The Essential Resource for The Insurance Fraud Professional

Zalma's Insurance Fraud Letter

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Volume 26, Issue 2 – January 15, 2022
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Quote of the Issue

"The time is always right to do what's right."

Martin Luther King

Convicted Insurance Fraudster Loses Appeal

In *The People of The State Of New York v. Kevin A. Ashby*, No. 2021-07434, Supreme Court of New York, Fourth Department (December 23, 2021) after he was convicted, Kevin A. Ashby appealed the jury verdict of insurance fraud in the third degree and attempted grand larceny in the third degree.

Ashby contended that the indictment was jurisdictionally defective. The failure of the first count of the indictment to recite all the elements of the crime in full. However, the appellate court found that the failure did not constitute a jurisdictional defect because that count specifically referred to the applicable section of the Penal Law.

Although defendant further contended that each count of the indictment was legally insufficient because the counts do not set forth sufficient factual allegations, he failed to preserve his contention for the court's review.

Ashby also contended that count one of the indictment was impermissibly amended.

Contrary to defendant's contention, he was required to preserve that contention for appellate review. Although past cases of this Court have not required preservation of such a contention defendant failed to preserve his contention for review and the court declined to exercise its power to review it as a matter of discretion in the interest of justice.

Wisdom

"The thing I remember best about successful people I've met all through the years is their obvious delight in what they're doing, and it seems to have very little to do with worldly success. They just love what they're doing, and they love it in front of others." – **Fred McFeely Rogers**

"Let each citizen remember at the moment he is offering his vote that he is not making a present or a compliment to please an individual — or at least that he ought not so to do; but that he is executing one of the most solemn trusts in human society for which he is accountable to God and his country." —**Samuel Adams**

"Say little but do much." — **Pirkei Avos**

"The meaning of life is to find your gift. The purpose of life is to give it away."— **Pablo Picasso**

"Dependence begets subservience and venality, suffocates the germ of virtue, and prepares fit tools for the designs of ambition." — **Thomas Jefferson**

"They that can give up essential liberty to purchase a little temporary safety, deserve neither liberty nor safety." —**Benjamin Franklin**

"The art of living lies less in eliminating our troubles than in growing with them." — **Bernard M. Baruch**

"Curiosity is the essence of our existence." – **Gene Cernan**

"Those who deny freedom to others, deserve it not for themselves; and, under a just God, can not long retain it." –**Abraham Lincoln**

"You cannot find peace by avoiding life." – **Virginia Woolf**

"Wish not so much to live long as to live well." – **Benjamin Franklin**

"It is well to be up before daybreak, for such habits contribute to health, wealth, and wisdom." — **Aristotle**

"Success is sometimes the outcome of a whole string of failures." – **Vincent van Gogh**
"Just 'cause somethin' ain't been done Don't mean it can't be did." – **Shel Silverstein**

After Insurance Fraud Indictment Dismissed Defendants Sue Police Officer

Arrest Warrant Issued Fairly Defeats Malicious Prosecution Suit

Evidence Required to Support Malicious Prosecution Against Police

Vicki Davis and Robin Trawick filed suit against Defendants State Farm Fire and Casualty Company ("State Farm"), Don Allen, and the Georgia Office of Insurance and Safety Fire Commissioner ("OCI") because they were arrested for insurance fraud which charges were later dismissed. Defendants Allen and OCI moved the court to dismiss the malicious prosecution action in *Vicki H. Davis and Robin R. Trawick v. State Farm Fire and Casualty Company, et al.*, No. 1:21-cv-2988-MLB, United States District Court, N.D. Georgia, Atlanta Division (December 23, 2021).

BACKGROUND

On December 26, 2016, a fire destroyed Plaintiff Davis's residence and all her personal belongings. Plaintiff Davis notified Defendant State Farm of the fire and made a claim pursuant to policy she had with it. Defendant State Farm extended coverage and made a payment of $239,200.00 for loss of the residence but did not issue any payment for loss of her personal property.

Defendant Allen, an investigator for OCI, submitted a warrant application to the Magistrate Court for Grady County, Georgia for Plaintiffs' arrests. The application stated Plaintiff Davis "collected insurance money for living expenses that were not legal. Made false statement to Insurance Company." Plaintiffs made their first appearance after being arrested and booked.

The Grady County Magistrate Court dismissed the criminal warrants for lack of evidence.

Plaintiffs then sued Defendants Allen and OCI alleging three counts: (1) state law malicious prosecution; (2) federal § 1983 unreasonable seizure of person, and (3) federal § 1983 malicious prosecution. Defendants Allen and OCI moved to dismiss. Since the Plaintiffs did not dispute OCI should be dismissed and their state law claim for malicious prosecution against Defendant Allen should be dismissed. The Court, therefore, dismissed both counts.

DISCUSSION

Eleventh Amendment Immunity

Defendant contended that any claims against him in his official capacity are barred by the Eleventh Amendment and 42 U.S.C. § 1983. Plaintiff, however, represents Defendant "Allen is being sued in his personal capacity.

Federal § 1983 Unreasonable Seizure

Plaintiffs asserted an independent "Fourth Amendment Unreasonable Seizure of Person" claim. Plaintiffs alleged Defendant's conduct "in causing and facilitating the arrest and detention of Plaintiffs . . . without arguable probable cause constituted an unreasonable seizure of person in violation of the Fourth Amendment." Although it was not entirely clear from the complaint whether Plaintiffs are trying to plead a freestanding false arrest claim, but, if they are, that claim failed as a matter of law.

A claim of false arrest or imprisonment under the Fourth Amendment concerns seizures without legal process, such as warrantless arrests. The issuance of a warrant-even an invalid-one constitutes legal process, and thus, where an individual has been arrested pursuant to a warrant, his claim is for malicious prosecution rather than false arrest. Regardless of the validity of the warrant, plaintiff's allegations support a § 1983 malicious prosecution claim rather than a § 1983 false arrest claim.

The Court had no option, therefore, but to dismiss Plaintiffs' "Fourth Amendment Unreasonable Seizure" claim since the plaintiffs were arrested and detained under the authority of a warrant.

Federal § 1983 Malicious Prosecution

Plaintiffs also bring a federal § 1983 malicious prosecution claim. Plaintiffs claim Defendant caused a felony criminal prosecution to be initiated against them for the offense of insurance fraud and participated and assisted with the continuation of that prosecution for 231 days. They allege Defendant knew or should have known that there was no arguable probable cause to support the prosecution which was based on statements by an insurance company that were either knowingly false or made with reckless disregard for the truth. Plaintiffs contend Defendant knew those statements were false or continued the prosecution of Plaintiffs with reckless disregard for the truth, and thus the prosecution was carried out maliciously, without probable cause, and was ultimately terminated in Plaintiffs' favor.

Malicious prosecution is "a violation of the Fourth Amendment and [a] viable constitutional tort under § 1983." *Blue v. Lopaz,* 901 F.3d 1352, 1357 (11th Cir. 2018). To maintain a claim of malicious prosecution, Plaintiffs must overcome two hurdles:

1. They must prove they suffered a seizure pursuant to legal process that violated the Fourth Amendment. This burden requires them to "establish:
    1. that the legal process justifying their seizure was constitutionally infirm and
    2. that their seizure would not otherwise be justified without legal process.
    3. the elements of the common law tort of malicious prosecution.
2. To establish common-law malicious prosecution, a plaintiff must show:
    1. a criminal prosecution instituted or continued by the present defendant;
    2. with malice and without probable cause;
    3. that terminated in the plaintiff accused's favor; and
    4. caused damage to the plaintiff accused.

A warrant violates the Fourth Amendment if the affidavit supporting it contains deliberate falsity or reckless disregard for the truth, which applies to both statements and omissions. Plaintiffs claim Defendant either knew the statements by the insurance company were false or he continued the prosecution with reckless disregard for the truth.

Survival of such claim requires some evidence establishing Defendant's subjective belief about the veracity of the assertions made in his affidavit. A plaintiff's attack on an affidavit thus must be more than conclusory and must be supported by more than a mere desire to cross-examine. There must be allegations of deliberate falsehood or of reckless disregard for the truth, and those allegations must be accompanied by an offer of proof. They should point out specifically the portion of the warrant affidavit that is claimed to be false; and they should be accompanied by a statement of supporting reasons

Plaintiff did not identify what false information was put in the reports or why that information was false. Rather, plaintiff presented nothing more than conclusory statements about false evidence, statements, and reports. Plaintiff, therefore, has failed to allege fact demonstrating that the defendant intentionally or recklessly made false statements or omissions in procuring the arrest warrant and that the false statements were necessary to the finding of probable cause.

While including repeated, generic allegations of intentional misconduct, Plaintiffs did not point out specifically the portion of the warrant affidavit they claimed was false or include any statement of supporting reasons as to why it was false or why Defendant knew that. Plaintiffs' conclusory allegations were insufficient to demonstrate an unconstitutional warrant since they fail to allege facts demonstrating that Defendant intentionally or recklessly made false statements or omissions in procuring the arrest warrant and that the false statements were necessary to the finding of probable cause.

The law states that an arresting officer is required to conduct a reasonable investigation to establish probable cause. In making an arrest affidavit or seeking an arrest warrant, a police officer may not close her or his eyes to facts that would help clarify the circumstances of an arrest. An officer need not "take 'every conceivable step . . . at whatever cost, to eliminate the possibility of convicting an innocent person.'" [*Williams v. City of Homestead, Fla.*, 206 Fed.Appx. 886, 888 (11th Cir. 2006)]. And not "every failure by an officer to discover 'easily discoverable facts' violates the Fourth Amendment." [*Washington v. Rivera,* 939 F.3d 1239, 1248 (11th Cir. 2019)] Officers cannot conduct an investigation in a biased fashion, elect not to obtain easily discoverable facts, or choose to ignore information that has been offered to him.

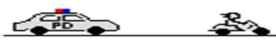
Plaintiffs claim State Farm provided Defendant a statement which was the basis of their prosecution. Plaintiffs contended Defendant was required to verify the information provided by State Farm and did not undertake any reasonable avenues of investigation which would have exonerated Plaintiffs.

However, officers may generally rely on a victim's statement to support probable cause absent allegations indicating that their reliance was unreasonable.

The factual allegations in the complaint fail to demonstrate a lack of probable cause. The Court, therefore, granted Defendants Don Allen and Georgia Office of Insurance and Safety Fire Commissioner's Motion to Dismiss.

ZIFL OPINION

State Farm was not a party to these motions but will probably bring its own motion since the report to the police was probably made in accordance with the insurer's obligation to report suspicion of crime by state law or common law and that is why plaintiffs spent their time against the police officer.



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Workers' Compensation Board Improperly Ignored Evidence of Fraud

NEW YORK WORKERS' COMPENSATION BOARD ABUSED ITS DISCRETION

After the Workers' Compensation Board ruled, among other things, that the application of Everest National Insurance Company was required to pay benefits it appealed seeking review of the decision of the Workers' Compensation Law Judge that its actions were untimely, and from a decision of said Board, filed October 28, 2019, which denied an application by Everest National Insurance Company for reconsideration and/or full Board review. Everest appealed because it was not provided proper notice, was not the insurer and because the allegedly injured worker was perpetrating a fraud.

In the Matter of the Claim of Michel Salinas v. Power Services Solutions LLC et al., and South Side Services Inc. et al. Workers' Compensation Board, No. 2021-0732, Supreme Court of New York, Third Department (December 23, 2021) the appellate court resolved the dispute.

FACTS

Claimant experienced a work-related accident in 2017, and a Workers' Compensation Law Judge (hereinafter WCLJ) subsequently established the claim for post concussive syndrome, major depressive disorder and various other injuries. The identification of claimant's employer occurred over a series of hearings and through a number of ordered investigations, and the WCLJ ultimately found that claimant was employed by Salvador Almonte, the owner and operator of, among other businesses, Power Services Solutions LLC, and that the accident occurred while claimant was performing work for Kingdom Associates Inc., which had a contract with Power Services.

The workers' compensation insurer for Kingdom, Starr Indemnity & Liability Company, eventually submitted a certificate of insurance to the WCLJ that indicated that Everest National Insurance Company provided coverage to Power Services at the time of the subject accident. The WCLJ determined that Everest needed to be put on notice, and a copy of that decision was mailed to Everest.

Due to an apparent printing error, Everest's name and address on the notice of hearing were obscured by a list of the dozens of other interested parties on this claim. Everest failed to appear at that hearing, and the WCLJ ultimately discharged several other would-be employers and carriers, finding that Power Services was the proper employer and that Everest was the proper carrier.

A copy of the February 14, 2019 decision memorializing those findings was also mailed to Everest. That decision, however, continued to caption Kingdom as the employer and Starr as the carrier, reflecting same on the recipient page where Everest was still listed as only an interested party. On March 7, 2019, the Workers' Compensation Board filed a corrected EC-1 form reflecting that Everest was the proper carrier for the subject claim.

Everest and its third-party administrator appealed to the Board on May 23, 2019, arguing, among other things, that the notice sent to it for the February 11, 2019 hearing was deficient and that it never provided coverage for Power Services. A panel of the Board denied the appeal on the ground that it was untimely, finding that, although the notice issue could possibly excuse Everest's absence from the February 11, 2019 hearing, no explanation was provided for its delay in appealing the February 14, 2019 decision, which Everest had not denied receiving. Meanwhile, on or around September 5, 2019, Almonte was indicted for his alleged participation in an extensive insurance fraud scheme, which notably involved the creation and issuance of false certificates of insurance. By decision filed October 28, 2019, the full Board denied Everest's application, and these appeals ensued.

ANALYSIS

A party seeking review of a WCLJ's decision is required to file an application for review with the Board within 30 days of the filing of the decision. The Board is afforded broad discretion to accept or reject such application as untimely, and, absent an abuse of that discretion, the Board's determination will not be disturbed

In the view of the appellate court, the Board abused that discretion.

The early stages of this claim were notably protracted, and Everest was brought into the fold a year and a half after the claim was filed, missing the first six hearings and all of the investigations regarding claimant's actual employer and issues of coverage. Correspondence sent to Everest, including the February 14, 2019 decision, continued to facially reflect that Kingdom and Starr were responsible for this claim.

It is only in the middle of a paragraph on the second page of that decision that Power Services is named as the employer and Everest as its carrier. The Board did not update its own file to reflect the proper carrier until about one month after the February decision, and,

although that may have given Everest several days in which to still file a timely appeal, there was no indication, or allegation, in the record before the court that the corrected notice of case assembly was also forwarded to Everest.

It is not difficult to understand why Everest, receiving either defective or facially misleading correspondence from the Board regarding this claim, was not immediately aware that a policy attributed to it – covering an employer with which it had never contracted – was at issue.

Significantly, the proof submitted by Everest in support of its administrative appeal strongly suggests that the certificate of insurance provided to the Board was not authentic, and, based upon the limited record before us, the certificate appears to have been an important, if not the only, factor in the WCLJ's decision as to Everest. In other words, Everest has brought to the Board's attention the strong possibility that it has issued a decision based perhaps entirely upon fraudulent documentation.

Although the appellate court was aware that the Board has broad discretion as to this matter and will generally not be considered to have abused that discretion by strictly enforcing its own regulations, the court found that it could discern no rational reason why the Board would decline to investigate when presented with legitimate, presently uncontested evidence that a fraud was perpetrated upon it.

It would seem unlikely that a criminal matter involving allegations of pervasive workers' compensation insurance fraud was unknown to the Board by the time of its full Board decision or, at the very least, the Board panel decision settling the record for this appeal – issued over a year after Almonte's highly-publicized indictment.

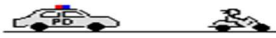
Under these facts, it is not an adequate answer to say that this kind of determination is usually discretionary and the very purpose of the discretion afforded to the Board is to grant relief in circumstances such as these.

Although Almonte's criminal charges was not part of the administrative record, it is a matter of public record and need not be ignored. Based upon the foregoing, the appellate court found that the Board abused its discretion in denying Everest's application for review.

Therefore, the court ordered that the decision filed August 5, 2019 is reversed, without costs, and matter remitted to the Workers' Compensation Board for further proceedings not inconsistent with this Court's decision.

ZIFL OPINION

No insurer should be abused by a workers' compensation appeals board who ignored its own error when holding Everest to provide benefits to Almonte even though it was clear that it was the victim of an insurance fraud, the allegedly injured employee was charged with fraud in a very public manner, and the pleadings presented to the Everest by the Board deceived it into believing it was not involved. The Board's abuse of discretion required a reversal and allowed the Board to correct its error.



Free Insurance Videos

Barry Zalma, Esq., CFE has published five days a week videos on insurance claims, insurance claims law, insurance fraud and insurance coverage matters at

Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 52 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.

Mr. Zalma is the first recipient of the first annual Claims Magazine/ACE Legend Award.

Over the last 53 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

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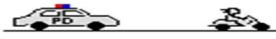


A Proposal to Defeat Insurance Fraud

A Proposal that Every Insurer Should Establish a Corporate Position to Refuse to Pay a Fraud

See the full video of this proposal at https://rumble.com/vs8qes-how-to-defeat-insurance-fraud.html and at https://youtu.be/USCEdOuXs2A Every first party property policy of insurance contains the following language mandated by the statutory New York Standard Fire Policy.

> This entire policy shall be void if, whether before or after a loss, the insured has willfully concealed or misrepresented any material fact or circumstance concerning this insurance or the subject thereof, or the interest of the insured therein, or in case of any fraud or false swearing by the insured relating thereto. [California Insurance Code Section 2071]

If, after a thorough investigation of a claim the insurer determines a fraud has been attempted and the insurer has obtained a preponderance of all available evidence that can establish a fraud was attempted, the insurer must advise the insured it will not pay and will declare the policy void in accordance with the policy language quoted above.

The *Qui Tam* Solution to Insurance Fraud

In a case of amazing and surprising perspicacity, the California Legislature recognized the problem and added to The California Insurance Frauds Prevention Act ("CIFPA") a *qui tam* provision that made it possible for insurers to file whistleblower suits against fraud perpetrators. The law is unique because the law allows individuals to sue on behalf of private insurance companies and for insurers to sue fraud perpetrators in the name of the state. Additionally, if the case is successful, the individual who brought the lawsuit, receives a portion of the recovery.

If the insurer reports hundreds of suspected fraudulent claims to a Department of Insurance like California's Department of Insurance Fraud Division, it left only with the following options:

1. Pay the fraudster what he or she demands.
2. Refuse to pay the fraudster and be ready to expend the effort and money needed to defeat the fraudster's bad faith suit.
3. File a suit for declaratory relief seeking confirmation by the court that the insured perpetrated a fraud and is not entitled to any benefits of the insurance policy.
4. Be ready to defend a cross-claim for bad faith by the fraudster's lawyers.
5. File a qui tam action under statute Section 1871.7.

This is a real weapon available to insurers who wish to defeat insurance fraud. The insurer who has collected sufficient evidence to establish beyond a preponderance of the available evidence, was the victim of a single or multiple acts of insurance fraud may file suit under the statute in the name of the state of California. The punishment, if successful, will be enormous and the state and the insurer will share in the funds obtained.

The California Legislature created the Insurance Fraud Protection Act (IFPA) to combat insurance fraud. When an insurance company brought a *qui tam* action to recover damages and fees occasioned by the surgical center's fraudulent billing practices it did so in the name of the state, not the insurer.

The purpose of section 1871.7 is to prevent and remedy insurance fraud. Insurers, not the state government, are the direct victims of the fraud. Insureds are the indirect victims who pay higher premiums due to the prevalence of insurance fraud. The government does not necessarily recover funds lost to it because of a fraud perpetrated on it.

What is Actually Happening to Insurance Fraud Perpetrators

Today, a person perpetrating an insurance fraud need only be concerned that an aggressive fraud investigation might delay, or reduce, the amount he might recover from his crime. Criminal prosecution for the crime of insurance fraud is so minuscule, in relation to the amount of fraud, as to be nonexistent. It certainly does not act as a deterrent.

If the legislatures really want insurers to fight insurance fraud; if the legislatures wish to keep strong and viable this important industry; if the legislatures want to reduce the insurance premiums paid by their constituents, they must make practical the war on insurance fraud. As long as the tort of bad faith and the exposure of punitive damages hangs over insurance companies, the war will be one of attrition where no one will win.

Since it is often difficult to convince a state department of insurance, a state Attorney General or local prosecutors to prosecute insurance fraud perpetrators insurers must proactively act to defeat insurance fraud. If there is no opportunity to file a qui tam action the insurer must, as a corporate requirement, refuse to pay any insurance fraud perpetrator.

What to do to Defeat or Deter Insurance Fraud

The insurer who truly desires to defeat insurance fraud must:

1. Require that the entire staff of claims handlers be trained to recognize attempts at insurance fraud.
2. Require that the entire staff of claims handlers be trained to recognize the "red flags of fraud."
3. Create, maintain and effectively fund an SIU staffed with insurance and fraud trained investigators.

4. Require a thorough investigation of every claim.
5. Require the claims staff to refer suspected insurance fraud attempts to the SIU when a claims investigation establishes no less than three red flags of fraud.
6. Require the SIU to conduct a thorough suspected fraud investigation.
7. When the SIU collects what it believes to be an attempt at insurance fraud it should refer, for advice and counsel, the claim to an experienced insurance coverage lawyer in the state where the claim was presented.
8. If, after review of the claims investigation, coverage counsel opines that there is a preponderance of evidence establishing a fraud was attempted and claims management is convinced the advice is proper the claim must be rejected as a fraud.

Once a suspected fraudulent claim is denied two events will occur:

First, the insured will accept the denial and try another insurer who is less aggressive.

Second, the insured will sue for breach of contract and breach of the covenant of good faith and fair dealing seeking contract, tort and punitive damages.

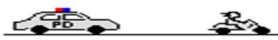
If the first option happens the files are closed and nothing further is required other than a report to the Department of Insurance in accordance with the requirements of the state's IFPA.

If the second option is chosen by the insured the insurer must:

1. Publish to the insurance buying public that it is the insurer's incorruptible opinion that it will never pay what it believes to be a fraudulent claim.
2. Retain counsel to defend the insurer.
3. Instruct defense counsel that the insurer expects counsel to take the matter to trial.
4. Instruct defense counsel to aggressively defend the lawsuit.
5. Instruct defense counsel to conduct every needed discovery immediately without courtesy.
6. Instruct defense counsel to depose every insured, every witness and every expert consulted by the insured, as soon as possible after the filing of the law suit.
7. Instruct defense counsel to move the trial court for orders limiting the actions of the plaintiff including, but not limited to, motions for summary judgment, motions to compel discovery responses, motions in limine and any other motion available to limit the case.
8. Instruct defense counsel that he or she has no authority to settle or even consider negotiating a settlement.
9. Instruct defense counsel to advise the policyholder's counsel that the case must go to trial and there will be no settlement discussions.
10. Instruct defense counsel to advise the court that because the insurer believes it was defrauded it is against the insurer's corporate policy to pay anything to a fraud perpetrator.
11. Instruct defense counsel to provide no "courtesy" to policyholder's counsel.
12. If, after trial, there is an adverse judgment against the insurer instruct counsel to immediately file an appeal.
13. If the court finds the insurer owes nothing as a result of fraud the insurer should consider litigation against the insured for damages, including punitive damages, for fraud.

By so doing a proactive insurer will establish proactively spend millions to defend against fraud and refuse to pay tribute to anyone, especially a fraud perpetrator.

Setting up such company policy will go a long way to reduce insurance fraud attempts against the insurer. Fraud perpetrators will move from that insurer to another. Those insurers who do not have such a corporate policy will find more attempts at insurance fraud and will be encouraged to take on the aggressive anti-fraud position taken by the insurer following the anti-fraud position proposed.



Good News From the

Coalition Against Insurance Fraud

An adjuster abused an insurer's computer system to reopen claims, issue expense checks to ghost vendors, then close the claims the same day in Orlando. Walter Malet and a desk examiner at Security First Insurance added eight vendors to the insurer's

expense account in the $262.5K scheme. Malet's ring made 90 payments to the fake vendors, yet issued no invoices. The phony vendors had family ties to several of his ring members. By reopening and closing the claims in the same day, the Security First computer system didn't record them as open claims, which helped avoid supervisory scrutiny. Some 85 of the 90 checks were deposited into bank accounts. Security First stopped payment on five checks after discovering the con in a routine audit. The ring also hacked the computer credentials of five other Security First employees as part of the scheme. Malet received three years in state prison.

Na Var Derick Lee met women through the online dating service *Plenty of Fish*. He convinced them to phone in a false claim to their auto insurer in Nevada. All the claims involved similar stories of the insured women hitting Lee with their vehicles. Lee told the women exactly what to say, and called in the false claims as himself or as another person. He then submitted bogus medical records for crash-injury treatment to the insurers. Lee stole more than $50K. He received 28-72 months suspended, the state AG announced.

A father-son towing firm overcharged consumers and government agencies, prosecutors say in Jacksonville, Fla. *Officials allege:* A random inspection by the Florida Highway Patrol last revealed more than a dozen cases of customers being overcharged by Southern Wrecker and Recovery. Reporters also uncovered consumer complaints that go back more than seven years. Southern Wrecker and Recovery didn't post rates at the shop and couldn't provide customers a copy of rates when they asked. Drivers were overcharged for environmental fees, added winching fees and absorbent material fees. Employees told the shop owners their concerns about high fees. The employees were told not to ask questions and just do what they were told. The firm was removed from the Florida Highway Patrol's towing rotation.

Former NFL running back Clinton Portis was stiff-armed with six months in federal prison for defrauding the NFL's health plan for retired players. He's the 10th player sentenced out of 15 players accused in the $4M plot. The two-time Pro Bowler played for the Denver Broncos and Washington Football Team, retiring in 2012. Portis then sought nearly $100K of payouts for med equipment he didn't need or use. That included $44.7K for an oxygen chamber and $54.3K for a cryosauna. Portis forged invoices, prescriptions and letters of medical necessity. The NFL's health plan gives retired players and their families tax-free reimbursement for healthcare costs. Some former players even claimed therapy devices used on horses. The scam jeopardized the plan's tax-exempt status — threatening the ability of honest former players and their families to receive tax-free repayments for legitimate medical expenses.

Insurance Fraud Conviction Affirmed

Conviction Deserved When Perpetrator Admits He Was Not Injured

In *State of Utah v. Julio Ayala*, No. 20170928-CA, 2022 UT App 1, Court of Appeals of Utah (January 6, 2022) the prosecution proved that Julio Ayala was involved in multiple automobile accidents while driving his truck and trailer. Ayala filed claims with several insurance companies, and those insurers paid for, among other things, numerous chiropractic treatments and property damage claims. Ayala later admitted to a private investigator that he had not been injured in the accidents but nonetheless believed he had a right to receive insurance benefits.

After Ayala was criminally charged, the case was tried without a jury and the court convicted Ayala on one count of a pattern of unlawful activity and one count of felony insurance fraud. Ayala appealed, claiming (1) that the trial court committed plain error when it convicted him based on insufficient evidence that his crime met the threshold for a third-degree felony and (2) that his counsel was ineffective for failing to call an expert witness to opine on interpretation errors in Ayala's interview with the private investigator.

Background

Between January 2010 and July 2012, Ayala was involved in five automobile accidents. In each accident, he was rear-ended by another vehicle. For three of those accidents-the first in January 2010, the second in December 2010, and the third in April 2012-Ayala filed claims with his insurance company, which in turn paid for chiropractic care for him and damage to his vehicle and trailer.

In March 2013, Ayala had another similar accident. When he again sought insurance benefits for alleged damage to his trailer, the insurance company sent a private investigator to interview him. Because Ayala speaks primarily Spanish, the private investigator provided an interpreter (Interpreter) to relay questions to Ayala and his attorney. Ayala's attorney, who was present during the interview, spoke English and Spanish and interjected several times to aid in and clarify the interpretation of the questions the investigator asked Ayala.

During the interview, Ayala admitted that he had not been injured in any of the accidents. Ayala stated that his insurance coverage entitled him to chiropractic treatments following the accidents, even if he had not been injured. Ayala agreed with the private investigator that he had "received treatment for no reason" and added, "[S]ince I am covered because of my insurance and that's my right." At the end of the interview, Ayala affirmed that he had understood all the investigator's questions.

A complaint was made with the Insurance Fraud Division of the Utah Insurance Department, and the State charged Ayala with one count of a pattern of unlawful activity and two counts of insurance fraud.

The trial court concluded that Ayala had filed claims for chiropractic treatment following the January 2010 accident, the December 2010 accident, and the April 2012 accident, despite the fact that he had not been injured in those accidents. The trial court also convicted Ayala on the felony insurance fraud count.

Analysis

With regard to Counsel's awareness of the interpretation issues, the court found the following on remand:

- Counsel was aware of the deficiencies with the interpretation but believed he could rely on his own fluency in Spanish to address any of its problems through cross-examination rather than calling on an expert to testify.
- Counsel believed that the testimonies from several chiropractors would objectively establish that Ayala was injured, and he considered the problems with the interpretation a "side-issue."
- In retrospect, Counsel wished he had called an expert to testify about issues with the interpretation.

About the testimonies of the two experts, the court made the following findings:

1. The two expert interpreters' evaluations of the interview were based solely on the transcripts, and they did not listen to an audio recording of the interview.
2. The first expert interpreter "acknowledged that a good portion of language is non-verbal. Vocal tone, eye contact, body language, and gestures do not come across in written translation, and an interpreter sitting next to the individual for whom they are interpreting may more easily be able to determine if the individual is understanding the interpretation."
3. The second expert interpreter conceded that "he [was] missing some context and nuances that [could] not be ascertained solely from reviewing the transcript."
4. The expert interpreters pointed out some words in the interpretation that could have been substituted with more accurate terms. The first expert noted that for the English word "injury," the Interpreter used Spanish language that typically refers "to hurt feelings or actual physical injury, depending on the context."
5. The expert explained that it would have been more accurate to employ different Spanish language that is "commonly used to describe a more serious injury."
6. The second expert interpreter noted that when Ayala talked about his "right" to receive insurance benefits, a more accurate interpretation would have conveyed that Ayala believed he was "deserving" of receiving the benefits.
7. Although the two expert interpreters "were credible" and their "expertise unquestioned [,] . . . many of the objections to the quality of [the] interpretation were more technical than practical."

The hearing testimony and report of the experts did not persuade the trial court that the interpretation was misunderstood by Ayala to any substantial degree, or that Ayala's responses during the insurance investigation were so misperceived and misstated as to obscure their essential meaning.

Ayala asked the appellate court to conclude that the trial court wrongly convicted him of felony insurance fraud because the evidence did not show that he received at least $1,500 in fraudulent insurance benefits-the minimum threshold for a third-degree felony.

Contrary to the request, the appellate court concluded that the trial judge did not commit error, because there was evidence sufficient to show that Ayala received nearly $2,000 in insurance benefits in connection with his fraudulent insurance claim. Specifically, defense exhibit 5 (which Ayala produced at trial) included six claim forms for chiropractic treatments received from April 20 to May 18, 2012, in connection with the April 2012 accident and claim. Accordingly, there was sufficient evidence to support Ayala's third-degree-felony conviction.

Ayala's defense was not prejudiced by Counsel's alleged deficient performance and the trial court found that Counsel was familiar with the facts of the case and was confident in his ability to cross-examine Interpreter on his own, and thus he would not need to hire an expert. Counsel's cross-examination of Interpreter elicited the same information about the problematic aspects of the interpretation as would have been offered by the two experts. Thus, it is clear that the testimonies of the experts about the quality of interpretation-had they been included at trial-would not have had an impact on the proceeding's outcome for the simple reason that their testimonies would have added nothing substantive to the testimony about the interpretation deficiencies Counsel elicited on his own.

Although it may be true that the interpretation was inelegant in that it suffered from certain deficiencies and a lack of nuance, any problems with it were not so profound as to undermine the appellate court's confidence in the proceeding's outcome.

Therefore, the court of appeals concluded that the trial court did not err in convicting Ayala of felony insurance fraud, because sufficient evidence was presented at trial that Ayala received more than $1,500 in insurance benefits in connection with the fraudulent claim related to that count.

ZIFL OPINION

Major insurance frauds are ignored by prosecutors. A $1500 to $2000 fraud was tried, the defendant was properly convicted and will be appropriately punished because he was ignorant enough, with is lawyer present, to tell an investigator that he was not injured in any

of the accidents and received chiropractic treatment as – what he believed to be a right – even though there was no physical reason for the treatment. Taking this case up on appeal is an example of why states are loathe to bring insurance fraud cases to trial because of the expense of a trial and an appeal far exceed the amount taken in the fraud. However, if other states emulate Utah any prosecution and conviction will deter others from attempting fraud.

Health Insurance Fraud Convictions

UC San Diego Health Pays $2.98 Million To Resolve Allegations of Ordering Unnecessary Testing

UC San Diego Health, the academic health system of the University of California, San Diego, paid $2.98 million to the U.S. to resolve allegations that it violated the False Claims Act by ordering medically unnecessary genetic testing reimbursed by Medicare.

The settlement resolves allegations that, from December 2015 to October 2019, UC San Diego Health ordered and submitted referrals for medically unnecessary genetic testing performed by **CQuentia Arkansas Labs, CQuentia NGS** and **Total Diagnostic II** (collectively "the CQuentia labs"). The government alleged that this conduct led to the submission of false claims for payment to Medicare for these tests.

Health Care Providers Agree to Pay $600k To Settle False Claims Act Liability

Central Medical Systems, LLC, Joan Harley, and **Alan Trent Harley** have agreed to pay the United States $600,000 to resolve allegations that they violated the False Claims Act by participating in a scheme to defraud Medicare.

The United States previously intervened in a civil whistleblower lawsuit against Central Medical Systems and Alan Trent Harley on January 18, 2018, and later filed an amended complaint adding Joan Harley, **Arthur Wright,** and **Meddex Solutions, LLC**, as defendants, alleging the defendants conspired to make false claims to the United States in violation of the False Claims Act.

The civil lawsuit and settlement relate to the submission of claims for wound care supplies sold by Central Medical Systems. According to the lawsuit, Alan Trent Harley would routinely change quantities of items while billing and manipulated orders in Central Medical Systems' billing software. This allegedly resulted in Central Medical Systems seeking and receiving inflated Medicare payments for more expensive products than were provided to patients or for products that were never provided at all.

The government's suit alleged that Central Medical Systems and Alan Trent Harley conspired with Joan Harley (his wife), Arthur Wright, and Meddex Solutions to fraudulently submit Central Medical Systems' claims through Meddex Solutions in an attempt to bypass Medicare's suspension of payments to Central Medical Systems.

Alan Trent Harley pleaded guilty to one count of wire fraud on November 30, 2020, and was sentenced to 15 months' imprisonment. According to court documents in that criminal case, Harley co-founded Central Medical Systems in 1986. As president and sole active owner of the business, Harley was responsible for submitting claims to Medicare on behalf of Central Medical Systems. From at least 2011 through 2015, Harley knowingly defrauded the government of more than $870,000 by submitting fraudulent claims to Medicare. Although his employees provided him with accurate data about which wound care supplies were sent, and in what quantities, Harley frequently changed that data (with respect to both product type and quantities) before submitting claims to Medicare, in order to obtain fraudulently higher reimbursements from Medicare.

The United States previously entered into a civil settlement agreement with Arthur Wright and Meddex Solutions, effective June 1, 2021, under which they agreed to pay the United States $77,741.93, to resolve the False Claims Act allegations against them in this case.

The settlement resulted from a lawsuit originally filed in the United States District Court for the Middle District of Florida by Relator Jael Cancel. Ms. Cancel sued under the *qui tam*, or whistleblower, provisions of the False Claims Act that permit a private citizen to sue on behalf of the United States for false claims and to share in the recovery. The Act also allows the United States to intervene and prosecute the action. The United States intervened in this matter and litigated the case. Ms. Cancel will receive $144,000 of the proceeds from the civil settlement with Central Medical Systems, Alan Trent Harley, and Joan Harley.

Ohio Home Healthcare Provider Agrees to Pay $500,000 As Part of False Claims Act Settlement

Academy Health Care Services is a home healthcare agency based in Dayton providing service to patients in Ohio, many of whom are disabled and living in group homes.

Academy's owners include **Jagdish, Nita** and **Vijay Patel**, all of Ohio.

The settlement unsealed today details that the healthcare provider's billing practices routinely caused Ohio Medicaid to pay at a higher level of reimbursement than warranted by the services provided as well as the setting in which the services were provided.

From 2014 until 2017, Academy billed for individual healthcare services when any services it actually provided were in group settings. Further, Academy nurses did not spend the time required with patients to receive reimbursement for individual services.

The healthcare provider will pay $500,000 in total, of which $250,000 is restitution.

As part of the settlement, Academy agrees to cease operations no later than June 30, 2022, and agrees that after Dec. 31, 2021, it will no longer provide services to beneficiaries of federal healthcare programs, including the Ohio Medicaid program, and will not submit claims for any services provided to beneficiaries of federal healthcare programs.

$630,000 From Home Health Care Company Resolves False Billing Allegations

Home Care VNA and its owners **Constant Ogutt** and **Shakira Lubega** failed to ensure that claims submitted to MassHealth complied with a plan-of-care requirement certifying the services as being medically necessary. Home Care VNA, Ogutt, and Lubega also allegedly knew that they had received overpayments from the state as a result of their submission of claims but made no attempt to notify or return any overpayments to MassHealth.

Massachusetts Attorney General Maura Healey announced January 6, 2022 that her office reached a $630,000 settlement with a Chicopee-based home health care company and its owners to resolve allegations that they billed the state's Medicaid program, MassHealth, for services that had not been appropriately authorized by a physician.

According to the AG's Office, home health care agencies that accept state funds must be held to high standards of transparency and integrity. The AG's investigation into Home Care VNA began following a referral by MassHealth. To bill MassHealth for home services, the member's physician must review and sign a plan of care. Home health agencies are required to maintain updated medical records of medically necessary services provided to each member for at least six years after the date they were first administered.

Ogutt and Lubega also own **Altranais Home Care**, a home health care company that agreed to pay $3.1 million in 2020 to settle similar allegations by of falsely billing MassHealth.

The settlement is part of a larger effort by AG Healey and MassHealth to combat fraud in the home health industry.

ZIFL wonders why people who defrauded the state before under a different name were allowed to reconstitute themselves and do more of the same kind of fraud.

Other Insurance Fraud Convictions

Louisiana Woman 30th Guilty Plea in Staged Auto Crash Cases

Donisha Lee, age 30, admitted that on September 6, 2017, on the I-10 near the Almonaster exit, she was a passenger in Erica Lee's 2015 RAV4 being driven by their former co-defendant, when he intentionally crashed into a tractor-trailer owned by Averitt Express. After the staged accident, the driver exited the RAV4 and told Erica Lee to get behind the wheel of the RAV4 to make it appear that Erica Lee was driving the vehicle at the time of the staged accident. The defendants contacted the New Orleans Police Department and falsely claimed that Erica Lee was the driver at the time of the collision. Passenger A falsely claimed to the NOPD that she was Thompson.

Lee, a Louisiana woman pleaded guilty to Conspiracy to Commit Mail Fraud arising out of a staged automobile accident with a tractor-trailer occurring in New Orleans, making her the 30th guilty plea in "Operation Sideswipe."

According to the U.S. Department of Justice, approximately one or two days after the staged accident, Donisha Lee, **Donreion Lee, Erica Lee**, and Thompson went to an attorney's office for the purpose of collecting money from the insurance and trucking company. sought medical treatment from doctors and healthcare providers. Thompson was treated despite not being in the RAV4 at the time of the staged accident. Donisha Lee retained counsel and made a claim for damages. The total settlement for the Averitt accident was approximately $30,000.

On March 26, 2019, each provided false testimony in depositions taken in conjunction with the Thompson Lawsuit. Donisha Lee faces a maximum sentence of five (5) years of incarceration.

Pastor To Spend 15 Weekends in Jail for Insurance Fraud

Codie D. Malesker, a pastor and board member of the Faith Community Tabernacle and operator of the **Malesker Agency** in Hastings, Nebraska pleaded guilty to a single count of mail fraud. Federal court records show that US District Court Judge John M. Gerrard sentenced him to five years probation and 30 days in jail, to be served in two-day increments on the weekends.

Malesker, a Nebraska insurance agent and church pastor will spend 15 weekends in jail and pay $63,443.77 in restitution for filing false insurance claims.

Malesker was an agent for the **Midwest General Agency** in Lincoln, which assigned him as the producer for Malesker Agency in Hastings. He was also a partner with **Shaun Peck Family Construction LLC**.

Federal prosecutors say that Malesker defrauded insurers four times by filing false insurance claims for alleged damage and losses to the church and the agency.

The scheme started in 2013, when Malesker brokered an insurance policy for his church through The Hartford's Sentinel Insurance Co., according to an indictment filed by the U.S. Attorney's Office. Three years later, he filed a claim stating that the church has been damaged in a July 6, 2016 storm and emailed contractor and subcontractor invoices to the insurer.

Malesker issued $49,088.30 in checks from Faith Community Tabernacle's bank account to Shaun Peck Construction and diverted $19,238.07 of that to his personal accounts, the indictment says. He also transferred $29,293.24 from the church's bank account to his own bank account.

In April 2016, Malesker filed a claim with Sentinel stating that $5,125 in cash premiums had been stolen from his insurance agency's office. He submitted receipts, which were later determined to be fraudulent. Sentinel paid $5,125 on the claim.

Malester brokered a new insurance policy for his agency through Tri-State Insurance Co. of Minnesota in October 2016. The same month, he filed a claim reporting that $13,388 in cash paid for insurance premiums and $18,723 in personal property were stolen. The insurer paid $31,648.77.

In August 2016, Malesker obtained a policy for his church through Brotherhood Mutual Insurance Co. On Nov. 7, 2015, he filed two claims: One reported that $13,388 in cash church donations and $18,723.11 in personal property has been stolen from his office at the Malesker Agency. The second claim reported that cash donations and property were stolen from the church basement.

Brotherhood paid the church $7,500 on the first claim and $5,352.59 on the second. Malesker wrote a check on the church's account to Malesker agency for $7,000.

Prosecutors say total losses amounted to $76,296.48. The court ordered less restitution than that amount because Malesker had already repaid Brotherhood for its losses.

The US Attorney's Office dropped four fraud counts after Malesker agreed in September to plead guilty to a single count of insurance fraud. The office had recommended that Malesker be sentenced to eight months in prison, which prosecutors said was the minimum amount suggested by federal sentencing guidelines.

But Malesker filed a motion in October requesting a variance that would allow a more lenient sentence. According to the statement, he is 47 years old and was scheduled for a surgery last month to correct a heart ablation. Malesker said he already paid $21,779.41 in restitution and has no previous criminal record.

The court granted the variance on Friday, just before sentencing Malesker to probation and 15 weekends in jail.

Of course, if he fails to make full restitution, he should be ordered to serve the full five years.

U.K. Puts Personal Injury Claimant in Prison for 12-Months for Fictional Work Injury

Ashley Bowell was employed as a warehouse operative for a freight company in Coventry in 2016 when he claimed to have suffered an injury jumping from a container to the floor. The claim was found to be fundamentally dishonest at Walsall County Court in June 2019. The court found the claimant had knowingly made a series of false statements swore falsely in court testimony.

Bowell, a personal injury claimant was sentenced by the High Court in London for falsely claiming to have suffered a fall at work. The claimant admitted in an earlier hearing that the fall had never happened.

Mr. Charles Morrison (sitting at Deputy High Court Judge) concluded on 8 December that the claimant's conduct had adequately met the "custody threshold" given the serious nature of his contempt and immediate custody was the only appropriate option.

The court also ordered Mr. Bowell to pay the defendant's costs.

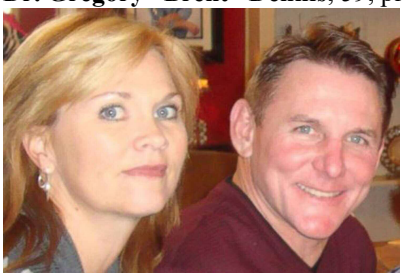
Flint, Michigan, Man Sentenced to Federal Prison for Aggravated Identity Theft

Patrick Robert McKee, a/k/a William Patrick O'Hara, Age 77 from Flint, MI, to two years in federal prison for the charges of Social Security False Statements, False Statements, Health Care Fraud, and Aggravated Identity Theft. Judge Traynor also sentenced McKee to 3 years supervised release and a $400 Special Assessment.

Investigation determined that McKee stole the identity of J.C. (Identity Protected) in 1997 and then converted J.C.'s identity to William Patrick O'Hara while retaining J.C.'s social security number. Since 1997, McKee fraudulently lived and worked under J.C.'s identity. He used J.C.'s identity to obtain healthcare benefits, home mortgages, credit cards and for numerous other fraudulent pretenses.

Husband Pleads Guilty to Killing Wife with Antifreeze, Opioids After Death Was First Ruled Suicide

Dr. Gregory "Brent" Dennis, 59, pleaded guilty to voluntary manslaughter charges and faces three to 10 years in prison. Dennis, a Nevada psychiatrist pleaded guilty to voluntary manslaughter in the death of his wife, who he killed with antifreeze and opioids.



Dennis' wife, attorney Susan Winters, died in 2015. Reports indicated that there was enough antifreeze in her system to kill her twice over. She also had a lethal amount of oxycodone in her system.

Winters' death was originally ruled a suicide. Dennis was arrested in February 2017 and charged with one count of murder with a deadly weapon.

An arrest report at the time claimed that Dennis was battling a cocaine addiction that drained his finances. He stood to inherit approximately $2 million — including a $1 million life insurance policy — upon his wife's death.

Although he pleaded guilty, Dennis still maintains his innocence a clear contradiction that should not be acceptable to a competent judge who will never accept a guilty plea if the defendant claims the guilty plea is false.

Excellence in Claims Handling

A Series of Video Presentations and Text on Insurance Claims

Go to "Excellence in Claims Handling" and subscribe at https://barryzalma.substack.com/welcome and go to https://zalmaoninsurance.locals.com/subscribe subscribe to my locals account. See the introductory video at https://youtu.be/kLSSBG7kZy0 and at https://rumble.com/vrhaka-excellence-in-claims-handling.html

Professional Insurance Adjusting

At the turn of the century, insurers, in a search for profit, decimated their professional claims sta. They laid off experienced personnel and replaced them with young, untrained and unprepared people.

A virtual clerk replaced the old professional claims handler. Process and computers replaced skill and judgment.

Insurers intentionally forgot that the promises made by an insurance policy are kept by the professional claims person. A professional claims staff is a cost-effective method to avoid litigation.

The professional claims person is an important part of the insurer's defense to litigation against insurers for breach of contract.

A staff of claims professionals dedicated to excellence in claims handling are a profit center for an insurance company. Experience establishes that claims professionals resolve more claims for less money without the need for either party to involve counsel. A happy insured or claimant satisfied with the results of his or her claim will never sue the insurer.

Incompetent or inadequate claims personnel force insureds and claimants to lawyers. Every study performed on claims establish that claims with an insured or claimant represented by counsel cost more than those where counsel is not involved.

Prompt, effective and professional claims handling saves money and fulfills the promises made when the insurer sold the policy.

Insurers who believe they can handle first or third-party claims with young, inexperienced and inexpensive claims handlers will be faced with the screams of angry stockholders. Profits, thin as they are, will move rapidly into negative territory. Punitive damages as punishment for bad faith claims handling will deplete reserves. Insurers will quickly question why they are writing insurance. Those who stay in the business of insurance will either adopt a program requiring excellence in claims handling from every member of their claims staff, or they will fail.

Insurance is a business. It must change if it is to survive. It must rethink the firing of experienced claims staff and reductions in training to save "expense."

Excellence in Claims Handling

Excellence in claims handling is a program that can help insurers avoid charges of bad faith in both first and third party claims.

An insurer must understand that it cannot adequately fulfill the promises it makes to it insured and the Fair Claims Practices Act which exist in almost every state, when dealing with claimants without excellence in claims handling. An insurer must work intelligently and with vigor to create a professional claims department.

A Proposal to Create Claims Professionals

To avoid claims of bad faith; to avoid punitive damages; to avoid losses; and to make a profit insurers must maintain claim staffs who are dedicated to excellence in claims handling. That means they will make sure every promise made in every policy is satisfied by the:

1. Insurers who only hire insurance claims professionals.
2. Insurers who train the claims staff to be insurance claims professionals.
3. Insurers who require that the claims staff treat every insured with good faith and fair dealing.
4. Insurers who demand excellence in claims handling from the claims staff.
5. The insurance industry for the last 25 years has decimated the number of insurance claims professionals for insurers to hire.
6. If any experienced claims professionals exist in the insurer's staff, the insurer must cherish and nurture them. If none are available, the insurer has no option but to train its people.
7. Those who treat all insureds and claimants with good faith and fair dealing and provide excellence in claims handling must be honored with increases in earnings and perquisites.
8. The insurer must immediately eliminate those who do not provide excellence in claims handling from the claims staff.

What Sources Are Available to Obtain Training?

Insurance training is available across the country by correspondence, in local colleges and universities and from law firms that will provide the training as a marketing tool. None of these sources are directed to producing insurance claims professionals. They do provide the basic background information necessary to begin the process of becoming an insurance claims professional. In that regard, I have created electronic training programs on professional claims handling that are available from experfy.com and a different set of courses from illumeo.com.

An excellence in claims handling program can include a series of web-based lectures supported by text materials like my claims books available at amazon.com and over the insurance claims library at my web site at https://zalma.com.

The web lectures must be supplemented by meetings between supervisors and claims staff on a regular basis to reinforce the information learned in the lectures.

In addition, the insurer must institute a regular program of auditing claims files to establish compliance with the subjects studied. There is no quick and easy solution. The training takes time. Learning takes longer. The insurer's management must support and reinforce the training regularly.

The excellence in claims handling program requires a minimum of the following:

1. The insurance policy — how to read and understand the contract that is the basis of every adjustment.
2. The formation of the insurance policy.
3. Tort law including negligence, strict liability in tort, and intentional torts.
4. Contract law including the insurance contract, the lease agreement, the bill of lading, non-waiver agreements, proofs of loss, releases and other claims related contracts.
5. The duties and obligations of the insured in a personal injury claim.
6. The duties and obligations of the insurer in a personal injury claim.
7. The duties and obligations of the insured in a first-party property claim.
8. The duties and obligations of the insurer in a first-party property claim.
9. The Fair Claims Practices Act and the regulations to enforce it.
10. The thorough investigation.
11. Basic investigation of an auto accident claim.
12. Basic investigation of a construction defect claim.
13. Basic investigation of a non-auto negligence claim.
14. Basic investigation of a strict liability claim.
15. Basic investigation of the first-party property claim.
16. The recorded statement of the first-party property claimant.
17. The recorded statement or interview of a third-party claimant.
18. The recorded statement of the insured.
19. The red flags of fraud.
20. The SIU and the obligation of the claims representative when fraud is suspected.
21. Claims report writing.
22. The evaluation and settlement of the personal injury claim.
23. How to retain coverage counsel to aid when a coverage issue is detected.
24. How to control coverage counsel.
25. How to retain an expert.
26. How to control the expert.
27. Dealing with a plaintiffs' lawyer.
28. Dealing with personal injury defense counsel.
29. The evaluation and settlement of the property damage claim.
30. Arbitration and mediation and the claims representative

It Takes Courage to Fight Insurance Fraud

The legislatures of the various states, the United States Congress, the National Association of Insurance Commissioners, The National Insurance Crime Bureau and insurance industry groups have finally decided that the war against insurance fraud is worth fighting.

Until the states, the local police agencies, the district attorneys, the United States Attorneys, and the Attorneys General of the various states join in the battle it will be fought to a stalemate. The insurance industry cannot successfully fight insurance fraud alone.

Insurance industry sources estimate insurance fraud from lows of $80,000,000,000 ($80 billion) a year to highs of $300,000,000,000 ($300 billion) a year. Regardless of which, if any, estimate is accurate the amount of money going to insurance criminals is staggering and approaches no less than 3% to 10% of premium collected.

Every two weeks *Zalma's Insurance Fraud Letter* publishes lists of convictions. The major volume of such convictions deal with Medicare and Medicaid fraud. Basic property and casualty fraud convictions are seldom described except when the perpetrator confesses or pleads guilty. Few go to trial. Those who are convicted usually are sentenced to short stays in jail or to home confinement.

Proposal

Insurance fraud is not a local problem. It is a depletion of the wealth of the entire country. The lawyer for the Department of Insurance of each state is the State Attorney General. A special unit could be established in the office of the Attorney General, funded with the monies taken from the insurance industry to support the war against insurance fraud. This unit should be given a simple mandate:

File and prosecute every insurance fraud brought to the unit by the Fraud Division that has a better than 50% chance of success.

The unit should not concentrate its efforts on major insurance frauds. Those can best be prosecuted by major fraud units already existing in the District Attorney's offices and in offices of the US Attorney.

The state's unit should concentrate on prosecuting every-day insurance fraud, the frauds of opportunity that take 90% of the money paid to fraud perpetrators, in the range of $5,000 to $50,000.

Single counts should be prosecuted. When prosecutors file multiple charges against individual defendants the case becomes a major action requiring a great deal of time to prosecute. Judges and juries do not want to be involved in a prosecution that takes months to prosecute.

If there are multiple counts available, the prosecutor should charge only the one where the evidence of fraud is overwhelming. If the jury finds for the defendant the prosecutor can charge the next count continuously until the statute of limitation runs.

If all available are charged in one case the prosecutor will offend the judge and jury and the defendant will get mercy from the jury. Overcharging prosecution is as bad as not charging at all.

Teeth must be put in the posters that say "commit insurance fraud, go to jail." Departments of Insurance are receiving reports from insurers of thousands of potential fraudulent claims a month. They do not have the staff, the ability or the desire to investigate and prosecute every case brought to them. If only 5 percent of those claims are investigated and prosecuted to conviction, the deterrent effect will be enormous. The Department of Insurance should issue a press release concerning every arrest and conviction. Newspapers should report daily that insurance criminals have been arrested and are going to trial or were convicted and are going to jail. Jail sentences should be made mandatory and remove from local judges the right to grant convicted felons probation and restitution only.

Sentences across the state must be consistent and true punishment. I have seen such inconsistency where cases, after conviction, the criminals received sentences that ranged from 24 hours to 24 years.

It is not enough for the state to say that the insurance companies must investigate and work to fight fraud. The state must also aggressively and vigorously fight insurance fraud.

Today, a person perpetrating an insurance fraud need only be concerned that an aggressive fraud investigation might delay, or reduce, the amount he might recover from his crime. Criminal prosecution for the crime of insurance fraud is so minuscule, in relation to the amount of fraud, as to be nonexistent. It certainly does not act as a deterrent. In conjunction with the formation of a special insurance fraud prosecution unit in the attorney general's office, the legislatures should enact the following statutes:

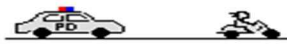
- As of the effective date of this statute there is no tort of bad faith in this state.
- Punitive damages may not be awarded in this state.
- Any insurer that, without malice, reports to the Fraud Division, Department of Insurance that it has rejected a claim because of fraud may not be sued in any court of this state, for any tort cause of action.
- This section is not intended to eliminate the right of any insured to sue its insurer for breach of the insurance contract.
- If the legislatures really want insurers to fight insurance fraud; if the legislatures wish to keep strong and viable this important industry; if the legislatures want to reduce the insurance premiums paid by their constituents, they must make practical the war on insurance fraud. As long as the tort of bad faith and the exposure of punitive damages hangs over insurance companies, the war will be one of attrition where no one will win.

If enough people complain perhaps, the prosecution levels will increase. Although each of the stories in this book are based in fact, the names, locations and facts of the claims have been changed to protect the guilty. No resemblance to any person, except those specifically named, is intended and any resemblance is purely coincidental.

Zalma on Insurance Blog Posting

- Supreme Court of Delaware Applies Policy as Written January 14, 2022
- Guilty Verdict Stands for Failure to Preserve Issue for Appeal January 13, 2022
- Insurance Fraud Conviction Affirmed January 12, 2022
- Forced Placed Insurance only Insured the Risk Faced by the Lender January 11, 2022
- Federal Court Retains Jurisdiction of Rescission Case January 10, 2022
- How to Defeat Insurance Fraud January 10, 2022

- Second Edition: Construction Defects and Insurance Part Three Now Available January 7, 2022
- It Doesn't Pay to Lie to Your Insurer January 7, 2022
- After Insurance Fraud Indictment Dismissed Defendants Sue Police Officer January 6, 2022
- Excellence in Claims Handling – A Video Series January 5, 2022
- Contract Provides Effective Transfer of Risk January 5, 2022
- Workers' Compensation Board Improperly Ignored Evidence of Fraud January 4, 2022
- ClaimSchool, Inc. – Insurance Education January 3, 2022
- Excellence in Claims Handling – A Video Series January 3, 2022
- Zalma's Insurance Fraud Letter – January 1, 2022 January 3, 2022
- Happy New Year's Eve December 31, 2021
- Excellence in Claims Handling December 27, 2021
- Join the "Zalma on Insurance" Community on Locals.com December 24, 2021
- Excellence in Claims Handling Now Available on Substack December 23, 2021



Barry Zalma, Esq., CFE Barry Zalma, Esq., CFE, now limits his practice to service as an insurance consultant specializing in insurance coverage, insurance claims handling, insurance bad faith and insurance fraud almost equally for insurers and policyholders. He also serves as an arbitrator or mediator for insurance related disputes. He practiced law in California for more than 44 years as an insurance coverage and claims handling lawyer and more than 54 years in the insurance business. He is available at http://www.zalma.com and zalma@zalma.com.

Over the last 54 years Barry Zalma has dedicated his life to insurance, insurance claims and the need to defeat insurance fraud. He has created the following library of books and other materials to make it possible for insurers and their claims staff to become insurance claims professionals.

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