Insurance Fraud

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UP FRONT

- **Property/casualty insurance fraud amounts to about $32 billion a year, according to industry estimates.**
- **The insurance industry works hard to keep flood damaged vehicles off the road. This effort includes including VINCheck, a free service set up by the NICB to help consumers spot flooded vehicles that may be reconditioned and fraudulently put up for sale as undamaged following a flood disaster such as Hurricane Sandy.**

THE TOPIC

Insurance industry estimates generally put fraud at about 10 percent of the property/casualty insurance industry's incurred losses and loss adjustment expenses each year, although the figure can fluctuate based on line of business, economic conditions and other factors.[1] Using this measure, over the five-year period from 2009 to 2013, property/casualty fraud amounted to about $32 billion each year. Also, the Federal Bureau of Investigation said that healthcare fraud, both private and public, is an estimated 3 to 10 percent of total healthcare expenditures.[2] Based on U.S. Department of Health and Human Services' Centers for Medicare and Medicaid Services' data for 2010, healthcare fraud amounted to between $77 billion and $259 billion.

Fraud may be committed by different parties involved in insurance transactions: applicants for insurance, policyholders, third-party claimants and professionals who provide services and equipment to claimants. Common frauds include "padding," or inflating actual claims; misrepresenting facts on an insurance application; submitting claims for injuries or damage that never occurred, services never rendered or equipment never delivered; and "staging" accidents.

Forty-two states and the District of Columbia have set up fraud bureaus (some bureaus have limited powers, and some states have more than one bureau to address fraud in different lines of insurance). These agencies have reported increases in referrals (tips about suspected fraud), cases opened, convictions and court-ordered restitution.

Healthcare, workers compensation and auto insurance are believed to be the lines most vulnerable to insurance fraud. But the nature of fraud is constantly evolving. Shortly after the enactment of the 2010 healthcare reform law, the Health and Human Services secretary issued warnings about a proliferation of phony health insurance policies.

Auto theft, a related issue, is discussed in Insurance Issues Updates, Auto Theft.

[1] Estimate based on research conducted by the Battelle Seattle Research Center for the Insurance Information Institute in 1992 (*Fighting the Hidden Crime: A National Agenda to Combat Insurance Fraud*. Insurance Information Institute, March 1992) and other industry reports (including *Insurance Fraud, Renewing the Crusade*, Conning, 2001).

[2] Federal Bureau of Investigation, *Financial Crimes Report to the Public*, Fiscal Year 2007.

RECENT DEVELOPMENTS

- The Coalition Against Insurance Fraud's State of Insurance Fraud Technology report, issued in September 2014, found that about half (51 percent) of the 42 insurers who participated in the survey said that suspected fraud has increased to some degree. Seven percent said it increased significantly. The study was conducted in June and July 2014.
- Ninety-five percent of the respondents said they use antifraud technology, up from 88 percent in 2012. Seventy-one percent of respondents said that detecting claims fraud is the primary use of their antifraud technology.

- About half of the insurers (53 percent) cited lack of IT resources as the stumbling block in implementing antifraud technology.
- The Coalition's report also discussed emerging fraud trends, identifying those that involve bodily injuries and suspicious activities by medical providers—especially in the workers compensation and auto lines of insurance—as becoming more prevalent.
- Insurers are also faced with cyber fraud as they collect a large amount of personal information, and the number of companies reporting attacks increased significantly since 2012.
- **Attitudes Toward Fraud:** Fewer people now believe it is acceptable to increase an insurance claim to make up for the deductibles they have to pay, according to the Insurance Research Council (IRC). Its online poll released in February 2013 found that 24 percent of the public thought it acceptable to pad an insurance claim to make up for the deductible, lower than the 33 percent who thought it acceptable in a 2002 telephone survey. The study also found that 18 percent of respondents believe it is acceptable to pad a claim to make up for premiums paid in the past, the lowest percentage since the same question was first asked in a 1981 survey.
- The IRC said that younger, male respondents were much more likely to condone claim padding. Twenty-three percent of 18 to 34 year-old males agreed that it is all right to increase claim amounts to make up for earlier premiums, compared with 5 percent of older males and 8 percent of females of the same age.
- The IRC study, *Insurance Fraud, A Public View, 2013 Edition*, also found that 86 percent of Americans think that "insurance fraud leads to higher rates for everyone" and 10 percent think that "insurance fraud doesn't hurt anyone."
- Almost half (45 percent) of 143 U.S. insurers surveyed by the Property Casualty Insurers Association of America and FICO (a predictive analytics provider) said that fraud accounts for 5 to 10 percent of their claims costs. However, almost one-third of respondent insurance companies (32 percent) in the August 2012 survey said that fraud was as high as 20 percent.
- Results of a survey released in September 2013 by FICO showed that one in three insurers does not feel adequately protected against fraud. The survey found that insurers feel most vulnerable in the areas of premium leakage and new applications, when policyholders often underestimate or leave out such information as annual auto mileage that would have an adverse effect on the cost of the policy.
- 35 percent of insurers estimated that insurance fraud costs represent 5-10 percent of their total claims, while 31 percent said the cost is as high as 20 percent. More than half (57 percent) of insurers expect to see an increase in fraud losses this year on personal insurance lines (mainly auto and home insurance), while only 5 percent of insurers expect to see a decline in dollar fraud losses on personal lines.
- Respondents said they expect the biggest fraud loss increases to hit personal property, workers' compensation and auto insurance. 58 percent of insurers forecast an increase in personal property fraud, 69 percent forecast an increase in workers' compensation fraud, and 56 percent forecast a rise in personal auto fraud.

No-Fault Insurance Fraud

No-fault auto insurance is a system that allows policyholders to recover financial losses from their own insurance company, regardless of who was at fault in the accident. However in many no-fault states, unscrupulous medical providers, attorneys and others perpetrate fraud by padding costs associated with a legitimate claim, for example by billing an insurer for a medical procedure that was not performed.

- **Florida:** A no-fault auto insurance reform bill that went into effect in 2012 (HB 119) has helped reduce fraud and resulted in rate reductions. In January 2015 the Florida Office of Insurance Regulation released an analysis of personal injury protection (PIP) rates covering 81 percent of Florida's personal auto market among the top 25 insurers. PIP coverage rate changes that were approved by the Office of Insurance Regulation resulted in an average 13.6 percent decrease statewide in Florida between January 1, 2011 and January 1, 2015. The office noted that some benefits previously covered under PIP moved to other coverages such as bodily injury and uninsured motorist. Data showed that both of these coverages experienced increases in frequency and severity, and that these trends are expected to continue over the next year. According to the report, there was limited data available to determine the true impact of HB 119, but the data collected show a major impact on the personal auto market.
- HB 119 requires people injured in an auto accident to visit an emergency room or physician, chiropractor or dentist within 14 days in order to use PIP coverage. It also bans treatment for acupuncture or massage therapy and imposed a requirement that all entities seeking reimbursement under the no-fault law obtain licenses (except hospitals, entities owned by a hospital, doctor or other licensed healthcare professional). Penalties for doctors who commit fraud were strengthened to make convicted healthcare practitioners lose their licenses for five years and prohibit their receiving PIP reimbursement for 10 years. Insurers were allowed to extend the time spent on investigating fraud from 60 days to 90 days. Other provisions create standards for awarding attorney fees that are in line with prevailing professional standards.
- **New York:** In his 2014-15 Executive Budget (see page 28), Governor Andrew Cuomo said he would expand the ability of the New York Department of Financial Services (DFS) to audit healthcare providers participating in the no-fault auto insurance system in order to prevent fraudulent providers from receiving payment and fining providers who engage in illegal activities. The department will be authorized to make unannounced inspections.
- The Cuomo Administration had already taken several steps to curb fraud. In February 2013 the DFS adopted three amendments to Regulation 68, the law that implements the state's no-fault law claim settlement procedures. The first amendment prevents billing for services that were not provided or billing more for services than the established fee. The second amendment sets a deadline for healthcare providers to respond to requests for verification that the treatment provided was medically necessary. The third amendment prevents immaterial paperwork errors from invalidating a denial of a claim or a request for verification. This last amendment should substantially reduce litigation and arbitration dealing with claim processing errors and speed up the resolution of no-fault claims, the department says.
- A January 2011 study on New York's no-fault system by the Insurance Research Council (IRC, www.insurance-research.org) showed how prevalent fraud is in the New York City area. About one in every five no-fault claims closed appeared to have some element of fraud and as many as one in three appeared to be inflated (built up). Over the period 2007 to 2010, the percentage of no-fault claims that were fraudulent or were inflated by excessive billing by unscrupulous medical care providers or by unnecessary medical services rose from 29 percent to 35 percent. In the fall of 2010 alone, fraud was found in 22 percent

of all New York City metropolitan area no-fault auto insurance claims and buildup in another 14 percent. By comparison, outside the city fraud was found in only 4 percent of no-fault claims settled and build-up in another 4 percent.

- Additional findings released in November 2011 from the IRC's closed claim study show that claimed losses for medical expenses, lost wages and other expenses from auto accidents in New York City rose 70 percent in the 10 years ending in 2010, well over the 49 percent increase in medical care inflation over the same period. The average claimed loss per PIP claimant in New York City was $15,086, more than double the $6,870 for claimants in the rest of the state. Claimants in New York City were much more likely to visit chiropractors, physical therapists and acupuncturists; to receive expensive diagnostic procedures and to be treated in pain clinics; and to hire attorneys.

Healthcare Fraud

- State and federal authorities have reported increases in fraud, such as identity theft, fraudulent billing and deceptive sales practices, after the Affordable Care Act was passed in 2010.
- The most prevalent complaints involve older Americans. Under the law, people age 65 and over, who are on Medicare, do not need to buy supplemental coverage. Nonetheless, some marketers are pushing expensive add-on policies by falsely claiming that such coverage is required, state authorities say. Others are telling people that the law means they need new Medicare cards—not true. And still others are charging fees as high as $100 to "help" people navigate the new insurance landscape.
- Federal filings for healthcare fraud cases grew 3 percent in the fiscal year ending October 2013 and almost 8 percent from five years ago, according to Department of Justice statistics obtained from the Transactional Records Access Clearinghouse, a nonprofit group that tracks federal spending.

KEY STATE LAWS AGAINST INSURANCE FRAUD

(As of December 2015)

State	Insurance fraud classified as a crime	Immunity statutes	Fraud bureau	Mandatory insurer fraud plan	Mandatory auto photo inspection
Alabama	X	X			
Alaska	X	X	X		
Arizona	X	X	X		
Arkansas	X	X	X	X	
California	X	X	X	X	
Colorado	X	X	X (4)	X	
Connecticut	X	X	X (1), (4)		
Delaware	X	X	X		
D.C.	X	X	X (5)	X	
Florida	X	X	X	X	X
Georgia	X	X	X		
Hawaii	X (1), (2)	X	X		
Idaho	X	X	X		
Illinois	X	X	X (1)		
Indiana	X	X	X		
Iowa	X	X	X		
Kansas	X	X	X	X	
Kentucky	X	X	X	X	
Louisiana	X	X	X	X	
Maine	X	X	X	X	
Maryland	X	X	X	X	
Massachusetts	X	X	X		X
Michigan	X	X			
Minnesota	X	X	X	X	
Mississippi	X	X (3)	X (1), (4)		
Missouri	X	X	X		
Montana	X	X	X		
Nebraska	X	X	X		
Nevada	X	X	X (4)		
New Hampshire	X	X	X	X	
New Jersey	X	X	X (4)	X	X
New Mexico	X	X	X	X	
New York	X	X	X (1)	X	X
North Carolina	X	X	X		
North Dakota	X	X	X (1)		
Ohio	X	X	X	X	
Oklahoma	X	X	X		

Oregon	X	X			
Pennsylvania	X	X	X (4)	X	
Rhode Island	X	X (6)	X (4), (7)	X	X
South Carolina	X	X	X (4)		
South Dakota	X	X	X (4)		
Tennessee	X	X		X	
Texas	X	X	X	X	
Utah	X	X	X		
Vermont	X	X		X	
Virginia	X	X	X (7)		
Washington	X	X	X	X	
West Virginia	X	X	X		
Wisconsin	X	X			
Wyoming	X	X (3)			

(1) Workers compensation insurance only.
(2) Healthcare insurance only.
(3) Arson only.
(4) Fraud bureau set up in the state Attorney General's office.
(5) In the District of Columbia fraud is investigated by the Enforcement and Consumer Protection Bureau in the Department of Insurance, Securities and Banking which investigates fraud in all three financial sectors.
(6) Auto insurance only.
(7) Fraud bureau set up in the state police office.

Source: Property Casualty Insurers Association of America; Coalition Against Insurance Fraud.

Chart Notes: This chart defines laws that can effectively deter fraud. Also see Background: State Legislation. 1. Insurance Fraud Defined: Insurance fraud is specifically declared unlawful in the state's laws. A fraudulent act is committed if information in insurance applications is falsified in an attempt to obtain lower premium rates or to inflate the amount of loss in a claim. Defining the crime specifically helps educate law enforcers about insurance fraud and provides prosecutors with clear-cut cases. Raising the level of the crime from a misdemeanor to a felony not only increases the penalties but also acts as a deterrent to future crimes. Includes claims, underwriting and insurer fraud. (All jurisdictions but not all lines of insurance.) 2. Immunity Statutes: These laws provide protection for good faith exchange of information between insurers or others and state insurance departments or law enforcement officials. Individuals or organizations are exempt from libel or unfair trade practices lawsuits, which could be brought against them for releasing information on prior claims. (All jurisdictions but not all lines of insurance.) 3. Fraud Bureaus: Special units have been set up, generally, in state insurance departments to identify fraudulent acts, collect information on repetitive offenders and investigate cases. The main purpose of the bureau is to set up documented criminal cases that can be readily prosecuted. Some bureaus have law enforcement powers. (44 states and D.C. but not all lines of insurance.) 4. Mandatory Insurer Fraud Plan: Insurers are required by law to set up a specific program that identifies insurance fraud and outlines actions taken to reduce insurance fraud. (21 states and D.C.) 5. Mandatory Photo Inspection: Photos must be taken of used cars before collision or comprehensive insurance is issued. This is designed to eliminate claims for damage sustained prior to the issuance of a policy and the purchase of insurance for nonexistent vehicles. (Five states.)

BACKGROUND

Introduction: Insurance fraud can be “hard” or “soft.” Hard fraud occurs when someone deliberately fabricates claims or fakes an accident. Soft insurance fraud, also known as opportunistic fraud, occurs when people pad legitimate claims, for example, or, in the case of business owners, list fewer employees or misrepresent the work they do to pay lower premiums for workers compensation.

People who commit insurance fraud range from organized criminals, who steal large sums through fraudulent business activities and insurance claim mills, to professionals and technicians, who inflate the cost of services or charge for services not rendered, to ordinary people who want to cover their deductible or view filing a claim as an opportunity to make a little money.

Some lines of insurance are more vulnerable to fraud than others. Healthcare, workers compensation and auto insurance are believed to be the sectors most affected.

Insurance fraud received little attention until the 1980s, when the rising price of insurance and the growth in organized crime fraud spurred efforts to pass stronger antifraud laws. Allied with insurers were parties affected by fraud—consumers who pay higher insurance premiums to compensate for losses from fraud; direct victims of organized fraud groups; and chiropractors and other medical professionals who are concerned that their

reputations will be tarnished.

In their fight against fraud, insurers have been hampered by public attitudes, which in some cases condone insurance fraud. In a 2008 report, the Coalition Against Insurance Fraud found that four of five Americans think that a variety of insurance crimes were unethical, and one out of five thought it was acceptable to defraud insurance companies under certain conditions. The Coalition report found that the public was consistently more tolerant of specific insurance frauds today than it was 10 years before. For example, 82 percent of respondents thought it was unethical to misrepresent facts on an insurance application in order to lower their premiums, down from 91 percent in 1997. Moreover, a 2010 Accenture survey found that most people think it is extremely important for insurers to investigate claims fraud (98 percent) and more than half (55 percent) think it is more likely that an insurer's poor service will cause a person to commit insurance fraud against that company. Three-quarters of respondents said that people are more likely to commit insurance fraud during a recession (76 percent), up from 66 percent in 2003.

Studies by the Insurance Research Council show that significant numbers of Americans still think it is all right to inflate their insurance claims to make up for insurance premiums they have paid in previous years when they have had no claims or to pad a claim to make up for the deductible, although the proportion was found to be lower in the 2013 poll. According to a study ("*See no evil, speak no evil: why consumers don't report fraud*") published in the Winter 2012/2013 Journal of Insurance Fraud in America, five studies published between 2009 and 2012 strongly suggest that some portion of insurance fraud committed by consumers is driven by revenge or retaliation for a personal service exchange which they think is unfair. They may retaliate in order to "get a return" or "get their money's worth." Researchers classified respondents to a survey as reporters—those who observed an act of insurance fraud and reported it; nonreporters, who observed insurance fraud and did not report it; and those who neither observed nor reported insurance fraud. Among those who said they knew about a fraud, only 23.1 percent reported the crime. People were less likely to report fraud if they perceived fraud to be very prevalent, expressed greater acceptance of fraud or had stronger perceptions of the unfairness of insurer-insured relationships.

The authors suggest that in order to increase fraud reporting, insurers should develop broadly targeted campaigns focusing on raising concern, improving service quality and publicizing the abnormality of insurance fraud. In addition, a study entitled "*A call to action: Identifying strategies to win the war against insurance fraud*" by Deloitte Development LLC published in 2012 explored four major steps to combat insurance fraud: develop a fraud management strategy, implement the strategy by acquiring the resources needed, improve claim information quality and employ advanced analytics.

Auto Insurance Fraud: Auto insurance fraud and claim buildup added between $4.8 billion and $6.8 billion to closed auto injury claim payments in 2007, according to the Insurance Research Council's November 2008 study, *Fraud and Buildup in Auto Insurance Claims: 2008 Edition*. The study found that fraud and buildup in auto injury claims varied widely by state and by type of liability coverage. For example, among the 12 no-fault states, Florida had the highest rates of fraud and buildup in both bodily injury (BI) and personal injury protection (PIP) claims while North Dakota had the lowest for BI and Kansas had the lowest PIP rates. Since the study involved only claims closed with payment it most likely underestimates the incidence of fraud and buildup in all claims filed, since claims that included the most blatant examples of fraud would not have been paid.

Rate evasion, where policyholders misrepresent facts on applications, includes the use of a false Social Security number to avoid showing a bad credit score, misrepresenting the major use of a vehicle and giving a false address where rates are cheaper. Industry observers estimate that this type of fraud costs auto insurers about $16 billion a year. Another example of auto insurance fraud is owner give-up, where the owner abandons or sets fire to a vehicle.

Another common auto fraud involves vehicles damaged by storm flooding that later appear in used car lots and auction sales. In some states, vehicles that have been flooded bear the words "salvage only" on their titles, usually after damage to the vehicle has reached about 75 percent of its value. Unscrupulous sellers may switch or clone manufacturers' serial number plates and put them on a flooded vehicle that has been repaired. They may also resell a car that has a salvage title in a state that has more lax title standards. This practice is called "title washing."

Standardized state rules for titling vehicles are necessary to combat salvage fraud. In recent years some states in the hurricane-prone parts of the United States have adopted rules that require that the words "flood vehicle" be included on the titles of vehicles that have been water damaged and rebuilt. Before such a vehicle can be sold, the buyer must be notified in writing of the vehicle's past flood damage. However, if one state in the region does not have such strict laws it can become a dumping ground for undeclared flooded vehicles.

After the hurricanes of 2005, the National Insurance Crime Bureau (NICB) created a database in which vehicle identification numbers (VINs) and boat hull identification numbers (HINs) from flooded vehicles and boats are stored and made available to law enforcers, state fraud bureaus, insurers and state departments of motor vehicles. The database (VINcheck) is online and can be accessed by the general public.

Another attempt to solve the problem of title washing is the National Motor Vehicle Title Information System (NMVTIS), a database that requires junk and salvage yard operators and insurance companies to file monthly reports on vehicles declared total losses. The program operates under the auspices of the U.S. Department of Justice and is administered by the American Association of Motor Vehicle Administrators. By February 2013, 88 percent of the U.S. vehicle population was represented in the system, and 33 states were reporting data to the system. It can be accessed by the public at http://www.nmvtis.gov.

One type of fraud involves reporting a vehicle as stolen when it has, in fact, been disposed of by the owner. Another type of fraud involves thieves using legitimate vehicle identification numbers for stolen cars of the same make and model cars.

Industry observers say that counterfeit airbags are being produced for nearly every make of vehicle. Unscrupulous auto body repair shops use these less expensive airbags and obtain reimbursement from insurance companies for legitimate airbags. In addition, stolen airbags are also used in repaired vehicles.

Workers Compensation Fraud: One type of workers compensation fraud involves employers who misrepresent their payroll or the type of work carried out by their workers to pay lower premiums. Some employers also apply for coverage under different names to foil attempts to recover monies owed on previous policies or to avoid detection of their poor claim record. Medical care abuse, such as "upcoding" (where providers exaggerate treatment provided to injured workers) and claimants over-utilizing medical care to keep receiving lost income (indemnity) benefits are common problems. Fraud investigators warn that more than one suspicious aspect of an employee claim may signal fraud. Common red flags are injuries reported on a Monday morning, after a delay, before or after a strike or layoff, without a witness or without treatment. Other warning signs are suspicious behavior before a claim, such as a claimant's history of numerous claims, jobs, addresses or medical providers.

Health Insurance and Medical Fraud: According to the Federal Bureau of Investigation, healthcare fraud, both private and public, is estimated to account for between 3 and 10 percent of total healthcare expenditures, or between $81 billion and $270 billion in 2011. The Institute of Medicine said in a 2012 report that the U.S. healthcare system wastes $75 billion a year on fraud. The Institute, part of the National Academy of Sciences, is an independent government adviser.

Fraud and abuse take place at many points in the healthcare system. Doctors, hospitals, nursing homes, diagnostic facilities, medical equipment suppliers and attorneys have been cited in scams to defraud the system.

One type of fraud is the abuse and resale of legal narcotic and other prescription drugs. According to *Prescription for Peril*, a 2007 report by the Coalition Against Insurance Fraud, drug diversion costs health insurers up to $72.5 billion a year in fraudulent claims involving opioid abuse alone, including up to $24.9 billion annually for private health insurers.

Another concern is health identity theft, where criminals steal victims' names, health insurance numbers and other personal data and then defraud insurers by making false claims. The Federal Trade Commission received nearly 22,000 complaints of health identity theft in 2010 (latest data available). To combat the problem, some medical facilities have limited employee access to data and require photo IDs for people seeking treatment.

The FBI, in its *Financial Crimes Report*, 2010-2011, (latest report available) said that the most prevalent types of healthcare fraud are: billing for services not rendered; upcoding services and medical items (where the provider submits a bill using a code that yields a higher payment than for the service or item that was actually rendered); filing duplicate claims; unbundling (billing in a fragmented fashion for tests or procedures that are required to be billed together at reduced cost); performing excessive services; performing unnecessary services; and offering kickbacks.

Private Healthcare Fraud: The Blue Cross and Blue Shield Association says its antifraud investigations saved or recovered more than $510 million in 2009 for an average return of $7 for every $1 spent in antifraud efforts. The $510 million includes preventing $318 million from being paid for fraudulent or erroneous medical claims (62 percent higher than in 2008) and $192 million in recoveries paid for fraudulent and abuse claims (28 percent higher than in 2008).

Federal Healthcare Fraud: The U.S. Department of Health and Human Services (HHS) Secretary and the Justice Department said that in the last three years, for every dollar spent on healthcare-related fraud and abuse investigations, the government recovered $7.90, the highest average return in the 16-year history of the Health Care Fraud and Abuse Program. The program's healthcare fraud prevention and enforcement efforts recovered a record $4.2 billion in fiscal year 2012, up from almost $4.1 billion in fiscal year 2011 for a total of $14.9 billion over the past four years. The program targets fraud mainly in Medicare and Medicaid.

The Affordable Care Act of 2010 included fraud fighting efforts such as allowing the U.S. Department of Health and Human Services Secretary to exclude providers who lie on their applications from enrolling in Medicare and Medicaid and the Improper Payments Elimination and Recovery Act that requires agencies to conduct recovery audits for programs every 3 years and develop corrective action plans for preventing future fraud and waste. Other efforts were implementing an Automated Provider Screening system to review enrollment applications; allowing the Secretary of Health and Human Services to impose a temporary moratorium on newly enrolled providers or suppliers if necessary to combat fraud; authorizing the Centers for Medicare and Medicaid Services, in conjunction with the Office of the Inspector General, to suspend payments to providers or suppliers during the investigation of a credible allegation of fraud; and ensuring that providers and suppliers found guilty of fraud in one of the Centers' systems, such as Medicare, cannot have service privileges in another area, such as Medicaid, or within state programs.

In 2012, the Department of Health and Human Services and the Department of Justice formed the National Fraud Prevention Partnership to combat health care fraud. The group also consists of private and public groups such as health care companies and their organizations, the National Association of Insurance Commissioners, the National Insurance Crime Bureau and the National Health Care Anti-Fraud Association. The groups will share information on claims from Medicare, Medicaid and private insurance to be administered by a third-party vendor.

State Healthcare Fraud: Medicaid programs also operate on the state level, where they are also subject to fraud. In Massachusetts the attorney general said that the office's Medicaid Fraud Division had recovered more than $66 million in 2010, a record amount. In the past four years the division has recovered over $191 million for the state's Medicaid program.

Catastrophe-related Property Fraud: The hurricanes of 2005, especially Hurricane Katrina, resulted in cases of insurance fraud where, for instance, homeowners or renters made claims for expensive home appliances that were never purchased and where homeowners inflated claims for items actually destroyed. Some of the fires that broke out in buildings in New Orleans and other affected communities after Hurricane Katrina were suspected cases of arson, committed by flood victims who did not have flood coverage, and thousands of flood-damaged cars were cleaned up and resold without disclosing their flood status.

In September 2005 the Department of Justice created the Hurricane Katrina Fraud Task Force, now known as the National Center for Disaster Fraud (NCDF). The expanded task force is designed to combat fraud relating to natural and man-made disasters such as the Deepwater Horizon oil spill. In addition to insurance fraud, the NCDF targets charity scams, identity theft and contract and procurement fraud. Since its inception the NCDF has prosecuted 1,360 people in cases related to Hurricanes Katrina, Rita and Wilma alone.

The increase in billion-dollar weather catastrophes in recent years and the propensity of claimants to commit opportunistic fraud has resulted in some insurers turning to forensic meteorologists. These experts can accurately verify weather conditions for an exact location and time, allowing claims adjusters to validate claims and determine whether more than one type of weather element is responsible for damage. Because they use certifiable weather records, their findings are admissible in court.

Another example of opportunistic fraud following natural catastrophes is contractor fraud. A handful of states have attempted to protect homeowners from contractor fraud, by enacting laws that provide for notices and contract termination rights and prohibiting rebating or other compensation to induce homeowners to sign contracts. According to the Property Casualty Insurers Association of America, Iowa and Kentucky have similar bills pending in their legislatures and Illinois, Indiana, Minnesota, Missouri, Nebraska and South Dakota have enacted these laws in the past few years.

Crop Insurance Fraud: Federally sponsored multiple peril crop insurance is sold and serviced by the private market but is subsidized and reinsured by the federal government. It covers crop losses as a result of all types of natural disasters and is a source of financial protection for farmers. The U.S. Government Accountability Office has found evidence of fraud in the federal crop insurance program and recommended a number of actions, including reducing premium subsidies to those who repeatedly file questionable claims, improving the effectiveness of growing season inspections and strengthening oversight of insurance companies' use of quality controls. Government investigators are increasingly using satellite images to match actual crop planting and growing practices in suspicious cases with information submitted in claims. Federal prosecutors in Attorney General's office said that a North Carolina tobacco farming case in 2013 involving farmers, insurance agents and claims adjusters uncovered about $100 million in fraud.

Insurers' Antifraud Measures: The legal options of an insurance company that suspects fraud are limited. The insurer can inform law enforcement agencies of suspicious claims, withhold payment and collect evidence for use in a court. The success of the battle against insurance fraud therefore depends on two elements: the level of priority assigned by legislators, regulators, law enforcement agencies and society as a whole to the problem and the

resources devoted by the insurance industry itself. To that end most insurers have established special investigation units (SIUs). These entities help identify and investigate suspicious claims. By 2001 about 80 percent of property/casualty insurers had SIUs, according to the Coalition Against Insurance Fraud. These units range from small teams, whose primary role is to train claim representatives to deal with the more routine kinds of fraud cases, to teams of trained investigators, including former law enforcement officers, attorneys, accountants and claim experts. More complex cases involving large-scale criminal operations or individuals that repeatedly stage accidents may be turned over to the National Insurance Crime Bureau (NICB), which has special expertise in preparing fraud cases for trial and serves as a liaison between the insurance industry and law enforcement agencies.

Insurance company surveys confirm that SIUs dramatically impact the bottom line of many companies. In the 1990s insurers said that for every dollar they invested in antifraud efforts, including in SIUs, they got up to $27 back, but these returns have become harder to achieve as many easy to root out cases of fraud have been eliminated and fraud schemes have become more sophisticated.

Insurers have also created a national fraud academy. A joint initiative of the Property Casualty Insurers Association of America, the FBI, the NICB and the International Association of Special Investigating Units, it is designed to fight insurance claims fraud by educating and training fraud investigators. It offers online classes under the leadership of the NICB.

Insurers may also file civil lawsuits under the federal Racketeering Influenced and Corrupt Organizations Act (RICO), which requires proving a preponderance of evidence rather than the stricter rules of evidence required in criminal actions and allows for triple damages. Since the late 1990s, some of the largest insurers in the country, especially auto insurers, have been filing and winning lawsuits concerning insurance fraud against individuals and organized rings. Since 2003, Allstate Insurance Company has filed 48 lawsuits and has sought about $237 million in damages in New York state alone.

New Technology to Combat Fraud: Advances in analytical technology are crucial in the fight against fraud to keep pace with sophisticated rings that constantly develop new scams. For example, in the past organized rings that must obtain policies before staging accidents and making claims found agents who did not ask probing questions. Direct insurance websites bypass agents and allow them to exploit loopholes in applications and underwriting. They can test the system by filing many applications and observing which ones are flagged for additional information. According to a company that develops insurance fraud analytics, insurers typically see evidence of organized staged accidents within 60 days of starting a direct Internet channel.

Traditional approaches that concentrated on detection after payments were made (pay and chase programs) have been improved by predictive modeling, claims scoring and other tools that attempt to uncover fraud before a payment is made. Newer strategies are employed when claims are first filed. Suspicious claims are flagged for further review while those with no suspicious elements are processed normally.

Data-mining programs, which scan many insurance claims, have been improved by the consolidation of insurance industry claims databases, such as ISO's ClaimSearch, the world's largest comprehensive database of claims information. Systems that identify anomalies in a database can be used to develop "rules" that enable an insurer to automatically stop claims. An insurance technology expert said that this approach has produced 20 to 50 percent reductions in fraud loss for some insurers. Newer programs that analyze patterns and text, such as adjuster notes, can search various kinds of data formats for key terms and word patterns.

Insurance investigators are increasingly scanning social media sites such Facebook, Twitter and YouTube when they examine workers compensation claims. Software developers offer systems that scan publicly accessible sites for claimants who post activities from which they would be physically restricted due to their claims, according to an A.M. Best article.

State Antifraud Legislation: The realization that it is easier to prosecute cases of insurance fraud in states where it is identified as a specific crime in the penal code and where what constitutes insurance fraud is defined along with the penalties that can be imposed has prompted all states to enact these laws to some degree. See chart: Key State Laws on Insurance Fraud.

To successfully bring a fraud case to trial, insurers must be able to provide information to prosecutors on individuals suspected of fraud. Immunity laws that allow insurance companies to report information without fear of criminal or civil prosecution now exist in all states, but not all laws cover insurance fraud specifically or allow information to be reported to law enforcement agencies as well as to state departments of insurance. Many are limited in other ways, providing protection against libel suits or violation of unfair claims practices acts only in auto insurance fraud, for example. Some experts believe that immunity laws should be extended to include good faith exchanges of certain kinds of claim-related information among insurance companies.

Federal Antifraud Legislation: Federal laws that were enacted prior to the Affordable Care Act of 2010 include the Health Insurance Portability and Accountability Act of 1996, which focused on rooting out fraud in federal programs such as Medicare but also impacts private healthcare, especially in defining the crime of healthcare fraud. Although healthcare insurance is generally outside the purview of property/casualty insurance, healthcare fraud affects all types of property/casualty insurance coverage that include a medical care component, such as medical payments for auto accident victims or workers injured in the workplace. The act makes "knowingly and willfully" defrauding any healthcare benefit program a federal crime. The Violent Crime Control and Law Enforcement Act (1994) makes insurance fraud a federal crime when it affects interstate commerce. Insurance company employees, including agents, who embezzle or misappropriate any company funds can be punished similarly if their actions adversely affect the solvency of any insurance company.

OTHER SOURCES OF INFORMATION:

- **National Insurance Crime Bureau** https://www.nicb.org//
- **Coalition Against Insurance Fraud** http://www.insurancefraud.org
- **Insurance Research Council** http://www.insurance-research.org/
- **Federal Bureau of Investigation** http://www.fbi.gov/scams-safety/fraud

Insurance Topics at a Glance

Auto Insurance
Homeowners and Renters Insurance
Life Insurance
Financial Planning
Preparedness and Safety
Disasters
Business Insurance
Other Coverages
Life Stages
The Business of Insurance
Financial Results and Commentary
Información Sobre los Seguros en Español

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