to interfere with the judicial system's ability impartially to adjudicate a matter by improperly influencing the trier of fact or unfairly hampering the presentation of the opposing party's claim or defense. For the trial court to properly exercise its discretion regarding dismissal of a case for fraud on the court, it must have an evidentiary basis to make that decision. Where a court believes that a fraud has been perpetrated upon it, it must attempt to afford the party allegedly perpetrating the fraud an evidentiary hearing, at which the party is given an opportunity to rebut the information the court has with regard to the alleged fraud, before the court can properly dismiss the action.

Examples

The trial court conducted an evidentiary hearing which provided evidentiary basis for court's assessment of veracity of deposition testimony and interrogatory responses in case where a customer committed fraud on the court when he provided intentionally false deposition testimony and interrogatory answers in his personal injury action against a furniture store, whose delivery personnel allegedly negligently connected a bridge on an entertainment unit which fell on the customer's head and injured him, and as a sanction for fraud on the court, the customer's action would be dismissed; the customer's misrepresentations concerning his prior medical treatment were directly related to the central issue in case, and such misrepresentations by their very nature unfairly hampered presentation of store's defense. Ramey v. Haverty Furniture Companies, Inc., 993 So.2d 1014 (Fla. 2d DCA 2008).

The trial court in a former wife's action seeking to establish ownership of half of a lottery prize awarded to her former husband could not dismiss the wife's claim with prejudice as sanction for wife's alleged misconduct, including her failure to disclose the lottery claim in separate bankruptcy and divorce proceedings, and her giving of deposition testimony inconsistent with the allegations in her complaint; conduct in the bankruptcy and divorce proceedings had no relation to the lottery action, and any alleged inconsistencies in the wife's testimony went to her credibility, and did not amount to a fraud on the court. Bertrand v. Belhomme, 892 So. 2d 1150 (Fla. 3d DCA 2005).

In another case, husband and wife tenants engaged in a clear and convincing scheme to interfere with judicial system's ability to adjudicate their claims against apartment complex based on husband's alleged fall on a sidewalk outside apartment so as to warrant dismissal of action for fraud, even though the husband and wife attempted to excuse their presentation of false or misleading information on the ground that the husband suffered memory problems, where they attempted to conceal the fact that the husband had suffered a dog attack causing the injury he attributed to the fall and attempted to conceal the symptoms the husband experienced before the fall, and the wife did not suffer from memory problems, was present during the husband's depositions, and never attempted to correct or add to the husband's testimony. Hutchinson v. Plantation Bay Apartments, LLC, 931 So.2d 957 (Fla. 1st DCA 2006).

In contrast, the discrepancies between a motorist's discovery responses regarding treatment for prior injuries and the evidence developed by the city in its investigation of the motorist's personal injury claim after being involved in a collision with the city's police vehicle did not support dismissal of motorist's claim with prejudice for fraud on the court where no witness testified on the motion to dismiss, and the allegations of inconsistency, nondisclosure, even falseness, could be dealt with through cross-examination or impeachment. Gehrmann v. City of Orlando, 962 So.2d 1059 (Fla. 5th DCA 2007).

However, the trial court did not abuse its discretion in dismissing with prejudice a plaintiff's personal injury action for committing fraud on the court, as the court found that the plaintiff repeatedly attempted to

conceal material facts related to his medical condition and work history and that this concealment amounted to a fraud on the court. Saenz v. Patco Transp., Inc., 969 So.2d 1145 (Fla. 5th DCA 2007).

Black Letter Law
A trial court has the inherent authority to dismiss an action as a sanction when the plaintiff has perpetuated a fraud on the court, but this power should be exercised cautiously, sparingly, and only upon a clear showing of fraud on the court. Hernandez v. City of Miami, 35 So. 3d 942 (Fla. 3d DCA 2010). When reviewing a case for fraud on the court, the court should consider the proper mix of factors and carefully balance a policy favoring adjudication on the merits with competing policies to maintain the integrity of the judicial system. Gilbert v. Eckerd Corp. of Florida, Inc., 34 So. 3d 773 (Fla. 4th DCA 2010). Except in the most extreme cases, where it appears that the process of trial has itself been subverted, factual inconsistencies, even false statements are well managed through the use of impeachment and traditional discovery sanctions rather than dismissal. Id.

If the motion to dismiss for fraud on the court would not likewise survive a motion for summary judgment, the trial court should presume the matter not subject to dismissal. Id. Evidence was insufficient to support trial court's dismissal of store patron's negligence action against store as sanction for fraud on the court, even though store produced evidence that patron did not work for company as she claimed, as support for her claim for damages, where store failed to provide an explanation for income patron reported on her tax return from alleged employment, and trial court did not expressly resolve issue in its dismissal order following non-evidentiary hearing. Id. To support a dismissal for fraud on the court, the court must find the false testimony was directly related to the central issue in the case, and the mere conflict between discovery depositions, interrogatories and records disclosed during the discovery process should not warrant dismissal on the basis of fraud on the court. Id.

GEORGIA

The insurance industry in Georgia is committed to reducing fraud by teaching claims professionals how to recognize suspicious claims and work with law enforcement and fire services.

Accordingly, Georgia enacted a statute specifically dealing with investigation of insurance fraud; O.C.G.A. § 33-1-16 essentially authorizes an insurer to notify law enforcement when it reasonably believes a person committed a fraudulent insurance act. The statute also allows the insurer to provide information relevant to the fraudulent insurance act, including, but not limited to, the application for insurance; policy premium payment records; history of previous claims made by insured, proofs of loss, and notice of loss. Furthermore, it removes civil liability for libel, slander, or any related cause of action for filing reports or for releasing the foregoing information. Additionally, as a means of protecting the person investigated from unwarranted injury, the documents provided by the insurer to law enforcement or the Commissioner are not subject to public inspection for so long as the Commissioner deems reasonably necessary to complete the investigation. Even in light of these protections, out of an abundance of caution, an insurer would be wise to limit the number of people with whom the fraud accusation is shared to only those necessary parties.

In most states, a concern is the alleged defrauder bringing a claim for malicious prosecution against the insurer if he is ultimately found innocent. Georgia, however, tries to protect the insurer by providing within the above-mentioned statute a provision stating, “In the absence of fraud, no insurer or agent authorized by an insurer to act on its behalf, law enforcement agency, or their respective employees or an insured shall me subject to any civil liability of libel, slander, or related cause of action by virtue of filing reports or for releasing or receiving any information” pursuant to the statute. (emphasis added).

Even so, the alleged defrauder might still try to bring a claim for malicious prosecution. To prevail on a malicious prosecution claim under Georgia law, a plaintiff must show: (1) prosecution for a criminal offense instigated by the defendant, (2) issuance of a valid warrant, accusation, indictment, or summons, (3) termination of the prosecution in favor of the plaintiff, (4) malice, (5) want of probable cause, and (6)

damage to plaintiff. Ashmore v. Foster, 254 Ga. App. 97, 561 S.E.2d 228 (2002); Kaiser v. Tara Ford, Inc. 248 Ga. App. 481, 546 S.E.2d 861 (2001); Sherill v. Stockel, 252 Ga. App. 276, 567 S.E.2d 8 (2001).

Accordingly, it is advisable for insurers to document all evidence of probable cause, and to hand the investigation over to the Commissioner or law enforcement agencies as soon as it reasonably believes fraud may be at hand.

Equally important, Georgia has a criminal statute for false reporting of a crime. O.C.G.A. § 16-10-26. The prosecution must show that defendant insurer willfully or knowingly gave or caused a false report of crime to be given to a law enforcement agency. Despite the intent requirement, when corresponding with law enforcement agencies or the Commissioner, an insurer should couch the accusation in terms of acts of a suspicious nature, as opposed to plainly asserting "insurance fraud."

HAWAII

Insurance Fraud Criminal Statute

Under Hawaii law, insurance fraud is a crime that may result in charges ranging from a misdemeanor to a Class B felony depending on the value of the benefits, recovery, or compensation obtained or attempted to be obtained. Haw. Rev. Stat. § 431:2-403. The insurance fraud statute does not supersede any other law relating to theft, fraud, or deception. Id. Insurance fraud may be prosecuted under this part, or any other applicable statute or common law, and all such remedies shall be cumulative.

Remedies for Fraudulent Claims

In addition to or in lieu of criminal penalties under section 431:2-403(b) , any person who commits insurance fraud as defined under section 431:2-403 , may be subject to the administrative penalties. Haw. Rev. Stat. § 431:2-405. The insurance commissioner may assess any or all of the following penalties: (1) restitution to any insurer or any other person of benefits or payments fraudulently received or other damages or costs incurred; (2) a fine of not more than $10,000 for each violation; and (3) reimbursement of attorneys' fees and costs of the party sustaining a loss under this part; provided that the State shall be exempt from paying attorneys' fees and costs to other parties. Id.

An insurer or other licensee shall have a civil cause of action to recover payments or benefits from any person who has violated section 431:2-403; provided that no recovery shall be allowed if the person has made restitution under the administrative remedy statutes. Haw. Rev. Stat. § 431:2-408.

No Civil Liability for Reporting Fraud

A person, insurer, or other licensee, including an insurer's or other licensee's adjusters, bill reviewers, producers, representatives, or common-law agents shall not be subject to civil liability for providing information, including filing a report, furnishing oral, written, audiotaped, videotaped, or electronic media evidence, providing documents, or giving testimony concerning suspected, anticipated, or completed insurance fraud to administrative or law enforcement agencies. Haw. Rev. Stat. § 431:2-408(b).

IDAHO

I. Insurance Fraud

Idaho defines insurance fraud as follows:

All statements and descriptions in any application for an insurance policy. . . shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts, and incorrect statements shall not prevent a recovery under the policy or contract unless either:
(a) Fraudulent; or
(b) Material either to the acceptance of the risk, or to the hazard assumed by the insurer; or

(c) The insurer in good faith would either not have issued the policy or contract, or would not have issued it at the same premium rate, or would not have issued a policy or contract in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or contract or otherwise.

I.C. § 41-1811. It is a crime for "[a]ny insurance agent or other person who with intent to defraud or deceive and insurer presents or causes to be presented to or by an insurer, a purported insurer or agent, a materially false or altered application of insurance." State v. Hoyle, 140 Idaho 679, 685-86, 99 P.3d 1069, 1075-76 (2004) (quoting I.C. § 41-293(1)(c)); see also I.C. § 41-293(1)(a) (making it illegal to knowingly present a false statement "as part of, or in support of, a claim for payment or other benefit").

If there is intent to commit fraud, the fact upon which the fraud is based need not be material: "[A]n immaterial false statement made with the intent to deceive an insurer to obtain or extend benefits can be punished by up to fifteen years in prison, a fine of up to $15,000, or both." State v. Maynard, 139 Idaho 117, 121, 73 P.3d 731, 735 (Ct. App. 2003) (holding that state was not required, pursuant to I.C. § I.C. § 41-293(1)(f), to show that insured's false statement was material to his worker's compensation claim); see also I.C. § 41-294 ("[a]ny person who willfully burns or in any other manner injures or destroys any property which is at the time insured against loss or damage, with intent to defraud or prejudice the insurer or for personal gain, whether the same be the property of, or in possession of, such person or any other, is guilty of a felony punishable by imprisonment in the state prison not less than one (1) year nor more than fifteen (15) years, and shall be ordered to make restitution to the insurer or any other person for any financial loss sustained as a result of a violation of this section.")

Without intent, an insurance misrepresentation is only actionable if the fact upon which the action is based is material. A fact, statement or representation is "material" if it includes any fact which, if communicated to the producer, insurer, adjuster or representative thereof, would induce him to either decline insurance altogether or not accept it unless a higher premium is paid by the insured; a fact which, if disclosed, would be a fair reason for rejecting a claim for insurance benefits. I.C. § 41-293. A material fact can also be defined as a fact, the knowledge or ignorance of which would naturally influence the insurer in making or refusing the contract, in estimating the degree or character of the risk, or in fixing the rate of premium; would naturally influence the insurer in accepting or rejecting a claim for insurance benefits or compensation, or in determining the amount of compensation or insurance benefits to be paid to the insured; or that necessarily has some bearing on the subject matter of the insurance coverage or claim for benefits under an insurance contract. Id.

II. Duty to Report Insurance Fraud

Not only are protections from libel, slander or any other relevant tort cause of action made explicit in I.C. §§ 41-292(5), (6), further, "[a]ny insurer which has facts to support a belief that a fraudulent claim is being or has been made shall" notify the director of insurance "within sixty (60) days of the receipt of such notice." I.C. § 41-290 (emphasis added); see also I.C. 41-292(2)(a)("[w[hen an insurance company has facts to support a belief that a loss in which it has an interest may be of other than accidental cause, then, for the purpose of notification and for having such loss investigated, the company shall, in writing, notify" the director or state fire marshal). The director shall determine the extent of "fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim" and notify law enforcement as appropriate and possibly impose fines and penalties. Id.

III. Remedy for Insurance Fraud

"[A]s a general rule material misrepresentations of fact on the part of the assured which induce the insurer to assume the risk which otherwise it would not have taken, constitute legal grounds for avoidance." Charlton v. Wakimoto, 70 Idaho 276, 281, 216 P.2d 370, 372 (1950). However, "conditions, warranties and misstatement of facts sufficient to avoid the risk may be by the company waived." Id. at 281, 216 P.2d at 372-73. Estoppel, waiver, and laches all apply. Id. An insurer can

avoid waiver, however, by "act[ing] promptly in tendering to respondent the premiums paid" after discovery of the misrepresentation." Pond v. Idaho Mut. Ben. Ass'n, 81 Idaho 38, 46, 336 P.2d 314, 318 (1959).

ILLINOIS

Fraudulent Claims in Illinois and Responsibilities of Insurer
Illinois codifies the requirement for fraud reporting, i.e., where claimant makes a fraudulent claim, at 215 ILCS 5/155.23. This statute requires insurers doing business in Illinois to report factual information pertinent to suspected fraudulent insurance claims. This information includes dates and description of loss, policy information, name of claimant or insured's attorney, name of physicians used, descriptions of injuries, history of claims, places of treatment, policy payment records, any material related to the investigation, and any facts evidencing fraud or arson. In the absence of malice, no insurer, or person who furnishes information on its behalf, is liable for damages in a civil action for libel or related claim.

Illinois' Separate Motor Vehicle Fraud Statute
Under 215 ILCS 5/155.24(c), Illinois requires that if an insurer knows or reasonably believes to know the identity of a person who has committed a criminal or fraudulent act related to a motor vehicle insurance claim, then the insurer or other is required to notify an authorized governmental agency of their knowledge or reasonable belief and provide any additional relevant information, including information regarding the history of the insurance policy. Where no prior incident report has been made, the insurer shall report the suspected criminal or fraudulent act directly to the attorney general or state's attorney in the county or counties where the incident is claimed to have occurred. If a fraudulent claim is made outside the State of Illinois, the insurer shall send the report directly to the attorney general's office. Any information furnished from the insurer to the attorney general is considered privileged and not a part of public record. No insurer, or agent authorized by an insurer, shall be subject to civil or criminal liability in a cause of action for releasing or receiving any information pursuant to this section.

INDIANA

Insurance Fraud
I. Criminal Statutes Relating to Insurance Fraud.

Like many other states, Indiana has enacted laws that criminalize insurance fraud and insurance application fraud. It is a felony for any person, who, knowingly and with intent to defraud (1) issues a claim statement to an insurer or insurance claimant that contains false, incomplete, or misleading information concerning the claim, or (2) issues a statement that is known to contain materially false information or conceals said information relating to a fact material to the rating of an insurance policy, a claim for benefits, premiums paid, payments according to the terms of a policy, or an application for a certificate of authority. See Ind. Code § 35-43-5-4.5 (a), (b).

II. Obligations of Insurers and Concerns Regarding Reporting Fraud.

Often times, fraud investigations by insurers arise in an arson or theft context.

(a) Arson Reporting.

Under Indiana law, when an insurer has reason to believe that a claimed fire loss was caused by non-accidental means, the insurer is obligated to notify the state fire marshal or fire department, the superintendent of the state police, the prosecuting attorney in the county, the attorney general, or an arson investigator, and provide that entity with all information developed from the insurer's investigation. Ind. Code §§ 27-2-13-1, 27-2-13-3. This information must also be provided at the request of the entities previously mentioned. Ind. Code § 27-2-13-2.

(b) Vehicle Theft Reporting.

Similar to the duties outlined for arson reporting, an insurer having reason to believe that a theft claim made by an insured is fraudulent, the insurer must notify the state police, the prosecuting attorney in the county where the theft occurred, or other law enforcement agency and provide that entity with all material from the insurer's inquiry. Ind. Code §§ 27-2-14-1, 27-2-14-3.

(c) Immunity from Liability for Insurers for Arson or Theft Reporting.

Insurers clearly may be wary of releasing information regarding fraud, even to authorized agencies, for fear of defamation or bad faith lawsuits. However, an insurer who releases information pursuant to the applicable code sections described above is immune from any civil or criminal liability for providing that information. Ind. Code §§ 27-2-13-4, 27-2-14-4. Insurers should be careful when reporting suspicions of fraud and provide only the information outlined in the statute, as immunity will not likely apply to conclusions or accusations made by an insurer or its agents.

III. Claim Handling and Fraud Investigations by Insurers.

(a) Insurer's Investigation.

Indiana law provides that an insurer with a reasonable belief that an application for insurance or a claim for benefits is being made based upon misrepresentation and with intent to defraud may obtain or provide information related to the claim or application without authorization of the claimant or applicant. Ind. Code § 27-2-19-6. The exception to this rule pertains to medical information, where an insurer is required to obtain an authorization from the claimant or applicant unless there is a claim made for bodily injury. Even when a claim for bodily injury is made, only information related to the injury claimed, the date of the alleged injury, and the identification of medical providers for the injury claimed may be obtained without prior authorization from the claimant. Id. Any insurer who receives or provides information under this section in good faith is immune from liability arising from receiving or providing the information. Ind. Code § 27-2-19-7.

Again, with any reservation of rights letter, communication with an applicant or claimant, or request for information, an insurer should always be mindful to avoid accusatory statements or conclusions about the claimant's conduct.

(b) Defamation.

If an insurer publishes a statement that a claimant or applicant has committed fraud, then a claimant or applicant may file a defamation action. To maintain an action for defamation, a plaintiff must show: a communication with defamatory imputation, the falsity of the communication, malice, publication, and damages. Trail v. Boys & Girls Clubs of Northwest Indiana, 845 N.E.2d 130, 136 (Ind. 2006). A false communication that a claimant or applicant for insurance has committed fraud or violated Indiana Code section 35-43-5-4.5 constitutes defamation per se, as a statement has defamatory imputation if it imputes "criminal conduct." Baker v. Tremco, 917 N.E.2d 650, 567 (Ind. 2009).

(c) Bad Faith.

The Indiana Supreme Court recognized for the first time a cause of action in tort for breach of the duty of an insurance company to deal in good faith with an insured in 1993. Erie Insurance Company v. Hickman by Smith, 622 N.E.2d 517 (Ind. 1993). The obligation of good faith and fair dealing with respect to the discharge of the insurer's contractual obligation includes the obligation to refrain from (1) making an unfounded refusal to pay the policy proceeds; (2) causing an unfounded delay in making payment; (3) deceiving the insured; and (4) exercising any unfair advantage to pressure an insured into settlement of his claim. Id. at 519. However, an insurer who wrongfully denies a claim based on a theory of fraud is not automatically liable for bad faith. Bad faith amounts to more than mere negligence or poor judgment. Bad faith involves the conscious doing of wrong because of dishonest purpose or ill will. Johnston v. State Farm Mutual Automobile Insurance Company, 667 N.E.2d 802, 805 (Ind. Ct. App. 1996). A finding of bad faith may form the predicate tort for an award of punitive damages, but it does not follow that punitive damages automatically follow a finding that an insurer acted in bad faith. Punitive damages in Indiana are limited to the greater of three times actual damages or $50,000.00. Ind. Code § 34-51-3-1 et seq.

IV. Insurer's Defense Based on Fraud and Remedies Available to Insurer.

(a) Insurer's Remedies for Fraud in Insurance Application.

An insured's material misrepresentation or omission of fact on an insurance application renders coverage voidable at the insurer's option if the misrepresentation or omission was relied on by the insurer in issuing the policy. Colonial Penn Ins. Co. v. Guzorek, 690 N.E.2d 664, 672 (Ind. 1997).

(b) Defending a Breach of Contract Claim Based on Fraud.

In defending a claim on the theory that an insured committed fraud in violation of an insurance policy, an insurer must establish the truth of its claim of fraud perpetrated by the insured by a preponderance of the evidence. See Dean v. Ins. Co. of North America, 453 N.E.2d 1187, 1194 (Ind. Ct. App. 1983). In presenting such a defense, an insurer may rely on circumstantial evidence. Id. at 1194-96.

(c) Insurer's Claim Against Insured.

To recover damages incurred in investigating a claim which later is denied due to fraud, an insurer may file a civil suit against its insured. However, this is rare due to an insurer's fear that bad faith counter-claims or others might be brought and also due to an insurer's interest in maintaining positive relationships with its insureds.

IOWA

Basic legal considerations in handling a potentially fraudulent claim

Iowa has established an Insurance Fraud Investigation Bureau within the Insurance Division to investigate insurance fraud. See Iowa Code chapter 507E. Under Iowa law, a person commits a class "D" felony if the person, with the intent to defraud an insurer, does any of the following:

a. Presents or causes to be presented a fraudulent claim to an insurer knowing that the claim contains false information concerning a material fact;

b. Assists or conspires with another to present such a claim;

c. Presents or causes to be presented to an insurer an application for insurance coverage knowing that such claim contains false information concerning a material fact. Iowa Code §507E.3.

The Insurance Fraud Bureau is commissioned to investigate claims submitted to it. Iowa Code §507E.7 provides immunity to persons acting without malice, fraudulent intent, or bad faith in filing a report of alleged fraudulent acts. This immunity specifically applies to an authorized representative of an insurance carrier. *Id*. In addition to immunity from liability, the statute provides for an award of court costs and reasonable attorney fees if the person or entity reporting the claim is subjected to an action for liable, slander, or other relevant tort where the action involves acts entitled to immunity under this chapter. *Id*. Investigation files, investigation reports, and investigative information generally remains confidential and are not subject to discovery pending completion of the investigation. Iowa Code §507E.5.

In addition to statutory procedures, Iowa law provides a common law fraud action which may subject the person committing the fraud to monetary damages. To establish a claim for fraud, a plaintiff is required to prove: (1) Defendant made a representation to the Plaintiff, (2) The representation was fault, (3) The representation was material, (4) The Defendant knew the representation was fault, (5) The Defendant intended to deceive the Plaintiff, (6) The Plaintiff acted in reliance on the truth of the representation and was justified in relying on the representation, (7) The representation was a proximate cause of Plaintiff's damages, and (8) The amount of damages. *Gibson v. ITT Hartford Ins. Co.*, 621 N.W.2d 388, 400 (Iowa 2001). The elements of fraud must be proven by "a preponderance of clear, satisfactory, and convincing evidence." *Grefe v. Ross*, 231 N.W.2d 863, 864 (Iowa 1975).

KANSAS

Insurance Fraud Criminal Statute
Under Kansas law, insurance fraud is a crime resulting in charges ranging from a class C nonperson misdemeanor to a severity level 6, nonperson felony, depending on the value of the amount involved. KAN.STAT.ANN. § 40-2,118 (e).

Statute defines a "fraudulent insurance act" as: an act committed by any person who, **knowingly and with intent to defraud,** presents, causes to be presented or prepares with knowledge or belief that it will be presented to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto. KAN.STAT.ANN. § 40-2,118 (a) (emphasis added).

Suspected Insurance Fraud
Kansas law requires an insurer that has knowledge or a good faith belief that a fraudulent insurance act is being or has been committed to report such information to the commissioner. KAN.STAT.ANN. § 40-2,118 (b). Any other person possessing knowledge, or a good faith belief, may also provide pertinent information to the commissioner. KAN.STAT.ANN. § 40-2,118 (c).

Antifraud Initiatives
Each insurer is required to have antifraud initiatives reasonably calculated to detect fraudulent insurance acts, including, but not limited to: fraud investigators or an antifraud plan submitted to the commissioner prior to July 1, 2007. KAN.STAT.ANN. § 40- 2,118 (d). Any antifraud plan submitted to the commissioner is for informational purposes only, is not public record, and shall not be subject to discovery or subpoena in a civil action, unless the court determines (upon in camera review) the plan is relevant and otherwise admissible under the rules of evidence. *Id.*

Remedies for Fraudulent Claims
In addition to criminal penalties under section 40-2,118 (e), a person who violates this statute shall be ordered to make restitution to the insurer or any other person or entity for any financial loss sustained as a result of such violation. KAN.STAT.ANN. § 40-2,118 (f). An insurer shall not be required to provide coverage or pay any claim involving a fraudulent insurance act. *Id.* However, an insurer is not entitled to attorney fees under insurance fraud statute requiring payment of restitution to the insurer for any "financial loss sustained" as a result of a violation; the statute does not expressly authorize attorney fees. K.S.A. 40-2, 118(c); *Hershaw v. Farm & City Ins.* Co., 87 P.3d 360 (2004).

No Civil Liability for Reporting Fraud
In the absence of fraud, bad faith or malice, no person or insurer shall be subject to civil liability for libel, slander or any other relevant cause of action for filing reports or furnishing other information relating to suspected fraudulent insurance acts furnished to or received from law enforcement officials, their agents and employees or for the publication of any report or bulletin related to the official activities of the insurance department by the commissioner or any employee of the insurance department. KAN.STAT.ANN. § 40-2,119.

Criminal Anti-Fraud Division
There is established, within the insurance department, a criminal anti-fraud division of the Kansas insurance department, which shall accept information and complaints regarding possible insurance fraud. KAN.STAT.ANN. § 40-113(a). The criminal anti-fraud division also investigates possible violations of Kansas criminal statutes pertaining to and related to insurance fraud, and prepares criminal cases for prosecution by special assistant attorneys general and assists in prosecution of those cases. *Id.* The criminal anti-fraud division accepts complaints of insurance fraud from Kansas consumers, other divisions

within the insurance department, other state and federal law enforcement agencies, and insurance companies. KAN.STAT.ANN. § 40-113(b) The criminal anti-fraud division's investigators additionally prepares reports concerning investigations and preserve evidence. *Id.* The criminal anti-fraud division assists in the preparation and presentation of criminal cases and perform other such duties in the prevention, detection and prosecution of insurance fraud as may be necessary. KAN.STAT.ANN. § 40-113(c) Said preparation includes affidavits, interviews, preservation of evidence and securing the attendance of individuals involved in the case. *Id.* In presenting the prosecution's case, members of the criminal anti-fraud division may testify as to the facts of the case. *Id.*

KENTUCKY

Fraudulent Claims and Non-Accidental Fire Losses

1. Suspected Fraudulent Insurance Claim

Any insurer having knowledge or belief that an insurance claim is fraudulent must report that suspicion to the Division of Insurance Fraud Investigation of the Kentucky Department of Insurance. KRS 304.47-050(2). A "fraudulent insurance act" occurs when a person knowingly, and with intent to defraud an insurer, files an insurance claim containing false, incomplete, or misleading information concerning a material element of the claim. KRS 304.47-020(1)(b). Additionally, any person who "assists, abets, solicits, or conspires" with another to commit such an act is also guilty of a "fraudulent insurance act." KRS 304.47-020(1)(k).

The report made to the Division of Insurance Fraud must include any pertinent information in regard to the suspected claim (name of person making the claim, their location, etc.); additionally, the party filing the report should be prepared to provide additional information as required. KRS 304.47-050(2). The Division of Insurance Fraud will then make a report to the Attorney General, or other prosecuting agency with jurisdiction, for the commencement of prosecution. KRS 304.47-050(5). The reporting insurer is protected from civil liability for libel, slander, and related causes of action, assuming the insurer is proceeding without malice, fraud, or gross negligence. KRS 304.47-020(8).

Any person who violates KRS 304.47-020(1)(b) is guilty of a misdemeanor if the value of the claim is less than or equal to $500. If the value of the claim exceeds $500, the person is guilty of a felony, punishable by imprisonment of between one and five years, and a fine of between $10,000 and $100,000. KRS 304.47-020(2)(b).

2. Suspected Non-Accidental Fire Loss

If a person with intent to defraud an insurer sets fire to, burns, or causes to be burned any insured goods, wares, merchandise, or other personal property, that person is guilty of "burning personal property to defraud an insurer." KRS 513.060(1)(a-b). Additionally, any person who "aids, counsels, or procures" such an act is also guilty of "burning personal property to defraud an insurer." Any person who violates KRS 513.060(1) is guilty of a Class D felony. KRS 513.060(2).

3. Remedies for a Fraudulent Insurance Claim

In addition to the criminal penalties imposed by KRS 304.47-020(2)(a-b) and KRS 513.060(1), Kentucky law also provides restitution to parties damaged by a fraudulent claim. KRS 304.47-020(2)(d). The injured party may recover either the monetary value of the actual loss, or twice the offender's gain received as a result of the violation, whichever amount is greater. KRS 304.47-020(3). Additionally, if there is a criminal adjudication of guilt, the insurer may recover all reasonable investigation and litigation expenses, including attorney's fees. *Gibson v. Ky. Farm Bureau Mut. Ins. Co.,* 328 S.W.3d 195 (Ky. App. 2010) (interpreting KRS 304.47-020(3)).

LOUISIANA

1. What Rights Does an Insurer Have if Claimant is Suspected of Fraud

The Louisiana Insurance Code provides clear steps that must be taken when a fraudulent claim is suspected. Louisiana Revised Statute 22:1926 states:

Any person, company, or other legal entity including but not limited to those engaged in the business of insurance, including agents, brokers, and adjusters, which believes that a fraudulent claim is being made, shall within sixty days of the receipt of such notice, send to the section of insurance fraud, on a form prescribed by the section, the information requested and such additional information relative to the claim and parties claiming loss or damage because of an occurrence or accident as the section may require. The section of insurance fraud shall review such reports and select such claims as, in its judgment, may require further investigation. It shall then cause an independent examination of the facts surrounding such claim to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists in the submission of the claim

The section of insurance fraud shall report any alleged violations of law which its investigations disclose to the appropriate licensing agency, the insurance fraud investigation unit of the office of state police, the insurance fraud support unit of the Department of Justice, and the prosecutive authority having jurisdiction with respect to any such violation. These units shall work jointly on criminal referrals.

Thus, when an insurance company or other previously named body suspects that an insurance claim is fraudulent, it must provide the section of insurance fraud with documentation, in proper form, of its suspicions of fraud. This must be completed within sixty (60) days of its receipt of the notice of loss from the insured/claimant. Additionally, the section of insurance fraud must work with criminal prosecutors during the prosecution of any alleged fraudulent claimants.

An insurance company that denies a claim, in good faith, because of the suspicion of fraud shall enjoy civil immunity. According to Louisiana Revised Statute 22:1928:

No insurer, employees, or agents of any insurer , or any other person acting without malice, fraudulent intent, or bad faith, shall be subject to civil liability for libel, slander, or any other relevant tort, and no civil cause of action of any nature shall exist against such person or entity by virtue of the filing of reports or furnishing other information, either orally or in writing, concerning suspected, anticipated, or completed fraudulent insurance acts when such reports or information are required by this Part of required by the section of insurance fraud as a result of the authority herein granted or when such reports or information are provided to [omitted] …

As stated, the Insurance Company that acts in good faith and follows the stipulations of the revised statutes will enjoy civil immunity when claims are denied due to a suspicion of fraud.

2. What is the Standard for Dismissing a Case for Fraud After the Commencement of Litigation?

Louisiana Civil Code article 856 provides, “When fraud is alleged, the circumstances constituting fraud shall be alleged with particularity”. If fraud or mistake is plead, the factual circumstances that constitute fraud or mistake must be alleged with particularity. A condition of mind, such as malice, intent, or knowledge, can be alleged generally. La. Code Civ. Proc. Ann. art. 856. The failure to plead fraud with factual particularity will prohibit introduction of evidence of fraud at trial. Laneaux v. Theriot, 488 So. 2d 1327 (La. Ct. App. 3d Cir. 1986). It is subject to the exception of vagueness rather than the exception if no clause of action. Abadie v. Metropolitan Life Ins. Co., 784 So. 2d 46 (La. Ct. App. 5th Cir. 2001). The Louisiana Practice Guide gives the following examples:

Examples
The intentional act exception to the immunity afforded by worker's compensation law must be pleaded with particularity. Hillery v. Hartford Acc. and Indem. Co., 503 So. 2d 592 (La. Ct. App. 4th Cir. 1987); Mayer v. Valentine Sugars, Inc., 444 So. 2d 618 (La. 1984).

A purchaser's petition against the corporation's officers, which alleged they withheld information concerning an encroachment on the property, failed to allege fraud with the required particularity, where

the complaint did not contain the word "fraud," but rather alleged that the defendants "intentionally failed to reveal the existence of an existing encroachment at the time the original contract was negotiated," and did not further elaborate on the circumstances surrounding the alleged intentional misrepresentation. B-G & G Investors VI, L.L.C. v. Thibaut HG Corp., 985 So. 2d 837 (La. Ct. App. 4th Cir. 2008).

The Second Circuit Court of Appeals for Louisiana has stated the following standard for overturning a district court's finding of fraud and credibility determinations: "Where documents or objective evidence so contradict a witness' story, or the story itself is so internally inconsistent or implausible of its face, that a reasonable fact finder would not credit it, then the court of appeal may find manifest error in a finding purportedly based on a credibility call. Absent such factors, however, the district court's decision to credit testimony of one or two or more witnesses can virtually never be plainly wrong." Perow v. Lenzly, 716 So.2d 519 at 522 (La. App. 2d Cir. 8/19/98).

Fraudulent claims will void the terms of an insurance policy and absolve the insurance provider of any coverage that would have been provided under the terms of the policy. Many policies, by their own terms, contain explicit language that fraudulent claims will result in the voiding of all or parts of the policy itself.

3. In addition to having recourse against claimants making fraudulent claims, a manufacturer may have recourse against the attorneys of these claimants under both Louisiana state law and Federal law.

Louisiana Code of Civil Procedure article 863 provides in relevant part:

> B. Pleadings need not be verified by or accompanied by affidavit or certificate, except as otherwise provided by law, but the signature of an attorney or party shall constitute a certification by him that he has read the pleading; that to the best of his knowledge, information, and belief formed after reasonable inquiry it is well grounded in fact; that it is warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law; and that it is not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation….
>
> D. If, upon motion of any party or upon its own motion, the court determines that a certification has been made in violation of the provisions of this Article, the court shall impose upon the person who made the certification or the represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, including a reasonable attorney's fee….

Based on the above article, if counsel for a claimant making a fraudulent claim fails to exercise due diligence in investigating his clients' claims and thereby fails to discover the fraudulent nature of the claim, the defendant named therein may seek sanctions against the claimants' attorney.

Further, a manufacturer may similarly move for sanctions against the claimants' attorney pursuant to Rule 11 of the Federal Rules of Civil Procedure. Rule 11 provides in relevant part:

> (b) Representations to the Court. By presenting to the court a pleading, written motion, or other paper—whether by signing, filing, submitting, or later advocating it—an attorney or unrepresented party certifies that to the best of the person's knowledge, information, and belief, formed after an inquiry reasonable under the circumstances:
>
> (1) it is not being presented for any improper purpose, such as to harass, cause unnecessary delay, or needlessly increase the cost of litigation;
>
> (2) the claims, defenses, and other legal contentions are warranted by existing law or by a non-frivolous argument for extending, modifying, or reversing existing law or for establishing new law;
>
> (3) the factual contentions have evidentiary support or, if specifically so identified, will likely have evidentiary support after a reasonable opportunity for further investigation or discover; and

(4) the denials of factual contentions are warranted on the evidence or, if specifically so identified, are reasonably based on belief or a lack of information.

(c) Sanctions.

(1) In General. If, after notice and a reasonable opportunity to respond, the court determines that Rule 11 (b) has been violated, the court may impose an appropriate sanction on any attorney, law firm, or party that violated the rule or is responsible for the violation. Absent exceptional circumstances, a law firm must be held jointly responsible for a violation committed by its partner, associate, or employee.

Pursuant to Rule 11 (c)(4), the sanction imposed may be a nonmonetary directive; an order to pay a penalty into court; or, if imposed on motion and warranted for effective deterrence, an order directing payment to the moving party of part or all of the reasonable attorney's fees and other expenses directly resulting from the violation.

MAINE

I. Insurance Fraud in Maine

Maine Revised Statute Title 24-A, also known as the Maine Insurance Code, was enacted in 1969. 24-A M.R.S.A. §1. Title 24-A also created the Maine Insurance Bureau which, through its Superintendent, enforces the Maine Insurance Code. 24-A M.R.S.A. §211. What follows is a summary of the sections of Maine Insurance Code relevant to understanding fraudulent insurance acts in Maine.

A. Fraudulent Insurance Act Defined

The definition of a fraudulent insurance act in Maine is provided in 24-A M.R.S.A. §2186. This statute is broadly worded and requires the following acts or omissions to be committed knowingly and with intent to defraud: Presenting any information containing false representations as to a material fact with knowledge or belief that the information will be presented by or on persons engaged in the business of insurance concerning applications, ratings, claims, payments, or premiums; filing documents with the superintendent, insurance regulatory officials, financial conditions or actions of an insurer, issuing or reinstating insurance policies; Soliciting or accepting insurance risks on behalf of an insolvent insurer; destroying assets or records; embezzling; unlicensed insurance practice; aiding and abetting any of the above. 24-A M.R.S.A. §2186.

This provision also requires insurers to report fraudulent insurance acts to the superintendent annually on or before March 1st, but without containing any information identifying any individuals or entities. 24-A M.R.S.A. §2186(4). Insurers must also include a fraud warning on all applications and claim forms of any kind with the statement: "It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalities may include imprisonment, fines or a denial of insurance benefits." 24-A M.R.S.A. §2186(3)(A).

An insurer is able to recover reasonable costs and attorney's fees in a civil action having proven a person committed a fraudulent insurance act. 24-A M.R.S.A. §2186(7); But see Pine Ridge Realty, Inc. v. Massachusetts Bay Ins. Co., 752 A.2d 595, 602 (Me. 2000) (Despite clear fraud, no costs or fees awarded because insurer mistakenly issued wrong policy). Conversely, the court can award the person reasonable costs and attorney's fees if the insurer's allegations were not supported by any reasonable basis of law or fact. 24-A M.R.S.A. §2186(7).

If an insurer, or anyone for that matter, alleges fraud, they bear the burden of proving it by clear and convincing evidence. Laforge v. LeBlanc, 18 A.2d 138, 141 (Me. 1941).

B. Civil Penalties

The Attorney General and the Superintendent of Maine's Bureau of Insurance, if the Attorney General does not intend to pursue action in Superior Court, have the authority to issue civil penalties for violations of any provision under Title 24-A. 24-A M.R.S.A. §12-A. Subject to other applicable law, the superintendent has authority to issue penalties on individuals up to $500 and on corporations up to $10,000 for each violation. The Attorney General may assess civil penalties between $500 and $5,000 for individuals and between $2,000 and $15,000 for corporations, per violation. Wood v. Superintendent of Ins., 638 A.2d 67, 73 (Me. 1994) (Affirming civil penalties imposed on licensee by Superintendent for misrepresentation on license application form).

Civil penalties may be imposed, for example, where the insurer engages in certain "unfair practices," among them: Failing to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies; Failing to develop and maintain documented claim files supporting decisions made regarding liability; and Refusing to pay claims without conducting a reasonable investigation. 24-A M.R.S.A. §2164-D(3)(C-D); 24-A M.R.S.A. §2186(5). But see Lessard v. Allstate Ins. Co., 2001 WL 1712653, *2 (Me. Super. Mar. 12, 2001) (Insureds are not entitled to bring a private cause of action for violations of section 2164-D).

C. Criminal Penalties

Maine also enforces criminal penalties where a person is guilty of deceptive insurance practices. 17-A M.R.S.A. §901-A. As applicable to an insured, one is guilty of deceptive insurance practices if in the business of insurance that person intentionally makes a false statement with respect to a material fact concerning, or intentionally materially alters, any documents similarly referenced under 24-A M.R.S.A. §2186, supra. Violation of 17-A M.R.S.A. §901-A is a Class D crime, punishable by up to 364 days incarceration and a $2,000 fine. See 17-A M.R.S.A. §1252.

D. Reporting Immunity

Maine requires insurers to make relevant information and evidence available to assist authorized agencies in conducting investigations of fraudulent insurance acts. 24-A M.R.S.A. §2187(2). Consequently Subsection (5) also provides beneficial immunity to insurers who disclose the required information: "In the absence of fraud, malice or bad faith, any person, including but not limited to, an insurer or authorized agency, that furnished information relating to suspected, anticipated or completed fraudulent insurance acts is not liable for any damages in any civil action for furnishing the information if that information is furnished to or received from an authorized agency." 24-A M.R.S.A. §2187(5).

This provision also gives insurers the right to receive upon request other information collected by the authorized agencies related to suspected fraud. 24-A M.R.S.A. §2187(4). Additionally, insurers themselves are also protected by statute from defamatory actions of persons making, publishing or disseminating oral or written statements which are false, maliciously critical or derogatory to an insurer. 24-A M.R.S.A. §2157.

II. Misrepresentation

An insurer can prevent recovery of a claim based on a misrepresentation, omission, concealment of facts or incorrect statement only where that statement or omission was fraudulent or material to the acceptance of risk or hazard assumed by the insurer, such that the insurer in good faith would have not issued the insurance contract or amended it significantly. 24-A M.R.S.A. §2411; See Liberty Ins. Underwriters, Inc. v. Estate of Faulkner, 957 A.2d 94, 100 (Me. 2008) (Analyzing history of §2411); York Mut. Ins. Co. v. Bowman, 746 A.2d 906 (Me. 2000).

Section 2411(3) lists a number of specific types of insurance covered by the statute but is not inclusive of all insurance types. Case law has developed to hold that where the alleged misrepresentation is of a type listed in the statute, the insurer may prove either fraud or materiality, but if the contested insurance is of an unlisted type, the insurer must prove both fraud and materiality. Estate of Faulkner, 957 A.2d at 100. In all circumstances, the insurer must prove reliance. Id. In some other situations, however, even where an insurer may rely on a material incorrect statement, the resolution is not to prevent recovery, but amend the benefits available. See e.g. 24-A M.R.S.A. §2508 (Misstatement of age in life insurance and annuity contracts resolved by paying benefits in amount accruing if premium purchased at correct age).

III. Conclusion

In 2009, "An Act To Create the Insurance Fraud Division within the Department of Professional and Financial Regulation, Bureau of Insurance" (SP0466, LD 1285) was presented to the 124th Maine State Legislature but it was voted down. Maine's Bureau of Insurance and Superintendent are therefore still left with limited authority and ability to investigate and prevent insurance fraud. As a result, Maine lags behind many states in its ability to deter and punish insurance fraud.

MARYLAND

Maryland, like many states, has enacted laws which would discourage the making of fraudulent insurance claims.

Section 27-802 of the Maryland Insurance Code, for example, specifically requires that an insurer or insurance producer report suspected insurance fraud in writing either to the Maryland Insurance Administration or to the appropriate law enforcement authority. If the person who reports the suspected fraud is acting in good faith, no civil liability will attach to the reporting.

Section 27-805 requires that most applications for insurance and claim forms contain the following statement or a substantially similar statement: "Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison."

Maryland common law also provides some guidance as to fraud issues. For example, there are a number of older Maryland cases which have discussed the circumstances under which an insurer may assert fraud as a defense to a first party claim. This defense, sometimes known as "false swearing," is a difficult one to assert. As the Maryland Court of Appeals explained in the context of a fire insurance policy:

> To constitute false swearing within the meaning of the contract of insurance, so as to render the policy void, the statement so made must not only be untrue, but it must be shown that it was knowingly and intentionally stated with knowledge of its untruthfulness, or that it was so stated as a truth when the party did not know it to be true, and had no reasonable grounds for believing it to be true, and was so made with the purpose to defraud.

United States Fire Ins. Co. v. Merrick, 171 Md. 476, 491; *see also Great Southwest Fire Ins. Co. v. S.M.A., Inc.*, 59 Md. App. 136, 142 (1984) (to constitute false swearing within the meaning of a contract of insurance, the misstatements must be "knowingly and intentionally stated…, and the "[i]ntent to defraud is not to be presumed.") Fraud is never presumed, the burden of proof is upon the insurer, and this issue is one normally for the trier of fact. *United States Fire Ins. Co.,* 171 Md. at 491. An "honest mistake on the part of the insured as well as … the tendency to believe that which is to one's own interest" is not sufficient to demonstrate the requisite false swearing. *Tru-Fit Clothes v. Underwriters at Lloyd's London,* 151 F.Supp. 136, 139 (D. Md. 1957).

More recent cases have also held that an insurer may under appropriate circumstances assert fraud as a defense to a first-party claim. In Phillips v. Allstate Indemnity Co., the insured, in pursuing a claim for the

alleged theft of his motorcycle, made several material misrepresentations during his recorded statement. *Phillips v. Allstate Indemnity Co.,* 156 Md. App. 729, 734-37 (2004). Using this policy provision (as well as others), Allstate denied the claim. Id. at 736 . Thereafter, the insured filed a complaint for declaratory judgment. Id. Allstate moved for summary judgment and the circuit court granted its motion. Id. at 736-37. On appeal, the Maryland Court of Special Appeals held that "the circuit court did not err by granting summary judgment." Id. at 748.

Similarly, the U.S. District Court for the District of Maryland addressed over-inflation of a claim under a fire insurance policy. In *Simms v. Mutual Ben. Ins. Co*., 2009 WL 1702999, *7 (D. Md. 2003) the court stated:

> Where an insured person, in making proof of loss by fire, overestimates the value of the property destroyed by mistake or inadvertence, the overvaluation alone does not amount to fraud sufficient to avoid the policy. The jury should make all reasonable allowance for lack of knowledge, or sound judgment, or for honest mistake on the part of the insured as well as for the tendency to believe that which is to one's own interest. If the trier of fact finds that there was a willful misstatement made with the intent to defraud, the insurance policy is void, even if defendants were not prejudiced by relying on the misstatements. Whether an insured intended to deceive an insurer is a question of fact. "To constitute false swearing and willful misrepresentation in the proof of loss so as to bar insured's recovery on policy as a matter of law, it must appear undisputed that misstatements were knowingly made with intent to deceive or defraud the insurer." (citations omitted).

Id. At *7, the district court ultimately denied the insurer's motion for summary judgment, finding that genuine issues of material fact existed as to whether plaintiffs knowingly made false statements with an intent to defraud the defendant. *Id*. At 8.

In addition to the fraud provision of the policy, insurers can sometimes also assert a "lack of cooperation" as another basis for the denial of coverage. *See, e.g. Travelers Ins. Co. v. Godsey*, 260 Md. 669 (1971); *Fidelity & Cas. Co. of New York v. McConnaughy*, 228 Md. 1(1962); *Farm Bureau Mut. Auto. Ins. Co. v. Garlitz*, 180 Md. 615 (1942).

> The contractual obligation to cooperate with the insurer includes the obligation to make a fair, frank and truthful disclosure to the insurer for the purpose of enabling it to determine whether or not there is a defense and the obligation, in good faith, both to aid in making every legitimate defense to the claimed liability and to render assistance in the trial.

The Travelers Ins. Co. v. Godsey, 260 Md. 669, 673 (1971).

Despite these provisions, there is the possibility of a common law action for defamation or malicious prosecution where fraud is reported. Consequently, it is important that a claims file is well documented, that the suspicion concerning fraud is legally and factually supported, and that there is review of the claims file by more than one person prior to any fraud reporting.

MASSACHUSETTS

I. Insurance Fraud in Massachusetts

By now, Massachusetts is better known for Mass. Gen. Laws Ann. ch. 93A, which exposes companies, including insurers, to as much as treble damages for engaging in fraudulent, unfair or deceptive practices. While it is important for insurers to be dutifully aware of their responsibilities under 93A, such duties are not addressed in detail here. The present analysis alternatively focuses on Massachusetts laws designed to protect the insurers and their rights against fraudulent insureds.

A. Background

By way of background, many of Massachusetts' multiple insurance fraud statutes are derived in part from the elements of the crime of larceny by false pretenses. See

generally 32 Mass. Prac. Series, Criminal Law §347. The elements of larceny by false pretenses include: (1) making a false statement of fact; (2) the defendant knew or believed that the statement was false when he made it; (3) the defendant intended that the person to whom he made the false statement would rely on it; and (4) the person to whom the false statement was made did rely on it and, consequently, parted with property. Id.; See e.g. Com. v. Mills, 764 N.E.2d 854, 863 (Mass. 2002) (outlining elements of false pretenses).

As discussed below, these elements prevail, albeit with degrees of variation, in several subsequently enacted statutes. See Mass. Gen. Laws Ann. ch. 12 §§5B-5O (Massachusetts False Claims Act); Mass. Gen. Laws Ann. ch. 118E §40 (Medicaid False Claims Act); Mass. Gen. Laws Ann. ch. 152 §14 (Workers' Compensation Fraud); Mass. Gen. Laws Ann. ch. 175 § 113V (Over-Utilization of Practice or Fraud Involving Automobile Insurance Claims); Mass. Gen. Laws Ann. ch. 175 §186 (Misrepresentation or Warranty by Insured); Mass. Gen. Laws Ann. ch. 175H §1-8 (False Health Claims); Mass. Gen. Laws Ann. ch. 266 §110 (Fraudulent Invoice of Ship Cargo to Defraud Insurer); Mass. Gen. Laws Ann. ch. 266 §111 (False Affidavit of Ship Cargo to Defraud Insurer); Mass. Gen. Laws Ann. ch. 266 §111A (Insurance Fraud Generally); Mass. Gen. Laws Ann. ch. 266 §111B (Motor Vehicle Insurance Fraud).

B. The Insurance Fraud Bureau ("IFB")

In 1991, Massachusetts legislators created the Insurance Fraud Bureau ("IFB"). See St.1990, c. 338; St.1991, c. 398, §99; St.1996, c. 427, §13; St.2002, c. 279, §5. While never codified by the Massachusetts General Laws, this legislation created the IFB which essentially replaced the now defunct Fraudulent Claims Board ("FCB") of the Massachusetts Division of Insurance codified under Mass. Gen. Laws Ann. ch. 26 §8B. See Dwyer v. Commissioner of Insurance, 376 N.E.2d 826 (Mass. 1978) (describing failure and closure of the FCB). The Division of Insurance itself now provides a link on its website to the IFB (www.ifb.org).

The role and authority of the IFB is outlined in detail in Com. v. Ellis, 708 N.E.2d 644, 646-47 (Mass. 1999) (citing St.1996, c. 427 §13); See also U.S. v. Pimental, 380 F.3d 575, cert. denied 543 U.S. 1177 (1st Cir. (Mass.) 2004). In short, the IFB is a combination of members and resources from the Automobile Insurance Bureau of Massachusetts (AIB) and the Workers' Compensation Rating and Inspection Bureau of Massachusetts (WCRIB), created with the purpose of preventing and investigating fraudulent insurance transactions. In pertinent part, §13(e) reads: "Any insurer…or other similar entity, having reason to believe that an insurance transaction may be fraudulent, or having knowledge that a fraudulent insurance transaction is about to take place, or has taken place, shall within thirty days after determination that the transaction may be fraudulent, send to said [IFB] on a form prescribed by [IFB]…and such additional information relative to the transaction and the parties involved [as may be required]." Of note is that "fraudulent insurance transactions" is broadly interpreted to include fraud, as defined by any laws of the commonwealth, committed or aided by any conceivable participant to the fraud, including but not limited to: the claimant, medical provider, attorney, agents, and insurers. §13(e).

Upon receipt of the report, the IFB shall review and investigate the validity of the concerns and underlying transaction. §13(f). To assist the investigation, the IFB has full access to records kept by the Registry of Motor Vehicles, Department of Industrial Accidents, Department of Revenue, insurance company records, Department of Transitional Assistance, WCRIB records, Department of Employment and Training, and criminal offender records. §13(d). Effective in 2005, Mass. Gen. Law Ann. ch. 175 §113V created the additional authority for the IFB, and the AIB in particular, to exchange

information with the medical licensing boards to compare records and seek out practitioners or groups over-utilizing or fraudulently using automobile insurance claims.

If the investigation concludes that a material fraud, deceit or intentional misrepresentation has been committed in an insurance transaction, or that a violation of any other law of the Commonwealth concerning insurance fraud has occurred, the matter is referred to the Attorney General, appropriate District Attorney or United States Attorney. §13(h). The suspected violation is also reported to appropriate licensing agents such as the Registry of Motor Vehicles, medical review boards, or Board of Bar Overseers.

If a person is ultimately convicted for the violation of any law concerning insurance fraud, they must make restitution to the insurer for any financial loss sustained as a result of such violation. §13(k). Conversely, in the absence of bad faith or malice, no insurers, members of the IFB or any other person involved in the statements, reports or actions related to the IFB investigations shall be subject to civil or criminal liability for damages. §13(i).

II. Insurance Fraud Generally

The broadest statute in Massachusetts addressing insurance fraud is Mass. Gen. Laws Ann. ch. 266, §111A, enacted in 1926 and amended in 1982 and 2002. This section reads in pertinent part:
Whoever, in connection with or in support of any claim under any policy of insurance issued by any company…and with intent to injure, defraud or deceive such company, presents to it, or aids or abets in or procures the presentation to it of, any notice, statement, proof of loss…knowing that such notice, statement, proof of loss…contains any false or fraudulent statement or representation of any fact or thing material to such claim…or whoever aids or abets in [the same], shall…be punished by imprisonment in the state prison for not more than five years or imprisonment in jail for not less than six months nor more than two and one half years or by a fine of not less than $500 nor more than $10,000, or by both such fine and imprisonment in jail.

M.G.L.A. c. 266 §111A (emphasis added). This law is enforced across various types of insurance fraud. See Com. v. Williams, 827 N.E.2d 1281 (Mass.App.Ct. 2005) (workers' compensation benefits fraud); Com. v. Shuman, 462 N.E.2d 80 (Mass. 1984) (motor vehicle fraud); Com. v. Siano, 344 N.E.2d 920 (Mass.App.Ct. 1976) (fire related property damage fraud). These types of fraud have their own specific statutes and applications as well which are discussed, infra. Also, in 2004, Massachusetts enacted Mass. Gen. Law Ann. ch. 266 §111C, aimed at prosecuting providers and those that assist providers, termed "runners," seeking to defraud insureds and/or insurers. See e.g. Com. v. Lonardo, 908 N.E.2d 831 (Mass.App.Ct. 2009).

A. Misrepresentations

Massachusetts has a statute to address misrepresentation by insureds during negotiations for coverage which allows insurers to subsequently invalidate a policy in certain circumstances. Mass. Gen. Laws Ann. ch. 175 § 186; See Northwestern Mut. Life Ins. Co. v. Iannacchino, 950 F.Supp. 28 (D.Mass. 1997). Under §186(a), the statute defines material misrepresentation as when the insured (or one acting on her behalf) made misrepresentations with actual intent to deceive or the misrepresentation increased the risk of loss. See e.g. Hanover Ins. Co. v. Leeds, 674 N.E.2d 1091 (Mass.App.Ct. 1997); But see Quincy Mut. Fire Ins. Co. v. Quisset Properties, Inc., 866 N.E.2d 966 (Mass.App.Ct. 2007) review den. (Absent provision in policy requiring insured to notify insurer of particular changes, court held it was not misrepresentation for insured to not identify material changes).

In §186(b), the statute specifically addresses physical conditions and health risks in relation to life or endowment insurance, and incorporates the same material definition as (a). However, §186(b) also adds misstatements may be material if knowledge or ignorance of it would have otherwise influenced the insurer in making the contract, estimating risk, or fixing the rate of premium. See e.g. Mass. Mut. Life Ins. Co. v.

Fraidowitz, 360 F.Supp.2d 243 (D.Mass. 2005), aff. 443 F.3d 128. To avoid or cancel an insurance policy under §186, the insurer bears the burden of proof to show actual misrepresentation, intent and/or increased risk of loss. See e.g. Hanover Ins. Co. v. Treasurer and Receiver General, 910 N.E.2d 921 (Mass.App.Ct. 2009).

B. Considerations When Alleging Fraud Against Insured

An insurer must be aware of the risk of retaliatory accusations available to an insured if an investigation into alleged fraud is not handled appropriately. Typical accusations by an insured following or accompanying investigations for fraud may include breach of contract for failure to pay a claim, unfair and deceptive practice under Massachusetts consumer protection statute Mass. Gen. Laws Ann ch. 93A, defamation, and invasion of privacy. See Ellis v. Safety Ins. Co., 672 N.E.2d 979 (Mass.App.Ct. 1996).

When addressing allegations of defamation by an insured, it is important to note that submitting fraudulent insurance claims is a crime under M.G.L.A. c. 266 §111A, and imputation of crime is defamatory per se, requiring no proof of special damages. Id.; Phelan v. May Dept. Stores Co., 819 N.E.2d 550, 554 (Mass. 2004). While analyzed on a case by case basis, in many such cases an insurer's actions should be defensible unless the investigation or denials of claims were fraudulent or made in bad faith. See St. 1996 c. 427 §13(i); See also Adams v. Liberty Mut. Ins. Co., 799 N.E.2d. 130, 141 (Mass.App.Ct. 2003) (Elements of malicious prosecution also include required showing of malice).

Given the potential for retaliatory actions by insureds, it is of course wise for the insurer to keep a detailed record of their own investigation and appropriately manage their investigators. See Ellis v. Safety Ins. Co., 672 N.E.2d at 983, fn 6 (Insurer liable for actions of investigator through respondeat superior). Additionally, the authority invested in the IFB to conduct thorough investigations, recommend punishments, and notice prosecutors under the protection of the law, provides good incentive for insurers to take advantage of that entity.

III. Insurance Fraud Specifically

As already referenced, supra, Massachusetts enacted a number of statutes addressing specific categories of insurance fraud. Of those statutes, the following is a brief outline of some of the major "branches" of statutes enacted to combat insurance fraud and provide insurer's an avenue of recourse.

A. Motor Vehicle Insurance Fraud

Fraudulent insurance claims specific to motor vehicles were criminalized by Mass. Gen. Law Ann. ch. 266 §111B, which incorporated much of the same language as Mass. Gen. Laws Ann. ch. 266 §111A. See also Mass. Gen. Laws Ann. ch. 266 §27A (Crime of removal or concealment of a motor vehicle with the intent to defraud an insurer). This section also requires intent, covers any aiders and abettors and calls for comparable, yet slightly different, punishments. See e.g. Com. v. Jerome, 780 N.E.2d 108 (Mass.App.Ct. 2002). §111B expands its scope to specifically include motor vehicle damage appraisers who, under the same standards, face the additional penalty of having their license revoked for a period not to exceed two years.

The other additional penalty under §111B calls upon the court, after conviction, to conduct an evidentiary hearing to determine the financial losses caused by the motor vehicle fraud. In all cases, in addition to the criminal punishments, the fraudulent party must pay restitution to the insurer for that financial loss or be held in contempt of court. Two primary differences between motor vehicle insurance fraud and larceny by false pretenses, is that §111B does not require either reliance or actual deprivation of property and larceny by false pretenses does not require material misrepresentation. Com. v. Charles, 704 N.E.2d 1137 (Mass. 1999); See generally Massachusetts v. Mylan

Laboratories, 357 F. Supp. 2d 314, 321-22 (D. Mass. 2005) (Articulating definitions of misrepresentation and reliance thereupon).

B. Health Insurance Fraud

Massachusetts has enacted the Medicaid False Claim Act under Mass. Gen. Law Ann. ch. 118E §40. Anyone who knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for a Medicaid benefit may face imprisonment of up to two and one-half years and a fine of not more than $5,000.00, or by both a fine and imprisonment. The Division of Medical Assistance has the authority to verify the applicant's income and resources through banks, the Internal Revenue Service and the Social Security Administration. Actual submission of a claim to Medicaid is required in order to show Medicaid fraud by a service provider in making a false statement or representation of a material fact for use in determining rights to medical assistance benefits or payments under state statutes. Com. v. Kobrin, 893 N.E.2d 384 (Mass.App.Ct. 2008); Com. v. Brown, 904 N.E.2d 452, 463 (Mass.App.Ct. 2009) review granted, 910 N.E.2d 909 (Mass. 2009) and aff'd, 925 N.E.2d 845 (Mass. 2010) (In connection with the various prescriptions and office visits found by the jury to have been without an intended medical purpose, the defendant was convicted of Medicaid fraud).

Mass. Gen. Law Ann. ch. 175H §2 also broadly criminalizes health insurance fraud, once again incorporating the standard insurance fraud requirements of showing the insured intentionally ("knowingly and willfully") misrepresented material facts. See also Mass. Gen. Law Ann. ch. 175 §108 (Addressing misstatements of fact by insured to health insurance providers). This provision also prohibits, under penalty of fine or imprisonment, payments or referrals to use services covered by insurance. Mass. Gen. Law Ann. ch. 175H, § 3. The rest of the sections describe available jurisdictions for the criminal proceedings, authority of the Attorney General to investigate, and the additional penalties available under civil proceedings, independent of the outcome of criminal proceedings, for the insurer to recover reimbursement of paid benefits, reasonable attorneys fees and costs, investigation costs. Mass. Gen. Law Ann. ch. 175H §§4-8.

C. Workers' Compensation Fraud

Massachusetts enacted statutes which protect both the insured and the insurer in Workers' Compensation claims. See Mass. Gen. Laws Ann ch. 152, §14. Under M.G.L.A. c. 152 § 14(1), an insurer can be held responsible for the cost of proceedings, additional compensation, and double back-benefits if an insurer brought, prosecuted or defended a claim without reasonable grounds. This same statute, c.152 § 14(1), also punishes employees and/or their counsel for any proceedings unreasonably bought.

In either situation, if any party, including the party's attorney, expert witness or anyone acting on the party's behalf concealed or knowingly failed to disclose that which is required by law, the insurer, or insured, should refer the situation to the WCRIB or IFB. Id. at §14(2); St.1996, c. 427 §13. Notwithstanding whatever action the IFB may take, the fraudulent party could be: issued a penalty of six times the average weekly wage of the Commonwealth, referred to the Board of Bar Overseers (if attorney), referred to the medical disciplinary board (if medical professional), imprisoned for not less than six months and not more than two and half years, fined not less than one thousand dollars and not more than ten thousand dollars and/or have to pay restitution for any loss. M.G.L.A. c. 152 §14(3).

IV. Conclusion

When addressing an issue of potential insurance fraud in Massachusetts, it is important to understand these three primary considerations: 1) The law expects both parties, insurer and insured, to produce and share accurate, truthful information at all times; 2) When that does not happen, the claim should be

referred to the IFB; 3) If a party is deemed to have concealed or negligently failed to disclose that which is required by law, it can be punished criminally and civilly at a considerable expense.

MINNESOTA

Minnesota's legislature has taken action to reduce fraudulent claims. MINN. STAT. §§ 60A.951–.956 (2012). Insurers that have a reasonable belief that an act of insurance fraud is being committed shall furnish and disclose all relevant information to the Division of Insurance Fraud Prevention or to any authorized person and cooperate fully with any investigation conducted by the Division. *Id.* § 60A.952 subdiv. 2. Insurers are immune from any liability, civil or criminal, for the good faith release or reporting of the information. *Id.* § 60A.952 subdiv. 3. Insurers must establish and maintain an antifraud plan. *Id.* § 60A.954. An antifraud plan shall establish procedures to prevent fraud, report fraud to law enforcement and cooperate with the prosecution of insurance fraud cases. *Id.*

Where a person misrepresents a material fact relating to even a part of a claim, Minnesota courts have held that their entire claim may be denied. *See, e.g.*, *Collins v. USAA Prop. & Cas. Ins. Co.*, 580 N.W.2d 55, 57 (Minn. Ct. App. 1998) (finding that insured lost all right to recover after a fire, including for loss of building, by misrepresenting value of personal property); *Bahr v. Union Fire Ins. Co.*, 209 N.W. 490, 491 (Minn. 1926) ("[A]ny attempt to defraud the insurer by the insured voids the policy, even though that attempt be abortive, or did not influence . . . the insurer"); *see also Hamberg v. St. Paul Fire & Marine Ins. Co.*, 71 N.W. 388, 389 (Minn. 1897) (holding that "willful false swearing" as to any material article of insurance policy prevents insured from recovering under whole policy).

These cases are consistent with MINN. STAT. § 65A.01 subdiv. 3, which provides:

> This entire policy shall be void if, whether before a loss, the insured has willfully, or after a loss, the insured has willfully and with intent to defraud, concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interests of the insured therein.

And an automobile insurer may recover all benefits paid due to intentional misrepresentation. *Id.* § 65B.54 subdiv. 4.

Minnesota's criminal statutes prohibit false representations or concealment of any material fact concerning the application, claim, or payment process under an insurance policy. *Id.* § 609.611 subdiv. 1(a).

Sometimes an insured or claimant tries to bring a claim for malicious prosecution, where the insurer has taken steps under Minnesota's anti-fraud scheme. Just like any other malicious prosecution plaintiff, the insured or claimant must prove that: (1) the insurer accused the plaintiff of fraud without probable cause and with no reasonable ground on which to base a belief that the plaintiff would prevail on the merits; (2) the insurer's suit must have been brought and prosecuted with malicious intent; and (3) the insurer's suit must terminate in favor of the defendant. *See Jordan v. Lamb*, 392 N.W.2d 607, 609 (Minn. Ct. App. 1986).

MISSISSIPPI

A. Insurance Fraud

A person or entity shall not knowingly and willfully falsify, conceal or omit material facts or make any false statements or representations in connection with the provision of insurance programs. Miss. Code Ann. § 7-5-303(5). Furthermore, a person or entity shall not fraudulently deny the payment of an insurance claim. Miss. Code Ann. § 7-5-303(6). In Mississippi, the Insurance Integrity Enforcement Bureau, an arm of the Attorney General's Office, is designated with the task of policing insurance claims to reduce fraud. *See* Miss. Code Ann. §§ 7-5-301. This unit investigates and prosecutes insurance fraud. If any workers' compensation provider, health insurance provider, employee of the Workers' Compensation Commission

or other person or entity has a belief or has information regarding a false or misleading statement or representation or fraud or fraudulent denial has been made in connection with any workers' compensation claim or insurance claim, such person or entity may report this information to the Bureau. Miss. Code Ann. §§ 7-5-307(1). The Attorney General or the district attorney in the district where the violation occurred may institution the prosecution of cases involving insurance fraud and will be conducted in the name of the State of Mississippi. Miss. Code Ann. § 7-5-307(2).

In *Washington v. Woodland Village Nursing Home*, 25 So.3d 341 (Miss.App.2009), the Mississippi Court of Appeals declined to declare that public policy bars the receipt of workers' compensation benefits when a claimant has committed workers' compensation fraud, deciding that it overreached their judicial authority. The Court reasoned that because the Mississippi Workers' Compensation Law is a legislative creation, the Legislature alone has the power to create and modify statutes. The Legislature did not include a provision in the Workers' Compensation Law that would cause the forfeiture of benefits if the claimant committed insurance fraud. Instead, the Legislature vested the Commission with the duty to determine the viability of claims, including the authority to reject claims that are not credible Miss. Code Ann. § 71-3-1. The Court declined to create an exception, holding that the enactment of such a provision lies firmly within the legislative sphere. Certiorari was denied in January, 2010.

Senate Bill 2649, which was introduced in the 2012 regular session, attempted to make law that would deny an employee the right to receive workers' compensation payments or benefits if a court of competent jurisdiction or the commission determined that the employee knowingly made false representations to secure benefits. The Bill also sought to increase the criminal fines for misrepresentation to obtain workers' compensation payments or benefits and to amend Miss. Code Ann. § 7-5-309, to increase the criminal fines for insurance fraud. However, said Bill died in committee.

Pursuant to Miss. Code Ann. § 7-5-309, the current penalties in Mississippi for insurance fraud are imprisonment for not more than three (3) years, or by a fine of not more than Five Thousand Dollars ($5,000.00) or double the value of the fraud, whichever is greater, or both. Sentences imposed for convictions of separate offenses may run consecutively. If the offender is an organization within the definition of the section, then a fine of not more than One Hundred Fifty Thousand ($150,000.00) shall be imposed for each violation. Also, in addition to these penalties, the court will assess double the reasonable costs incurred by the Insurance Integrity Enforcement Bureau or by the district attorney's office.

Also, Miss. Code Ann. § 97-17-11 provides that a person who, willfully and with intent to injure or defraud the insurer, burns or attempts to burn or who causes to be burned or assists in burning any structure or personal property which is insured is guilty of a felony and is sentenced to the penitentiary for not less than one (1) year nor more than ten (10) years. The inability to recover on the policies is not a defense to prosecution. *Brower v. State*, 64 So.2d 576 (Miss.1953). Burden of proof is established upon a showing that the property burned and was caused by criminal agency. *Id.*

B. Fraudulent Claims Generally

Under Mississippi law, a person who is accused of an offense, such as fraud, may pursue a claim for malicious prosecution or defamation.

1. Malicious Prosecution
   The elements of a prima facie case of malicious prosecution are: (1) the institution or continuation of original judicial proceedings, either criminal or civil; (2) by, or at the insistence of the defendants; (3) the termination of such proceeding in plaintiff's favor; (4) malice in instituting the proceeding; (5) want of probable cause for the proceedings; and (6) the suffering of injury or damages as a result of the action or prosecution. *Stephens v. Kemco Foods, Inc.*, 928 So. 2d 226, 229 (Miss. Ct. App. 2006).

2. Defamation
   To prove defamation under Mississippi law, the following elements must be shown: (1) a false statement that has the capacity to injure the plaintiff's reputation; (2) an unprivileged publication to a third party; (3) negligence or greater fault on part of publisher; and (4) either actionability of statement irrespective of special harm or existence of special harm caused by publication. *Mayweather v. Isle of Capri Casino, Inc.*, 996 So.2d 136, 141 (Miss. Ct. App. 2008). However, "statements made in connection with judicial proceedings, including pleadings, are, if in any way relevant to the subject matter of the action, absolutely privileged and immune from attack as defamation, even if such statements are made maliciously and with knowledge of their falsehood." Central Healthcare Services, P.A. v. Citizens Bank of Philadelphia 12 So.3d 1159, 1168 (Miss. Ct. App. 2009).

C. Disbarment for Fraudulent Claims

If an attorney knowingly files a false claim, he or she risks disbarment. *Mississippi Bar v. Arledge*, 37 So.3d 607 (Miss. 2009). In *Arledge*, the attorney sent fraudulent claims to a pharmaceutical manufacturer in order to receive settlement funds. *Id.* Arledge was found guilty of conspiracy, mail fraud, and wire fraud. *Id.* In addition to his criminal convictions, Arledge violated Rule 6 of the Rules of Discipline for the Mississippi State Bar which states in pertinent part that any attorney found guilty of any felony or misdemeanor involving fraud, dishonesty, or misrepresentation shall be disbarred. *Id.*

MISSOURI

Insurance Broad Statutes

Missouri has enacted legislation against insurance fraud at R.S.Mo. § 375.991, which makes it an unlawful act to present a claim for payment where the claimant knows the claim contains "materially false information concerning any facts material thereto or if such person conceals, for the purpose of misleading another, information concerning any fact material thereto." The Missouri statute goes on to state that a fraudulent insurance act will also include: "unbundling," where a claim requests a number of medical procedures instead of a single comprehensive procedure; "upcoding," where a claim is made for a more serious or more extensive procedure than actually was performed; "exploding," where a claimant claims that a series of tests was performed on a single sample when actually the series of tests was part of one battery of tests; and "duplicating," where the medical claim is resubmitted through separate health care providers after the original submission.

Criminal and Civil Repercussions of Fraud

Violating R.S.Mo. § 375.991 is a Class D felony. "Any person who pleads guilty to or is found guilty of a fraudulent insurance act who has previously pled guilty or has been found guilty of a fraudulent insurance act shall be guilty of a Class C felony." Further, any person who pleads guilty or is found guilty of a fraudulent insurance act owes restitution to the insurer for any financial loss sustained as a result of such violation, and the Court shall determine the nature and method of the restitution.

Responsibilities of the Reporting Insurer

Any company which believes that a fraudulent claim is being made against them has sixty (60) days after notice of said claim to report the fraudulent claim to the Department of Insurance, Financial Institutions and Professional Registrations ("Department"). They must do so on a form prescribed by the Department, and the Department will review such reports and select such claims as, in its judgment, may require further investigation. The Department shall then do an independent examination of the facts surrounding the claim to determine the extent of possible fraud or deceit and report any alleged violations of law to the appropriate licensing agency and prosecutive authority having jurisdiction with respect to the violation. Any violation under § 375.991 falls also under R.S.Mo. § 374.048, which lists the different types of appropriate relief beyond simple restitution, which will be determined on a case-by-case basis.

Insurer's Bad Faith Statute

R.S.Mo. § 375.445 codifies the bad faith practices statute in Missouri. This statute states an insurer may be liable if it conducts its business fraudulently, fails to carry out contracts in good faith, or habitually or as

a matter of business practices compels claimants to accept either less than the amount due or resort to litigation against other parties to secure payment of amounts due.

MONTANA

FRAUDULENT CLAIMS

I. General Rule.

In Montana, an insurer is entitled to recover restitution damages, under contract theories, for any amounts they paid out for a false or fraudulent claim. An insurer, insurance producer, or other person who sustained any losses and who was awarded restitution may bring suit to recover those sums, including any attorney fees, interest at 10% a year, and costs incurred in obtaining a judgment. Fraud generally voids the insurance contract. However, depending on the language in the contract, the duty to defend may still exist, even if fraud is alleged.

II. Case law.

A. *Tyler v. Fireman's Fund Ins. Co.,* 255 Mont. 174 (1992). Insurer could recover money paid to insured on claim pursuant to restitution theory, even though one insured was unaware of fraud by other insured; under contract, where cause of fire was arson by one insured, policy was void and insureds were not entitled to any of payments made on loss.

B. *McDonald v. Northern Ben. Ass'n*, 113 Mont 595 (1942). When an insurer has paid a claim for loss under mistake of fact, it is entitled to recover the amount paid.

III. Statutory law.

A. Mont. Code Ann. § 33-1-1302. *Insurance Fraud.*

A person commits the act of insurance fraud or viatical settlement fraud by engaging in any transaction, act, practice, course of business, or course of dealing that involves a violation of insurable interest laws. The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose the penalties provided for in 33-1-317 for a violation of 33-1-1304 or this section. Failure to pay a fine under this section results in a lien upon the assets and property of the person as provided in 33-1-318(3). In addition to any penalty provided for in 33-1-317, the commissioner may require a person regulated under this title who commits insurance...fraud to make full restitution to the victim for all financial losses sustained as a result of the fraud with interest of 10% a year from the date of the fraud plus any costs and reasonable attorney fees, less the amount of any income, refund, or other benefit received by the victim from the insurance, viatical settlement, medical care discount card, or pharmacy discount card.

The commissioner may require a person who commits a violation of this part to make full restitution to any person who may have sustained any losses as a result of the fraud with interest of 10% a year from the date of the loss plus any costs and reasonable attorney fees. An insurer, insurance producer, or other person who sustained any losses and who was awarded restitution may bring suit to recover those sums, including any attorney fees, interest at 10% a year, and costs incurred in obtaining a judgment.

B. Mont. Code Ann. § 33-1-317. *Penalty imposed by commissioner.*

The commissioner may, after having conducted a hearing pursuant to 33-1-701, impose a fine not to exceed the sum of $25,000 upon a person found to have violated a provision of this code or regulation promulgated by the commissioner, except that the fine imposed upon insurance producers or adjusters may not exceed $5,000 per violation. The fine is in addition to all other penalties imposed by the laws of this state and must be collected by the commissioner in the name of the state of Montana. Imposition of a fine under this section is an order from which an appeal may be taken, pursuant to the provisions of 33-1-711.

C. Mont. Code Ann. § 33-1-1303. *Reporting requirements*.

An insurer, insurance producer, or other person who has reason to believe that insurance...fraud has occurred shall report the suspected fraud to the commissioner or to the insurance producer's or other person's insurer within 60 days of discovery of the occurrence. An insurer shall review a report given to

the insurer, and if the insurer determines that there is a reasonable likelihood that fraud has occurred the insurer shall forward the report to the commissioner within 30 days of receipt. In the absence of malice, an insurer, insurance producer, or other person may not be subjected to civil liability for reporting or providing information or otherwise cooperating with an investigation of insurance, viatical settlement, medical care discount card, or pharmacy discount card fraud.

D. Mont. Code Ann. § 17-8-401. *False claim against governmental entity.*

If the false claim is made against a governmental entity it falls under Mont. Code Ann. § 17-8-401, the Montana False Claims Act, punishable with $1000 fine or 1 year in prison.

NEBRASKA

Nebraska has enacted legislation which prohibits fraudulent insurance acts. The Insurance Fraud Act was passed "to confront the problem of insurance fraud in Nebraska by facilitating the detection of insurance fraud, eliminating the occurrence of insurance fraud through the development of fraud prevention programs, authorizing imposition of civil penalties, authorizing restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims." Neb. Rev. Stat. § 44-6602 (Reissue 1995).

The Insurance Fraud Act, Nebraska Revised Statute § 44-6604; Enumerated (Reissue 2009), provides that an insured commits a fraudulent insurance act when they act with knowledge, willfulness, or intent to defraud or deceive an insurer or an agent of an insurer. Nebraska law provides for civil and criminal liability if an insured is found to be in violation of the Insurance Fraud Act. (*See*; Neb. Rev. Stat. § 44-6607, & Neb. Rev. Stat. § 28-631).

I. Civil Liability.

Nebraska statutory law provides that any person in violation of the Nebraska Insurance Fraud Act is subject to "a civil penalty not to exceed five thousand dollars for the first violation, ten thousand dollars for the second violation, and fifteen thousand dollars for each subsequent violation." Neb. Rev. Stat. § 44-6607 (1995). This statute provides that costs and expenses "incurred in any investigation or other action arising out of a violation under the Insurance Fraud Act" and restitution for fraudulent claims already paid may be sought in any judgment, court decree, or other final result. Neb. Rev. Stat. § 44-6607 (1995).

II. Criminal Liability

Additionally, criminal liability attaches to fraudulent insurance acts. Such acts may be classified as a felony or misdemeanor depending on the amount attempted to be fraudulently obtained. Nebraska Revised Statute § 28-631 provides in relevant part:

> (2) (a) A violation of subdivisions (1) (a) through (f) is a Class III felony when the amount involved is one thousand five hundred dollars or more.
> (b) A violation of subdivisions (1) (a) through (f) of this section is a Class IV felony when the amount involved is five hundred dollars or more but less than one thousand five hundred dollars.
> (c) A violation of subdivisions (1) (a) through (f) of this section is a Class I misdemeanor when the amount involved is two hundred dollars or more but less than five hundred dollars.
> (d) A violation of subdivisions (1) (a) through (f) of this section is a Class II misdemeanor with the amount involved is less than two hundred dollars.
> (e) For any second or subsequent conviction under subdivision (2) (c) of this section, the violation is a Class IV felony.

Insurance Fraud Prevention Division

Nebraska provides that activities involving insurance fraud will be investigated by the Insurance Fraud Prevention Division. The Division is organized of certified law enforcement officers of the State of Nebraska who have the authority to investigate allegedly fraudulent insurance claims and make arrests when necessary.

Immunity from Civil Liability
Nebraska Revised Statute § 44-6605, and Nebraska Revised Statute § 44-3,133 provide protection to an insurer when an insurer denies a claim based on suspected fraud or reports suspected fraud to the Insurance Fraud Prevention Division. These statutory laws provide immunity from civil liability as long as the insurer acts in good faith in furnishing the information relating to suspected fraudulent insurance acts, or in denying the claim based on suspected fraudulent acts.

NEW HAMPSHIRE

Basic Legal Considerations in Handling Potentially Fraudulent Claims in New Hampshire

I. Insurance Fraud: Criminal

New Hampshire defines insurance fraud as follows:
A person is guilty of insurance fraud, if, such person knowingly and with intent to injure, defraud or deceive any insurer, conceals or causes to be concealed from any insurer a material statement, or presents or causes to be presented to any insurer, or prepares with knowledge or belief that it will be so presented, any written or oral statement including computer-generated documents, knowing that such statement contains any false, incomplete or misleading information which is material to:
(a) An application for the issuance of any insurance policy.
(b) The rating of any insurance policy.
(c) A claim for payment or benefit pursuant to any insurance policy.
(d) Premiums on any insurance policy.
(e) Payments made in accordance with the terms of any insurance policy.

NH RSA 638:20, II. Insurance fraud can be a Class A or Class B felony depending on the value of the fraudulent claim for payment under the insurance policy, and is a misdemeanor in all other cases. NH RSA 638:20, IV. The statute also holds accomplices criminally liable. NH RSA 638:20, III.

The New Hampshire Insurance Department maintains an investigation unit that assists the department commissioner in investigating insurance fraud and other insurance-related criminal activity. NH RSA 417:23. The unit also works with other law enforcement agencies. Id.

Any person or entity regulated under New Hampshire's insurance laws that suspects that an insurance fraud or insurance-related criminal activity has been committed must report the suspected fraud or criminal activity to the investigation unit within 60 days, and possibly even sooner in some cases. NH RSA 417:28. The unit determines which claims are worth pursuing. Id. Disclosure to the unit does not waive claims of privilege or confidentiality. Id.

An insurance company or person on behalf of the insurance company who furnishes information to the investigation unit will not be held liable either civilly or criminally for any oral or written statement made to the unit regarding the suspected fraud or insurance-related criminal activity, absent their own fraud or malice. Id. NH RSA 400-A:36-b provides similar protections for persons not associated with an insurance company.

II. Common Law Fraud

New Hampshire law also provides a remedy for common law fraud, which is sometimes referred to as misrepresentation or deceit. In order to establish a claim for fraud, the plaintiff must prove that: (1) the defendant intentionally made; (2) material false statements; (3) to the plaintiff; (4) which the defendant knew to be false or which he had no knowledge or belief were true; (5) for the purpose of causing; (6) and which does cause; (7) the plaintiff to reasonably rely to his detriment. Caledonia, Inc. v. Trainor, 123 N.H. 116, 124 (1983). See also Snow v. Am. Morgan Horse Ass'n, 141 N.H. 467, 468 (1997). The defendant's "conscious indifference to [the statement's] truth" can satisfy the knowledge requirement. Hall v. Merrimack Mut. Fire Ins. Co., 91 N.H. 6, 10 (1940). The plaintiff must prove fraud by clear and convincing evidence. Caledonia, 123 N.H. at 124. Circumstantial evidence is permitted. Id.

NEW JERSEY

Insurers Laud New Jersey Fraud-Fighting Legislation
February 3, 2011

http://www.insurancejournal.com/news/east/2011/02/03/183218.htm

The Property Casualty Insurers Association of America (PCI) says it wants New Jersey lawmakers to adopt legislations that would enhance fraud-fighting efforts.

The insurers' trade group, which testified today in support of the bill, says the pending legislation would broaden the scope of information sharing between insurance carriers and law enforcement. It would also make "reverse rate evasion"—in which a resident registers and insures his vehicle in another state—a violation of the "New Jersey Insurance Fraud Prevention Act," and provides for additional anti-fraud measures to be added to that act.

"Insurance fraud hurts all consumers," said Richard Stokes, PCI counsel and regional manager for New Jersey. "Whether committed by a consumer seeking inappropriate results from an insurance policy or a professional who seeks to swindle an insurance company, everybody shares in the costs that result."

PCI said nearly a quarter of all questionable claims in New Jersey (23 percent) stem from faked or exaggerated injuries, the number of which doubled from 183 in 2007 to 379 in 2009, the most recent year for which complete statistics are available. Referrals due to excessive treatment have increase the most over this period (from eight in 2007 to 198 in 2009), even though the quantity of questionable claims is now only slightly more than half the number for faked/exaggerated injuries. Questionable claims numbers for all other referral reasons, except for application misrepresentation and medical providers, have risen significantly over the last three years.

The Insurance Information Institute estimates that fraud accounts for 10 percent of the property casualty insurance industry's incurred losses and loss adjustment expenses, or about $30 billion a year. The Coalition of Insurance Fraud also reports that hardworking people are damaged or even ruined by insurance fraud that results in lost savings, health and jobs and that consumer goods cost more and premiums stay high.

"New Jersey has come a long way in fighting insurance fraud, and we hope it will go even further," Stokes said. "We supported the recent reorganization of the Bureau of Fraud Deterrence within the Department of Banking and Insurance, and other changes as an opportunity to invigorate the state's ability to fight insurance fraud. Insurance fraud continually changes as criminals find new ways to defraud people and companies out of their money."

NEW MEXICO

Insurance Fraud Statutes

New Mexico has enacted legislation against insurance fraud. NMSA 1978, § 59A-16C-1 through 59A-16C-16 is titled the "Insurance Fraud Act." Based on a legislative finding that insurance fraud is "pervasive and expensive, and has the potential for increasing premium rates" and placing businesses at risk, the legislature determined it must aggressively confront the problem of insurance fraud. The purpose of the Insurance Fraud Act is to permit the superintendent of insurance to investigate and detect insurance fraud more effectively, to halt insurance fraud, and to work with state, local, and federal law enforcement and regulatory agencies against the commission of insurance fraud.

The Insurance Fraud Act requires the superintendent of insurance to investigate reports of insurance fraud. Insurers and licensed insurance professionals who have reason to believe an act of insurance fraud will be, is, or has been committed "shall furnish and disclose knowledge and information" about the

fraud to the superintendent of insurance. People who make good faith reports of insurance fraud to the proper authorities are immune from civil liability pursuant to NMSA 1978, § 59A-16C-7.

New Mexico's Insurance Fraud Bureau ("IFB") is a state-wide investigation and prosecution office, created by the legislature in 1998 to combat insurance fraud. The IFB initiates inquiries and conducts investigations of insurance fraud, reviews notices of insurance fraud submitted by insurance companies, assists agencies in the investigation of insurance fraud, maintains records, and conducts public awareness and outreach programs relating to insurance fraud.

Medicaid Fraud is a Criminal Offense. NMSA 1978, 30-44-1, et. seq. The statute is aimed primarily at those providing services or medical goods to Medicaid recipients.

Bad Faith Practices

Under New Mexico law an insurer may be liable to its insureds for bad faith pursuant to NMSA 1978, §§ 59A-16-1 through 59A-16-30 (1984, as amended through 2009). The New Mexico Supreme Court also recognizes that a third party plaintiff may have a direct action against an insurer. Hovet v. Allstate Insurance Co., 2004-NMSC-010, 135 N.M. 397, 89 P.3d 69 (third parties having claims against drivers who are insured under compulsory automobile liability policies are intended beneficiaries of those insurance policies and can sue the insurer for unfair settlement practices under New Mexico's Insurance Code).

Criminal and Common Law Fraud

In the criminal context, fraud consists of the intentional misappropriation or taking of anything of value that belongs to another by means of fraudulent conduct, practices or representations. Fraud can either be a misdemeanor or a felony, depending on the value of the property misappropriated. NMSA 1978, § 30-16-6.

To prevail on a claim of fraud in a civil lawsuit, a party must demonstrate that a representation of fact was made which was not true; either the falsity of the representation was known to the party making it or the representation was recklessly made; the representation was made with the intent to deceive and to induce the party claiming fraud to rely on the representation, and; the party claiming the fraud did in fact rely on the representation. Each of these elements must be proved by clear and convincing evidence. NMRA 2011, 13-16-33.

NEW YORK

New York Insurance Fraud

As a general precept, insurance fraud involves more than just an unproven claim. Fraud requires a conscious effort to create a claim, manufacture damages, stage an accident, set a fire or facilitate a theft.

The Statutory Scheme

In an effort to address fraud in insurance claims, the New York Legislature enacted Article 4 of the New York Insurance Law. Section 409 requires insurers to file with the Insurance Department a plan for the detection, investigation and prevention of insurance fraud. N.Y. Ins. Law § 409 (McKinney 2010). Each Fraud Prevention Plan must include provisions for establishing a Special Investigations Unit (SIU), separate and apart from any underwriting or claims units, to perform those functions.

Fraud Prevention Plans

Fraud Prevention Plans also must include provisions for in-service training programs for investigation, underwriting and claims staff in identifying and evaluating suspected insurance fraud; development of public awareness programs; and the development of a Fraud Detection and Procedures Manual. Each company has broad latitude in deciding how much of its resources will be allocated to fraud prevention. However, companies must justify the adequacy of the dedicated anti-fraud resources.

Fraud Prevention Plans are confidential. Section 409(e) of the New York Insurance Law states that, "Any [Fraud Prevention] plan and 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 court order or by request from any law enforcement agency or authority."

Reporting Insurance Fraud

If an insurer has reason to believe that an insurance claim may be fraudulent, or has knowledge that a fraudulent insurance transaction may take place or has taken place, it must report the transaction to the Department of Insurance. N.Y. Ins. Law § 405 (a) (McKinney 2010). This reporting obligation is applicable in all instances where an insurer has reason to suspect that an insurance transaction may be fraudulent.

To report suspected insurance fraud to the Department of Insurance, the insurer must do so on a prescribed reporting form issued by the Insurance Frauds Bureau, or upon any other form approved by the Superintendent. Reporting may also be accomplished by means of any electronic medium or system approved by the Superintendent. *See* N.Y. Comp. Codes R. & Regs. tit. 11, § 86.5 (2000) (Reg. 95).

Immunity for Reporting Fraud:

With regard to immunity, in the absence of fraud or bad faith, no person shall be subject to civil liability, and no civil cause of action of any nature shall arise against such person:

> (i) for any information relating to suspected fraudulent insurance transactions furnished to law enforcement officials, their agents and employees;
>
> (ii) for any information relating to suspected fraudulent insurance transactions furnished to any other person subject to the provisions of this chapter; and
>
> (iii) for any such information furnished in reports to the insurance fraud bureau, its agents or employees or any state agency investigating fraud or misconduct relating to workers' compensation insurance, its agents or employees.

Please note that, generally, the standard for "bad faith" is New York is a "gross disregard for the insured's interests" (*Pavia v. State Farm Mut. Auto. Ins. Co***.,** 82 N.Y.2d 445, 605 N.Y.S.2d 208 [1993]). In order to invoke and take advantage of this statutory immunity, it is recommended that all reporting of possible insurance fraud be:

a) centralized and well-documented;

b) made to bona fide law enforcement officials, such as the Insurance Frauds Bureau; and

c) on the prescribed fraud reporting forms.

Fraud Warning Statement

In New York, it is also important to remember that a fraud warning statement must be presented to every applicant as part of the insurance application process. *See* N.Y. Comp. Codes R. & Regs. tit. 11, § 86.4 (2000) (Reg. 95). The warning must state that:

> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be

> subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

However, the medium of the insurance fraud warning statement may vary with the medium and method of the application.

NORTH CAROLINA

North Carolina has statutes on insurance fraud as are typical for many states. Under North Carolina General Statute § 58-2-161, it is a Class H felony for any person to knowingly submit a false or misleading written or oral statement to an insurer in connection with any type of insurance claim or benefit. The person making the claim need not be an insured, and the statute applies to a person who assists in making a false claim. This statute applies to companies that are self-insured for workers compensation purposes, but would apply to insurance claims only.

A Class H felony provides for 5 months to 2 years imprisonment. The statute also provides that restitution may be ordered as a condition of probation. An insurer also has a private right of action under this statute, and if it prevails, can recover attorneys' fees and costs, and if there is a pattern of violations, may also recover treble damages.

Per statute, material misrepresentations in an application for an insurance policy may prevent recovery on the policy. See N.C. Gen.Stat. § 58-3-10 (2007) ("[a]ll statements or descriptions in any application for a policy of insurance ... shall be deemed representations ..., and a representation, unless material or fraudulent, will not prevent a recovery on the policy") (emphasis added). "[A] representation in an application for an insurance policy is deemed material 'if the knowledge or ignorance of it would naturally influence the judgment of the insurer in making the contract [.]' " Goodwin v. Investors Life Insurance Co. of North America, 332 N.C. 326, 331, 419 S.E.2d 766, 769 (1992). However, in order to void coverage under a fire insurance policy based on concealment or misrepresentation of any material fact or circumstance, the insurer must show that the insured made statements that were (1) false, (2) knowingly and willfully made, and (3) material. N. C. Gen. Stat. § 58-44-15; Bell v. Nationwide Ins. Co., 146 N.C. App. 725, 554 S.E.2d 399 (2001).

Moreover, fraud in an application for or in connection with motor vehicle liability insurance is not a defense to the insurer's liability once injury has occurred, except as to amounts greater than the statutory minimum limits. Odom v. Nationwide Mut. Ins. Co., 101 N.C. App. 627, 634, 401 S.E.2d 87, 91 (1991).

Post-loss fraud will also void coverage under policies, other than minimum limits auto and workers compensation coverage, provided the policy states that any material misrepresentation relating to the policy will avoid coverage. Smith v. State Farm Fire and Cas. Co., 109 N.C. App. 276, 279-280, 426 S.E.2d 457, 459 (1993).

With respect to workers compensation policies, fraud by an employer in connection with a workers' compensation policy will not typically defeat the rights of an injured worker to recover. Oxendine v. TWL, Inc., 184 N.C. App. 162, 164, 645 S.E.2d 864, 865 (2007).

If an insurer learns of a potential false claim, by statute it must notify the Commissioner of Insurance. N.C. Gen. Stat. § 58-2-163. Any report to the Commissioner is privileged. Thus, if any suspected fraudulent insurance claims are submitted to the Commissioner for investigation, the insurer will be protected from a possible civil claim by the claimant for defamation or malicious prosecution.

NORTH DAKOTA

North Dakota has both criminal and civil statutes concerning insurance fraud. North Dakota, however, does not have an abundance of recent case law interpreting the current versions of these statues. Most of

North Dakota's older case law is now codified in its civil statutes permitting rescission of insurance contracts due to fraud.

I. Criminal Statutes

North Dakota has enacted a version of the National Association of Insurance Commissioners' ("NAIC") Fraud Prevention Model Act. *See* N.D. CENT. CODE § 26.1-02.1 (2012); NAIC Insurance Fraud Prevention Model Act, NAIC Model Reporting Service at 680-1 (1995). The Act establishes an insurance fraud unit for the purpose of conducting independent investigations, reviewing complaints, and studying the extent of fraud. N.D. CENT. CODE § 26.1-02.1-08.

The Act prohibits "fraudulent insurance acts" and intentional interference with the enforcement of the Act. *Id.* at § 26.1-02.1-02.1. A fraudulent insurance act is broadly defined to include a variety of acts and omissions by both insurers and insureds. *Id.* at § 26.1-02.1-01(3). For example, a person commits a fraudulent insurance act by presenting false or misleading information concerning a fact material to: an application for an insurance policy, a claim for payment or benefit pursuant to an insurance policy, or premiums paid on an insurance policy. *Id.* at (3)(a). The definition of a fraudulent insurance act also includes: theft, embezzlement, and conversion of an insurer's assets. *Id.* at (3)(d). Furthermore, the definition prohibits acceptance of insurance risks by a person who knows or should know that an insurer is insolvent. *Id.* at (3)(b).

A person who violates the Act is guilty of a felony if the property or services he or she retains exceeds five thousand dollars. *Id.* at § 26.1-02.1-05(1). All other persons who violate the Act are guilty of a misdemeanor. *Id.* The Act does not establish a private statutory cause of action for insurance fraud. It does, however, require a person who violates the Act to pay restitution to the insurer or any other person who suffers a financial loss as a result of the violation. *Id.* at (3).

A person engaged in the business of insurance with knowledge or a reasonable belief of a past, present, or future fraudulent insurance act is required to report the act. *Id.* at § 26.1-02.1-06(1). Reporting by any other person is permissive. *Id.* at (2).

II. Civil Statutes

North Dakota has enacted statutes that provide for rescission of an insurance contract due to fraud. N.D. CENT. CODE §§ 26.1-29-13 – 26.1-29-28 (2012). The statutes establish two bases for rescission: (1) concealment, *id.* at §§ 26.1-29-13–26.1-29-21, and (2) false representation, *id.* at §§ 26.1-29-22–26.1-29-28.

Concealment of information that a party "knows and ought to communicate," whether intentional or unintentional, entitles an injured party to rescind an insurance contract. *Id.* at §§ 26.1-29-15–26.1-29-14. The parties to an insurance contract are required to communicate in good faith all known and material facts that the other party is unable to discover on his or her own. *Id.* at § 26.1-29-13. Disclosure is not required regarding information that the other knows, that the other ought to know, that the other waives access to, or is immaterial, even if such information is related to an excluded risk. *Id.* at § 26.1-29-16. Materiality is determined by "the probable and reasonable influence of the facts upon the party to whom the communication is due in forming the party's estimate of the disadvantages of the proposed contract or in making the party's inquires." *Id.* at § 26.1-29-17. A party is presumed to have knowledge of "all the general causes which are open to the party's inquiry equally with that of the other and which may affect either the political or material perils contemplated and all general usages of trade." *Id.* at § 26.1-29-18. Waiver can occur explicitly or by implication when a party neglects to inquire into facts that are "distinctly . . . implied in other facts of which information is communicated." *Id.* at § 26.1-29-19.

False representation of a material fact entitles an injured party to rescind an insurance contract. *Id.* at § 26.1-29-24. Materiality is determined under the same standard as concealment, discussed above. *Id.* Furthermore, in order for a misrepresentation to permit rescission it must

either: (1) be made with actual intent to deceive, or (2) increase the risk of loss. *Id.* at § 26.1-29-25. An insured is not responsible for the truth of a representation, even though he or she lacks personal knowledge of a fact, so long as he or she believes that the representation is true and explains that the representation is based upon the information of others. *Id.* at § 26.1-29-26. The representation's meaning is interpreted using general rules of contract interpretation. *Id.* at § 26.1-29-23. The representation may be made before or at the time of the insurance policy's issuance, is presumed to refer to the time when contract was completed, and may be altered or withdrawn only before the insurance becomes effective. *Id.* at §§ 26.1-29-22, -27, -28.

III. Case Law

An insurer in North Dakota may file a declaratory judgment action against its insured to rescind an insurance contract due to fraud or it may plead fraud as an affirmative defense in an action by the insured. *See Zuraff v. Empire Fire & Marine Ins. Co.*, 252 N.W. 2d 302, 306 (N.D. 1977) ("The rule that fraud in any material part of the transaction is fully available as a defense is consistently adhered to in other jurisdictions and it does no more than restate the law of fraud as to insurance contracts in general."). An insurer, however, may not avoid coverage due to fraud for statutorily mandated automobile insurance after an accident when a claim is made by an innocent third-party. *Kambeitz v. Acuity Ins. Co.*, 772 N.W.2d 632, 637 (N.D. 2009) ("[A]n insurance company cannot avoid coverage under any compulsory automobile liability insurance policy provisions after an accident when a claim against the policy is made by an injured innocent third party.")

a. Concealment

As discussed above, failure to disclose known and material facts constitutes concealment. *N.Y. Life Ins. Co. v. Fleck*, 12 N.W.2d 530, 533 (N.D. 1944) ("[O]mission is at times as much a concealment as commission."). Failure to qualify an untrue statement that one does not know to be true may also constitute concealment. *See id.* at 534 (applying principal that "an unqualified statement of that which one does not know to be true is equivalent to a statement of that which one knows to be false" where insured "asserted as a fact that which was false and which he had no reason to believe was true").

b. False representation

Also as discussed above, "either a misrepresentation made with the intent to deceive or a misrepresentation material to the risk of loss, without an intent to deceive is a ground to avoid the policy." *Lindlauf v. N. Founders Ins. Co.*, 130 N.W.2d 86, 89 (N.D. 1964).

i. Intent to Deceive

The party alleging fraud bears the burden to prove intent to deceive by clear and convincing evidence. *Equitable Life Assurance Soc. of U.S. v. Boisvert*, 262 N.W. 188, 191 (N.D. 1935) ("This statement was false, and is admitted by the insured to have been false. But such statement must be more than false. It must be made with intent to deceive. . . . The burden of proof is upon the company . . . ."); *Donahue v. Mutual Life Ins. Co. of N.Y*, 164 N.W. 50, 53 (N.D. 1917) ("[T]he burden of proof [is] on the party alleging fraud to prove it by clear and convincing evidence."). A misrepresentations will not justify rescission if it was made in good faith, and does not otherwise cause an increased risk of loss. *See id.* at 54–55.

Intent to deceive is most often question of fact for the jury. *See, e.g.*, *Kambeitz v. Acuity Ins. Co.*, 772 N.W.2d 632, 637 (N.D. 2009) ("Fraud, intentional and material misrepresentation, concealment, and collusion are all generally questions of fact for the trier of fact."); *Zuraff*, 252 N.W. 2d at 306 (N.D. 1977) (finding that insurer's allegations "involving state of mind are among several kinds of cases which are not usually suited for disposition on summary judgment" and that "[f]raud is basically a fact question which needs to be tried and resolved by the trier of facts . . . ."); *Farmers Ins. Exch. v. Nagle*, 190 N.W.2d 758, 764 (N.D. 1971) (deferring to lower

court's finding of fact that "[m]isrepresentations on the matter of driving convictions were . . . made with intent to deceive"); *Jakober v. Commercial Union Assurance Co.*, 191 N.W. 480, 480 (N.D. 1922) ("The jury determined that he made no false statements or representations in the application, hence, under the terms of the above section, the plaintiff was entitled to recover . . . the stated amount of the insurance written in the policy.").

ii. Increased Risk of Loss

The burden of proof to show an increased risk of loss is on the insurer. *Brown v. Inter-State Bus. Men's Accident Ass'n of Des Moines, Iowa*, 224 N.W. 894, 898 (N.D. 1929) ("The burden of proof is on the [the insurer], and while 'increase of risk' may be a question of law, there must be something on which to predicate it."). The risk in question is the risk that is insured against. *Boisvert*, 262 N.W. at 192 ("It is the risk insured against that must be increased before a misrepresentation can be permitted to avoid the policy on that score."); *O'Keefe v. Zurich General Acc. & Liability Ins. Co.*, 43 F.2d 809, 812 (8th Cir. 1930) ("[T]here is no decision in North Dakota holding that what might reasonably influence an insurer's entering into the contract necessarily also increases the risk of loss under the contract."). Good faith is no excuse to the falsity of a misrepresentation if it increased the insurer's risk of loss. *See Van Woert v. Modern Woodmen of Am.*, 151 N.W. 224, 228 (N.D. 1915) ("Whether the applicant acted in good faith is immaterial.").

Risk of loss is more often determined as a matter of law. *See, e.g.*, *Indus. Comm'n of N.D. v. McKenzie County Nat. Bank*, 518 N.W.2d 174, 178 (N.D. 1994) (holding as a matter of law that a misrepresentation regarding the record of an easement on the insured property did not increase the insurer's risk of loss); *Nagle*, 190 N.W.2d at 764 ("Surely the applicant was a less desirable risk for automobile insurance than he would have been had he had a perfect driving record. Thus the misrepresentations did increase the risk of loss and were material."); *Lindlauf*, 130 N.W.2d at 91 (affirming jury's verdict for insurer but finding that "the misrepresentations made by the insured . . . increased the risk of loss as a matter of law" where the insured misrepresented "the fact that the insured had had symptoms of possible heart disease"); *Fleck*, 12 N.W.2d at 533 ("That the falsity of these statements materially increased the risk needs no demonstration. Clearly the company would not have insured deceased if it had known he had a fatal disease."); *Thomas v. N.Y. Life Ins. Co.*, 260 N.W. 605, 617 (N.D. 1935) ("[I]f it is proven that the insured, in answer to questions concerning his health, gave false answers, and the insurance experts testify that if true answers had been given insurance companies generally would not have accepted the risk, and it appears from the records that reasonable minds must agree that the matter misrepresented increased the risk of loss, it then becomes a question of law for the court."); *Satterlee v. Modern Bhd. of Am.*, 106 N.W. 561, 563 (N.D. 1906) (reversing jury verdict where misrepresentation regarding pregnancy status increased risk of loss as a matter of law).

OHIO

In handling a potentially fraudulent claim, reader should consider its obligations under Ohio statutory law and possible ramifications of mistakenly identifying claims as fraudulent.

A. <u>Obligations Under Ohio Statutory Law</u>

Where one receives a claim which it ***reasonably believes*** is fraudulent, it arguably has a statutory duty to report the situation to the State of Ohio Department of Insurance. Indeed, Ohio Revised Code 3999.42, titled "Insurer to notify department of insurance fraud", states:

> (A) **If an insurer**, as defined in division (A) of section 3999.36 of the Revised Code, **has a reasonable belief that a person is perpetrating or facilitating an insurance fraud**, as established by section 2913.47 of the Revised Code, or has done so, **the insurer shall notify the department of insurance**.
>
> (B) The notification required by division (A) of this section shall be made in accordance with rules adopted by the department of insurance.
>
> (C) Division (A) of this section does not require notification of the department of insurance if the insurance fraud involves a claim of an amount less than one thousand dollars.
>
> (D) This section applies to insurance fraud perpetrated or facilitated by any person, including, but not limited to, any applicant, policyholder, subscriber, or enrollee, or any officer, director, manager, employee, representative, or agent of the insurer.

(Emphasis added.) As indicated above, the statutory obligation arises upon the satisfaction of three elements: (1) an entity's classification as an "insurer"; (2) an insurer having a "reasonable belief" that an individual is "perpetrating or facilitating" insurance fraud; and (3) a claim in an amount exceeding one thousand dollars.

Ohio legislators likely contemplated that R.C. 3999.42 would extend to self-insurers. R.C. 3999.36 defines "insurer" to include "any [ ] person engaging either directly or indirectly in this state in the business of insurance[.]" Moreover, R.C. 2913.47, discussing insurance fraud, specifically includes in its definition of "insurer" "any legal entity that is self-insured and provides benefits to its employees or members." Indeed, insurer should remain aware of its statutory obligations under 3999.42 when handling potentially fraudulent claims.

As noted above, R.C. 3999.42 turns on the interpretation of an insurer having a "reasonable belief" of insurance fraud. It is suggested that insurer implement internal guidelines, if not already in place, to differentiate between claims which are merely suspicious and those which are reasonably likely to be fraudulent. Determination of the latter should only occur after the completion of a thorough and impartial investigation.

B. <u>Ramifications Under Common Law for Mistakenly Identifying Claims as Fraudulent</u>

On the heels of the above discussion, reader should also be aware of ramifications for mistakenly identifying a claim as fraudulent. Such an identification would likely lead to the denial of benefits as well as possible reporting to the State of Ohio Department of Insurance.

Where the preceding action was only a denial of the claim, it is common for a claimant to initiate legal action against an insurer or self-insured entity to recover for alleged damages. The cause(s) of action asserted by a plaintiff would be fact-dependent. But if a plaintiff proves that the claim was improperly dismissed, the claimant may be liable for prejudgment interest on the award.

Where the preceding action also involved reporting to the State of Ohio Department of Insurance, a plaintiff may bring forth a malicious prosecution claim against the insurer or self-insured entity. "The Ohio Supreme Court [has] stated that the essential elements to sustain a claim of malicious prosecution are: '(1) malice in instituting or continuing the prosecution, (2) lack of probable cause, and (3) termination of the prosecution *in favor of the accused*.'" *Trussell v. General Motors Corp.* (1990), 53 Ohio St.3d 142. The majority of these claims, however, fail upon a plaintiff's inability to prove malice by an insurer who has a statutory duty to report a claim it believes as fraudulent. As a practical matter, an insurer's organized and well-documented efforts of investigating a claim may be its best defense in these cases.

In *Reinoehl v. Trinity Universal Insurance Company* (1998), 130 Ohio App.3d 186, the Court of Appeals of Ohio, Tenth Appellate District, upheld a trial court's award of summary judgment against a plaintiff who had filed malicious prosecution and intentional infliction of emotional distress claims against an insurer.

The insurer had previously denied the plaintiff's insurance claim and had reported it to authorities as being fraudulent upon completion of an investigation.

The Tenth Appellate Court agreed that the plaintiff had failed to prove malicious prosecution as a matter of law. Specifically, it concluded that the plaintiff failed to meet his "burden of showing that Trinity acted with 'an improper purpose, or any purpose other than the legitimate interest of bringing an offender to justice.'" *Id.* at 199. In support, the Court pointed to Trinity's statutory obligation to report suspected insurance fraud. Moreover, Trinity's records clearly indicated an investigation into the claim, discussion regarding suspicious characteristics, and transfer of all information to the authorities upon having a reasonable suspicion of fraudulent activity. As a result, the Court held that there was probable cause that the claim was fraudulent, the prosecution independently acted to indict the plaintiff, and Trinity acted without malice. *Id.* Here again, an insurer's ability to thoroughly and impartially investigate a claim and document its efforts proved influential in dismissing the plaintiff's claims as a matter of law.

OKLAHOMA

1. Insurance Fraud

Oklahoma, like other states, has enacted laws which would discourage the making of fraudulent insurance claims. For instance, Oklahoma has created an "Anti-Fraud Unit" within the Legal and Investigation Division of the Oklahoma Department of Insurance. 36 O.S. § 361. The Anti-Fraud Unit is charged with investigating whether a violation of any statute or administrative rule has occurred with respect to insurance fraud. The Unit may initiate any necessary investigations and, depending on the nature of the evidence, may refer the matter to the Oklahoma State Bureau of Investigation for further investigation. The Department of Insurance retains jurisdiction to initiate and prosecute any civil action it deems necessary or advisable. 36 O.S. § 361(B). If an insurer believes that any person or entity has engaged in fraudulent or illegal activities, the insurer is obligated to report such activities to the Anti-Fraud Unit of the Insurance Department. 36 O.S. § 363. In the absence of fraud, recklessness or malice, no person, insurer or agent will be civilly or criminally liable for supplying information concerning suspected insurance fraud to the Anti-Fraud Unit, or to any other agency involved in the investigation or prosecution of suspected insurance fraud. 36 O.S. § 363(B).

The Oklahoma Department of Insurance has created a website that describes the purposes of the Anti-Fraud Unit. The website also provides forms and instructions regarding reporting allegations of fraud. See http://www.ok.gov/oid/Consumers/Report_Fraud_Anti-Fraud_Unit/index.html (last visited January 7, 2011).

Oklahoma follows the majority rule that any fraud or misrepresentation under an insurance policy voids all coverage under the policy. *See, e.g ., Long v. Insurance Co. North America*, 670 F.2d 930 (10th Cir.1982) (noting the "false swearing" provision in Section 4803(G) and holding that all coverages are voided by fraud in the claims process); *Niagara Fire Insurance Co. v. Wilkerson*, 1930 OK 593, ¶30, 300 P. 686, 691 (coverages under a policy held severable where "[u]nder the stipulation any question of fraud or wrongdoing passe[d] out of the case."); *American Diver's Supply and Manufacturing Corp. v. Boltz*, 482 F.2d 795, 798 (10th Cir.1973) ("The penalty for attempted fraud in an insurance case where a fraud clause exits ... is not simply forfeiture of the excess or inflated recovery amount but the voiding of all actual loss benefits as well."); *Transportation Insurance Co. v. Hamilton*, 316 F.2d 294, 296 (10th Cir.1963) ("Where an insured knowingly and willfully over-estimates the value of the property destroyed in his proof of loss, with the intention to deceive the insurer, the policy is voided and the insured's right to recover thereon is defeated.").

In addition, Oklahoma has a general statute that allows an insurer to avoid a policy based on certain statements or comments made by an insured during the application process. The statute states:

A. All statements and descriptions in any application for an insurance policy or in negotiations therefor, by or in behalf of the insured, shall be deemed to be representations and not warranties. Misrepresentations, omissions, concealment of facts and incorrect statements shall not prevent a recovery under the policy unless:

1. Fraudulent; or
2. Material either to the acceptance of the risk, or to the hazard assumed by the insured; or
3. The insurer in good faith would either not have issued the policy, or would not have issued a policy in as large an amount, or would not have provided coverage with respect to the hazard resulting in the loss, if the true facts had been made known to the insurer as required either by the application for the policy or otherwise . . .

See 36 Okla. stat. § 3609(A). Substantial case law has interpreted this statute. Before an insurer can rescind or cancel a policy based on this statute, the insurer must establish that the insured "intended to deceive" the insurer. *See Scottsdale Ins. Co. v. Tolliver*, 261 Fed.Appx. 153 (10th Cir. 2008). Indeed, at trial, the insurer will be required to show such intent by "clear and convincing evidence." *Id.* at 162.

In conjunction with this statute, the insurer must also comply with the statutory requirements for rescission. That statute requires that (1) rescission be accomplished "promptly" upon discovering facts entitling the party to rescind and (2) the rescinding party must restore to the other party everything of value which has been received under the contract, or must offer to restore same upon the condition that the other party do likewise. 15 O.S. § 235. The Courts have reasoned that a party cannot repudiate a contract and yet retain the benefits which he has derived from it. *See Great American v. Strain*, 377 P.2d 583 (Okla. 1962). However, if it is clear that an insured would not receive the tender of premium, such tender is unnecessary. *See Scotsdale*, 261 Fed.Appx. at 159.

2. Other Fraudulent Claims

With respect to fraudulent claims that are made against a business or entity (outside of the insurance context), Oklahoma recognizes causes of action in the form of malicious prosecution, abuse of process and defamation. For purposes of a malicious prosecution claim, the plaintiff must show that the defendant (1) previously brought a cause of action against the plaintiff, (2) the action was successfully terminated in favor of the plaintiff, (3) the defendant did not have probable cause to bring the action, (4) the defendant acted with malice, and (5) the plaintiff suffered damages. *See Tulsa Radiology Associates v. Hickman*, 1984 OK CIV APP 11, 683 P.2d 537. A person has "probable cause" to bring an action if he "reasonably believes in the existence of facts upon which his claim is based." *Id.*

The tort of "abuse of process" requires proof of: (1) the issuance of process, (2) an ulterior purpose, and (3) a willful act in the use of process not proper in the regular conduct of the proceeding. *Id.* at 538. The tort requires a showing of some "definite act or threat not authorized by the process, or aimed at an objective not legitimate in the use of the process . . . and there is no liability where the defendant has done nothing more than carry out the process to its authorized conclusion, even though with bad intentions. The improper purpose usually takes the form of coercion to obtain a collateral advantage, not properly involved in the proceeding itself." *Id.* at 539.

A publication is libelous *per se* (when the defamatory impact is apparent on its face) if it "exposes any person to public hatred, contempt, ridicule or obloquy, or which tends to deprive him of public confidence or to injure him in his occupation. . . ." To determine whether a publication is libelous per se, the writing must be measured by its natural and probable effect upon the mind of the average lay reader. Certain words are deemed actionable on their face when they prejudicially disparage a person's skill, knowledge, or conduct in his (or her) business. A writing is actionable *per se* when the language used is susceptible of but a single meaning that is opprobrious (i.e., contemptuous or disgraceful). In contrast, a publication is deemed libelous *per quod* if the words are reasonably susceptible of both a defamatory and an innocent meaning. The latter form of libel requires proof by extrinsic facts to show a defamatory meaning. *See Gaylord v. Thompson*, 1998 OK 30, 958 P.2d 128, 146-47.

Such causes of action are difficult to maintain in Oklahoma because the standard is so low for bringing a tort lawsuit against a defendant. The underlying tort action must be frivolous before such actions will be allowed to proceed. Worse still, for action such as malicious prosecution and abuse of process, the plaintiff must go further and show malice or improper purpose in instituting the proceedings.

In cases where a fraudulent claim is suspected, caution should be the rule for purposes of investigating your belief. To be sure, an insurer who elects to rescind an insurance policy on the basis of fraud *must* conduct a reasonable investigation of the facts and circumstances of the claim. At a minimum, this would include: having discussions with the insured regarding the claim, conducting an independent investigation of the circumstances of the claim, interviewing potential witnesses, reviewing relevant documents, and discussing the matter with the insurance agent/broker (if appropriate). It may be beneficial to have an attorney involved in that process, as well. There is no guarantee that the involvement of an attorney will automatically prevent discovery of the investigation, but the attorney will nevertheless be able to guide you in making investigative decisions.

If you merely have a generalized belief that a claimant may be pursuing a fraudulent or bogus claim, caution should be exercised, as any such investigation or internal discussions may be subject to later discovery. For instance, you should avoid making statements, drafting memorandum or sending email communications using the words "fraud" or "fraudulent claims" or other similar adjectives. You should instead indicate that the claim is being investigated for potential fraud or that the claim is "suspect" or "suspicious." In addition, do not use pejorative terminology in communications with the insured or with the insured's representatives. The communications should be phrased in terms of your "investigation," or that you have additional questions or concerns regarding the status or circumstances of the claim. If you elect to turn the fraudulent claim over to the authorities, be absolutely confident in the grounds you have stated to the authorities. Adequately document your file concerning your findings.

PENNSYLVANIA

Pennsylvania has made insurance fraud a crime, and by statute provided insurers with a civil remedy for insurance fraud. The common law tort of intentional misrepresentation provides means to others of pursuing losses resulting from fraudulent claims.

I. The Crime of Insurance Fraud

The Pennsylvania Crimes Code includes the offense of "Insurance Fraud". 18 Pa.C.S. § 4117 (Purdon 2010). The statute prohibits the presentation of "false, incomplete or misleading information" regarding any fact or thing material to a claim to an insurer or self-insured in support of, or as part of, a claim. The crime extends to those who assist, abet, solicit or conspire with others in presenting this false information, which includes information documenting or supporting an amount claimed in excess of an actual loss. Insurance fraud is also committed by one who knowingly benefits, directly or indirectly, from the proceeds derived from a fraudulent claim. Furthermore, one commits insurance fraud when borrowing or using another's insurance information (or allowing another to borrow or use one's insurance information) to present a fraudulent claim.

The crime of insurance fraud may be investigated and prosecuted by the county district attorneys or the Pennsylvania Attorney General. The law also establishes a private civil cause of action which may be pursued by insurers damaged as a result of a violation of the statute. The statute provides immunity from civil or criminal liability to insurers and their employees and agents who supply or release information to any entity authorized to receive information by Federal or State law, or by Insurance Department regulations.

II. Intentional Misrepresentation

Fraudulent claims may also support claims for the tort of intentional misrepresentation. This tort requires misrepresentations of material facts that a person knows to be false or believes are false, made with the intent to induce another person to act (or refrain from acting) in reliance on the misrepresentation. Gibbs v. Ernst, 538 Pa. 193, 647 A.2d 882, 889 (Pa. 1994). The aggrieved party must actually rely on the misrepresentation and be justified in doing so. Of course, the misrepresentation must cause the aggrieved party to be damaged.

Other considerations

Insurers (and self-insureds) must be mindful of the liability that may be imposed for mistakenly identifying a claim as fraudulent. Insurers and self-insureds may be exposed to liability for defamation if a legitimate claim is labeled fraudulent. They should also take precautions in instituting their own lawsuits to recover losses associated with fraudulent claims.

I. Defamation

An insurer or self-insured must be careful to avoid defaming a claimant asserting a claim suspected to be fraudulent. Pennsylvania law requires that in addition to proving the elements of common law defamation, the allegedly injured party must make a showing of fault for all defamation causes of action; at least a showing of negligence is required to establish defamation. See 42 Pa.C.S. § 8341 et seq.; § 8343, § 8344 (Purdon 2010). Slander per se may be established, however, when a statement is of a certain type which does not require a showing of "special damages" as in the typical suit for slander. Imputing that another person committed an indictable criminal offense punishable by imprisonment constitutes slander per se. Brinich v. Jencka, 757 A.2d 388, 397 (Pa. Super. 2000).

II. The Dragonetti Act

The "Dragonetti Act" codifies the tort of wrongful use of civil proceedings. 42 Pa.C.S. § 8351 et seq. (Purdon 2010). A Dragonetti action involves the "procurement, initiation or continuation" of civil proceedings against another in a grossly negligent manner or without probable cause. The party pursuing the Dragonetti suit must establish that the original lawsuit was instituted primarily for a purpose other than that of securing the proper discovery, joinder of parties or adjudication of a claim. Furthermore, the original lawsuit must have been terminated in favor of the person against whom it was brought.

Bearing in mind statute of limitations concerns, a party injured as a result of a fraudulent claim may wish to gauge the success of the criminal case before pursuing a civil suit. In any event, the aggrieved party contemplating civil action should consult the definition of "probable cause" set forth in the Dragonetti Act and carefully consider the quality of its investigation to insure that any suit rests on sound foundation.

Pennsylvania recently repealed and reenacted with significant amendments its Arson Reporting Immunity statute. The new statute is effective December 26, 2010. The statute provides that "in the absence of fraud or bad faith", "no person or his employes or agents shall be subject to civil liability and no civil cause of action shall arise" for providing information regarding suspected fraudulent insurance acts or persons suspected of engaging in such acts to law enforcement or in connection with information received from law enforcement concerning suspected fraudulent insurance acts or persons suspected of engaging in such acts. 40 P.S. § 474.1.

RHODE ISLAND

I. Considerations For Addressing Insurance Fraud in Rhode Island

Rhode Island legislation enacted statutes which criminalized insurance fraud, authorized civil penalties for acts of insurance fraud and targeted common types of insurance fraud with their own statutes, including the creation of motor vehicle and workers' compensation insurance fraud investigation offices.

A. General Insurance Fraud Statutes in Rhode Island

1. Criminal Statutes

Rhode Island's primary insurance fraud statute is R.I. Gen. Laws §11-41-29, enacted in 1993. This statute essentially can be summarized into two versions of illegal acts. Combining subsections (b)(1)-(2), a person shall be guilty of a misdemeanor where he/she, with the intent to deceive, prepares or assists in the preparation of any written statement intended for any insurer as part an application for an insurance policy, claim or benefit, knowing that the statement contains false information material to that application, claim or benefit. Upon conviction, that person shall be punished by a fine of not more than one

thousand dollars, or by imprisonment for a period of not more than one year, or both.

Combining subsections (b)(3)-(4), a person shall be guilty of larceny where he/she, with the intent to deceive, presents or causes to be presented to any insurer a written statement in support of a claim for payment or benefit, or to any claimant in support of contesting a claim, knowing the statement contains false information material to the claim. See R.I. Gen. Laws §11-41-1 (Defining Larceny); R.I. Gen. Laws §11-41-5 (Penalties for Larceny). Under this statute, the crime of larceny has the added element of specific intent. R.I. Gen. Laws §11-41-29(a)(2).

Case law reveals that prior to its enactment, fraudulent insurance acts were still punished under statutes besides § 11-41-29. See State v. Henshaw, 557 A.2d 1204, 1207 (R.I. 1989) (Punishing insurance fraud under R.I. Gen. Laws § 11-41-4); State v. Ferreira, 463 A.2d 129, 130 (R.I. 1983) (Defendant indicted under §11-41-4, -5, and -6); State v. Donato, 414 A.2d 797, 798 (R.I. 1980) (Defendant indicted on insurance fraud under §11-41-3 and §11-41-5).

2. Civil Statutes

The insurance fraud statute only criminalizes deceit in connection with insurance claims, applications and related statements. R.I. Gen. Laws § 11-41-29. Therefore, §11-41-29 cannot serve as a basis for civil liability. W. Reserve Life Assur. Co. of Ohio v. Conreal LLC, 715 F. Supp. 2d 270, 287 (D.R.I. 2010). For civil liability, the courts will look to R.I. Gen. Laws § 9-1-2 which reads:

Whenever any person shall suffer any injury to his or her person, reputation, or estate by reason of the commission of any crime or offense, he or she may recover his or her damages for the injury in a civil action against the offender, and it shall not be any defense to such action that no criminal complaint for the crime or offense has been made; and whenever any person shall be guilty of larceny, he or she shall be liable to the owner of the money or articles taken for twice the value thereof, unless the money or articles are restored, and for the value thereof in case of restoration.

According to Rhode Island case law, a plaintiff's only obligation under § 9-1-2 is to establish defendant's guilt of the crime of larceny by proof either of a conviction or of an admission of guilt in a prior prosecution. Rhode Island Hosp. Trust Nat. Bank v. Ellman, P.C. 87-0501, 1988 WL 1017221, *2 (R.I. Super. Apr. 5, 1988); Ludwig v. Kowal, 419 A.2d 297 (1980); DaCosta v. Rose, 70 R.I. 163, 37 A.2d 794 (1944). Therefore, where insured pleads guilty to § 11-41-1 (larceny), § 11-41-4 (obtaining property by false or fraudulent pretenses), or § 11-41-29 (insurance fraud) under which a convicted defendant would be “deemed guilty of larceny,” Section 9-1-2 would apply and the insured could owe the insurer for twice the value of any loss. See Ellman, 1988 WL 1017221 at *3.

B. Specific Insurance Fraud Statutes in Rhode Island

1. Motor Vehicle Fraud Prevention and Investigation

Rhode Island pays considerable attention under its laws to motor vehicle fraud with statutes for an investigation office, immunity for reporting suspected fraud and criminal charges. In broad terms, R.I. Gen. Laws § 31-50-1 through § 31-50-6 create and describe the authority of the Office of Automobile Theft and Insurance Fraud. The scope and purpose of the Office of Automobile Theft and

Insurance Fraud shall be to investigate and prosecute crimes involving the theft or other unauthorized use of motor vehicles and to investigate and prosecute all forms of automobile insurance-related fraud. R.I. Gen. Laws § 31-50-1(b). This Office is partnered with and directed by the state police and is granted authority to make arrests, execute warrants and serve civil and criminal process. R.I. Gen. Laws § 31-50-1(d).

Fraudulent claims for stolen motor vehicles has its own criminal statute under R.I. Gen. Laws §11-18-1.1, which reads: "Any person who knowingly and with criminal intent shall file a fraudulent claim with an insurance company for the purpose of securing money based on a claim of a stolen motor vehicle when, in fact, the motor vehicle did not exist or was not stolen, shall be guilty of a felony punishable by imprisonment for not more than five (5) years, or by a fine of not more than ten thousand dollars ($10,000), or both."

The function of the Office of Automobile Theft and Insurance Fraud and enforcement of §11-18-1.1 is aided by the Motor Vehicle Theft and Motor Vehicle Insurance Fraud Reporting-Immunity Act. R.I. Gen. Laws § 27-49-1 through § 27-49-6. Under these statutes, insurers are expressly authorized and obligated to share information regarding motor vehicle theft or insurance fraud with designated government agencies. R.I. Gen. Laws § 27-49-1. Insurers shall release upon request any relevant information including policy information, premium payments records, previous claims and generally anything requested by an authorized agency. R.I. Gen. Laws § 27-49-3. To facilitate the exchange of information, insurers are granted civil and criminal immunity related to the production of the requested documents. R.I. Gen. Laws § 27-49-5.

2. Health Insurance Fraud Prevention

Incorporating similar language to R.I. Gen. Laws § 11-41-29, Rhode Island also enacted a statute specifically targeting health insurance fraud: "Every person who shall obtain health care services from a provider of those services by any false pretense or pretenses with intent to cheat or defraud a health care services insurer…shall be guilty of larceny". R.I. Gen. Laws § 11-41-30.

Rhode Island also grants immunity from civil and criminal liability to insurers and authorized agents of insurers acting in good faith by producing factually accurate information relating to suspected or discovered health insurance fraud. R.I. Gen. Laws § 27-63-1(a). This statute also grants immunity from discharge or retaliation to employees who report or testify to law enforcement about health care fraud. § 27-63-1(b).

3. Workers' Compensation Fraud Prevention

In similar fashion to motor vehicle fraud, Rhode Island specifically recognizes Workers' Compensation Insurance as an area deserving of its own fraud investigation unit and fraud reduction statute. A combination of R.I. Gen. Laws § 42-16.1-12 through § 42-16.1-16 creates and describes the purpose and authority of the Workers' Compensation Fraud Prevention Unit. The purpose of this Unit is to "formulate an integrated state plan to reduce and prevent fraud arising out of claims made pursuant to the workers' compensation laws of this state and to conduct investigations as authorized by the director." R.I. Gen. Laws § 42-16.1-12.

To encourage fewer fraudulent acts, R.I. Gen. Laws § 27-7.1-13.1 reads: "No person, firm, corporation, association, or organization shall willfully withhold information that will affect the rates or premiums chargeable under this chapter or knowingly give false or misleading information to the director, any statistical

agency or advisory organization designed by the director or any insurer." The statute does not however, clarify specific penalties, civil or criminal, for violation of the statute.

C. Obligations and Concerns for the Insurer

1. Anti-Fraud Act

The Anti-Fraud Act just became effective January 1, 2011. R.I. Gen. Laws § 27-54.1-1 through § 27-54.1-6. In addition to providing a more comprehensive definition of "fraudulent insurance act" which applies to insureds and insurers alike, it puts more emphasis on responsibilities of the insurers. New requirements include: preventing felons from participating in the business of insurance (§ 27-54.1-2(c)(1)-(2)), inclusion of a fraud warning statement on every claim form and application (§ 27-54.1-3(a)), creating antifraud initiatives calculated to detect, report, prosecute and prevent fraudulent insurance acts such as hiring investigators (§ 27-54.1-5(a)), and the duty to report suspected insurance fraud to the appropriate agency (§ 27-54.1-5(b)). Failure to satisfy the requirements of this chapter may result in suspension or revocation of license and/or restitution payments to those aggrieved by violations of the chapter.

2. The Insurance Fraud Prevention Act ("IFPA")

Apart from the specific criminal statute against insurance fraud by insureds, Rhode Island also enacted the Insurance Fraud Prevention Act ("IFPA") in 1994 aimed at regulating the conduct of insurers. R.I. Gen. Laws § 27-54-1 through § 27-54-11. Apart from the relevant sections presented below, are sections placing a ten year statute of limitations on actions brought under the IFPA (§ 27-54-10) and a prohibition on insurers permitting persons with felonious fraud convictions hold positions as directors, officers or other senior management positions. § 27-54-5.

The first section of the IFPA outlines criminal penalties against those who knowingly and with intent to deceive pass false statements or material misrepresentations to the director of business regulation either regarding any financial condition or material fact relative to an insurance company or in conjunction with the enforcement of any other section of the IFPA. A person convicted under any provision of this section shall be fined not exceeding fifty thousand dollars ($50,000) or imprisoned not exceeding twenty (20) years, or both. § 27-54-1. The language of § 27-54-1 is clear and unambiguous that it does not require the Director to request information before a person may be criminally liable for failing to disclose information. State v. Clark, 2009 WL 3328555 (Superior Court of R.I., Aug. 3, 2009).

In addition to the criminal penalties in § 24-54-1, the IFPA also assigns civil penalties up to fifty thousand dollars ($50,000), or the amount of damages created by the conduct, whichever is greater, for each violation. These civil penalties are enforced through civil actions by the Attorney General or Director of Business Regulation. § 27-54-2. Insurers and their offices have an affirmative duty to notify the Director of any known false misstatements or misrepresentations within ten days of discovery or face fines of one thousand dollars and imprisonment for one year. § 27-54-4. The Director of Business Regulation has the authority to conduct investigations in response to such notice or in whatever manner necessary to uphold the provisions of the IFPA. § 27-54-3. Insurers are prohibited from retaliation or discrimination against any person or employee for their role in assisting the Director with enforcement or investigations under the IFPA. § 27-54-7.

Applicants for insurance coverage must disclose any arson convictions within ten years prior to their application for insurance, and insurers are permitted to deny coverage based on such conviction. Failure by the applicant to disclose a conviction is a misdemeanor offense punishable by not more than one year imprisonment. Insurers are obligated to include a passage on all application forms putting applicants on notice of the criminal penalties for failure to comply under this section. § 27-54-8.

3. Additional Notice Requirements

In addition to the notice requirements already presented above, under the following statutes, insurers must report certain incidents to designated entities: R.I. Gen. Laws § 27-49-3(b) (motor vehicle fraud to Office of Automobile Theft and Insurance Fraud); R.I. Gen. Laws § 27-8-14 (stolen vehicles to National Insurance Crime Bureau); R.I. Gen. Laws § 27-8.1-3(d)(1) (fire loss to fire martial); R.I. Gen. Laws § 42-16.1-14 (Workers' Compensation fraud to Workers' Compensation Fraud Prevention Unit).

4. Tort of "Insurer's Bad Faith"

Rhode Island recognizes the tort of "insurer bad faith." R.I. Gen. Laws § 9-1-33; Skaling v. Aetna Ins. Co., 799 A.2d 997, 1003 (R.I. 2002); Asermely v. Allstate Ins. Co., 728 A.2d 461, 464 (R.I. 1999); Bibeault v. Hanover Ins. Co., 417 A.2d 313, 319 (R.I. 1980). Insurers in Rhode Island are therefore "'obligated to act in good faith in their relationship with their policyholders', and that a 'violation of this duty will give rise to an independent tort claim.'" Skaling, 799 A.2d at 1004 (quoting Bibeault, 417 A.2d at 319). Where "a claim is 'fairly debatable,' no liability in tort will arise.'" Id.

A plaintiff has the burden to "show the absence of a reasonable basis for denying benefits of the policy and the defendant's knowledge or reckless disregard of the lack of reasonable basis for denying the claim." Id. Where plaintiff does meet this burden and the insurer is found to have acted in bad faith, the "insurer is liable for both compensatory and punitive damages." Skaling, 799 A.2d at 1004.

5. Defamation

In order to prove an action for defamation in Rhode Island, a plaintiff must prove: 1) the utterance of a false and defamatory statement, 2) an unprivileged communication to a third party, 3) fault on the part of the publisher amounting at least to negligence, 4) damages, unless the statement is actionable irrespective of special harm. Bray v. Providence Journal, Co., 220 A.2d 531, 534 (R.I. 1966).

There is insufficient case law to assess the balance of immunity afforded insurers for disclosure of information to authorized agencies and enforcement of defamation allegations by insureds. However, insurers should be aware that statements imputing that someone has committed a crime, such as accusing one of violating the insurance fraud statute, constitutes defamation per se. See Bosler v. Sugarman, 440 A.2d 129, 131 (R.I. 1982) (Accusing plaintiff of intending to defraud insurance carrier was slander per se).

II. Conclusion

The majority of Rhode Island's insurance fraud statutes put as much or more expectations on insurers to prevent and avoid fraud than the insureds, with strong penalties for failing to cooperate in good faith with insureds and investigative agencies. Despite not having a true investigative office to handle all fraud by insureds, with the creation of offices for motor vehicle and workers' compensation insurance fraud investigations, Rhode Island does appear focused on detecting and punishing insurance fraud through criminal prosecutions.

SOUTH CAROLINA

There are three areas of South Carolina law that could come into play in fraud investigations.

First, in the insurance arena, South Carolina has statutes in place that are specifically applicable to insurance fraud. The statue has a variety of purposes, its strongest one being to "confront aggressively the problem of insurance fraud in South Carolina by facilitating the detection of insurance fraud." S.C. Code Ann. § 38-55-520 (2002). This legislation also provides for the Attorney General to establish an Insurance Fraud Division to receive claims or allegations of insurance fraud. S.C. Code Ann. § 38-55-560 (2002). Further, this legislation grants immunity for reporting suspected insurance fraud; prescribes penalties, both civil and criminal, for insurance fraud; and requires restitution for victims of insurance fraud. S.C. Code Ann. § 38-55-520 (2002).

Second, the accusing one of committing fraud could bring about a claim for defamation per se. A statement is classified as defamatory if it tends to harm the reputation of another as to lower him in the estimation of the community or to deter third persons from associating or dealing with him; and becomes defamation per se when the meaning or message is obvious on its face . McBride v. School District of Greenville County, 389 S.C. 546, 698 S.E.2d 845 (2010). To be actionable, the defendant must have alleged defamatory statements which charge the plaintiff with one of five types of characteristics, to include a crime of moral turpitude. Id. Because fraud could be considered a crime or moral turpitude, an accusation of fraud could be determined to be a defamatory statement. For a successful defamatory claim, a plaintiff must show 1) that a false and defamatory statement was made; 2) the unprivileged publication was made to a third party; 3) the publisher was at fault; and 4) either actionability of the statement irrespective of special harm or the existence of special harm caused by the publication. Id.

A principle most relevant to fraudulent claim investigation is that South Carolina has recognized that "even a mere defamatory *insinuation* is actionable as a positive assertion if it is false and malicious and its meaning is plain." Murray v. Holman, Inc., 344 S.C. 129 (Ct. App. 2001) (emphasis added). Also of note for fraudulent claim investigation is that "defamatory communications between employees of an organization are qualifiedly privileged only if made in good faith and in the usual course of business." Bell v. Bank of Abbeville, 208 S.C. 490 (1946).

Accordingly, it would be prudent to avoid labeling claims as "fraudulent" until there is proof thereof. Further any communication about the potentially fraudulent claim (the publication element) should only occur between those that would be protected by the privilege.

Finally, the accusation of making a fraudulent claim could bring about a claim of malicious prosecution. In South Carolina, "elements of malicious prosecutions are (1) the institution or continuation of original judicial proceedings; (2) by or at the insistence of the defendant; (3) termination of such proceedings in plaintiff's favor; (4) malice in instituting such proceedings; (5) lack of probable cause; and (6) resulting injury or damage. McBride, 389 S.C. at 565. The "malice" element could proceed from an ill-regulated mind which is not sufficiently cautious before causing injury to another person; may be implied where the evidence reveals a disregard of the consequences of an injurious act; or can be inferred from a lack of probable cause to institute the prosecution. Id.

Accordingly, claims for fraud should not be pursued and prosecuted without adequate probable cause. Further, it may be advisable to not partake in instituting the enforcement yourself, but turn over the information you have to the proper authorities.

SOUTH DAKOTA

Criminal and Civil Penalties for Insurance Fraud

South Dakota has established an Insurance Fraud Prevention Unit to investigate and prosecute activities involving fraudulent insurance acts. SDCL 58-4A-4. The insurance fraud prevention unit has authority to initiate and conduct investigations, review complaints, undertake studies to determine extent of fraud, promote awareness of insurance fraud, and prosecute fraudulent insurance acts. SDCL 58-4A-3. All investigative records and files of the insurance fraud prevention unit are confidential and not subject to subpoena and may be released only with a court order. SDCL 58-4A-12.

Pursuant to SDCL Ch. 58-4A, the insurance fraud chapter, a person may be guilty of a Class 1 or 2 misdemeanor or Class 4 felony if the person does any of the following:

(1) Knowingly and with intent to defraud or deceive issues or possesses fake or counterfeit insurance policies, certificates of insurance, insurance identification cards, or insurance binders;

(2) Is engaged in the business of insurance, whether authorized or unauthorized, receives money for the purpose of purchasing insurance and converts the money to the person's own benefit or for a purpose not intended or authorized by an insured or prospective insured;

(3) Willfully embezzles, abstracts, steals, misappropriates, or converts money, funds, premiums, credits, or other property of an insurer or person engaged in the business of insurance or of an insured or prospective insured;

(4) Knowingly and with intent to defraud or deceive makes any false entry of a material fact in or pertaining to any document or statement filed with or required by the Division of Insurance;

(5) Knowingly and with intent to defraud or deceive removes, conceals, alters, diverts, or destroys assets or records of an insurer or other person engaged in the business of insurance or attempts to remove, conceal, alter, divert, or destroy assets or records of an insurer or other person engaged in the business of insurance;

(6) Knowingly and with intent to defraud or deceive presents, causes to be presented, or prepares with knowledge or belief that it will be presented to or by an insurer, or any insurance producer of an insurer, any statement as part of a claim, in support of a claim, or in denial of a claim for payment or other benefit pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to a claim;

(7) Assists, abets, solicits, or conspires with another to prepare or make any statement that is intended to be presented to or by an insurer or person in connection with or in support of any claim for payment or other benefit, or denial, pursuant to an insurance policy knowing that the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim; or

(8) Makes any false or fraudulent representations as to the death or disability of a policy or certificate holder in any statement or certificate for the purpose of fraudulently obtaining money or benefit from an insurer.

The insurance fraud chapter also provides for civil penalties. Pursuant to SDCL 58-4A-7, the insurance fraud prevention unit or its designees may initiate a civil action against any person. If that person is found to have committed a fraudulent insurance act, the person is subject to a civil penalty not to exceed five thousand dollars for the first violation, ten thousand for the second violation, and fifteen thousand for each subsequent violation. *Id*. Such a civil action may be in lieu of criminal prosecution with approval by the director and attorney general. *Id*. Costs are also recoverable. SDCL 58-4A-9. In cases where a civil action is filed, the prevention unit or its designee are allowed to enter into a written agreement in which the person alleged to have committed a fraudulent insurance act does not admit or deny the charges but consents to payment of the civil penalty. SDCL 58-4A-10.

The chapter also grants immunity from civil liability for filing a report with or for furnishing any information relating to suspected, anticipated, or completed fraudulent insurance acts. SDCL 58-4A-13. In order to be shield by this immunity, the person reporting or filing the suspected fraudulent insurance act must be acting in good faith. *Id*.; *see* SDCL 58-33-37 (explaining liability of those who supply information or testify as to fraud). SDCL Ch. 58-33 lists a host of other unfair methods of competition and unfair and deceptive acts or practices in the business of insurance. *See* SDCL 58-33-4 to 58-33-37.

Other common-law actions may also apply. Larceny charges and embezzlement charges may be brought under certain circumstances. *See Miessner v. All Dakota Ins. Associates, Inc.*, 515 N.W.2d 198, 199 (S.D. 1994). Malicious prosecution claims have been asserted along with claims for defamation. *Id*. Misrepresentation claims by an insurer or insured could also be asserted. *Railsback v. Mid-Century Ins. Co.,* 2004 SD 64, 680 N.W.2d 652, 656.

TENNESSEE

Tennessee also has malicious prosecution and defamation and statutory bad faith. The primary weapon used by insureds, however, is the Tennessee Consumer Protection Act, T.C.A. 47- 18-109.

TEXAS

Texas law offers several potential avenues of redress when insurance fraud is suspected or has been committed. The most efficient avenue is to report the alleged fraud to the Texas Department of Insurance Fraud Unit. Created by section 701.101 of the Texas Insurance Code, the Fraud Unit is tasked with investigating insurance fraud on a statewide basis. Section 701.001 defines fraudulent insurance act as an act that is a violation of the penal law and is (A) committed while engaging in the business of insurance; (B) committed or attempted as part of or in support of an insurance transaction; or (C) part of an attempt to defraud the insurer. As stated on its website, the "units" responsibilities including receiving and reviewing reports of fraud, initiating inquiries, and conducting investigations…." Thus, the Fraud Unit represents a centralized state agency under which insurance fraud complaints may be handled.

The fraud may also be reported to any authorized governmental agency which is defined as any municipal, county, or state law enforcement agency, the prosecuting attorney of the municipality, county, or state, or the United States Attorney's office.

The reporting of suspected insurance fraud is required under TEX. INS. CODE ANN §701.051. According to the statute, a person who determines or "reasonably suspects" that a fraudulent insurance act (defined, in part, as "part of an attempt to defraud an insurer") had been or is about to be committed shall report the information in writing to the Fraud Unit, to the National Association of Insurance Commissioners (NAIC), or to any authorized governmental agency, as defined above. The Texas Department of Insurance may

request the assistance of local law enforcement officers in conducting an investigation of a fraudulent act as defined under Section 35.02 of the Texas Penal Code. The statue requires that the reporting occur within 30 days after the person determined or "reasonably suspects" the fraudulent insurance act, but does not contain a specific sanction or penalty for failure to report within 30 days. In addition, what constitutes "reasonable" suspicion is undefined. It is recommended that a report of suspected fraud be made as soon as possible, however, so that the one may benefit from the favorable light that full compliance with statutory guidelines tends to generate. Insurers have a duty to provide any relevant information or material relating to a matter under investigation upon the request of any authorized government official. Tex. Ins. Code. Ann. § 701.107. As a means of protecting the insured, all information obtained by the Texas Department of Insurance fraud unit is privileged information that is not available to the public. Tex. Ins. Code. Ann. § 701.151.

One of the key advantages in reporting the fraud to the Fraud Unit or to a governmental agency is that it allows the reporting party to take advantage of statutory immunity that arises under §701.052. That provision of the Texas Insurance Code provides that anyone who furnishes information about a "suspected, anticipated or completed" fraudulent act to the Fraud Unit, an authorized governmental agency, or SIU of an insurer, as well as other specified entities or persons, cannot be held liable in a civil action related to the provision of that information. In many instances, those against whom fraud is alleged will pursue claims of fraud and slander against their accusers. Section 701.052 specifically prevents such actions, as well as other claims against the accuser of fraud for providing the information about the fraud to various specific entities. The statute provides both immunity from liability and liability from suit, thereby preventing even a lawsuit from being brought against the accuser.

The statute also specifies that this conditional immunity does not apply in cases in which the accuser acts with malice, fraudulent intent, or bad faith. Not surprisingly, instances in which the person accused of fraud has filed suit against his or her accuser, malice, fraudulent intent, and bad faith are usually pled. However, under Texas law, these are notoriously difficult to prove as they involve allegations of subjective mental states that are often not manifested in objective evidence, such as documents. Thus, in these instances, summary judgment is usually an appropriate defensive tactic to defeat these claims.

Section 701.052 also provides an even bigger stick to benefit the accuser of insurance fraud. If the person accused of fraud files suit and that suit is defeated under §701.052's immunity provisions, the prevailing party is entitled to attorney's fees and costs. This cost shifting often represents a significant disincentive to those who might be inclined to file slander or libel suits against their accusers.

Once the reports are made to the Fraud Unit or authorized agency, the Texas Penal Code provides a set of significant statutory tools to pursue the perpetrators of fraud in the criminal justice system. Texas Penal Code §35.02 states the following:

> (a) A person commits an offense if, with intent to defraud or deceive an insurer, the person, in support of a claim for payment under an insurance policy:
>
> a. Prepares or causes to be prepared a statement that:
>
> i. The person knows contains false or misleading material information; and
>
> ii. Is presented to an insurer; or
>
> b. Presents or causes to be presented to an insurer a statement that the person knows contains false or misleading material information.
>
> (b) A person commits an offense if, with intent to defraud or deceive an insurer, the person solicits, offers, pays, or receives a benefit in connection with the furnishing of goods or services for which a claim for payment is submitted under an insurance policy.

The Texas Legislature also enacted a range of punishments for violations of the insurance fraud statute that increases with the monetary value of the offender's fraudulent claim. Specifically, it is a Class C misdemeanor if the value of the claim is less than $50.00; a Class B misdemeanor if the claim is between $50.00 and $500.00; Class A misdemeanor if the claim is between $500 and $1,500.00; a state jail felony if the value is between $1,500 and $20,000; a third degree felony if the value is between $20,000 and

$100,000; a second degree felony if the value is between $100,000 and $200,000; and a first degree felony if the claim is more than $200,000 or if the act places a person at risk of death or serious bodily injury. Thus, the range of punishments can vary from a fine only to life in prison. The monetary amounts may also be aggregated, thus allowing a prosecutor to seek punishment based on the total value of all acts of fraud in cases of multiple instances of insurance fraud.

Further, a prosecutor may be able to pursue charges of criminal conspiracy against multiple individuals who are involved in a fraudulent scheme or act, even if some members of the conspiracy did not actually commit the fraud.

Aside from the criminal grounds for insurance fraud, an insurer may also file a separate civil suit against an alleged defrauder. Texas does not have a separate "insurance fraud" cause of action. However, the insurer may make a claim for common law fraud, in which the insurer must show that: (1) the defendant made a material representation to the insurer; (2) the representation was false; (3) the defendant made the false representation when he/she knew it was false or made it recklessly, as a positive assertion, and without knowledge of its truth; (4) the misrepresentation was made with the intent that the insurer rely upon it; (5) the insurer did rely upon it; and (6) the representation cased the insurer injury (i.e., sustained monetary damages). Further, if the fraud appears to be a part of a concerted effort or scheme by more than one person, a cause of action of civil conspiracy may also be available.

If an insurer acts maliciously, fraudulently or in bad faith alleges that the insured has instituted a fraudulent insurance claim, upon a finding of innocence, the insured may institute a malicious prosecution claim against the insurer. Under Texas law, claims for malicious prosecution have the following elements: (1) the institution or continuation of civil proceedings against the plaintiff; (2) by or at the insistence of the defendant; (3) malice in the commencement of the proceeding; (4) lack of probable cause for the proceeding; (5) termination of the proceeding in plaintiff's favor; and (6) special damages resulting from some physical interference with a party's person or property in the form of an arrest, attachment, injunction, or sequestration. *Tex. Beef Cattle Co. v. Green*, 921 S.W.2d 203, 207-09 (Tex.1996).

Rule 13 of the Texas Rules of Civil Procedure provides for imposition of sanctions for groundless or bad faith pleadings. If a fraudulent pleading is filed in violation of Rule 13, "the court, upon motion or upon its own initiative, after notice and hearing, shall impose an appropriate sanction available under Rule 215.2 (b), upon the person who signed it, a represented party, or both." Id. Sanctions under Rule 13 require a showing of good cause. A groundless pleading is not sanctionable unless it was also brought for the purpose of harassment. The party moving for sanctions must prove the pleading party's subjective state of mind at an evidentiary hearing. Bad faith does not exist when a party exercises bad judgment or is negligent, but requires a showing of dishonest or malicious purposes.

A civil suit is recommended in cases in which the fraudulent activity has already resulted in significant economic losses by the insurer. In a civil case, the insurer is always susceptible to a counter claim for claims of intentional infliction of emotional distress, fraud, and other claims from which it might otherwise be protected if it avails itself of the immunity protection under the Insurance Code. There may be some judicial immunity from suit for slander or defamation if the objectionable statements are made within judicial pleadings. However, this immunity may not extend to the other causes of action mentioned above. Thus, there is a risk of enhanced costs, additional expenses, and possible exposure as the blanket immunity under the Insurance Code appears available only in the cases where the fraudulent activity is pursued by the Fraud Unit or law enforcement.

The Texas Department of Insurance regulates workers' compensation benefits. Remedies for fraudulent workers compensation claims are found in the Texas Labor Code under the Workers Compensation Act. The Texas Labor Code states that "a person commits a violation if the person, to obtain or deny a payment of a workers' compensation benefits or the provision of a benefit for the person or another, knowingly or intentionally (1) makes a false or misleading statement; (2) misrepresents or conceals a material fact; (3) fabricates, alters, conceals, or destroys a document;" or (4) conspires to commit any act listed in (1), (2), or (3). TEX. LAB. CODE ANN. art. 415.008 (Vernon 2006). The Workers Compensation Act provides that a person who has received excess payment is liable for full repayment plus interest.

TEX. LAB. CODE ANN. art. 415.008. The Texas Workers Compensation Act provides that an offense constituting a fraudulent act is a Class A misdemeanor if the amount of benefits fraudulently obtained is less than $1,500.00 and a state jail felony if the amount of the premium avoided is $1,500.00 or more. TEX. LAB. CODE ANN. art. 418.002. The Texas Department of Insurance has an online reporting system for employers and carriers and a Special Investigation Unit.

UTAH

Insurance Fraud Statutes

Like most states, Utah has enacted legislation prohibiting insurance fraud. *See* Utah Code Annotated §31A-31-103 makes it a fraudulent act for a person to knowingly present an insurance claim that misrepresents a material fact. It is also a fraudulent practice to accept the benefit of the proceeds derived from a fraudulent act, or to assist, abet, solicit or conspire to commit a fraudulent act. *See* Utah Code Ann. §31A-31-103.

Remedies for Fraudulent Claims

If an insurer has already paid out on a fraudulent claim, the Insurance Fraud Act provides for civil penalties against the perpetrator of the fraud. The person who has violated the Act "shall make full restitution" to the person damaged by the fraudulent insurance act. Utah Code Ann. §31A-31-109

An insurer also has the right to rescind a policy due to fraud if the insurer can meet one of three criteria: (1) the insurer relies on the material misrepresentation made by the applicant, (2) the insurer relies on a misrepresentation that was made by the applicant with intent to deceive; or (3) if the applicant's misrepresentation contributes to a loss. *See Derbridge v Mutual Protective Insurance Company Ins. Co.*, 963 P.2d 788 (Utah App. 1998).

Bad Faith Practices

An insurer who brings a civil suit against its insured for insurance fraud is not guilty of bad faith if the claim brought by the insured is fairly debatable. A claim is fairly debatable "[i]f the evidence presented creates a factual issue as to the claim's validity" *Prince v Bear River Mut. Ins. Co.* 2002 UT 68 ¶ 34, 56 P.3d 524, 535 (UT 2002).

In *Callioux v Progressive Ins. Co.*, the insurer's investigation of a car fire led it to believe that the fire was the result of arson perpetrated by the insured, and therefore denied the insured's claim. *Callioux v Progressive Insurance Co.* 745 P.2d 838 (Utah App 1987). After a criminal trial, the insured was found not guilty of both arson and insurance fraud. The insurer then paid out the claim to the insured. The insured subsequently brought a bad faith claim against the insurer. Utah courts have consistently held that the implied covenant of good faith contemplates that the insurer will (1) diligently investigate the facts of every claim to determine its validity; (2) fairly evaluate a claim; and (3) act promptly and reasonably in rejecting or settling a claim. To the extent that the insurer meets these obligations, and a claim is fairly debatable, the insurer is entitled to debate it, whether the debate concerns a matter of fact or law. *Callioux v Progressive Insurance Co.* 745 P.2d 838, 842 (Utah App 1987). Before bringing an action for insurance fraud, or claiming insurance fraud as an affirmative defense, an insurer should be careful to diligently investigate, and fairly evaluate the validity of a claim.

Utah Insurance Fraud Division

The Insurance Fraud Act of 1994 gave rise to the Insurance Fraud Division. This division is charged with the responsibility of conducting criminal investigations and prosecutions of insurance fraud violators. The Fraud Division is recognized as an official law enforcement agency in the State of Utah and investigators for the division are special function law enforcement officers. Additional information regarding the Utah Insurance Fraud Division can be found at *ifd.utah.gov*.

VIRGINIA

There is actually very little in the way of legal guidance specific to a potentially fraudulent claim. It may be helpful to think of such a claim (from a legal standpoint) as simply a dubious claim that might eventually be rejected depending on the outcome of investigation.

There are two areas of Virginia law that come into play in fraud investigations.

First, where insurance is involved, Virginia has a statute on insurance fraud. *Va. Code* §§ 52-36 to 52-44. It applies only to insurance claims, not claims generally. At the point an insurer becomes involved in a claim, the statute would become relevant. The statute provides for a special Unit of the Virginia State Police to study and investigate such fraud, § 52-37, and provides a qualified immunity to insurers and their employees against claims for defamation, invasion of privacy or negligence for providing information in accordance with the statute if done without malice or a willful intent to injure. § 52-41. Also where insurance is involved, Virginia has a provision allowing disclosure of certain confidential or privileged information on individuals to law enforcement to prevent fraud. *Va. Code* § 38.2-613(B) (5). Additionally, where insurance is involved, Virginia has an Arson Reporting Immunity Act, *Va. Code* §§ 27.85.3 et. seq., which allows certain disclosures and provides for qualified immunity similar to the insurance fraud provisions on those issues noted above.

Second, Virginia has the usual possibility of a common law action for defamation or malicious prosecution where fraud is alleged or prosecuted. While unlikely, it is possible that the process of designating a claim as fraudulent could lead to a civil action. It is impossible to guarantee that such a claim will not be brought, but the following suggestions are made to limit the likelihood of such an event.

Defamation: It is likely that an accusation of making a fraudulent claim would be deemed to be defamation per se, allowing the claim to be made based upon presumed damages, since this is likely to be considered an allegation of a crime involving moral turpitude. *Great Coastal Express, Inc. v. Ellington,* 230 Va. 142, 334 S.E.2d 846 (1985) (giving as examples petit larceny and the making of a false statement to obtain unemployment benefits). Accordingly, if investigation has reached a point where it is believed that the claim is fraudulent, the following is suggested:

- Avoid making a statement or writing using the words “fraudulent claim” with respect to a named individual. Use “possibly,” “suspicious” etc.
- Limit communications that identify an individual as such a claimant to the fewest “need to know” personnel possible, and do not communicate at all outside the company.
- Do not use the word “fraudulent” or equivalent in communications with the claimant or claimant’s representative. Note that you have questions or concerns that prevent the claim from being honored.

Malicious Prosecution: A plaintiff making such a claim must prove that the prosecution was malicious, was instituted by or with the cooperation of the defendant, without probable cause, and terminated in a manner not unfavorable to the plaintiff. *Reilly v. Shepherd,* 273 Va. 728, 643 S.E.2d 216 (2007). This is not a favored claim, but it is a potential claim. If a decision is made that the claim is indeed fraudulent, and should be turned over to law enforcement, it is suggested:

- Do not institute enforcement yourself, but turn over the information you have to law enforcement.
- Most of all, be sure of your ground. The law is a bit murky on the extent of involvement in starting the prosecution that is necessary, but is clear that the existence of probable cause is a full defense. You cannot control the success of the prosecution, but you can document the existence of probable cause before it begins.

WASHINGTON

Basic Legal Considerations in Handling Potentially Fraudulent Claims in Washington

A. Statutory Guidance

Statutory legal guidance relating to potentially fraudulent claims generally pertains to situations where insurance is involved. To that end, Washington has some very good anti-insurance fraud legislation. RCW 48.01.030 states:

> The business of insurance is one affected by the public interest, requiring that all persons be actuated by good faith, abstain from deception, and practice honesty and equity in all insurance matters. Upon the insurer, the insured, their providers, and their representatives rests the duty of preserving inviolate the integrity of insurance.

In addition, it is unlawful for any person to present a false or fraudulent insurance claim, or any proof in support of such a claim, for the payment of a loss under an insurance policy. RCW 48.30.230. If the value of the claim exceeds $1,500, the violation is a Class C felony. Insurers in Washington have a statutory duty to report fraud and to cooperate with law enforcement agencies in prosecuting insurance fraud. RCW 48.30A.050(3).

Insurers who release information to authorized agencies, including, but not limited to, law enforcement agencies, are immune from liability in any civil or criminal action, suit or prosecution arising from the release of the information, unless actual malice can be shown by the insured. RCW 48.50.070. Additionally, in denying a claim, insurers who rely on a written opinion from an authorized agency that criminal activity that is related to the claim is being investigated, or a crime has been charged, and that the claimant is a target of the investigation or has been charged with a crime, are not liable for bad faith or other extra-contractual theory of damages as a result of this reliance. RCW 48.50.075.

B. Claims Handling Guidance

The investigation process is an intrinsic part of the claims management process because it is the essential step necessary to determine claim validity and compensability. In order to “ferret out” fraud, it is essential to promptly review all documents, including the accident or law enforcement agency report, physician's reports, and any statements obtained from the injured party and other witnesses. In reviewing these documents, be sure and promptly determine whether additional information or documentation is needed to make a determination. If such additional information or documentation is necessary, actively pursue obtaining the information or documents. Frequently, you will need to obtain additional witness statements, diagrams of the area where the incident or accident occurred, further medical clarification or any other facts which will enable you to correctly administer the claim for benefits. If professional investigation is warranted, you may use outside entities to conduct surveillance or background checks.

If your investigation reveals that fraud may be present, it is important not to document your file with ultimate conclusions about the claim. Keep written entries to the file limited to concerns about concerns or the potential of fraud. Obviously, it is important to document the file with all evidence obtained indicating the potential of fraud. If you come to the conclusion that the claim is likely fraudulent, it is best to notify the appropriate law enforcement agency and avoid performing functions that the agency would normally perform.

WEST VIRGINIA

Although West Virginia has enacted legislation making insurance fraud a crime, that law does not create a civil cause of action. The law also provides for mandatory reporting requirements to aid the state in its enforcement of the law’s provisions. The common law tort of misrepresentation provides a civil remedy to those suffering damages as a result of insurance fraud.

I. Insurance Fraud

The West Virginia Insurance Fraud Prevention Act, W.Va.Code §§ 33-41-1 et seq. (2010), authorizes the commissioner of insurance to investigate suspected criminal acts relating to the business of insurance, and to appoint special prosecutors where the county prosecuting attorney is not available. This statute does not provide for a private cause of action.

Any person who knowingly and willfully and with intent to defraud submits a materially false statement in support of a claim for insurance benefits or payment pursuant to a policy of insurance or who conspires to do so is guilty of a crime. § 33-41-11. A person convicted of insurance fraud will be required to provide restitution.

This law also provides immunity from civil liability to any person for the furnishing of information concerning suspected fraud when that information is provided to or received from the commissioner of insurance, law enforcement, a person involved in the prevention or detection of insurance fraud or the National Association of Insurance Commissioners. § 33-41-6. Those subject to the law's mandatory reporting requirements, however, will not have immunity for "materially incorrect statements made maliciously or fraudulently", and no person is immune for statements made in reckless disregard of the truth or falsity of the statement.

II. Misrepresentation

Misrepresentation occurs when a defendant makes a statement that was material and false, upon which a plaintiff justifiably relied, resulting in damages. *Jennings v. Farmers Mut. Ins. Co.*, 224 W. Va. 636, 641, 687 S.E.2d 574, 579 (2009). Defendant's misrepresentations need not be the sole inducement for the plaintiff's actions; plaintiff must prove only that the representations contributed to the formation of the conclusion in his/her mind which prompted action.

Other considerations

Insurers and self-insureds addressing potentially fraudulent claims should consider their exposure to liability for defamation or malicious prosecution.

I. Defamation

Insurers and self-insureds should refrain from labeling potentially fraudulent claims as "fraudulent".

The West Virginia Supreme Court of Appeals has identified the essential elements for a successful defamation action by a private individual: (1) defamatory statements; (2) a non-privileged communication to a third party; (3) falsity; (4) reference to the plaintiff; (5) at least negligence on the part of the publisher; and (6) resulting injury. *Belcher v. Wal-Mart Stores*, 211 W. Va. 712, 719, 568 S.E.2d 19, 26 (2002). West Virginia recognizes the concept of defamation *per se* regarding statements imputing crimes of moral turpitude upon an individual. *Mauck v. Martinsburg*, 167 W. Va. 332, 336, 280 S.E.2d 216, 219 n. 3 (1981), citing *Restatement (Second) of Torts* §§ 571-74 (1977).

II. Malicious Prosecution

An action for malicious prosecution requires proof of three elements: (1) That the prosecution was malicious; (2) that it was without reasonable or probable cause; and (3) that it terminated favorably to the plaintiff. *Clark v. Druckman*, 218 W. Va. 427, 433-434, 624 S.E.2d 864, 870-71 (2005). The term malicious is defined as "substantially certain to cause injury" and "without just cause or excuse." *Id.* citing BLACK'S LAW DICTIONARY 977 (8th Ed. 2004). This definition implies an improper or evil intent or motive or the intent to do harm.

WISCONSIN

A. Fraudulent Claims Involving Insurance

Wisconsin statutory law contains a provision in its criminal code specifically dealing with insurance fraud. Wis. Stat. §943.395, entitled "Fraudulent insurance and employee benefit program claims," makes it unlawful to submit a fraudulent insurance claim. That section reads, in pertinent part:

(1) Whoever, knowing it to be false or fraudulent, does any of the following may be penalized as provided in sub. (2):

(a) Presents or causes to be presented a false or fraudulent claim, or any proof in support of such claim, to be paid under any contract or certificate of insurance; or

(b) Prepares, makes or subscribes to a false or fraudulent account, certificate, affidavit, proof of loss or other document or writing, with knowledge that the same may be presented or used in support of a claim for payment under a policy of insurance.

(c) Presents or causes to be presented a false or fraudulent claim or benefit application, or any false or fraudulent proof in support of such a claim or benefit application, or false or fraudulent information which would affect a future claim or benefit application, to be paid under any employee benefit program created by ch. 40.

(d) Makes any misrepresentation in or with reference to any application for membership or documentary or other proof for the purpose of obtaining membership in or noninsurance benefit from any fraternal subject to chs. 600 to 646, for himself or herself or any other person.

(2) Whoever violates this section:

(a) Is guilty of a Class A misdemeanor if the value of the claim or benefit does not exceed $2,500.

(b) Is guilty of a Class I felony if the value of the claim or benefit exceeds $2,500.

In order to foster the reporting of such claims, the Wisconsin legislature has also established civil immunity to persons who, without malice, files a report with or furnishes information concerning suspected, anticipated, or completed insurance fraud. This section not only provides civil immunity to those who report such activity but also grants such persons their expenses and attorneys fees if an action is filed against them and the court finds they are immune. Wis. Stat. §895.486, entitled "Civil immunity exemption; reports of insurance fraud," reads in pertinent part:

(1) In this section, "insurance fraud" means the presentation of any statement, document or claim, or the preparation of a statement, document or claim with the knowledge that the statement, document or claim will be presented, that the person knew or should have known contained materially false, incomplete or misleading information concerning any of the following:

(a) An application for the issuance of an insurance policy.

(b) A claim for payment, reimbursement or benefits payable under an insurance policy.

(c) A payment made in accordance with the terms of an insurance policy.

(d) A premium on an insurance policy.

(e) The rating of an insurance policy.

(2) Any person who, absent malice, files a report with or furnishes information concerning suspected, anticipated, or completed insurance fraud is immune from civil liability for his or her acts or omissions in filing the report or furnishing the information to any of the following or to their agents, employees or designees:

(a) The office of the commissioner of insurance.

(b) A law enforcement officer.

(c) The National Association of Insurance Commissioners.

(d) Any governmental agency established to detect and prevent insurance fraud.

(e) Any nonprofit organization established to detect and prevent insurance fraud.

(f) Any insurer or authorized representative of an insurer.

(3) Any information furnished by an insurer in response to a report or information furnished under sub. (2) is confidential and may be made public only if required in a civil or criminal action.

(4) If a civil action is commenced against a person for damages related to the filing of a report or the furnishing of information under sub. (2) and the court determines that the person is immune from civil liability for his or her acts or omissions in filing the report or furnishing the information, the person filing the report or furnishing the information shall recover costs under ch. 814 and, notwithstanding §814.04(1), reasonable attorney fees.

B. Fraud Claims Not Involving Insurance

Wisconsin also has statutes and common law claims that can be asserted where fraud is alleged or prosecuted. A statutory claim for misrepresentation can be brought under Wis. Stat. §100.18, entitled "Fraudulent Misrepresentations; Improper Solicitations," and provides for the recovery of costs and attorneys fees to the successful party.

Wisconsin also has common law misrepresentation claims which may be asserted under one of three theories: intentional, negligent, and strict responsibility. An explanation detailing the differences between these three theories has been explained by the Wisconsin Supreme Court in Lewis v. Paul Revere Life Ins. Co., 80 F.Supp.2d 978, 1000 (E.D. Wis. 2000):

Intentional misrepresentation has two elements beyond those common to all forms of misrepresentation. First, the defendant must either have known the representation was untrue or have made the representation recklessly without caring whether it was true or false; second, the defendant must have made the representation with intent to deceive and induce the plaintiff to act upon it to the plaintiff's pecuniary damage. Whipp v. Iverson, 43 Wis.2d 166, 168, 168 N.W.2d 201 (1969). These elements (and the three common elements) must be proven by the "middle" burden of proof, that is, with evidence that clear, satisfactory, and convincing.

Negligent misrepresentation has only one element beyond the three common elements for all forms of misrepresentation: The defendant must have failed to exercise ordinary care in making a misrepresentation or in ascertaining the facts where a duty of care is required or voluntarily assumed.

Whether the defendant knew or did not know the represented facts is immaterial to strict responsibility. Whipp, supra, 43 Wis.2d at 170, 168 N.W.2d 201. When strict responsibility liability is imposed, it is not due to the defendant's knowledge or negligence, but rather due to public policy. The elements unique to strict responsibility misrepresentation are first, that the defendant had an economic interest in the transaction; and second, that the misrepresentation must be made on the defendant's personal knowledge or under circumstances in which he necessarily ought to have known the truth or untruth of the statement.

See also Lundin v. Shimanski, 124 Wis.2d 175, 368 N.W.2d 676 (1985). The party alleging the fraud has the burden of proving the elements by clear and convincing evidence. Id.

Wisconsin also has the usual possibilities of a common law action for defamation or malicious prosecution were fraud is alleged of prosecuted. A claim for malicious prosecution in Wisconsin has six essential elements:

(1) There must have been a prior institution or continuation of some regular judicial proceedings against the plaintiff in this action for malicious prosecution;

(2) Such former proceedings must have been by, or at the instance of, the defendant in this action for malicious prosecution;

(3) The former proceedings must have terminated in favor of the defendant therein, the plaintiff in the action for malicious prosecution;

(4) There must have been malice in instituting the former proceedings;

(5) There must have been want of probable cause for the institution of the former proceedings; and

(6) There must have been injury or damage resulting to the plaintiff from the former proceedings.

Brownsell v. Klawitter, 102 Wis.2d 108, 112, 306 N.W.2d 41, 43 (1981). The burden of proof is upon the plaintiff to establish all six elements; and, if he fails with respect to any one of them, the defendant prevails. Tower Special Facilities, Inc. v. Investment Club, Inc., 104 Wis.2d 221, 311 N.W.2d 225 (Wis. App. 1981). There is a strong reason of public policy for thus making it rather onerous for a person to successfully maintain an action for malicious prosecution. Yelk v. Seefeldt, 35 Wis.2d 271, 277, 151 N.W.2d 4, 7 (1967)

The elements of a common law action for defamation in Wisconsin are: (1) a false statement; (2) communicated by speech, conduct or in writing to a person other than the one defamed; and (3) the communication is unprivileged and tends to harm one's reputation, lowering him or her in the estimation of the community or deterring third persons from associating or dealing with him or her. Torgerson v. Journal/Sentinel, Inc., 210 Wis. 2d 524, 534, 563 N.W.2d 472 (1997). Also, if a defamation claim is asserted, the circumstances surrounding the claim must be analyzed to determine whether a privilege applies to the alleged defamatory statement. In Wisconsin, there are two classifications of privilege - - absolute and conditional. An absolute privilege gives complete protection from claim of defamation while a conditional privilege may be forfeited if abused.

The law in Wisconsin is that statements made in the course of judicial, quasi-judicial and investigative proceedings are absolutely privileged and insulate the speaker from liability so long as the statements "bear a proper relationship to the issues." Bergman v. Hupy, 64 Wis.2d 747, 750, 221 N.W.2d 898, 900 (1974). As referenced above, the only requirements necessary to invoke the absolute privilege are:

1. the statements must be made in a procedural context that is recognized as affording the privilege;

2. the statements must be made by and to persons involved in and closely connected to the proceeding; and

3. the statements must be relevant to the proceeding.

Rady v. Lutz, 150 Wis.2d 643, 647-49, 444 N.W.2d 58, 59-60. All questions of relevancy are to be resolved in favor of a finding that the statements are relevant. Bussewitz v. Wisconsin Teachers' Ass'n., 188 Wis. 121, 125, 205 N.W. 808, 810 (1925). If the statements are determined to be absolutely privileged, the maker of the statements is absolutely immune from liability for the statements, and this absolute immunity precludes claims for defamation. Bergman, 64 Wis.2d at 749, 221 N.W.2d at 900; see also, Churchill v. WFA Econometrics Corp., 2002 WI App 305, 258 Wis.2d 926 (2002).

If an absolute privilege does not apply, certain communications are conditionally privileged and therefore not actionable, even if the statement is otherwise defamatory, because the maker of the statement "is acting in furtherance of some interest of societal importance, which is entitled to protection even at the expense of uncompensated harm to the plaintiff." Zinda v. Louisiana-Pacific Corp., 149 Wis.2d 913, 921-22, 440 N.W.2d 548 (1989). Even though the privilege is recognized, courts also recognize that a conditional privilege may be forfeited if abused. Olson v. 3M, 188 Wis.2d 25, 38, 523 N.W.2d 578 (Ct.App.1994). A privilege may be abused if any one of the following is found to apply:

(1) if, at the time of making the statement, the publisher knew that such statements were false or made them in reckless disregard as to the truth or falsity of them;

(2) if the defamatory matter is published for some purpose other than that for which the particular privilege is given - - i.e. if made solely from spite or ill will;

(3) if the statement was made to persons who had no interest in or connection with the accomplishment of the purpose of the particular privilege;

(4) if the publisher of the statement did not reasonably believe that the making of the statement was necessary to accomplish the purpose for which the occasion is privileged;

(5) the publication includes unprivileged matter as well as privileged matter; or

(6) if the publisher made statements believed by him to be true but then added statements known by him to be false.

Vultaggio v. Yasko, 215 Wis.2d 326, 33132, 572 N.W.2d 450, 452 (1998); see also WIS J I--CIVIL 2507.

WYOMING

Wyoming has not adopted a fraudulent claims or false reporting statute relating to insurance fraud; however, a bill that would provide immunity from civil liability for furnishing information relating to insurance fraud to law enforcement has been proposed for the 2011 session.

Presently, if a person makes a fraudulent claim in Wyoming, the injured party could bring a claim for fraud/intentional misrepresentation or negligent misrepresentation. To make a claim for negligent misrepresentation, a plaintiff must show that "one who, in the course of his business, profession or employment, or in any other transaction in which he has a pecuniary interest, supplies false information for the guidance of others in their business transactions, is subject to liability for pecuniary loss caused to them by their justifiable reliance upon the information, if he fails to exercise reasonable care or competence in obtaining or communicating the information." *Brit v. Wells Fargo Home Mortg., Inc.,* 2003 WY 102, ¶ 42, 75 P.3d 640, 656 (Wyo. 2003); *Restatement of Torts (Second)* § 552, p. 126 (1977). Negligent misrepresentation must be proven by a preponderance of the evidence. *Excel Constr., Inc. v. HKM Eng'g, Inc.,* 2010 WY 34, ¶ 33, 228 P.3d 40, 48 (Wyo. 2010).

A party claiming fraud/intentional misrepresentation must prove the following elements: "(1) the defendant made a false representation intended to induce action by the plaintiff; (2) the plaintiff reasonably believed the representation to be true; and (3) the plaintiff relied on the false representation and suffered damages." *Excel Constr.,* 2010 WY 34, ¶ 33, 228 P.3d at 48. To prove "intentional misrepresentation,

the plaintiff must show that the misrepresentation was made intentionally, with knowledge of its falsity, or that the maker of the misrepresentation was at least aware that he did not have a basis for making the statement." *Id.; Restatement (Second) of Torts* § 526 (1977). Fraud must be proven by clear and convincing evidence and pled with particularity. *Excel,* 228 P.3d at 49.

Another possible cause of action for a party injured by a false or fraudulent claim is slander. In Wyoming, "disparagement of another's goods or property is not slanderous per se and special damages must be shown." *Diefenderfer v. Totman*, 280 P.2d 284, 286-87 (Wyo. 1955). Slander is an oral defamatory communication, which is a communication that "tends to hold the plaintiff up to hatred, contempt, ridicule or scorn or which causes him to be shunned or avoided; one that tends to injure his reputation as to diminish the esteem, respect, goodwill or confidence in which he is held." *Wilder v. Cody Country Chamber of Commerce*, 868 P.2d 211, 224 (Wyo. 1994) (quoting *Tschirgi v. Lander Wyoming State Journal*, 706 P.2d 1116, 1119 (Wyo. 1985)). To be actionable, the defamatory or disparaging words "must affect the plaintiff in some way that is peculiarly harmful to one engaged in his trade or profession." *Wilder*, 868 P.2d at 224 (quoting *Restatement (Second) of Torts* § 573 at 194, cmt. e).

Like many other states, Wyoming has a claim for malicious prosecution. If a person accused of filing a false or fraudulent claim is found innocent, he or she could file an action to recover under this cause of action. "The following elements are necessary to sustain a cause of action for malicious prosecution: (1) The institution or continuation of original judicial proceedings, either criminal or civil; (2) Such proceedings having been by or at the instance of the defendant…; (3) The termination of such proceedings in favor of the plaintiff…; (4) Malice instituting the proceedings; (5) Want of probable cause; and (6) The suffering of injury or damage as a result of the action complained of." *Toltec Watershed Improvement Dist. v. Johnston,* 717 P.2d 808, 811 (Wyo. 1986). To preclude a malicious prosecution action, the party instituting the action must show probable cause. *Id.* Therefore, it is important to thoroughly document any possible false or fraudulent claim to avoid a malicious prosecution action.

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