Focus on Insurance Fraud

An Issues Roundtable

Sponsored by

The Coalition Against Insurance Fraud

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FOCUS ON INSURANCE FRAUD

On October 7, 1993, the Coalition Against Insurance Fraud brought together 50 experts from various disciplines and perspectives to discuss and debate the problem of insurance fraud and potential solutions. The results of this issues roundtable will help the coalition develop and implement a national agenda to address insurance fraud. Below is a summary of the discussions. The roundtable was facilitated by Roy Rudd Jr. of New York University.

Defining the Problem

Adrian Tocklin
Executive Vice President
The Continental Corporation

Insurance fraud costs the industry a lot of money, and hence it costs insurance consumers a lot of money. For the industry it's difficult to underwrite against dishonesty. It's a moral hazard, and insurance underwrites for fortuitous events. Fraud is not a fortuitous event.

The deterioration of morality is evident by a recent study that 46% of employers in Florida were found to underestimate payrolls in order to reduce workers compensation premiums.

The recent bus sting in New Jersey where "ghostriders" were caught is another example that has direct results. Bodily injury claims ranged from $30,000 a bus to $400,000 a bus. Premiums on the busline went from $9,000 per bus to $25,000 per bus in just a couple of years. One doctor who was arrested in the sting billed for 11 doctor visits that weren't needed and 37 that never took place for one patient.

Fraud undermines the integrity of the entire system that is based on trust. We cannot treat our policyholders like we're cops -- it will increase costs and lead to consumer hostility. We need to balance our approach of preventing and detecting fraud, and trust in our customers.

Dishonest and financially troubled insurers contribute to the problem of trust, as well.

We've got to get across that fraud is plain wrong, and that honest people are subsidizing the cheaters.

Insurers should not treat fraud as a cost of doing business. Some insurers who publicly claim they are fighting fraud privately feel it's just a cost of doing business and don't like the fact that other insurers have formed the coalition and are "rocking the boat."

We have to be relentless and single-minded in ferreting out fraud as an industry. The industry should work with consumers, state fraud bureaus and others, and should establish special investigation units (SIUs). We should ferret out insider fraud, as well.

We need to work with the coalition and with the National Insurance Crime Bureau (NICB) to raise public awareness of this major economic issue that is up there with tax evasion. We need to change laws - financial solvency, regulation laws, and work for better prosecution, funding of district attorneys and local law enforcement, if need be.

As insurers, we need to send a clear signal to our employees, agents, brokers, adjusters and policyholders that we will not tolerate fraud—and it shouldn't be just a handful of companies. Long-term success only will be achieved if it's an overall industry effort.

If the coalition does not succeed in implementing effective reform, the job of combatting insurance fraud will fall back on the industry and its trade associations, whose record on this issue has been a complete and dismal failure because the industry has been typecast as self-interested. Let's not blow this opportunity. ■

Stephen Brobeck
Executive Director
Consumer Federation of America

At present insurance fraud is not a high priority issue for either the consumer movement or for many members of the Consumer Federation of America. In part this is because concentrating on claims fraud has the potential to alienate many consumers who believe that insurers have overcharged them and provided less than satisfactory service.

So why has CFA taken the time to help establish and lead the Coalition Against Insurance Fraud? There are three reasons:

■ Insurer fraud remains a problem. Even though small businesses are the principle victims of this type of fraud, as we have seen recently in Southern California, their victimization hurts communities as well.

■ Claims fraud imposes huge costs on consumers. Rising losses are the main reasons for escalating auto and homeowner premiums, and fraud is a major cause of these increasing losses.

■ Insurance fraud is one important manifestation of a decline in moral standards that is fundamentally destructive of society. Through the coalition we can make a modest, but important, contribution to the solution of this problem.

Any ethical decline and consumer dissatisfaction with insurers have created an environment where fraud can flourish. But insurance fraud is also encouraged by the inadequacy of current fraud prevention efforts. In spite of their commendable efforts, insurers, consumer groups, regulators and law enforcement officials still have not done enough to fight fraud. If there's one contribution that the coalition could make, it is to serve as a catalyst to increase the importance of fraud prevention within our society. To do this, we must put this prevention on our society's public agenda.

How can we accomplish this lofty goal? While it's not going to be easy, I would suggest the following approach: First, we need to identify or define model fraud prevention programs within industry, the regulatory community and law enforcement agencies, then relentlessly promote these programs until there is widespread acceptance. Without the establishment of an effective fraud prevention infrastructure, we will never succeed.

Insurance fraud is one important manifestation of a decline in moral standards that is fundamentally destructive of society.

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Second, we need to persuade the consumer community that insurance fraud needs to be a high priority. This is important because, for better or for worse, consumer groups will have great credibility speaking out on fraud-related issues. This credibility extends beyond policy-makers and the news media to individual consumers.

Third, we must mount a high-

ly visible campaign that focuses public attention on outrageous examples of fraud and the costs of fraud to consumers and to society. Then we must outline, as simply as possible, the most effective public response to the problem. Such a campaign must feature the release of studies that the media are likely to cover and thus, will be communicated to opinion leaders and consumers.

One caveat that must be considered, however: Our fraud prevention efforts must be measured and responsible. We must recognize that overzealousness can threaten both consumer privacy and pro-customer service programs.

This meeting today is historic. It represents the first time that leaders of every community with a stake in resolving insurance fraud problems have come together to share insights and develop strategies. At the close of the day, I hope we leave with a renewed commitment to work more closely together on an effective fraud prevention campaign. ■

Richard A. Derrig, PhD
Senior Vice President
Automobile Insurers Bureau of Massachusetts

Fraud and abuse are not well defined concepts. Even experts viewing claims files in studies done in Massachusetts do not define fraud the same way. That's one reason no one knows how much fraud there is because we haven't agreed on a definition. Pick a number and you may be right. For example, according to our data in Massachusetts, fraud and abuse combined for automobile bodily injury claims can be anywhere from 48% to 0.2% of the claims, based on the definition.

- 48.00 % of claims have some perception of fraud or abuse;
- 9.00 % of claims have some perception of fraud;
- 1.00 % of claims are referrable for criminal investigation;
- 0.67 % are acceptable for criminal investigation;
- 0.33 % are referable for prosecution;
- 0.17 % are prosecuted successfully.

Insurance fraud can be defined under four testable parts:

1) - Clear and willful action:
2) - Proscribed by law;
3) - To obtain money or value;
4) - Under false pretenses.

Abuse fails one of the four. All four parts are difficult to prove for law enforcement, and they are very difficult for insurance companies to prove. That's why there should be a group effort.

There are a variety of types of auto fraud, including:

- staged accidents
- jump-ins (every accident in Lawrence, Mass., had an average of four people in the car)
- false document
- opportunistic injuries
- claimant rings without assistance from providers
- provider rings
- adjuster-agent-claimant rings
- staged thefts
- chop shops
- body shop fraud

In workers compensation, the variety of fraud include:

- working while collecting
- malingering
- staged accidents

- professional claimants
- false loss statements
- failure for businesses to obtain policies
- prior injuries
- premium avoidance
- injuries unrelated to work
- fraud by medical providers, attorneys
- theft by insurance agents

The group effort to fight fraud should include:

- insurance companies
- law enforcement
- prosecutors
- judiciary

Comments from roundtable participants:

Consumerist: Industry will oppose anti-fraud proposals on the legislative front on the theory that they are doing it already and they don't want any more government regulation. How do we handle it?

Insurer: Non-insurers should put pressure on insurers to support anti-fraud efforts. Explain to them that while their individual efforts are commendable, they should support joint efforts and support reform legislation.

Consumerist: The minority usually drives change. Those insurers who are committed to real solutions should argue the case relentlessly in the industry that this is in the long-term interest of the industry to embrace anti-fraud efforts. Our goal is not to get every insurer to sign on to our campaign, but to diffuse the opposition who can stop us at the local level, state level and national level. The industry leaders should make a substantial argument to those who don't want to join us so at least they won't work against us.

Federal prosecutor: Seven years ago it struck me how timid insurance companies were about insurance fraud. There wasn't much strength in their arguments that it was something that should be prosecuted. But there has been a change. It has been a priority for the Justice Department.

Insurer: Companies have been timid because we don't want to unfairly accuse our customers, and because of unfair trade practices, which require insurers to pay claims promptly. We need to stop looking at others for blame (insurers and consumers) and each look in the mirror. Insurance fraud is rooted in the moral and ethical decline of this country. The problem resides in each and every one of us, and is not simple.

Consumerist: Is fraud more prevalent in insurance than in industries of comparable size?

If we were the clothing industry or any other retail industry, we would not tolerate, nor would our customers accept, paying an additional 10% or 20% for shoplifting.

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Insurer: Yes. If we were the clothing industry or any other retail industry, we would not tolerate, nor would our customers accept, paying an additional 10% or 20% to cover shoplifting.

Consumerist: What is it about the insurance transaction that encourages fraud? The first real experience people have with the industry is car insurance. If I make $8/hour as a 19-year-old construction worker in Baltimore and am required to pay

$2,300 annually for insurance without ever having a car accident or traffic tickets, my moment of truth is that there is something wrong with this industry. If I thought I got ripped off up front, I may think it's fair to get back what I feel was taken from me unfairly.

Consumerist: The view of the insurance industry is at the root of the fraud problem -- the cost of auto insurance, the inability to get insurance, as a small business the inability to get property insurance, people forced into off-shore insurance companies . . . it creates an attitude that encourages soft fraud. It sets a tone that makes it difficult to tackle the larger issue.

Insurer: There are negative feelings about insurance companies. A lot of 18- and 19-year olds don't pay for their own insurance; they are still living at home, or maybe are away at college. We need various mechanisms (criminal, empowerment of insurance companies, regulators, civil fines, suspending licenses of professionals). I think we make a mistake if we say we have to define fraud and decide who's going to jail. There are a lot of other options. We can't rely on law enforcement.

Consumerist: In his presentation, Richard Derrig left out consumers and media as interests in fighting fraud. Consumers don't define fraud like insurers or regulators. Should we consider a different definition for consumers?

Consumerist: What insurers and regulators define as abuse, consumers don't define as abuse. We can most productively concentrate our efforts on hard fraud because most in society agree that it is wrong and that we should do something about it. If we focus on hard fraud and insurer fraud, it will give us and the industry some moral authority to start fighting soft fraud. I don't think more than 2% of consumers think the industry has the moral authority to talk about soft fraud because of its lack of credibility.

Fraud investigator: Consumers think, "I never had a claim; why are my premiums increasing?" and "My car is worth $4,000; why am I paying $2,000 in insurance?" In Massachusetts, people pay two-thirds of their premiums for lawsuits against bodily injury claims. The money is not in theft. Soft fraud is uncontrollable.

Federal prosecutor: I think it's dangerous to start distinguishing between soft fraud and hard fraud, fraud and abuse. All of this stuff is fraud. You can draw a line as far as where we will dedicate your resources, but in the criminal fraud, you're going to invite fraud if you label it as "soft" fraud or abuse. There is no usefulness in using that phrase.

State investigator: I agree. If you make those distinctions between soft and hard fraud -- like "she's just a little bit pregnant," you're inviting dishonesty. If soft fraud is illegal, then it should be prosecuted. Fraud is not on anyone's agenda as a hot ticket for prosecutors. You can double the number of statutes, but it will be useless unless more law enforcement is added. It's a great idea to build public awareness and to get the industry's attention. But if you're talking about criminal prosecution, it's less effective unless you find more prosecutors who understand white collar crime and help them become interested in pursuing it because it isn't very sexy for a jury to hear. You're also going to have to get the attention of the judiciary that white collar crime is a real crime. The only reason for 48% to 0.2% is because of the lack of people to enforce and prosecute.

State investigator: The insurance industry

is imbued with an unenlightened self interest. A major insurer reported theft of $300,000 in premium fraud by one of its independent agents. Upon our request, they declined to provide information. What they did was sign a re-payment agreement. They turned the theft into a loan. A year later, they come back and revoke this agent's license and get him prosecuted. I won't go to a prosecutor with a case like that. He'd laugh me out of his office. The problem with the industry continues to be a lack of courage to deal with the problem themselves. The problem is not laws—we have plenty of laws—the problem is people and the courage to deal with it.

Every policy says that the insurer can deny the claim if false information is given in making the claim. Most insurance companies in workers comp and other areas feel much more attuned to compromising the claim because of the expense involved in defending it. Many insurers set themselves up many times as a victim. The industry needs to create its own socialization that it's not going to stand for this kind of thing. They can start by training adjusters. Underwriting, especially in personal lines, has gone from true underwriting to paper processing in many insurance companies.

Regulators should help to create an atmosphere where insurers can deal more easily and effectively with insurance fraud.

Insurer investigator: The industry is becoming far more aggressive in pursuing prosecution for external and internal fraud. Because of the risk-averse nature of the industry, it was conservative in its approach. The industry is committing the resources to attack this problem, but we're not there yet. We need to crawl before we can walk.

We have to differentiate fraud from abuse. Fraud is submitting a claim for an accident that never occurred, not someone taking advantage of an opportunity to get their premium back.

Insurer: The industry is expected to be both things: the prompt payer of claims and an aggressive investigator of fraud. Balancing those two roles is never an easy one. Most companies decide to err on the side of believing the consumer rather than consistently facing the penalties of the regulator. There's a balance in all of this that needs to be met in terms of defining the problem to acknowledge there are image issues for the industry, and there are questions of moral standards for the country. If we have to wait to enhance the image of the industry before we defeat the fraud problem, we might as well all go home. It will be a lifetime process for many of us.

Whether it's hard or soft fraud, the underlying motivations are the same—we want to get something for nothing. How do we, through prosecution and education, begin to let people understand that it does impact a $2,300 auto premium in Maryland—and impact our ability to return a profit to shareholders? Controlling fraud is not something the industry can do alone.

As an insurer, our frustration is in being soft on soft fraud. ▲

Consumerist: The moment of truth for this group is the extent you are willing to look at insurer fraud, as well as consumer fraud. This group won't have much credibility with consumers and legislators unless we address

insurer fraud. Some companies are doing a good job in handling insider fraud, but the problem is the companies that are not doing it.

Insurer: It bothers me when we talk about hard fraud and soft fraud. There are some who say, "let's forget about the minor sins." For the industry, soft fraud is not easily detected or prosecuted and that's our bigger problem. We should not just address the staged accidents and jump-ins, but soft fraud, as well. Fraud is fraud.

If we think we can put them into two different categories and treat them differently, I think we're missing the whole point here. As an insurer, our frustration is in being soft on soft fraud. When we turn down these claims, there's no penalty to the person who submitted the fraudulent claim.

Our problem now becomes a bad faith lawsuit from that individual and it becomes the billion-dollar organization against this poor guy on the street who's paying a $2,300 premium for his car and he's probably unemployed and we simply are seen as discriminating against this individual; we took advantage of this individual. This is where we have big-time problems.

Causes and factors

Donald Segraves
Executive Director
Insurance Research Council

There's a climate of opinion in the United States where about 20% of people say it's acceptable to pad a claim or lie on an application. They also feel it's OK to cheat on taxes, falsify a bank loan and lie on an employee application. Rising premium costs exacerbate fraud; that is, as insurance premiums rise, people tend to accept cheating more readily.

A surplus of lawyers and medical providers looking for work seems to add to the fraud problem. There has been a noted increase in attorney involvement in bodily injury claims.

In 1977 attorneys were involved in 19% of claims; today that figure has risen to more than 40%. In some states attorneys are involved in more than half of claims. Many times insurers are first notified of an accident when they receive notice from a claimant attorney. Most claimants seek out a lawyer within a week of the accident. They don't wait to find out whether the insurer will treat them right or not. The tort system itself is a major part of the problem of fraud. There is a much higher incidence of suspicious claims in the fault-based coverages than in the non-fault-based coverages.

Changes in behavior also impact insurance fraud. There has been a 30% increase in the bodily injury rate per 100 car accidents between 1980 and 1989. Some increase has occurred everywhere: in nearly all states, urban, rural. But there are wide variations in the amount of increase, even within states. Data for 1989-91 show Pittsburgh had 18 injury claims per 100 accidents, while Philadelphia reported 78. Either there is some mysterious malady affecting the necks and backs of the people of Philadelphia or there is a radical difference in claiming behavior.

In Baltimore, there are 58 bodily injury claims per 100 accidents. Statewide it is 33 claims per 100. There has to be some effect on insurer behavior as well.

Increases in claims are almost entirely due to neck and back strains. No increase in other types of injuries, such as broken bones. In some instances, other types of injuries have decreased. The number of accidents per 100 cars has gone down, as well. Neck and back strains account for nearly two-thirds of auto injuries. It was 50% in 1977. Many incentives in the current system encourage this behavior. ■

Sean Mooney
Senior Vice President & Economist
Insurance Information Institute

There is some evidence that "soft" fraud, that is, individual opportunistic fraud like padding a claim, is growing.

In 1981, the percentage of people who said it's OK to increase a claim to recover a deductible was at 15 percent; in 1989 the percentage was at 18 percent. The percentage of people who agreed strongly that it's OK to recover a deductible by raising a claim rose from one percent in 1981 to six percent in 1989.

It shouldn't be too surprising that individual fraud is getting worse. Most social indicators suggest a society with reduced standards of individual responsibility and behavior. A recent Wharton School of Economics study on attitudes towards fraud shows a strong relationship between moral standards and insurance fraud.

There is a lot of anecdotal and some empirical evidence that "hard core" insurance fraud—fraud committed by people in the business of insurance fraud—grew rapidly in the 1980s. The 1980s saw the rise of medical and litigation mills in many areas of the country. These mills attract a large number of claims through advertising and other means, like "capping" (soliciting workers compensation claims for non-existent injuries) and generate a high profit to their owners. As documented in numerous court cases and in television shows such as "Prime Time" and "20/20," some mills increase their revenue through falsifying claims.

Another indicator of the level of fraud is the ratio of bodily injury liability claims to physical damage liability claims. A high ratio of bodily injury claims indicates a more litigious and possibly fraudulent level of claiming activity. In 1992, the ratio nationwide stood at 36.5. In California, the ratio was at 67.7, confirming most observers' opinion of a high level of fraud in California. By way of contrast, in less litigious Illinois, the ratio stood at 31.0. The ratio nationwide has been increasing, rising from 30.9 in 1988 to 36.5 in 1992. However, the increase from 1991 to 1992 was only 0.4 percentage points (from 36.1 in 1991 to 36.5 in 1992), indicating some progress in the battle against hard core insurance fraud. ■

. . . we're kidding ourselves if we think (we) will convince people that they are only stealing from themselves. What works is sanctions . . . ▲

Charles L. Owens
Chief, Economic Crimes Unit
Federal Bureau of Investigation

The top priority for the FBI in the area of insurance fraud is to address insurance solvency of the bogus, offshore, fraudulent insurers who take in premiums over a short period of

time and fail to pay claims. A total of 175 investigations currently are underway of insolvent insurance companies. The second area of priority is health care fraud. The FBI recently established a separate unit to focus on this area for both private carriers and medicare. The third area of emphasis is in the major false claims activity, specifically the systemic types of problems—payoffs, false claims in the entire process. FBI does not have the resources to deal with individual claims type of insurance fraud.

Things that contribute to insurance fraud:

■ High level of tolerance of insurance fraud in the general public and in the industry.

■ Unwillingness by mainline insurers to write high-risk insurance that makes the marketplace susceptible to bogus carriers to come in and fill that void.

■ Lack of prosecutorial deterrent. It's getting better, but more activity and willingness is needed at the state and federal level.

■ Difficulty in prosecuting many cases. In the health care area, for example, we're dealing with the professional judgment of doctors, and it's a fine line between abuse and fraud.

■ Perception by the public that insurers will not follow up on claims. Companies are sometimes too quick to pay claims without asking questions, and that may encourage some people to commit fraud.

We need to understand where all the various players fit in the effort to combat insurance fraud. Individual types of claims should be a state and local problem. The more egregious type of activity that crosses state lines or results in a lot of dollars or results in insolvent insurance companies is handled more appropriately by federal authorities. ■

Comments from roundtable participants:

State investigator: Many people see the billion-dollar company as the only victim of claims fraud, so they see it as a victimless crime. But we need to talk about other aspects of fraud, such as the insolvencies it could cause and the unauthorized insurers, and agents not remitting premiums, and the law enforcement and judicial system's inability to keep up with this aspect of fraud. This should be a priority.

Insurer: It is perceived as a victimless crime, while in reality there are significant economic consequences. We have a Hurricane Andrew in this industry every year—a $15 billion loss—if the estimates are correct. That's $70 for every man, woman and child in the United States.

The causes and factors of insurance fraud are:

■ Public moral attitude (applies beyond insurance); it's easy to defraud; there's little, if any, penalty.

■ Insurance is an intangible product. It doesn't provide pleasure when you buy it and it's mandated. Insurance companies have big buildings so it looks like they have big profits. In reality, profits are below those of the composite Fortune 500.

There's a presumption from the beginning that the insurance process is unfair. The industry, as well as schools, doesn't teach its economic value that insurance underpins the economic fabric of this country. It perpetuates this attitude of unfairness. The industry needs to be more proactive. But it's not an insurance industry issue alone. The weakness has been the fragmentation in combatting fraud. Rather than blaming each other, let's unify and figure

out how we work together to combat the real enemies who unwittingly steal from themselves and their neighbors (soft fraud), as well as the organized rings (hard fraud).

Insurer: Let's look at fraud in a realistic way. Public education is important, but we're kidding ourselves if we think it will convince people that they are only stealing from themselves. Morality is not going up. What works is sanctions . . . that if you commit this crime, there are known consequences. In drunk driving and seat belt campaigns, public education that was not backed up by sanctions was a waste of time. When sanctions are applied to people who behave wrongly, then there are some results. It's not going to be done by telling people to act like good neighbors.

Consumerist: The insurers seem to be saying, "the insurance business would be wonderful if we didn't have policyholders." It sounds like an "us vs. them" attitude and feeds into the hard vs. soft fraud and abuse issue. A distinction should be made between soft and hard fraud, and the major focus should be placed on hard fraud. Abuse should be handled differently—through internal education to create better understanding by policyholders about insurance. We're evolving into a country where several different languages are spoken. People who organize into fraud rings usually speak the same language—and people in the insurance companies, specifically agents and adjusters, are not speaking those languages.

The different types of fraud are equally serious, but soft fraud and abuse need to be treated in a different way.

I don't think we can equate a rise in back and neck injuries with the involvement of attorneys in insurance claims. Use of attorneys may be attributable to a rise in the understanding of rights, and insurance is complicated, so people seek out advisers to guide them.

Consumerist: The argument that insurance fraud is a burden to all consumers doesn't take you very far because if you're not going to get caught, the economic rational thing to do is to abuse the insurance system.

In the future, we should not react defensively when our own constituency or group is blamed for the problem. Every segment owns some of the blame. We all have to accept responsibility for this problem: insurers are not active enough to correct the problem. There is insurer fraud, but that does not justify a consumer who's paying even $16,000 for auto insurance cheating his or her insurance company.

We need to ensure we do not create a climate in the country that encourages people to avoid addressing the problem. We need to set aside reacting defensively and create a simple action plan that the public, policymakers and press can understand.

Consumerist: Perhaps we can learn from the reduction in car thefts in Massachusetts and apply it to insurance fraud?

The goal is to give insurers the courage and ability to confront suspected fraud and to pay quickly and generously when claims are legitimate.

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Consumerist: One reason for the high incidence of insurance fraud is that people perceive the system is unfair. That's not an excuse for fraud, but a reason. We should develop some solutions other than law enforcement to help make the system more fair. Outlaw insurers are successful because they are filling a need in the marketplace not being met by legitimate insurers.

Federal investigator: Many legitimate insurers back away from high-risk areas, such as taxicabs and asbestos removal, for sound underwriting reasons. Insurance regulators have competing interests at heart, wanting to provide available insurance markets and keeping potential outlaw companies out of the market.

Some existing legitimate companies are taken over by con artists with the intention of bleeding the company dry. These cases involve high dollars that threaten the solvency of the guaranty funds.

There's nothing worse for the general public than to lose faith in insurance when one of these scandals is uncovered. The most prominent case is the insurer that walked out on high school athletes with medical claims. Cases like this taint all insurers.

Insurer: In many cases where outlaw insurers have gone into a market, it's not so much the availability of the product as it is the price of the product.

State investigator: Different problems require different solutions. We have to talk about hard fraud and soft fraud because they come from different origins, have different causes, and therefore, will require different solutions.

The system needs to be changed to solve the soft fraud problems. The economic incentives are there to defraud the system. In the lottery, people flock to put down a dollar to get back 40 cents. In insurance, people put down a dollar and there's a 99% chance they'll get four or five dollars back with a one-tenth of 1% chance of getting caught.

Consumerist: One of the problems is that we don't change the game; we just change the rules of the game. We go from the tort system to no-fault, we have a threshold. The game is still the same. The threshold is increased from $200 to $500, and the rule now is how to build up the claim to get over $500. That is some of the causes. We have an archaic system that no longer works. We need to move to a whole new game—like going to a managed care system to control costs.

Insurer: Society has created systems that give incentives to people to cheat, such as double recovery in health care.

State investigator: As an adjuster, we used to make first-call settlements. Insurers are not looking at automobiles they are covering. The adjusting process encourages people to inflate claims, thinking that the adjuster will cut it down. Insurers don't get enough information on applications, which are too often signed by the agent or broker, so then we cannot prosecute that claimant. We're giving people a blank check telling them to determine what was lost.

Who is really responsible for this problem? The insurance industry is writing this business, adjusting the losses. It can identify what's really going on out there. Each carrier is responsible to investigate its suspected fraudulent claims and separate the honest claims—which should be handled fairly and promptly.

Is the industry willing to commit resources to identify and defend suspected fraud cases?

Regulatory & Insurer Programs

Walter Dartland
Executive Director
Consumer Fraud Watch

A study conducted by the University of Miami Law Review in 1992 concluded that the most frequent reason for unsuccessful prosecution was the lack of admissible evidence. Because of that, insurers cite that as a reason for not reporting. Few prosecutors have experience in handling insurance auto fraud. Legislation, regulation and enforcement are needed to see to it that insurers and government work together to deter and prosecute fraud.

The goal is to give insurers the courage and ability to confront suspected fraud and to pay quickly and generously when claims are legitimate.

Legislators must reform state laws undermining either the planning or execution of investigation by insurers. Insurers should be required to report all suspected cases of insurance fraud. In addition, regulators should penalize insurers who fail to report, and legislators, regulators and the courts should reward insurers who report suspected fraud.

Very little information exists on the effectiveness of fraud legislation and programs. We have problems in convincing legislators because they ask, "How effective is this reform proposal?" "How much money will it save?"

The auto fraud study conducted this year by Mark Cooper says: Although the evidence available does not allow for precise measurement of the results of anti-fraud evidence, it clearly suggests that pre-inspection and other programs reduce thefts and are cost-effective. Comprehensive programs deserve public support. ■

Frank Doolittle
Director, Fraud Division
Florida Insurance Department

Only 15 states have fraud bureaus; only 3 have law enforcement powers. The structure, authority, funding are vastly different from state to state. Many states don't have specific insurance fraud statutes. The coalition can help by helping to enact model laws on fraud and advancing the notion that all states should have fraud bureaus.

Fourteen states have elected commissioners who may tend to be more consumer-oriented and that can create an "us vs. them" attitude with the industry, which is not conducive to a good working relationship to fighting fraud. Additionally, appointed commissioners may have a more difficult time in getting funding for fraud bureaus.

The largest fraud bureaus are Florida with 95 employees in 12 branch offices, and New Jersey with one office and 150 employees (soon to be 170). California also has more than 100 employees in its fraud bureau. Some states have only one or two people in their fraud bureaus. There's no standard model for fraud bureaus. n

Patrick Watts
Senior Council
National Association of Insurance Commissioners

There are several forms of unauthorized insurers:

• Out and out illegal scams set up to collect premiums and disappear, only to surface elsewhere to start the scam all over again;

• Legitimate insurers that make mistakes and write business when they are not authorized;

• Agent and brokers who collect premiums, hoping to find an insurer to take the risk, but don't, and then decide to self-insure, paying claims themselves or letting their errors and omissions carrier pick up the claims.

Some people exploit the gray areas within federal and state laws, such as problems with multiple employer welfare arrangements (MEWAs) and with risk retention groups. Gray areas attract people who want to come in, make a quick buck and get out.

Regulators oversee insurers that are licensed, so if a company fails to get licensed they evade that oversight. Regulators need to be on guard at all times against these unauthorized insurers. Often regulators don't find out about the scams until it's too late—when claims don't get paid. Regulators need to watch for advertising by sham operators. ■

Betty Cordial
Special Services Coordinator
National Association of Insurance Commissioners

In 1991 A.M. Best published a study on property/casualty insolvencies that occurred between 1969 to 1990. Of the 302 insolvencies (from a total of 372) that were analyzed, A.M. Best concluded that 30, or 10%, were due to alleged fraud.

After reviewing each of these insolvent insurers, we were able to determine that a minimum of 88, or 30%, actually became insolvent due to fraudulent activities. What is termed "internal" financial fraud was either the primary reason for the insolvency or contributed substantially to the insolvency. Additionally, law enforcement authorities consider many of the other "causes" of the insolvencies to be fraudulent or highly questionable activities.

Overstated assets and deficient loss reserves were cited in more than 100 cases. Isn't that another way of saying that false financial statements were prepared and filed? Rapid growth and significant change in business can usually be traced to questionable agency activities or management's last-ditch effort to create cash flow for an already impaired or insolvent company. In many instances, reinsurance failure can be traced to non-existent or phony offshore reinsurers. If you consider these additional potentially fraudulent activities, the actual percentage of insolvencies due to fraud is somewhere between 60 and 80%.

SIUs need to select their cases carefully for prosecution, and once selected, have the determination to go forth, whether criminally or civilly.

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An insurer has never gone under because of claims fraud. Financial or internal fraud causes insolvencies and that directly affects the remainder of the industry (guaranty fund assessments and how the industry is regarded by the public). Insolvencies are not victimless crimes. Claims in many insolvencies are not covered by guaranty funds. It is not a victimless crime when insolvencies result in financial and psychological devastation for hundreds of thousands of consumers. ■

John Swedo
Vice President, Special Activities Unit
Continental Insurance

To say SIUs have experienced explosive growth would be an understatement. A 1992 survey by the Insurance Research Council of the largest 200 property/casualty insurance companies revealed that in 1983 a total of 51.4% of the companies had SIUs. That figure jumped to 66.3% in 1992. The oldest SIU is 13 years old. The newest is 3 months old. Most of the growth has been in the past 2-3 years.

Legislation mandating the establishment of SIUs has accelerated the growth. We're making progress but it's still not enough. We have to recognize that from an industry standpoint we're in the infancy stages. Organizations like the International Association of Special Investigations Units have also experienced significant growth. In 1992, the association had 800 members and one year later, the number is to 1,400.

SIUs may vary in terms of size, philosophy, and approach to detecting and combatting fraud. Some insurers have centralized national programs; others have decentralized programs where the SIUs report to regional claims managers. They are staffed primarily by people with either prior law enforcement or claims experience. SIUs work closely with the claims department and play key roles in training claims personnel, underwriters, agents and the public.

Fraud bureaus are vitally important in the fight against fraud. They are one of the primary vehicles for SIUs to get cases prosecuted. We encourage the establishment of fraud bureaus by all states and recommend that they be given adequate resources and authority. We also work closely with the National Insurance Crime Bureau and law enforcement.

For SIUs to be effective, they must have the commitment of senior management in providing support as well as resources. The SIU has to be properly aligned with the strategic goals of the organization. An effective anti-fraud program has to be a customer-focused program and we need to know who that customer is. The claim department is our primary customer. We need to recognize that the SIU alone is not the answer to the fraud problem. We need to teach our customer the claim department, how to investigate simple cases of fraud. As a result, we will create an "army of people" who have a heightened awareness of fraud. Our philosophy on selecting and developing our SIU staff is to "grow our own" from within the ranks of the claim department. Based upon my experience, the best investigators are people with claim experience. We can teach them how to investigate fraud.

One key in developing effective SIU programs is to take a prospective, rather than a retrospective, approach. Our responsibility

goes beyond detection only. A three-pronged approach involving prevention, detection and deterrence is important. We work with underwriters and agents in an effort to stop it at its earliest stage.

SIUs need to carefully select their cases where prosecution is the goal. Once identified, a determination has to be made whether the approach should be to proceed with civil or criminal.

Comments from roundtable participants:

Insurer: Let's develop model legislation and model standards on insurer conduct in anti-fraud investigation, so we don't have 50 standards out there that make it impractical for insurers.

Insurer: Just because they may be different, it does not make them all bad. There are different things that work with different companies.

In more than 30 states, there was legislation introduced in 1993 to create specific statutes governing insurance fraud or to create immunity for insurers. The legislative perception is that this is not a universal problem that needs to be addressed.

In Texas, they hang horse thieves, but they don't prosecute insurance fraud. We need to target states with model bills. It sometimes takes two, three, four legislative sessions to get this stuff through. We need to work with the NAIC and get regulators involved in combatting fraud.

Consumerist: NAIC is considering establishing an insurance fraud subcommittee on model fraud.

Regulator: NAIC has three basic fraud models—one that makes insurance fraud a specific crime; one that creates a fraud bureau within the insurance department and one that allows immunity for those who report suspected fraud.

State investigator: Some states, such as California, New York and Florida, do require SIUs. A current proposal in Florida doesn't have specific requirements because that may kill the bill.

Insurer: In lieu of legislation, we need professionalism to overcome the resistance of insurers to get involved in fraud.

Consumerist: If the existing programs by companies were really working, we wouldn't be sitting around the table today. Let's look at things that are working at the law enforcement level and the company level and see how that can be extended to other states and other companies. A good way to deter fraud is to make fraud criminals understand that they are going up a brick wall, no matter what state they move to or what company they defraud. Right now the brick

Traditional law enforcement and using ex-cops might not be the right approach because this is a different type of crime.

▲

wall has a lot of holes that are allowing criminals to creep through.

Insurer investigator: If you look at the arson problem in this country, back in the late 1970s, it was the big issue. Companies got involved in anti-arson efforts, all states passed immunity legislation, and as time passed, the focus shifted. Yet arson continued to be a big problem and it's not getting the attention it deserves.

Arson investigator: We failed to seize the opportunity to solve the arson problem. There are some things we can do without legislation to fight arson. Public and private sectors may not understand the full extent of the immunity statutes in place. Statutes need to be reviewed to see if they are being properly applied in the 50 states.

We lack trained professional fire investigators. Until the cause of the fire is determined, it's impossible to say whether an insurance fraud has been committed. Some untrained investigators are blaming people unfairly for setting fires; they are not catching arson in other cases. There's a standard by the National Fire Prevention Association that does exist for law enforcement and for insurers who have in-house or hired investigators. A quality manual, published by NFPA, also is available.

Insurer: To what extent are the objectives of this coalition being pursued by other groups? It is important for the coalition to identify other groups working in insurance fraud and work with those other groups. The coalition seems to have a large agenda. It should break down the issues by subcommittees.

Overall, the coalition should adopt a cohesive and cooperative approach, and we should combine databases so they are accessible by insurers and law enforcement and fraud bureaus. And we need to undertake an aggressive public education campaign that is driven by consumer advocates.

Potential Solutions

Jonny J. Frank
Senior Investigations Counsel
U.S. Attorney's Office

I urge you to share the many perspectives being discussed today with members of the United States Department of Justice. Prosecutors have difficulty perceiving multi-billion dollar corporations as being helpless victims of crime, but that is what insurers are—helpless in the sense that law enforcement is not providing help and helpless because insurance fraud is so difficult to detect.

Nonetheless, insurers are victims, and I suggest that you demand the rights afforded to victims under federal criminal law.

Combatting insurance crime requires special planning. Detection and investigation of insurance fraud demand a highly proactive approach.

Insurance fraud is difficult to detect because there is no incentive for anyone to report the crime. Insurance crime is difficult to prosecute because the govern-

We need to understand the difference in the evidentiary standard—of preponderance of evidence and reasonable doubt. ▲

ment must rely upon circumstantial evidence to prove an individual's state of mind.

Proactive techniques such as employing informants and relying upon undercover operations are oftentimes essential to these investigations.

Despite these difficulties, it is important that insurance crime be prosecuted. Unlike other areas of criminality, there is a real general deterrence benefit to prosecuting cases of this sort.

Moreover, the federal sentencing guidelines have stiffened the penalties for insurance fraud. The guidelines effectively provide mandatory jail time for any substantial economic crime case unless the defendant substantially assists law enforcement in the prosecution of others.

The ability for insurers to obtain restitution may well depend upon the relationship with the prosecutor. Prosecutors in the United States, unlike in Europe, do not "represent" the victim; rather, they represent the government. The victim is represented by separate counsel. This does not mean that prosecutors are indifferent to the needs of victims.

However, counsel for the victim must be aggressive in focusing the prosecutor's attention on the restitution issue. This is not difficult in the federal arena given the Victim and Witness Protection Act.■

Judy Fitzgerald
Director of Government Affairs
National Insurance Crime Bureau

One concern is the possible fragmentation between the coalition and other industry lobbying groups in the 1994 legislation session. Classic political problems need to be avoided. It may help to talk to the Advocates of Highway & Auto Safety and see how that organization overcame these problems. Careful coordination needs to take place among all interests.

As we craft our agenda, we need to take a close look at creative solutions.

We will support a white collar crime bill in Congress; anti-fraud warning language and auto pre-inspection (with certain exemptions) in high theft/fraud states as a start, although the industry is split on this issue.

Additionally, we need to look at civil penalties; surcharges to fund prosecutors; and develop a model plan that includes making insurance fraud a specific crime, contains immunity provisions, addresses restitution and provides for efficient report procedures. ■

Philip DiDomenico
Deputy Director
New Jersey Fraud Bureau

In New Jersey, we utilize the civil justice system to its fullest extent. In New Jersey we don't characterize our cases as "soft" or "hard" fraud; it's just fraud. Persons found guilty of violation of the Insurance Fraud Prevention Act are liable for a $5,000 fine for the first offense, $10,000 for the second offense and $15,000 for the third and subsequent offenses.

Over the past three years, the Fraud Division has fined more than 5000 violators over $24 million. Over 30% of the subjects fined pay their fine without litigation; others are sued in State Superior Court. Money collected is turned over to the State to offset the accrued debt of the now-defunct residual market underwriting authority.

Before the enactment of the New Jersey Insurance Fraud Prevention Act, an attempt to commit insurance fraud was punished merely by denial of the claim. Therefore, "nothing ventured, noting gained." Now, we are trying to take the incentive out of doing the crime.

If a person fraudulently reports an $8,000 car stolen, he forfeits the vehicle, owes the fraud division $5,000, has to pay for the outstanding loan, and has his claim denied! This is not a profitable transaction.

In regards to the unscrupulous medical providers and attorneys, pro-active investigations seem to be the vehicle to use to prosecute. The recent undercover operation involving the staging of bus accidents expended lots of resources and money. In addition to catching the phantom passengers, doctors, lawyers and "runners" were also prosecuted. Criminally, only two indictments have been returned, making the investment not cost effective. Civilly, however, over 120 subjects have been identified, including the same doctors lawyers and "runners." Each is liable for a $5,000 fine and each professional is additionally subject to license-connected disciplinary action. Thus, the answer to the fraud problem in our view, is to take the financial incentive out of attempting the crime.

New Jersey's fraud division, which has a $7 million budget, is funded by the insurance industry. As of September 30, 1993, we have collected over $7 million in fines and have been instrumental in the restitution of $28 million to the industry.

The Fraud Division began in 1985 in New Jersey. Its focus is fraudulent claims concerning all types of insurance. Insurer fraud is handled by another division within the Department of Insurance. The division is organized into 14 sub-bureaus specializing in types of insurance and are mission-oriented. Overall, we feel that we are gaining some ground in the fight against insurance fraud but realize that we still have a long way to go. Pre-inspection of automobiles has helped to reduce the reported theft rate in New Jersey by 12% in one year. Other states with this regulation have experienced similar success. I urge the passage of this type of regulation in all states with a high theft rate.

Auto insurers licensed in New Jersey are required to report suspected fraudulent claims, have an SIU and adhere to an approved fraud plan. We have within the fraud division a compliance bureau that audits insurers to determine if they are complying with the regulations. There are penalties for non-compliance with any aspect of the regulation. ■

Comments from roundtable participants:

Federal investigator: Let's determine where the biggest problems are and then develop a strategy to employ resources to those areas. Industry must do the analysis of where the problems lie—they are closest to the problem.

Federal prosecutor: If one is a victim, they should act like a victim. It's unrealistic to just assume that law enforcement is going to deal with it just because someone is a victim of insurance fraud. Insurers need to identify the problem for law enforcement. That's what a victim does. The FBI is not going to figure out the problem for them.

Federal investigator: This problem should be broken down into several areas. False claims is a huge problem, but the FBI is not going to get involved to a great extent. They will get involved in the insolvency problem,

the bogus offshore companies, which affects the legitimate insurers as well, so they should be involved, too. We need to segment the approach to the problem.

Insurer: NICB has offered access to its database to the 15 fraud bureaus; nine are hooked up for access. All fraud bureaus should come on line. It's free of charge.

Insurer: There are other alternatives to relying on a private/public partnership in using criminal remedy. Insurers oftentimes can sue people who defraud for recovery. Suing medical providers and attorneys can be a deterrent, as well.

S**tate investigator**: While law enforcement is not going to take every case, people who know that insurers will take suspicious claims to law enforcement will be less likely to commit fraud. Right now the perception is that insurers are not taking cases to law enforcement. At most, many are just denying the claim and not doing anything to follow it up.

State investigator: In Massachusetts, before the fraud bureau was formed, AEtna had a case of a conspiracy involving more than 100 claims with body shops. AEtna shopped the case to all the district attorneys and state attorneys. Unsuccessful, it sued civilly and was awarded treble damages under RICO, and collected nearly $1.5 million—about equal to its lawyer fees. Massachusetts statutes mandate that once convicted, the fraud bureau must seek to suspend licenses. To date, insurers have filed 85 complaints with the chiropractor board with zero results.

Insurers have the opportunity for two approaches: denial of claims and criminal prosecution. Massachusetts statistics show that insurers reduce claims by 22% when they suspect buildup.

We need to understand the difference in the evidentiary standard: of preponderance of evidence and reasonable doubt. Preponderance allows for denials of claims and reasonable doubt can get criminal convictions if intent is demonstrated.

Intent can be demonstrated, for example, in workers comp where claimants are required to sign a statement that they indeed are injured. Once Massachusetts required these signatures, claims frequency was reduced. It also can help to prove intent by the statement on the backs of claims checks under the signature line that says: "I have not provided any false information in receiving these insurance benefits."

State investigator: One reason why fraud bureaus should have law enforcement powers is that without it, the insurance department and insurers would have to go to the federal or state prosecutors, who, because of limited resources, may have high thresholds where they accept only large cases. Local prosecutors may not have the expertise to deal with insurance fraud. Fraud bureaus with law enforcement capabilities fill that gap.

State investigator: New Jersey just indicted 20 body shops, which took three years to complete. Fines in these cases will equal $1.2 million plus loss of license. Civil penalties far outweigh any criminal penalties.

State investigator: In the Georgia department of insurance, there are just eight investigators. We need to recognize that everything that is being done in New Jersey and Florida is right for every state. Claims fraud is the predominant responsibility of the industry. With only eight investigators, Georgia cannot possibly deal with any significant number of cases. As a regulator agency we deal with a great

number of agents and companies, and that has to be the principle emphasis of our activities. We need to deal with and prevent the insolvencies and sham carriers.

We can help the industry by accepting and disseminating information about suspected fraudulent cases because we have immunity. We can help establish a legal environment to help the industry combat fraud. We can help eliminate draconian bad-faith statutes. We can help create public awareness of the fraud problem. For example, our investigators are required to speak before public groups.

By indicting a few lawyers and chiropractors, we've got the attention of the professional societies in Georgia and they now are becoming more interested in fraud.

We expect the industry to train adjusters to detect fraud and preserve evidence. Insurers must have the ability to investigate fraud, although that doesn't mean that every insurer needs an SIU. Reinsurers don't need SIUs. Reinsurers should encourage their customers—the primary carriers—to have SIUs. Insurers should report fraud to the insurance department and seek prosecution themselves.

Insurer: Insurers and others should be empowered to investigate suspected claims with some relief from bad faith. What about bad faith of presentation of claims by lawyers and medical providers? Juries are asked to punish billion-dollar corporations that neglect to pay a legitimate $300 claim by fining them $10 million. Why not the same recourse for wealthy doctors and lawyers who defraud insurers? That would even up the score.

Consumerist: Some of the cases where people climb on buses to defraud or unemployed workers who are approached by cappers is based on impulse, so fines may not serve as a good deterrent for these desperate people. A better tactic may be to get at the licenses of those who are perpetuating the fraud because they have much more at stake. Given the way that professionals are licensed, the coalition should seek ways to pull those licenses. Make an example of a few medical providers and lawyers and others in their profession and they will think twice about defrauding the system.

Educator: I've seen two extremes: lawyers with billboards with a picture of a can of peanuts that say, "this is what you will get from your insurance company if you don't hire us," to one insurance company that is no longer in business that didn't have claims personnel. They had attorneys whose job it was to resist every claim by finding some legal ground to deny it.

Consumerist: We're looking at claims fraud where we have a lot of suggested solutions and perhaps the coalition will come up with even more creative solutions. The coalition should divide its agenda at least between claims fraud and sham insurers, and maybe subgroups to address.

What one thing would you like to see the coalition accomplish?

- Coordinate efforts of the organizations involved in combating insurance fraud. Share information.
- Develop models to help insurers prosecute insurance fraud.
- Affect change using the common resources available to the coalition.
- Work on a more global basis towards meaningful legislative change.

■ Identify components of the fraud problem. Identify the appropriate roles each segment should play in combating fraud. Develop education campaigns for the public, industry, prosecutors and judges.

■ Help consumer leaders carry the message to their constituents that fraud should not be tolerated.

■ Encourage small-and mid-sized insurers to use industry data bases.

■ Get local and state prosecutors involved in the campaign to fight fraud. Influence public attitude.

■ Proactively involve consumers in the business of insurance so they don't feel alienated.

■ Develop common understanding with all the elements involved in fighting fraud. Hold annual conferences with law enforcement agencies.

■ Tap the vast resources of the industry and the public in fighting insurance fraud.

■ Look for multiple approaches to the problem. Keep communications open.

■ Consider "Lawrence, Mass." model where insurers "invested" in anti-fraud efforts.

■ Design grassroots programs for local consumer groups and community organizations. Target programs that are measurable.

■ Identify other groups that are pursuing anti-fraud efforts. Break down the coalition's board into sub-groups to tackle small aspects of the problem. Develop aggressive public relations program.

■ Communicate with others who are combating health care fraud.

■ Consider embracing anti-arson efforts.

■ Continue cooperative effort that has begun so far.

■ Influence and change public opinion. Encourage insurers to work in the consumers' interest.

■ Don't search for the perfect solution. It doesn't exist. Experiment to determine effective approaches.

■ Develop model laws for fraud bureaus and for offshore carriers. Do roadshow. Take message to the people, using the many ambassadors committed to this issue.

■ In a visible way, help consumers who have been hurt by insurer fraud.

■ Don't reinvent the wheel. Consider the current proposals that have already been developed.

■ Take heart. Don't get overwhelmed by the size and complexity of the issue. Develop well-thought out priorities and stick to them.

■ Take advantage of the "hot" health care issue; get involved in health care fraud now to realize quick success. Work to eliminate duplicative payments.

■ Break down the issue into workable pieces. Consider New Jersey as a model.

■ Don't preach to the choir. Consider conducting research that would assist state fraud bureaus.

■ Train all stakeholders.

■ Make fraud a felony in every state.

■ Encourage adjuster training. Encourage insurers not to overload adjusters with too many claims.

■ Become the lead group in the U.S. for gathering and disseminating fraud information and for training.

■ Provide support for local/ state legislative

efforts.

■ Focus on insurer fraud. Focus on claims fraud. Develop rights and responsibilities for consumers in several languages.

■ Help build consensus on developing SIUs and fraud bureaus. Build public support for the issue. Aggressively publicize major cases and the solutions to insurance fraud.

■ Become a clearinghouse for all insurance fraud information.

■ Educate consumers not to become victims of outlaw insurers.

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About the Coalition

The Coalition Against Insurance Fraud was launched in June 1993 as a broad-based effort to combat a national, multi-billion-dollar problem. The primary means by which the coalition combats insurance fraud include legislative reform, public information, consumer education and research.

Members of the coalition include national and international organizations that represent consumers, regulators, prosecutors, attorneys general and insurers, as well as individual insurance companies.

Organizations currently serving on the board of directors of the coalition are:

Consumer Organizations

Consumer Action
Consumer Federation of America
Consumer Fraud Watch
National Association of Consumer Agency Administrators
National Urban League

Insurer Organizations

AEtna Life & Casualty
American Insurance Association
The Continental Corporation
Farmers Insurance Group of Companies
Fireman's Fund Insurance
ITT Hartford Insurance
National Insurance Crime Bureau
Nationwide Insurance
State Farm Insurance Companies
The Travelers Insurance Companies

Government Organizations

International Association of Insurance Fraud Agencies
National Association of Insurance Commissioners
National Conference of Insurance Legislators
National District Attorneys Association
Office of Attorney General, Minnesota

The coalition targets all forms of insurance fraud, including hard and soft fraud, claims and underwriting fraud, and internal fraud committed by employees within the insurance industry.

Its initial focus will be on hard fraud committed by professional criminals and by medical providers, lawyers and body shops, as well as by con artists who set up sham insurance operations. Specific lines of insurance that will be targeted include auto insurance and workers compensation.

In June of 1993 the coalition published a study on auto insurance fraud and an analysis of the effectiveness of specific anti-measures on the state level.

Legislative and regulatory initiatives supported by the coalition include:

• Making insurance fraud a specific crime and a felony on the state level.

• Making internal fraud a federal crime with strict penalties including fines and prison sentences.

• Automatically suspending all professional, business and occupational licenses of anyone convicted of insurance crime.

• Requiring insurance companies to cooperate fully with law enforcement and regulatory authorities in investigating fraud.

• Requiring the printing of fraud warnings on all damage estimates, claims forms and body shop estimates.

• Creating, where necessary, fraud bureaus on the state level that have subpoena power, fining authority and at least one state prosecutor assigned to fraud cases on a full-time basis.

• Requiring insurance companies to create and implement anti-fraud plans, hire fraud investigators, and train adjusters, frontline supervisors and underwriters in fraud detection.

• Requiring insurance companies to inspect and photograph automobiles prior to issuing coverage as a means of preventing "phantom" cars or previously damaged vehicles from being fraudulently insured.

The coalition also is developing comprehensive national campaigns to educate consumers from being taken advantage of by unscrupulous insurers, medical providers and lawyers. The coalition also seeks ways to provide better coordination among insurers, regulators and law enforcement in fighting fraud.

Coalition staff includes:

• Dennis Jay, executive director

• Deborah E. Anderson, director of communications

• Howard I. Goldblatt, director of government affairs

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