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An Introduction to No-Fault Insurance and No-Fault Insurance Fraud

By 1930, the automobile was ubiquitous in American life. In 1900, there were only 8,000 automobiles registered in the United States, but in 1930, there were over 23,000,000.¹ This dramatic expansion in automobile use, the driving public's lack of experience with the new technology, and the absence of sufficient safety features led to a similarly dramatic increase in highway accidents and fatalities.²

As automobile accidents increased, scholars began to observe that the traditional tort system did not fairly and adequately compensate accident victims. One of the most notable early studies was a 1932 report by the Committee to Study Compensation for Automobile Accidents, conducted under the auspices of Columbia University's Council for Research in the Social Sciences

¹ JAMES M. ANDERSON, ET AL., *THE U.S. EXPERIENCE WITH NO-FAULT AUTOMOBILE INSURANCE: A RETROSPECTIVE* 23 (2010).

² *Id.*

(the “Columbia Report”).³ The Columbia Report reached several discomfiting conclusions about the viability of the traditional tort system in the context of automobile accident compensation:

- i. Despite a few very high awards, the tort system generally did not fully compensate accident victims, especially with respect to more serious losses;
- ii. financially irresponsible defendants typically provided no meaningful compensation to accident victims, but even financially responsible defendants did not sufficiently compensate accident victims;
- iii. to the extent that accident victims were compensated to some degree, receipt of the compensation often was delayed, with attendant hardship to the accident victims;
- iv. most accident victims had lower incomes and therefore were in a weaker bargaining position when it came to bargaining for compensation; and
- v. there was a considerable disparity in compensation among accident victims, with some being overcompensated and others receiving inadequate compensation.⁴

The Columbia Report concluded that liability for fault should be abolished in the context of automobile accidents, and its authors posited a system of mandatory insurance similar to the workers compensation system.⁵ By the late 1950s, however, no state had enacted any type of no-fault insurance law.⁶

Unsurprisingly—given the continued increase in automobile usage and a concomitant increase in automobile accidents—the inequities in the tort system became more and more apparent as

³ Committee to Study Compensation for Automobile Accidents, Report to the Columbia University Council for Research in the Social Sciences (1932) (hereinafter the “Columbia Report”); see also Fleming James, Jr., *The Columbia Study of Compensation for Automobile Accidents: An Unanswered Challenge*, 59 COLUM. L. REV. 408 (1959) (referring to the Columbia Report as “probably the most significant contribution to the study of torts to appear so far in the twentieth century.”).

⁴ James, *supra* note 3, at 408–10.

⁵ Columbia Report, *supra* note 3, at 15–217.

⁶ James, *supra* note 3, at 410.

the 20th century progressed.⁷ There were, for instance, dramatic increases in automobile-related lawsuits, healthcare costs, and liability costs between 1955 and 1970.⁸

Ultimately, in 1965, Robert E. Keeton, a law professor at Harvard University, and Jeffrey O'Connell, a law professor at the University of Illinois, published *Basic Protection for the Traffic Victim: A Blueprint for Reforming Automobile Insurance*, which generally is considered to be a landmark on the road to widespread enactment of no-fault insurance laws.⁹ Keeton and O'Connell's diagnosis of the problems with the tort system was substantially similar to the conclusions in the Columbia Report, inasmuch as they sought to address (i) general undercompensation of accident victims, especially with respect to more serious injuries; (ii) overcompensation for minor injuries; (iii) delays in compensation; (iv) high administrative costs; and (v) perverse incentives for dishonesty amongst both accident victims and tortfeasors.¹⁰

In place of traditional tort liability, Keeton and O'Connell proposed—in essence—mandatory first-party automobile insurance through which drivers would insure themselves, coupled with the abolishment of the fault-based tort system to the extent of that first-party coverage.¹¹ To buttress their recommendations, Keeton and O'Connell included a model statute in their proposal as well as an actuarial opinion to demonstrate that the proposal would result in cost savings.¹²

In 1971, Massachusetts became the first state to enact a no-fault law.¹³ In keeping with the exceptional influence of Keeton and O'Connell, the leading advocate for the Massachusetts statute was

⁷ ANDERSON, *supra* note 1, at 28–30.

⁸ *Id.*

⁹ See, e.g., *Id.* at 35 (referring to BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE as a “landmark work”); Florida Senate Committee on Banking and Insurance, *Report on Florida's Motor Vehicle No-Fault Law* 6 (2005) (noting that Keeton and O'Connell “were instrumental in developing the concept of no-fault insurance in the mid-1960's”).

¹⁰ ROBERT E. KEETON & JEFFREY O'CONNELL, *BASIC PROTECTION FOR THE TRAFFIC VICTIM: A BLUEPRINT FOR REFORMING AUTOMOBILE INSURANCE* 2–3 (1965).

¹¹ *Id.*, at 5, 273, and *passim*.

¹² *Id.* at 299–339.

¹³ Gary T. Schwartz, *Auto No-Fault and First-Party Insurance: Advantages and Problems*, 73 S. CAL. L. REV. 611 (2000).

Michael Dukakis—then a state legislator—who had been one of Keeton’s students at Harvard Law School and who liaised frequently with Keeton as he pushed the no-fault law through the Massachusetts legislature.¹⁴ Thereafter, during the early-to-mid 1970s, at least 16 states adopted some sort of no-fault insurance law.¹⁵ However, no state has adopted a no-fault law since 1976, and several states—namely Colorado, Connecticut, Georgia, and Nevada—have repealed their no-fault laws.¹⁶

Currently, 12 states have a no-fault law, specifically Florida, Michigan, New York, New Jersey, Pennsylvania, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah. While there are considerable variations among the no-fault laws in each of these states, they can broadly be classified by the degree to which the respective systems permit or abolish tort liability and—assuming tort liability is permitted—the type of threshold an injured party must meet before tort liability is permitted.

In this context, it is worthwhile to note that no state has adopted “pure” or “absolute” no-fault laws, meaning a system that totally abolishes recovery in tort in exchange for unlimited or near-unlimited coverage for economic loss.¹⁷ Indeed, Keeton and O’Connell themselves did not recommend a pure no-fault system and instead proposed the type of “modified” or “hybrid” no-fault system that currently is in place in every state with a no-fault law, because they believed that a pure no-fault plan would be “doomed to founder as unable to muster the necessary widespread political support.”¹⁸ In a hybrid system, first-party insurance benefits for economic loss are provided regardless

¹⁴ *Id.* at 612, n. 3.

¹⁵ ANDERSON, *supra* note 1, at 2. However, some contend that a larger number of states enacted no-fault laws. See, e.g., ROBERT H. JOOST, *AUTOMOBILE INSURANCE AND NO-FAULT LAW* §§ 2:18, 2:19 (2d ed. 1992) (positing that 25 states enacted some type of no-fault law).

¹⁶ Memorandum from the N.D. Legis. Council Staff on No-Fault Insurance in Other States 1 (Nov. 28, 2005) (observing that Pennsylvania—like Colorado, Connecticut, Georgia, and Nevada—repealed its no-fault law, but then adopted another no-fault law).

¹⁷ Schwartz, *supra* note 13, at 616. It is worthwhile to note that Michigan comes closest to a pure no-fault system, inasmuch as a Michigan accident victim can recover unlimited amounts for medical expenses and it is very difficult to sue in Michigan for noneconomic loss. *Id.* at 619; See also N.D. Legis. Council Staff, *supra* note 16, at 1.

¹⁸ KEETON & O’CONNELL, *supra* note 10, at 164, n. 52.

of fault and the right to sue for noneconomic loss, such as pain and suffering, is permitted only after an injured party meets a statutory threshold.¹⁹

There are, generally, two types of statutory thresholds in place among states with no-fault laws: “verbal” thresholds and “monetary” thresholds.²⁰ In monetary threshold states, an accident victim must suffer damages exceeding a particular dollar amount—\$2,000, \$10,000, and so on—before she will be permitted to bring a tort suit. Currently, Hawaii, Kansas, Kentucky, Massachusetts, Minnesota, North Dakota, and Utah have monetary thresholds.

By contrast, verbal threshold states require an accident victim to have suffered an injury that can be described in a particularized way before the victim can sue in tort. At present, Florida, Michigan, New Jersey, New York, and Pennsylvania have verbal thresholds. There is a fairly wide disparity among the verbal thresholds that have been adopted by verbal threshold states. As a general matter, however, in verbal threshold states a party must suffer death or a serious injury such as dismemberment, serious disfigurement, a broken bone, or the like before he will be permitted to pursue tort recovery.²¹

While no-fault insurance regimes vary somewhat among states, there are common elements among most no-fault insurance systems that create similar perverse incentives for similar types of fraudulent conduct. For instance, healthcare expenses are the most common type of economic losses that the no-fault laws were designed to address. As a result, most no-fault insurance systems permit injured parties to assign their right to receive no-fault insurance benefits to healthcare services providers in exchange for treatment.²² Then, the healthcare services providers can submit their bills directly to—and obtain payment directly from—automobile insurance companies. This makes

¹⁹ Schwartz, *supra* note 13, at 617; N.D. Legis. Council Staff, *supra* note 16, at 1.

²⁰ Anderson, *supra* note 1, at 12; Schwartz, *supra* note 13, at 617.

²¹ See, e.g., N.Y. Ins. Law § 5102 (defining the “serious injury” threshold to include such things as—among other things—death, dismemberment, significant disfigurement, or a fracture); FLA. STAT. § 627.737 (setting forth a verbal threshold of death, significant and permanent loss of an important body function, other types of permanent injuries, and significant and permanent scarring or disfigurement); MCLS § 500.3135 (death, serious impairment of body function, or permanent serious disfigurement).

²² See, e.g., 11 N.Y.C.R.R. § 65-3.11; N.J. STAT. § 39:6A-4.

perfect sense, so far as it goes. After all, an accident victim might not have sufficient funds on hand to pay for critical or acute care in the immediate aftermath of an automobile accident. By extension, without the comfort of knowing that they could bill insurance companies directly, healthcare providers might be disinclined to provide much-needed services.

However, the interplay between this type of no-fault insurance reimbursement system and the tort thresholds described above often is a critical driver of fraudulent no-fault claims submissions. For example, corrupt healthcare service providers that engage in no-fault insurance fraud often are in league with personal injury attorneys, who refer insureds to the healthcare providers with the understanding that (i) the healthcare providers will purport to provide medically unnecessary or illusory “treatments” to the insureds based on false contentions in the healthcare providers’ treatment reports and billing and that the insureds suffered serious injuries in their automobile accidents, thereby (ii) permitting the insureds to contend that they meet the tort thresholds and permitting the personal injury attorneys to file tort cases on behalf of those insureds. All of the participants in this type of scheme—which is widespread—profit. The healthcare providers profit because they get to bill insurers for medically unnecessary and illusory treatments. The insureds and the personal injury attorneys profit because they get to prosecute tort claims.

What is more, for this type of no-fault reimbursement system to work, it is not sufficient to permit healthcare services providers to take assignments of no-fault benefits from insureds and then to directly bill automobile insurance companies for their services. Such an arrangement, on its own, would permit insurance companies to deny, delay, or reduce payments to healthcare services providers via endless challenges to the medical necessity of the underlying services, the cost of the underlying services, and so on. The result would be the worst of both worlds—not only would automobile accident victims be precluded from suing in tort, they also would be unable to obtain medical treatment because healthcare providers would be disinclined to enter or remain in the market.

As a result, state no-fault laws include provisions requiring expedited handling and prompt payment of no-fault insurance claims. For example, New York, Michigan, North Dakota, and Florida, among other states, generally require insurers to pay no-fault claims within

30 days of receipt.²³ In New Jersey, insurers generally must pay claims within 60 days of receipt.²⁴

Not only do no-fault states normally require expedited claims handling, they also—as a general matter—set other certain standards of conduct that automobile and other insurers must follow when handling claims. For instance, North Dakota, Pennsylvania, Kansas, and various other no-fault states require insurers to attempt in good faith to effectuate prompt, fair, and equitable settlements of claims submitted in which liability has become reasonably clear.²⁵ Along similar lines, New York admonishes insurers to “not treat the applicant [for no-fault insurance benefits] as an adversary.”²⁶

What is more, state no-fault regimes impose significant penalties on insurers that fail to process claims within the requisite time frames. Minnesota, for example, generally permits recovery of 15 percent annual interest on overdue payments.²⁷ Kentucky permits recovery of 12 percent annual interest on overdue claims, but if the “delay was without reasonable foundation,” the rate climbs to 18 percent.²⁸ North Dakota, New Jersey, and other no-fault states permit recovery of interest at the judgment rate.²⁹ New York permits recovery of 2 percent interest per month on tardy claims and—like Massachusetts and most other no-fault states—also permits claimants to recover attorneys’ fees incurred in securing payment on claims.³⁰ In Kentucky, a prevailing claimant can recover attorneys’ fees if the insurer’s delay or denial was “without reasonable foundation.”³¹

Insurers have every reason to be wary of these types of interest and attorney fee provisions because they often face a stacked deck in the event that an insured—or, more commonly, the insured’s healthcare provider assignee—moves aggressively to recover on a disputed claim.

²³ See N.Y. INS. LAW § 5106; 11 N.Y.C.R.R. § 65-3.8; FLA. STAT. § 627.736; MCLS § 500.3142; N.D. CENT. CODE, § 26.1-41-09.

²⁴ See N.J. STAT. § 39:6A-5.

²⁵ See, e.g., N.D. CENT. CODE § 26.1-04-03; 40 P.S. § 1171.5; K.S.A. § 40-2404.

²⁶ See 11 N.Y.C.R.R. § 65-3.2.

²⁷ See MINN. STAT. § 65B.54.

²⁸ See KRS § 304.39-210.

²⁹ See, e.g., N.D. CENT. CODE, § 26.1-41-09.

³⁰ See, e.g., N.Y. CLS INS. § 5106; ALM GL ch. 90, § 34M.

³¹ See KRS § 304.39-210.

In New Jersey, New York, and Hawaii, for instance, no-fault insureds or their assignees can submit virtually any dispute regarding no-fault benefits to arbitration.³² Minnesota requires no-fault disputes to be submitted to arbitration in cases where the claim at issue amounts to \$10,000 or less.³³

Although the arbitral rules vary from state to state, they normally provide for a very expedited procedure, with limited opportunities for insurers to prove their defenses. For instance, New York's no-fault arbitration regulations vest the arbitrator with considerable discretion in determining whether or not evidence is relevant or material and—by extension—whether or not an insurer is entitled to discovery.³⁴ The result, as a practical matter, is what the Second Circuit has described as “an expedited, simplified affair meant to work as quickly and efficiently as possible” where “[d]iscovery is limited or non-existent.”³⁵ In New Jersey, the only document discovery that a healthcare provider is required to provide in the context of a no-fault collections arbitration is “a written report of the history, condition, treatment, dates and costs of such treatment of the injured person. . . .”³⁶ The arbitration rules in Minnesota and Hawaii contain similar limitations on discovery.³⁷

What is more, state no-fault regimes often force insurers to bear many of the arbitration costs, which can be high relative to the amount of the underlying claim. In New York, for example, the State Department of Financial Services has designated the American Arbitration Association (“AAA”) as the body that is responsible for the administration of the no-fault arbitration process. In every individual case where an insurer is named as a respondent by a healthcare provider seeking payment on a no-fault claim that the insurer has denied, the insurer is required to pay AAA a mandatory, nonrefundable fee.³⁸ As a no-fault proceeding progresses through the arbitral process, the insurer-respondent is subject to additional fees regardless of the size

³² See N.J. STAT. § 39:6A-5.1; N.Y. CLS INS. § 5106; HRS § 431:10C-213.

³³ See MINN. STAT. § 65B.525.

³⁴ See 11 N.Y.C.R.R. § 65-4.5.

³⁵ *Allstate Ins. Co. v. Mun.*, 751 F.3d 94, 99 (2d Cir. 2014).

³⁶ See N.J. STAT. § 39:6A-13.

³⁷ See, e.g., HRS § 658A-17; MINN. NO-FAULT ARB. R. 12.

³⁸ See 11 N.Y.C.R.R. § 65-4.1, *et seq.*

of the underlying no-fault claim, whether the case is meritorious, or whether the applicant ultimately withdraws the claim at any stage during the process.³⁹ These fees typically amount to several hundred dollars per case. By contrast, the healthcare provider–claimants are required to pay only a comparatively nominal filing fee.

In Minnesota, where the AAA also administers the no-fault arbitration process, insurers must pay a \$130 filing fee when they are named as respondents in no-fault arbitration, whereas the claimants' filing fee is only \$35.⁴⁰ Moreover, if the arbitration proceeds, an insurer may be required to pay up to \$300 in arbitrator's fees.⁴¹ While these additional fees may be assessed against the claimant at the direction of the arbitrator, as a practical matter the insurers generally are obligated to pay at least half of the arbitrator's fees. Similarly, in New Jersey, insurers generally must pay arbitration fees of at least \$200 when they are named as respondents in no-fault collections arbitration.⁴² Hawaii splits no-fault arbitration fees equally between claimants and insurer-respondents "unless otherwise allocated by the arbitrator," which means that unless the insurer can demonstrate that a claim is completely without color, it will be saddled with at least half of the fees.⁴³

Insurers also can find themselves at a procedural disadvantage in states without compulsory no-fault arbitration, as local courts respond to clogged no-fault dockets by "leaning" on insurers to forego important discovery and settle their cases. One study from the Florida Insurance Consumer Advocate observed that tens of thousands of no-fault collections lawsuits had been filed against insurers in Florida county courts and that the number of suits appeared to be increasing exponentially.⁴⁴ In New York, where no-fault claimants have the option of resorting either to arbitration or to the courts, local judges have lamented the situation in their decisions. One New York City Civil Court judge opined that "the Legislature's current no-fault system

³⁹ *Id.*

⁴⁰ See MINN. NO-FAULT ARB. R. 39–40.

⁴¹ *Id.*

⁴² See N.J. NO-FAULT PIP ARB. R. 23–26 (2013).

⁴³ See HRS § 431:10C-213.

⁴⁴ See OFFICE OF THE INSURANCE CONSUMER ADVOCATE, REPORT ON FLORIDA MOTOR VEHICLE NO-FAULT INSURANCE 36 (2011).

threatens to engulf the state judiciary into a swamp of unresolved and tangled questions.”⁴⁵ Another made reference to the “overflowing dockets of no-fault first-party benefits cases” and called for the legislature to impose a solution.⁴⁶

In addition, some no-fault insurance states have what amount to preclusion rules, which effectively eliminate or restrict an insurer’s ability to contest a no-fault claim in a subsequent arbitration or lawsuit unless the insurer processes the claim within a relatively short time period. In New York, for example, there is a so-called “30-day rule,” which provides that most of an insurer’s defenses to a no-fault claim—including most defenses based on fraudulent misrepresentations by the healthcare provider–claimant—will be precluded if the insurer does not process the claim within 30 days.⁴⁷ In New Jersey, if an insurer precertifies treatment proposed by a healthcare provider—and insurers generally are required to handle precertification requests within a very short 72-hour time period—the insurer typically will be precluded from challenging a resulting claim based on lack of medical necessity unless the insurer can show that the precertification request involved fraud or misrepresentation.⁴⁸

⁴⁵ *Universal Acupuncture Pain Servs., P.C. v. Lumbermens Mut. Cas. Co.*, 195 Misc. 2d 352, 353 (N.Y. Civ. Ct. 2003).

⁴⁶ *Socrates Psychological Servs., P.C. v. Progressive Cas. Ins. Co.*, 7 Misc. 3d 642, 645, fn. 1 (N.Y. Civ. Ct. 2005).

⁴⁷ See, e.g., *Fair Price Med. Supply Corp. v. Travelers Indem. Co.*, 9 Misc. 3d 76, 78 (N.Y. App. Term 2005), *aff’d* *Fair Price Med. v. Travelers*, 42 A.D. 3d 277 (N.Y. App. Div. 2d Dep’t 2007), *aff’d* *Fair Price Med. Supply Corp. v. Travelers Indem. Co.*, 10 N.Y.3d 556 (N.Y. 2008) (“[A] defense based on a provider’s fraudulent scheme to obtain no-fault benefits is precluded by defendant’s untimely claim denial.”). It is, however, important to emphasize that while the “30-day rule” may preclude an insurer’s defenses to an allegedly fraudulent no-fault claim, it does not preclude a subsequent action by the insurer to recover fraudulently-obtained no-fault insurance benefits. See, e.g., *Fair Price Med. Supply Corp.*, 9 Misc. 3d at 79–80 (“[A]n insurer precluded from defending a claim based on provider fraud is not without remedy; after paying such a claim, the insurer, for example, may have an action to recover benefits paid under a theory of fraud or unjust enrichment . . . and it may seek criminal sanctions for insurance fraud and obtain restitution. . . .”); see also *Allstate Ins. Co. v. Mun.*, 751 F.3d 94, 101 (2d Cir. 2014) (“The weight of New York authority holds that the 30-day process . . . does not constrain later insurer actions seeking recovery for fraud.”).

⁴⁸ See N.J.A.C. 11:3-4.7(g).

The totality of these circumstances creates a powerful incentive for automobile insurers to pay no-fault claims as they are submitted, or to settle disputed claims before trial or before an arbitral process concludes, except in the relatively rare event that the insurer can obtain and present proof of fraud to the court or arbitrator. Because corrupt healthcare services providers are fully aware of these circumstances, they also create powerful, perverse incentives for no-fault insurance fraud.

All of this is not to say that insurers lack at least some means to investigate suspected fraud and to delay payment of suspect claims during the pendency of such investigations. Toward this end, automobile insurance companies generally maintain in-house investigators dedicated to ferreting out fraudulent claims.

In New York, for instance, automobile insurers generally are required by law to maintain “special investigations units” that are “responsible for investigating information on or cases of suspected fraudulent activity and for effectively implementing fraud prevention and reduction activities. . . .”⁴⁹ Kentucky, New Jersey, and Florida law impose similar requirements.⁵⁰ In Kansas, special investigation units (“SIUs”) are encouraged, but not required, inasmuch as automobile and other insurers are required to have “antifraud initiatives reasonably calculated to detect fraudulent insurance acts” that “may include” investigators.⁵¹ Along similar lines, Minnesota requires insurers to implement anti-fraud claims but does not specifically require SIUs.⁵² Pennsylvania requires automobile insurers to implement anti-fraud plans that include, among other things, specific procedures to “review claims in order to detect evidence of possible insurance fraud and to investigate claims where fraud is suspected.”⁵³

Whether or not state law requires anti-fraud plans in general or SIUs in particular, automobile insurers develop anti-fraud plans and employ investigators in every no-fault state. The required qualifications can vary considerably from state to state and from insurer to

⁴⁹ See N.Y. CLS INS. § 409.

⁵⁰ See KRS § 304.47-080; N.J.A.C. 11:16-6.4; FLA. STAT. § 626.9891.

⁵¹ See K.S.A. § 40-2,118.

⁵² See MINN. STAT. § 60A.954.

⁵³ See 75 PA. CONS. STAT. § 1812.

insurer, and even those states that impose specific requirements for members of insurer SIUs cast a fairly wide net.

In New York, for example, an individual may qualify as a special investigator if she has either (i) an associate's or bachelor's degree in criminal justice or related field, (ii) five years of insurance claims investigation experience or professional investigation experience with law enforcement agencies, or (iii) seven years of professional investigation experience involving economic or insurance-related matters.⁵⁴ In New Jersey, special investigators must have either: (i) a bachelor's degree, (ii) an associate's degree plus a minimum of two years' experience with insurance-related employment, (iii) a minimum of four years of experience with insurance-related employment, or (iv) a minimum of five years of law enforcement experience.⁵⁵ Kentucky does not impose any particular educational or experience requirements on special investigators, and Florida simply requires that insurers provide appropriate training to employees in their SIUs.⁵⁶

As a result, insurer SIU investigators can vary widely in background and—by extension—in investigative methodology. Many SIUs recruit personnel from other departments in the insurance companies, such as claims departments, where routine claims handling can give the employees an instinct for spotting fraudulent claims. Investigators with a claims background may use a data-driven, claims-handling approach to identifying fraud, for instance by tracking suspicious claims volume, billing for unusual types of healthcare services, and minor accidents that result in substantial medical billing. This type of investigator often is particularly strong in flushing out billing for medically unnecessary or illusory services.

Some SIUs seek out personnel with a law enforcement background, such as retired police officers. These types of investigators may take a “shoe-leather” approach that relies less on claims data and more on site visits to suspect healthcare practices, witness interviews, and the like. Investigators who take this approach may be strongest when dealing with frauds involving the illegal corporate structure or management of a healthcare practice, billing for healthcare services

⁵⁴ See N.Y. CLS Ins. § 409.

⁵⁵ See N.J.A.C. 11:16-6.4.

⁵⁶ See 806 KAR 47:030; 69D-2.003, F.A.C.

that never were provided in the first instance, staged-accident rings, and other types of schemes where the proof commonly is obtained by “boots on the ground.” Both types of investigators have their strengths, and—obviously—there are plenty of investigators who combine both approaches.

Though insurers maintain SIU departments, certain factors limit insurers’ ability to effectively investigate no-fault insurance fraud. The first and most obvious issue is that SIU investigators are not law enforcement officials. They cannot obtain search warrants and cannot issue subpoenas except through counsel in the context of some ongoing civil litigation. As such, SIU investigations generally are limited in their means to claims data analysis, site visits to suspicious health-care offices; witness interviews; review of publicly available information such as corporate documents, licenses, online databases, and the like. In addition, and as discussed above, most states enjoin insurers to handle claims in good faith and to refrain from treating claimants as adversaries. These provisions can seem to be in tension with the concomitant statutes requiring insurers to maintain SIU units and to investigate suspicions of fraud.

Oftentimes, insurers’ investigations of suspected no-fault insurance fraud rings are limited by a practical inability to share information with, and obtain information from, other insurance companies. There are many reasons why it is in the interests of insurance companies to cooperate with one another in investigating suspect health-care providers, yet there are equally compelling reasons why this does not always occur.

On the one hand, insurers may have suspicions regarding a healthcare provider’s billing but lack the “complete picture” necessary to plead a viable complaint. For instance, if an insurer has only 25 percent of the market in a given state, yet routinely receives billing for five or six hours of healthcare services per day from a single chiropractor in that state, it is a fair bet that the chiropractor is billing for services he is not actually providing. This is because, if the insurer has only 25 percent of the market, there is reason to expect that the five or six hours of chiropractic services billed to that insurer by a single chiropractor per day represents only 25 percent of the overall billing that the chiropractor submits per day to every insurance company in the market. Obviously, the chiropractor is not working 20 to 24 hours per day. Even so, it is at least possible—if not plausible—that the suspicious chiropractor only treats customers of a single insurer on any

given day. In order to prove otherwise, the insurers within the market should have a way to compare notes.

Along similar lines, an insurer may notice that a suspicious physiatrist routinely submits billing for range-of-motion tests that report identical test data across 15 percent of her patients. These identical data, while improbable, are not necessarily impossible. However, if the insurer could demonstrate that other insurance companies likewise received a critical mass of billing from the same physiatrist that reported the same identical test data, its case against the physiatrist would be substantially stronger. In order to do so, the insurers would—again—have to compare notes.

In some cases, an insurer may investigate a fraudulent health-care provider and leverage the results of its investigation to obtain a release of the provider's claims. However, because the investigation and consequent release are insurer specific, the provider is able to continue to defraud other insurers within the market who are unaware of the fraud. In this context, inter-insurer investigative cooperation could put the fraudulent provider out of the fraud business across the board.

Even so, there are a number of reasons why such cooperation can be elusive. As discussed above, many SIU departments recruit from within their insurance companies, oftentimes from claims departments. As a result, SIU investigators may have a long tenure with a single company and, by extension, may lack extensive contacts in SIU departments at other companies. While inter-insurer SIU conferences provide some opportunity for information sharing, such conferences occur infrequently. Even if they occurred with greater regularity, the opportunities to develop productive cooperative relationships at such events is rather limited—not least because such cooperation can require corporate approval, which can take time and resources to obtain, to the extent that it can be obtained at all.

Moreover, insurers understandably may be reluctant to share the results of their investigations with their competitors, especially if they anticipate that the investigation could lead to litigation against a suspicious healthcare provider. The insurer that is first to file a lawsuit to recover fraudulently obtained no-fault insurance benefits generally will be in the best position to actually recoup money. Conversely, insurers that file later may find that the well has run dry because the provider has gone out of business, secreted or dissipated its ill-gotten gains, and so forth.

One way in which insurers share investigative information is through the National Insurance Crime Bureau (NICB). The NICB is a not-for-profit organization with a membership that includes virtually every major property and casualty insurance company in the United States, and its stated mission is to “lead a united effort of insurers, law enforcement agencies and representatives of the public to prevent and combat insurance fraud and crime through data analytics, investigations, training, legislative advocacy and public awareness.”⁵⁷ Formed in 1992 from a merger of the National Automobile Theft Bureau, which helped insurers investigate vehicle thefts, and the Insurance Crime Prevention Institute, which investigated various types of insurance fraud, the NICB performs a number of useful services for insurers. These services include gathering information regarding suspicious claims, analyzing the data, and issuing bulletins to the NICB’s constituent insurer-members. Since the NICB obtains much of its information regarding suspicious claims from its insurer-members and then shares the information across its membership, the organization can serve as a kind of networking platform for SIU investigators and claims departments.

While the NICB serves a useful function, it may not be able to provide the sort of specific information that would permit an insurer to actually plead a complaint, let alone the kind of complaint that would meet the heightened fraud-pleading requirements. For example, insurers that have developed truly valuable evidence of fraud through their in-house SIU investigations may prefer not to share it.

Different varieties of no-fault insurance fraud—like any fraud—evolve over time; nonetheless, they can be broken down into their most prevalent current forms. These include, on the broadest level, claims containing misrepresentations as to the corporate structure or legitimacy of the healthcare provider-claimant, claims containing misrepresentations regarding the medical necessity of the pertinent services, claims containing misrepresentations as to whether the pertinent services were provided in the first instance, and claims that misrepresent the reimbursement to which a healthcare provider is entitled in connection with a given service.

⁵⁷ See National Insurance Crime Bureau, *Vision and Mission* (March 6, 2017), https://www.nicb.org/about-nicb/vision_and_mission.