

Take the Money and Run: The Fraud Crisis In New York's No-Fault System

BY ROBERT A. STERN

When New York's "No-fault"¹ auto insurance law took effect in 1973, the objective was to speed the handling of claims. Today, the process is afflicted by extensive fraud and abuse.

The effects go beyond the impact on insurance premiums and the payment of claims for injuries in automobile accidents. Healthcare dollars are being diverted from more productive uses, and the already scarce resources of the court system are being burdened with litigation gamesmanship designed to extract unwarranted cash settlements.

The No-fault Law allows policyholders and others who sustain injuries in automobile accidents to be compensated by a policyholder's automobile insurance company for basic economic loss, which consists of lost wages and reasonable and necessary medical expenses, generally subject to a maximum of \$50,000 per person.² Reimbursement for reasonable and necessary medical expenses includes examinations, treatments, tests and medical equipment provided or ordered by properly licensed healthcare providers. Under the No-fault Law, licensed healthcare providers are allowed to accept assignments from their patients and bill insurance companies directly for their services.

The intent of the No-fault Law was to provide a tradeoff: prompt first-party insurance benefits (*i.e.*, reimbursement of basic economic loss to eligible injured persons or covered persons) in exchange for a limit on the right to sue in tort for non-serious injuries.³ In accepting the derogation of their common law right to sue, parties injured in automobile accidents were promised prompt reimbursement of lost wages and reasonable and necessary medical expenses.

When enacted, the No-fault Law championed two simple and laudable objectives. First, provide quick compensation to injured parties, regardless of fault. Second, reduce the strain on the tort system and judiciary by limiting the ability to sue to only those cases involving serious injuries.⁴

While there might be debate about whether the No-fault Law ever achieved its objectives, today one thing is

clear: it is a system that lends itself to fraud and abuse on an unprecedented scale. The majority of providers are legitimate healthcare professionals supplying valuable services to injured people, but today's no-fault system has been infiltrated by organized crime and by criminals masquerading as healthcare providers. In recent years, local, state and federal agencies have announced arrests and prosecutions of no-fault insurance fraud rings on an alarmingly routine basis.⁵

The commitment of significantly greater law enforcement resources to the investigation and prosecution of insurance fraud is an important and welcome development, but the funding that law enforcement needs to eradicate a systemic problem that threatens the financial basis for the no-fault system still falls short of the mark. If meaningful reform of the No-fault Law and additional anti-fraud funding are not provided, more insurers will be likely to withdraw coverage from the state, leaving consumers with fewer competitive choices for their insurance.

Such a problem was encountered in New Jersey in the late 1990s, when State Farm Insurance left the state because of the rising cost of fraud, and others threatened to follow. As a result, New Jersey enacted significant insurance fraud measures, including pre-certifica-



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The author wishes to acknowledge that many legitimate medical providers and reputable law firms are providing valuable services under the No-fault Law.

tion of medical services and the creation of an insurance fraud prosecutor's office. These and other measures led to significantly reduced insurance fraud in that state, resulting in lower automobile insurance premiums for its residents.

The No-fault Law Today

The legislators who enacted the no-fault system in New York in 1973 would be shocked at what has become of the law. They could hardly have imagined that a consumer-driven statute with important public policy goals would become the conduit by which organized crime would launder money through sham professional corporations or medical mills.⁶

Licensed doctors now sell their names and licenses to lay individuals for a fee, thereby allowing the lay individuals, who are unlicensed and not authorized to own professional corporations in New York State, to assume ownership in violation of Article 15 of the Business Corporation Law.⁷ The sole purpose of these sham professional corporations and/or medical mills is to fraudulently bill insurance companies for services that were medically unnecessary and/or never rendered.

In turn, these corporations and medical mills (so-called "clinics") have created an insatiable demand for a patient population, as well as for runners who satisfy that demand by paying individuals for participating in staged or paper accidents. Clinics pay the runners as much as \$2,000 per individual for each referral. Participants in the staged and paper accidents are referred to the clinics for a fee paid by the runner, often between \$400 and \$800, and undergo treatment for injuries they did not suffer, because the accidents in which they sustained their "injuries" never happened. These individuals are also offered the prospect of a monetary settlement from their personal injury claim pursued by attorneys, many of whom were assigned to them by the clinics to which they were referred by the runner.

Claimants who were involved in actual accidents but were not injured are also contacted by runners and referred to no-fault clinics, with the promise of money through a personal injury claim in which legal representation would be provided through a referral from their provider.

The clinics create fictitious reports and generate boilerplate narratives. The services for which they bill insurers often do not vary from patient to patient, or reflect any changes in the patient's condition. Their billing

procedures exploit the no-fault process and drain the maximum amount of dollars from insurance companies for every patient, regardless of whether treatment was required.⁸ Through the use of runners providing a steady flow of patients, the owners of these medical mills are able to engage in a systematic, fraudulent billing scheme premised on their ability to pass millions of dollars through illegally created professional corporations. In the realm of no-fault, the profession of medicine has frequently been converted to the illegitimate business of medicine.

The surreal world of no-fault today is the primary cause of escalating automobile insurance premiums. The Coalition Against Insurance Fraud has estimated that New York residents pay an additional \$75 to \$115 in

automobile premiums to cover losses attributable to insurance fraud. Other insurance industry estimates place the cost to consumers as high as \$400 each year per premium.⁹ In 2001, New York ranked second highest in the nation in automobile premiums,¹⁰ the primary cause of which is the escalating cost of insurance fraud. Between 1995 and 2000, the average no-fault claim increased by more than 63%, including an increase of 32% in 2001.¹¹ The number of no-fault claims filed in New York State in 2000 rose twice as fast as in Florida, the next highest state in Personal Injury Protection (PIP) claim occurrence.¹² The average no-fault claim in New York State is now 47% higher than the national average.¹³ All told, the New York State Insurance Department and the insurance committees in both the New York State Senate and Assembly each estimate that no-fault insurance fraud is costing New York State consumers in excess of \$1 billion a year.¹⁴

Effect on Healthcare Resources

No-fault insurance fraud schemes also deplete the limited healthcare resources that are already under strain to meet legitimate healthcare needs.

Sham professional corporations deprive certain communities of access to legitimate doctors, because healthcare professionals will not establish businesses in locations where they believe the marketplace may already be overcrowded. Consequently, fraud in the no-fault system subjects patients to treatment by non-physicians, disguised as medical doctors, who are simply seeking to profit from a system designed to protect consumers. Furthermore, the very schemes that bring patients into the clinics through staged accidents compromise street and highway safety, exposing innocent, unsuspecting individuals to potentially life-threatening conditions.¹⁵

Exploitation of the No-fault Law is diminishing the resources of the judiciary, particularly the Civil and District Courts in New York City and Long Island.

Even the claimants who participate can become victims of their own fraud. "Patients" from staged and paper accidents are often subjected to unnecessary diagnostic testing and "treatment" performed without regard to the risks involved. To the extent that services are provided at all, these "patients" are unnecessarily exposed to radiation for x-rays and video fluoroscopy, in which the ionization-producing equipment that is used may not be properly licensed, registered or maintained, and the testing may not be administered by a properly licensed and/or trained healthcare professional. These tests and others, including nerve conduction velocity tests and electromyography (EMG), are all expensive diagnostic procedures that expose the patients to unnecessary invasive and potentially dangerous procedures conducted on a routine basis for no reason other than pecuniary benefit.

Effect on the Courts

Exploitation of the No-fault Law is diminishing the resources of the judiciary, particularly the Civil and District Courts in New York City and Long Island, where the vast majority of no-fault suits are filed in downstate New York.

Such actions, which are filed under the mandatory Personal Injury Protection endorsements required under New York's No-fault Law, are commonly referred to as PIP suits. Under the No-fault Law and implementing regulations, a provider who disputes the denial of its claim by an insurer has the option to file for arbitration or commence an action contesting the denial.¹⁶

Recent statistical trends involving PIP litigation reveal that the courts have increasingly become the forum of choice for no-fault clinics.¹⁷ Between 1999 and 2002, arbitrations and court actions reversed places in the volume of cases filed. During this period, filings for arbitrations remained relatively steady,¹⁸ while PIP lawsuit filings increased, eclipsing arbitrations in the number of cases filed each year. The fact that arbitrations have remained constant while PIP suits have increased points to a conclusion that PIP litigation in general is spiraling out of control.

The explanation can be attributed to a reversal of fortune. Before 1999, providers generally preferred to file for arbitration because it provided a more efficient and speedier dispute resolution process than the courts. More important, they stood a better chance of winning. Over time, an increasing number of arbitrators became aware of some of the more common patterns of fraud and abuse in the claims that the clinics were presenting, and they began to rule against them with greater frequency. As arbitration became a less hospitable environment for fraudulent claims, the no-fault clinics turned to the courts.

With the shift to court filings, however, the clinics had to deploy new litigation tactics to hasten the process of securing a judgment as quickly as they once obtained awards through arbitration. Indeed, for many clinics, no-fault is a volume business, predicated on billing and collecting. If collections lag, there is a resulting inability to pay kickbacks to the various associated providers, runners and others involved in fraudulent schemes.

Adapting quickly to the new environment, the no-fault clinics retained counsel with sophisticated tickler and computer systems that positioned them to take a default judgment on the 30th day that an answer was due. In any other area of litigation, it is unusual for a plaintiff to immediately take a default judgment against a large company, such as an automobile insurer. Plaintiffs generally prefer to deal with the defendant on the merits rather than waste time arguing a motion to vacate a default judgment that is almost invariably granted. In the no-fault arena, however, the paradigm shifts, and no-fault stands apart from any other area of practice.

Another tactic used to hinder insurers from timely filing answers involves serving hundreds of complaints at a time, all of which need to be identified by the insurer, routed to the appropriate claims processing unit, logged into a system and forwarded to the insurer's counsel to serve an answer and defend. If the insurer is unable to do this within 30 days, the clinics file papers seeking default judgments.¹⁹

Filing for a default judgment on the 30th day brings the clinics closer to their ultimate goal of collecting money. The taking of a default judgment often represents the first of three occasions during litigation when many no-fault clinics attempt to force a settlement. Because many judgments are for nominal amounts, ranging from a few hundred to a few thousand dollars, the clinics believe that the insurers will advise their counsel to settle rather than incur the costs associating with filing a motion to vacate the default judgment.²⁰

Next, if the insurer does not settle and successfully moves to vacate the default judgment, a number of clinics will file a motion for summary judgment, regardless of the merits of the litigation. The gamble and hope is that the insurer will instruct counsel to settle, as opposed to having to draw up and submit opposition papers to defeat the motion.

Finally, if the insurer successfully opposes the motion for summary judgment, counsel for a number of clinics will file a notice of trial, even if outstanding discovery remains. In doing so, they falsely certify that all discovery has been completed when in fact it has not. The gamble is that the insurer will instruct its counsel to settle, as opposed to authorizing counsel to file a motion to strike and seek sanctions for such wrongful filings.

In their haste to force settlements, some lawyers file many notices of trial at once wherein they make the same false certification concerning the completion of discovery, even though they have no intention of trying the case when it first appears on the trial calendar. In the process, court dockets are inundated with so many of these cases that they begin to seem like No-fault Parts. Even in situations where motions to strike are filed by counsel for an insurer, many judges are so overwhelmed with no-fault cases that they do not take the measures necessary to deter the improper filings, such as awarding costs and sanctions.

In yet another abusive tactic, some law firms send what they denominate in correspondence to insurers as "courtesy copies" of complaints that they purportedly will serve if the matter is not settled within 30 days. Notwithstanding the fact that the summons and complaint have not been properly served, the same law firms file papers for default judgments based on the "courtesy copies" they sent to the insurer, in the hope that the insurer will settle rather than move to vacate and dismiss based on lack of personal jurisdiction.

The litigation tactics of the clinics' lawyers are intended to overwhelm the insurers through the filing of complaints, the taking of default judgments, the filing of motions for summary judgment, regardless of merit, and having matters placed on the trial calendar as soon as possible through the false filings of certificates of readiness. By doing so, the clinics try to extort settlements and speed up collections, something that they once were able to do more easily through arbitration.

On a daily basis, the Civil and District Court dockets are overloaded with PIP matters. PIP litigation is exploding, and the courts do not have the resources or time to deal with the influx of cases involving nominal amounts, particularly if the insurers are intent on defending the claims based on fraud.

In encountering such resistance, insurers find themselves in a paradox. Article 4 of the Insurance Law requires the insurers to investigate and report suspected fraudulent claims to the Insurance Department. The Insurance Department's Regulation 95²¹ requires insurers to maintain special investigative units with the mandate to investigate suspect claims. Article 4 of the Insurance Law and Regulation 95 were implemented in recognition of the spiraling costs of insurance fraud and the impact it has on consumers and the economy due to rising premiums.

The fraud problem confronting the no-fault system has been acknowledged by insurance regulators and is supported by overwhelming statistical evidence.

In attempting to fulfill their mandate, however, insurers are confronted with courts that cannot afford to allow each case to proceed to trial, let alone decide each and every motion that is filed. Accordingly, each time a case is forced on the court's calendar by the provider, the courts prefer to see the parties settle as opposed to having to decide a motion, even if false representations were made by providers and their lawyers in the process.

Ironically, insurance companies provide the perfect foil for the schemes that have permeated the no-fault system, because the companies are widely perceived as monolithic and unsympathetic big businesses. As a consequence, insurers are unable to garner meaningful

support for legislative reform, or to persuade the courts of the magnitude of the problem. Moreover, in this "Alice in Wonderland" world that is the no-fault system, no-fault providers and their lawyers are perceived as the ones championing the rights of the consumer. In no-fault, however, where many personal injury claims are made and settled pre-suit, fraud and abuse are often the outcome being championed by the providers and the claimants.

The fraud problem confronting the no-fault system has been acknowledged by insurance regulators and is supported by overwhelming statistical evidence. It has become too costly to everyone for it to continue to be ignored by the legislature and the courts.

Potential Remedies

Problems with the no-fault system that require attention include the relaxation, if not overturning, of the Court of Appeals' decision in *Presbyterian Hospital v. Maryland Casualty*,²² wherein the Court held that, in the absence of a timely denial, insurers were precluded from contesting the medical necessity of billed-for services. Since that 1997 ruling, many lower courts have misinterpreted *Presbyterian*, resulting in the 30-day rule being used as both a sword and a shield by fraudulent and sham professional corporations.

To ease the strain on the courts and return no-fault to the speedy dispute resolution that it originally promised, one possible solution is to require compulsory arbitration. Currently Insurance Law § 5106(b) provides claimants and their assignees with the unilateral option to choose whether to submit a disputed claim to binding arbitration or commence an action in court.

Any attempt to make arbitration of no-fault disputes compulsory for all parties, not just insurance companies, is likely to be met with constitutional challenges by

the plaintiff's bar. Importantly, however, compulsory arbitration would be limited to resolving disputes of first-party no-fault claims; third-party bodily injury claims could still be litigated in the courts. As such, the expeditious resolution of no-fault disputes through the no-fault system would fulfill the original intent of the No-fault Law – prompt payment of claims and dispute resolution. Moreover, because the current no-fault arbitration mechanism is considered to be compulsory, any due process concerns will similarly require the courts to exercise a broader scope of review than in cases of consensual arbitration.²³ As such, appropriate safeguards will be in place to ensure that the arbitration awards are, among other things, supported by the evidence and rationally based.²⁴

Alternatively, if appropriate amendments are made to the No-fault Law, the Department of Insurance could amend the PIP endorsements to allow insurers to include a provision for mandatory arbitration in their automobile insurance contracts. To avoid any ambiguity that the endorsements apply to healthcare providers who accept assignments, the assignment of benefit forms promulgated by the Department of Insurance can also be amended to include the provision that the assignment is subject to all terms and conditions of the policy of insurance, including the submission of any disputes to arbitration. If such a provision is included in the insurance policies, the parties will have contractually and consensually agreed to arbitrate any and all no-fault disputes. Accordingly, the courts should deem the arbitration provisions consensual and therefore withstand any challenges to their enforceability.

Whether no-fault reform is accomplished by statute, regulation, contract changes or any combination thereof, the need to overhaul the system is clear.

Compulsory arbitration, with experienced, knowledgeable and fair arbitrators, provides one important way to ensure that fraudulent claims are denied payment. Such arbitrators, with specialized training, would be able to commit the time and resources necessary to hear arguments relating to contested claims, something the courts are not equipped to do at this time. Moreover, the public will benefit from a system that efficiently processes meritorious claims and roots out those grounded in fraud. Compulsory arbitration will also free the courts to attend to the needs of other more pressing litigations. Similarly, compulsory arbitration would also reduce the litigation costs associated with disputed no-fault claims, thereby reducing insurance premiums.

In the absence of mandatory arbitration, the legislature could amend the Civil and District Court Acts to require that PIP suits be commenced by the filing of the summons and complaint or summons with notice with

the clerk of the court, as is required in the Supreme and County Courts.²⁵ Currently, PIP suits under the monetary jurisdiction threshold of \$25,000 and \$15,000²⁶ are filed in the Civil or District Courts of New York, respectively, and commenced by service.²⁷

In addition, to promote the voluntary filing of arbitrations, the legislature could remove the incentive for filing lawsuits by limiting the right of the claimant to recover attorneys' fees and interest only in arbitration.²⁸ At present, the right to recover such penalties is available to the claimant who seeks dispute resolution in either forum.

Conclusion

As currently constituted, New York's no-fault system lends itself to fraud and abuse. Where it once provided meaningful, affordable coverage to consumers, no-fault often exists today as a cash cow being milked by certain greedy and nefarious medical providers. No-fault reform would accomplish important public policy objectives.

Compulsory arbitration would represent one such reform. Other reform measures would include allowing insurers to assert defenses beyond the 30-day rule on claims based on fraud, and new anti-fraud laws.

1. The "Comprehensive Motor Vehicle Insurance Reparations Act," enacted by the New York Legislature in 1973.
2. Under the No-fault Law and implementing regulations promulgated by the Department of Insurance, an insured has the option of increasing the amount of basic economic loss coverage. See 11 N.Y.C.R.R. §§ 65-3 *et seq.*
3. See *Montgomery v. Daniels*, 38 N.Y.2d 41, 378 N.Y.S.2d 1 (1975) (upholding the constitutionality of the No-fault Law and discussing the legislative history and reasons for its enactment).
4. See *id.* at 46.
5. See Department of Insurance Web site, at <http://www.ins.state.ny.us/news1.htm> (containing press releases announcing numerous no-fault insurance fraud-related arrests).

See also Suffolk Cty. Dist. Att'y Office, Press Release, August 2003 (85 individuals, including medical providers, attorneys and runners indicted in a massive insurance fraud bust, with the District Attorney indicating that nearly 500 additional related arrests are expected to be announced in the future); N.Y. Dist. Att'y Office, Press Release, Feb. 26, 2003 (attorneys indicted for participation in insurance fraud scam, illegal fee-splitting and violations of the anti-kickback statute); 68 *Reportedly Stolen Vehicles Worth \$1.6 Million Recovered in 26-month Undercover Insurance Fraud Sting Operation; Thirty Individuals Charged Including Owners Who Allegedly Falsely Reported That Their Cars Had Been Stolen in Order to Get Large Insurance Settlements and Middlemen Who Allegedly Sold the Cars to Undercover Detectives Posing as Junkyard Dealers*, Queens Dist. Att'y Office, Press Release, March 12, 2002; *Sting Operation Implicates Health Care Providers at Two Bronx Clinics in Scam to Cheat Auto Insurance Companies*, Bronx Dist. Att'y Office, Press Release, March 7, 2002 (healthcare providers

