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SUPREME COURT OF TEXAS
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Case No. 15-0426

IN THE SUPREME COURT OF TEXAS

ALLSTATE INSURANCE COMPANY, ALLSTATE INDEMNITY COMPANY, ALLSTATE PROPERTY & CASUALTY INSURANCE COMPANY, ALLSTATE COUNTY MUTUAL INSURANCE COMPANY, and ALLSTATE FIRE & CASUALTY INSURANCE COMPANY, *Petitioners*

v.

REHAB ALLIANCE OF TEXAS, INC. d/b/a STEEPLECHASE FAMILY HEALTHCARE AND STEEPLECHASE PAIN MANAGEMENT & SURGICAL ASSOCIATES, SHEILA SMITH f/k/a SHEILA GOYER, DENNIS SMITH, D.C., THE DIAGNOSTIC & INJURY CENTER OF HOUSTON, L.L.C., and IHSAN SHANTI, M.D., *Respondents*

On Petition for Review from the Fourteenth Court of Appeals – Houston

Cause No. 14-13-00459-CV

BRIEF OF AMICUS CURIAE COALITION AGAINST INSURANCE FRAUD IN SUPPORT OF PETITIONER'S BRIEF ON THE MERITS

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INTERESTS OF AMICUS CURIAE

Since 1993, the Coalition Against Insurance Fraud has advanced the interests of consumers, insurers, and government agencies alike in combating fraud. The Coalition is the only anti-fraud alliance in the country uniting, defending and empowering the interests of these diverse groups. The Coalition's outreach is wide-ranging, consisting of information, research, data and service as a leading voice in the anti-fraud community. This ongoing mission includes identifying court cases such as the instant case which present opportunities to strike back against fraud.

This case presents the Texas Supreme Court with a compelling opportunity to allow insurers to protect their policyholders and the general public by allowing them to respond and adapt to increasingly sophisticated fraudulent practices by certain healthcare providers. The issues at stake go far beyond the measure of damages sought by Petitioner Allstate. Healthcare fraud is a major problem in Texas and across the nation, costing society and policyholders tens of billions of dollars. Families pay hundreds of additional dollars each year to cover these costs. Rampant fraud can put the cost of insurance out of reach for many policyholders and discourages insurers from expanding the availability of insurance products.

Additionally, such fraud damages the quality of medical service available to the injured in Texas. Insurers are unable to promptly process claims because

further investigation is needed. Claimants cannot receive proper medical care because their medical providers are more focused on turning a profit than treating injuries. There is evidence medical providers who defraud also cut corners on the quality of care. Medical providers who commit fraud are more likely to over-treat and cause patient harm.

Allowing medical providers to submit fraudulent claims with impunity creates a culture of fraud. It not only entices existing medical providers to defraud, but encourages criminal elements to move into Texas to set up operations.

Petitioner paid 107 claims over the span of four years for claimants who received treatment from a single medical provider who submitted fraudulent claims. Extrapolating those numbers to other insurers in Texas, one can readily envision the number of fraudulent claims rapidly increasing unless something is done. This case presents this Honorable Court with an important opportunity to reverse this tide and protect the citizens of Texas.

As medical providers become more sophisticated in adapting and insulating themselves against fraud-prevention measures, the nature of the fraud committed will become less visible and less detectable, yet be more widespread. This so-called "soft fraud" is particularly insidious because, by its very nature, it is difficult to detect and its damages difficult to prove. For this self-same reason, this

Honorable Court should send this case back to the lower court to allow the Petitioner to present its evidence of fraud by Respondents, Rehab Alliance et al.

The Coalition Against Insurance Fraud hereby states that it is paying its own fees and costs associated with the preparation and filing of this Brief and, pursuant to Tex. R. App. P. 11(c), none of the parties in this case will contribute to paying the fees or costs for this Brief.

STATEMENT OF CASE

The Coalition Against Insurance Fraud agrees with the Statement of Case set forth in Petitioners' Brief on the Merits.

STATEMENT OF JURISDICTION

The Coalition Against Insurance Fraud agrees with the Statement of Jurisdiction set forth in Petitioners' Brief on the Merits.

ISSUES PRESENTED

The Coalition Against Insurance Fraud agrees with the Issues Presented as set forth in Petitioners' Brief on the Merits.

STATEMENT OF FACTS

The Coalition Against Insurance Fraud agrees with the Statement of Facts set forth in Petitioners' Brief on the Merits.

SUMMARY OF ARGUMENT

The summary judgment against Petitioner should be reversed because Respondents were fraudulently enriched by their actions in inflating the cost of medical treatment charged to bodily injury insurers, such as Petitioner. Allowing the trial court's summary judgment to stand effectively rewards Respondents' efforts in manipulating the system and concealing fraud.

ARGUMENT

This case presents a major challenge faced by insurers both in Texas and all around the country. The summary judgment granted by the lower court, if allowed to stand, will deprive insurers of the ability to prove fraud in recovery litigation. The lower court's decision was predicated on the fact that there was no evidence of actual legal injury through fraud, because of the inability to separate what was paid through fraudulent claims from what was or would have been paid for legitimate treatment. This will deny insurers true recourse in civil courts against fraudulent activity, such as that undertaken by Respondents in this case. Insurers are placed in an impossible situation. They are forced to prove hypotheticals to recover when the very nature of the fraud committed is designed to make it undetectable. Fraudulent activity of the kind found in this case calls the entire value of the claim into question. When fraud is detected, insurers should be able to recover the full value of the claims paid.

Otherwise, the only winners are those parties who will continue perpetuating insurance fraud. Insurers and their policyholders alike will continue to pay the price of unchecked insurance fraud.

Respondents deliberately seized upon actual injury claims by claimants to significantly and artificially inflate the amounts charged to Petitioner. Respondents' actions included unnecessary treatment, miscoded treatment, misrepresentations about who was performing services, and whether claimants were financially responsible for this treatment. These actions, pursuant to Texas law regarding damages, renders all of the amounts paid fraudulent, and should make the full value recoverable. This activity was solely designed to take what once may have been a legitimate claim, and instead inflate and distort it into an opportunity to defraud insurers through buildup of medical charges incurred.

Respondents' conduct is designed to be difficult to detect and quantify. Consequently, Respondents prevailed on a motion for summary judgment at the trial court level. The Coalition Against Insurance Fraud believes these issues should be argued at trial and submits this brief in support of Petitioner to address the following issues before the Court:

A. Respondents engaged in fraudulent practices, resulting in actual damages to Allstate. A decision in favor of Respondents will embolden medical providers to engage in similar behavior and thwart anti-fraud efforts in Texas.

Respondents, in their opposition to Petitioner's Motion for Rehearing, at no

point denied they engaged in fraudulent and unlawful conduct. Rather, they sought to misdirect the attention of the Court by underplaying the consequences of their behavior. Respondents stated, "[this] is not a case involving allegations of staged accidents, faked symptoms and injuries or billing for treatment where no treatment was provided." Respondents' Motion for Rehearing at 2, n. 1. Rather, it is a case where "Allstate contends the Respondents' medical records contained misrepresentations." *Id*. Respondents dismissively concluded, "this case does not involve the type of allegations that one may expect where one of the largest and most sophisticated insurance companies in the United States sues a group of local healthcare providers." *Id*. Respondents sought to justify their fraudulent activity on the grounds it does not resemble fraud schemes prevalent in the past.

This is the exact reason the lower court's decision should be reversed and this case allowed to proceed to trial on the merits. The fact fraud in a particular claim is difficult to detect or quantify does not mean it should be allowed to be perpetuated. The result would be rewarding and encouraging agents of fraud to camouflage their actions. As insurers, courts, and legislatures adapt to the changing face of insurance fraud in order to combat it, so too will purveyors of fraud adapt to get away with it.

In the future, fraud will look less like the blatant staged accidents and faked injuries of the past. It will take the form of what Petitioner referred to in its Motion

for Rehearing as "soft fraud," the most common form of which is known as "buildup," or the artificial inflating of damages in "otherwise legitimate claims."[1]

The damage done by buildup of claims cannot be understated. Studies show in 2012 alone, fraud added anywhere from $5.6 billion to $7.7 billion in excess payments to auto injury claimants.[2] Under the five main private-passenger auto injury coverages, excess payments represent 13-17 percent of total payments made. Evidence of buildup appears in 21 percent of all bodily injury claims and 18 percent of all Personal Injury Protection (or "PIP") claims. When taken together, 15 percent of all total dollars paid for bodily injury and PIP claims nationwide showed indicia of buildup.[3] Buildup is most likely to appear in claims where patients treat with chiropractors, physical therapists, practitioners of alternative medicine, and pain clinics.[4]

Thus, savvy but unscrupulous healthcare providers recognize the opportunity a legitimate claim presents to artificially inflate charges. The underlying accident and injuries provide cover for the fraudulent activity which then takes place. This blurring of the line between legitimate and illegitimate is no accident. It is far more difficult to detect than the blatant fraud of a non-existent accident or injury. It is

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[1] *See* Coalition Against Insurance Fraud, *By the numbers: fraud statistics*, http://www.insurancefraud.org/statistics.htm (last visited 5/19/2016).

[2] *See* Insurance Research Council, *Auto Injury Insurance Claims: Countrywide Patterns in Treatment, Cost and Compensation, 2014 Edition*. Last completed study available for 2012.

[3] Coalition Against Insurance Fraud, Footnote 1, *supra*.

[4] Insurance Research Counsel, footnote 2, *supra*.

also more difficult to quantify exactly how much of a total claim is due to fraud and how much is legitimate.

This was a difficulty the lower court confronted when faced with Petitioner's claim. An insurer, if unable to recover the full value of the fraudulent bills paid, is placed in an impossible position where it must prove a hypothetical scenario regarding whether the claimant would have accepted a lesser amount, or if the ultimate costs and expenses would be less than actually paid. This confusion of the legitimate and the illegitimate is not an unintended consequence; it is a tactic, as the conduct of Respondents demonstrates in this case. The only viable remedy for insurers is to be able to recover the full value of claims paid. Despite the initiating factor of a legitimate accident, the nature of the fraud committed makes the entire claim illegitimate, because the practices of providers like Respondents, once detected, remove all responsibility from the insurer to pay anything on the claim.

Respondents' actions in the underlying case are a classic example of how this claim occurs, and how it renders the full value of the claim fraudulent. First, Respondents misrepresented the financial liability of their patients; patients were not obligated to pay for the treatment they received to encourage them to continue to incur unnecessary medical expenses. Respondents misrepresented to Petitioner that the patients were financially liable. Under Texas law, medical procedures for which the patient is not liable for payment cannot be included in their personal

injury claims. Tex. Civ. Prac. & Rem. Code § 41.0105. This inflated the amounts of the settlements ultimately paid; none of this treatment should be included in settlements, according to statute.

Next, Respondents miscoded examinations to make them appear more comprehensive or elaborate than they actually were, and thus, more expensive. Respondents also recommended unnecessary medical procedures and doctor-shopped for recommendations for unneeded but pricey treatment. Texas law limits recoveries for medical expenses to what is reasonable and necessary. *Texarkana Mem'l Hospital v. Murdock*, 946 S.W.2d 836, 839-40 (Tex. 1997). Following the state of the law, Petitioner is not obligated to pay for any treatments where the patient incurred no financial liability, or where the treatment was unnecessary.

This conduct by Respondents meets the common law definition of fraud espoused by Texas courts: "(1) . . . a material representation was made; (2) . . . it was false; (3) [Respondents] knew it was false when made . . . ; (4) [Respondents] made it with the intention that it be acted upon by [Petitioner]; (5) [Petitioner] acted in reliance upon it; and (6) suffered an injury or damage as a result thereof." *State Farm Mut. Auto. Ins. Co. v. Giventer*, 212 F. Supp. 2d 639, 650-51 (N.D. Tex. 2002). Thus, the damages recoverable should constitute the full value of what was fraudulently induced; in this case, that would be all the treatment provided pursuant to these illegitimate practices.

The difficulty comes not from proving fraud took place, but rather in separating the necessary charges from those fraudulently inflated. Respondents' behavior is a perfect example of how a legitimate injury becomes a golden opportunity to inflate the cost of treatment and defraud the insurer, and this fraudulent conduct should not be condoned because the measure of damages is intentionally made unclear. The measure of damages should be commensurate with the scope of the fraud; because Respondents induced claimants to treat with them solely for the purposes of receiving larger bodily injury settlements, Petitioner's damages are the entire amount of the settlements paid, not only a portion.

This case should be presented as an opportunity to prevent fraud, rather than an obstacle. The statistics provided in the research studies done show a certain class of providers, including Respondents, is more likely to engage in this kind of behavior than others. Their conduct renders the entire value of the services they perform fraudulent, because the treatment they provide is part of a scheme to profit from inflated settlements. While the initial injury suffered by the claimant may be legitimate, the course of the treatment certain providers like Respondents prescribe is fraudulent from its beginning. Insurers are seeking to recover from these unscrupulous providers, who lure patients in to exploit them for financial gain.

This case thus provides a prime opportunity for the Court to recognize the latest permutation of auto accident injury fraud, and refuse to be complicit in its

growth and expansion into Texas. The alternative is a concession to providers who intentionally muddy the waters and engage in fraudulent buildup of their claims. If this opportunity is not taken, the result will be a green light statewide to continue these practices. The consequences, as explained below, will be far-reaching.

B. A decision in favor of Respondents will burden insurers and policyholders through increased costs and investigations. Medical providers will remain unjustly enriched and costs will be shifted to not only insurers, but those least equipped to bear them: policyholders and claimants. The quality of medical care for injured claimants and the ability of insurers to promptly settle claims will both suffer.

If this opportunity to help reverse the tide of soft fraud by medical practitioners is not taken, this kind of fraud will continue to occur. Further, the amounts paid for fraudulent claims will increase as others are encouraged to engage in fraudulent behavior, as well. The result will necessarily be increased costs to insurers and delays in payment of claims due to enhanced investigations. As a result, unchecked fraud will shift the burden of paying fraudulent claims to policyholders and those who suffer legitimate injury.

The sum total of insurance fraud in the United States is estimated to be $80 billion. The actual number is in all likelihood higher due to the amount of fraud which remains undetected.[5] Unless insurers are given the tools to recover as much of this amount as possible, the cost of insurance will rise and the quality of care

[5] Coalition Against Insurance Fraud, *Insurers: Victim impact statements*, http://www.insurancefraud.org/ the-impact-of-insurance-fraud.htm (last visited: May 19, 2016).

will deteriorate, and the burden will fall on the insured and those treating for legitimate injuries.

The nature of insurance means the more money insurers spend on fraudulent claims, the more they will be forced to raise insurance premiums. In addition, the need to increase the scope and intensity of investigations will also raise the cost of providing insurance to policyholders. Unlike most services, insurance coverage is state-mandated, and policyholders cannot avoid paying for coverage.[6]

States like New York, New Jersey and Florida have some of the highest policy premiums in the nation because of the combination of mandatory insurance coverage, including both PIP and BI, and high incidences of fraud.[7] Texas, like those states, requires insurance companies to offer PIP coverage to consumers in addition to bodily injury coverage; however, the limits are comparatively low. Tex. Ins. Code § 1952.152. As a result, Texas faces a different challenge than the "no-fault" states, who endure first-party fraud by insureds against their own insurance. Fraud in bodily injury claims, such as that committed by Respondents, increases the number of victims to include the third party whose insurance is paying the injured claimant. Without adequate measures to combat insurance fraud and recoup money from perpetrators of fraud, the cost of maintaining state-mandated bodily injury coverage will continue to increase. Some Texas citizens will eventually be

[6] *Id*.
[7] *Id*.

forced to choose between paying higher premiums or allowing their insurance to lapse, in violation of the law.

The quality of medical care injured people receive is threatened by buildup of fraudulent insurance claims, as well. It is no exaggeration to say patients "are maimed, disfigured and forced into lives of permanent pain when dishonest doctors perform unneeded and often botched surgery to inflate their insurance billings."[8] However, even in the less extreme cases, the quality of care suffers as the injured patient is forced to navigate their course of treatment without knowing whether the provider with whom they treat is legitimate. Patients cannot know in whose best interest the medical advice they receive has in mind. Their medical provider may be trying to get them in the door solely to exploit their bodily injury claim.

Thus, the lower courts' decisions should be revaluated in light of the immediate ramifications of a decision in favor of Respondents. Without the opportunity to recoup benefits paid as a result of fraud, the cost to insurers, policyholders and injured claimants would be enormous, and would only increase as this type of soft fraud proliferates. This Court can prevent this burdensome result to the public at large in this case. Otherwise, as explained below, the far-reaching effects will severely compromise the availability of the State of Texas to combat fraud.

[8] *Id*.

C. Insurers will shift resources away from the State of Texas and into states where their anti-fraud efforts receive adequate protection under the law. This will result in Texas falling behind the rest of the nation in antifraud measurers and opening a door attracting unscrupulous medical providers and criminal elements looking to set up fraudulent schemes.

The most far-reaching negative impact of a decision in favor of Respondents is the State of Texas will fall behind in efforts to combat fraud and become a haven for this and other fraud schemes. Combating fraud requires a partnership amongst insurers, policyholders, legislatures and courts. If Texas cannot provide assurance to insurers and policyholders they are willing to take an effective stance against fraud, insurers become dis-incentivized to maintain large presences in the state, deploy effective anti-fraud measures there and, perhaps, even continue doing business there.

Combating fraud often takes the form of both civil suits and criminal prosecutions. Insurers lead the charge in the former, while the Texas Department of Insurance leads in the latter. In 2015, the Texas Department of Insurance Fraud Unit received 13,513 reports of suspected fraud, which resulted in 112 cases being referred for prosecution, involving $8.56 million dollars.[9] Any increase in those numbers would necessarily result in greater strain on the resources of the Department and the criminal justice system. Those numbers will increase if

[9] Texas Department of Insurance Fraud Unit, *Fast Facts*, http://www.tdi.texas.gov/fraud/facts.html (last vitied May 20, 2016).

insurers are unable to police fraud effectively through the civil courts. A decision in favor of Respondents in this case would place a heavier burden on law enforcement to police fraud through the criminal justice system. If they are unable to allocate sufficient resources to meet the increased burden, fraud will go undetected and unpunished, and its negative effects will compound unabated.

Civil fraud suits can alleviate the burden imposed by criminal fraud prosecutions. Other jurisdictions allow insurers to pursue civil suits to recover damages, costs and fees as part of their criminal anti-fraud statutes. *See State Farm Mut. Auto. Ins. Co. v. Lincow,* 715 F. Supp. 2d 617, 632 n.13 (E.D. Pa. 2010) ("The Insurance Fraud Statute . . . authorizes an insurer that is injured as a result of a violation of the statute's criminal provisions to bring a civil action to recover compensatory damages, investigative costs, and attorneys' fees.").

In others, the civil remedy is either a claim of common law fraud or claim of unjust enrichment, but the right to recover in civil court is not challenged. *See State Farm Mut. Auto. Ins. Co. v. Kugler*, No. 11-80051, 2011 U.S. Dist. LEXIS 107005, at *39 (S.D. Fla. Sep. 21, 2011). Courts applying Texas law have in the past allowed insurers to recover under a theory of common law fraud. *Giventer*, 212 F. Supp. 2d at 653. Texas Penal Code § 35.02 allows insurers to seek restitution after a criminal prosecution, but provides no civil remedy. Thus, an adverse decision in this case would close the civil courts of Texas to insurers

entirely, and place the entire burden of fraud recovery on the criminal justice system.

The long-term effects will damage the presence insurers will have in the State of Texas going forward. It is not unprecedented for insurance companies to attempt a cessation of doing business in a state where the cost of doing business is too high, or where financial loss is guaranteed because of the rampant costs of dealing with fraud.[10] The net result will be less choice to consumers and a climate where fraud is encouraged, and the companies that have attempted to combat fraud, and lost, will steer clear.

Insurers and the insured have a mutual interest in combatting fraud. It benefits both parties as the insurer is able to provide benefits at a reasonable cost, and the insured can receive benefits in the most cost-effective and efficient manner possible. For this reason, insurers will take the lead in bringing fraud issues to the forefront, up to and including seeking civil judgments against the fraudulently enriched, to achieve these mutually advantageous goals. Where the state government, both its legislature and its courts, must respond is when these opportunities to combat fraud are identified and placed before them by insurance companies.

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[10] *See, e.g.,* Iver Peterson and Joseph B. Treaster, *Major Insurers May Pull Out of New Jersey*, New York Times, 21 June, 2001 (citing increased claims and medical price gouging as reasons why auto companies considering leaving the state).

If the state legislature or the courts do not respond, the unfortunate message conveyed is insurance companies and their policyholders will continue to do battle with perpetrators of fraud alone. When the cost becomes too high for the insurance company to bear, and no more of the burden can be shifted to the consumer, the insurer is left with little choice but to take its business elsewhere—a situation where no one wins, except for the perpetrators of fraud.

As a result, in the instant case, beyond punishing the fraud committed by Respondents, and allowing Petitioner to recover the money it unjustly paid, this case presents an opportunity to set the tone in Texas for anti-fraud measures and assures the public this Court is receptive to their concerns about being at the mercy of unscrupulous health care providers.

CONCLUSION

Upholding the summary judgment against Petitioner will have a general chilling effect on anti-fraud efforts throughout the State of Texas. Respondents were fraudulently enriched by their actions in inflating the cost of medical treatment charged to bodily injury insurers, such as Petitioner. Allowing the lower court decision to stand in effect rewards their efforts in concealing their fraud. Rather than forcing insurers to separate what treatment may be legitimate from what is fraudulent, this Court should recognize that the scope of the fraud committed renders the cost of the entire course of treatment recoverable as the proceeds of fraud. This decision will have both immediate and far-reaching effects on the business of insurance in Texas.

A decision in favor of Respondents means the burdens of higher premiums, ineffective or dangerous medical treatment, and inability to quickly process claims will fall on insureds. Law enforcement and the criminal justice system will have to pick up the slack once insurers lose the ability to pursue their claims in civil court. In the long run, insurers will be dissuaded from increasing their presence in Texas and may be encouraged to cease doing business there.

Due to its large population, Texas is an important and influential state. Allowing this decision to stand will empower other medical providers to commit fraud and reward their efforts to manipulate the system throughout the United

States. The State can be at the forefront of the effort to combat fraud, rather than the background.

For all the above reasons, it is imperative the Texas Supreme Court vacate the summary judgment by the Court of Appeals and remand this case to be tried on the merits.

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CERTIFICATE OF SERVICE

This is to certify that a true and correct copy of the above and foregoing Amicus Curiae brief has been forwarded via electronic service, on this the 8th day of June, 2016, to the following counsel on record:

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief is in compliance with the rules governing the length of briefs prepared by electronic means. The brief was prepared using Microsoft Word 2010. According to the software used to prepare this brief, the total word count, including footnotes, but not including those sections excluded by rule, is 4,037. The brief was prepared using "Times New Roman" 14-pt. font for the body, and 12-pt. font for the footnotes.

/s/Matthew J. Smith
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