

IN THE MATTER OF THE
MARYLAND INSURANCE
ADMINISTRATION

v.

BRIANNA C. HICKS
5107 Marlin Court
Waldorf, MD 20604-2640

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BEFORE THE MARYLAND
INSURANCE COMMISSIONER

CASE NO. : MIA-2016-10-012
Fraud Division File No.: R-2016-3749A

ORDER

This Order is entered by the Maryland Insurance Administration (“MIA”) against Brianna C. Hicks (“Respondent”) pursuant to §§ 2-108, 2-201, 2-204 and 2-405 of the Insurance Article, Md. Code Ann. (2011 Repl. Vol. & Supp.)(“Insurance Article”).

I. Facts

1. Respondent had a cancer insurance policy with American Family Life Assurance Company of Columbus (“AFLAC”), an authorized insurer. The policy went into effect on September 19, 2008.

2. The AFLAC policy provided cancer treatment coverage for Respondent as well as her dependent children.

3. Between December, 2011 and February, 2016, Respondent submitted 148 healthcare claim forms to AFLAC for treatments she purportedly received. Relying on those claim forms, AFLAC paid Respondent \$69,620.17 in benefits via direct deposit into her personal bank account. Among the claims submitted, 22 were for treatment at University of Maryland Medical Center, 41 claims were for blood-work at Charles Regional Medical Center, and four were disability claims ostensibly signed by Respondent’s employer, Southern Maryland Electric Cooperative, Inc. (“SMECO”).

4. Each of the aforementioned claim forms identified Respondent as the policyholder. In support of Respondent's University of Maryland hospital claims, Respondent submitted an "Itemized Statement of All Charges." In support of her blood work at Charles Regional Medical Center, Respondent submitted receipts. In support of her disability claims, Respondent submitted AFLAC Disability Claim forms apparently signed by a SMECO representative which contained a statement regarding Respondent's time missed from work.

5. On August 12, 2015, an AFLAC Claims Specialist contacted University of Maryland Medical Center to verify Respondent's treatment. The treatment could not be verified. Therefore, the claims specialist referred the matter to AFLAC's Special Investigations Unit ("SIU") for further investigation.

6. Section 27-802(a)(1) of the Maryland Insurance Article states,

An authorized insurer, its employees, fund producers, insurance producers, ... who in good faith has cause to believe that insurance fraud has been or is being committed shall report the suspected insurance fraud in writing to the Commissioner, the Fraud Division, or the appropriate federal, State or local law enforcement authorities.

AFLAC, having a good faith belief that Respondent committed insurance fraud, referred the matter to the MIA Fraud Division.

7. During the course of its investigation, MIA contacted AFLAC and confirmed its handling of Respondent's claims. AFLAC confirmed benefits were paid to Respondent via direct deposit.

8. MIA contacted a representative from the Central Billing Office for the University of Maryland Medical Center. The representative confirmed that eight treatment visit receipts were valid but 14 were not. The representative noted that each patient treatment visit generates a different patient identification number on the treatment form; however, on 13 forms, the same

patient number was entered, and one form did not contain a patient identification number. Relying on these 14 fraudulent claim forms, AFLAC paid Respondent \$31,829.70 in benefits for this fictitious treatment.

9. MIA contacted the billing manager from the Charles Regional Medical Center Billing/Finance department. The manager confirmed that one treatment visit receipt was valid but 40 were not. The manager noted that each patient treatment visit generates a different patient number on the receipt. On all 41 receipts, the same patient number was listed. For the 40 invalid claim forms, the representative confirmed Respondent did not have the blood work performed as reflected on the claims forms. Relying on these fraudulent claim forms, AFLAC paid Respondent \$9,750.00 in benefits for this fictitious blood work.

10. MIA contacted the SMECO Benefits & Wellness Manager. She confirmed that one of the disability forms was valid but three were not, and although the Benefits & Wellness Manager's name appeared on the invalid forms she had not signed them. SMECO provided payroll records noting Respondent worked or was on paid leave for dates she claimed to be on disability. SMECO also provided badging reports demonstrating Respondent had entered company facilities for dates and times she claimed to be unable to work and on disability. Relying on the three fraudulent disability claim forms, AFLAC paid Respondent \$15,390.00 in disability benefits.

II. Violation(s)

11. In addition to all relevant sections of the Insurance Article, the Administration relies on the following pertinent sections in finding that Respondent violated Maryland's insurance laws:

12. §27-403

It is a fraudulent insurance act for a person:

(2) to present or cause to be presented to an insurer documentation or an oral or written statement made in support of a claim...with knowledge that the documentation or statement contains false or misleading information about a matter material to the claim.

13. §27-408(c)

(1) In addition to any criminal penalties that may be imposed under this section, on a showing by clear and convincing evidence that a violation of this subtitle has occurred, the Commissioner may:

(i) impose an administrative penalty not exceeding \$25,000 for each act of insurance fraud; and

(ii) order restitution to an insurer or self-insured employer of any insurance proceeds paid relating to a fraudulent insurance claim.

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(2) In determining the amount of an administrative penalty, the Commissioner shall consider:

- (i) the nature, circumstances, extent, gravity, and number of violations;
- (ii) the degree of culpability of the violator;
- (iii) prior offenses and repeated violations of the violator; and
- (iv) any other matter that the Commissioner considers appropriate and relevant.

14. By the conduct described herein, Respondent violated §27-403. As such, Respondent is subject to an administrative penalty under the Insurance Article §27-408(c).

III. Sanctions

15. Insurance fraud is a serious violation which harms consumers in that the losses suffered by insurance companies are passed on to consumers in the form of higher premiums. The Commissioner may investigate any complaint that alleges a fraudulent claim has been submitted to an insurer. Insurance Article §§ 2-201(d)(1) and 2-405.

16. Respondent submitted fraudulent hospital bills, blood work receipts, and disability forms to AFLAC. Relying on those claim forms, AFLAC paid Respondent a total of \$56,969.70. The claim forms were submitted for services never performed and for time not missed from work.

Having considered the factors set forth in § 27-408(c)(2) and COMAR 31.02.04.02, MIA has determined that \$50,000.00 is an appropriate penalty.

17. Additionally, Respondent is ordered to reimburse AFLAC \$56,969.70, which is the amount she received based upon AFLAC's reliance on claims later determined to be fraudulent.

18. Administrative penalties shall be made payable to the Maryland Insurance Administration and shall identify the case by number (R-2016-3749A) and name, (Brianna C. Hicks). Unpaid penalties will be referred to the Central Collections Unit for collection. Payment of the administrative penalty shall be sent to the attention of: Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202.

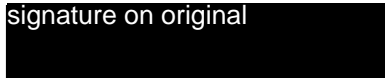

19. Notification of reimbursement to AFLAC shall be made in writing to the Associate Commissioner, Insurance Fraud Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Such notification shall include a copy of the money order or cancelled check issued to AFLAC as proof of reimbursement and identify the case by number (R-2016-3749A) and name, (Brianna C. Hicks).

20. This Order does not preclude any potential or pending action by any other person, entity or government authority, regarding any conduct by Respondent, including the conduct that is the subject of this Order.

WHEREFORE, for the reasons set forth above, and subject to the right to request a hearing, it is this 15th day of October 2016, **ORDERED** that:

- (1) Brianna C. Hicks pay an administrative penalty of \$50,000.00 within 30 days of the date of this Order.
- (2) Brianna C. Hicks pay restitution to AFLAC in the amount of \$56,969.70 within 30 days of the date of this Order.

ALFRED W. REDMER, JR.
Insurance Commissioner

BY: 
STEVE WRIGHT 
Associate Commissioner
Insurance Fraud Division

RIGHT TO REQUEST A HEARING

Pursuant to §2-210 of the Insurance Article and Code of Maryland Regulations (“COMAR”) 31.02.01.03, an aggrieved person may request a hearing on this Order. This request must be in writing and received by the Commissioner within thirty (30) days of the date of the letter accompanying this Order. However, pursuant to §2-212 of the Article, the Order shall be stayed pending a hearing only if a demand for hearing is received by the Commissioner within ten (10) days after the Order is issued. The written request for hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Attn: Hearings and Appeals Coordinator. The request shall include the following information: (1) the action or non-action of the Commissioner causing the person requesting the hearing to be aggrieved; (2) the facts related to the incident or incidents about which the person requests the Commissioner to act or not act; and (3) the ultimate relief requested. The failure to request a hearing timely or to appear at a scheduled hearing will result in a waiver of your rights to contest this Order and the Order shall be final on its effective date. Please note that if a hearing is requested on this initial Order, the Commissioner may affirm, modify, or nullify an action taken or impose any penalty or remedy authorized by the Insurance Article against the Respondent in a Final Order after hearing.