No. 125918

IN THE SUPREME COURT OF ILLINOIS

ROSEMARIE HAAGE, Plaintiff-Appellee, v. ALFONSO MONTIEL ZAVALA, PATRICIA SANTIAGO, JOSE PACHECO-VILLANUEVO, OKAN ESMEZ and ROSALINA ESMEZ, Defendants, and STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, Intervenor-Appellant.	On Appeal from the Appellate Court of Illinois, Second Judicial District, Consolidated Docket Nos. 2-19-0499 & 2-19-0500 There Heard on Rule 307 Interlocutory Appeal from the Circuit Court of the Nineteenth Judicial Circuit Lake County, Illinois, Cause No. 17 L 897 The Honorable Mitchell L. Hoffman, Judge Presiding
AGNIESZKA SURLOCK and EDWARD SURLOCK, Plaintiffs-Appellees, v. DRAGOSLAV STARCEVIC, Defendant, and STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY, Intervenor-Appellant.	On Appeal from the Appellate Court of Illinois, Second Judicial District, Consolidated Docket Nos. 2-19-0499 & 2-19-0500 There Heard on Rule 307 Interlocutory Appeal from the Circuit Court of the Nineteenth Judicial Circuit Lake County, Illinois, Cause No. 18 L 39 The Honorable Diane E. Winter, Judge Presiding

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BRIEF OF AMICUS CURIAE NATIONAL INSURANCE CRIME BUREAU IN SUPPORT OF INTERVENOR-APPELLANT, STATE FARM MUTUAL AUTOMOBILE INSURANCE COMPANY

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STATEMENT OF INTEREST OF AMICUS CURIAE

Amicus Curiae National Insurance Crime Bureau (NICB) respectfully submits this brief in support of Intervenor-Appellant State Farm. The NICB submits this *amicus curiae* brief to apprise the Court of the practical and deleterious repercussions that, if left uncorrected, the decision below will have on the ability of federal and state law enforcement agencies, the insurance industry, and *amicus* to combat insurance fraud.

The NICB is a not-for-profit corporation which, along with its predecessors, has a nearly 100-year history of fighting insurance fraud and crime. The NICB's membership includes approximately 1,200 leading commercial and property/casualty insurers, self-insured organizations, rental car companies, and transportation related firms. Intervenor-Appellant State Farm Mutual Automobile Insurance Company ("State Farm") is one of NICB's member companies.

The NICB's nearly 400 employees work with law enforcement agencies, technology experts, government officials, prosecutors, and international crime-fighting organizations in the fight against insurance fraud and related crimes.

In Illinois, the NICB is the state-designated repository of questionable claims information. Thus, if an insurance company in Illinois has factual information that is pertinent to suspected insurance fraud, it is *required* by law to report that information to the NICB.[1]

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[1] 215 ILCS 5/155.23(2). *See also* Letter from Dale Emerson, Assistant Deputy Director, Illinois Department of Insurance, to Thomas P. Dixon, Staff Attorney, National Insurance Crime Bureau (Jan. 20, 2004) (on file with *amicus,* NICB).

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The NICB is also specifically named in the immunity statutes of eleven states for the sharing of information relating to suspected insurance fraud;[2] and in most other state's immunity laws the NICB is referenced by a description, such as an "insurance support organization."

The NICB complies with all state and federal laws concerning the protection of confidential information, including medical records. Many NICB employees have direct access to records in the FBI's National Crime Information Center database. As a result, the FBI requires that all NICB employees pass a fingerprint background check and audits NICB's access to this information.[3]

The Protective Order at issue in this case directly impacts the NICB's ability to carry out its obligations as the state-designated repository of questionable claims information in Illinois, and its overall organizational mission.

NATURE OF THE CASE

Plaintiffs sued to recover damages for bodily injuries sustained in automobile accidents allegedly caused by defendants' negligence. Plaintiffs asked the court to enter a restrictive HIPAA-qualified[4] protective order that would require all protected health

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[2] 3 CCR 702-6; FLA STAT. §626.989(c)(3); HAW. REV. STAT. §431:2-408(b)(5); IDAHO CODE ANN. §41·292(5)(c); K.S.A. §304.47-055; LA. STAT. ANN §40:1425(B); §375.993, R.S. Mo.; NY CLS Fin Serv §405; S.C. CODE §38-55-580(0)(2); Va. Code Ann. §52·4l(B); WASH. REV. CODE §48.50.070.

[3] The NICB is one of only two nongovernmental organizations with direct computer access to National Crime Information Center data, the other being the National Center for Missing and Exploited Children.

[4] Health Insurance Portability and Accountability Act of 1996, Pub.L 104-191 (Aug. 21, 1996), 110 Stat.1936 (1996), codified at 42 U.S.C. § 1320d et seq.

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information ("PHI") pertaining to plaintiffs to be returned or destroyed at the end of the litigation. State Farm Mutual Automobile Insurance Company ("State Farm"), which insured the defendant in each case, petitioned to intervene and proposed that the court adopt the Cook County Circuit Court Law Division's standard medical protective order ("Cook County protective order"). The Cook County protective order meets HIPAA's requirements while also avoiding any conflict with insurance laws and regulations governing property and casualty insurers' retention, use, and disclosure of records containing PHI. The trial court allowed State Farm to intervene, but then entered Plaintiffs' restrictive HIPAA-qualified protective order, not the Cook County protective order.

The intermediate appellate court upheld the trial court's decision to enter the Plaintiffs' restrictive HIPAA-qualified protective order. Although the court recognized that State Farm was not a "covered entity" under HIPAA, it found that State Farm was and should be subject to the use-and-disclosure restrictions in the HIPAA-qualified protective order. It said that State Farm was not required to retain plaintiffs' PHI at the end of the litigation under federal or Illinois law and regulations. Alternatively, if State Farm was required to retain PHI, the court below said that HIPAA preempted any conflicting law and regulations. The court found that the McCarran-Ferguson Act did not compel reverse preemption in favor of the existing Illinois insurance law and regulations. Finally, it ruled that, before adopting Plaintiffs' restrictive HIPAA-qualified protective order, the trial court was not required to consider other means of handling PHI consistent with HIPAA that avoided any conflict with the property and casualty insurance regulatory framework, were less intrusive to insurers' operations, and did not impede anti-fraud efforts undertaken pursuant to Illinois law and regulations.

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State Farm's Petition for Leave to Appeal followed, and this Court granted the petition on September 30, 2020.

ISSUES PRESENTED FOR REVIEW

Whether the trial court properly endorsed plaintiffs' restrictive HIPAA-qualified protective order over State Farm's objections; and, specifically, whether HIPAA preempts the regulatory framework governing property and casualty insurers' retention, use, and disclosure of records containing plaintiffs' PHI in personal injury cases such as these.

Whether the trial court erred by entering plaintiffs' restrictive HIPAA-qualified protective order to the extent it conflicts with insurance laws and regulations governing property and casualty insurers' retention, use, and disclosure of records containing PHI, and where other means of handling PHI consistent with HIPAA were available.

ARGUMENT

Standard of Review

This case presents questions of law subject to *de novo* review. *Haage v. Montiel Zavala,* 2020 IL App (2d) 190499, ¶ 62*; Carter v. SSC Odin Operating Co.,* 237 Ill. 2d 30, 39 (2010).

Introduction

The court below approved an unnecessarily restrictive protective order that limits the use of PHI to the litigation in which it is produced and requires the return or destruction of records containing PHI within 60 days of the litigation's end. Allowing that decision to stand will significantly reduce the ability of organizations such as insurers, the NICB, and law enforcement to uncover, report, and prosecute healthcare fraud. Without the ability to

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investigate and ultimately prosecute the offenders, costs of health insurance, automobile liability insurance, Medicare, and Medicaid will invariably increase.

The inability to fight health insurance fraud will be borne on the backs of an already economically beleaguered American consumer. The decision below is a significant, unnecessary impediment to the multi-state effort to discover and deter, and ultimately, investigate and prosecute healthcare fraud. The court below erroneously concluded that property and casualty insurers need not retain or use PHI for any purpose outside of the litigation in which it is produced in discovery. *Haage v. Montiel Zavala,* 2020 IL App (2d) 190499, ¶ 60.

Property and casualty insurers, such as State Farm, and insurance-support organizations, such as NICB, are heavily-regulated entities who are required by law to retain PHI and who are permitted to use PHI for specified purposes beyond litigation. By enacting HIPAA, Congress did not displace federal and state insurance laws and regulations governing property and casualty insurers, who are expressly excluded from the definition of "covered entity" in HIPAA. 45 C.F.R. § 160.103 (2018). The use of PHI by property and casualty insurers, and insurance-support organizations such as NICB, for authorized insurance functions is governed by a separate regulatory framework, which can and should be recognized and accommodated under HIPAA's terms. The use-and-disclosure restrictions in the restrictive HIPAA-qualified protective orders entered by the courts below conflict with insurer and NICB obligations under other laws and regulations, but that conflict could have been avoided by entering a HIPAA-compliant order under 45 C.F.R. §164.512(e)(1)(i).

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The protective orders entered below will prevent the NICB from performing its job by precluding insurance companies from sharing information with the NICB about suspected fraud, which they are legally required to do. *See* 215 ILCS 5/155.23. The decision below therefore must be reversed. This Court should require a protective order that expressly allows for automobile insurers such as State Farm here, and insurance-support organizations such as NICB, to use, retain and disclose PHI in conformity with the property and casualty regulatory framework governing them.

Intervenor-Appellant State Farm's brief sets forth the Constitutional, statutory, and other legal issues at stake. This brief supports those arguments and will address the impact of the decision below on the detection of healthcare fraud.

I. The Decision at Issue Upsets the Current National Statutory and Regulatory Scheme for a Public-Private Partnership to Fight Insurance Fraud.

Oftentimes, when we think of healthcare fraud, we think of an individual "padding" claims or exaggerating injuries. This appears to have been the case when the Illinois court below erroneously rejected State Farm's concerns that the protective order impeded its ability to comply with its anti-fraud obligations under Illinois law. The court said: "In this case, there is no indication of fraud and no evidence that the Director [of the Illinois Department of Insurance] has determined that any PHI is necessary to detect fraud or arson. *Thus, there can be no factual information pertinent to any suspected fraud.*" *Haage v. Montiel Zavala*, 2020 IL App (2d) 190499, ¶ 56 (emphasis added).

While individuals may "pad" their claims and sometimes seek unnecessary treatment to exaggerate a liability claim, healthcare fraud is primarily committed by healthcare professionals. For example, on September 7, 2011, Attorney General Eric

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Holder and Health and Human Services (HHS) Secretary Kathleen Sebelius announced charges against 91 defendants, including doctors, nurses, and other medical professionals, for their alleged participation in Medicare fraud schemes involving approximately $295 million in false billing.[5] The charges were based on a variety of schemes involving medical treatments and services such as home health care, physical and occupational therapy, mental health services, psychotherapy, and durable medical equipment. In many cases, the charges involved "services" that were medically unnecessary and often never provided.

The press reported that:

> As part of a coordinated action, 70 individuals were charged by Strike Force prosecutors in indictments unsealed yesterday and today in six cities alleging a variety of Medicare fraud schemes involving approximately $263.6 million in false billings. As part of takedown operations last week, 18 additional defendants were charged in Detroit and one defendant was charged in Miami in cases unsealed on Sept. 1, 2011, for their alleged roles in Medicare fraud schemes involving approximately $29.4 million in fraudulent claims. Additionally, two individuals are scheduled to appear in court today on charges filed on Aug. 24, 2011, for their roles in a separate $2 million health care fraud scheme.

Id. (footnote 5). Citing the use of data analysis techniques and broad cooperation among law enforcement and other partners, Attorney General Holder said that "anti-health care fraud efforts have never been more innovative, collaborative, aggressive – or effective." *Id*.

If applied to a healthcare fraud case involving automobile insurance medical payments, the ruling below would have prevented investigators from aggregating insurance information from innocent policyholders, such as the plaintiffs here, to detect fraudsters. The misguided assumption of the lower courts that healthcare investigations center on exaggerated injuries of individual plaintiffs led those courts to allow an order to stand that

[5]https://www.fiercehealthcare.com/payer/medicare-fraud-strike-force-charges-91-individuals-for-approximately-295-million-false

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will thwart the efforts to accomplish what is illustrated above. If medical professionals will submit false billings on Medicare recipients, certainly they would do the same to insurance companies, especially if insurance companies are stripped of their most important tools in discovering healthcare fraud.

From years of careful analysis of claims, the NICB has concluded that the main cost of healthcare fraud to third-party payors arises from sophisticated interstate, often international, fraud rings which include unscrupulous medical providers who will, for example, submit bills for fictitious treatment on people who previously died or on people whose identities they have stolen. Yet, by erroneously concluding that in the plaintiffs' lawsuits here "there can be no factual information pertinent to any suspected fraud," the rulings below would make impossible the modern data analysis techniques that are the most innovative, collaborative, aggressive, and effective in detecting massive healthcare fraud. *See Haage v. Montiel Zavala*, 2020 IL App (2d) 190499, ¶ 56

II. Data Gathering and Analysis Plays a Critical Role in Fighting Insurance Fraud.

Most property and casualty insurance companies subscribe to the ClaimSearch database operated by the Insurance Services Office, Inc. Subscribers can enter information about insurance claims into this database. If an insurance company believes that a claim is "questionable" it can designate the claim as such and the claim then goes into NICB's questionable claim database and is reported, on behalf of the insurer, to the applicable state. NICB personnel review these questionable claims for anomalies and may request complete claim files from insurers to investigate and determine if the matter should be referred to law enforcement for further investigation and possible prosecution. Law enforcement

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officers may also come to the NICB for assistance in gathering and analyzing claim files when they have already started a criminal investigation.

The NICB also works with many insurers on an aggregate medical database, where detailed insurance claim information, scrubbed to remove personal identifiers, is aggregated and examined for patterns indicating possible fraud, such as many patients traveling great distances to a certain clinic or medical personnel billing for more than 24 hours in a day, or billing on Sundays if their offices are closed on Sundays. The NICB's ability to review large volumes of medical data, especially medical data related to automobile liability policies, has been an increasingly critical tool in the fight against healthcare fraud and is vital to support law enforcement.

III. The Decision Below Will Severely Undercut the Ability to Collect and Analyze the Information Necessary to Effectively Fight Insurance Fraud.

The ruling below, if allowed to stand, would effectively prevent the NICB from being able to discover insurance fraud and support law enforcement in their efforts to combat these crimes. Most states, like Illinois,[6] have statutes requiring insurance companies to report questionable claims to the state. Protective orders similar to the protective order issued in this case will make it difficult, if not impossible, for insurance companies to comply with their statutory duties to report insurance fraud.

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[6] Under Section 155.23 of the Insurance Code in Illinois, the Director of Insurance is authorized to require insurers to report factual information in their possession -- including PHI such as the claimant's name, the identity of the physician or any other person rendering medical treatment, a description of the injuries, and the place of medical treatment -- that is pertinent to suspected fraudulent insurance claims upon a determination that the information is necessary to detect fraud or arson. 215 ILCS 5/155.23(1) (West 2018).

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In addition to hindering insurers' ability to meet their statutory obligations, the protective order specifically impedes NICB's statutory obligations and its mission to combat healthcare fraud in Illinois. Under Section 155.23 (2) of the Insurance Code, 215 ILCS 5/155.23(2) (West 2018), the Director of Insurance "may designate one or more data processing organizations or governmental agencies" to assist in gathering and making compilations of anti-fraud information. The NICB and the Department of Insurance have entered into a memorandum of understanding designating the NICB as the repository and developer of a database for reporting potentially fraudulent insurance claims in Illinois. (R.C445.) Thus, if an insurance company in Illinois has factual information that is pertinent to suspected insurance fraud, it is required by law to report that information to the NICB. *See* 215 ILCS 5/155.23(2).[7]

The decision below contended that "the statute requires an insurer to report only factual information in their possession. An insurer that has returned or destroyed PHI in accordance with a HIPAA qualified protective order cannot violate the statute, because it does not possess any such information." *Haage v. Montiel Zavala*, 2020 IL App (2d) 190499, ¶ 56. But, if insurers return or destroy all PHI provided in litigation because of protective orders such as the one the courts entered below, the necessary claim information to combat healthcare fraud could never be gathered and complied by insurance-support organizations designated by the Director for law enforcement purposes (such as the NICB). If PHI can be used only in the litigation and must be returned or destroyed within 60 days of the end of the litigation, relevant healthcare information required for modern data

[7] *See a* Letter from Dale Emerson, Assistant Deputy Director, Illinois Department of Insurance, to Thomas P. Dixon, Staff Attorney, National Insurance Crime Bureau (Jan. 20, 2004) (on file with amicus, NICB).

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analysis techniques used by insurance-support organizations such as NICB, and law enforcement, to detect and prove insurance fraud will no longer be available for that laudable purpose.

It is essential to the NICB's fraud fighting efforts on behalf of its members, law enforcement, regulators, and the general public to have access to medical information, including such health information as billing and procedure codes, to look for fraud indicators across a broad pool of apparently neutral insurance claims information. (R.C442-43.) This requires the gathering, maintaining, and processing of medical information for an aggregate review to help determine:

1. If an individual or group of individuals has filed multiple claims with different insurers for the same or similar injury(s).

2. If healthcare providers are billing multiple insurers for the same care provided to a patient.

3. Whether a healthcare provider is billing more than 24 hours in a day, which can usually only be discovered by looking at aggregated medical data from many claims.

4. Whether a healthcare provider is billing for periods of time the healthcare provider is incarcerated or out of the country.

5. If the healthcare provider is submitting bills on individuals who are deceased.

6. Whether the claimed injuries are consistent with the alleged accident, which might involve comparing the medical records of all individuals in an accident to find out why some individuals had only minor injuries and others were claiming extensive injuries.

7. If a healthcare provider is billing for an expensive procedure that is so uncommon it only is necessary for 1 out of 100 patients, but is billing for this procedure in 90% of patients treated. This could only be discovered by reviewing an aggregate of many different possibly innocent individuals' health records.

Provisions such as those found in Illinois Insurance Code Section 155.23(1)-(2) make gathering and analyzing this information possible. According to the National Health

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Care Anti-Fraud Association, many states have responded vigorously to the threat of healthcare fraud, not only by strengthening insurance fraud laws and penalties, but also by requiring insurers "to meet certain standards of fraud detection, investigation and referral as a condition of maintaining their licenses in the state."[8]

The use-and-disclosure restrictions in the protective order entered by the court below would effectively nullify Illinois Insurance Code 155.23(1)-(2), would make it impossible for NICB and individual insurers to carry out fully their statutory obligations under Illinois law, and would thwart the public imperative to detect and combat healthcare fraud.

IV. Examples of Cases Where the NICB and Law Enforcement Jointly Used Data Collected by the NICB to Thwart Insurance Fraud.

The best way to illustrate the impact that this decision would have on the united effort to fight insurance fraud is to examine several actual cases that the NICB investigated and analyzed leading to the arrest and prosecution of insurance fraudsters. If the decision below stands, such results will become far more difficult to achieve and therefore more criminals will escape detection.

1. Illinois - Law enforcement requested NICB assistance regarding the alleged fraudulent billing practices of a medical provider. In response, a task force agent was able to provide vital information with research and investigation supporting the alleged billing discrepancies. After a criminal investigation involving federal and state officials and multiple member company Special Investigation Units, the provider was indicted on 19 Counts of Insurance Fraud. The exposure of the indictment is approximately $9.7 million dollars.[9]

[8] National Health Care Anti-Fraud Association, The Challenge of Health Care Fraud, https://www.nhcaa.org/resources/health-care-anti-fraud-resources/the-challenge-of-health-care-fraud/ (last visited December 2, 2020).

[9] https://www.nicb.org/news/regional-news/billing-practices

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2. North Carolina - An investigation of staged accidents and fraudulent medical billing has resulted in charges against eight individuals.[10]

3. New Jersey - Two former state public education system employees pled guilty and were sentenced to prison terms in federal court for defrauding New Jersey state health benefits programs by submitting fraudulent claims for medically unnecessary compounded prescriptions. The defendants were sentenced to 37 months and 46 months in prison, respectively.[11]

4. New Jersey - A Hudson County, New Jersey, man was sentenced to 12 months and one day in prison in federal court for his role in an automobile accident scheme in which healthcare practitioners fabricated or exaggerated accident victims' injuries to support fraudulent insurance claims to Personal Injury Protection (PIP) insurance plans for medically unnecessary services.[12]

5. Washington - The NICB assisted federal law enforcement with a staged accident ring investigation that identified and resulted in charges against 22 participants using at least 48 aliases. The case has resulted in convictions for 21 individuals; only the leader remains at large.[13]

6. Florida - A Palm Beach County, Florida doctor was arrested and charged with conspiring to commit healthcare fraud and wire fraud for his alleged participation in a massive years-long healthcare fraud scheme throughout Palm Beach County, billing for fraudulent tests and treatments for vulnerable patients seeking treatment for drug and/or alcohol addiction.[14]

7. Georgia - A Florida man who operated a durable medical equipment company admitted participating in a Medicare kickback and telemedicine fraud scheme. The defendant entered a guilty plea in federal court to one count of conspiracy and admitted paying kickbacks in return for "leads," which were signed orders from physicians and nurse practitioners, and then billing those orders to Medicare.[15]

8. Texas - A chiropractor was issued a chiropractic license in 2003. In 2016, that license was revoked by the Texas Board of Examiners for various alleged violations. Regardless, he allegedly continued to provide chiropractic services and

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[10] https://www.nicb.org/news/regional-news/north-carolina-staged-accident-investigation
[11] https://www.nicb.org/news/regional-news/mid-atlantic-medical-fraud-task-force-nj-public-education-employees-sentenced
[12] https://www.nicb.org/news/regional-news/mid-atlantic-medical-fraud-task-force-car-accidentinsurance-fraud-scheme
[13] https://www.nicb.org/news/regional-news/2-additional-guilty-pleas
[14] https://www.nicb.org/news/regional-news/florida-doctor-charged-massive-681-million-substance-abuse-treatment-fraud
[15] https://www.nicb.org/news/regional-news/durable-medical-equipment-company-owner-admits-kickback-scheme

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bill member companies. On October 1, 2020, the chiropractor was sentenced in three cases. In case one, he pled guilty to practicing without a license and was sentenced to three days in the county jail but was credited with times served. In case two, he pled guilty to third degree felony insurance fraud less than $20,000 and was convicted and sentenced to five years in the Department of Corrections which was probated for 10 years. He was also ordered to pay restitution. In the third case, he pled guilty to third degree felony insurance fraud less than $30,000 and his conviction was deferred for a period of 10 years. He will be on probation for 10 years and was ordered to pay restitution.[16]

9. California - A joint effort by the California Department of Insurance and the Orange County District Attorney's Office led to charges against five defendants in connection with a fraud ring allegedly designed to traffic vulnerable substance abuse patients from outside California into treatment facilities in Orange and Riverside counties and to bilk insurance companies out of millions of dollars.[17]

Preventing insurers from aggregating claimant medical information through a third party, such as the NICB, does not protect an individual's privacy. It only protects those who are attempting to commit fraud against the American people. There was no showing that State Farm, any other insurer or the NICB ever misused any individual's medical information. However, there is extensive evidence of how fraudsters submit false medical billings to insurers and to the federal government for their own greed, which the decision of the Illinois court below, if allowed to stand, would make it more difficult to detect and deter.

CONCLUSION

For the reasons stated, amicus curiae National Insurance Crime Bureau respectfully submits that this Court reverse the opinion and judgment below and direct the courts below to enter protective orders that expressly allow for the use, retention, and disclosure of PHI in conformity with all federal and state laws and regulations.

[16] https://www.nicb.org/news/regional-news/chiropractor-sentenced-three-cases
[17] https://www.nicb.org/news/regional-news/additional-arrest-warrants-issued-60-million-sober-living-home-fraud-scheme

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Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Illinois Supreme Court Rules 341 and 345. The length of this brief, excluding the pages containing the Rule 341(d) cover, the Rule 341(h)(1) table of contents and points and authorities, the Rule 341(c) certificate of compliance, is 15 pages.

By:/s/ Patrick D. Cloud

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