DODGING SPEED TRAPS: CHEATERS MAY AVOID FLORIDA NO-FAULT REFORMS

Florida's reforms are a model of the many possibilities that fraud fighters may have to contend with in their reform efforts elsewhere in the U.S. Fraud fighters can learn from the Florida example, or risk learning on their own.

By Stephen M. Rosansky, Esq.

IDENTIFYING MEDICAL IDENTITY THIEVES THWARTS REPUTATION DAMAGE

Tech-savvy schemers are exploiting the evolving healthcare environment to steal consumer and doctor identities. Well-planned "cloud" storage of patient data is one breakthrough to prevent fraud.

By Bill Fox, JD, MA & Nicholas J. Diamond, JD, MBE

SEE NO EVIL, SPEAK NO EVIL: WHY CONSUMERS DON'T REPORT FRAUD

Recent studies in the fields of marketing and insurance strongly suggest that a portion of consumer insurance fraud is driven by revenge, or retaliation for a personal service exchange that is seen as inequitable or unfair.

By William C. Lesch, PhD & Bruce W. Byars, JD

PUBLIC WORKERS EXPLOIT DISABILITY TO GAIN CUSHY EMPLOYMENT

Recent discoveries of potentially $1 billion in dubious disability claims that landed early and lucrative retirements for employees of the Long Island Railroad aren't isolated imbroglios, but incidents that happen with some frequency.

By James Quiggle

THE HONEST TRUTH ABOUT DISHONESTY

Most people cheat up to the level that allows them to retain a self-image as reasonably honest individuals. One insurer deliverable: Annoying customers imposes an avoidable cost on businesses — especially insurers.

By Dennis Jay

TRENDWATCH: NEW DEVELOPMENTS ABOUT FRAUD IN AMERICA

Deadly airbag scams gain new urgency... Tiny pharmacy in Florida lands whistleblower convictions against large drugmakers... Nursing home owner leaves seniors in starvation while getting rich off of Medicare and Medicaid.

By Coalition staff
Americans are good at uncovering problems, and better at solving them. This approach goes to the heart of JIFA. The Coalition’s leadership quarterly routinely captures the newest thinking about fraud, and incisive solutions. Just read this edition.

Florida drivers suffer impossibly high auto premiums due to cons by crooked clinics. Landmark reforms passed last spring, and swindlers quickly started trying to evade the law. But auto insurers can counter the cheaters. Plenty of sharp legal advice is packed into an article by prominent Florida no-fault attorney Stephen Rosansky. In fact, anyone involved with auto fraud should read it closely.

As for life-threatening medical identity theft...Health providers should consider storing sensitive patient data in well-armored digital clouds, consultants Bill Fox and Nicholas Diamond say. And how do you convince consumers to report expensive insurance cons? Consumers must believe their insurers provide varsity-level customer service, say insurance researchers Bill Lesch and Bruce Byars.

JIFA is a problem definer. But more, it shines a light on solutions.

Sincerely,

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The Journal of Insurance Fraud in America is published quarterly by the Coalition Against Insurance Fraud.

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Abstract: Florida’s landmark no-fault fraud reforms passed in 2012 had a variety of intended but also actual effects. The reforms are a model for the many possibilities that fraud fighters may have to contend with in their reform efforts elsewhere in the U.S. Fraud fighters can learn from the Florida experience, or risk learning on their own. The reforms raise questions about their short-term and long-term effects, and how swindlers will try to circumvent the reforms. Requiring more information on police crash reports, for example, will enable fraud fighters to use this information to investigate a single claim. The information also will permit possible uncovering of other suspected staged crashes. But it will not prevent or curtail staged-vehicle accidents, accidents involving “phantom vehicles” or illicit recruiting of participants. Medical professionals also will “rent” their licenses to lay clinic owners looking to illicitly hide their ownership of clinics. So, Florida will still have to contend with “De Facto Ownership” issues and intentional avoidance of the licensing requirements. But perhaps tightening the loophole will make these problems less prevalent. One prediction: Providers may all elect to “Opt Out” of the no-fault system altogether. The goal will be to avoid the new fraud legislation and obligations under the statute.
this epidemic, HB119 is the legislature’s latest attempt to address the widespread no-fault fraud, which remains pervasive throughout Florida.

The dynamics of Florida’s fraud environment may have similarities to many other no-fault states, and many states with fault-based auto-insurance systems. The Florida experience thus is a robust laboratory that fraud fighters in other states should follow closely. The lessons, successes and failures will provide a detailed blueprint that helps guide other states through the mine-strewn field of automobile schemes and reform efforts.

**Intended vs. actual effects**

While HB 119 retains aspects of Florida’s current no-fault system, various changes were made to combat still-pervasive fraud by dishonest medical providers and staged-accident rings.

Some of the key fraud-related revisions of the no-fault law and peripheral statutes address:

- Traffic crash reports and required information on the reports (§316.066);
- Healthcare clinic license requirements and exemptions (§§400.990-995); and
- Redefining required no-fault benefits and compensable services; enacting tolling provisions when fraud is suspected; and providing for discovery of facts about the claimant and disputed amounts (§627.736).

Each reform and its impetus will be addressed in detail below. But now that the reforms have passed, we should ask:

- What will be their immediate and longterm impact?
- Will the legislative intent be realized?
- How will swindlers try to undermine the current reforms? and
- How can the current reforms act as a national model for anti-fraud legislation?

**Traffic crash reports (§316.066)**

Florida has seen a steady statewide rise in questionable claims over the past decade. Many stem from bogus vehicle crashes that appear to be set up for fake injury claims.

They often involve “jump-in” claimants who were not in the vehicles at the time of the so-called crashes.

Unfortunately, auto insurers often are blindsided by mystery claimants not appearing on police crash reports. Insurers also are placed at a significant disadvantage by less-than-complete crash reports that fail to document information that is key to processing and investigating questionable claims. The legislature thus has mandated the proper completion and inclusion of this information in accident reports.

Regardless of the accident form used (Long/Short/Drivers Exchange) and under what circumstances the accident has occurred, the report now must contain:

- Date, time and location of the crash;
- Description of the vehicles;
- Names and addresses of the parties, including all drivers and passengers, and identification of the vehicles involved;
- Names and addresses of witnesses;
- Name, badge number and law-enforcement agency of the officer investigating the crash; and
- Names of the insurers of the parties in the crash.

Aside from the rebuttable presumption established by §316.068, that persons not documented in the report were not involved in the crash, the inclusion of the above information intends to allow investigators (state or insurer) to better complete their investigations. They can use this information to investigate a single claim. The trending of the information also will permit multi-claim analysis and possible uncovering of other suspected staged crashes or bogus injury claims.

Unfortunately, this reform will not prevent or curtail staged-vehicle accidents, accidents involving “phantom vehicles” or the illicit recruiting of participants. Nor will it account for poor documentation by the investigating officer because there is no penalty for officer nonfeasance.

These documentation requirements likely will lead to more “phantom vehicle” losses involving vehicles “occupied” by multiple claimants. The claimants will argue that they were present (even if they were not), and that the officer failed to properly document the report.

These “phantom claimants” also will now have
a detailed account of how the accident occurred, and the vehicles and parties involved. This will make rebutting the presumption of involvement that much easier.

**Healthcare licensing (§§400.990-995)**

The legislature enacted reforms in 2001 and 2003 requiring clinics to be registered and licensed. The legislature also required clinic owners to hire a licensed medical professional to act as the medical or clinical director. This person also would accept legal responsibility for ensuring compliance with same.

These provisions were inspired in part by the 15th statewide Grand Jury Report in 2000, which documented widespread and illicit ownership of healthcare clinics by unscrupulous laypersons instead of by medical doctors. The realization dawned that the state had no way to ensure compliance with regulatory statutes and administrative codes aimed at curbing fraudulent medical services.

Of course there were exceptions to the registration/licensure requirements under both the clinic-registration measure and Health Care Clinic Act. They exempted from clinic licensing almost any healthcare professional licensed by Florida. Laypersons who could not or would not endure the scrutiny of the license-application process, and requirements thus would illicitly pay licensed medical professionals to “rent” their licenses. Those professionals would falsely hold themselves out as the clinic owners and operators.

Realizing that the exemption provision of the Health Care Clinic Act created a loophole that unscrupulous laypersons were more than happy to exploit, the legislature tried to close the loophole by restricting who could be exempt from licensing.

So now, only physicians, dentists, chiropractors and their families, hospitals and medical schools are exempt from licensing. Noticeably absent from the exemption list are massage therapists, who no longer are permitted to bill no-fault insurers for massage services.

The exclusion of massage therapists from the exemption list is obvious: Why would the state permit ownership of a health clinic, free from the license requirements, when the licensee no longer can submit bills for services rendered? The latent rationale is more in line with preventing “rent a doc” clinic ownership scenarios. The legislature thought such scenarios would be less prevalent among physicians and chiropractors.

The phantom “retention” of such personnel also would likely become more costly to the lay owner, because these physicians may be less inclined to jeopardize their freedom and professional licenses.
Of course there will still be medical professionals willing to “rent” their licenses, and there will be lay clinic owners looking to illicitly benefit from this arrangement. So, Florida will still have to contend with “De Facto Ownership” issues and intentional avoidance of the licensing requirements. But perhaps tightening the loophole will make these problems less prevalent.

This said, insurers should review the corporate history of providers who submit bills for reimbursement. Note the changes in clinic ownership from layperson to chiropractor, massage therapist or doctor, and now from massage therapist to doctor or chiropractic physician. The latter is a reaction to HB 119.

Another problem is the five-month gap between the effective dates of the licensing provision on July 1, 2012 and the exemption provision on January 1, 2012. This means a five-month period during which facilities must be licensed but the old exemptions still may apply.

Redefining required benefits et al ($627.736)

Benefits & compensable services

The latest amendments to §627.736 created “…a new no-fault motor vehicle insurance system, the Emergency Care Coverage (ECC) Law, to replace the personal injury protection (PIP) system,” according to an initial House of Representatives staff analysis of HB 119.

That section now requires claimants to receive initial services and care within 14 days of a motor-vehicle accident to be eligible for PIP benefits. Those initial services must be provided by a medical doctor (MD); doctor of osteopathic medicine (DO); dentist (DDS); chiropractor (DC) or hospital. Followup care must be consistent with the original diagnoses, and may only be provided by a hospital ambulatory surgical center, MD, DO, DDS, DC, physician’s assistant (PA), advanced registered nurse practitioner (ARNP), physical therapist (PT) or licensed healthcare clinic. Massage and acupuncture aren’t reimbursable either, regardless of the person or entity rendering those treatments.

The plaintiff bar, however, argues that medical personnel licensed under any chapter other than Ch. 480 (Massage Therapy) still may render “massage” and be compensated for same, since they are not rendering “massage” under Ch. 480.

The defense’s counter-argument must be that the legislature intended to deem massage therapy non-compensable and selected a pre-existing statutory definition to identify the non-compensable acts. Merely because the act is being performed by someone other than a licensed massage therapist does not render the service compensable. This is evidenced by the statutory language “regardless of the person or entity rendering those treatments.”

The new reforms also provide that $10,000 in PIP benefits are available for services rendered when a claimant suffers an “emergency medical condition” as diagnosed by an MD, DO, DDS, PA or ARNP. But only $2,500 are available when a claimant does not suffer an emergency condition.

As a whole, this legislation aims to encourage legitimately injured claimants, especially those suffering an emergency condition, to seek prompt treatment by licensed medical professionals. The thought is that seriously injured claimants with legitimate complaints naturally would seek medical attention within a reasonable time. Claimants suffering from non-emergency conditions would neither seek nor require initial or followup care. Thus they would be less likely to submit a PIP claim.

Seriously injured emergency claimants would be entitled to seek initial and followup care from licensed providers if they had, in fact, suffered an “emergency medical condition.” The predicted problem and source of potential litigation is, of course, in the application of this new scheme.

Arguably there is no requirement to make an “Emergency Medical Condition” determination, and no requirement for when such a determination needs to be made. The plaintiff bar, in reliance upon §627.736(1)(a), will argue that the statutory default is $10,000 if there is no determination by a “provider” (interpreted by the plaintiff bar to mean only the treating physician) that the patient has suffered an “Emergency Medical Condition.”

The anticipated position of the plaintiff bar seems untenable, given the express language of §627.736(1)(a)(3). It creates a statutory condition precedent that a practitioner licensed under one of the enumerated chapters makes the “Emergency Medical Condition” determination before the full $10,000 is available. Otherwise, the statutory default must be $2,500.

Note that absent from the list of practitioners authorized to make the “Emergency Medical Condition” determination is massage therapists licensed under Ch. 480.
Condition” determination are chiropractors, who are the primary treating discipline and often the recipients of the majority of a claimant’s PIP benefits.

The effect of this exclusion is that chiropractors may render both initial and followup care and services. But they may only do so, and legitimately expect reimbursement up to $2,500, absent an “Emergency Medical Condition” determination by a practitioner licensed under one of the enumerated chapters.

The anticipated problem with this relates back to when the determination must be made. A chiropractor may elect to provide both initial and followup care and services in excess of the $2,500 up and through the full $10,000. An insurer may, in reliance upon §627.736(1)(a)(3)-(4) deny payments for services rendered in excess of the $2,500 but then receive a report from an enumerated practitioner, making the “Emergency Medical Condition” determination. At this point, the insurer may be left “holding the bag.”

In fact, we have already seen advertisements directed to chiropractors, promising “Emergency Medical Condition” determinations so that the full $10,000 in PIP benefits will be available.

We can expect more “pay-to-play” arrangements, especially involving PAs and ARNPs. We can also expect more multi-disciplinary clinics where the examining physicians have a financial interest in making the “correct” diagnosis of an emergency condition regardless of the patient’s true condition. Thus, the reform will be undermined by what are essentially purported “independent medical exams” rubber-stamping the diagnoses and ensuing bogus injury claims.

Tolling provisions for suspected fraud

Another key provision added to Florida’s no-fault statute is §627.736(4)(i). It requires an insurer with a “reasonable belief” that a fraud was committed to notify the claimant that the claim is being investigated. The insurer must do so in writing within 30 days of the claim’s submission. After the 30 days, the insurer has another 60 days to investigate for fraud and either deny or pay the claim, with interest. The insurer must report claims denied for suspected fraud to the state Division of Fraud. This provision has pros and cons.

On one hand, the added time allows insurers to better investigate suspected fraud or validate legitimate claims; locate and speak with the claimant and witnesses; obtain and provide records and bills to experts; complete Examinations Under Oath (EUO) and Sworn Statements; and send letters requesting records if warranted.

On the other hand, there may be some argument in court over the term “reasonable belief.” Claimants certainly will challenge the provision during litigation. Insurers thus must carefully and thoroughly document the basis of their “reasonable belief.”

Further courtroom arguments may occur over the term “claimant,” which could mean the patient, but also the claimant’s assignee(s). Thus, insurers may be required to notify both the patient and assignees, and insurers will be challenged for any failure to do so. This definitely will put both the patient and assignee on notice of the insurer’s investigation, and thus may significantly hamper future investigation of the claim or medical provider.

Moreover, insurers must be mindful of how the
claimant is notified, what is divulged and the tenor of the notice. All of this could potentially be used against the insurer to establish a general business practice or other grounds for extra-contractual liability such as a bad-faith lawsuit.

**Discovery of facts about claimants**

Lastly, there appears to be a legislative “fix” of the so-called Custer court decision. That state-court decision created significant doubt over whether insurers could conduct vital examinations under oath (EUOs). In response, the legislature established the claimant’s submission to EUOs as a statutory condition of attempting to recover PIP benefits.

While this provision restores a key investigative tool to insurers, it also may limit the inquiry to the ever-so-vague “relevant information or information that could reasonably be expected to lead to relevant information,” according to the new law (Section 627.736(6)(g)).

Moreover, it doesn’t require a witness to bring documents to the EUO, thus potentially nullifying any such document requests and lack-of-cooperation defenses based on non-compliance if the insurer is sued. The measure also has no provision extending the EUO requirement to medical providers.

Lastly, it subjects an insurer to potential extra-contractual liability if EUOs are sought as a general business practice with a “reasonable basis.” Of course, there is no definition of “reasonable basis,” so insurers must carefully and thoroughly document the basis for which they request an EUO.

**Conclusions and predictions**

Some will say HB 119 has gone too far, and others will say it has not gone far enough. Only time will tell who is correct. Fraud-reform provisions have been added and existing ones strengthened, all with the best intentions. However, we all know where a road paved with good intentions can lead.

Here are the author’s Top Five predictions about the impact of HB 119 on the insurance community over the next few years:

1) Providers may all elect to “Opt Out” of the no-fault system altogether. They will avoid the new fraud legislation and obligations under the statute, in favor of accepting Letters of Protection and pursuing “Dollar One” personal-injury claims.

2) Providers, attorneys, runners and staged-crash participants will continue to create bogus injury losses. They also will find ways to use the new documentation requirement to their advantage.

3) Laypersons will continue to exploit loopholes in the licensing requirements of the Health Care Clinic Act.

4) Provider-friendly medical vendors will become a factor in determining whether and how much in PIP benefits will be owed.

5) The trial bar will target or “set up” insurers for extra-contractual liability such as bad-faith actions when insurers routinely request EUOs of the same provider’s patients.

Florida’s anti-fraud leaders have a highly developed grasp of the legislative process through their deep involvement in often highly contentious battles. They also know many of the laws needed to help thwart ever-present no-fault swindles, and how to mobilize often-disparate groups to support reforms. Fraud fighters also have witnessed the unintended negative consequences of well-intended reforms. Anti-fraud reformers in other states should closely study the Florida’s experience. This is far from an isolated one-state battle. It is a model for the many possibilities that fraud fighters may have to contend with elsewhere.

Fraud fighters can learn from the Florida experience, or risk learning on their own. But sooner or later, they will learn.

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Spotting medical ID thieves thwarts damage, large costs

Cloud computing enables more data storage, and attracts innovative fraudsters

By Bill Fox, JD, MA & Nicholas J. Diamond, JD, MBE

The relentless media focus on the healthcare reform debates over the last few years has brought unprecedented attention to the business of healthcare. Passage of the Affordable Care Act (ACA) in 2010 — and President Obama’s reelection — ensure that healthcare will remain big news for years to come.

Policymakers, doctors and insurance-company executives are not the only ones paying attention. Highly adaptive, technology-savvy fraudsters are seeking to exploit the current and emerging healthcare environment to profit from theft of people’s medical information.

And in the process, these swindlers are endangering victims’ health and lives. They also are exposing victimized health providers of all sizes to large remediation expenses, and possibly larger longterm reputational damage.

While the ACA is largely a driver of macro-level policy change, it also has shifted how we think of healthcare at the individual level. This distances us

Abstract: Tech-savvy schemers are exploiting the evolving healthcare environment to steal consumer and doctor identities. The damage to a breached organization can be significant. This can include large remediation expenses, longterm reputational damage, compromised ability to serve customers, and placing its operational and strategic goals at risk. Medical ID theft is an estimated $30-billion crime annually. People’s individual identities are stolen, and organized crime is heisting identities in volume to make false treatment claims. Cloud computing has great potential to better protect an organization’s valuable patient data from theft. The move to cloud computing, participation in a health insurance exchange, and adoption of other innovative clinical or technical programs designed to improve and expand quality care, can be made intelligently and with confidence. Adoption of these advanced analytic techniques, and meaningful use of EMRs, is crucial to bending the cost curve. By carefully thinking through the implementation of big data, cloud and other IT initiatives, organizations can protect data from criminals who seek to steal for their financial gain.
can quickly derail innovative projects that are crucial to a health-related company’s survival in a rapidly changing and highly regulated business environment.

Medical identity theft is a lucrative enterprise. On a small scale, a stolen medical identification card is much more valuable on the black market than other stolen identity documents. A patient’s health records can be worth $50 on the street, according to some estimates. This figure is markedly greater than estimates for other forms of identity theft, such as Social Security numbers and a mother’s maiden name. They are thought to fetch only $3 to $6.

National medical identity theft estimates are staggering. This crime heists $30 billion a year in the U.S. and is growing, the Ponemon Institute says. More critical still, this number is thought to represent only about half of such thefts because many remain unreported.

This article discusses the nature of medical identity theft and explores the impact of this $30-billion problem. The article also considers how crucial drivers of health reform, like health information exchanges and electronic medical records, might create more opportunities and incentives for insurance swindlers.

By intelligently leveraging a combination of new technologies such as cloud computing and analytics — plus good old-fashioned vigilance, monitoring and repeated training — organizations can better pursue their business goals and serve their customers.

**Medical identity theft: the basics**

Medical identity theft can take many forms. But it is primarily the act of using a person’s name or other identifying information, such as an insurance policy number, to obtain medical care or goods such as power wheelchairs without their or their insurer’s consent.

Importantly, this act often results in falsification of medical records to support these claims, and often coincides with other forms of identity theft. The legitimate identity holders often are unaware that
their medical identity has been compromised, only to realize the full damage when unexplained medical bills arrive. One woman received a bill from a local hospital for amputating her right foot, and walked into the surgeon’s office to show that she clearly still had both feet.⁸

Like many fraud crimes, medical identity theft is often a reactive crime of opportunity, though it is morphing into a favorite proactive gambit of organized crime. The most common method of misusing medical identities is when family members share or steal them.⁹ The level of opportunity is at its highest in a trusted family or office environment. The Ponemon Institute found that 26 percent of surveyed individuals admitted sharing their health credentials with family members.¹⁰

The second common method of medical identity theft in terms of impact and dollars falls under the broader category of data breach. A data breach can encompass a gamut of scenarios, ranging from a laptop stolen from a healthcare employee’s car to a massive phishing attack or well-financed system infiltration by organized crime. Even physicians’ IDs have become targets for theft.

Such thefts also can be made by lower-level staffers such as database operators, data-entry clerks or IT staffers who may have broad access to patient files. They can download data onto a thumb drive and sell the information to ring members who make large volumes of claims for phantom medical treatments.

Data breaches have become increasingly serious in recent years:

- September 14, 2011. A data breach in the Virginia-based military healthcare provider TRICARE Management Activity affected 4.9 million people;¹¹
- January 21, 2011. A data breach in the California insurer Health Net, Inc., was not detected and reported for two months. It affected 1.9 million people;¹² and
- December 23, 2010. A data breach in the North Bronx Healthcare Network of the New York City Health and Hospitals Corporation involved tapes containing 20 years of protected health information (PHI) of employees, vendors and patients. It affected 1.7 million people.¹³

Though no evidence of medical ID theft has publicly surfaced from these breaches, they illustrate the vast potential for criminality in the hands of a well-organized medical ID thief.

Critically, increasing amounts of personal health information are aggregated and transferred via electronic medical records, Health Information Exchanges (HIEs) and other electronic media. Organized criminal enterprises will probe and seek to exploit weak links within health systems, and between them.

How serious has the involvement of organized crime, and the sophistication and resources they apply, become in healthcare fraud? The rise of criminal enterprises in healthcare fraud is the “most challenging and disturbing trend I have witnessed in my tenure,” says Gerald T. Roy, Deputy Inspector General for Investigations, Office of Inspector General, U.S. Department of Health and Human Services.¹⁴

The long term costs of a data breach can be very serious for any organization. Consider a simple example: Imagine that an employee’s laptop, which contains a few thousand patient records, is stolen from her car. Because proper measures were not taken to ensure encryption, these records are now compromised.

Suppose, further, that these compromised patient records include patients from multiple states. Apart from the standard direct costs of fines, penalties and notification of the theft, there remains the added cost of complying with individual state privacy and security laws, remedial education and, perhaps most importantly, the longterm
reputational damage. Victims of such breaches are also increasingly launching class-action lawsuits potentially worth up to hundreds of millions of dollars each.

On the individual level, data breaches can carry significant and oftentimes overlooked health risks, because fraudsters often change stolen medical records to suit their illicit needs. This is the greatest risk to patient safety, suggests the World Privacy Forum’s aptly titled report, Medical Identity Theft: The Information Crime that Can Kill You.¹⁵

A victim’s medical records might be inaccurate the next time he seeks treatment, thus putting him at risk. The ripple effects of a data breach also can damage both large business-driven systems, and smaller operations such as clinics.

Imagine when a victim’s blood type is changed by a fraudster who used that medical card to obtain care. What happens if the legitimate insured later goes to the emergency room after a car accident and is given the wrong blood type based on a falsified record?

Open source, the cloud and PHI

Virtually every business, from smaller startup to Fortune 100, is quickly incorporating cloud computing as a key strategic initiative. Cloud computing is a dynamic, location-independent infrastructure rooted in information technology. It consists of computing services, such as data storage, pooled with virtualization technologies. Collectively, they enable efficient use of available computing power.

Cloud computing can offer tremendous cost savings. It also offers the ability to nimbly adapt to
changing business environments and demands by leveraging the efficiency and availability of cloud data. But in some cases, the combination of pressing economic times and business imperatives is driving adoption without enough attention to privacy, or concern about fortifying against medical identity theft and other crimes.

Robust technology can secure these environments, so it is vital that the options are understood and adopted by organizations leveraging the cloud to better serve their customers.

Cloud technology is a vast and evolving topic. Businesses must weigh a number of issues, often unique to their environment, in determining how cloud computing can best suit their needs.

To name just a few: Do your organization's needs require a private, hybrid or public cloud? Will you maintain responsibility for your data through some form of “tunnel,” or will you cede that responsibility? Under HIPAA and HITECH, can you cede that responsibility to the cloud vendor?

Also crucial to understand is that whether a health provider is securing a hospital, insurance company or doctor's office against fraud, the considerations and methodologies are very similar. The goal of a secure environment against medical identity theft can be attained by vigilant implementation and monitoring.

Several of the many questions health providers should ask include: Who has access to the data? Why do they need access? When do they need it? How is the data secured (e.g., made unable to load onto a thumb drive)? But these questions form the basis of only one side of the formula. What controls will be put in place to fight medical identity theft and create a secure operating environment?

The other equally important side of protecting personal health information is: What measures will be put in place to ensure those safeguards are followed, updated and improved? Do all employees and customers understand these measures, their role in protecting PHI, and the consequences for themselves and the company if they don't? Is there real C-Suite support for creating a culture in which every decision takes protection of PHI into account?

Emerging cloud capabilities can bring previously unattainable levels of privacy and security against medical identity theft to PHI and identity analytics. Instead of simply using outdated definitions of a “record” as what exists on a piece a paper, emerging cloud technologies allow privacy, security and access to be assigned with far greater granularity and accuracy.

“Imagine when a victim’s blood type is changed by a fraudster who used that medical card to obtain care. What happens if the legitimate insured later goes to the emergency room after a car accident and is given the wrong blood type based on a falsified record?”

Several benefits accrue when this culture of medical identity theft prevention is adopted: The move to cloud computing, participation in a health insurance exchange, and adoption of other innovative clinical or technical programs designed to improve and expand quality care, can be made intelligently and with confidence.

Adoption of these advanced analytic techniques, and meaningful use of EMRs, is crucial to bending the cost curve. Simply staying away from these innovations because the security and privacy issues are new is not an option, and it is unnecessary.

Reform: why fraudsters can’t win

The effects of health reform can look pretty enticing to fraudsters. The ACA seeks to achieve near-universal health insurance coverage in a relatively short time. It uses a number of mechanisms. Among them are quality measurement, expanding Medicaid coverage, and offering insurance subsidies to some individuals to help defray the cost of insurance.

But the ACA does more than just improve access. It supports innovations that help cut costs
and produce better care, such as promoting the use of EMRs and HIEs by providers.

Taken together, increasing access and promoting these IT-based innovations create a mandate to adopt and continuously improve both corporate cultures and technologies that protect PHI against breach by identity thieves.

“Big Data” has ceased to be viewed as simply massive lumps of information. Data is now being aggressively analyzed and used as actionable intelligence to drive better business and consumer outcomes. Cloud computing allows organizations to transform how they understand data. This intelligence becomes a dynamic part of the business and is directly relevant to advancing an organization’s strategic goals to a much greater extent than before.

Conclusion

Innovation in healthcare, technology and insurance — public and private — will drive the quality improvements needed to achieve better, and sustainable, healthcare for all Americans. It is generally agreed that information sharing, including PHI, is a cornerstone of these improvements.

Cloud computing enables storage, and more importantly, the use and analysis of massive data sets at far lower costs and faster speeds than ever before. Insurers are the nexus of patients, providers and data. The lure of all this data also will drive innovation by the fraudsters. By carefully thinking through the implementation of big data, cloud and other IT initiatives that touch PHI, organizations can stay one step ahead of criminals who seek to derail progress.

At that point we believe there will be a move toward a more-integrated, secure and cost-effective healthcare system that is better equipped to thwart the efforts of even the most organized and pernicious identity thieves.

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endNOTES


3 Kaiser Family Foundation, see note 1.


6 Ponemon Institute, Second Annual Survey on Medical Identity Theft, March 2011. Available at http://www.protectmyid.com/images/education_center/pdf/50TypesofFraud/1_type%20of%20fraud_medical%20study.PDF.

7 Ibid.


9 Ponemon Institute, see note 6.

10 Ibid.

11 Ibid.

12 Ibid.


14 Ibid.

15 Ibid.

16 Corresponding author, see note 16.


See no evil, speak no evil: why consumers don’t report fraud

Better service is a key to convincing more people to turn in cheaters

By William C. Lesch, PhD & Bruce W. Byars, JD

According to recent Department of Justice data, two-thirds (67 percent) of household thefts went unreported by victims in 2010 (Berzofsky et al, 2012).1 Reporting both of violent and property crimes has remained stable over the period of 2000-2010, at about 50 percent and 40 percent respectively (Truman, 2011).2

The role of bystanders as a source of crime reports is generally one of gatekeeper. Birkbeck, Galaldon and LaFree (1993)3 have modeled bystander reporting to the police as related to three broad sets of factors: the nature of the incident (e.g., its seriousness, and relationship of victim and perpetrator), victim characteristics (e.g., demographic profile, prior involvement in crime), and the relationship between the police and citizenry (e.g., attitudes toward police, accessibility).

In addition, the level of personal responsibility felt toward the circumstances has been demonstrated to determine bystander intervention (see e.g., the review by Bickman and Rosenbaum 1977),4 although a number of explanations have been offered to explain both reporting by victims, and bystander intervention (Birkbeck, Galadon and LaFree 1993,5 Greenberg and Beach 2004)6.

Criminologists have not, unfortunately, examined factors associated with reporting of insurance fraud, a crime of considerable financial magnitude. While parallels may be drawn between

Abstract: Reporting of criminal acts is generally considered a critical component of effective policing and interactive with law-enforcement efforts. This study models factors contributing to reporting of insurance fraud and finds that one’s relationship with insurance providers and social norms about insurer-insured relations contribute to an individual’s decision to report a fraud. An individual’s personal ethical stance did not influence the decision to report. Implications to insurers managing fraud are also discussed.
insurance fraud and other property crimes, insurance fraud stands apart in that it is perpetrated under terms of a contract with a commercial entity. Socially, some also have labeled fraud a “victimless crime,” perhaps owing in most instances to the absence of personal violence.

This leads some to question the very occurrence of a crime. This article contributes to our understanding of why consumers do, and do not, report insurance fraud we examine the quality of the relationship between the parties — insurer and insured — as primary to understanding this form of citizen involvement. Secondarily, a basket of demographic and other personal/societal factors relating to the “normality” of insurance fraud also is examined.

Modeling bystander reporting of insurance fraud

Recent studies in the fields of marketing and insurance strongly suggest that a portion of consumer insurance fraud is driven by revenge, or retaliation, for a personal service exchange that is seen as inequitable or unfair (e.g., Lesch and Brinkmann 2012; Lesch and Baker 2011; Costonis and Bramblett 2010; Miyazaki 2009; Lesch and Baker 2012).

Customers who feel they have been treated unfairly in a transaction may try to reconcile their position by voicing dissatisfaction to company representatives, friends and family (negative word of mouth). It occasionally escalates, leading in extreme cases to physical retaliation (e.g., Gregoire, Laufer and Tripp 2010; Bougie, Peiter and Zeelenberg 2003).

From this point of view, consumers who fail to report an observed fraud may have an opportunity to restore a sense of fairness (“an eye for an eye”) to their relationship with their service provider specifically, or “the industry” generally. Factors that may contribute to this decision include:

- Personal ethics;
- Perceptions of how “normal” and/or prevalent insurance fraud may be (a normal part of the give and take between the insurer and insured);
- Use of rationalizations (fraud is morally if not legally questionable);
- Favorable or unfavorable attitudes toward the industry, company, and/or agent;
- Concern one has about insurance fraud; and
- Acceptance of insurance fraud as “normal.

Viewed in this manner, the refusal to report an observed fraud may in fact be a form of consumer voice (e.g., Hirschman 1970) albeit a silent, retaliatory response intended to “even the score.”

This study investigated connections between these factors (above), and whether a consumer reported an observed fraud. The researchers added two more variables thought to affect consumer satisfaction, and thus influence reporting behavior: the perceived impact of fraudulent acts on the cost of insurance, and whether consumers felt that their insurance premium was within reason.

Sampling design and methods

Data for the project came from the 2007 public attitudes study by the Coalition Against Insurance Fraud. The sample reflects a national profile, with some oversampling of New York, California, Florida, Pennsylvania, New Jersey and Texas. Excluded were potential participants who self-identified as being employed in the advertising/marketing industry, insurance industry or insurance regulation, and personal-injury attorneys. Participants (N=1,169) completed an online questionnaire referencing attitudes toward insurance fraud, demographics and industry-related items.

Measures were constructed from items in the Coalition questionnaire to reflect a) bystander reporting behavior; b) the normative climate surrounding insurance fraud, level of acceptance of insurance fraud, perceived equity
in the consumer-insurance industry exchange, their personal insurance ethics, and attitudes toward industry/company/agent; and c) a range of demographic variables (age, gender, education).

Several miscellaneous, single-item measures also were used to reflect the level of concern held by respondents about fraud; and their perception of the reasonableness of current insurance premiums.

**Independent variable**

Reporting behavior was a self-report measure including first whether respondents personally knew about the commission of an insurance fraud, and whether they reported the infraction to an insurance company or law-enforcement authority.

Persons were exclusively classified into one of three groups:

- Observed and reported a fraudulent act (Reporters);
- Observed but did not report a fraudulent act (Non-Reporters); and
- Neither observed nor reported a fraudulent act (Naïves).

Persons who answered “Don’t know” to the question of personal knowledge were excluded from these analyses.

The sample for these present analyses was thus somewhat smaller than the original sample (net n=955).

**Dependent variables**

*Normative climate* was operationalized as a multi-item variable comprised of answers to five statements concerning the prevalence of forms of insurance fraud. These included application fraud (two items), inflated deductible (one item), accident misrepresentation for fraudulent recovery (one item), and the use of false receipts or false estimates (one item).

The *level of acceptance* of insurance fraud was a multi-item variable reflecting respondents’ acceptance of each of the fraudulent acts as acceptable, or not.

*Perceived equity* in the relationship between the insurer and insured was measured using six items relating to consumer reasoning to justify their attempts to achieve/restore equity in their exchange(s) with insurers. Three statements tapped the fairness of the cost/expectation of return on premiums, and perceived levels of (unwarranted) premium escalation. One item addressed the assumption that premiums included a pricing factor to “cover fraud,” and one item reflected the level of respect consumers afforded insurers. A final item reflected consumer frustration, and purported that fraudulent behavior was the only manner in which to “get the insurance coverage they are owed.”

*Insureds’ ethics* were measured by response to two items inquiring about how ethical one deemed claim exaggeration, and /or “misrepresentation of an incident” to obtain coverage for an uncovered loss.

The reliability of these (above) multi-item measures was found to be good to very good in all cases (Cronbach’s alpha ≥ 0.80).  

*Price fairness* was indexed by two remaining items: perceived cost of insurance, and the perceived impact of fraud on the cost of insurance. Inclusion of these items is based on the review of literature on consumer perceptions of price fairness by Xia, Monroe and Cox (2004), including the possibility of revenge. We point out here that in a highly regulated market, in which purchase of insurance may be
mandatory, that loss of control by consumers in the transaction may contribute to perceived unfairness (Seiders and Berry 199817).

“Trapped by the system,” some consumers may resent the perceived high price of insurance, and the manner in which insurers “pass along the costs” in the form of higher premiums. They may retaliate in order to balance the equation (e.g., “get a return” or “get their money’s worth”).

Concern about fraud, and a series of industry attitude measures (toward agent, carrier and the industry) also were included. Some studies of industry trust and image have demonstrated the comparatively low standing of insurance, (e.g., Edelman 201118; and Halliburton and Poenaru 201019), although individual firms perform more favorably (Ipsos 200620).

The research design included the use of Multiple Analysis of Variance in which the independent variable used to group respondents was their reporting status (three levels): Reporters, Non-Reporters and Naives.

Dependent variables predicted to differ among the groups included the two price/fraud impact items; normative climate; personal ethics; equity and acceptance; and demographic items (age, education, gender).21

**Directional hypotheses**

Prior research suggests these directional hypotheses:

- Females and older consumers will be more likely to report fraud;
- Education level will not influence reporting behavior;
- Higher levels of acceptance of fraud are associated with non-reporting;
- Higher levels of perceived unfairness are associated with non-reporting;
- Higher perceived levels of the prevalence of fraud are associated with non-reporting;
- Higher levels of concern are associated with reporting;

- Higher levels of satisfaction with premium, and impact on fraud, are associated with reporting; and

- More favorable attitudes toward agent, carrier and/or the industry are associated with reporting.

**Results**

Overall, referrals of a fraudulent act were made by about 5.45 percent (52/955) of the total sample. However, among persons who said they knew about a fraud (n=225), about 23.1 percent (52/225) reported the crime.

The overall multivariate test for differences was statistically significant (p ≤ 0.000)22 evidence of relationships between reporting behavior and the variables in the study. Their nature is explored more visually in charts below. In the interest of brevity, discussion is mostly confined to the statistically significant factors.

**Demographic Influences on Reporting.** Among the demographic variables, only age showed a significant difference among the groups. Older consumers had a higher likelihood of reporting an observed fraud. Males and females did not differ in their reporting behavior. Similarly, the education levels of the three groups were similar. Thus, two of the three hypotheses regarding demographic contributions to reporting were supported.

**Dispositional Influences.** For the block of dispositions, significant differences were found for all, except for one’s personal ethical stance. Persons who reported a higher perceived prevalence of fraud were less likely to report, as were those who expressed a greater acceptance of fraudulent behavior. Individuals with stronger perceptions of the unfairness of an insurer-insured relationship also were less likely to report fraud.

However, the greater their concern about fraud, the more likely they were to report an observed fraud. Reporters had the most favorable attitudes toward agents and the industry, with no differences among the three groups on their attitudes toward their carrier.

Finally, policy price did not appear to influence reporting behavior. The mean scores were not
different (statistically) among the three groups. Thus, with few exceptions (personal ethics; attitude toward the carrier; price fairness/impact of fraud on premiums), the reporting behavior of consumers was related to the bulk of the dispositional variables, as predicted.

One measure of the strength of the relationship between the independent and dependent variables is referred to as the Eta-Squared coefficient. Using this measure, the most powerful variables contributing to reporting include the normative climate (4.4 percent), perception of an equitable exchange (3.4 percent), level of acceptance of fraud (2 percent), personal concern about fraud (1.7 percent), and one's attitude toward the insurance industry (1.4 percent).

Overall, these and age account for slightly under 15 percent (14.8 percent) of the total variance in explaining one's reporting behavior.

It is clear that older insureds were more likely to report an infraction than others, with the remaining groups more or less homogeneous in their reporting behavior. Those who report fraud tend to express higher levels of concern than their counterparts.

Attitudes toward the industry indicate that Reporters differ significantly from those who do not report; those who do not report are different from Naïves. Reporters do not differ from Naïves. Reporters tend to have more favorable dispositions toward the insurance industry than Non-Reporters; Non-reporters expressed attitudes least favorable toward the industry.

One's attitudes toward the agent also may contribute to reporting behavior, in that Reporters were more favorable toward their agents than were Non-Reporters and Naïves. Non-Reporters were slightly less positive toward their agents compared to Naïves.

No differences were found based on attitudes toward the current carrier.

Reporters and Non-Reporters differed from Naïves. Those who have observed insurance fraud, regardless of whether or not they have reported it, attributed a higher level of fraud’s prevalence than Naïves. As for acceptance of insurance fraud, Non-Reporters showed the highest levels, but differed significantly only from Naïves.

This pattern was repeated with perceptions of the equity in the exchange, where only Non-Reporters and Naïves differed. In this case, Non-Reporters expressed the highest levels of perceived inequities compared to both Reporters and persons with no expressed experience with insurance fraud.

Discussion

This study investigated factors in the insurer-insured relationship that may contribute to bystander-insureds reports of insurance fraud. Recent studies reveal that some customers may commit fraud in retaliation for perceived unfairness in their relationship with their carrier or the insurance industry. This study examined whether this posture extends into the voluntary reporting of insurance fraud. Summary findings and their implications to managing fraud are now discussed.

First, this study affords a baseline for bystander reporting of insurance fraud. About one-quarter of bystanders aware of fraudulent acts said that they reported fraud to law enforcement or an insurer. This affords the anti-fraud community an initial number from which to extrapolate any change over time in the reporting environment.

Reporting of insurance fraud was seen as contingent upon most of the variables that were initially identified as having predictive power. These include the level of observers’ concern about these infractions, and age. Older consumers, perhaps due to greater likelihood of exposure over time, or possibly due to higher levels of comparative ethics (e.g., Lesch 2011), were more likely to report fraud. Reporters also tended to have the most positive
attitudes toward the industry, with Non-Reporters expressing the least-favorable dispositions toward the same.

The sources of this negative attitude warrant careful review, since at least some portion are within the direct control of industry members since they provide services. Some evidence suggested that Reporters differed from both Naïves and Non-Reporters about their attitudes toward their agents. This again suggests that further investigation of what constitutes successful agent management of the insurer obligations, and the manner of delivery, may make a difference in bystander behavior.

Both Reporters and Non-Reporters perceived a higher prevalence of insurance fraud than their Naïve counterparts. Non-Reporters expressed much higher acceptance of fraud compared to Naïves, but did not differ from Reporters. These findings point to the “normality” of fraud in the industry. They suggest that unless strides are made to reduce these beliefs, that refusals to report observed fraud will persist and some portion of claims will be paid on illegitimate grounds that otherwise may be prevented.

Non-Reporters also viewed the insurance relationship as much less equitable than did Reporters and Naïves. Here, improving the quality of the relationship with insureds is required. Specific elements requiring attention were not the domain of this study. Rather, insurers are best served through continuous monitoring of customer satisfaction with all facets of service, especially those under an insurer’s direct control. The more fair the consumers’ point of view on the service exchange, the higher the likelihood of reporting an insurance fraud.

In summary, conversion of thinking among Non-Reporters — those who witness insurance fraud but do not act — may be influenced by insurers through service improvements (changing perceived fairness in providing services), and by increasing insureds’ concern about these crimes. Campaign themes to impact these two variables may also impact Non-Reporters’ attitudes toward the industry, and acceptance of insurance fraud in ways that directly improve reporting. Some evidence of an insured’s relationship with insurance agents suggests that improvements may increase reporting behavior.

Readers should not overlook the status of Naïve persons — who report not having any knowledge of an insurance fraud. At some point, a portion of these will observe a reportable fraud. In most cases, their perceptions were between those held by either Reporters and/or Non-Reporters. Campaigns intended to move their attitudinal mindset in the direction of those who report are best undertaken before they observe a fraud, in order to maximize their reporting.

"...insurers are best served through continuous monitoring of customer satisfaction with all facets of service, especially those under an insurer’s direct control. The more fair the consumers’ point of view on the service exchange, the higher the likelihood of reporting an insurance fraud."

Thus, broadly targeted campaigns (total audience efforts) focused on raising concern, improvements to service quality, and the abnormality of fraudulent acts may increase levels of reported insurance fraud.

Interestingly, one’s personal ethics concerning insurance fraud did not influence reporting behavior. Other studies have shown its relevance to acceptance of fraud, but this did not carry over to reporting of infractions. Nor, was it shown that consumers linked premium levels or the possibility of increased premium levels due to fraud, with their decision to report. The latter is surprising, given the focus of some state-level campaigns (e.g., Pennsylvania) upon the cost of fraud. The lack of knowledge of rate setting, and/or the belief that the cost of fraud is a not substantial “built-in” factor, also may have played roles. Reporting also was invariant to level of education and gender, and one’s attitude toward the firm. Improvements to industry standards of service quality, and the most tangible aspect of the insurer’s role — agent skills and interpersonal competencies — represent possible areas for more investigation. Changes here may also pay dividends to renewals and industry image.

In sum, this study demonstrates that reporting insurance fraud is at least partially influenced...
by consumer beliefs about the quality of their relationship with insurers. Age and beliefs about how common fraud was attributed to be in society also emerged as important. Efforts to influence these factors consistent with social goals — justice on both sides of the contractual agreement — may reduce insurance fraud and offer promise to improve bystander reporting of its occurrence.

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15. See Coalition Against Insurance Fraud (2007), to examine the questionnaire. Components of each scale can be obtained from the authors.16 Xia, Lan, Kent Monroe and Jennifer Cox (2004). “The price is unfair! A conceptual framework of price unfairness perceptions,”Journal of Marketing, 68 (October), 1-15.


21. Complete statistical findings available from the authors.
Abstract: Government-funded disability pension programs can be valuable safety nets for honest people, but also a feeding trough for exploitive beneficiaries. Workers in many jurisdictions allegedly have lodged false, abusive or suspicious claims against taxpayer-funded disability pension programs involving the federal government, cities of Long Island, Boston and Chicago and other jurisdictions. The stolen money can be a significant drain on jurisdictions trying to balance budgets in a languid economy. Many systems suffer from lax oversight that allows exploitation. Reforms can include moves such as greater funding for investigation, outlawing certain abusive and fraudulent practices that slip through loopholes in the law, and improving datamining to better uncover suspicious bases.

By James Quiggle

Electrician Gary Satin retired on disability from the Long Island Railroad (LIRR) in 2005 at age 55. His annual pension and disability benefits totaled $68,000 by 2010. But he performed landscaping, contracting and electrical work after retiring, and lied to a grand jury. He was convicted and faces up to 10 years in federal prison when sentenced.

Fellow employee Gregory Noone retired with purportedly severe pain while gripping and bending. But surveillance allegedly caught him playing tennis several days a week, and playing golf at one course 140 days over a nine-month period.

Hundreds of LIRR employees have claimed fraudulent or questionable injuries that landed early disability retirements with lucrative pensions that could have cost up to $1 billion if all the money was paid out. The LIRR is possibly the largest disability-fraud con in U.S. history, officials say.

Most public employees who incur career-ending injuries make honest disability-insurance requests. But the LIRR scandal is emblematic of a systematic fraud and abuse problem playing out with often...
generous federal, state and local disability pension plans around the U.S.

Whittling down cash-draining cons gains urgency as governments try to balance shrinking budgets in an unsteady economy. This is equally true of private citizens who soak the federal government for disability payouts. Such scams also threaten to erode public faith in public employees, including those who protect people's safety such as fire fighters and police.

In the LIRR case, workers paid facilitators $1,000 to connect them with three allegedly crooked doctors. The physicians routinely filled out benefit forms lying that the workers were disabled. Three New York area doctors accounted for 86 percent of the LIRR disability applications filed before 2008, prosecutors say.

So far 22 have been charged, including two doctors who allegedly made false diagnoses. The case is so large that the feds are offering amnesty for retirees who confess to bogus disabilities.

Other states and cities are wrestling with similar fraud issues, though none apparently on the same scale as the LIRR imbroglio. A sampler:

**Chicago.** Police officer Charles T. Siedlecki allegedly went on safari big-game hunts while hauling in more than $715,000 in tax-free disability pay because he said he couldn’t safely fire a gun any more.

Siedlecki said he fell and hurt his left shoulder while chasing teenagers 20 years ago, and never returned to work. Since then, he allegedly has shot and killed a hippo, a wildebeest and a bear in Alaska after a 1,600-yard stalk. But Siedlecki’s doctor signed a report two years ago stating he is not “capable of safely discharging a firearm.”

Nearly 350 Chicago police officers are out on disability for up to 33 years. They receive 50-75 percent of their current salary they held when they supposedly got hurt — up to $78,764 annually. These presumably disabled officers collect a combined $18 million a year, most of it taxpayer money.

Other retired Chicago officers receive substantial disability money while becoming lawyers, small-business owners, a car salesman and a construction worker, a Chicago Sun-Times investigation has found.

Siedlecki’s payments, meanwhile, have been suspended, and the police pension board has asked the state Attorney General to investigate.

A federal grand jury began investigating disability payments of police, fire fighters and paramedics for fraud an abuse in October 2012. The jury is demanding that the three agencies produce a large volume of records dating back to 2006.

Chicago mayor Rahm Emanuel has proposed reforms to address fraud and abuse, including:

- Firefighters, paramedics and police officers on disability would have to report their annual incomes, thus revealing their income from other jobs;
- Fire personnel and police officers can apply for disability leave only after the department’s medical staff examines them to determine if the injured workers can do other jobs within their departments; and
- Firefighters on disability who are currently examined only every two years would face more frequent medical checkups.

**Massachusetts.** In Boston, 102 firefighters claimed permanent and disabling job-related injuries while briefly filling in for positions at a higher pay grade. This increased their pensions an average of $10,300 annually for the rest of their lives. The practice was called the “king for a day” rule. The U.S. Attorney General found the practice so abusive and potentially fraudulent that the Massachusetts legislature made “king for a day” illegal in 2009.

Separately, Boston fire fighter Albert Arroyo tried to collect a $65,000-a-year disability pension after falling down firehouse stairs. He was discovered competing as a bodybuilder. Though acquitted of federal fraud charges in 2011, Arroyo was fired and the city has cut off his disability payments.

**New Jersey.** A Newark policeman claimed he was blind, and filed for a lifetime disability pension worth $1 million. But internal affairs caught him on video — driving on the Garden State Parkway.

When the officer parked near his doctor’s office, he donned sunglasses, grabbed a cane and was...
“helped” into the medical building by his wife. His claim was denied.

Another state transit police officer stapled himself in the finger and sought disability retirement. Claim denied.

Abuse of New Jersey’s pension system is enough of a problem that a reform bill (SB 1913) was proposed. It had cleared a committee as of June 2012. It would:

- Create a fraud unit in the AG’s office;
- Require anyone applying for ordinary disability and accidental disability benefits to be certified as incapacitated for their former job, but also for another other available job that might be assigned for the same pay; and
- An ordinary disability retirement wouldn’t be available until after 10 years of service (instead of the current four years).

**Rhode Island.** A local television show caught a retired Providence fire fighter who supposedly was out of work on disability lifting weights at a gym. That prompted the city to fund an outside audit of its $27 million disability pension program last year. The audit did not turn up enough evidence to charge anyone criminally.

**Federal disability.** Perhaps the largest trough of potential fraud and abuse lies with federal disability claims even as the government fights to avoid toppling over the so-called fiscal cliff.

Thousands of healthy people may be lodging claims against Uncle Sam’s $128-million Social Security disability insurance program, a 2010 report by the Government Accountability Office (GAO) found. In fact, fraud and other improper payments soaked up $25 billion in disability payments between 2005 and 2009, the report found.

“The GAO analyses provide an indicator of potentially improper and fraudulent activity,” the report says. About 1,500 civilian employees may be improperly receiving $17 million a month in improper or fraudulent disability benefits in just three agencies alone — the Treasury, U.S. Postal Service and Defense Finance and Accounting Service.

Also, 62,000 supposedly “disabled” private-sector workers drive trucks or buses while banking federal disability checks.

A man who applied for disability benefits by claiming a mental disorder, low IQ, and difficulty reading and writing. The man also said he was homeless. But he actually graduated from college with a business degree and worked full time as a bank teller. He admitted guilt.

A Pennsylvania woman collected disability checks even as surveillance video showed her working as a mail clerk. Total cost: $19,000 in fraudulent payments.

Four mentally disabled adults were found locked in the basement of an apartment complex in 2011. They were malnourished and chained to a water heater. Four suspects allegedly held them hostage for years to steal their federal disability checks.

After climbing up trees to clear away storm debris, an able-bodied tree trimmer asked his customer, “Could you make the check out to my mom? I’m on disability.” The tree trimmer’s customer was Sen. Tom Coburn (R-Okla.), one of the nation’s leading advocates of federal benefits reform, who he’d asked to defraud Social Security disability. Busted.

The number of enforcement reviews is low, and the government should do more datamining for possible fraud, the GAO report urges.
The horrific Philadelphia case involving imprisoned disability beneficiaries prompted a U.S. Senate bill (S. 2026) in 2011 requiring background checks on representative payees. It was last reported under committee scrutiny.

The federal government also projects fully $339.6 million in savings through investigations that denied improper disability payments in fiscal 2012.9

The White House wants to spend $4.3 billion over five years to fight Social Security disability fraud. Budget office officials say every dollar spent by the Social Security Administration to review disability claims will save $11 in erroneous payments.

The problem stems from lack of oversight. Federal spending on disability insurance leaped 65 percent from 2001 to 2007, “yet the number of full medical reviews, one type of review for evaluating claims for eligibility for continuing disability payments, fell from 840,000 in 2001 to 190,000 in 2007,” says the Social Security Administration.10

Federal employees have their own workers compensation disability program. The Labor Department, which oversees the program, paid out about $2.8 billion in disability money over a recent 12-month span, without ensuring whether federal workers employees are exploiting the program, U.S. Sen. Susan Collins (R-Maine) charges. She has asked the GAO to audit.11

Likely billions of dollars of taxpayer money are wasted on lucrative but suspect disability retirement for government workers who are far more vigorous than they let on. Other employees deserve every dollar they get; they battered their bodies beyond repair in the public service.

The full scope of retirement robbery may never be accurately defined. But perhaps the deceivers have a crippling disability after all: in their moral compass.

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About the author: James Quiggle is director of communications for the Coalition Against Insurance Fraud.
The honest truth about dishonesty

Why Americans cheat and what we can do about it

By Dennis Jay

Research on dishonesty in America is plentiful, but most deals with how we cheat, and how much. Very little indepth research has been conducted on why we cheat, and what situations influence dishonest behavior. Perhaps more importantly, more data is needed on how to reinforce moral behavior.

Perhaps that’s one reason for the popularity of a book like “The (Honest) Truth About Dishonesty.” It tells of dozens of fascinating experiments to better understand why ordinary, normally honest people cheat. Author Dan Ariely is a professor of psychology and behavioral economics at Duke University, and director of the Center for Advanced Hindsight. His book should be required reading for anyone who
develops strategies to curb so-called soft fraud by insurance claimants and applicants.

Ariely’s extensive research challenges traditional thinking about why people cheat and commit crime. Developed many years ago, the Simple Model of Rational Crime (SMORC) says humans perform a cost/benefit analysis, and act accordingly. They calculate the possible gain in any situation and weigh it against the potential negative outcome. As Ariely explains:

“...if we’re short on cash and happen to drive by a convenience store, we quickly estimate how much money is in the register, consider the likelihood that we might get caught, and imagine what punishment might be in store for us if we are caught. On the basis of this cost-benefit calculation, we then decide whether it is worth it to rob the place.”

But Ariely says it’s much more complicated than that. Most people, won’t commit such a crime even with zero chance of getting caught. But minor cheating is a different story.

Ariely set up experiments asking students to take a math test in a classroom. As an inducement, each would receive $1 for every correct answer. Students were given a time period to complete the test. The instructor then reviewed each question and revealed the correct answers. Students tallied their correct answers, and one by one, walked to the back of the room and fed their answer sheets into a paper shedder. They walked back to the front of the room, reported their correct answers to the instructor, got paid and left.

Seems like a perfectly normal test experiment. Except the shredder only shredded the margins of the paper, leaving the answers intact. With this data, researchers calculated how truthfully students reported correct answers. Very few people cheated a lot, the researchers found. But a significant majority cheated a little. Students who were only correct on four of 20 questions, for example, reported they answered six correctly and pocketed an extra $2.

Ariely repeated this experiment over and over, using different variables and different subjects. He received the same results. In one experiment, the award was increased from $1 to $10 and cheating actually declined slightly. This casted doubt on the plausibility of the SMORC model that cheating would decrease if you increase the reward while keeping the risk of getting caught the same. Other experiments varied the chances of getting caught, with the same results.

From these and other experiments, Ariely made an astute observation:

“...most people cheat up to the level that allows them to retain a self-image as reasonably honest individuals.”

Ariely thought the insurance claims process would be fertile ground to test his theories. He approached a large personal-lines insurer about devising various scenarios to test cheating. He met with claims staff and came up with several possible experiments, all of which insurer lawyers quashed. Ariely didn’t identify the insurer in the book.

Insurer staff offered an alternative option involving a routine questionnaire sent to policyholders that asked them to report the miles they drove annually. Ariely didn’t identity the insurer in the book.

Most people cheat up to the level that allows them to retain a self-image as reasonably honest individuals.”

The only difference in the forms sent to the two groups was the warning language’s location. On one form, the warning and signature line were placed as traditionally at the end of the form. In the other batch, the warnings were placed on top of the first page. All policyholders had to read and sign before completing the form. Not surprisingly, the data the two groups reported differed. With the warning at the end, policyholders reported they drove an average 23,700 miles per year. The other group reported 26,100 miles — a statistically significant difference of 10 percent.
The insurer deliverable: Moving the fraud warning up top likely will allow insurers to collect more premium and reduce the amount honest policyholders are subsidizing the cheaters.

This and other experiments strongly suggest that people are more honest when they pledge to be — or are reminded about — morality and honesty. In one experiment involving the shredder, Ariely tested two questions against each other: How many of the Ten Commandments can you name versus how many books read in college can you name? People in the first group didn’t cheat at all, while cheating in the second group was higher, on par with other experiments.

Other research found that students who sign a statement upholding the school’s honor code before taking a test are less likely to cheat — even when the school has no honor code.

While fraud warnings, reviewing the Ten Commandments and pledging to honor codes seem to deter cheating, the effects are short-lived, according to Ariely.

This tracks with claiming behavior reported by insurers who say suspect claims decline after a well-publicized arrest or sting operation, but then rise after a few months, at best. People have short memories.

In another series of experiments that may be relevant to insurance, researchers tested whether annoyed people were more likely to cheat. The experiment was set up at a local diner where an actor, who served as a waiter, returned too much cash back to to diners after they paid for their meals. In half of the cases, just before the diners received their change, the waiter received a cell-phone call. While it was a relatively quick call, diners still had to wait to finish the transaction, count their change, leave a tip and depart.

Some 45 percent of the diner group with no call returned the extra cash. That was three times the rate of the annoyed diners.

“The insurer deliverable: Annoying customers imposes an avoidable cost on businesses – especially insurers.”

“Results suggest that once something or someone irritates us, it becomes easier for us to justify our immoral behavior,” Ariely writes. The results agree with previous research that claimants who perceive they are treated fairly are less likely to inflate a claim.

Ariely’s research extends beyond consumer behavior and also focuses on various professions, including medical providers. He discusses the mental process doctors go through in steering patients to undergo tests and use equipment in which the doctor has a financial interest.

While this steerage may not usually seem to equate with cheating, Ariely concludes that there is almost no way for a physician to make an objective decision when money is at stake. He’s even more critical of doctors who accept gifts, speaking fees and other compensation from drug makers. Ariely interviewed drug reps and reveals a number of tricks they use to influence physicians’ prescribing practices.

Ariely’s team also reviewed data from millions of dental procedures over a 12-year period and found that the longer a dentist has a relationship with a patient, the more likely the dentist is to order an unneeded test or perform an unnecessary procedure. And the longer the patient has seen a dentist, the less likely the patient is to challenge the dentist’s advice.

Such behavior is known as collaborative cheating and how people around us influence our behavior. Ariely is convinced that cheating is infectious and can be increased by observing the bad behavior of others around us. He writes:

“...as we see other members of our own social groups behaving in ways that are outside the acceptable range, it’s likely that we too will recalibrate our internal moral compass and adopt their behavior as a model for our own. And if the members of our in-group happen to be an authority figure – a parent, boss, teacher or someone else we respect – chances are even high that we’ll be dragged along.”

He’s also adamant that the best strategy to curb the increase in cheating is to stop the collaborative spread, and perhaps most importantly, by prevent the first instance of cheating:

“The effects of individual transgressions can go beyond a singular dishonest act. Passed from per to person, dishonesty has a slow, creeping
socially erosive effect. As the ‘virus,’ mutates and spreads from one person to another, a new, less ethical code of conduct develops.

And although it is subtle and gradual, the final outcome can be disastrous. This is the real cost of even minor instances of cheating and the reason we need to be more vigilant in our efforts to curb even small infractions.”

Ariely seems to follow the “broken window theory” that was popular in the 1980s, and employed in several major cities to reduce crime. If urban environments are monitored and maintained in a well-ordered condition, the theory goes, that orderliness will stop further vandalism and escalation into more serious crime. One broken window in an abandoned building will lead to more broken windows, and ultimately to blight. But if the window is quickly repaired, the chance of a second broken window diminishes.

New York City officials credit this strategy with sharply reducing graffiti on subway cars.

In any event, Ariely agrees we should pay more attention to minor transgressions, and especially the first ones people make. This suggests insurers should be especially vigilant about spotting and deterring the seemingly minor “soft” scams. Unchallenged, the small scams could lead to more or bigger ones.

“There’s no such thing as a single act of dishonesty as just one petty act. We tend to forgive people for their first offense with the idea that it is just the first time and everyone makes mistakes. And although this may be true, we should also realize that the first act of dishonesty might be particularly important in shaping the way a person looks at himself and his actions from that point on – and because of that, the first dishonest act is the most important one to prevent. That is why it is important to cut down on the number of seemingly innocuous singular acts of dishonesty. If we do, society might become more honest and less corrupt over time.”

An insurer claims executive once suggested that insurers would reduce fraud and claims cost by just putting out barrels of cash in their lobbies and letting claimants take whatever money they feel they deserve. He was not serious, of course. But after digesting Ariely’s research, perhaps it’s worth a try.

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About the author: Dennis Jay is executive director of the Coalition Against Insurance Fraud.

endNOTES


TrendWatch: new developments about fraud in America

Airbag bust suggests many drivers imperiled

Thousands of motorists may be driving with malfunctioning airbags, threatening the lives of motorists involved in crashes.

That’s the upshot of a major bust of a Chinese national who flooded the U.S. with cheap knockoff bags forged in his factory in China. Dai Zhensong’s 37-month federal sentence last fall also, for now, revived dormant public attention on the deadly con – and stolen insurance money that fuels many scams.

Zhensong imported several hundred thousand airbags. Some were tested after his arrest. Several bags only partially inflated. Others spewed fire and shrapnel at crash dummies. A bolt shot into one dummy’s forehead.

His operation was a playbook for exploiting the U.S. market. He reverse-engineered legitimate airbags, then crafted shoddy knockoffs to look like bags from mainstream carmakers. Zhensong then imported the bags to the U.S. in small, mislabeled shipments to avoid scrutiny by U.S. Customs, federal officials close to the case said at a private briefing during the Coalition’s annual membership meeting in December.

Zhensong’s bust was the first seizure involving China. He also was lining up a Middle East importer, federal officials said.

Airbag fraud is sustained by an attractive profit potential. Counterfeitors churn out knockoffs for $50-$75 apiece and sell them for large markups. Body shops, in turn, charge insurers $1,000 or more by lying that the bag is legitimate. Body shops also install cheap junk bags, or none. Investigators even have found airbag compartments filled with beer cans, packing peanuts, old sneakers and other trash.

Salvaged and used vehicles, plus late models being repaired after crashes, all are vulnerable.

Sites such as eBay and Alibaba.com are active marketplaces for trafficking in suspect airbags and system parts, officials say.

There are no reliable estimates of the scope of airbag scams or stolen insurance money. And only a few documented cases of death or injury in crashes have surfaced. But the constant potential for grievous harm makes airbag fraud a public-safety risk warranting urgent attention, the Coalition tells state legislatures and reporters.

In one highly publicized case, a Toyota driven by Damaris Gatihhi was bumped from behind on a Seattle-area interstate. She died when her car spun and hit another vehicle head-on. Gatihhi had bought the vehicle used; the airbag was removed, according to news reports at the time.

The U.S. is seeking cooperation with China to block more imports, federal officials told the Coalition. Investigators also are probing for domestic distributors connected to Zhensong and other counterfeiters, federal prosecutors say. And federal prosecutors can wield counterfeiting, smuggling, and copyright and trademark infringement laws.

But no federal law forces body shops or dealers
to replace deployed airbags. Several states, however, have made airbag fraud a specific crime. Others such as New York and Rhode Island require bodyshops to keep records of airbag purchases. Florida exposes body shops to manslaughter charges if a motorist dies from an airbag con. Public-interest groups such as the Coalition also are educating motorists to have certified mechanics inspect the airbags before buying used or salvaged vehicles.

**Tiny pharmacy lands billions in whistleblower settlements**

An obscure pharmacy in the Florida Keys is making a fortune by lodging whistleblower suits against Medicare and Medicaid cheaters. Most recently, Ven-A-Care will receive at least $23 million from a $156-million settlement with a drugmaker.

In this year alone, the drugstore has accounted for $6.5 billion in court awards against drug behemoths Abbott, Actavis, GlaxoSmithKline and Merck, says the Washington-based nonprofit Taxpayers Against Fraud.

Almost half of all state and federal whistleblower settlements between November 21, 2010 and July 18, 2012 were initiated by Ven-A-Care, says a September report by the nonprofit consumer group Public Citizen.

More settlements are being made between state and federal governments and the drug industry than ever before. Overall, much of the recent spike in enforcements stems from individual state attorneys general prosecuting suspected fraud against their Medicaid programs. Since 1991, Kentucky has concluded the most settlements, Public Citizen says.

Ven-A-Care won its first Medicaid settlement in 2000, and today is America’s most successful whistleblower. The little giant sues under the federal False Claims Act whenever it suspects a fraud against Medicare or Medicaid.

Whistleblower laws allow private citizens or companies to file lawsuits on behalf of the government. The government can opt to take over the suit. If federal prosecutors win, the initiator can receive 15-25 percent of the settlement.

A suit in California by Ven-A-Care alleged that a one-gram vial of the antibiotic vancomycin was sold to providers for $6.29, but billed to Medi-Cal for $58.37. And 50-milligram tablets of the blood pressure medication atenolol were billed to pharmacies at $3.04 but to Medi-Cal at $70.30.

**Thief lives high life while impoverished seniors suffer**

Sometimes a fraud scheme rises to the level of gruesome. George Houser tried to get rich by running three nursing homes as part of the Forum Healthcare Group. In fact the facilities were little more than houses of horror.

His attempted $32.9-million Medicare and Medicaid cons left low-income residents of his Georgia nursing homes starving near their bodily waste. The facilities suffered food shortages bordering on starvation, leaking roofs, virtually no nursing or cleaning supplies, poor sanitary conditions, major staff shortages and safety concerns.

Employee paychecks bounced, and Houser pocketed money intended for staff health premiums. The policies thus lapsed, leaving employees with unpaid surgery and other treatment bills. The remaining staff spent their own money to feed residents, and washed residents’ laundry in their own homes. Houser also didn’t replace broken air conditioning units, washing machines or water heaters.

Roofs leaked water and eventually fell on residents’ beds. Meanwhile, Houser bought his ex-wife a $1.4-million home with Medicare and Medicaid money. He also put her on his payroll as a nurse, though she never worked at any of his homes. He bought Mercedes-Benz cars, furniture and vacations, and planned the construction of several hotels in Rome, Ga.

Houser received 20 years in federal prison in August.

His statement of remorse: “I am sorry that I spent any money I did on property. I am sorry I got into a financial squeeze and had problems.”
The Coalition Against Insurance Fraud is a national alliance of insurers, consumer groups and government agencies combatting all forms of insurance fraud through legislation, public education and research.

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