IN THE MATTER OF THE	*	
	*	
MARYLAND INSURANCE ADMINISTRATION	*	
	*	
v.	*	
	*	**CASE NO.: MIA-**2021-04-017
BA'LAUREN ASHLEA HALL	*	
3417 Juneway	*	
Baltimore, Maryland 21213	*	**Fraud Division File No.: R-2020-4513A**
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ORDER

This Order is issued by the Maryland Insurance Administration (the "MIA") against Ba'Lauren Ashlea Hall ("Respondent") pursuant to §§ 2-108, 2-201, 2-204 and 2-405 of the Insurance Article, Md. Code Ann. (2017 Repl. Vol. & Supp.) (the "Insurance Article") for the violations of the Maryland Insurance Article identified and described.

I. RELEVANT MATERIAL FACTS

1. On August 25, 2016, Respondent applied for a Hospital Confinement Indemnity insurance policy (the "Policy") with American Family Life Assurance Company of Columbus ("AFLAC"), an authorized insurer. Respondent signed the policy immediately after the following fraud warning:

> Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

2. The AFLAC policy took effect on October 1, 2016, and provided coverage for Respondent and two dependents, hereinafter, "DW1" and "DW2." The policy remained in effect at all relevant times for which Respondent submitted claims, enumerated in this Order.

3. Between March 2017 and March 2019, Respondent submitted six claims to AFLAC. Four of the claim forms were accompanied by treatment records, ostensibly issued by the treating providers, for treatment received by Respondent or her dependents, DW1 and DW2:

- DW1 - March 7 to March 9, 2017 – MedStar Franklin Square Medical Center ("MedStar")
- DW1 - March 17 to March 23, 2018 - Johns Hopkins Hospital ("Hopkins")
- Respondent - October 15, 2018 – Hopkins
- DW2 - October 27 to November 2, 2018 – Hopkins
- DW2 - January 8, 2019 – Hopkins
- DW2 - February 3 to February 10, 2019 – Hopkins

4. Relying on information contained within the claims, AFLAC paid Respondent $5,810.00 under her Hospital Confinement Indemnity insurance policy. Respondent electronically signed each claim form immediately after the fraud warning:

> Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.
>
> By signing this claim form, I verify the information above is accurate and correct.

5. An AFLAC representative noted that the dates for alleged treatment of DW2 at Hopkins from February 3 to February 10, 2019 appeared "altered." Therefore, in an effort to authenticate the claim documents, the representative contacted Hopkins. A Hopkins representative advised that it had no record of treating DW2 from February 3 to February 10, 2019, nor did it have records for treating DW2 from October 27 to November 2, 2018. Consequently, AFLAC referred Respondent's claims to its Special Investigations Unit ("SIU") for further investigation.

6. On May 6, 2020, an AFLAC investigator contacted Hopkins to verify treatment DW1 reportedly received from March 17 to March 23, 2018. A Hopkins representative advised that DW1 "was not treated at that time."

7. On June 9, 2020, an AFLAC investigator contacted Hopkins and MedStar in an effort to authenticate the claims submitted by Respondent. A representative for Hopkins advised that it had no records related to the treatments Respondent and her dependents reportedly received on the dates enumerated in paragraph 3 *supra*. Likewise, a MedStar representative advised it had no record of treating DW1 from March 7 to March 9, 2017.

8. On June 9, 2020, AFLAC sent a letter to Respondent, wherein it requested that she contact the SIU investigator within three days, to discuss her claims. Respondent failed to comply. Later, AFLAC sent Respondent a letter which stated, in pertinent part:

> During the course of the investigation, we were unable to validate information submitted in the claim(s). As a result, benefits were paid to you erroneously. At this time, Aflac requests that the total amount of benefits you received in the amount of $5,810, be paid back as soon as possible. We ask that this money be returned in the form of a cashier's check or money order made payable to Aflac...

9. AFLAC, having a good faith belief that Respondent committed insurance fraud, referred the matter to the MIA under Section 27-802(a)(1) of the Maryland Insurance Article, which states,

> An authorized insurer, its employees, fund producers, or 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.

II. The Administration's Investigation

10. In the course of its investigation, an MIA investigator contacted AFLAC and confirmed the facts regarding its handling of Respondent's claims.

11. On March 1, 2021, an MIA investigator contacted Hopkins to authenticate the five Hopkins treatment claims Respondent submitted to AFLAC for treatment she and her dependents reportedly received, on the dates cited in paragraph 3 *supra*. The Hopkins representative examined

the claims Respondent submitted to AFLAC, and concluded that Hopkins had no record of treating Respondent or her dependents on the dates listed on the claims.

12. On March 31, 2021, an MIA investigator contacted MedStar to authenticate the claim Respondent submitted to AFLAC for treatment DW1 reportedly received, from March 7 to March 9, 2017. The MedStar representative examined the claim documents and concluded that DW1 was not treated at any MedStar facility on those dates.

III. Violation(s)

13. In addition to all relevant sections of the Maryland Insurance Article, which apply to acts and omissions of the Respondent in the State.[1]

14. **Section 27-403** of the Insurance Article provides, in pertinent part:

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[.]

15. **Section 27-408(c)** of the Insurance Article provides, in pertinent part:

(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

* * *

(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.

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[1] The failure to designate a particular provision in this proposed Order does not deprive the Commissioner of the right to rely on that provision.

16. By the conduct described herein, Respondent violated § 27-403. Respondent committed a violation of the Insurance Article when she submitted false claims to AFLAC. As such, Respondent is subject to an administrative penalty pursuant to § 27-408(c) of the Insurance Article.

IV. Sanctions

17. 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.

18. Having considered the factors set forth in § 27-408(c)(2), the MIA has determined that $2,500.00 is an appropriate administrative penalty against Respondent.

19. The aforesaid administrative penalties shall be paid within thirty (30) days of the date of this Order to the Maryland Insurance Administration. Payment shall be made by immediately payable funds and shall identify the case by number (R-2020-4513A) and Respondent's name, (Balauren Ashlea Hall). Payment of the administrative penalty shall be sent to the attention of: Associate Commissioner, Insurance Fraud and Enforcement Division, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202. Unpaid penalties will be referred to the Central Collections Unit for collection.

20. Additionally, the Respondent is ordered to reimburse AFLAC $5,810.00, which is the amount AFLAC paid Respondent when it relied on medical claims, she submitted, later found to be fraudulent.

21. Notification of reimbursement to AFLAC shall be made in writing to the Associate Commissioner, Insurance Fraud and Enforcement 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-2020-4513A) and name (Balauren Ashlea Hall).

22. 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 Respondent's right to request a hearing, it is this 20th day of April 2021, **ORDERED** that:

(1) Ba'Lauren Ashlea Hall shall pay an administrative penalty of Two Thousand Five Hundred dollars ($2,500.00) within 30 days of the date of this Order.

(2) Ba'Lauren Ashlea Hall shall pay restitution to AFLAC in the amount of Five Thousand Eight Hundred and Ten dollars ($5,810.00) within 30 days of the date of this Order.

KATHLEEN A. BIRRANE
Insurance Commissioner

BY: signature on original
STEVE WRIGHT
Associate Commissioner
Insurance Fraud and Enforcement 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 served. The written request for hearing must be addressed to the Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202, Attn: Melanie Gross, Executive Assistant to the Deputy Commissioner. 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