Chapter 4

Direct Your Learning

Insurance Fraud

After learning the content of this chapter and completing the corresponding course guide assignment, you should be able to:

- Explain why insurance fraud is a threat to the financial stability of the insurance industry.
- Given a claim, identify the possible types of fraud involved.
- Describe the motives for insurance fraud.
- Given a claim, identify any fraud indicators present in the claim.
- Describe the anti-fraud efforts made by the following:
  - Insurers
  - Government
  - Industry organizations
- Define or describe each of the Key Words and Phrases for this chapter.

OUTLINE

Develop Your Perspective

What are the main topics covered in the chapter?

The costs of insurance fraud to insurers and to the public continue to grow. This chapter explores issues surrounding insurance fraud, including the types of claim fraud, motives for committing fraud, factors that influence fraud, detection of fraudulent activity, and anti-fraud efforts.

Consider the effects of insurance claim fraud.

- How does insurance claim fraud affect insurance premiums?
- Who bears the costs of insurance claim fraud?

Why is it important to learn about these topics?

Because claim representatives may uncover potential fraud in their claim investigations, they play a key role in detecting and preventing insurance fraud. Claim representatives must be able to detect fraud and know when to make an appropriate referral to a special investigation unit (SIU) or law enforcement.

Compare some of the "red flag" fraud indicators to a claim you are handling.

- Does your claim contain any of these red flags?
- If so, what other information would you look at to either confirm or rule out the possibility of fraud?

How can you use what you will learn?

Evaluate a claim being handled by SIU.

- What type of activity constituted the potential fraud?
- What actions are SIU personnel taking to prepare the file for disposition?
- What actions would you take if this was your file?

Chapter 4
Insurance Fraud

Insurance fraud is any deliberate deception committed against an insurer or an insurance producer for the purpose of unwarranted financial gain. It can occur during the process of buying, selling, or underwriting insurance, or making or paying a claim. Insurance is intended to protect insureds against accidents or fortuitous events. When fraud is committed and is not detected, insurers pay for nonaccidental or nonfortuitous events. This drains vital resources and increases the cost of insurance for everyone.

Insurance fraud
Any deliberate deception committed against an insurer or an insurance producer for the purpose of unwarranted financial gain.

Insurance fraud is often described as a victimless, white-collar crime because it involves deception rather than violence and the "victim" is a company instead of an individual. In fact, the losses and adjusting expenses caused by fraudulent claims are eventually paid by the policyholders through increased premiums. Consequently, all policyholders are the victims of insurance fraud.

This chapter explains why fraud detection is important and describes types of claim fraud, motives for committing claim fraud, factors that influence claim fraud, claim fraud indicators, and anti-fraud efforts. It explores solutions to the problem of claim fraud and examines how the claim representative can help reduce fraudulent activity. This foundation of knowledge about fraud will help claim representatives reduce the effect of insurance fraud through detection and prevention.

IMPORTANCE OF INSURANCE FRAUD DETECTION

Fraud costs the insurance industry billions of dollars each year. The Coalition Against Insurance Fraud (CAIF) estimates that insurance fraud is the second most costly economic crime in America after income tax evasion.[1] The Insurance Information Institute estimates that the total cost of all insurance fraud is between $85 billion and $120 billion a year.[2] Some studies show that fraudulent claims account for 10 percent of all claim dollars; others suggest a much higher percentage. The Insurance Information Institute estimates that property-casualty fraud cost insurers $29 billion in 2003.[3] Some estimates suggest that property-casualty insurance fraud costs each household in the United States an extra $200–$300 per year in insurance premiums.[4] During the past decade, insurers, law enforcement officials, and state and local governments have invested considerable money and manpower in

identifying and combating fraud and educating agents, brokers, employees, and policyholders about this problem. Despite these efforts, the problem of insurance fraud persists because of varying degrees of support from the public; insurers; and federal, state, and local governments.

Fraud must be detected and prevented by claim representatives because they are most familiar with individual claims. They must be able to identify fraud indicators ("red flags") and make the necessary referral to special investigation units (SIU) for review and action. Although a claim representative may suspect that a claim is fraudulent, he or she must behave ethically and in good faith at all times when dealing with insureds and claimants. Insurers, too, need to maintain a balance between preventing and detecting fraud and treating policyholders with dignity and trust.

TYPES OF INSURANCE FRAUD

In order to identify the types of insurance fraud, it is important to understand what constitutes fraud. Fraud occurs when all the following elements exist:

- An individual or an organization intentionally makes an untrue representation.
- The untrue representation concerns an important or material fact or event.
- The untrue representation is knowingly made.
- The untrue representation is intended to deceive.
- The victim relies on and acts on the untrue representation.
- The victim suffers some detriment, such as loss of money and/or property, as a result of relying upon and acting on the untrue representation.

Insurance fraud can be committed by anyone—insured, claimant, doctor, lawyer, mechanic, claim representative—involved in the insurance transaction or in a claim. For example, an applicant for workers' compensation insurance may deliberately under-report the amount of payroll to the insurance agent, broker, or underwriter. The underwriter relies on the payroll information provided by the applicant to set the premium amount. The applicant's misrepresentation causes the underwriter to charge a workers' compensation premium that is lower than the premium appropriate for the risk, and the insurer thereby suffers a loss of premium income. An agent, in collusion with an applicant, may over-report the square footage of a commercial building, permitting the applicant to purchase higher insurance limits with the intent of burning the building, collecting the insurance money, and splitting the proceeds with the agent. Or, an underwriter may provide an agent with a low premium quote in exchange for a payoff. Examples of fraudulent claims are staged accidents, inflated medical bills, and the intentional burning of an insured property. These are all examples of insurance fraud.

Insurance fraud can be classified as either hard or soft. **Hard fraud** involves actions that are undertaken deliberately to defraud. False claims or intentional losses are examples of hard fraud. **Soft fraud,** also known as **opportunity fraud,** occurs when a claim is exaggerated. The perpetrator uses the "opportunity" of a legitimate claim to obtain unwarranted personal gain.

Hard fraud
Actions that are undertaken deliberately to defraud.

Soft fraud, or opportunity fraud
Fraud that occurs when a legitimate claim is exaggerated.

Hard Fraud

Hard fraud involves schemes to defraud insurers by filing false claims for losses that have not occurred or by intentionally creating losses. Hard fraud can be a staged or invented accident, injury, or theft that results in a false claim. Hard fraud can also be an intentional loss, such as that resulting from arson.

False Claims

False claims arise when an insured pursues a claim for property damage or injury that has not actually occurred. Many types of false claims involving many types of insurance coverage can be made. For example, an insured may file a homeowners claim for stolen jewelry when no jewelry was stolen, or an employee may fake a back injury to get paid time off under a workers' compensation policy.

False claims can also include misrepresentation, concealment, or distortion of a material fact. In insurance, a **material fact** is a fact that would affect the insurer's decision to provide or maintain insurance or to settle a claim. **Misrepresentation** is a false statement of a material fact on which a party relies. **Concealment** is the intentional failure to disclose a material fact.

Material fact
In insurance, a fact that would affect the insurer's decision to provide or maintain insurance or to settle a claim.

Misrepresentation
A false statement of a material fact on which a party relies.

Concealment
The intentional failure to disclose a material fact.

For example, store patrons who intentionally pull display items on top of themselves and then file bodily injury claims commit misrepresentation. Also, restaurants are frequently the victims of people who falsely claim injury or illness from improperly prepared food, another act of misrepresentation.

Some false claims can involve the insured's collusion with others. For example, an auto body shop may prepare a repair estimate for alleged damage to an auto when no damage exists. Workers at vehicle salvage yards may collude with others to purchase insurance on unrepairable vehicles; after the insurance is in effect, the "owner" files a false claim for damages when, in fact, the vehicle was already damaged at the time it was insured.

Intentional Losses

Another type of hard fraud is an intentional loss, one that is not accidental or fortuitous and that results from an intentional act. Intentional losses can be distinguished from exaggerated and false claims. An exaggerated claim is based on an actual loss, but the value of the loss is inflated. In a false claim, no loss has actually occurred. In contrast, intentional losses involve an actual incident with resulting damage. In this case, however, the incident is not accidental and the damage is intended.

Staged accident
An accident deliberately caused by a person who intends to feign injury and collect on the ensuing claim.

Arson committed by an insured or at an insured's direction is an example of an intentional loss. A business owner may burn his own warehouse and file a claim to recover the insurance proceeds. Another example of intentional loss, a **staged accident**, is deliberately caused by a person who intends to feign injury and collect on the ensuing claim. The intent of those who stage accidents is to defraud an insurer. Typical staged accidents include rear-end automobile collisions. When the collision occurs, the scammer claims to be severely injured and to require transportation to a hospital by ambulance, while feigning great pain. Alleged injuries from staged accidents vary, but the most common involve soft-tissue injuries to the neck and back because they are harder to medically disprove.

Staged Accidents

An insurer sued to recover more than $4.6 million in claim payments from participants in a staged car-accident ring in Texas. Most of the claims arose from collisions resulting when a car stopped suddenly in front of an innocent victim's auto, allegedly causing injuries. Lawyers, law-office employees, medical clinics, and others participated in the scheme.

Soft Fraud

Soft fraud, or opportunity fraud, is the exaggeration or padding of a legitimate claim for the purpose of receiving greater reimbursement than would be received for the actual loss. Such claims may exaggerate the value of the property or the severity of an injury. For example, an insured may state that a stolen computer is six months old rather than its actual age of two years to increase the value of the claim.

Injury claims can be exaggerated or padded several ways. Some medical providers exaggerate claims by overtreating patients. Overtreatment involves performing more procedures, or more expensive procedures, than are medically necessary to treat an injury. These treatments may include additional or unnecessary diagnostic tests, such as X-rays, CT scans, or MRIs; extra office visits; or extended physical therapy. Overtreatment or unnecessary treatment by medical providers can occur with many insurance coverages, including automobile liability, workers' compensation, and homeowners liability.

Overtreatment is a form of medical provider fraud, that is, fraud that occurs when healthcare professionals help insureds file insurance claims for treatment that is unnecessary, is not related to the injury, or has not been rendered. For example, a doctor may recommend that a patient receive physical therapy three times per week for twelve weeks when three times per week for eight weeks would suffice. The patient may be aware of the deception and go along with it, or the patient may be unaware of the scheme and may simply be following the doctor's orders. The unnecessary treatment "pads" or exaggerates the true value of the claim, costing the insurer more money. The medical provider increases revenues by overtreatment.

Examples of Exaggerated/Padded Claims

- Overstated value of property
- Overstated severity of injury
- Overtreatment for injuries
- Unnecessary treatment for injuries

MOTIVES FOR INSURANCE FRAUD

People who perpetrate insurance claim fraud are as varied as the general population, and their motives vary as well. Motives for insurance fraud include the following:[5]

- Individual financial gain or profit
- Sense of entitlement
- Participation in organized crime

Individual financial gain or profit is the primary motive for insurance claim fraud. The person(s) committing the fraud may be motivated by financial difficulty or by greed. Concocting an insurance claim may appear to be an easy way to improve personal or business finances. An increasingly common type of fraudulent claim for financial gain involves leased motor vehicles. When a leased vehicle has excess mileage that will result in penalty fees when the lease expires, an unscrupulous lessee may have the vehicle shipped out of the country and claim it was stolen or burn it to avoid paying the excess mileage fee.

Arson is another insurance fraud scheme for financial gain. An arson-for-profit contractor is an individual hired to set fire to a business or residence so that the property owner may reap financial gain through insurance. The property owner establishes an alibi using witnesses who will testify that he or she was far from the fire scene. Any participation in such an arrangement is a criminal offense.

Arson-for-profit schemes occur in all areas of property ownership, but failing business enterprises account for many of the claims. According to the National Fire Protection Association, almost one-third of all restaurant fires raise suspicions of fraud. Because location affects a restaurant's success, problems with location can create a motive for fraud. For example, if a highway located near a restaurant is rerouted or closed for repairs, resulting in lost revenue for the restaurant, the owner may have a motive for insurance fraud. Similarly, a restaurant located next to a large factory may suffer financially if the factory closes or relocates. The owner may decide that burning the restaurant and collecting the insurance is an attractive, albeit criminal, way to recoup losses.

Obsolete, unsalable, or excess inventory, equipment, or supplies can also provide a financial motive for fraudulent claims. The owner may claim water, smoke, or fire damage to the unprofitable goods and attempt to recover the money invested in the useless inventory.

Example of Financial Motive

The chief executive officer of a software distributor allegedly used a severe earthquake as an excuse to destroy unmarketable merchandise. He received $840,000 of a $5 million claim before an employee reported the fraud.[6]

A sense of entitlement is another motive for insurance fraud. Some individuals believe that if something bad happens, someone should pay for it. They use that reasoning to justify exaggerating or padding a claim to cover their insurance deductible or to recover some of the premium. Some people consider their premium payments a sort of "fund" from which they can be repaid in the event of a claim. They further justify their sense of entitlement with the opinion that insurers are large, impersonal, wealthy institutions that will not miss a few extra dollars added to an auto claim or a workers' compensation claim. For those individuals, committing fraud is a means to collect what they believe is rightfully theirs.

Fraud Fact

In a survey conducted by Accenture in 2002, nearly one in four U.S. adults surveyed said they believe that overstating the value of claims to insurance companies is acceptable, and one in ten said they approve of submitting insurance claims for items that were not lost or damaged or for treatments that were not provided.[7]

Organized crime rings created for financial gain are responsible for many multi-million dollar insurance fraud schemes. Crime rings can involve many people and many business entities. A typical crime ring includes people who stage the accidents, medical providers who treat the victims, and lawyers who represent the victims and claimants who stage the accidents.

One example of an organized crime scheme is a network of "chop shops." A chop shop is an auto repair facility that dismantles stolen autos and either sells the parts or uses them to repair vehicles brought into the shop by unsuspecting patrons. An auto thief is paid a flat sum to steal a specific make and model of vehicle and deliver it to the chop shop. The auto is stripped, and the shell is sold as scrap or dumped back on the street for the city sanitation department or other city agency to haul away. The stolen parts may be used to repair an insured's vehicle at the repair facility, and a bill is prepared as if the parts had been ordered from a legitimate parts distributor. Thus the insurer is billed for the stolen parts and repairs.

In an effort to fight this type of organized insurance fraud, auto manufacturers stamp a vehicle identification number (VIN) on several component parts of new vehicles, including the trunk, hood, and doors. The VIN helps detectives who investigate suspected chop shops in tracking the distribution of stolen auto parts. Many law enforcement organizations have auto-theft task forces that specialize in identifying and investigating suspected organized-crime chop shop operations.

States address crime rings by setting strict penalties to reduce the profit that results from insurance fraud. For example, New York's Organized Fraud Unit concentrates on organized crime rings engaged in systematic, ongoing claim fraud.[8] The California Department of Insurance, Federal Bureau of Investigation, California Highway Patrol, and National Insurance Crime Bureau (NICB) spent four years investigating and tracking down members of a Chinese crime ring that allegedly shipped high-value luxury autos to Hong Kong and filed stolen auto claims totaling more than $6 million. Seventy-two individuals were arrested. The scheme involved recruiting people to purchase luxury autos, insuring the autos, and giving them to intermediaries who shipped them to Hong Kong. After the autos were out of the U.S., the owners would report a theft and file insurance claims, reporting that they parked their auto in a lot and that it was missing when they returned. In most cases, the autos were new and shipped within one month of purchase. However, in some cases, the intermediaries recruited lessees who were behind on lease payments and therefore had a motive to participate in the scheme.

Whether those committing insurance fraud are participating in crime rings or acting alone, financial need or the desire for financial gain are the most common motives. Coupled with these financial motivators, several factors can increase the likelihood that fraud will occur.

FACTORS THAT INFLUENCE FRAUD

Once someone has a motive to commit fraud, he or she may look for an opportunity to commit fraud. Several factors may create an opportunity for fraud. These include insurers' underwriting and claim practices, managed care practices, and public distrust of insurers. Recent efforts to cut costs associated with underwriting and claim adjustment, such as for on-site inspections, have made it easier for insureds to get coverage for property that does not exist as stated on the application and to receive claim payment quickly without inspection of the property or damages. Telephone adjusting activities further preclude the claim professional from initiating in-person contact and inspecting property. As a result, those predisposed to commit fraud see an opportunity to do so because their application or claim may not be thoroughly investigated. Additionally, some insurers hesitate to undertake the costs associated with denying suspected fraudulent claims and defending those denials. Other insurers consider fraud a cost of doing business that can be covered with increased premiums. These approaches may ultimately promote fraud.

Managed care pressures may lead medical providers to participate in fraudulent activity. Fee schedule guidelines exert ongoing pressure to reduce costs. Facing continuing threats to profits, unscrupulous providers may turn to fraudulent behavior, such as overtreatment or overbilling, to fund their businesses.

Consumers who believe they are being charged exorbitant insurance premiums may attempt to recover those premiums when a loss occurs (opportunity fraud). Distrust of the insurance business in general and insurance companies in particular has resulted in an "every man for himself" attitude, which has led to an increase in individual fraud and a tolerance of fraud by others.

To detect fraud, it is important to understand the factors that influence it. When this understanding is coupled with an awareness of fraud indicators, the claim representative is better able to detect fraud in insurance claims.

FRAUD INDICATORS

Insurers rely on claim representatives to notice certain elements in claims that are potential fraud indicators—called red flags—and to investigate any detected indicators thoroughly. Fraud-fighting organizations such as the National Insurance Crime Bureau publish lists of indicators of claim fraud.[9] Some insurers use software programs based on those lists to detect characteristics that are common to fraudulent claims. Such programs can analyze vast amounts of data across different lines of insurance to identify claim patterns and other similarities that may indicate fraud. Several organizations offer electronic anti-fraud databases that contain claim-related records or provide access to public records that may be used to gather evidence of fraud. Claim representatives who are aware of fraud indicators can more readily recognize cases that warrant review by an SIU investigator.

Claim representatives should watch for red flags in the insured's or claimant's behavior that indicate the possibility of fraud. Other red flags are specific to the type of claim, such as medical claims, lost earnings claims, fire claims, auto claims, or burglary and theft claims. The sections that follow provide examples of fraud indicators in each of these types of claims.

Behavioral Fraud Indicators

Claim representatives should be alert for potential fraud indicators in the insured's or claimant's behavior when the claim is first presented to the insurer. The NICB lists the following red flags related to insured or claimant behavior:

- *The insured is excessively eager to accept blame for an accident or is overly insistent in demanding a quick settlement.* This behavior may be an attempt to conceal a fraud by preventing the claim representative from conducting a thorough investigation. In the alternative, the insured may be seeking to resolve a claim quickly because the injury or loss has caused a financial hardship.

- *The insured or claimant is unusually familiar with insurance, medical, or vehicle-repair terminology and claim procedures.* The insured or claimant may have gained this familiarity from having submitted many prior claims or may be receiving "coaching" from a professional in order to perpetrate a fraud. In the alternative, the insured or claimant may have a legitimate reason for knowing this terminology; for example, his or her spouse may be a doctor, nurse, auto repair person, or claim representative.
- *The insured or claimant is willing to accept a small settlement rather than provide documentation.* This behavior may be an attempt to conceal a fraud. In the alternative, the insured or claimant may simply be attempting to resolve a claim for which documentation is legitimately unavailable.
- *The insured or claimant conducts transactions in person and avoids using the mail.* This behavior may indicate that the insured or claimant is trying to avoid a federal mail fraud charge if the insurance fraud is detected. In the alternative, the insured or claimant may simply want to ensure that documents are not lost.
- *The insured or claimant is recently separated or divorced.* Such a change in marital status can present a financial motive for fraud. However, it may have no bearing on the claim at all.

APPLY YOUR LEARNING

A Word of Caution

As shown, valid reasons may exist for any of the red flags listed in this chapter. Claim representatives should be aware of an increased risk of fraud when the indicators exist but also should avoid jumping to conclusions. Nothing surpasses the value of a good investigation in determining the validity of a claim.

Behavioral indicators of fraud can also come from other parties involved in the claim. If a claim representative suspects a fraudulent claim, contact with the producer can reveal additional fraud indicators. The NICB offers the following potential fraud indicators based on producer information:

- *The insured's business was unsolicited, new, or walk-in business not referred by a current policyholder.* In this case, the producer has no knowledge of or experience with the insured and can provide only a superficial assessment of the insured. The insured may be intentionally trying to hide information. In the alternative, the insured may have been seeking a new insurance producer and have selected a new one from a directory.
- *The insured arrived at the producer's office at noon or at the end of the day when staff are rushed.* This timing may be an attempt to hide information because the staff may not be as thorough at these times. In the alternative, it may be the only time the insured can get away from his or her job.
- *The insured neither works nor lives near the agency.* The insured may be attempting to hide information by making it inconvenient for the agent to drive to the insured's home or workplace to verify information. This

indicator may also suggest a hidden connection between the agent and the insured. In the alternative, it can mean that the insured was referred to this particular agent by a friend or relative.

- *The insured's stated address is inconsistent with employment or income.* This inconsistency may indicate that the address is false or that the insured is living beyond his or her means. In the alternative, it may mean the insured has another source of income.
- *The insured cannot provide a driver's license or other identification or has a temporary, recently issued, or out-of-state driver's license.* The insurer may be attempting to hide information, such as true name or address. In the alternative, the insured may not have such identification because he or she does not drive or has recently moved and has not acquired a new driver's license.
- *The insured paid the minimum required premium.* The insured may be trying to get an insurance policy, pay the minimum premium, and avoid making any other premium payments. This approach to insurance fraud occurs frequently in auto insurance because an insurance card is given out upon receipt of the minimum payment. The insured never pays the rest of the premium and the policy is canceled, but the insurance card remains in the insured's possession. If stopped by police, the insured will present the card as proof of insurance. In the alternative, the insured may be able to pay only the minimum premium because of financial issues and may fully intend to make all subsequent payments.

Medical Fraud Indicators

Claims for medical expenses can arise under several types of insurance coverage, including liability coverage; first-party coverages, such as automobile, medical payments, or personal injury protection; or workers' compensation coverage. Although policies differ, many medical fraud indicators are the same regardless of the type of coverage.

The wide variety of medical fraud indicators includes the following:

- *Exaggerated claims and claims for services that were never rendered.* The insured or claimant may be working with the medical provider to exaggerate the need for medical treatment. In the alternative, the medical provider may be overbilling the insurer without the knowledge of the insured or claimant.
- *The diagnosis is not consistent with the treatment.* For example, the claimant's diagnosis is diabetes, but the prescription is for an anti-convulsant drug. This discrepancy may indicate an attempt to pad the claim by choosing a diagnosis that would increase the medical bills. In the alternative, it may suggest the need for further investigation to determine whether the diagnosis and treatment really are inconsistent with one another, as the drug prescribed may have other less common or "off-label" uses.

- *The healthcare provider has a reputation for questionable claims.* This may indicate the provider's willingness to pad the claim. In the alternative, it may have no bearing on the claim.
- *Medical bills are summaries rather than itemized statements.* The provider may be attempting to hide information or create documentation for a fictitious injury. In the alternative, the medical provider may be able to supply itemized statements if asked to do so.
- *Medical bills are photocopies rather than originals.* Photocopies may have been made to camouflage alterations to the original bill. In the alternative, another insurer may have required an original.
- *Bills indicate that treatment was given on holidays or weekends.* Such bills may indicate an attempt to pad a claim by billing for treatment on dates when the medical provider is usually closed. In the alternative, the facility may have been open or the client may have been treated on an emergency basis.
- *All the claimants involved in one accident submit bills from the same healthcare provider.* The claimants may have been directed to a particular provider who is participating in a fraud scheme. In the alternative, all the claimants may be members of the same family and use the same provider.
- *The extent of medical treatment is not consistent with the damage to the automobile.* This discrepancy may indicate an attempt to inflate the value of the claim by overtreating the injury. In the alternative, the treatment may be legitimate if the person was physically susceptible to a more extensive injury.

Any of these red flags, when considered in the context of the entire claim, can be sufficient reason to refer the claim to an SIU investigator.

Lost Earnings Fraud Indicators

Workers' compensation insurance provides medical and wage-loss benefits to employees with injuries and illnesses that are work-related. Disability income insurance is designed to replace a portion of the income lost by a worker who becomes unable to work because of an accident or illness. Lost earnings fraud occurs when workers' compensation or disability insurance is used to pay for lost earnings that are not caused by covered illness or injury. Examples of lost earnings fraud include the following:

- An employee who is injured at home falsely claims that the injury is work-related in order to collect wage benefits from workers' compensation insurance.
- An employee stays home from work and continues to receive workers' compensation wage-loss benefits or disability income benefits after he or she has fully recovered from the injury and is capable of returning to work.
- An employee who has not been injured files a claim for workers' compensation benefits for a fictitious injury after a layoff is announced.

- An employee works a second job while claiming disability and receiving workers' compensation benefits or disability income benefits from his or her primary job.
- An employee seeks reimbursement under an employer-provided disability insurance policy for loss of wages that have already been reimbursed by the employer's workers' compensation insurer.

Like other fraud indicators, lost earnings fraud indicators can have legitimate explanations. Nevertheless, they can alert the claim representative to seek further verification. Lost earnings fraud indicators include the following:

- *The lost earnings statement is handwritten or typed on blank paper.* A lost earnings statement that is not on business letterhead may not have come from the insured business. In the alternative, all the business stationery may have been destroyed in the loss, and the documents were created from back-up records.
- *The business telephone number given to verify the claimant's lost wages reaches an answering machine or answering service during regular business hours.* This suggests that the number provided by the claimant may belong to someone other than the insured business. In the alternative, it can mean the business at which the claimant is employed is not a traditional business. It may be on run entirely out of the owner's home.
- *The business phone number is unlisted or the business has only a post office box for an address.* The business may be fictitious or the claimant may have provided false documentation. In the alternative, there may be a legitimate reason for the business number to be unlisted and the business's using a PO box. For example, it may be a temporary number and PO box because the insured location was destroyed by the loss.

Fire Fraud Indicators

Arson-related insurance fraud is committed when someone deliberately sets fire to property to collect on insurance. Although arson may also be committed for revenge or to conceal criminal activity, this section deals only with insurance-related arson.

Estimates of arson property losses range from $1.5 billion to more than $5 billion per year.[10] Arson has serious consequences because property is permanently lost. For example, a historic building can never be replaced. Even property that is not burned is often damaged by smoke.

Approximately 40 percent of all structure fires in the U.S. are intentionally set. Some sources indicate that nearly half the arsons committed involve damage to structures. The remainder is divided between damage to mobile units and damage to other property (for example, forest fires). Damage to structures resulting from arson is divided evenly between commercial and residential properties.[11]

Claim representatives should be alert to indicators of arson, such as the following:

- *The insured removes valuable inventory before a fire occurs, then claims damage to a large amount of old or out-of-season inventory.* The insured may be using the fire as a means of recovering some of the money spent to acquire inventory that did not sell. In the alternative, the insured may simply have had an unsuccessful year and was unfortunate enough to also have a fire that year.
- *The building or contents were offered for sale for a long period before the loss.* An unsalable building or contents can present a motive to commit arson. In the alternative, the cause of the fire may be unrelated to the failure of the property to sell.
- *The family pet was not on the property at the time of the fire.* The absence of the pet may indicate advance knowledge of the fire. In the alternative, there may be a reasonable explanation for the pet's absence, such as a visit to the groomer.
- *There are multiple mortgages on the property.* This situation may indicate that the insured was having financial difficulties. In the alternative, it may mean that the insured's business was expanding and lenders found the property to be valuable enough to sustain multiple mortgages.
- *Contents with sentimental value were not damaged.* The insured may have had advance knowledge of the fire and moved or secured the valued items. In the alternative, the insured may make it a practice of keeping items of sentimental value in a protected area.

Arson is often easy to prove because a telltale accelerant or ignition source is usually found at the fire scene. What is far more difficult to prove is that the insured started the fire or hired someone to start it. If a fire claim raises any suspicions of arson, the claim representative should involve SIU in the investigation.

Auto Fraud Indicators

Auto repair facilities that specialize in fraudulent insurance schemes have contributed to auto insurance fraud problems in many states. In some states, soaring auto insurance rates caused partially by fraudulent claims have influenced elections and have generated new legislation.

Red flags for auto fraud include the following:

- *For a serious accident, no police report is submitted or a police report is completed at the police station rather than at the accident location.* This situation may mean that the accident never occurred or was staged. In the alternative, there may be a valid reason that no police report was made, based on the circumstances.
- *No towing charge has been claimed, although repair estimates suggest that the vehicle could not have been driven from the scene of the accident.* This may indicate that the vehicle was previously damaged and was in the repair facility when the accident allegedly occurred. In the alternative, it may mean that the auto was still drivable.

- *The vehicle that is subject to the claim is reported to be an expensive, late-model automobile recently purchased with cash.* If the claim is for auto theft, the vehicle may be a "phantom" vehicle, existing only on paper. In the alternative, the insured may have had sufficient disposable income to purchase the auto with cash.
- *The accident occurred shortly after the vehicle was purchased or insured or after physical damage coverage was added to the policy.* The auto may have been purchased and insured solely for use in a staged accident. In the alternative, the insured may simply have been unlucky to be in an accident just after purchasing or insuring the auto.
- *All the vehicles in a multi-vehicle accident are taken to the same repair facility.* This may indicate collusion among those involved in the accident and the repair facility. In the alternative, it may be because this repair facility has the best service in the area.
- *An appraiser has difficulty locating the vehicle for an inspection.* This may indicate that the vehicle does not exist or that the damage is inflated or preexisting. In the alternative, it may mean the insured cannot afford to take the vehicle off the road for even a short period of time.

Burglary and Theft Fraud Indicators

Insurance fraud is common in burglary and theft fraud claims because the fact that the property involved is not available for inspection makes it difficult to detect claims that are exaggerated or false. The following red flags may indicate burglary and theft fraud:[12]

- *Losses are incompatible with the insured's residence, occupation, or income.* This incompatibility may indicate that the claim is exaggerated. For example, if the insured is a single mother working for a small lumber yard, it is unlikely that she will have high-end audio and video equipment. In the alternative, the insured may have another source of income, or the items may have been gifts.
- *Losses include appraised items or scheduled property, making proof of value readily available.* If only appraised or scheduled property was stolen, while other high value items were not, the claim may be false. In the alternative, items that are appraised or scheduled on a policy are usually high value, and those are most likely be the target of a thief.
- *Losses include many new items or gifts for which no receipts are available.* The absence of receipts to prove ownership or value makes it easy to exaggerate a claim. In the alternative, the insured may have received the gifts for a recent birthday or anniversary.
- *Loss inventory does not differ significantly from the original police report.* Initial police reports are usually made shortly after discovering the burglary or theft and before the victim has time to make a complete inventory. A complete inventory presented at the time the loss is reported may have been made in advance with the intention of filing a false claim. In the

alternative, the insured may simply be thorough and able to give the police an accurate initial inventory.

- *The insured does not remember when or where new items were purchased.* The insured may be attempting to conceal an exaggerated claim. In the alternative, the insured may just be forgetful, or the items may have been gifts.
- *Receipts have incorrect sales tax figures or no store logo, are numbered in sequence, or have the same handwriting.* The receipts may be false. Most stores use equipment that accurately calculates sales tax, and store receipts usually have an identifying mark, logo, or address. It is also unlikely that the insured would make consecutive purchases or that the same salesperson would handle all the transactions. In the alternative, there may be a logical reason for each of these circumstances.
- *The loss involves a stolen auto.* Improved auto anti-theft systems have reduced the frequency of automobile theft claims. However, those systems do not prevent vehicle theft fraud. Claim representatives should be aware of the types of vehicles that are most likely to be stolen, such as luxury autos and sport utility vehicles. Organized crime rings are especially interested in such vehicles. Claims for other types of vehicles can raise suspicions if any of the indicators listed in Exhibit 4-1 are present. As with all claims, the claim representative must conduct a balanced investigation to determine whether the existence of the indicator has a reasonable explanation.

EXHIBIT 4-1

Indicators of Vehicle Theft Fraud

Indicators of vehicle theft fraud related to coverage

- The loss occurs within one month of the issue or expiration of the policy.
- The loss occurs after the cancellation notice was sent to the insured.
- Coverage is for minimum liability with full comprehensive coverage on a late-model or an expensive vehicle.
- Coverage was recently increased.

Indicators of vehicle theft fraud related to reporting

- The insured has failed to submit or delayed submitting a police report.
- No report or claim has been made to the insurer within one week after the alleged theft.
- Neighbors, friends, and family are not aware of the loss.
- The license plate does not match the vehicle or is not registered to the insured.
- The title indicates that the vehicle is junk, salvage, or from out of state, or the title is photocopied or a duplicate.
- The title history shows nonexistent addresses.
- Repair bills are consecutively numbered or dates show work performed on weekends or holidays.
- An individual, rather than a bank or financial institution, is named as the lienholder.

Source: National Insurance Crime Bureau

Maintaining a Balanced Investigation

Claim representatives must maintain a balance between suspicion of fraud and the possibility that a claim is legitimate despite the presence of one or more fraud indicators. To achieve this balance, a claim representative can use the questions listed in Exhibit 4-2.

EXHIBIT 4-2

Questions to Help Maintain a Balanced Investigation

Having identified one or more fraud indicators in a claim, claim representatives should ask the following questions and conduct the investigation to obtain the answers:

- Given the circumstances of the loss, what would the reasonable or expected actions/responses be for any party involved in the loss?
- What part of the reasonable action or response is missing?
- What has been added to the reasonable action or response?
- Is there a rational explanation for the appearance of the fraud indicator?
- Is there physical evidence to support the reported version of the loss?
- Is the loss as reported physically possible?
- Would someone other than the insured, such as a retailer, supplier, or customer, have records that may confirm or refute the insured's version of the loss?
- Would a local or state governmental agency have records that may confirm or refute the insured's version of the loss?
- Is there a witness to the loss whose motives for coming forward may be suspect?
- Is there a rational or innocent explanation for all or some of the suspicions?
- Is any part of this analysis based on an assumption? If so, can it be proven?

An example illustrates how this analysis can work. Claim representative Marie Johnson is investigating a homeowners claim for the theft of personal items from the trunk of an auto the week before Christmas. The insured has submitted a lengthy list of toys and sports equipment that were stolen from the trunk. The insured stated that the items were all Christmas presents for his family and that the trunk was the only place no one in the family would look to discover the gifts. The insured also says that he paid cash for most of the items and left the receipts in their respective bags in the trunk. The insured claims that the total value of the items in the trunk exceeds $10,000. A partial list of the items reported stolen includes the following:

A set of Calloway golf clubs	$3,500
A Nike golf bag	$ 500
A motorized pull cart for the golf clubs	$ 200
A 27-inch TV/VCR/DVD	$1,000
A 21-inch computer monitor	$3,000

All items were in their original boxes, along with many smaller items.

Marie's conversations with the insured raises her suspicions about the veracity of the list. While she believes that hiding Christmas presents in an auto's trunk and keeping the receipts with the items could be considered reasonable behavior, she questions whether reasonable behavior would include paying cash for these items. She also questions whether physical evidence would support the claim that all the items, in their original boxes, would fit into the trunk of the insured's 1999 Toyota Camry with the trunk closed.

Marie contacts the insured to confirm that the listed items were in the trunk, that the trunk was closed at the time of the loss, and that the auto's back seats were not folded down. Marie also confirms that there is minimal damage to the trunk lock.

Marie asks the insured where he obtained the cash for the presents. He replies that he made the purchases over the course of several weeks after getting the cash out of his local automated teller machine (ATM). Marie then asks for a copy of his bank statement for that period or the ATM receipts to confirm the withdrawals. The insured is reluctant to supply them. Marie also asks for the dates and locations of each of the major purchases. The insured's answers are not specific enough for Marie to verify the purchases at the stores.

Finally, Marie decides to reconstruct the loss. She obtains boxes from various sources that match the size of the items claimed and asks the insured to place these boxes in the trunk of his auto in the same positions they were in at the time of the loss. The insured is unable to pack the trunk with all the items after several tries. Marie ultimately decides that the insured has exaggerated his claim and makes the appropriate denial.

This example demonstrates a balanced investigation. Marie seeks more information to determine whether there is a rational explanation for behavior that doesn't appear reasonable, and, testing her suspicions against the physical evidence, determines that the physical evidence does not support the claim.

A claim representative's detection of fraud on a claim-by-claim basis fits into a broader framework of efforts among the government, the insurance business, and the public to detect and prevent insurance fraud.

ANTI-FRAUD EFFORTS

Insurers; federal, state, and local governments; insurance industry organizations; and the public all play a part in countrywide anti-fraud efforts. Governments and insurers recognize that the enormous costs of insurance fraud reach far beyond an individual insurer or the insurance industry and can significantly affect an area's economic growth. Their anti-fraud efforts include not just detecting fraud and punishing those who commit it, but also raising public awareness of these costs and deterring fraudulent behavior.

Anti-fraud efforts must start with the public. A survey published in 2003 by the Insurance Research Council (IRC) found that many people find certain types of fraudulent activity acceptable. The study showed that when presenting a claim, some consumers believe they are entitled to collect the deductible and the amount of premiums they have paid by adding them to the claim amount (padding). One-third of respondents agreed that it is acceptable to pad insurance claims to compensate for the deductible that has been paid. One-fifth of respondents agreed that it is acceptable to pad claims to compensate for premiums paid.[13] While these figures represent a slight drop in acceptance from other years, tolerance of insurance fraud remains high. Exhibit 4-3 summarizes findings relating to the acceptability of different types of fraud.

EXHIBIT 4-3

Acceptance of Fraud and Buildup: Insurance and Other Areas

Percentage of Respondents Who Agree It Is All Right To. . .

	Total Agree	Strongly Agree	Agree	Probably Agree	Total Disagree	Probably Disagree	Disagree	Strongly Disagree
Insurance:*								
Increase claim amount to make up for deductible	33%	3%	17%	12%	60%	6%	32%	22%
Increase claim amount to make up for premium	22%	2%	10%	10%	71%	8%	34%	29%
Other areas:								
Exaggerate current income in a job interview to get a higher salary	15%	2%	8%	5%	84%	6%	51%	28%
Not report all income to IRS to lower taxes otherwise paid	11%	2%	7%	2%	88%	5%	48%	35%
Withhold information about debts when applying for bank loan	10%	1%	6%	4%	88%	5%	52%	31%
Exaggerate education or past experience on a job application	9%	1%	6%	2%	90%	4%	49%	37%

Note: Percentages may not equal totals because of rounding.

* 2002 data represent the average of findings from two separate telephone studies conducted in May and October 2002. The May 2002 sample of 1,000 respondents was conducted as part of the Insurance Research Council's *Public Attitude Monitor* series.

Source: Insurance Research Council, *Insurance Fraud: A Public View*, June 2003, p. 12.

However, in the same survey, respondents had much less tolerance for fraud in a few areas. Only 4 percent of the respondents found it acceptable to return to the doctor or chiropractor for treatment after an injury has healed, and only 4 percent found it acceptable to describe a stolen auto as having greater value than actual.[14]

Adding to the complexity of the insurance fraud issue is the fact that, according to a 2003 IRC survey, "respondents indicated that they recognize the economic effect that fraud has had on insurance costs and advocate strong measures against individuals who commit fraud. They appear less certain, however, about fraud's effect on accessibility of insurance coverage and are less committed to the idea of personally helping bear the costs associated with fighting fraud."[15] While most of those surveyed agreed that sterner measures need to be taken against those who commit insurance fraud, more than one-third of those surveyed are unwilling to contribute an extra dollar to their insurers for anti-fraud efforts.[16]

Public awareness of the costs and ramifications of insurance fraud, along with criminal penalties, appears to reduce the public's tolerance of fraud. Insurers, government, and insurance organizations work to raise public awareness in addition to detecting and deterring fraud and prosecuting and punishing those who commit it.

Insurers

Insurers are the first line of defense against insurance fraud because they are the most likely to detect it and report it. To assist claim representatives in detecting and reporting insurance fraud, insurers have created special investigation units (SIUs) to investigate claims that raise suspicions of fraud. Many states now mandate that insurers maintain an SIU as part of their anti-fraud efforts (see Exhibit 4-4).

SIUs use technology to help detect fraud. As mentioned previously, databases maintained by insurance-related organizations accumulate information on insurance fraud. These databases cross-index claims to pinpoint multiple filings and provide historical information about claimants. In addition to using such technology, many SIU personnel have law enforcement or investigative experience, and some have criminal justice degrees. Such qualifications help SIU personnel conduct the intensive investigations that are often necessary to substantiate claim denials based on fraud.

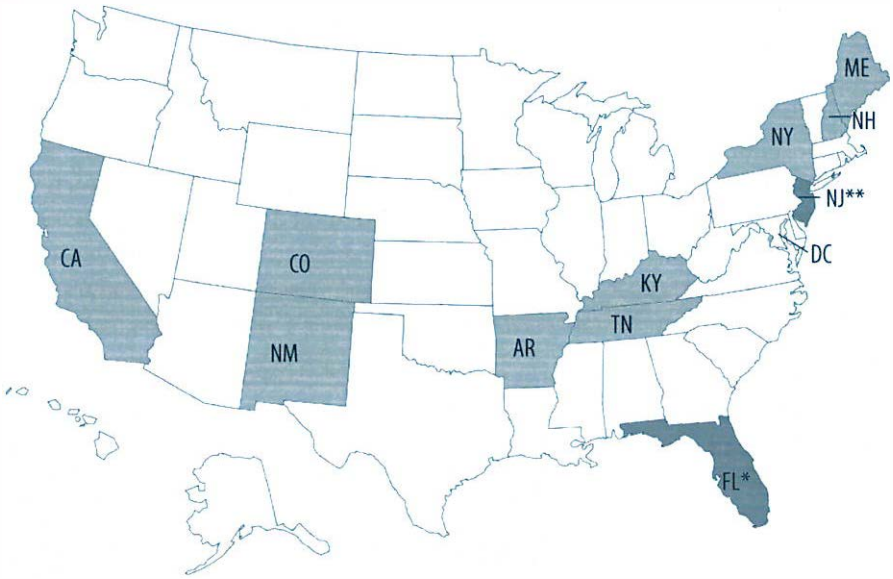
Claim representatives refer claims to SIUs based on criteria that vary by insurer. Some insurers refer every claim that raises suspicions to an SIU. Others refer claims based on the extent of the suspected fraud, the prospects of obtaining proof of the fraud, the size of the claim, or the type of coverage.

Insurers, as well as several states, require continuing education for claim representatives and appraisers. Such continuing education can include fraud awareness training. To the extent that continuing education focuses on preventing and detecting fraud, it contributes to the insurer's efforts to reduce fraudulent claims.

EXHIBIT 4-4

States That Require SIUs

These states require that insurers maintain a special investigation unit either in-house or vendor provided. At least two states have also set education requirements for investigators.



Florida and New Jersey have specifics regarding this mandate. In all other states, carriers are required to maintain an SIU regardless of premium or policy count.

* Florida: An SIU is required for insurers admitted to do business writing $10 million or more in direct premium.

** New Jersey: An SIU is required for insurers who, in the previous year, had 2,500 New Jersey auto policies or 10,000 health insurers' lives.

Source: Adapted from GAB Robins, GAB Robins Risk Management Services, Inc., Insurance Investigation Unit's "Guide to SIU Regulatory Compliance," 2005 edition. Used with permission.

Resources are available to assist claim representatives in fraud detection, but the claim representative must know how to use the resources most effectively in combating fraud. In another recent IRC survey, 87 percent of responding insurers said that they offered fraud awareness training and 97 percent of responding SIU professionals said they spend time training company personnel. Claim representatives should take advantage of this training to become more informed and effective in fighting fraud.[17]

Insurers can also help combat fraud by educating the individual consumer about the costs associated with insurance fraud. Some insurers are making efforts to bring awareness of the problem to schools, organizations, and consumer groups.

Government

Responsibility for legal efforts to combat insurance fraud lies with a variety of city, state, and federal regulatory bodies, including state insurance departments, state fraud bureaus, and law enforcement agencies. Many states have enacted anti-fraud legislation that includes all or some of the following components:

- Expanding the definition of insurance fraud to include reckless conduct
- Increasing civil and criminal penalties for committing insurance fraud
- Requiring insurers to cooperate with law enforcement authorities in cases of suspected fraud
- Giving broad immunity from civil lawsuits to insurers that share information about suspected fraud
- Requiring insurers to form SIUs, develop anti-fraud plans, and place fraud warnings on all applications and claim forms

The Coalition Against Insurance Fraud (CAIF) advocates the following measures to detect, prosecute, and deter fraud:

- Make insurance fraud a specific crime with appropriate penalties, including restitution for victims.
- Require administrative action against licensed individuals or businesses—medical providers, lawyers, insurance agents, adjusters, contractors, and body shops—upon conviction of insurance fraud.
- Establish fully functioning fraud bureaus in states with moderate or severe problems of insurance fraud. The bureaus should have subpoena power and fining authority and should work with law enforcement and industry to investigate fraud.
- Require insurers to commit to specific plans to prevent and detect fraud.
- Require claim forms and insurance applications to display a warning that insurance fraud is illegal and treated as a serious crime.
- Provide immunity to insurers when sharing fraud information with other insurers, fraud investigators, and law enforcement.
- Require visual inspection of certain types of automobiles before insurance is granted to curtail the practice of insuring phantom vehicles and subsequently reporting them stolen. This requirement would also curtail the practice of insuring autos with existing damage.[18]

Pre-Inspection

To combat the dual problem of auto theft and fraudulent auto-repair facilities, some states and insurers require the insurer to physically inspect vehicles as a prerequisite to providing insurance. Pre-inspection programs prove to be effective in reducing theft claims for nonexistent or phantom vehicles. Pre-inspection can also deter inaccurate reporting of drivers and vehicle garaging locations that results in a lower than adequate premium. For example, a pre-inspection may reveal that the vehicle is routinely driven by

someone other than the insured or that the car is rarely kept at the location designated as its principal garaged location. Some states also require photographic documentation as a part of pre-inspection. In Massachusetts, for example, an insurer must photograph a vehicle from the front and rear. The vehicle identification number is also photographed. This type of photographic documentation helps prevent attempts by the policyholder, insurance producer, or vehicle inspector to insure a phantom vehicle.

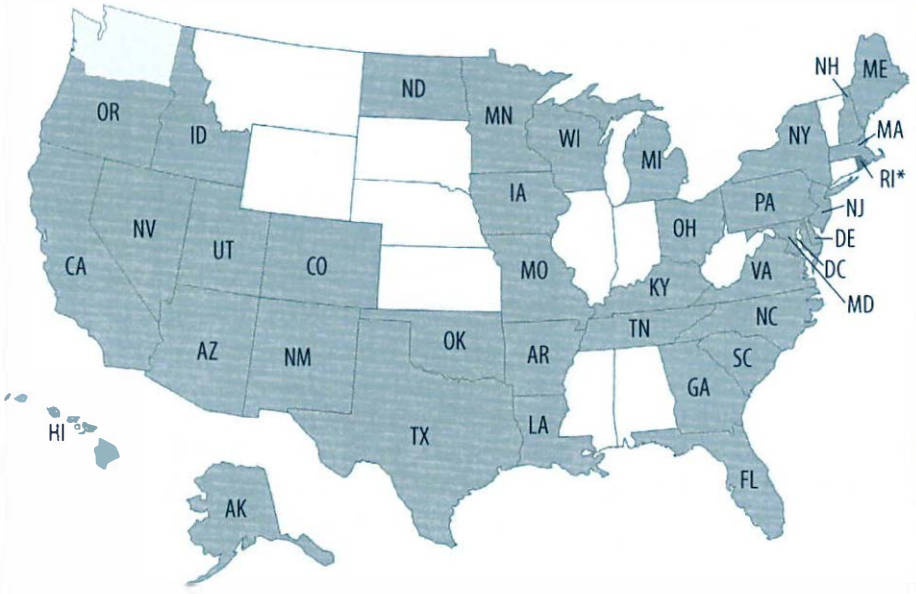
Mandatory Reporting

Cooperation and information sharing between insurers and law enforcement are essential in fighting insurance fraud. Most states have laws requiring insurers to report claims that raise suspicions to law enforcement or other authorities. New Jersey, for example, requires an insurer to report a fire loss from "other than accidental means" to the county prosecutor for investigation and prosecution. Mandatory reporting laws were enacted as a means to bring those who commit fraud to the attention of authorities for possible criminal or civil prosecution. These authorities may include the FBI or other law enforcement agency, district attorney's office, state fraud bureau, state insurance department, or NICB. Without these mandatory reporting laws, insurers may be hesitant to report suspected fraud because they may face a civil suit if they are unable to prove the allegation (see Exhibit 4-5).

EXHIBIT 4-5

States That Have Mandatory Reporting Laws

These states have set procedures for when and how insurers must report suspected insurance fraud as defined by their respective fraud laws.



*Rhode Island's mandatory reporting law applies to workers' compensation only.

Source: Adapted from GAB Robins, GAB Robins Risk Management Services, Inc., Insurance Investigation Unit's "Guide to SIU Regulatory Compliance," 2005 edition. Used with permission.

Immunity Statutes

To further protect insurers who report potentially fraudulent claims, states have adopted immunity statutes. **Immunity statutes** allow insurers and law enforcement officials to share information about fraudulent activity without facing civil lawsuits for defamation, harassment, malicious prosecution, bad faith, or breach of privacy. Most statutes grant this immunity if the report is made in the absence of fraud, malice, or criminal intent. Statutes vary by jurisdiction and each should be reviewed before a report is made.

Immunity statute
A law that allows insurers and law enforcement officials to share information about fraudulent activity without facing potential civil lawsuits for defamation, harassment, malicious prosecution, bad faith, or breach of privacy.

Sharing information about suspected fraudulent claims can help stifle fraud. For example, an individual purchases an auto and insures it with six different insurers. Allegedly, the auto is involved in an accident and destroyed. The claim representative investigating the claim is unaware that five other claim representatives are looking at the same vehicle for the same loss. The owner of the auto may have used six different names and addresses for the various policies on the same vehicle. Under the shield of the immunity statute, insurers can share information relating to the loss to determine whether the same claim has been submitted elsewhere, without the potential of a civil lawsuit. Database searches assist claim representatives and special investigators in detecting duplicate claims. For example, database queries may reveal that the same vehicle identification number was recorded six times in a one-month period or that one of the fictitious names was used previously in a fraudulent claim.

Civil or Criminal Penalties

Civil or administrative action to punish people who make fraudulent insurance claims is increasingly used as an anti-fraud effort. For example, in 2002, twelve fraud bureaus reported taking civil action against people who committed fraud.[19] In New Jersey, medical practitioners convicted of insurance fraud must surrender their license for one year. If convicted again, the practitioners are permanently barred from their professions. A California statute (California Insurance Code §1871.7) has allowed several major property and casualty insurers to file multiple lawsuits for civil fines and damages against attorneys and doctors who knowingly pay runners (persons hired to steer accident victims to a particular attorney or doctor) or participate in submission of fraudulent claims.

The following are some advantages to pursuing civil action in fraud cases:

- Civil damages can be recovered from the wrongdoers.
- Organized fraud activity may be actionable, not only under common law, but under a number of different civil statutes relating to conspiracy or statutory fraud, including the federal Racketeer Influenced and Corrupt Organizations (RICO) statute.
- Civil prosecution may be easier than criminal prosecution because the burden of proof is less strict than in a criminal case.

- Civil litigation can focus attention on fraudulent activity of suspected individuals or organizations. Such action may alert law enforcement officials, who may pursue their own investigation into criminal activity.
- Civil litigation allows for greater discovery of information and broader subpoena power than criminal prosecutions do, making it easier to gather information.

A functional anti-fraud program uses all the tools available and includes processes for pursuing both civil and criminal remedies.

An Example of Civil Penalties for Fraud

Using all available anti-fraud tools, West Virginia authorities investigated and prosecuted an insurance fraud case that resulted in both incarceration and restitution. The fraud scheme took place over ten years and included sixty arsons across southern West Virginia that burned mobile homes, buildings, and automobiles. A husband and wife team was convicted. The wife was sentenced to fifteen years in prison, and the husband was sentenced to eight years and five months. The couple was ordered to pay $300,000 in restitution to fifteen insurers. The wife had three different Social Security numbers, and as many as seventeen aliases. She had been convicted on previous fraud-related felonies in the early 1990s.[20]

Fraud Prevention Bureaus

Another government anti-fraud effort involves the creation of fraud prevention bureaus. State fraud bureaus, which operate in thirty-three states representing approximately 75 percent of the U.S. population, evaluate potentially fraudulent cases submitted by insurers. After the referrals have been evaluated and enough evidence has been gathered, the information is presented to a prosecutor. Prosecutors can become involved during any phase of the investigation; when they become involved depends on the scope and size of the suspected fraud.

State fraud bureaus have a common goal of fighting insurance fraud, but their scope of operation may vary. Some were formed specifically to combat workers' compensation fraud. Some fraud bureaus are charged with enforcement activities beyond fraud, such as enforcing laws that require businesses to carry workers' compensation coverage. Virginia's insurance fraud bureau is part of the state police department, while Florida's is a division of the Department of Insurance.

Statistics show that fraud crimes increase in states located near other states that establish fraud bureaus or strengthen anti-fraud initiatives. For example, after California cracked down on fraud through legislation and the creation of a fraud bureau, fraud incidents in Arizona increased. Fraudsters tend to target states where tracking and monitoring systems are weak or nonexistent. This is known as migrating fraud.

...ristics show that anti-fraud efforts are working to some degree. The ...ber of criminal convictions is growing, especially in states that have had ...d bureaus in place for many years. Those states have greater investiga... experience, larger staffs, and more legal authority to prosecute criminals ...an states that do not have fraud bureaus. As shown in Exhibit 4-6, criminal ...nvictions resulting from fraud bureau investigations rose nationally from ...31 in 2001 to 2,535 in 2002.[21] Exhibit 4-7 indicates that civil prosecu... ...ns resulting from fraud bureau investigations have continued to increase ...ionally over the past several years. New Jersey accounted for 86 percent ...all civil actions among the twelve states that reported such prosecutions ...2002.[22]

EXHIBIT 4-6

Criminal Convictions—total number, 2002

Criminal Convictions

— total number, 2002 —

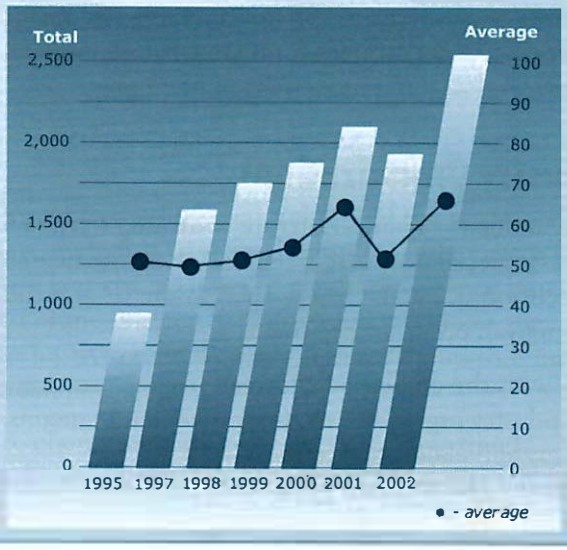
Florida	458
New York	389
New Jersey	302
Pennsylvania	221
South Carolina	98
North Carolina	86
Utah	82
Maryland	80
Texas	69
Virginia	55
Ohio	43
Kentucky	41
Louisiana	31
Massachusetts	30
Georgia	30
Arizona	29
Nevada	26
Arkansas	18
Iowa	17
Mississippi	15
Hawaii	12
Nebraska	12
Idaho	9
New Hampshire	7
Delaware	3
District of Columbia	3
Alaska	0
California*	* * *
Missouri*	* * *
New Mexico*	* * *

Workers comp bureaus

Nevada	220
Missouri	58
Oklahoma	44
Connecticut	13
Montana	10
Minnesota	8
Texas	7
Kansas	3

North Dakota	2
Louisiana	2
Rhode Island	2
Washington	* * *
Georgia	* * *
average	*74*

***data not available



...uced from *A Statistical Study of State Insurance Fraud Bureaus: A Quantitative Analysis*, December 2003 ...p. 16. © Copyright 2003 Coalition Against Insurance Fraud, Inc. Used with permission.

EXHIBIT 4-7

Civil Actions

Reproduced from *A Statistical Study of State Insurance Fraud Bureaus: A Quantitative Analysis*, December 2003 edition, p. 18. © Copyright 2003 Coalition Against Insurance Fraud, Inc. Used with permission.

Fraud Plans

Certain states mandate that insurers draft and implement a written plan for combating insurance fraud. Some states exempt insurers that write small amounts of premium. Some states require insurers to submit their plans to the insurance department for review before implementing them. Exhibit 4-8 shows states that require a written fraud plan.

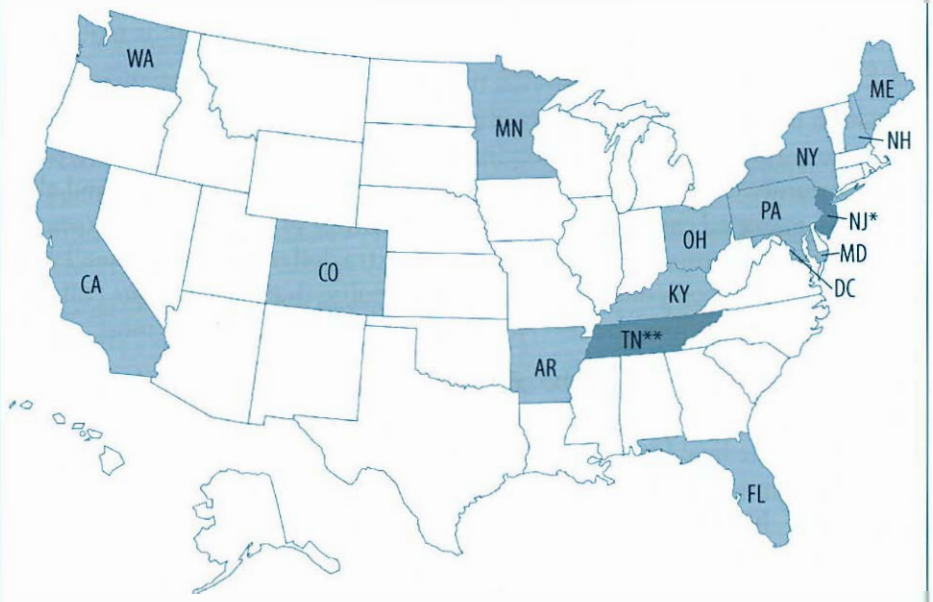
Industry Organizations

Many industry organizations are dedicated to the reduction of insurance fraud. Some, such as NICB and CAIF, are dedicated to the detection and prosecution of fraud. Others, such as the III and the IRC, compile statistical information on insurance fraud.

Even with the combined efforts of insurers, state and federal governments, and industry organizations, insurance fraud remains a pressing issue for insurers and claim representatives.

EXHIBIT 4-8

States That Require a Written Fraud Plan



* New Jersey requires fraud plans of insurers that write private passenger auto (personal or commercial) insurance and of all health insurers.

** Tennessee requires fraud plans only for workers' compensation.

Source: Insurance Information Institute, *2006 III Fact Book*.

SUMMARY

Insurance claim fraud is a threat to the financial stability of the insurance business. Many organizations, including insurers, law enforcement agencies, regulators, and legislators, are launching efforts to combat insurance fraud. Often viewed as a victimless crime, insurance claim fraud victimizes the average consumer, who pays for the crime through increased rates that may be charged to cover inflated claim payments.

Two categories of insurance claim fraud are hard fraud and soft fraud. False claims and intentional losses are examples of hard fraud. False claims are claims for events that never happened, such as the reported theft of a diamond ring that never existed. Many false claims involve several, or many, participants in a scam. For example, people other than the insured may participate in the fictitious diamond ring claim by creating a false appraisal and cash-register receipt. Intentional losses result from events that are purposely caused with the intent of defrauding an insurer. For example,

several individuals may collude and intentionally cause an automobile accident, often with an unsuspecting motorist. Exaggeration, an example of soft fraud, occurs when a claim is filed with an insurer for reimbursement of a greater sum than was actually incurred in the loss. Describing property as more valuable than it really is or an injury as more severe than it really is are examples of exaggerated claims.

Common motives for insurance fraud are profit and a sense of entitlement. Organized crime is another motive. In addition to motive, other factors create an opportunity for fraud, including an insurer's underwriting practices and claim practices, managed care practices, and public distrust of insurers. Consumers who believe that insurers will not miss a few extra dollars added to a small auto claim or workers' compensation claim do not realize that those dollars collectively add up to millions that everyone pays for through increased rates.

Claim representatives should be trained to look for fraud indicators (red flags) that can help detect fraud before a claim is paid. These indicators can relate to behavior, medical losses, lost earnings, fire, auto losses, burglary, and theft. The claim representative must maintain a balanced investigation once fraud is suspected, because fraud indicators are not proof of fraud.

Anti-fraud efforts are conducted by insurers, the government, and insurance industry organizations. These efforts include pre-inspection, mandatory reporting, immunity statutes, civil or criminal penalties, fraud prevention bureaus, and fraud plans. Some anti-fraud laws mandate that insurers report claims that raise suspicions to law enforcement authorities. Immunity statutes permit insurers to discuss suspected criminal activity with other groups, including state fraud bureaus, law enforcement officials, and other insurers, without facing potential civil lawsuits. Anti-fraud legislation can expand the definition of insurance fraud to increase civil and criminal penalties for committing insurance fraud. Many states have formed state fraud bureaus to track and report the status of insurance fraud. Insurers have increased their internal efforts to combat insurance fraud by creating special investigation units (SIUs), which are responsible for investigating claims that raise suspicions of fraud. Some states require claim representatives to complete a certain number of hours of continuing education each year. Insurance fraud courses are offered as a way for claim representatives to stay informed of current trends in insurance fraud.

Many insurance industry organizations are dedicated to reducing insurance fraud. Some work to detect fraud and prosecute the people who commit it; others compile statistical information.

When dealing with suspected insurance fraud, claim representatives must balance their awareness of the potential fraud with the necessity of conducting a good-faith claim investigation. The insurance contract is a contract of trust between policyholder and insurer, and it guarantees that the insurer will always act in good faith and with the highest ethical conduct. Most policyholders are honest, but claim representatives have a duty to be alert for those who try to defraud insurers and their policyholders by submitting fraudulent claims, while using good-faith claim handling practices. These practices are the subject of the next chapter.

CHAPTER NOTES

1. The Coalition Against Insurance Fraud (CAIF) is an anti-fraud organization that includes as members many national and international organizations that represent insurers, consumers, regulators, legislators, and investigators. Its Web site is at www.insurancefraud.org (accessed October 25, 2005).
2. Insurance Information Institute, *2005 III Fact Book*, p. 126.
3. Insurance Information Institute, *2005 III Fact Book*, p. 126.
4. National Insurance Crime Bureau, "Insurance Fraud," www.nicb.org/public/publications/brochures.cfm (accessed October 25, 2005).
5. Robert A. DuBois, *Insurance Fraud and Motor Vehicle Collisions* (Rochester, N.H.: The Haven House, 1992), p. 2.
6. Margo D. Beller, "Group lists top 10 fraud cases of 1997," *The Journal of Commerce*, January 29, 1998, p. 5A.
7. "By the Numbers: Fraud Stats," Coalition Against Insurance Fraud.
8. "Fraud arrests up 140% since '95 in New York," *The Journal of Commerce*, February 6, 1998, p. 5A.
9. The National Insurance Crime Bureau (NICB), based in Palos Hills, Ill., is a not-for-profit organization dedicated to fighting insurance fraud and vehicle theft. The NICB is supported by approximately 1,000 property-casualty insurers and self-insured companies.
10. National Fire & Arson Report, March 1997.
11. From the Uniform Crime Report, Department of Justice, Federal Bureau of Investigation, 1996.
12. Adapted from *Indicators of Property Fraud*, National Insurance Crime Bureau, 2003.
13. Insurance Research Council (IRC), *Insurance Fraud: A Public View*, June 2003, pp. 3–4.
14. IRC, June 2003, pp. 16–17.
15. IRC, June 2003, p. 5.
16. IRC, June 2003, p. 27.
17. Insurance Research Council and Insurance Services Office, Inc., *Fighting Insurance Fraud: Survey of Insurer Anti-Fraud Efforts*, December 2001, pp. 19, 27.
18. Coalition Against Insurance Fraud Fact Sheet, and "Insurance Fraud: The Hidden Tax," April 18, 2000, p. 24.
19. Coalition Against Insurance Fraud, www.insurancefraud.org/downloads/fraud_bureau_study.pdf (accessed January 26, 2006).
20. The National Underwriter Company, *Claims Magazine*, Claims eNews, March 30, 2005, Florida 771 (accessed October 25, 2005).
21. Coalition Against Insurance Fraud, www.insurancefraud.org/downloads/fraud_bureau_study.pdf. p. 16 (accessed December 29, 2005).
22. Coalition Against Insurance Fraud, www.insurancefraud.org/downloads/fraud_bureau_study.pdf. pp. 16, 18 (accessed December 29).