

THE GROWING PROBLEM OF FRAUDULENT CLAIMS (WITH DETECTION TIPS!)

Mike Carmoney

Insurance fraud is any act committed with the intent to fraudulently obtain payment from an insurer. Fraudulent claims account for a significant portion of all claims received by insurers, and cost insurers and their insureds billions of dollars annually. Research indicates that at least ten percent of property/casualty claims involve some form of fraud, and arson is suspected in as many as one out of four building fires. Insurance crimes range in severity, from slightly exaggerating claims to deliberately causing accidents or damage. Fraudulent activities also affect the lives of innocent people, both directly through accidental or purposeful injury or damage, and indirectly as these crimes cause insurance premiums to be higher. According to estimates by the Insurance Information Institute, insurance fraud accounts for ten percent, or about \$30 billion, of losses in the property and casualty insurance industries in the United States. The National Health Care Anti-Fraud Association estimates that three percent of the health care industry's expenditures in the United States are due to fraudulent activities, amounting to a cost of about \$51 billion. Other estimates attribute as much as ten percent of the total healthcare spending in the United States to fraud—about \$115 billion annually.

I. Causes

Not surprisingly, the chief motive in all insurance crimes is financial profit. However, recent research shows that a growing segment of the public believes that insurance fraud may be justified due to the high cost of insurance. For example, many believe it is not wrong to exaggerate a property loss in order to “absorb the deductible.” Of course, these attitudes among insureds contribute to the vicious circle of additional claim costs leading to rising premiums.

II. Losses Due to Insurance Fraud

It is virtually impossible to determine an exact value for the amount of money stolen through insurance fraud. By their nature, insurance fraud crimes are designed to be undetectable, unlike crimes such as robbery or murder that are very visible. As such, the number of cases of insurance fraud that are detected is much lower than the number of such acts that are actually committed. The Coalition Against Insurance Fraud estimates that in 2006 a total of about \$80 billion was lost in the United States due to insurance fraud. Many commentators believe that number is rising dramatically as many homeowners feel the pressure of rising personal debt and the effects of over-mortgaged real property purchases.

III. Hard vs. Soft Fraud

Insurance fraud can be classified into two types: hard fraud and soft fraud. Hard fraud occurs when someone deliberately plans or invents a loss, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive payment for damages that may or may not be real. Criminal rings are sometimes involved in hard fraud schemes that can steal millions of dollars. Soft fraud, which is far more common than hard fraud, is sometimes also referred to as opportunistic fraud. This type of fraud consists of policyholders exaggerating otherwise legitimate claims. For example, when involved in a collision an insured person might claim more damage than was really done to his or her car. Soft fraud can also occur when, while obtaining a new insurance policy, an individual misreports previous or existing conditions in order to obtain a lower premium on their insurance policy.

IV. Types of Insurance Fraud

The types of insurance fraud that exist are as diverse as the types of insurance policies that are available. Two of the major areas in which insurance fraud occurs are in the automobile and property insurance industries.

A. Automobile Insurance Fraud

The Insurance Research Council estimated that in 1996, 21 to 36 percent of auto-insurance claims contained elements of suspected fraud. Today's numbers are probably much higher. There is a wide variety of schemes used to defraud automobile insurance providers. These ploys can differ greatly in complexity and severity. Examples of soft auto-insurance fraud can include filing more than one claim for a single injury, filing claims for injuries not related to an automobile accident, misreporting wage losses due to injuries, or reporting higher costs for car repairs than those that were actually paid. Hard auto-insurance fraud can include activities such as staging automobile collisions, filing claims when the claimant was not actually involved in the accident, submitting claims for medical treatments that were not received, or inventing injuries. Hard fraud can also occur when claimants falsely report their vehicle as stolen. Soft fraud accounts for the majority of fraudulent auto-insurance claims, although many believe that hard fraud incidents are on the rise. Organized crime rings can also be involved in auto-insurance fraud, sometimes carrying out schemes that are very complex. An example of one such ploy is given by Ken Dornstein, author of *Accidentally, on Purpose: The Making of a Personal Injury Underworld in America*. In this scheme, known as a "swoop-and-squat," one or more drivers in "swoop" cars force an unsuspecting driver into position behind a "squat" car. This squat car, which is usually filled with several passengers, then slows abruptly, forcing the driver of the chosen car to collide with the squat car. The passengers in the squat car then file a claim with the other driver's insurance company. This claim often includes bills for medical treatments that were not necessary or not received.

B. Property Insurance

Fraudulent activities against property insurance providers consist of the destruction of property in order to receive insurance payments for it. Possible motivations for this can include obtaining payment that is worth more than the value of the property destroyed, or to destroy and subsequently receive payment for goods that could not otherwise be sold. According to industry experts, the majority of property insurance crimes involve arson. One reason for this is that any evidence that a fire was started by arson is often destroyed by the fire itself. According to the United States Fire Administration, in the United States there were approximately 31,000 fires caused by arson in 2006, resulting in losses of \$755 million. Property insurance fraud can also occur when claimants exaggerate the value of the property lost or damaged.

V. Detecting Insurance Fraud

The detection of insurance fraud generally occurs in two steps. The first step is to identify suspicious claims that have a higher possibility of being fraudulent. This can be done by computerized statistical analysis or by referrals from claims adjusters or insurance agents. The next step is to refer these claims to investigators for further analysis. Due to the sheer number of claims submitted each day, it would be far too expensive for insurance companies to have employees check each claim for symptoms of

fraud. Instead, many companies use computers and statistical analysis to identify suspicious claims for further investigation. Fraudulent claims can be one of two types. They can be otherwise legitimate claims that are exaggerated or “built up,” or they can be false claims in which the damages claimed never actually occurred. Once a built up claim is identified, insurance companies usually try to negotiate the claim down to the appropriate amount. Suspicious claims can also be submitted to “special investigative units”, or SIUs, for further investigation. These units generally consist of experienced claims adjusters with special training in investigating fraudulent claims. These investigators look for certain symptoms associated with fraudulent claims, or otherwise look for evidence of falsification of some kind. This evidence can then be used to deny payment of a claim in serious instances.

GENERAL INSURANCE FRAUD INDICATORS

Recent increase in coverage.

Loss occurred shortly after inception date of policy or shortly before expiration of policy period.

Insured verifies existence and extent of coverage shortly before loss.

Undisclosed duplicate coverage.

Insured willing to settle for substantially less than the purported value of the claim in order to speed claims settlement process or to avoid documentation of claim.

Over-familiarity with claims process.

Extensive history of similar claims, particularly claims not disclosed by insured.

Unwillingness by insured to respond to questions concerning the loss or injury or to provide documentation of same.

COMMERCIAL PROPERTY LOSS CLAIMS – FIRE AND THEFT

Any indication that the business is having financial difficulties or has immediate need for funds.

Deteriorated or outmoded facilities, business is in bad location or deteriorating neighborhood. Machinery, production equipment or inventory is obsolete or unmarketable. Property is over-insured.

Unusual presence of combustible material on the premises.

Unusual handling of combustible materials normally present on the premises.

Presence of multiple fires, accelerants.

Evidence that valuable property was recently removed from the premises or relocated to a safer place within the premises.

Any departure from long-standing routine (failure to activate alarm system; shut-down of sprinkler system; discharge of security guard).

No evidence of unlawful entry or evidence of unlawful entry appears to have been manufactured.

Real property is heavily mortgaged.

Business or personal property secures multiple and substantial debts.

Recent history of late payments or default on loans.

Principals in business have history of business failures.

Recent expansion of business facilities which caused insured to incur substantial debt; other over-extension.

Radically differing accounts of accident or manner in which loss occurred, including inconsistent reports from the same person.

Overlapping ownership of related businesses with inventory moving readily between businesses without adequate documentation.

Poor economic climate for particular business.

Damaged property discarded or not readily available for inspection.

INDIVIDUAL PROPERTY LOSS CLAIMS

Insured experiencing marital difficulties, including separation, divorce, substantial child support obligation or recent increase in child support obligation.

History of transiency when ownership of property lost is inconsistent with transient lifestyle.

History of gambling or alcohol or drug abuse.

Insured has spotty work history or extended period of unemployment.

Poor economic climate for insured's profession or trade.

Property lost or destroyed was being advertised for sale.

Loss limited to high ticket or scheduled items.

Insured's lifestyle is inconsistent with income.

Value of property lost is inconsistent with insured's income.

Too many receipts to support claim (e.g. insured produces receipt for socks purchased 6 months prior to loss).

Too few receipts, especially for recently purchased, high ticket items still under warranty.

Receipts are suspicious in nature (no store identification on receipt, consecutively numbered receipts, large number of undated receipts).

Recent movement of valuable or sentimental property to place of safety.

Unexplained absence of typical household items or non-combustible items at fire scene.

Unexplained absence of family pet at time fire or illegal entry occurred.

No evidence of unlawful entry or evidence of unlawful entry which appears to have been manufactured.

Pattern of past claims or losses.

Property heavily mortgaged or insured otherwise financially overextended.

Insured's' movements unaccounted for at time of loss.

Unexplained departure from habits.

Radically differing accounts of accident or manner in which Loss occurred, especially inconsistent reports from the same person.

Damaged property discarded or not readily available for inspection.

PERSONAL INJURY CLAIMS

Insured/claimant has extensive history of claims/accidents.

Descriptions of occurrence vary widely or are virtually identical suggesting rehearsal.

Legal representation sought shortly after injury occurred.

No treatment sought for injuries until a substantial period of time elapsed after the accident or until legal representation is obtained.

Course of treatment is questionable (no apparent relationship between injuries claimed and treatment provided; minor injuries result in major medical costs; medical bills are out of balance with treatment obtained).

Documentation of treatment is suspect (photocopies of bills supplied; no record of dates of treatment; no itemization of treatment provided)

Majority of complaints are subjective and incapable of corroboration.

Claim for pain and suffering is not consistent with severity of injuries.

Long-standing relationship between attorney and treating physician.

In products cases, injury-producing product has been lost or destroyed.

SPECIAL CONSIDERATIONS APPLICABLE TO AUTOMOBILE ACCIDENTS

Damage to vehicle is inconsistent with injuries claimed.

Absence of police report where logic dictates that a report should have been made.

Existence of multiple claimants as a result of same accident whose injuries vary widely in degree.

Multiple, unrelated occupants of same vehicle.

Relationship among occupants creates possibility of collusion.

Multiple claimants obtain representation from same attorney.

Multiple claimants obtain treatment from same physician and follow similar course of treatment.

SPECIAL CONSIDERATIONS APPLICABLE TO WORKERS' COMP CLAIMS

Unwitnessed Monday morning accident.

Claimant can seldom be reached by phone during the day.

Claimant repeatedly misses or reschedules doctor's appointments

Nature and extent of alleged injuries are inconsistent with how the accident occurred and/or doctor's diagnosis.

The claimant's co-worker has a prior history of workers' compensation or liability claims.

The claimant is self-employed or has a job that would allow the claimant to work for cash while collecting temporary disability.

The claimant's employer is experiencing financial or labor difficulties.

Claimant's job performance is poor and/or claimant has taken significant sick time for unexplained illness.

SOURCES:

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