IDENTIFYING AND HANDLING INSURANCE FRAUD CASES

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IDENTIFYING AND HANDLING INSURANCE FRAUD CASES

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In cooperation with the New Jersey State Bar Association **Insurance Law Section** and **Insurance Defense Special Committee** **M0591.23**

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§ 17:33A-1. Short title

This act shall be known and may be cited as the "New Jersey Insurance Fraud Prevention Act."

§ 17:33A-2. Purpose of act

The purpose of this act is to confront aggressively the problem of insurance fraud in New Jersey by facilitating the detection of insurance fraud, eliminating the occurrence of such fraud through the development of fraud prevention programs, requiring the restitution of fraudulently obtained insurance benefits, and reducing the amount of premium dollars used to pay fraudulent claims.

§ 17:33A-3. Definitions

As used in this act:

"Attorney General" means the Attorney General of New Jersey or his designated representatives.

"Commissioner" means the Commissioner of Banking and Insurance.

"Director" means the Director of the Division of Insurance Fraud Prevention in the Department of Banking and Insurance.

"Division" means the Division of Insurance Fraud Prevention established by this act.

"Hospital" means any general hospital, mental hospital, convalescent home, nursing home or any other institution, whether operated for profit or not, which maintains or operates facilities for health care.

"Insurance company" means:

a. Any corporation, association, partnership, reciprocal exchange, interinsurer, Lloyd's insurer, fraternal benefit society or other person engaged in the business of insurance pursuant to Subtitle 3 of Title 17 of the Revised Statutes (*C.17:17-1* et seq.), or Subtitle 3 of Title 17B of the New Jersey Statutes (*C.17B:17-1* et seq.);

b. Any medical service corporation operating pursuant to P.L.1940, c.74 (*C.17:48A-1* et seq.);

c. Any hospital service corporation operating pursuant to P.L.1938, c.366 (*C.17:48-1* et seq.);

d. Any health service corporation operating pursuant to P.L.1985, c.236 (*C.17:48E-1* et seq.);

e. Any dental service corporation operating pursuant to P.L.1968, c.305 (*C.17:48C-1* et seq.);

f. Any dental plan organization operating pursuant to P.L.1979, c.478 (*C.17:48D-1* et seq.);

g. Any insurance plan operating pursuant to P.L.1970, c.215 (*C.17:29D-1*);

h. The New Jersey Insurance Underwriting Association operating pursuant to P.L.1968, c.129 (*C.17:37A-1* et seq.);

i. The New Jersey Automobile Full Insurance Underwriting Association operating pursuant to P.L.1983, c.65 (*C.17:30E-1* et seq.) and the Market Transition Facility operating pursuant to section 88 of P.L.1990, c.8 (*C.17:33B-11*); and

j. Any risk retention group or purchasing group operating pursuant to the "Liability Risk Retention Act of 1986," *15 U.S.C. 3901* et seq.

"Pattern" means five or more related violations of P.L.1983, c.320 (*C.17:33A-1* et seq.). Violations are related if they involve either the same victim, or same or similar actions on the part of the person or practitioner charged with violating P.L.1983, c.320 (*C.17:33A-1* et seq.).

"Person" means a person as defined in *R.S.1:1-2*, and shall include, unless the context otherwise requires, a practitioner.

"Principal residence" means that residence at which a person spends the majority of his time. Principal residence may be an abode separate and distinct from a person's domicile. Mere seasonal or weekend residence within this State does not constitute principal residence within this State.

"Practitioner" means a licensee of this State authorized to practice medicine and surgery, psychology, chiropractic, or law or any other licensee of this State whose services are compensated, directly or indirectly, by insurance proceeds, or a licensee similarly licensed in other states and nations or the practitioner of any nonmedical treatment rendered in accordance with a recognized religious method of healing.

"Producer" means an insurance producer as defined in section 2 of P.L.1987, c.293

(*C.17:22A-2*), licensed to transact the business of insurance in this State pursuant to the provisions of the "New Jersey Insurance Producer Licensing Act," P.L.1987, c.293 (*C.17:22A-1* et seq.).

"Statement" includes, but is not limited to, any application, writing, notice, expression, statement, proof of loss, bill of lading, receipt, invoice, account, estimate of property damage, bill for services, diagnosis, prescription, hospital or physician record, X-ray, test result or other evidence of loss, injury or expense.

§ 17:33A-4. Violations

a. A person or a practitioner violates this act if he:

(1) Presents or causes to be presented any written or oral statement as part of, or in support of or opposition to, a claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (*C.39:6-61* et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or

(2) Prepares or makes any written or oral statement that is intended to be presented to any insurance company, the Unsatisfied Claim and Judgment Fund or any claimant thereof in connection with, or in support of or opposition to any claim for payment or other benefit pursuant to an insurance policy or the "Unsatisfied Claim and Judgment Fund Law," P.L.1952, c.174 (*C.39:6-61* et seq.), knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim; or

(3) Conceals or knowingly fails to disclose the occurrence of an event which affects any person's initial or continued right or entitlement to (a) any insurance benefit or payment or (b) the amount of any benefit or payment to which the person is entitled;

(4) Prepares or makes any written or oral statement, intended to be presented to any insurance company or producer for the purpose of obtaining:

(a) a motor vehicle insurance policy, that the person to be insured maintains a principal residence in this State when, in fact, that person's principal residence is in a state other than this State; or

(b) an insurance policy, knowing that the statement contains any false or misleading information concerning any fact or thing material to an insurance application or contract; or

(5) Conceals or knowingly fails to disclose any evidence, written or oral, which may be relevant to a finding that a violation of the provisions of paragraph (4) of this subsection a. has or has not occurred.

b. A person or practitioner violates this act if he knowingly assists, conspires with, or urges any person or practitioner to violate any of the provisions of this act.

c. A person or practitioner violates this act if, due to the assistance, conspiracy or urging of any person or practitioner, he knowingly benefits, directly or indirectly, from the proceeds derived from a violation of this act.

d. A person or practitioner who is the owner, administrator or employee of any hospital violates this act if he knowingly allows the use of the facilities of the hospital by any person in furtherance of a scheme or conspiracy to violate any of the provisions of this act.

e. A person or practitioner violates this act if, for pecuniary gain, for himself or another, he directly or indirectly solicits any person or practitioner to engage, employ or retain either himself or any other person to manage, adjust or prosecute any claim or cause of action, against any person, for damages for negligence, or, for pecuniary gain, for himself or another, directly or indirectly solicits other persons to bring causes of action to recover damages for personal injuries or death, or for pecuniary gain, for himself or another, directly or indirectly solicits other persons to make a claim for personal injury protection benefits pursuant to P.L.1972, c.70 (*C.39:6A-1* et seq.); provided, however, that this subsection shall not apply to any conduct otherwise permitted by law or by rule of the Supreme Court.

§ 17:33A-5. Remedies; penalties; fund established

a. Whenever the commissioner determines that a person has violated any provision of P.L.1983, c.320 (*C.17:33A-1* et seq.), the commissioner may either:

(1) bring a civil action in accordance with subsection b. of this section; or

(2) levy a civil administrative penalty and order restitution in accordance with subsection c. of this section.

In addition to or as an alternative to the remedies provided in this section, the commissioner may request the Attorney General to bring a criminal action under applicable criminal statutes. Additionally, nothing in this section shall be construed to preclude the commissioner from referring the matter to appropriate state licensing authorities, including the insurance producer licensing section in the Department of Banking and Insurance, for consideration of licensing actions, including license suspension or revocation.

b. Any person who violates any provision of P.L.1983, c.320 (*C.17:33A-1* et seq.) shall be liable, in a civil action brought by the commissioner in a court of competent jurisdiction, for a penalty of not more than $ 5,000 for the first violation, $ 10,000 for the second violation and $ 15,000 for each subsequent violation. The penalty shall be paid to the commissioner to be used in accordance with subsection e. of this section. The court shall also award court costs and reasonable attorneys' fees to the commissioner.

c. The commissioner is authorized to assess a civil and administrative penalty of not more than $ 5,000 for the first violation, $ 10,000 for the second violation and $ 15,000 for each subsequent violation of any provision of P.L.1983, c.320 (*C.17:33A-1* et seq.) and to order restitution to any insurance company or other person who has suffered a loss as a result of a violation of P.L.1983, c.320 (*C.17:33A-1* et seq.). No assessment shall be levied pursuant to this subsection until the violator has been notified by certified mail or personal service. The notice shall contain a concise statement of facts providing the basis for the determination of a violation of P.L.1983, c.320 (*C.17:33A-1* et seq.), the provisions of that act violated, a statement of the amount of civil penalties assessed and a statement of the party's right to a hearing in accordance with the "Administrative Procedure Act," P.L.1968, c.410 (*C.52:14B-1* et seq.). The noticed party shall have 20 calendar days from receipt of the notice within which to deliver to the commissioner a written request for a hearing containing an answer to the statement of facts contained in the notice. After the hearing and upon a finding that a violation has occurred, the commissioner may issue a final order assessing up to the amount of the penalty in the notice, restitution, and costs of prosecution, including attorneys' fees. If no hearing is requested, the notice shall become a final order after the expiration of the 20-day period. Payment of the assessment is due when a final order is issued or the notice becomes a final order.

Any penalty imposed pursuant to this subsection may be collected with costs in a summary proceeding pursuant to "the penalty enforcement law," *N.J.S.2A:58-1* et seq. The Superior Court shall have jurisdiction to enforce the provisions of the "the penalty enforcement law" in connection with P.L.1983, c.320 (*C.17:33A-1* et seq.). Any penalty collected pursuant to this subsection shall be used in accordance with subsection e. of this section.

d. Nothing in this section shall be construed to prohibit the commissioner and the person or practitioner alleged to be guilty of a violation of this act from entering into a written agreement in which the person or practitioner does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may contain a provision that it shall not be used in a subsequent civil or criminal proceeding relating to any violation of this act, but notification thereof shall be made to a licensing authority in the same manner as required pursuant to subsection c. of section 10 of P.L.1983, c.320 (*C.17:33A-10*). The existence of a consent agreement under this subsection shall not preclude any licensing authority from taking appropriate administrative action against a licensee over which it has regulatory authority, nor shall such a consent agreement preclude referral to law enforcement for consideration of criminal prosecution.

e. The New Jersey Automobile Full Insurance Underwriting Association and Market Transition Facility Auxiliary Fund (hereinafter referred to as the "fund") is established as a nonlapsing, revolving fund into which shall be deposited all revenues from the civil penalties

imposed pursuant to this section. Interest received on moneys in the fund shall be credited to the fund. The fund shall be administered by the Commissioner of Banking and Insurance and shall be used to help defray the operating expenses of the New Jersey Automobile Full Insurance Underwriting Association created pursuant to P.L.1983, c.65 (*C.17:30E-1* et seq.) or shall be used to help defray the operating expenses of the Market Transition Facility created pursuant to section 88 of P.L.1990, c.8 (*C.17:33B-11*).

§ 17:33A-5.1. Surcharge for insurance fraud

In addition to any other penalty, fine or charge imposed pursuant to law, a person who is found in any legal proceeding to have committed insurance fraud shall be subject to a surcharge in the amount of $ 1,000. If a person is charged with insurance fraud in a legal proceeding and the charge is resolved through a settlement requiring the person to pay a sum of money, the person shall be subject to a surcharge in an amount equal to 5 percent of the settlement payment. The amount of any surcharge under this section shall be payable to the Treasurer of the State of New Jersey for use by the Department of Banking and Insurance to fund the department's insurance fraud prevention programs and activities.

§ 17:33A-6. Statement on insurance claim forms

a. Insurance claim forms shall contain a statement in a form approved by the commissioner that clearly states in substance the following: "Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

b. (Deleted by amendment, P.L.1987, c.342.)

c. Insurance application forms shall contain a statement in a form approved by the commissioner that clearly states in substance the following: "Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties."

§ 17:33A-7. Actions by insurance companies against violators

a. Any insurance company damaged as the result of a violation of any provision of this

act may sue therefor in any court of competent jurisdiction to recover compensatory damages, which shall include reasonable investigation expenses, costs of suit and attorneys fees.

b. A successful claimant under subsection a. shall recover treble damages if the court determines that the defendant has engaged in a pattern of violating this act.

c. A claimant under this section shall mail a copy of the initial claim, amended claim, counterclaims, briefs and legal memoranda to the commissioner at the time of filing of such documents with the court wherein the matter is pending. A successful claimant shall report to the commissioner, on a form prescribed by the commissioner, the amount recovered and such other information as is required by the commissioner.

d. Upon receipt of notification of the filing of a claim by an insurer, the commissioner may join in the action for the purpose of seeking judgment for the payment of a civil penalty authorized under section 5 of this act. If the commissioner prevails, the court may also award court costs and reasonable attorney fees actually incurred by the commissioner.

e. No action shall be brought by an insurance company under this section more than six years after the cause of action has accrued.

§ 17:33A-8. Division of Insurance Fraud Prevention

a. There is established in the Department of Insurance the Division of Insurance Fraud Prevention. The division shall assist the commissioner in administratively investigating allegations of insurance fraud and in developing and implementing programs to prevent insurance fraud and abuse. The division shall promptly notify the Attorney General of any insurance application or claim which involves criminal activity. When so required by the commissioner and the Attorney General, the division shall cooperate with the Attorney General in the investigation and prosecution of criminal violations.

b. The commissioner shall appoint the full-time supervisory and investigative personnel of the division, including the director, who shall hold their employment at the pleasure of the commissioner without regard to the provisions of Title 11A of the New Jersey Statutes and shall receive such salaries as the commissioner from time to time designates, and who shall be qualified by training and experience to perform the duties of their position.

c. When so requested by the commissioner, the Attorney General may assign one or more deputy attorneys general to assist the division in the performance of its duties.

d. The commissioner shall also appoint the clerical and other staff necessary for the division to fulfill its responsibilities under this act. The personnel shall be employed subject to the provisions of Title 11A of the New Jersey Statutes, and other applicable statutes.

e. The commissioner shall appoint an insurance fraud advisory board consisting of eight representatives from insurers doing business in this State. The members of the board shall serve for two year terms and until their successors are appointed and qualified. The members of the board shall receive no compensation. The board shall advise the commissioner with respect to the implementation of this act, when so requested by the commissioner.

f. The Director of the Division of Budget and Accounting in the Department of the Treasury shall, on or before September 1 in each year, ascertain and certify to the commissioner the total amount of expenses incurred by the State in connection with the administration of this act during the preceding fiscal year, which expenses shall include, in addition to the direct cost of personal service, the cost of maintenance and operation, the cost of retirement contributions made and the workers' compensation paid for and on account of personnel, rentals for space occupied in State owned or State leased buildings and all other direct and indirect costs of the administration thereof.

g. The commissioner shall, on or before October 15 in each year, apportion the amount so certified to him among all of the companies writing the class or classes of insurance described in Subtitle 3 of Title 17 of the Revised Statutes (*C.17:17-1* et seq.), and Subtitle 3 of Title 17B of the New Jersey Statutes (*C.17B:17-1* et seq.), within this State in the proportion that the net premiums received by each of them for such insurance written or renewed on risks within this State during the calendar year immediately preceding, as reported to him, bears to the sum total of all such net premiums received by all companies writing that insurance within the State during the year, as reported, except that no one company shall be assessed for more than 5% of the amount apportioned. The commissioner shall certify the sum apportioned to each company on or before November 15 next ensuing, and to the Division of Taxation in the Department of the Treasury. Each company shall pay the amount so certified as apportioned to it to the said Division of Taxation on or before December 31 next ensuing, and the sum paid shall be paid into the State Treasury in reimbursement to the State for the expenses paid.

"Net premiums received" means gross premiums written, less return premiums thereon and dividends credited or paid to policyholders.

h. The total appropriations recoverable under this section for the operation of the division shall not exceed $ 500,000.00 during its first full fiscal year of operation.

§ 17:33A-9. Alleged violations; civil liability; records

a. Any person who believes that a violation of this act has been or is being made shall notify the division immediately after discovery of the alleged violation of this act and shall send to the division, on a form and in a manner prescribed by the commissioner, the information requested and such additional information relative to the alleged violation as the division may require. The division shall review the reports and select those alleged violations as may require

further investigation. It shall then cause an independent examination or evaluation of the facts surrounding the alleged violation to be made to determine the extent, if any, to which fraud, deceit, or intentional misrepresentation of any kind exists.

b. No person shall be subject to civil liability for libel, violation of privacy or otherwise by virtue of the filing of reports or furnishing of other information, in good faith and without malice, required by this section or required by the division as a result of the authority conferred upon it by law.

c. The commissioner may, by regulation, require insurance companies licensed to do business in this State to keep such records and other information as he deems necessary for the effective enforcement of this act.

§ 17:33A-10. Subpena powers; violations by persons licensed by State

a. If the division has reason to believe that a person has engaged in, or is engaging in, an act or practice which violates this act, or any other relevant statute or regulation, the commissioner or his designee may administer oaths and affirmations, request or compel the attendance of witnesses or the production of documents. The commissioner may issue, or designate another to issue, subpenas to compel the attendance of witnesses and the production of books, records, accounts, papers and documents. Witnesses who are not licensees of the Department of Banking and Insurance shall be entitled to receive the same fees and mileage as persons summoned to testify in the courts of the State.

If a person subpenaed pursuant to this section shall neglect or refuse to obey the command of the subpena, a judge of the Superior Court may, on proof by affidavit of service of the subpena, of payment or tender of the fees required and of refusal or neglect by the person to obey the command of the subpena, issue a warrant for the arrest of said person to bring him before the judge, who is authorized to proceed against the person as for a contempt of court.

b. If matter that the division seeks to obtain by request is located outside the State, the person so required may make it available to the division or its representative to examine the matter at the place where it is located. The division may designate representatives, including officials of the state in which the matter is located, to inspect the matter on its behalf, and it may respond to similar requests from officials of other states.

c. If (1) a practitioner, (2) an owner, administrator or employee of any hospital, (3) an insurance company, agent, broker, solicitor or adjuster, or (4) any other person licensed by a licensing authority of this State, or an agent, representative or employee of any of them is found to have violated any provision of this act, the commissioner or the Attorney General shall notify the appropriate licensing authority of the violation so that the licensing authority may take appropriate administrative action. The licensing authority shall report quarterly to the

commissioner through the Division of Insurance Fraud Prevention about the status of all pending referrals.

§ 17:33A-11. Handling of documents, records of investigations

Papers, documents, reports, or evidence relative to the subject of an investigation under this act shall not be subject to public inspection except as specifically provided in this act. The commissioner shall not detain subpenaed records after an investigation is closed or, if a claim for a civil penalty is filed by the commissioner pursuant to section 5 or subsection d. of section 7, upon final disposition of the claim by a court of competent jurisdiction, whichever shall be the later date. Subpenaed records shall be returned to the persons from whom they were obtained. The commissioner may, in his discretion, make relevant papers, documents, reports, or evidence available to the Attorney General, an appropriate licensing authority, law enforcement agencies, an insurance company or insurance claimant injured by a violation of this act, consistent with the purposes of this act and under such conditions as he deems appropriate. Such papers, documents, reports, or evidence shall not be subject to subpena, unless the commissioner consents, or until, after notice to the commissioner and a hearing, a court of competent jurisdiction determines that the commissioner would not be unnecessarily hindered by such subpena. Division investigators and insurance company fraud investigators shall not be subject to subpena in civil actions by any court of this State to testify concerning any matter of which they have knowledge pursuant to a pending insurance fraud investigation by the division, or a pending claim for civil penalties initiated by the commissioner.

§ 17:33A-12. Regulations

The commissioner may promulgate such regulations as he deems necessary for the effective implementation of this act.

§ 17:33A-13. Annual report on activities and cost effectiveness

The commissioner shall report annually to the Senate Labor, Industry and Professions Committee and the Assembly Banking and Insurance Committee as to the activities of the division and the cost effectiveness of the programs established by the division.

§ 17:33A-14. Criminal prosecution

The imposition of any fine or other remedy under this act shall not preclude prosecution for a violation of the criminal law of this State.

§ 17:33A-15. Filing of plan for prevention, detection of fraudulent health, auto insurance claims

a. Every insurer writing health insurance or private passenger automobile insurance in this State shall file with the commissioner a plan for the prevention and detection of fraudulent insurance applications and claims. The plan shall be deemed approved by the commissioner if not affirmatively approved or disapproved by the commissioner within 90 days of the date of filing. The commissioner may call upon the expertise of the director in his review of plans filed pursuant to this subsection. The commissioner may request such amendments to the plan as he deems necessary. Any subsequent amendments to a plan filed with and approved by the commissioner shall be submitted for filing and deemed approved if not affirmatively approved or disapproved within 90 days from the filing date.

b. The implementation of plans filed and approved pursuant to subsection a. of this section shall be monitored by the division. The division shall promptly notify the Attorney General of any evidence of criminal activity encountered in the course of monitoring the implementation and execution of the plans. Each insurer writing health insurance or private passenger automobile insurance in this State shall report to the director on an annual basis, on January 1st of each year, on the experience in implementing its fraud prevention plan.

c. In addition to any other penalties provided pursuant to P.L.1983, c.320 (*C.17:33A-1* et seq.), the commissioner may impose a penalty of up to $ 25,000 per violation on any insurer for: failure to submit a plan; failure to submit any amendments to an approved plan; failure to properly implement an approved plan in a reasonable manner and within a reasonable time period; failure to provide a report pursuant to subsection b. of this section; or for any other violation of the provisions of this section.

d. For the purposes of this section, "insurer" means an insurance company as defined in subsections a., b., c., d., e., and f. of section 3 of P.L.1983, c.320 (*C.17:33A-3*).

§ 17:33A-16. Office of the Insurance Fraud Prosecutor

There is established in the Division of Criminal Justice in the Department of Law and Public Safety the Office of the Insurance Fraud Prosecutor. The Insurance Fraud Prosecutor shall be appointed by, and serve at the pleasure of, the Governor with the advice and consent of the Senate and be under the direction and supervision of the Attorney General. Any person appointed as Insurance Fraud Prosecutor shall have had prosecutorial experience, including experience in the litigation of civil and criminal cases. The Attorney General shall establish standards of performance for the Office of Insurance Fraud Prosecutor, which shall include standards of accountability.

§ 17:33A-17. Appointment; transfer of personnel

The Attorney General may appoint such personnel, including attorneys and clerical personnel, as necessary to carry out the duties of the office. The personnel charged with investigatory work in the Division of Insurance Fraud Prevention in the Department of Banking and Insurance shall be transferred to the Office of the Insurance Fraud Prosecutor as determined by the Commissioner of Banking and Insurance and the Attorney General, in accordance with a plan of reorganization, and shall become the Fraud Investigatory Section of the Office of the Insurance Fraud Prosecutor. Personnel transferred from the Division of Insurance Fraud Prevention in the Department of Banking and Insurance to the Office of the Insurance Fraud Prosecutor pursuant to this section and any such reorganization plan shall be transferred with all tenure rights and any rights or protections provided by Title 11A of the New Jersey Statutes or other applicable statutes, as provided in section 8 of P.L.1983, c.320 (*C.17:33A-8*), and any pension law or retirement system.

§ 17:33A-18. Establishment of liaison between office, other departments; responsibilities

a. A section of the Office of Insurance Fraud Prosecutor shall be designated to be responsible for establishing a liaison and continuing communication between the office and the Department of Health and Senior Services, the Department of Human Services, any professional board in the Division of Consumer Affairs in the Department of Law and Public Safety, the Department of Banking and Insurance, the Division of State Police, every county prosecutor's office, such local government units as may be necessary or practicable and insurers.

b. The section of the office responsible for such liaison shall establish procedures: (1) for receiving notice from all entities enumerated in subsection a. of this section of any case in which fraud is suspected or has been substantiated; (2) for receiving referrals for the investigation of alleged fraud; (3) for receiving referrals for the prosecution of fraud by the office; (4) for

receiving and referring information regarding cases, administrative or otherwise, under investigation by any department or other entity to the appropriate authority; and (5) for providing information to and coordinating information among any referring entities on pending cases of insurance fraud which are under investigation or being litigated or prosecuted. The liaison section of the office shall maintain a record of every referral or investigation.

§ 17:33A-19. Duties of Insurance Fraud Prosecutor

The Insurance Fraud Prosecutor shall investigate and, if warranted, prosecute, cases referred to it by insurers, State agencies, or county and municipal governments. The Insurance Fraud Prosecutor may assist county prosecutors in the investigation and prosecution of fraud, and shall give county prosecutors access to the data base maintained pursuant to section 38 of this amendatory and supplementary act.

§ 17:33A-20. Establishment of Statewide fraud enforcement policy

The Attorney General shall, in consultation with county prosecutors, establish a Statewide fraud enforcement policy for all State and local agencies, including guidelines for the investigation and prosecution of fraud, which shall include standards for detecting fraud, for the investigation of alleged fraud and standards for the submission of cases for prosecution. Priorities shall be established among the cases referred to the office for prosecution or other litigation and the office shall assist referring entities in establishing priorities among investigations or cases to be disposed of by the entities themselves. The Insurance Fraud Prosecutor shall prosecute criminal cases, litigate civil cases as appropriate, or assist county prosecutors in prosecuting criminal cases in accordance with the guidelines and priorities so established.

§ 17:33A-21. Standards of performance for Fraud Investigatory Section.

Standards of performance shall be established for the Fraud Investigatory Section, which shall include, but not to be limited to, recording the cases referred by insures, local government agencies and others which are assigned to the Fraud Investigatory Section, investigatory Section, investigating cases of alleged fraud in accordance with te priorities established by the Insurance Fraud Prosecutor, recording the disposition of the cases referred to the section, and making

recommendations to the Insurance Fraud Prosecutor as to any procedural, regulatory, or statutory changes which may be necessary to carry out the provisions of this amendatory and supplementary act.

§ 17:33A-22. Maintenance of data base; reporting of claims information

a. The Insurance Fraud Prosecutor shall maintain a data base which includes referrals, reports of fraud investigations, prosecution, or litigation, and the results of such proceedings, which shall include: (1) identification of the referring entity; (2) type of fraud; (3) disposition of case; and (4) such other data as may be necessary to the work of the office and the referring entities.

b. The Insurance Fraud Prosecutor shall provide for the reporting of claims information by insurers writing at least $ 2,000,000 in direct insurance premiums in any calendar year, in a standard reporting form, which shall include, but shall not be limited to, information on stolen vehicles, including the owners of such vehicles, information on automobile accidents, including date and location of accidents, persons involved in accidents, the kinds of injuries sustained in accidents and treating health care providers, for the purpose of identifying patterns of possible fraudulent activity, which information shall be shared with county prosecutors, local law enforcement officials, and the New Jersey State Police. Every insurer shall submit the data required by the Insurance Fraud Prosecutor for all claims closing with payment during a period established by the Insurance Fraud Prosecutor.

§ 17:33A-23. Access to information provided to Insurance Fraud Prosecutor

The Insurance Fraud Prosecutor shall have access to all necessary information in the possession of the State or local public entities, including agency inspection reports, motor vehicle records and license information, individual case files, and intelligence information compiled and maintained by the Division of State Police in the Department of Law and Public Safety. Upon the request of the Insurance Fraud Prosecutor, any insurer which has referred a case to the Insurance Fraud Prosecutor or to any county or local government agency shall make available to the Office of the Insurance Fraud Prosecutor all information on the case in the insurer's possession.

§ 17:33A-24. Additional duties of office; annual report

The Attorney General shall direct the Office of the Insurance Fraud Prosecutor to:

a. Confer from time to time with departments or other units of State government which have units which investigate fraud, in order to coordinate activities, share information, and provide any assistance necessary to any State agency in overseeing administrative enforcement activities;

b. Formulate and evaluate proposals for legislative, administrative and judicial initiatives to strengthen insurance fraud enforcement;

c. In connection with insurance fraud enforcement activities, act as the liaison for the Executive Branch of government with agencies involved in insurance fraud enforcement outside the Executive Branch, including federal agencies and the Judiciary;

d. Provide an annual report to the Governor and the Legislature, no later than March 1 of each year, as to the activities of the Insurance Fraud Prosecutor for the preceding twelve months, including, but not limited to, the number of cases referred, the number of cases investigated, the number of cases in which professional licenses were suspended or revoked, by type of license, the number of cases prosecuted, the number of convictions procured, and the aggregate amount of money collected in fines and returned in restitution to insurers or others.

§ 17:33A-25. Recommendation for suspension, revocation of professional license

In the case of a professional licensed or certified by a professional licensing board in the Division of Consumer Affairs in the Department of Law and Public Safety who is guilty of fraud, the Insurance Fraud Prosecutor may recommend to the appropriate board a suspension or revocation of the professional license.

§ 17:33A-26. Restitution; seizure of assets

The Insurance Fraud Prosecutor shall consider the restitution of moneys to insurers and others who are defrauded as a major priority, in order that policyholders may benefit from the prosecution of those persons guilty of insurance fraud, and to that end, any assets of any person guilty of fraud shall be subject to seizure.

§ 17:33A-27. Specific goals, strategies

The Insurance Fraud Prosecutor shall have access to all information concerning insurance fraud enforcement activities in the possession of all State departments and agencies. The office shall meet on a regular basis with representatives of State departments and agencies and county prosecutors to set specific goals and strategies for the most effective resolution of insurance fraud cases, whether by criminal, civil, or administrative enforcement action, or a combination thereof.

§ 17:33A-28. Application for reimbursement

Any county prosecutor may apply to the Office of the Insurance Fraud Prosecutor for reimbursement for activities undertaken in connection with investigating and prosecuting insurance fraud. The Attorney General shall allocate such funds as he deems necessary from such moneys as may be appropriated for the operation of the Office of the Insurance Fraud Prosecutor to a fund dedicated for the purpose of reimbursing county prosecutors or sharing in fines levied by the Attorney General, which reimbursement or sharing may be made by the Attorney General at his discretion.

§ 17:33A-29. Provision of information from accident report

Every state and local law enforcement agency, including the New Jersey State Police, shall make available to investigators employed by insurers, upon presentation of appropriate identification, information from any accident report, as set forth in this section, no later than 24 hours following the time of occurrence. The information may include, but need not be limited to, the names and addresses of the owners of the vehicles, insurance information recorded on the accident report, and the names and addresses of passengers in the vehicles at the time of the occurrence and, if applicable, the name of any pedestrian injured in an accident. Every accident report form shall contain the names and addresses of any person occupying a vehicle involved in an accident, and any pedestrian injured in an accident.

§ 17:33A-30. Certification of amount allocable to office expenses

The Attorney General shall annually, on or before October 1, certify to the State Treasurer an amount allocable to the expenses of the Office of the Insurance Fraud Prosecutor for the preceding fiscal year, which amount shall be transferred to the Department of Law and Public Safety by the State Treasurer from the amounts assessed and collected for the operation of the Division of Insurance Fraud Prevention in the Department of Banking and Insurance pursuant to section 8 of P.L.1983, c.320 (*C.17:33A-8*).

2C:20-4. Theft by deception

2C:20-4. Theft by deception.

A person is guilty of theft if he purposely obtains property of another by deception. A person deceives if he purposely:

a.Creates or reinforces a false impression, including false impressions as to law, value, intention or other state of mind, and including, but not limited to, a false impression that the person is soliciting or collecting funds for a charitable purpose; but deception as to a person's intention to perform a promise shall not be inferred from the fact alone that he did not subsequently perform the promise;

b.Prevents another from acquiring information which would affect his judgment of a transaction; or

c.Fails to correct a false impression which the deceiver previously created or reinforced, or which the deceiver knows to be influencing another to whom he stands in a fiduciary or confidential relationship.

The term "deceive" does not, however, include falsity as to matters having no pecuniary significance, or puffing or exaggeration by statements unlikely to deceive ordinary persons in the group addressed.

L.1978, c.95; amended 2003, c.43.

N.J. Stat. § 34:15-57.4

Current through New Jersey 220th Second Annual Session, L. 2023, c. 16 and J.R. 1

LexisNexis® New Jersey Annotated Statutes > Title 34. Labor and Workers' Compensation (Chs. 1 — 21) > Chapter 15. Workers' Compensation (Arts. 1 — 12) > Article 4. Claims; Procedure (§§ 34:15-49 — 34:15-69)

§ 34:15-57.4. Workers' compensation fraud, crime of fourth degree; civil liability

a. A person shall be guilty of a crime of the fourth degree if the person purposely or knowingly:

(1) Makes, when making a claim for benefits pursuant to R.S.34:15-1 et seq., a false or misleading statement, representation or submission concerning any fact that is material to that claim for the purpose of wrongfully obtaining the benefits;

(2) Makes a false or misleading statement, representation or submission, including a misclassification of employees, or engages in a deceptive leasing practice, for the purpose of evading the full payment of benefits or premiums pursuant to R.S.34:15-1 et seq.; or

(3) Coerces, solicits or encourages, or employs or contracts with a person to coerce, solicit or encourage, any individual to make a false or misleading statement, representation or submission concerning any fact that is material to a claim for benefits, or the payment of benefits or premiums, pursuant to R.S.34:15-1 et seq. for the purpose of wrongfully obtaining the benefits or of evading the full payment of the benefits or premiums.

b. Any person who wrongfully obtains benefits or evades the full payment of benefits or premiums by means of a violation of the provisions of subsection a. of this section shall be civilly liable to any person injured by the violation for damages and all reasonable costs and attorney fees of the injured person.

c.

(1) If a person purposely or knowingly makes, when making a claim for benefits pursuant to R.S.34:15-1 et seq., a false or misleading statement, representation or submission concerning any fact which is material to that claim for the purpose of obtaining the benefits, the division may order the immediate termination or denial of benefits with respect to that claim and a forfeiture of all rights of compensation or payments sought with respect to the claim.

(2) Notwithstanding any other provision of law, and in addition to any other remedy available under law, if that person has received benefits pursuant to R.S.34:15-1 et seq. to which the person is not entitled, he is liable to repay that sum plus simple interest to the employer or the carrier or have the sum plus simple interest deducted from future benefits payable to that person, and the division shall issue an order providing for the repayment or deduction.

(3) Notwithstanding any other provision of law, and in addition to any other remedy available under law, a person who evades the full payment of premiums pursuant to R.S.34:15-1 et seq. or improperly denies or delays benefits pursuant to R.S.34:15-1 et seq. is liable to pay the sum due and owing plus simple interest.

d. Nothing in this section shall preclude, if the evidence so warrants, indictment and conviction for a violation of any provision of chapter 20, 21 or 28 of Title 2C of the New Jersey Statutes or any other law. For the purpose of this section,"purposely," "knowingly" and "purposely or knowingly" have the same meaning as is provided in chapter 2 of Title 2C of the New Jersey Statutes.

History

L. *1998, c. 74*, § 1, eff. Aug. 14, 1998.

Annotations

CASE NOTES

Civil Procedure: Pleading & Practice: Pleadings: Heightened Pleading Requirements: Fraud Claims

Governments: Legislation: Effect & Operation: Prospective Operation

Governments: Legislation: Interpretation

Workers' Compensation & SSDI: Administrative Proceedings: Claims: General Overview

Workers' Compensation & SSDI: Administrative Proceedings: Evidence: General Overview

Workers' Compensation & SSDI: Administrative Proceedings: Fraud

Workers' Compensation & SSDI: Benefit Determinations: Temporary Total Disabilities

Civil Procedure: Pleading & Practice: Pleadings: Heightened Pleading Requirements: Fraud Claims

Insurer's allegations, arising from the alleged fraudulent scheme by defendants to have an injured worker receive workers' compensation despite the fact that he was not actually a covered employee, were sufficient to withstand challenge by a dismissal motion with respect to the insurer's claims under *N.J. Stat. Ann. § 34:15-57.4(a)(1)*; the allegations included an ongoing scheme of secure workers' compensation benefits for the injured worker. *Virginia Sur. Co. v. Macedo, 2011 U.S. Dist. LEXIS 49077 (D.N.J. May 6, 2011)*.

Governments: Legislation: Effect & Operation: Prospective Operation

N.J. Stat. Ann. § 34:15-57.4C(1), which would allow workers' compensation benefits to be denied if they were based upon a fraudulent claim, was construed as not applicable to petitioner's claim for additional benefits attributable to a compensable accident; where evidence that the trial court relied upon to deny the added benefits occurred prior to the anti-fraud statute's effective date and none of the retroactive application requirements applied, the statute could not be applied retroactively. *Lombardo v. Revlon, Inc., 328 N.J. Super. 484, 746 A.2d 475, 2000 N.J. Super. LEXIS 77 (App.Div. 2000)*.

Governments: Legislation: Interpretation

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Workers' Compensation & SSDI: Administrative Proceedings: Claims: General Overview

All elements of the workers' compensation anti-fraud provision must be proven by competent evidence for a motion to dismiss to prevail. The movant must show 1) the injured worker acted purposefully or knowingly in giving or withholding information with the intent that he or she receive benefits; 2) the worker knew that the statement or omission was material to obtaining the benefit; and 3) the statement or omission was made for the purpose of falsely obtaining benefits to which the worker was not entitled. *Bellino v. Verizon Wireless, 435 N.J. Super. 85, 86 A.3d 751, 2014 N.J. Super. LEXIS 33 (App.Div. 2014)*.

Workers' Compensation & SSDI: Administrative Proceedings: Evidence: General Overview

Where employer failed to introduce into the record on appeal the surveillance videotapes of claimant it accumulated prior to and during medical testimony, the tapes were inadmissible; the appellate court had no basis for disagreeing with the workers' compensation tribunal that the claimant had not engaged in fraud, and, thus, the workers' compensation tribunal did not err in rejecting the employer's fraud defense and in awarding the claimant workers' compensation benefits. *Gross v. Borough of Neptune City, 378 N.J. Super. 155, 875 A.2d 251, 2005 N.J. Super. LEXIS 178 (App.Div. 2005)*.

Workers' Compensation & SSDI: Administrative Proceedings: Fraud

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Claimant was properly awarded temporary disability benefits and medical treatment because the employer did not prove that the claimant, in making misstatements about her medical history, had the intent to make false statements for the purpose of obtaining benefits. *Bellino v. Verizon Wireless, 435 N.J. Super. 85, 86 A.3d 751, 2014 N.J. Super. LEXIS 33 (App.Div. 2014)*.

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Workers' Compensation & SSDI: Benefit Determinations: Temporary Total Disabilities

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End of Document

Fraud During The Formation Of The Insurance Contract

Presenter: Loren L. Pierce

1

The Application

- The insurer-insured relationship typically begins with the submission of a written application.
- The prospective insured provides the insurer with the information it has requested on those issues necessary for the insurer to evaluate whether the risk should be accepted and, if so, on what terms.
- The application form usually includes a statement, certified by the applicant, that all of the information provided is true and correct.
- The policy also may include a statement that the insurer has relied upon the information provided by the insured in issuing the policy and that if the information is not correct, the policy may be voided or rescinded.

- The insurer's right to rely on the information provided by the insured in making underwriting decisions and setting the amount of premiums to be collected is well-settled.

- A misrepresentation or omission in an insurance application, including a renewal or reinstatement application, which materially affects the insurer's acceptance of the risk may constitute legal and/or equitable fraud, entitling the insurer to rescind or void the policy ab initio and may give rise to a claim for compensatory and treble damages under New Jersey's Insurance Fraud Prevention Act, N.J.S.A. 17:33A to -33 (the "Act" or "IFPA").

- Additionally, the insurer also has an affirmative obligation under the Act to report suspected violations of the IFPA to the Bureau of Fraud Deterrence (DOBI) and the Office of Insurance Fraud Prosecutor (Attorney General's Office).

- Misrepresentation in an application for insurance also may be punishable as a crime pursuant to N.J.S.A. 2C:21-4.6 (crime to make, cause to be made or omit any material fact from an application).

Legal or Equitable Fraud As A Basis Of Voiding The Policy

- Where the insured has made a material misrepresentation or omission, the insurer may void the policy or waive the defect and reform or ratify the contract, at the insurer's option.
- A notice of cancellation based on misrepresentation will not void the policy from inception. Cancellation operates prospectively.
- Rescission is an equitable remedy designed to restore the status quo and prevent the party responsible for the misrepresentation from benefiting from his or her act. It will void the policy from inception.
- Where the insurer learns of the misrepresentation or omission but retains the premiums paid and leaves the policy in force despite such knowledge, the insurer may be seen as having affirmed the contract.

- In considering an action sounding in legal or equitable fraud seeking rescission based on misrepresentation in the application process, New Jersey courts further distinguish between "equitable fraud" based upon the insured's answers to subjective questions from "fraud in the application," where the insured knowingly provided false answers to objective questions. See Ledley v. William Penn Life Ins. Co., 138 N.J. 627 (1995); Golden v. Northwest Mut. Life Ins. Co., 229 N.J. Super. 405 (App. Div. 1988). Subjective questions generally seek information about what the insured believes, while objective questions ask about what the insured knows. The accuracy of the insured's responses to objective questions may be established by direct evidence. In either case, the misrepresentation or omission in the application by the insured must be clear and unambiguous. Where the question is ambiguous, the ambiguity will be construed against the insurer.

The Misrepresentation Must Be Material

- An insured's misstatement or omission is material if, when made, it "naturally and reasonably influence[s] the judgment of the underwriter in making the contract at all, or in estimating the degree or character of risk, or in fixing the rate of the premium." Great Am. Ins. Co. v. Subranni (In re Tri-State Armored Servs)., 332 B.R. 690 (Bankr. D.N.J. 2005)

- Stated simply, the misrepresentation is material when it impacts:

  - (1) the decision to provide the insurance;
  - (2) the evaluation of the risk; or
  - (3) the amount of premium charged to cover the risk. Content

Ledley v. William Penn Life Ins. Co., supra, 138 N.J. at 638.

Intent: Legal v. Equitable Fraud

- Where the information is material, under a theory of equitable fraud, it does not matter whether the misrepresentation or omission was intentional or made by mistake in order to obtain rescission.
- The key distinction between legal fraud and equitable fraud is that legal fraud requires proof of intent while equitable fraud does not. Jewish Ctr. of Sussex Cty. v. Whale, 86 N.J. 619 (1981). Thus, an insurer seeking rescission is not required to establish an intent to deceive by the insured and will be relieved of liability even where the material misrepresentation or omission was not knowing or willful: The insurer is entitled to rescind the policy and declare it void ab initio without regard to intent. See Massachusetts Mut. Life Ins. Co. v. Manzo, 122 N.J. 104 (1991). See, also, TIG Ins. Co. v. Privilege Care Mktg, Inc., 2005 U.S. Dist. LEXIS 7428 (D.N.J. April 27, 2005).
- Where the misrepresentation or omission regards a question requiring a subjective response by the insured, however, the insured's knowledge of the falsity of the representation or omission may be considered by the court. See Chen v. Vigilant Ins. Co., 2009 N.J. Super. Unpub. LEXIS 2035 (App. Div. 2009).

Reliance

- While reliance is generally required as an element of legal fraud, in establishing equitable fraud, the insurer is not required to establish that it reasonably relied on the misrepresentation in order to void the policy. Longobardi v. Chubb Ins. Co. of NJ, 121 N.J. 530 (1990).

- A court will presume that the insurer will rely on the insured's representations, and the insurer is not necessarily required to investigate the truth of those representations.

- Related to the question of reliance is the question whether there was any information on the face of the insurance application which the insurer should have investigated further and whether the insurer knew or should have known of the misrepresentation. See Ledley v. William Penn Life Ins. Co., supra, 138 N.J. at 627. However, the insured generally cannot use the insurer's failure to investigate as a defense. Pioneer Nat'l Title Ins. Co. v. Lucas, 155 N.J. Super. 332, 342 (App. Div.), aff'd, 78 N.J. 320 (1978).

Rescission

- Where a material misrepresentation in the application is established, the insurer may void the policy from inception. If the insurer seeks to void the policy from inception, any premium paid on the policy must be refunded.

- **CAVEAT**: Where an innocent third party is impacted, the insurer may be estopped from rescinding the insurance contract as to that party.

Auto Liability

In cases where the insured made a misrepresentation in the application for automobile insurance which voids the policy, the insured still remains liable to innocent third parties.

Citizens United Reciprocal Exchange v. Perez, 223 N.J. 143 (2015)

Rutgers Cas. Ins. Co. v. LaCroix, 194 N.J. 515 (2008)

Lawyer's Professional Liability

Because rescission is an equitable remedy, courts have extended legal malpractice insurance coverage to innocent partners under equitable principles where a policy was void as to the law firm and defalcating partners. See Liberty Surplus Ins. Corp. v. Nowell Amoroso, P.A., 189 N.J. 436 (2007); First Am. Title Ins. Co. v. Lawson, 177 N.J. 125 (2003).

Medical Professional Liability

The New Jersey Supreme Court declined to extend protection to injured patients where it voided a medical professional liability policy based on the physician's misrepresentation in the application.

DeMarco v. Stoddard, 223 N.J. 363 (2015).

Lienholders/ Loss Payees

Under an ordinary loss payable clause, which directs the insurer to pay the proceeds of the policy to the lienholder to the extent of its interest before the insured receives payment, a breach by the insured would prevent recovery by the lienholder. See In re Tri-State Armored Services, Inc., supra, 332 B.R. at 590.

However, under a standard loss payable clause, which provides that the lienholder is not subject to the exclusions available to the insurer against the insured because an independent contract exists between the lienholder and the insurer, the lienholder may be entitled to recover under the policy. E.g., 495 Corp. v. New Jersey Ins. Underwriting Ass'n., 86 N.J. 157 (1981); Gallatin Fuels, Inc. v. Westchester Fire Ins. Co., 244 Fed. Appx. 424 (3d Cir. 2007).

What happens to the premiums paid?

- Where the insurer rescinds a contract of insurance on the basis of misrepresentation, as a general rule, the insurer must return all premiums paid.
- RATIONALE: The parties will be restored to their pre-contract status quo.
- In some circumstances, the insurer paying a claim under the voided policy may be entitled to a set-off and need not return the full premium.

Insurance Fraud Prevention Act

New Jersey's Insurance Fraud Prevention Act provides a statutory remedy for insurers seeking damages from fraudsters.

The Act was adopted in 1986, in order to "confront aggressively the problem of insurance fraud in New Jersey" by, among other things, "requiring the restitution of fraudulently obtained insurance benefits." N.J.S.A. 17:33A-2.

To that end, the Act provides insurers with a private right of action against persons who violate its provisions by making any material misrepresentation in connection with an entitlement to insurance benefits. See N.J.S.A. 17:33A-4(a)(3); see also, N.J.S.A. 17:33A-7. See, e.g., Palisades Safety & Ins. Ass'n v. Bastien, 175 N.J. 144, 148 (2003).

- Unlike a common law claim for rescission based on fraud in the application or equitable fraud, in order to allege a cause of action under the IFPA, the insurer must allege knowledge, falsity and materiality. See Horizon Blue Cross Blue Shield of N.J. v. Focus Express Mail Pharm., Inc., 2017 U.S. Dist. LEXIS 131013 (D.N.J. April 1, 2018). With respect to the Act's provisions requiring that the insured "knowingly" assists, conspires or violates any of its provisions, a plain-language understanding of the illegality is sufficient. See Allstate Ins. Co. v. Northfield Med. Ctr. P.C., 228 N.J. 596 (2017).

Conclusion

- Fraud during the application or renewal process can result in the rescission of the policy and denial of coverage when a claim is made.

- Additionally, any insured who knowingly misrepresents or omits a material fact in the application may be subject to civil and criminal liability under the IFPA.

QUESTIONS?

APPENDIX

Representative Cases Where Insured's Misrepresentations Voided Policy

Auto Insurance

- Rutgers Casualty Ins. Co. v. LaCroix, 194 N.J. 515 (2008). Insured's failure to disclose his youngest daughter as a resident of the household was a material misrepresentation voiding the policy against the insured but not against innocent victim.

Crime Insurance

- In re Tri-State Armored Servs., 332 B.R. 690 (D.N.J. 2005). Insured's failure to disclose knowledge that employees were stealing money from the company was a material misrepresentation voiding crime insurance policy.

Health/Disability Insurance

- Paul Revere Life Ins. Co. v. Haas, 137 N.J. 190 (1994). Despite statutorily-mandated incontestability clause, insured's failure to disclose progressive disabling disease in insurance application was a material misrepresentation voiding the policy.
- Hartford Life & Accident Ins. Co. v. Nittolo, 955 F. Supp. 331 (D.N.J. 1997). Despite statutorily-mandated incontestability clause, insured's overstatement of income and misrepresentation of medical condition in insurance application were material misrepresentations, voiding the policy.

Homeowner's Insurance

- Longobardi v. Chubb Ins. Co. of NJ, 121 N.J. 530 (1990). Insured's false representation that he had never previously applied to another insurance company to insure his art collection constituted material misrepresentation voiding the policy.
- Sesztak v. Great Northern Ins. Co., 2018 N.J. Super. Unpub. LEXIS 2491 (App. Div. 2018). Insured's misrepresentations in the application that home was owner-occupied constituted material misrepresentations, voiding the policy.

- Selective Insurance Company v. Fox, 2008 N.J. Super. Unpub. LEXIS 1754 (App. Div. 2008). Insured's failure to disclose utilization of land and barn on property for sale of rhododendrons in order to obtain a farmland assessment for tax purposes constituted material misrepresentation in her renewal application where she answered "none" to the request for details of any business run out of the home and voided the policy.

Life Insurance

- Mass. Mut. Life Ins. Co. v. Manzo, 122 N.J. 104 (1991). Notwithstanding that his subsequent death was unrelated to that medical condition, insured's failure to disclose diabetes in life insurance application was a material misrepresentation, voiding the policy.
- Ledley v. William Penn, 138 N.J. 627 (1995). Insured's failure to disclose thyroid problems in life insurance application voided the policy.
- Mendez v. American General Life Ins. Co., 2010 U.S. Dist. LEXIS 125312 (D.N.J. 2010), aff'd, 2011 U.S. App. LEXIS 25696 (3d Cir. 2011). Insured's failure to disclose cancerous brain tumor in life insurance reinstatement application voided the policy.
- Lincoln Nat'l Life Ins. Co. v. Schwarz, 2010 U.S. Dist. LEXIS 104451 (D.N.J. 2010). Beneficiaries' lack of an insurable interest based on misrepresentations in life insurance application may void policy ab initio.

Marine Insurance

- Continental Casualty Co. v. Hochschild, 2014 N.J. Super. Unpub. LEXIS 2753 (App. Div. 2014). Insured's misrepresentations as to purchase price of boat, extensive prior history of claims and losses, and cancellation of coverage by other insurers voided the policy. (Note, however, that the case remanded to decide insured's state of mind under the IFPA.)

Professional Liability Insurance

- DeMarco v. Stoddard, 223 N.J. 363 (2015). Podiatrist's statement that 51% of his medical practice occurred in Rhode Island in order to obtain coverage from Rhode Island insurer was a material misrepresentation, voiding the medical professional liability policy.

- Colony Ins. Co. v. Kwasnik, Kanowitz & Assocs., P.C., 2014 U.S. Dist. LEXIS 87659 (D.N.J. June 27, 2014). Principal completing application on behalf of law firm failed to disclose four professional liability claims, circumstances giving rise to a claim and disciplinary proceedings voided the lawyer's professional liability policy.
- Ironshore Indemn., Inc. v. Pappas & Wolf, LLC, 2018 N.J. Super. Unpub. LEXIS 1010 (App. Div. 2018). Insured's response of "no" to prior knowledge question constituted material misrepresentation, voiding the policy.
- Booker v. Blackburn, 942 F. Supp. 1005 (D.N.J. 1996). Insured's failure to disclose his knowledge of the fact that he was on notice that he would be named as a defendant in a professional negligence action voided his civil engineer's professional liability policy.

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FRAUD DURING THE CLAIMS PROCESS

By: John C. Grady, Esquire

In the lifecycle of fraudulent claims, claim fraud comes after the application for coverage and arises when a claim is made under the policy. In the case of some staged accident rings the false insurance application and subsequent false claims are all part of the same fraudulent scheme. But many a legitimately obtained policy can be the basis of fraud in the claim process. Fraud during the claims process takes many forms and can be as simple as altering an invoice and re-copying it or as sophisticated as a scheme to pay kickbacks and bribes in exchange for the referral of patients for laboratory work. Claims fraud is not unique to any economic class or ethnic group and embraces those who commit what we call "opportunistic" fraud and those who set out to commit fraud as part of their business plan.

This species of violation of the Insurance Fraud Prevention Act has its roots in the seminal case of Merin v. Maglaki, where in support of his fraudulent claim for the alleged death of his wife in the Philippines. Maglaki submitted six falsified documents: a claim form, an authorization to release information relating to his wife, a traffic-accident investigation report that purported to be a document prepared by the Manila Police Department, a certificate of death, a certificate of post-mortem examination, and a receipt for a burial permit. The last three submissions purported to be official documents from the Republic of the

Philippines. All six documents represented that Ms. Maglaki had died in an automobile accident in Manila on June 18, 1986. That each document contained false and misleading statements about the death of Antonieta Maglaki and the expenses surrounding her funeral and burial is undisputed. Each document also supported the false claim for accidental-death benefits presented by Merin v. Maglaki, 126 N.J. 430, 433, 599 A.2d 1256, 1258 (1992). The Supreme Court found that six separate violations occurred.

Health care claim fraud.

Starting with the most extreme of claim fraud examples, the BioDiagnostic Laboratory Services LLC investigation led to the successful federal prosecution of fifty-three defendants and the recovery of more than $142 million in fraudulent health care claims. That case started as a civil insurance fraud matter investigated by Horizon's SIU unit. Between 2006 and 2013, BioDiagnostic Laboratory Services, LLC (BLS) and entities it funded paid millions of dollars to physicians to induce them to refer patient blood samples to BLS. From these referrals, BLS received tens of millions of dollars from private health insurance companies and Medicare.

BLS bribed physicians under the guise of lease, service, or consulting agreements. Under the lease and service agreements, between 2006 and 2009, BLS often paid physicians thousands of dollars a month for space in medical offices that BLS did not need or use to perform routine blood drawing services that had little real dollar value.

Horizon Blue Cross Blue Shield of New Jersey uncovered the BLS scheme and referred their concerns to the United States Department of Health and Human Services, Office of Inspector General (HHS-OIG). Together, HHS-OIG and the Federal Bureau of Investigation opened a criminal investigation that began a more than four-year covert investigation reviewing records, conducting surveillances, interviewing witnesses, and developing the criminal case. For the size and complexity of this case, investigators from the United States Postal Inspection Service, the Internal Revenue Service, Criminal Investigations Division, and the United States Attorney's Office joined the investigative team. The covert enforcement action involved over 150 federal law enforcement agents, analysts, and examiners executing all operations simultaneously.

Because of this extraordinarily successful investigation and prosecution, courts ordered fifty-three defendants to forfeit nearly $142 million, pay more than $1.2 million in fines and assessments, and spend more than 98 years in federal prison.

The investigation started with Horizon policyholders reviewing their Explanation of Benefit statements and noticing that something was wrong. Some were so shocked by the testing and charges listed they called BioDiagnostic for an explanation. BLS told each not to worry, BLS would accept whatever Horizon paid as payment in full. The policyholders called Horizon and reported their concerns about tests they did not need and the hundreds or thousands of dollars

of "patient responsibility." Horizon's investigation found examples of unbundling, waiver of patient deductibles, and upcoding.

GLOSSARY OF TERMS IN HEALTH CARE FRAUD CLAIMS

Billing for Services not Rendered—this covers outright billing for services never performed. A chiropractor admitted that 40% or more of his entries on his patient treatment—"travel cards"—over a multiple year period never took place and were simply written in by him. There was an allergist who billed for seeing every patient who received an allergy shot from his nurses even when he did not see them because the insurer did not pay enough for the shots alone. The CPT code provides that for codes 95115 through 95119 the professional services necessary for delivering allergen immunotherapies (allergy injections) are included in the payment under those codes.

Office visit codes or what are commonly called evaluation and management codes (E & M) may be used along with the codes for the allergy injection only if another significant, separately identifiable service is provided by the same provider at the same time.

CPT Codes—CPT is a registered trademark of the American Medical Association. The intent of the CPT is to create a universal billing language so that providers and payors may have an objective, accurate, and mutual understanding of the services provided to patients. "The purpose of the [CPT] terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable

nationwide communication among physicians, patients, and third parties" CPT© Current Procedural Terminology.

Patient Financial Responsibility—this term refers to the deductible and co-insurance responsibilities of the patient or insured. Fraud claims related to waiver of patient financial responsibility are unpopular because the argument is that waiver saves patients money. This is an uninformed position because schemes that incorporate a pre-determined waiver of patient financial responsibility do so because they have increased the amount billed to the insurer by more than enough to account for the loss of revenue from the patient. For example, a $5,000 charge for an outpatient surgical procedure might be subject to patient financial responsibility for a $500 deductible and a 20% co-insurance translating to a payment from the insurance carrier of 80% of the $4,500 ($3,600) and the patient pays the $500 deductible and a $900 coinsurance. If the patient's financial responsibility of $1,400 is waived by the provider, the actual cost is $3,600. Had it been billed at $3,600 the insurer would have paid only $2,480.

When auto body shops "saved" customers their deductible by overstating the cost of repairs, everyone recognized it as fraud, a health care provider who does the same is no less fraudulent.

Unbundling— Unbundling occurs when a health provider, who at first issues a service as one package, breaks down the service into components and finds individual reimbursement codes for those components, so long as the individual

rates combined exceed the global rate." United States ex rel. Bledsoe v. Cmty. Health Sys., 501 F.3d 493, 498 n.4 (6th Cir. 2007). Certain CPT codes include all the services rendered for a particular treatment such as the initial follow up visit after a surgery. To increase revenue, some providers code these included services as if they were separate services. The use of codes -25 and -59 attached to a CPT code is a flag for such an effort, although some represent a legitimate use of the code.

Upcoding—Up-coding is over-billing of a particular kind: it is the practice of billing the insurance carrier for a more expensive medical service than the service provided. Because special billing codes exist for thousands of individual medical procedures, the term "up-coding" refers to the use of a higher code in the billing than is justified by the procedure performed. Becker v. Kroll, 494 F.3d 904, 909 n.1 (10th Cir. 2007). CPT codes tied to how long the provider spent providing services or the intensity of an office visit are often the subject of upcoding. The CPT Coding for patient evaluation and management has several levels of reimbursement tied to the complexity of the patient's history and medical condition, and the level of medical decision-making.

CLAIM FRAUD UNDER AUTOMOBILE OR HOME CASUALTY COVERAGES

A common example of fraud in the claims process is found in casualty coverage claims; damage to your home or automobile by fire, vandalism, or accident is most often false statements about when the damaging incident occurred, how it occurred, and what was damaged or taken.

Involvement of public adjusters in casualty claims.

In Liberty Mut. Ins. Co. v. Land, 186 N.J. 163 (2006) the Land's home was damaged when a neighbor's tree fell on it. Their nephew, who served as their public adjuster, misstated the damage to the home and enhanced the damage. A videotape depicts three men taking a portion of the fallen tree and slamming it against the roof, creating more damage and shattering a skylight. Liberty Mut. Ins. Co. v. Land, 186 N.J. 163, 165 (2006). The Land's eventual insurance claim overstated the amount of the damage caused by the fallen tree.

I often look at the involvement of Public Adjusters as a red flag for potential fraud in the claims process. I am sure I am ignoring the legitimate work of public adjusters who diligently help homeowners through the sometimes-complicated claims process for substantial losses from a house fire or flood damage. But my distrust comes from how public adjusters are paid – often from a percentage of what is recovered. This gives a public adjuster an incentive to inflate claims to increase their fee or to have the insured's net recovery equal or exceed the actual amount of the loss.

Misrepresentations about the cause of damage or when it occurred.

Misrepresenting the cause of damage is another area where casualty claim fraud is committed. Lansing v. Liberty Mut. Fire Ins. Co, 2013 N.J.Super Unpub. Lexis 1123, 2013 WL 1926612 (App. Div. 2013) (unpub) involved a claim for vandalism to an automobile. On a Sunday morning the insured left a voice mail reporting vandalism to his vehicle. By Wednesday and before the insurer could

inspect it the insured obtained an estimate and had the car repaired. An interview with the repair shop owner revealed that the shop observed no vandalism but had been asked by the insured to remove rust and make other repairs to "semi-restore" the vehicle to enhance its value.

We often see claims for alleged hit-and-run damage when the real cause is the driver accidentally backing into or scraping against something but claiming that an unknown third-party is responsible for the damage.

Timeline cases in auto theft claims.

Automobile theft claim fraud is often detected by what is often called a timeline case. That can be someone who reports their car stolen on Sunday morning, having last driven it Saturday evening—but it was found parked in an airport parking lot, or burning under a bridge in Philadelphia or Camden, the previous Tuesday. A fraudster reported to the Menlo Park Mall police substation that her car had been stolen from the mall. The next day, she called her insurance company. Defendant then submitted an affidavit to the insurance company asserting the theft. The investigation revealed that the vehicle had been found burning in Brooklyn, New York on November 27, 2003. State v. Fleischman, 383 N.J. Super. 396, 399, 891 A.2d 1247, 1249 (App. Div. 2006), aff'd, 189 N.J. 539, 917 A.2d 722 (2007). Despite the multiple false statements in the affidavit, the Court found that only one violation of the Insurance Fraud Prevention Act occurred.

Attention to detail and person-to-person investigation is the key to catching false representations in this area.

CLAIM FRAUD UNDER DISABILITY OR WORKERS COMPENSATION CLAIMS.

Claim fraud in the workers compensation context can include claiming an injury suffered off-the-job – for example from a weekend skiing, dirt-bike riding, or athletic injury was suffered after the employee reported to work on Monday morning.

Another frequent area of claim fraud is in the disability context. This is a misrepresentation of the extent of the claimant's restrictions and their activities. Surveillance is over-used by carriers in investigating these claims and rarely produces the "smoking gun" hoped for. Sometimes it can backfire, for example when a surveillance video shows a claimant or plaintiff engaging in a family activity and they acknowledge that they did it but ended up in the emergency room as a result of flat on their back in bed for the next several days.

What I found to be most effective was taking the surveillance video to the claimant's treating physician or physical therapist and asking them to compare the complaints made by their patient during their office or treatment visits and the activities they were engaging in on the surveillance video, often on the same day.

Their testimony after being "enlightened" about their patient's activities was persuasive and determinative.

Disclaimer

The remarks and observations in this presentation are not intended to constitute legal advice and are my own and do not reflect the official position of the State of New Jersey or any insurance carrier I currently, or in the future, represent.

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Detecting Insurance Fraud: The Role of the Special Investigation Unit (SIU)

Jonathan C. Magpantay, Esq., CPCU

What is Insurance Fraud?

- An intentional and material act to defraud an insurance transaction for unlawful gain.
- Can occur at the time of the insurance policy application or claim transaction.
- Can occur at the policy level – it is assumed and expected that applicants for insurance are acting truthfully.
- Can occur at the claim level – it is assumed and expected that a covered loss actually occurs and truthful and accurate facts are being reported.

Common Types of Insurance Fraud

- Staged accidents
- Exaggerated injuries
- Inflated medical bills
- False inflated theft repair claims
- Intentional damage claims
- Rate evasion
- False reports of stolen vehicles
- Application misrepresentations

Common Types of Insurance Fraud: Healthcare

- Can be perpetrated by physicians or patients.
- Physicians commit fraud by misrepresenting treatment or alter treatment costs.
- Patients commit fraud when providing false information during the application process, forging or selling prescription drugs, using transportation benefits for non-medical related purposes.

Common Types of Insurance Fraud: Automobile

- Occurs when a policyholder submits a claim for an accident that never happened.
- Files multiple claims for a single accident.
- Files claims for injuries not related to an automobile accident,
- Misrepresents wage losses due to injuries.
- Reports higher costs for car repairs than actually paid.

Insurance Fraud: Why Care?

- Insurance fraud steals at least $308.6 billion every year from American consumers. (*Coalition Against Insurance Fraud 2021*)
- Fraud occurs in about 10% of property-casualty insurance losses.
- Medicare fraud is estimated to cost $60 billion every year. (*AARP 2018*)

Insurance Fraud: Why Care?

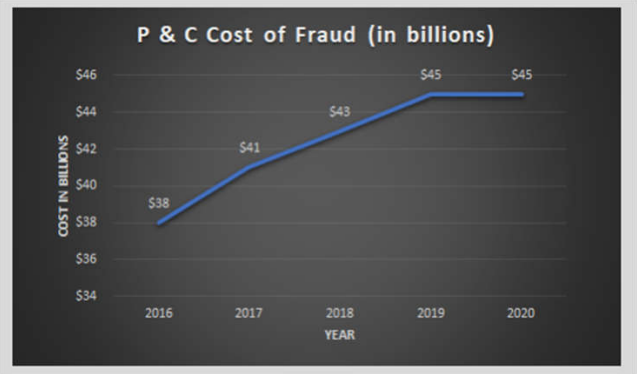
FINAL ESTIMATE OF THE COST OF INSURANCE FRAUD IN THE UNITED STATES:

(All numbers are in billions and figures are as of 2022)

Property & Casualty	$45B
Workers' Compensation	$34B
Premium Avoidance	$35.1B
Healthcare	$36.3B
Medicare and Medicaid Fraud	$68.7B
Life	$74.7B
Disability	$7.4B
Auto Theft*	$7.4B

$308.6 Billion Annually

Insurance Fraud: Cost to P&C Insurers



- Estimated $45 billion

What is SIU?

- Special Investigation Units (SIU) investigate suspected insurance fraud.
- Some US states require insurance companies to maintain an SIU to conduct business.
- Insurance companies meet these requirements by either hiring employees to staff an internal SIU and investigate potential insurance fraud or by contracting an outsourced SIU.
- Insurance carriers rely on SIU to investigate suspicious policies or claim transactions.
- Investigating and stopping insurance fraud protects the entire insurance system and prevents the cost of fraud being passed on to consumers through higher premiums.

Who Works for SIU?

- SIU Investigators come from all walks of life.
- Traditionally, SIU was staffed heavily with individuals with former law enforcement experience.
- SIU professionals also include claim adjusters, analysts, and other professionals with diverse but relevant skills.

What Does SIU Investigate?

- The types of insurance fraud that an SIU investigates depends on the types (or lines) of insurance that the insurance company (or carrier) writes.
- The insurance industry can generally be divided into two broad categories:

1. Property & Casualty (automobile, homeowners, property, liability, and workers compensation).
2. Life & Health (may also include accident, disability, etc.)

How Do SIU Investigate Suspected Fraud?

- Fraud detection can occur in various ways:
  - Identification of industry recognized indicators for fraud by front-line employees.
  - Leveraging technology.
  - Advanced analytics.
- Once fraud is suspected, a referral is made to the SIU for further investigation.

How Do SIU Investigate Suspected Fraud?

- The SIU department will assign the suspected fraud referral to an SIU investigator where the investigative process begins.
- Industry databases may be researched, policy or claim documents reviewed, witnesses and/or subjects of investigation interviewed, along with other investigative options. All with the intent to resolve the indicators of fraud, if possible.
- SIU are expected to follow strict codes of ethics, standards, and professionalism when investigating a suspicious insurance policy or claim.

How Do SIU Investigate Suspected Fraud?

- If the SIU investigation substantiates that a reasonable belief of insurance fraud is present then the SIU will report back to either their SIU manager or the original referring party, generally a claim adjuster or other insurance company professional.
- In addition, in many US states there are also duties to report that suspected insurance fraud to governmental authorities with the appropriate good faith immunity protection to do so. These SIU mandatory state reports may lead to criminal prosecutions for insurance fraud or other related offenses.

Services and Tools that Identify Fraud

- Scene inspection: Thoroughly investigates loss locations to validate the reported circumstances, obtain necessary photographs or source other pertinent information.
- Evidence gathering: Collectively compiles information from multiple sources to affect the correct claims decisions, accomplished through interviews with involved parties and witnesses, and by obtaining court records and documentation that is relative to the reported loss.

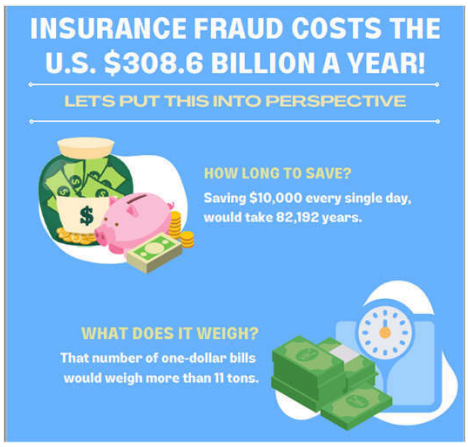
SIU Tools and Partners

- Data Analytics: Systematically sources medical provider treatment and billing records to identify patterns of abnormal behavior, in both individual claims as well as those spanning multiple claims and lines of business.
- Social network data mining: Comprehensively pulls data from social networking sites to aid SIU analysts as they gather information that may corroborate suspected fraud. Data mining assists with identifying possible associations between various parties to a claim, including claimants, medical providers, attorneys and witnesses. By using these tools, a SIU team can identify patterns of questionable behavior and activity that may otherwise remain undetected.

SIU Tools and Partners

- Link analysis: Visually connects networks and relationships, which aids investigators when uncovering possible associations between involved parties to a claim.
- National Insurance Crime Bureau (NICB): Enables quick and efficient ability to identify high-risk claims. In addition, the NICB provides jurisdictional expertise and acts as a resource for external fraud training.
- Coalition Against Insurance Fraud (CAIF): Provides outreach, education and information on combating insurance fraud.
- Federal/state/local enforcement agencies: Acts as an additional venue to refer suspect claims that have the potential for criminal investigation and prosecution.

Costs of Insurance Fraud



Questions

Thank You!

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Ethically Representing Parties in Insurance Coverage Cases

Nicholas M. Insua

Reed Smith, LLP

Serving Two Masters

"The lawyer's duty is of a double character. He owes to his client the duty of fidelity, but he also owes the duty of good faith and honorable dealing to the judicial tribunals before whom he practices his profession. He is an officer of the court – a minister in the temple of justice. His high vocation is to correctly inform the court upon the law and the facts of the case, and to aid it in doing justice and arriving at correct conclusions."

In re Turner, 83 N.J. 536, 538 (1980)

RPC 1.6(a)

A lawyer shall not reveal information relating to representation of a client unless the client consents after consultation, except for disclosures that are impliedly authorized in order to carry out the representation, and except as stated in paragraphs (b), (c), and (d).

3

Attorney-Client Privilege

- "[T]he oldest of the privileges for confidential communications known to the common law."
- Purpose is to encourage "full and frank communication" between attorneys and their clients
- Requires clients be free to "make full disclosure to their attorneys" of past wrongdoings to obtain "the aid of persons having knowledge of the law and skilled in its practice"

  U.S. v. Zolin, 491 U.S. 554, 562 (1989)

RPC 1.6(b)

A lawyer shall reveal such information to the proper authorities, as soon as, and to the extent the lawyer reasonably believes necessary, to prevent the client or another person:

(1) from committing a criminal, illegal or fraudulent act that the lawyer reasonably believes is likely to result in death or substantial bodily harm or substantial injury to the financial interest or property of another

(2) from committing a criminal, illegal or fraudulent act that the lawyer reasonably believes is likely to perpetrate a fraud upon a tribunal.

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A Rock and a Hard Place

- RPC 1.6(a) **requires** confidences be maintained
- RPC 1.6(b) **requires** confidences be revealed in certain circumstances

- *Prudential Ins. Co. of Am. v. Massaro* (D.N.J. 2000)
  - In-house counsel revealed confidential information and alleged Prudential was shredding documents
  - Attorney argued disclosure was mandated by crime-fraud exception, RPC 1.6(b)
  - Court found insufficient evidence to establish crime or fraud by Prudential
  - Instead, court found attorney violated RPC 1.6(a) and permanently enjoined him from further disclosures

RPC 1.6(d)

A lawyer may reveal such information to the extent the lawyer reasonably believes necessary:

(1) to rectify the consequences of a client's criminal, illegal or fraudulent act in the furtherance of which the lawyer's services had been used

. . .

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Past v. Future Wrongs

- RPC 1.6(b) is preventative in nature – prevent bodily harm or property damage or to prevent fraud on a tribunal
  - See *U.S. v. Zolin*, 491 U.S. 554 (1989) – attorney-client privilege "ceas[es] to operate at a certain point, namely, where the desired advice refers *not to prior wrongdoing*, but to *future wrongdoing*."
- RPC 1.6(d) is curative in nature – used to rectify past harms

RPC 1.6(e)

Reasonable belief for purposes of RPC 1.6 is the belief or conclusion of a reasonable lawyer that is based upon information that has some foundation in fact and constitutes prima facie evidence of the matters referred to in subsections (b), (c), or (d).

RPC 1.16(a)

Except as stated in paragraph (c), a lawyer shall not represent a client or, where representation has commenced, shall withdraw from the representation of a client if:

(1) the representation will result in a violation of the Rules of Professional Conduct or other law

. . .

RPC 1.16(b)

Except as stated in paragraph (c), a lawyer may withdraw from representing a client if:

. . .

(2)the client persists in a course of action involving the lawyer's services that the lawyer reasonably believes is criminal or fraudulent;

(3)the client has used the lawyer's services to perpetrate a crime or fraud;

. . .

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RPC 1.16(c)

A lawyer must comply with applicable law requiring notice to or permission of a tribunal when terminating a representation. When ordered to do so by a tribunal, a lawyer shall continue representation notwithstanding good cause for terminating the representation.

Attorney Withdrawal

- *Haines v. Liggett Grp. Inc.*, 814 F. Supp. 414 (D.N.J. 1993)
  - "[E]ven if withdrawal is otherwise appropriate, other considerations must sometimes take precedence, such as maintaining fairness to litigants and preserving a court's resources and efficiency."
- *Rusinow v. Kamara*, 920 F. Supp. 69, 71 (D.N.J. 1996)
  - Insurer advised counsel for plaintiff that plaintiff might be engaged in insurance fraud; counsel moved to withdraw
  - Court denied – no good reason given for withdrawal
  - Equitable considerations against withdrawal – "The frenetic flurry of activity by counsel to withdraw . . . on the eve of trial, will not be countenanced by this court. . . . Those who cannot live with risk, doubt and ingratitude should not be trial lawyers."

RPC 3.3(a)

A lawyer shall not knowingly:

(1) make a false statement of material fact to a tribunal;

(2) fail to disclose a material fact to a tribunal when disclosure is necessary to avoid assisting an illegal, criminal or fraudulent act by the client;

. . .

⑩ offer evidence that the lawyer knows to be false. If a lawyer has offered material evidence and comes to know of its falsity, the lawyer shall take reasonable remedial measures

. . .

RPC 4.1(a)

In representing a client a lawyer shall not knowingly:

(1) make a false statement of material fact or law to a third person; or

(2) fail to disclose a material fact to a third person when disclosure is necessary to avoid assisting a criminal or fraudulent act by a client.

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RPC 8.4

It is professional misconduct for a lawyer to:

(a) violate or attempt to violate the Rules of Professional Conduct, knowingly assist or induce another to do so, or do so through the acts of another;

. . .

(c) Engage in conduct involving dishonesty, fraud, deceit or misrepresentation;

. . .

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Montanez v. Irizarry-Rodriguez

- 273 N.J. Super. 276 (App. Div. 1994)
- Passenger (wife) injured in single vehicle accident sued insured driver (her husband) for negligence
- Insurance company appointed counsel to defend driver
- At trial, driver's testimony differed from statement previously provided to counsel; driver's attorney then attacked his credibility on witness stand by bringing up statements driver made to attorney outside of court
- Court ruled RPC 1.6(b) and 3.3(a) did not justify attorney's actions against his client; impeaching his own client was conflict of interest – insurer vs. insured
- Attorney should have disclosed info to court and withdrawn

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NJ Ethics Opinion 585 (1986)

- Attorney separately retained by driver and passenger obtained PIP benefits from driver's insurer
- Driver later admitted passenger had sustained injuries in prior accident and was not passenger at time of driver's accident
- Supreme Court Advisory Committee on Professional Ethics found RPC 1.6(d) applies because the attorney's services were used to defraud the insurer

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State v. Zwillman

112 N.J. Super. 6 (App. Div. 1970)

"It is not an attorney's responsibility to decide the truth or falsity of a client's representations unless he has actual knowledge or unless from facts within his personal knowledge or his professional experience he should know or reasonably suspect that the client's representations are false. The duty of the attorney is to seek for his client all that the client is entitled to under the law and not to act in the first instance as judge and jury."

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Hypothetical Case #1

- 3-member LLC owns hotel
- Hotel burns down
- LLC hires coverage counsel approximately 3 months after the fire
- Because hotel has burned down, limited resources to pay bills

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Hypothetical Case #1 (cont'd)

- Arson investigation into all 3 members
- Worker accused of arson
- 1 member linked to that worker
- Eventually that 1 member pleads guilty to arson
- 1 member has pled guilty; 2 members are innocent

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Hypothetical Case #1 (cont'd)

- LLC stops paying bills
- Court has set trial date
- Consider continued representation of just 2 innocent members
- Consider continued representation of LLC despite large A/R balance

Hypothetical Case #2 (based on NJ Ethics Opinion 642 (1990), 125 NJLJ 1097, 1990 WL 441608)

- Insurance claim involves damages for theft of a motor vehicle
- At the time of the issuance of the policy claimant represented that he was a resident of a suburban community in New Jersey and that the vehicle would be principally garaged in that community.
- Actually, however, plaintiff was, and is, a resident of New York.

Hypothetical Case #2 (cont'd)

- The vehicle was garaged in New York and was stolen while parked there. Claim was denied based on issues unrelated to residence.

- Claimant asks the attorneys to prepare and file a complaint. During the course of the suit interrogatories will be propounded and will have to be answered. Other discovery may also take place.

Hypothetical Case #2 (cont'd)

1. May counsel in the complaint or in answers to interrogatories either omit any reference to the residence address of his client; set out a fictitious New Jersey address, if client demands; or must he set out client's correct address?

1. Must counsel now reveal the fact of plaintiff's misrepresentation at the time of the application to his adversary?

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Hypothetical Case #2 (cont'd)

3. May the former merely do no further work on the case, thereby satisfying his ethical obligations?

4. If one member of the firm prepared the complaint and answers to interrogatories and another member of the firm learns of the client's misrepresentation, must the latter inform the ethics committee thereof?

Hypothetical Case #3

- Insured suffered severe damage to home and contents from storm
- Filed claims with homeowners insurance; insurance significantly undervalues cost of repair and replacement
- Insured forced to file for personal bankruptcy due to loss from storm; discharged from bankruptcy
- Insured then hires lawyer to pursue additional funds from insurance company

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Hypothetical Case #3 (cont'd)

- Insured does not tell coverage attorney about bankruptcy
- Insured does not tell bankruptcy attorney about insurance claim, and insurance not listed as asset in bankruptcy filings
- As part of insurance claim appeal, insured provides estimate to repair home from contractor; does not tell coverage attorney estimate prepared by son-in-law and coverage attorney submits estimate to insurance company

Hypothetical Case #3 (cont'd)

- Client admits to coverage attorney:
  - Filed for bankruptcy and debts discharged
  - Contractor is son-in-law
- What are attorney's obligations?

Hypothetical Case #4

- Insured's house severely damaged in flood; contents destroyed
- Insured claims flood-damaged house is primary residence
- Insurance company covers loss but severely undervalues claim
- Insured hires coverage attorney to pursue claim against insurance company

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Hypothetical Case #4 (cont'd)

- Insured indicted for insurance fraud on basis that damaged home was not primary residence (and subject to less coverage under flood insurance policy)
- Insured enters "not guilty" plea
- Insured provides coverage attorney with logical explanations disputing evidence that was basis for indictment

Hypothetical Case #4 (cont'd)

- Coverage attorney relies on insured's explanation of innocence and continues to press insurance claim for additional funds, arguing flood-damaged home is insured's primary residence
- Insured then pleads "**GUILTY**" to insurance fraud!
- Coverage attorney withdraws from representation

About the Panelists…

Al Garcia is Interim Insurance Fraud Prosecutor, Office of the Insurance Fraud Prosecutor, New Jersey Office of the Attorney General, Division of Criminal Justice, in Trenton, New Jersey. A prosecutor for more than 25 years, he was formerly Deputy Insurance Fraud Prosecutor, managed a staff of nearly 100 and was responsible for the day-to-day operations of the office.

A long-time member of the Board of Bar Examiners for the State of New Jersey, Mr. Garcia began his prosecutorial career at the Queens District Attorney's Office in New York City, where he prosecuted thousands of cases and was later designated as a Special Assistant United States Attorney for the Eastern District of New York (Brooklyn), where he was engaged in the prosecution of federal cases, including felony trials. After a stint as legal counsel for an insurance company he became an Assistant Prosecutor for the Mercer County Prosecutor's Office in 2001, where he investigated and prosecuted hundreds of matters. While there Mr. Garcia served as Chief of the Insurance Fraud Unit, the Bias Unit and Serious Collision Response Team, and served On Call for the Homicide Unit. From 2015-2018 he was Deputy Ethics Counsel for the Office of Attorney Ethics, and investigated and prosecuted attorneys for violations of the *Rules of Professional Conduct*. In 2018 he became Deputy Insurance Fraud Prosecutor.

Mr. Garcia is a *cum laude* graduate of Rutgers University's Newark College of Arts and Sciences and received his law degree from Rutgers School of Law-Newark.

Anthony J. Golowski II is a Partner in Goldberg Segalla LLP in the firm's Princeton, New Jersey, office, where he maintains an international commercial practice with a focus on corporate law, business litigation and alcoholic beverage law. He represents insurers in premium disputes, prosecutes civil insurance fraud claims and defends bad faith claims; and also represents clients in shareholder/member disputes, business breakups, contract disputes, employee dishonesty claims, internal investigations and professional malpractice claims. A large part of his practice is forensic investigation and analysis along with complex commercial transactions and complex commercial litigation.

Admitted to practice in New Jersey and Pennsylvania, and before the United Stated District Court for the District of New Jersey, the United States Tax Court and the United States Supreme Court, Mr. Golowski has been a member of the New Jersey State Bar Association, the New Jersey Alcoholic Beverage Control Advisory Committee and the Claims and Litigation Management Alliance (CLM) Insurance Fraud Committee. He is a former Deputy Attorney General who supervised a civil insurance fraud unit in the Division of Law, and was also assigned to the Divisions of Alcoholic Beverage Control and Criminal Justice. He has lectured for professional organizations and his articles have appeared in the *Insurance Law Coverage Bulletin* and other publications.

Mr. Golowski received his B.S. from Fordham University, his J. D. from Rutgers University School of Law and his LL.M. In Taxation from New York University School of Law.

John C. Grady, Certified as a Civil Trial Attorney by the Supreme Court of New Jersey, is a Partner in the Woodbury, New Jersey, firm of Cockerill, Craig & Moore, LLC. The former Lead

Deputy for the Insurance Fraud Section of the New Jersey Department of Law & Public Safety, he handles civil litigation for municipalities in land use and zoning, employment and civil rights matters in state and federal courts. He has handled civil trial and appellate litigation and was involved in precedent-setting litigation about the New Jersey's Insurance Fraud Prevention Act, "IFPA."

Mr. Grady is admitted to practice in New Jersey and Pennsylvania, and before the United States District Court for the District of New Jersey and the Eastern District of Pennsylvania, the Third Circuit Court of Appeals and the United States Supreme Court. He is a member of the American, New Jersey State, Pennsylvania, Camden County and Gloucester County Bar Associations.

Mr. Grady has been an instructor for the New Jersey Attorney General's Advocacy Institute and for the Office of Insurance Fraud Prosecutor's civil investigator training. He has lectured for ICLE, the Camden County Bar Association, the National Business Institute and other organizations.

Mr. Grady received his B.S., with honors, from St. John's University and his J.D., with honors, from Rutgers School of Law-Camden.

Nicholas M. Insua is a Partner in Reed Smith LLP in Princeton, New Jersey, where he concentrates his practice in insurance recovery litigation and counseling, and also represents clients in business disputes outside the insurance coverage context. His practice has increasingly focused on catastrophic first-party property damage and business interruption claims, including fire and storm claims.

Mr. Insua is admitted to practice in New Jersey and Pennsylvania, and before the United States District Court for the District of New Jersey, the Eastern District of Pennsylvania and the Southern and Northern Districts of New York; and the Third Circuit Court of Appeals. Past Chair of the New Jersey State Bar Association Insurance Law Section, he has been a member of the American, Pennsylvania and Morris County Bar Associations and Chair of the *Pro Bono* Committee of the NJSBA. Mr. Insua was Legislative Chair of the NJSBA Insurance Law Section, has served on the Advisory Committee of the *New Jersey Law Journal* and has been Co-Chair of the Excess and Umbrella Coverage Subcommittee of the ABA Section of Litigation's Insurance Coverage Litigation Committee. Post Sandy, he has helped individual policyholders *pro bono* via the New Jersey State Bar Association *Pro Bono* Standing Committee and Volunteer Lawyers for Justice (VLJ).

Mr. Insua previously served as an Adjunct Professor at Seton Hall University School of Law, where he taught the course Commercial Law Survey, and has been a guest lecturer on environmental insurance law at Rutgers School of Law-Camden. He co-authored the insurance section in the *Handbook for Victims of Superstorm Sandy* and also drafted the insurance section of the reference manual *FEMA and Disaster-Related Insurance Issues*. Co-author of *Business Income Insurance Disputes*, he has lectured for ICLE, the New Jersey State Bar Association and other organizations on insurance-related topics.

Mr. Insua received his B.A. from Yale University and his J.D., with highest honors, from Rutgers School of Law-Camden, where he was the recipient of the Paul C. Ireton Memorial Award for having the highest GPA in his graduating class. He served as Law Clerk to Associate Justice Jaynee LeVecchia, Supreme Court of New Jersey.

Jonathan C. Magpantay is an associate with Marshall Dennehy in Mt. Laurel, New Jersey, and a member of the firm's Fraud and Special Investigation Unit (SIU) Practice Group. Concentrating his practice in large loss and medical provider fraud, he handles matters that focus heavily on fraud investigation, and involve the assessment and evaluation of both medical provider fraud and fraudulent claims on the part of clients' insureds. Mr. Magpantay is experienced in dealing with insurance coverage disputes, representing insurance carriers across multiple states for the purposes of SIU investigation, bad faith litigation and general defense litigation. He has broad and extensive experience in New Jersey Personal Injury Protection (PIP) litigation and appears regularly before the courts and administrative bodies.

Mr. Magpantay is admitted to practice in New Jersey and the District of Columbia, and before the United States District Court for the District of New Jersey, the Third Circuit Court of Appeals and the United States Supreme Court. He received his Chartered Property and Casualty Underwriter (CPCU), Associate in Insurance Services (AIS), and Associate in Personal Insurance (API) designations from the American Institute of Chartered Property and Casualty Underwriters (The Institutes). He is a member of the Asian Pacific American Lawyers Association of New Jersey (APALA-NJ), the National Filipino American Lawyers Association (NFALA), the Camden County Bar Association and the New Jersey Superior Court, Camden Vicinage's Diversity, Inclusion & Community Engagement Committee.

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Sherilyn Pastor is a Partner in McCarter & English, LLP in the firm's Newark, New Jersey, office. Chair of M&E's Insurance Rcovery, Litigation and Counseling Group, she handles all phases of complex commercial litigation, including insurance coverage, reinsurance coverage and broker malpractice claims. She has secured hundreds of millions of dollars in insurance for corporate policyholders, litigates complex coverage matters throughout the country and abroad, and provides insurance coverage advice to clients.

Admitted to practice in New Jersey and New York, and before the United States District Court for the District of New Jersey and the Southern and Eastern Districts of New York, and the Third Circuit Court of Appeals, Ms. Pastor is a member of the American, New Jersey State, New York State and Essex County Bar Associations. She has been Chair (Policyholder Side) of the ABA Litigation Section's Insurance Coverage Litigation Committee, served as Vice-Chair from 2009-2012 and has been co-chair of several ICLC subcommittees since 2002. Ms. Pastor is a founding member and has served as Vice-Chair of the First Party Insurance Committee of the American College of Coverage and Extra-Contractual Counsel. A Fellow of the American Bar Foundation, she has also been a member of the New Jersey Supreme Court's Professional Responsibility Rules Committee and the Insurance Neutrals Review Committee of the International Center for Conflict Prevention & Resolution.

Recognized in the International *Who's Who of Insurance & Reinsurance*, Ms. Pastor has served on the Editorial Boards of the *Insurance Coverage Law Bulletin* and has been a consultant on the *New Appleman Insurance Law Practice Guide*. She publishes and lectures frequently on topics including insurance coverage, trial advocacy, pretrial practice and professional responsibility. She is also the recipient of the American College of Coverage and Extra-Contractual Counsel's Thomas F. Segalla Award for her dedication and service to the College.

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Loren L. Pierce is a Principal in the Business and Commercial Litigation Practice Group of Bressler, Amery & Ross in Florham Park, New Jersey. She concentrates her practice in commercial, insurance coverage and employment litigation, and she also has experience in environmental, class action, construction and fraud matters. She counsels clients on corporate and commercial matters and has prepared corporate-wide policies relating to compliance, employment and electronic discovery issues.

Ms. Pierce is admitted to practice in New Jersey, Pennsylvania and the District of Columbia, and before the United States District Court for the District of New Jersey and the Eastern and Middle Districts of Pennsylvania, the Third Circuit Court of Appeals and the United States Supreme Court. Past President of the New Jersey Women Lawyers Association, she served as the Association's Co-Chair of Corporate Relations for four years and is a member of the American, New Jersey State and District of Columbia Bar Associations, the Association of the Federal Bar of the State of New Jersey and the National Association of Women Lawyers. She is also a Fellow of the American Bar Foundation and was appointed to the District XIII Fee Arbitration Committee. A Trustee of the New Jersey State Bar Foundation, Ms. Pierce has also served on the Executive Committee of the NJSBA Young Lawyers Division and the Association's *Amicus* Committee, and in 2015 was honored with the Professional Lawyer of the Year Award by the New Jersey Commission on Professionalism in the Law on behalf of the New Jersey Women Lawyers Association. She has lectured on insurance coverage topics for ICLE and the New Jersey State Bar Association, and has published articles on bad-faith litigation.

Ms. Pierce received her A.B. from Lafayette College and her J.D. from Seton Hall University School of Law, where she was a member of the Moot Court Board. She was Law Clerk to the Honorable John A. McLaughlin, Superior Court of New Jersey.