Insurers Gain 2 New Weapons in Fight Against Fraud

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On January 1, 1993, the Illinois Legislature enacted one of the most comprehensive and far reaching insurance fraud statutes in the United States thereby expressing its intention of eliminating the State of Illinois as a "safe harbor" for perpetrators of staged or inflated property or bodily injury claims. The statute expanded the traditional focus on arson for profit schemes and staged accident rings by imposing criminal penalties for the submission of a false claim on "any policy of insurance" thereby including fraudulent bodily injury, workers compensation, disability, life and homeowner's claims.

The statute provides that a person commits the crime of insurance fraud when he or she "knowingly obtains, attempts to obtain, or causes to be obtained, by deception, control over the property of an insurance company. . . by the making of a false claim or by causing a false claim to be made. . .". The statute provides an array of criminal penalties ranging from a Class A Misdemeanor (when the value of the property involved is $300.00 or less) to a Class I Felony (when the amount exceeds $100,000.00). The statute also provides for the crime of aggravated insurance fraud based on the submission of three or more false claims arising from separate incidents during an 18 month period. Aggravated insurance fraud is deemed a Class I Felony regardless of the amounts involved in each of the three claims.

Of particular interest to insurance defense practitioners, the statute not only set forth criminal penalties for insurance fraud, it also created a civil cause of action on behalf of the victim. Section 5/46-5 creates a civil cause of action in favor of the insurer or self-insured entity that paid the claim or against whom the claim was made in an amount equivalent to three times the amount wrongfully obtained or twice the value of the attempted fraud. The statute also provides for the recovery of attorney's fees incurred in pursuing the action. In an attempt to ensure that only meritorious actions are pursued, the statute also provides that an insurer who brings an action under the statute in bad faith shall be liable to that person for twice the value of the property claimed plus reasonable attorney's fees. Of some interest, the statute specifically provides that in making a determination as to whether the insurer acted in bad faith, the court shall "relax the rules of evidence to allow for the introduction of any facts or relevant information on which the insurance company or self-insured entity may have relied on bringing an action. . .". As such, an insurer who brings an action under the statute and does not prevail, is <u>not</u> automatically liable to the defendant. Rather, the trial court may examine the totality of the circumstances, including evidence which would not ordinarily be admissible at trial. Therefore the standard of review undertaken by the trial court under the insurance fraud statute is closely analogous to the bad faith analysis which a trial court must undertake under Section 155 of the Illinois Insurance Code which governs the imposition of extra-contractual damages which may be imposed on an insurer who unreasonably or vexatiously delays or denies a claim.

Since 1993, the statute has been used consistently and effectively by the insurance industry not only to seek recovery from individuals who have attempted or committed insurance fraud and has also provided a tremendous deterrent effect, not only in the initial submission of fraudulent

claims, but in their continued pursuit in litigation following denial. Although this aspect of the statute is not susceptible to specific quantification, any practicing insurance defense attorney who routinely encounters or defends fraudulent claims is well aware of the significant prophylactic effect which even the specter of an action under the statute provides.

We are pleased to note, therefore, that effective January 1, 2000, the Insurance Fraud Act has been amended in at least two significant ways which will broaden its scope and impact. The amended statute (Public Act 91-232) now contains two sections, 720 ILCS 5/46-5,6 which provides as follows:

> (5) "False claim" means any statement made to any insurer, purported insurer, servicing corporation, insurance broker, or insurance agent, or any agent or employee of the entities, and made as part of, or in support of, a claim for payment or other benefit under a policy of insurance, or as part of, or in support of, an application for the issuance of, or the rating of, any insurance policy, when the statement contains any false, incomplete, or misleading information concerning any fact or thing material to the claim, or conceals the occurrence of an event that is material to any person's initial or continued right or entitlement to any insurance benefit or payment, or the amount of any benefit or payment to which the person is entitled.
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> (6) "Statement" means any assertion, oral, written, or otherwise, and includes, but is not limited to, any notice, letter, or memorandum; proof of loss; bill of lading; receipt for payment; invoice, account or other financial statement; estimate of property damage; bill for services; diagnosis or prognosis; prescription; hospital, medical or dental chart or other record, x-ray, photograph, videotape, pr movie film; test result; other evidence of loss, injury, or expense; computer-generated document; and data in any form.

Section 5 of the amended act is significant in that it further defines a false claim as any statement made to an insurer, servicing corporation, insurance broker or insurance agent in connection with the submission of a claim and significantly, in the application for the issuance of, or rating of, any insurance policy. As such, the act now gives rise to a civil cause of action based upon material misrepresentations contained in an application for any type of insurance, a remedy previously unavailable to the industry. This provision will have particular relevance to health and disability policies in which prospective insureds frequently misrepresent the current state of their health or conceal a serious pre-existing condition solely for purposes of obtaining coverage. Most health and disability policies contain contestability periods (typically one to two years) during which time the misrepresentations in the application must be discovered. Prior to the enactment of the Insurance Fraud Act, the only real remedy available to the insurer who discovers the fraud was to rescind the policy and refund the premiums paid. This resulted in a crap shoot in which insureds suffering from a serious health problem or a preexisting condition had little, if anything, to lose, by submitting a fraudulent application for health or disability coverage. The new Act will provide a significant weapon to the industry in combating this type of activity. It will also provide a remedy to homeowners and auto carriers who are misled into issuing a policy or calculating a premium based

upon material misrepresentations made by an insured including his or her prior claim history, true place of residency, or the status of the occupancy of a piece of property.

The second significant amendment is found in Section 6 which further defines the word "statement" in connection with the submission of an insurance claim. Of particular interest, the word statement has now been specifically defined to include correspondence, proofs of loss, financial statements, damage estimates, bills for services rendered, statements relating to diagnosis or prognosis, hospital and medical records, x-rays or "other evidence of loss, injury or expense." This expanded definition of the word "statement" sends a clear and unequivocal message to not only the attorneys and claimants who are actively participating in staged or inflated third party bodily injury claims but also to those physicians, chiropractors, x-ray labs, or other medical facilities who assist in the presentation of those claims by preparing medical reports and bills relating to fictitious or exaggerated injuries and treatment.

The amended Insurance Fraud Act manifests the intention of the Illinois legislature to eradicate every form of insurance fraud in every possible context both before and after the submission of a false or exaggerated claim. Therefore, and as we begin the new Millennium, the amended Act offers a powerful tool to the insurance industry, provided the industry continues and, hopefully, redoubles, its commitment to uncovering and defending fraudulent claims, and, under the new Act; affirmatively attacking the perpetrators of that fraud.

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