Graying Baby Boomers may swell ranks of fraudsters

America’s Baby Boomer generation is rapidly entering retirement age and creating a large bulge of seniors unlike any demographic shift our nation has ever seen. This also portends a possible bulge of insurance fraud.

By Matthew J. Smith, Esq.

Malingering imposes large costs on insurance companies and society

Disability fraud costs in the U.S. recently have been estimated to be as high as $180 billion annually. Despite these and other estimated costs, there is reluctance by healthcare providers and others to completely address the issue.

By Dominic A. Carone, PhD, ABPP-CN

Insurers advancing fraud fight with advanced high-IQ technology

Technology is an increasingly disruptive force for insurers in combating insurance fraud. Innovation is necessary: Suspicious activity has risen in the last three years, more than half of responding insurers say in a study.

By Dennis Jay

TrendWatch: new developments about fraud in America

Coalition defends right to sue suspects in Illinois … Kentucky law barring soliciting of crash patients overturned … Journalists start fast probes of newly released Medicare data … Spinal implants challenged in lawsuits against surgeons.

By Coalition Staff
ach issue of JIFA opens a window wider into important fraud-related trends. The Fall issue opens the window that much wider. Scammers who have long fleeced private and private health insurers such as Medicare are facing more pressure than ever thanks to several innovative counter-moves. Baby boomers are graying, and many worry about their financial future. The potential for a parallel bulge of scamming thus looms as millions of Boomers phase into retirement.

Insurers are adopting new anti-fraud technology with growing sophistication. All the better, because many insurers see an increase in scheming.

These are among the themes echoed by prominent authors in the Fall issue of JIFA. It’s a well-informed wave of optimism, tempered by stiff warnings. Count on JIFA to continue opening yet more windows. It’s field intelligence that fraudsters fear and decisionmakers seek.

Sincerely,

[Signature]
Abstract: Fraud has bled Medicare for decades, leading to untold billions of dollars in losses to fraud rings and crooked medical providers. But initiatives by the Obama Administration are having a promising impact. Task forces aimed at nine hotspot cities are rolling up fraud rings. New analytics are uncovering false claims with laser precision. The new Health Care Fraud Prevention Partnership also is finding that sharing of information among partnership members is uncovering millions of dollars in false claims against insurers in the public and private sectors. Despite their successes, such initiatives lack funds needed to achieve their potential impact. With promising new programs to strengthen the fight against healthcare fraud, now is the time for the nation to heed this call to action.
quickly unfolded. Healthcare reform was at the top of the President’s agenda. A parallel emphasis was the immediate launch of a war against fraud in the two major federal health programs, Medicare and Medicaid.

A joint initiative soon was created to combine the expertise and resources of the Justice Department and the Department of Health and Human Services. It was given the catchy title HEAT — or Health Care Fraud Prevention and Enforcement Action Team. We were leaders of the HHS component of HEAT, along with the HHS Inspector General.

The HEAT blueprint involved special strike forces aimed at fraud hotspots such as Florida, Texas and New York. Nine strike forces eventually were created, though this was less than half of what was needed. The remaining strike forces were put on hold due to lack of resources. Needed funds for the healthcare-fraud operation became one of the many victims of budget battles between Congress and the White House. HEAT still was an enormous success. The number and dollar value of healthcare-fraud convictions doubled and the recovery rate of the federal investment tripled. The federal government took in $4.3 billion in fraud judgments and settlements in FY2013 alone. Federal prosecutors also had 2,041 criminal investigations pending, involving 3,535 defendants. They filed criminal charges in another 480 cases involving 843 defendants. A total of 718 fraudsters were convicted in HEAT cases in FY2013.

HEAT a major turning point

Our informed impression is that HEAT has just scratched the surface of its potential despite these achievements. HEAT’s success involved more than recovering money and putting criminals in jail. HEAT became much more than a better version of the old and ineffective pay-and-chase approach to health-insurance fraud. HEAT was a major turning point in the war on fraud as the synergy between DOJ and HHS grew.

HEAT spawned innovation. Sophisticated data analytics were adopted to identify geographic anomalies and types of medical treatment most vulnerable to fraud schemes.

For the first time, law-enforcement and prosecutors had access to real-time claims data. Congress also got into the act, mandating the federal government’s first Fraud Prevention System at the Centers for Medicare and Medicaid Services (CMS).

We oversaw the creation of a fraud-prevention command center at the agency’s headquarters in Baltimore. The new center is physically impressive. The front wall houses a room-sized, multi-purpose video screen. The floor is bedecked with computer stations, each of which has computers and high-resolution monitors. Law-enforcement agents and CMS program integrity experts work together under one roof to investigate and prevent fraud.

But the invisible technology — not the cool sophisticated hardware — forms the center’s ultimate weapon against healthcare fraud.

Coursing through the Baltimore operation are hundreds of innovative computer algorithms forming the basis of the CMS Fraud Prevention System (FPS). Using predictive modeling to scrutinize healthcare providers and their claims, the FPS algorithms draw upon historical trends, public and internal data and other relevant information to
assess the risk of all Medicare providers and claims. The system generates alerts on high-risk behaviors in real time.

**System vulnerable to fraud**

It is a daunting task. More than 1.5 million medical providers are eligible to participate in Medicare, and some 18,000 new providers line up to enter the program every month.

CMS processes an average of 4.4 million claims a day, with a total daily value of $1 billion. With this number of participants and gigantic claims input, it is no wonder the healthcare system is so vulnerable to fraud. Still, the FPS has been an unqualified success. It is putting a substantial and defined dollar value on fraud prevention for the first time.

The Department’s use of FPS resulted in $54.2 million in actual and projected savings for the Medicare fee-for-service program in just its second year of operation, the HHS Office of Inspector General (OIG) recently certified. This represents a return on investment of $1.34 for every dollar spent on the FPS.

The OIG also certified some $210.7 million in unadjusted savings that the FPS identified. And the OIG spoke to the ongoing value of FPS in the future. The program will strengthen efforts to prevent fraud, waste and abuse in the Medicare fee-for-service program, the OIG stated.

“We oversaw the creation of a fraud-prevention command center at the agency’s headquarters in Baltimore. The new center is physically impressive.”

Vulnerability to fraud is built into health-insurance payment systems, both public and private. This crime is bleeding our healthcare system of countless billions of dollars every year.

The very designs and policies of our healthcare systems open them to schemes. Medicare, for example, is required by law to process claims of willing providers quickly — within just 30 days of receipt. This creates a narrow window for scrutinizing claims before Medicare must pay them. Estimates of Medicare fraud range as high as $90 billion annually, though all estimates remain unverified. Whatever the figure, it is unquestionably and unacceptably large. That alone should spur the nation into action.

But in our view, the issue is less about fraud’s annual costs than the inherent vulnerability of our programs. It is the high risk exposure that should trigger alarms for a more robust set of controls. No one intentionally created systems prone to fraud, but fraud is so prevalent, and the safeguards so short of resources, that we have virtually put out a welcome mat for thieves.

**Need more resources**

We do not minimize current fraud-fighting initiatives. They are, indeed, our best achievements to date. Law enforcement is more sophisticated than ever. Fraud prevention, heretofore the stepchild of pay-and-chase strategies, is now at the forefront of federal policy. But we need more. Our efforts are hindered by insufficient resources and inadequate integration between federal, state and private health-insurance programs.

There are opportunities to build on these successes by expanding the HEAT operations significantly, and giving law enforcement the needed tools to fulfill its mission.

But we will never prosecute our way out of healthcare fraud. Driven by predictive analytics, prevention will have the greatest longterm impact on reducing fraud and driving bad actors from our healthcare system.

Prevention efforts will be buttressed by the evolution of technology and continued support for growth of the Fraud Prevention System. But the technology will go only as far as the data take us. Right now, the available data exist in separate, seemingly impenetrable silos. It is characterized by lack of communicability, normalization and accessibility. Entrenched cultures and antiquated policies also prevent information sharing across payment systems.

The Obama Administration created the Health Care Fraud Public-Private Partnership to overcome these obstacles. Announced with great fanfare in the White House by the Attorney General and HHS...
Secretary in July 2012, the partnership consists of DOJ, HHS, state Medicaid agencies and private insurance companies.

The partnership fosters collaboration across the healthcare industry. Getting to this stage was a long time coming. Its roots date all the way back to enactment of the Health Care Fraud and Abuse Control Program in 1996. That statute required the HHS Secretary and Attorney General to consult with, and arrange for, the sharing of data with all health plans.

The mandate broadly included all plans or programs that provide health benefits, whether directly, through insurance or other means. This provides statutory authority for the public and private sectors to share data to fight fraud.

The partnership’s main vehicle is the trusted third party. It is an independent organization that collects claims data from all the partners. To protect patient privacy, the third party removes information that identifies patients, providers and the source of the data. It then aggregates claims and provides analysis to identify or prevent fraud.

**Useful data shared**

The trusted third party concept allows highly useful sharing of data while protecting privacy and proprietary rights. It emerged from similar experiences involving air safety and the property-casualty insurance industry. Operated under contract by the Federal Aviation Administration, the airline industry shares safety data.

The industry uses the data to identify and fix vulnerabilities, and create the safest flight operations in U.S. history. The property-casualty industry also uses a trusted third party to aggregate and assess data from its companies, with similar positive results.

The HFPP has begun slowly and modestly. Thirteen private payers have joined the federal partners, including industry giants United Healthcare, WellPoint, Aetna and Humana. Five state Medicaid programs are enrolled: Arizona, New York, Iowa, Ohio and Kansas. Eight private-sector associations also participate. Among them are leaders such as America’s Health Insurance Plans, Blue Cross and Blue Shield Association, Coalition Against Insurance Fraud and National Health Care Anti-Fraud Association.

The MITRE Corporation, a federally-chartered non-profit research organization, serves as an interim trusted third party and coordinator of HFPP.

The partnership’s work is divided into committees. They focus on issues such as data sharing, education and outreach, and law enforcement.

Expectations for immediate results were low as we initially moved forward. After all, the partnership involved a fraction of the potential universe of health plans and had a small operating budget. For example, there were not enough funds to create a fully operational trusted third party that could collect, house and analyze data. Instead, a subset of the partners took part in several demonstration projects. The demonstration group included the federal partners, four insurance companies, one national property-casualty insurer, two regional insurers, one state Medicaid agency and one trade association.

Lacking the resources and data-sharing agreements and procedures required to exchange data from healthcare claims, the participants...
contributed historical information on misused or abused claims codes and suspected fraud schemes each participant had identified internally.

There were 1,400 abused codes submitted, along with 122 suspected fraud schemes. The results were explosive, contrary to everyone’s muted hopes for such a constrained demonstration project. To widespread surprise, most partners discovered they were not aware of many of the codes and schemes already identified by other insurers or programs.

The sharing of this very basic information led CMS alone to identify more than $20 million in improper payments. That led to revoked privileges and suspended payments for the targeted active Medicare providers. Private payers also identified millions more dollars in waste. New potential fraud schemes were uncovered and referred to law enforcement for investigation.

**Billions of dollars returned**

To fully understand the potential value of the HFPP, consider the current state of healthcare fraud recoveries by the federal government. Nearly $26 billion in stolen money has been returned to the government since the Health Care Fraud and Abuse Control Program began operations in 1997. About $10 billion was returned in the last five years alone. This represents recoveries stemming from federal agencies and private whistleblowers. Data analytics were not employed, and sharing among public and private healthcare partners did not exist during most of this time. Imagine the untapped potential of full data sharing by all healthcare providers, including all private payers and all federal payers — then add military and veterans’ healthcare systems to the mix. Further imagine the data being subject to aggregated data analysis and predictive modeling. The power of the data, and ability to prevent fraud, would increase exponentially.

Expenditures under CMS programs represent approximately one-half of all health-insurance spending in the U.S. This does not necessarily mean that some $50 billion could have been recovered if public and private anti-fraud efforts already were more comprehensive, coordinated and operated with full resources. Nor does it mean larger sums could be prevented from being stolen.

But surely it means the potential value of concerted effort is substantial. The fledgling HFPP already has proven that the public and private sectors can work together successfully to combat fraud. Now it is time for the partnership to mature and reach its full potential.

The pay-and-chase approach to healthcare fraud was our only recourse for years. More criminals emerged for every cheater we put behind bars. And fraudsters simply moved when we targeted locations. They were always one step ahead of us.

We will overtake fraudsters if we build on our determination, add resources, expand our partnership and continue developing sophisticated prevention technology. With our insurance programs expanding at a breakneck pace, now is the time to heed the call.

**About the authors:** Peter Budetti was recruited by the Obama Administration to lead a new CMS initiative to combat healthcare fraud. Serving as the first Deputy Administrator for Program Integrity of CMS until retiring in 2013, he developed and directed the Center for Program Integrity. A board-certified pediatrician and lawyer (inactive), he has held numerous senior positions in government and the private sector.

About the authors: Marc Smolonsky is the former Associate Deputy Secretary of HHS. He worked for 15 years in various capacities in the Office of the Secretary and at the National Institutes of Health. He also was lead investigator for committees in the Senate and House for nearly 15 years, and is a former journalist and published novelist. Smolonski now works as a consultant on healthcare issues, focusing on fraud policy.

**endNOTES**

2 ibid.
3 ibid.
4 ibid.
Abstract: America’s Baby Boomer generation is rapidly entering retirement age and creating a large bulge of seniors unlike any demographic shift our nation has ever seen. This also portends a possible bulge of insurance fraud. Seniors tend to be less inclined toward criminality, according to studies, but their sheer numbers could create a spike in fraud. Older Americans also form nearly the largest demographic of America’s prison population. And recidivism is high. They form a large bloc of people convicted of general fraud — possibly an indicator of tendencies toward insurance crime. Cynicism over lost investments, failure to save properly and declining home values also could incline many seniors to seek an insurance bailout. Still, the insurance industry has yet to fully understand, study, and respond to the Boomer bulge as a looming fraud phenomenon. At stake are potentially many millions of dollars lost to Boomer scams unless the fraud-fighting community determines the potential scope of the problem and its needed responses.

By Matthew J. Smith, Esq.

As the 1950s dawned, insurance companies began to understand and prepare for the advance of the Baby Boomer generation as the greatest potential flood of new policyholders in America’s history.

Six decades later, tens of millions of Boomers are now seniors, with a large percentage moving into retirement. Yet most insurers have yet to understand the anti-fraud implications of America’s senior demographics. America may be on the cusp of a new criminal phenomenon: the graying of the nation’s fraud force.

In my 30 years of observing the anti-fraud profession, insurance investigators and claims employees have routinely given a free pass to questionable claims of consumers in the 60s, 70s, or 80s age brackets. Investigators assume older people are honest, conservative, and would not commit insurance fraud.

Testing that assumption against available data paints a circumstantial but highly suggestive picture: the Boomer bulge might gestate a fraud bulge. Some data appears more inconsistent and applicable than other data, but on balance should give insurers cause for concern.

Even granting, arguendo, that Boomers are proportionately less likely to engage in criminal actions because older people purportedly tend to be more conservative, the vast size of this demographic...
suggests a potential fraud trend in absolute numbers. This could cost the insurance industry many hundreds of millions of dollars unless the insurers understand and respond now to the possible looming bulge in questionable or false claims.

The insurance industry, however, normally moves cautiously when making significant changes. No carrier thus far has taken the public lead in seriously researching the impact of Boomers on insurance claims and fraud. While no studies publicly document claim files that never were investigated, it is plausible that insurers already have paid millions of dollars for fraudulent claims by incorrectly giving a free pass to dishonest persons based solely on their age. The industry should equally and fairly investigate claimants of all age groups. The sheer volume of older Americans dictates that insurers address this issue promptly.

**Senior boomers spiking**

We are on a statistical launching pad where older consumers will reach an estimated 90 million people by 2050. No other segment of the American population has grown by such numbers (See Exhibit 1). There will be roughly 72.1 million seniors by 2030, more than twice the number of only 14 years ago when the new millennium began. Consumers

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**Prison Population By Age Group**

Exhibit 2

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**Women**

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age 65 years and older represented 12.4 percent of the population in the year 2000, but will grow to 19 percent by 2030. A sharp increase in criminals was a significant fallout from America's rapid population growth in the 1950s and 1960s. Many factors came into play. The result included prisons housing the largest percentage of the American population ever held behind bars. The prison population remains at high levels today. Many are seniors, and it is reasonable to assume this reflects evidence of criminal tendency that could encompass insurance crimes.

Federal statistics detailing state and federal prisoners in 2013 suggest a valid concern. The four categories of oldest prisoners beginning with age 50 comprise 1,124 males per 100,000 inmates. This composite total is higher than any other age bracket except ages 30 to 34. A combined 119 older females also are incarcerated per 100,000 prison residents (see exhibit 2).

Prisoners are aging as well. The number of prisoners age 65 or older more than doubled, from 1,698 in 2001 to 3,534 in 2010. The median age of prisoners was 38 years in 2010, and 36 years in 2001 (see exhibit 3). Recidivism also is a prominent trait of older prisoners. Nearly 70 percent of inmates age 40 or older were re-arrested within five years of release. This compares reasonably well with the 84.1 percent of inmates age 24 or younger who were re-arrested, and 78.6 percent of inmates age 25 to 39.

Thus it appears that simply growing older has little downward impact on a person's likelihood of becoming a repeat offender.

The raw number of persons likely to engage in criminal acts and fraudulent activities should be cause for concern. Insurers should rethink how they investigate claims, and who is investigated.

This notion gains strength from federal conviction data involving general fraud, which likely would include insurance scams.

**Age as a Crime Factor**

While the number of convicted fraudsters skews downward for each age group beginning with age 50, the total number of fraudsters age 65 and over is rising more dramatically than at any point in U.S. history (See Exhibit 1).

So even if the percent of persons committing fraud lowers with age, America will see the most explosive growth period ever recorded for the number of persons age 50 and over. Among them will be people who were hardened to fraud from an early age. Their numbers are undetermined, but the size of the age group suggests the potential that many insurance fraudsters are contained within this demographic.

Not surprisingly, people who learn to lie when young are far more likely to commit insurance fraud later in life, says a study by the Josephson Institute. Consumers who believed cheating and lying were necessary to succeed were more than three times as likely to inflate an insurance claim. People who cheated on exams in high school two or more times were three times more likely to inflate a claim later in life. Multiple studies conducted since the 1960s have focused on the apparent decline in American morals and ethics. The studies range from cheating and
shoplifting to employer fraud and a general decline in Americans’ willingness to follow what were long held as “societal rules.” The generation that changed these values in their youth now comprises the older demographic, which until now tended to follow more-traditional values.

The insurance industry needs to re-think its historical assumptions while the data continues demonstrating that many older Americans hold onto the criminal habits of their younger days.

**Economic uncertainty**

Economy uncertainty and unwise spending habits also could impel more seniors to insurance fraud to buttress sagging finances and help secure their futures.

Many older Americans today believe they worked hard and fulfilled their responsibility to the American Dream. They also believe their employers and the government have not fulfilled their end of the bargain. These seniors believe they have been cheated out of the rewards of living an honest life.

“The 77 million-strong generation born between 1946 and 1964 is increasingly worried about retirement and their finances in light of the economic crisis of the past three years. Just nine percent say they are strongly convinced they will be able to live comfortably when they retire,” according to an Associated Press poll.8

A large minority of Americans nearing retirement age are ill-equipped financially. One of five has no retirement savings, says a recent survey conducted by the Federal Reserve Board.9

**Home values.** Large numbers of these worried seniors have homes in the Midwest or Northeast, where they raised their families. They want to move to warmer climates but cannot because home values have dropped dramatically.

“There is a concern about whether people will get money out of their house, they envision the home as a problem, not an asset and this unshakable belief as homes for a tool for retirement has been shaken to the core,” the poll also concluded.10

Arson investigators know that cash-strapped people who view their home as a liability instead of an asset are potential candidates for torching the dwelling for an insurance bailout, especially when the insurance policy has a high limit.

“Prisoners are aging as well. The number of prisoners age 65 or older more than doubled, from 1,698 in 2001 to 3,534 in 2010.”

**Large debt.** Many Boomers rang up huge debt by wanting to “have it all” right away during their younger adulthood. Credit was the way to live a lifestyle without waiting. As they now approach retirement, Boomers often still remain less willing to sacrifice now for financial security in their later years. Seniors approaching retirement fear or know they have not saved enough, but equally refuse to cut back on their spending or lifestyle, according to Bank of America’s Merrill Edge report:11

Many seniors fear going broke, yet 33 percent refuse to cut back on entertainment to save money; 30 percent say they will keep eating out, and 28 percent will continue going on vacation.

More seniors (63 percent) also think having money to live “in the here and now” is a priority than seniors who said saving for the future (48 percent) is a priority.

**Social Security.** Uncertainty about Social Security could motivate younger seniors or those nearing retirement to attempt fraud. They are unsure that all of their promised federal funds will be available as they age, according to the New York Times:12
“The Social Security Administration’s rules allow retirement as early as age 62 — an option nearly half those eligible use these days.

But doing so reduces monthly income an average of 25 percent. “Even this option is a dream for those in their late 50s who wonder how to bridge the gap in a virtually dead job market until retirement is possible. With another decade of Boomers still to come, the problems are only going to grow.”

Public-opinion research clearly points to the economy as a fraud driver, regardless of age. Four drivers contribute to insurance fraud: poor service, a difficult economy, the defrauder’s attitude, and consumers’ general attitude toward this crime, says research by Accenture.

Some of the most interesting findings were these: “[A]ccording to the survey of more than 1,000 adults, more than three-quarters (76 percent) of consumers said that people are more likely to commit insurance fraud during an economic downturn than they are in more normal times, up from 66 percent in 2003.

“While 83 percent of the Americans surveyed in 2003 believed insurance companies were capable of identifying or preventing fraud, only 72 percent thinks so today. More than two-thirds of respondents (68 percent) said they believe insurance fraud occurs because people believe they can get away with it, up from 49 percent in 2003.”

At a time when the insurance industry is devoting more effort to battling fraud, it is losing the public-perception battle by a 19-point drop. This amounts to nearly one of every five seniors of the extrapolated U.S. population who believe those who commit insurance fraud won’t get caught.

When people think they can get away with insurance dishonesty, they are more inclined to be dishonest. This fact, plus the perception that people believe they can get away with insurance fraud, are more indicators that insurance scams by older Americans may significantly rise in coming decades.

In this difficult environment, even many normally honest seniors may feel financially pressured enough to view insurance fraud as a convenient and low-risk income supplement. As defined pension plans fade into history and Americans continue grappling with lost investment income, many Boomers could decide it is time for an illicit cash reward from their insurer after paying premiums for so many years without making a claim.

Industry must respond

While the insurance industry has yet to adequately address this potential senior fraud bulge, lawyers, judges and those involved in the criminal justice system are studying the phenomenon. The Stetson Law Review observes:

“Even if the proportion of older persons
committing criminal acts is not increasing, the growth of the elderly population portends an increase in the absolute number of older criminals.16

"Further, a study of the categories in which older persons constitute a higher proportion of arrest than the norm, may suggest areas of discussion about the social and economic situations that caused this concentration."17 The eight categories of criminal activity in which persons age 65 and older constitute a higher proportion of arrests ... help demonstrate the pattern of elder criminality."18 One of the eight areas identified as leading the growing areas of elder crime is "larceny or theft," which would include insurance fraud, the article says.

The insurance industry must begin studying how it can better track information about the age of claimants, their attitudes, and their involvement in fraudulent or questionable claims. Such an initiative also should include actively supporting industry-wide anti-fraud training through insurers and trade associations to insurance employees, vendors, and legal counsel.

Insurers should never “target” the elderly or any group, but should affirmatively share information and statistics factually about age demographics and the need to watch diligently for fraud. Better investigative questioning concerning finances, medical expenses, retirement benefits, and plans to relocate should be a part of a more-thorough analysis of potential claim fraud.

The insurance industry either changes and adapts by better understanding the impact of the largest demographic age shift in recorded history or faces paying possibly many hundreds of millions of dollars in false Boomer claims for years to come.

endNOTES

4 ibid http://www.bjs.gov/content/pub/pdf/fjs10.pdf
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Malingering imposes large costs on insurance companies and society

Greater awareness needed to effectively discourage expensive disability problem

By Dominic A. Carone, PhD, ABPP-CN

In 2008, federal and state disability programs spent an estimated $180 billion on adult and pediatric patients who were probably malingering and $42.85 billion to $55.7 billion on patients who were definitely malingering.1 Malingering is the intentional production of false or grossly exaggerated physical or psychological symptoms (including cognitive symptoms) motivated by external incentives.2 An estimated $20 billion was spent on malingered mental disorders in adults (not counting chronic pain cases) in 2011 by Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs.3

In addition to the enormous primary costs of malingering to these programs starting from the date that disability is granted, secondary costs include retroactive lump-sum payments, attorney fees reimbursed by the Social Security Administration (SSA), and other insurance benefits illicitly received by patients and their beneficiaries (e.g., Medicare or Medicaid).

Some patients who receive SSDI also receive workers compensation benefits or previously had healthcare services reimbursed through traditional no-fault auto, workers compensation or healthcare insurance companies.

A recent study showed that patients who performed poorly on tests measuring the degree of

Abstract: Disability fraud costs in the U.S. recently have been estimated to be as high as $180 billion annually. Despite these and other estimated costs, there is reluctance by healthcare providers, hospital administrators, disability programs, insurance companies, and government officials to adequately address this issue. Reasons why the healthcare system enables exaggeration and malingering are discussed. Information also is provided on when to most suspect exaggeration and malingering. Several proposed solutions are offered to more effectively deal with this problem and the resultant costs to society.
effort applied to neuropsychological testing (one potential explanation of which is malingering) had more emergency-room visits and inpatient hospitalizations (number and length) over a one-year post-evaluation period than patients who exerted adequate effort.4

These findings were not caused by demographic factors or by medical or psychiatric co-morbidities (diagnoses). Possible explanations listed by the researchers included: a) continued unnecessary or inappropriate treatments if a correct diagnosis was not established; b) patients seeking diagnostic clarification; c) poor effort being a marker for treatment non-compliance that results in increased medical care; and/or d) intentional production or embellishment of symptoms.

The extensive costs of malingering in the SSDI system were recently documented by U.S. Sen. Thomas Coburn after a two-year investigation. A disability judge in Connecticut, for example, awarded more than $2.5 billion in federal lifetime disability benefits over a seven-year period after colluding with a local law firm.5 The judge received $96,000 in unexplained cash deposits. The law firm received a portion of the disability benefits and millions of dollars in annual attorney fees from the SSA.

At the judge’s clandestine direction, the law firm obtained signatures on pre-completed disability forms from doctors the law firm favored. The doctors received substantial fees, paid by claimants in pre-arranged deals with the law firm.

The forms often were identical across patients, conflicted with information in the medical charts and clearly constituted counterfeited medical evidence, according to the Senate investigation report. An independent review of 110 of the judge’s case files found that his disability determinations were highly questionable in the vast majority of cases. The judge and law firm retaliated against the SSA whistleblower who exposed these arrangements. The firm also destroyed key documents and computer hard drives during the investigation.

While Sen. Coburn’s report focused on the disability-insurance scheme involving the judge, law firm and doctors, it is fair to assume that a significant percentage of the patients also were willing participants.

In another recent case alleging similar involvement, 138 persons (mostly police and firemen) were indicted in New York City for faking total disability with fraudulent mental-illness claims (e.g., phobias of airplanes and skyscrapers) and cognitive impairment (e.g., memory and concentration problems) related to the 9/11 terrorist attacks.6 Up to 1,000 people are believed to have been involved in the New York City fraud scheme.

Claimants who said they were totally disabled and could not leave their homes were caught flying helicopters, catching large fish in the ocean, holding separate jobs, playing sports, and doing other tasks that totally disabled people normally cannot do. The claimants often posted action pictures on social-media sites such as Facebook. The scheme cost taxpayers an estimated $400 million, making it the largest known disability theft in the history of Social Security.8

Healthcare resources absorbed by patients who exaggerate or malingering also decrease available resources (e.g., disability benefits, healthcare appointments and treatment availability) for patients with genuine maladies.

As a result, some patients with real maladies may not receive timely diagnostic testing and treatment. This could worsen their conditions or delay physical and/or psychological recovery. This is another potential financial cost to consider, as is the rise of insurance premiums from fraudulent insurance claims.9

Overall, the costs of malingering often strain multiple insurance systems simultaneously or in succession.

Healthcare system enables malingering

Many complex interrelated factors explain why “the healthcare system” enables exaggeration and malingering. The enabling typically begins with healthcare providers who fail to assess for exaggeration and malingering or who ignore such
evidence when it surfaces. Reasons why this occurs include:

- Incorrectly believing that a healthcare provider’s role does not involve assessing or addressing exaggeration and malingering;
- Strong patient advocacy tendencies;
- An incorrect default assumption that patients are telling the truth;
- Valuing patients’ self-report, emotionally-laden behaviors (e.g., crying), and clinical judgment over objective data;
- Incorrectly believing that exaggeration and malingering are rare and occur only when there is pending litigation;
- Incorrectly believing that clinical intuition alone can accurately determine if a patient’s condition is valid;
- Not wanting to risk complaints or angry reactions from patients during feedback or after patients read their medical records;
- Pressure from plaintiff attorneys about what medical providers should say or write;
- Collusion-based fraud schemes; and
- Other financial incentives such as a desire to maintain insurance payments for expensive treatment and testing, and maintaining strong referral streams from sources allied with patients at high risk of malingering.

See Carone\(^\text{10}\) for a more detailed discussion of why the beliefs above can be incorrect.

At the hospital administration level, there are strong financial incentives to maintain high patient-satisfaction survey results, including a desire for repeat business and higher Medicare payments.\(^\text{11}\) This can lead to reluctance to support healthcare providers who identify exaggeration and malingering because it risks upsetting the patient.

This reluctance or lack of support can include administrative directives not to comment on exaggeration and malingering. Hospitals also can reflexively side with patients over the healthcare provider if there is a complaint, regardless of the scientific evidence.

At the governmental, insurance industry and political levels, there is not nearly enough oversight and review of cases where exaggeration or malingering most likely has occurred.

For example, SSA policy long has discouraged using the term “malingering” and will not pay for tests (known as effort tests, symptom-validity tests or performance-validity tests) that can identify invalid symptom reporting or performance.

SSA has also omitted the term “malingering” from numerous key publications based on reasons that have been found to lack empirical support, that have been described as inappropriate by Sen. Coburn, and that contradict decades of scientific research and national practice guidelines.\(^\text{12, 13, 14, 15}\)

Financial incentives for these approaches by SSA may include concerns that increased identification of malingering will decrease budget funding in each catchment (geographical) area (depending on the number of claimants) and monetary losses (e.g., withheld pay raises) for examiners who do not conclude cases quickly enough. The latter could happen in malingering cases under appeal.\(^\text{16}\)

At the private insurance level, there has been a lack of insistence that healthcare providers routinely use symptom and performance validity assessment techniques, and document this in the medical records.

**When to suspect malingering**

For the insurance industry, the most relevant external incentives to consider regarding exaggeration and malingering include obtaining
drugs (e.g., prescription pain medications), avoiding work and obtaining financial compensation (e.g., no-fault insurance, workers-compensation wage replacement, disability payments, and personal-injury litigation).

In addition to external incentives, the Diagnostic and Statistical Manual of Mental Disorders-5 specifies that malingering should be strongly suspected when any combination of the following is present:

- Medical-legal context of presentation (i.e., legal involvement such as a personal injury lawsuit);
- Marked discrepancy between the individual’s claimed stress or disability and objective findings and observations;
- Lack of cooperation during the diagnostic evaluation and compliance with prescribed treatment; and
- Antisocial personality disorder.

Specific criteria for malingered cognitive dysfunction have been set forth and were recently revised. The criteria include consideration of various factors such as:

- Poor performance on tests that assess the degree of effort put forth on the examination;
- Ratings on self-report scales that indicate exaggeration or fabrication of symptoms;
- Discrepancy between test data/self-report and known patterns of brain functioning, observed behavior, or reliable collateral reports; and
- Discrepancy between test data and documented background history. It also must be established that behaviors meeting the above criteria are not fully accounted for by psychiatric, medical or developmental factors.

It is important to note that a medical-legal context of presentation also involves patients who self-refer or who another healthcare provider refers in the context of ongoing litigation.

Many healthcare providers wrongly assume that if an attorney does not refer a patient then there is no need to evaluate for exaggeration and malingering. This problem is compounded in clinical settings by “stealth referrals.” In these cases, a healthcare provider ostensibly makes the referral for specialist consultation or diagnostic testing even though an attorney actually originated the referral.

The goal of the stealth referral is for the attorney to avoid legal costs by having the insurance company pay for expensive consultations, testing and ongoing treatments that can potentially support the patient’s claims in a legal proceeding or hearing.

Attorneys also are anecdotally known to tell patients seeking compensation to report symptoms to justify continued therapies, even though the symptoms may be resolved. The basis for this approach is concern that the compensation claim may be compromised if treatment has ended.

As a result, patients may later schedule new appointments at the attorney’s insistence even when therapists have documented no further need for treatment. The insurance company pays for these services under the presumption that treatment is necessary. In fact, treatment may be unnecessary and pursued primarily or solely to support a compensation-based claim.

“Another oddity the specialist notes is that many values given for these works seem unusually low for artists this wellknown.”

It is important to note that many patients suffer from medical conditions that deserve compensation.

A common example is a worker who sustains a moderate to severe traumatic brain injury, spinal cord injury, and/or multiple fractures from a fall at work involving a safety malfunction. Another example is a former CEO who no longer can work in that position due to cognitive and motor impairments from a stroke, and has resultant seizures and vascular dementia.

In such cases, the evidence supporting a moderate to severe injury or medical condition is indisputable based on objective evidence (e.g., radiology scans, pictures of the injured person and physical examinations). This is likely why it is uncommon for compensation-seeking patients with moderate to severe injuries or illness to exaggerate their condition or malingering.

For example, a national survey of neuropsychologists showed that the base rate of probable malingering or symptom exaggeration in compensation-seeking patients was only nine percent for patients with seizures, nine percent for moderate
to severe traumatic brain injuries (TBI), and two percent for vascular dementia.

However, the rate was 41 percent for patients with mild traumatic brain injuries, 39 percent for fibromyalgia or chronic fatigue, and 34 percent for pain or somatoform disorders (physical symptoms that suggest a medical condition but cannot be fully explained by one). Thus, exaggeration and malingering are inversely related to condition severity and objective pathology.

The base rate of probable malingering or symptom exaggeration was only eight percent when the referral type was medical or psychiatric, but 30 percent with referred personal injuries and 33 percent for disability/workers compensation.

Numerous studies consistently show that the base rate of malingering in settings where external incentives are present is around 30-50 percent. Consistent with this, the base rate of effort test failure was 48 percent during occupational-therapy evaluations in a medical-legal context, a recent study showed.

**Proposed solutions**

**Greater awareness**

1) Insurance companies and disability programs must be more aware that compensation-seeking patients with claimed injuries or illnesses with no (or mild) evidence of pathology are at highest risk for malingering and exaggeration. Use of anti-fraud detection software such as predictive analysis can be helpful.

2) Private insurance companies should require patients to notify them if they are (or later become) involved in litigation, retain an attorney, or file a disability claim involving a known or alleged health condition being evaluated and treated by a healthcare provider the insurance company is reimbursing.

3) Public officials serving on healthcare committees on the state and federal level should be the focus of lobbying efforts to increase awareness about this issue and pass anti-fraud legislation.

**Stricter/new policies**

1) Insurers should require performance validity and symptom validity assessments in patients who claim cognitive impairment, especially if they are in the high-risk groups mentioned above. Assessments also should be required for patients with physical impairment/disability claims, especially for high-risk patients.

Clinical neuropsychology is the profession best-equipped to assess exaggeration and malingering, and can help redirect resources to more appropriate venues (e.g., psychological counseling instead of years of unnecessary medical testing and treatments). This discipline should be used more often.

2) Patients at highest risk of exaggeration or malingering should receive the most scrutiny (e.g., independent file reviews) before excessive diagnostic testing, specialty consultation and treatments are authorized. Based on national base-rate data, the patient groups needing highest scrutiny have identifiable external incentives (especially compensation-seeking patients). The patient groups at the highest risk for malingering on neuropsychological evaluations are those who report chronic symptoms after mild traumatic head/brain injury (e.g., “post-concussion syndrome”), patients reporting chronic pain (e.g., “fibromyalgia,” low back pain), patients diagnosed with chronic fatigue syndrome, and patients claiming to suffer from neurotoxic disorders (e.g., “multiple chemical sensitivity”).

The official process for review and authorizations/denials should be established in new policies or guidelines, without identifying specific assessment procedures. The process should include a formal appeals mechanism that includes independent review by experts in symptom/performance validity assessment.

3) To reduce stealth referrals, insurers should require healthcare providers to clearly document in progress notes the reason for referral and medical necessity. Healthcare providers should be required to document if the reason for referral originated with an attorney.

4) Insurers should refer more patient insurance-fraud cases for prosecution when there is compelling evidence.

5) For more anti-fraud measures (e.g., formal anti-fraud training, data-analytic programs) see the recent report by the SSA Commissioner.

In summary, malingering is a difficult problem for the insurance industry to deal with and can easily go undetected without more awareness and concerted efforts to minimize its expensive and extensive impact.
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Insurers advancing fraud fight with advanced high-IQ technology

Tools counter emerging threats as fraud increases, insurers say in study

By Dennis Jay

Technology is an essential force in combating fraud. Financial industries such as credit cards, banking and investments deploy highly evolved analytics to structure defenses against virulent fraud schemes and cyber attacks. Many billions of dollars are saved. Fraud mitigation also has a stabilizing effect on America’s economy, and saves costs to consumers.

Technology has become an increasingly disruptive force for insurers in recent years as well. This is an expansive era for innovation of intelligent technology against the insurance-fraud pathogen. The firepower is increasing.

Modern tech weaponry can readily break open the most complex fraud rings. In turn, strong detection can deter fraudsters who perceive a given insurer as an unacceptably high-risk, low-reward target. The claims cycle also shortens as more fraud is purged. Staff can process legitimate claims more efficiently with fewer false claims to impede their workflow. This lowers costs and improves customer service.

Abstract: Technology is an increasingly disruptive force for insurers in combating insurance fraud. Innovation is necessary: Suspicious activity has risen in the last three years, more than half of responding insurers say in a study by the Coalition and the technology company SAS. Slightly more than half of responding insurers also agree that uncovering complex or organized fraud is a perceived benefit of technology. About one-third of insurers use technology to counter premium evasion at policy inception. Only 14 percent of insurers use anti-fraud analytics to counter cyber threats, but that total is expected to rise. Growing numbers of insurers use more-advanced weaponry such as predictive and link analysis. Higher-quality case referrals and more referrals were the leading perceived benefits of anti-fraud technology. A carefully crafted strategy using custom-bundled tools tailored for each insurer’s anti-fraud challenges can lead to more-accurate pricing, a competitive edge and lower pressure on rates for policyholders.
Not surprisingly, insurer use of anti-fraud technology is rising, more insurers see a positive ROI and they increasingly rely on technology to counter emerging threats.

These three insights among the findings of a just-released study, The State of Insurance Fraud Technology. It was conducted by the Coalition Against Insurance Fraud, with assistance from the business-analytics company SAS. More than 40 insurers took part, representing nearly 80 percent of the property-casualty market. This study follows up a nearly identical survey conducted in 2012.

The timing for expansion is right. Suspicious activity rose over the last three years, more than half of responding insurers agree. Precise figures for total dollar losses are elusive, though most observers agree insurance crime steals tens of billions of dollars a year.

Continued growth and innovation in anti-fraud analytics thus is a business imperative. This is a dangerous world. Attempted fraud flows throughout the policy cycle. Scamming starts during the application and renewal process and thrusts on through claims-handling.

Yet armed with increasingly advanced analytics, insurers are becoming more effective in breaking open fraud schemes of all shapes and sizes.

**Emerging threats**

Insurers mobilize analytics to identify and counter emerging threats. Tech weapons can be an insurer’s eyes and ears as these tools sift through data that’s often hidden from human eyes. Several threats the study surveyed:

**Organized rings.** Sophisticated rings form a recurring theme of the study. In fact, slightly more than half of responding insurers agree that uncovering complex or organized fraud is a perceived benefit of technology – about the same as in 2012. Money-laundering is a hallmark of organized rings, and about 25 percent of insurers now use technology to detect money washing.

The findings reflect an important and shifting reality. Organized fraud rings have operated widely for decades, but appear to be spreading at an accelerating velocity and volume.

Major fraud also is transiting from arson and fake auto thefts to spurious bodily-injury claims by medical providers often aligned with complex rings. This is especially true of automobile and workers compensation, where medical mills are an established presence.

A stream of high-profile cases involving large rings in recent years bears this out. One prominent example is a behemoth ring of mostly Russian immigrants based in New York City. The operation recently tried to steal more than $400 million in false injury claims from phantom and setup vehicle crashes. It was the largest auto-fraud scheme in U.S. history.

**Point of sale.** Insurers see increasing plots involving insurance applications and renewals – so-called point-of-sale fraud. About one-third of insurers use technology to counter premium evasion at policy inception, the study shows.

This crime is most common with online purchase of insurance, where automation and anonymity can be a stealth advantage for insurance thieves. Fraudsters can test system thresholds, for instance, by completing different applications online. A significant volume of claims fraud is done through illegally obtained policies, analysis suggests.

In another frequent version, drivers illegally register and garage their vehicles in states or local counties with lower premiums. Drivers in high-premium New York City, for instance, have falsely registered their vehicles in lower-premium states such as Pennsylvania and North Carolina.

**Cyber fraud.** Large-scale uber-hacking is another emerging threat. Insurers collect vast quantities of data that are valuable to identity thieves. Recent high-profile breaches of databases in health insurance, retail and other industries underscore the
potential of cyber attacks to steal the identities of tens of thousands of customers at a time. Damage to an insurer’s brand is a related fallout.

Yet only 14 percent of insurers use anti-fraud analytics to counter cyber threats. The number of insurers using technology of against cyber attacks, however, is expected to rise significantly in the next few years.

**Advancing advanced tools**

The study reveals a relatively wide insurer use of more-advanced tech weaponry. The traditional and most-basic first lines of tech defense are automated red flags/business rules. The large majority of insurers (81 percent) still use such tools. They are primarily adept at spotting warning signs of relatively lower-dollar “soft” fraud such as inflating the theft of a few possessions from a car. But red-flagging also can generate too many false positives.

Growing numbers of insurers are gravitating to more-advanced weaponry. These analytics are more accurate, detect schemes faster and earlier in the claims cycle, and can interpret larger volumes of data. Modern platforms also are especially skilled at upending complex, organized schemes. Many insurers thus are taking a more-assertive approach intended to place serious fraud offenders squarely on the defensive, the study findings suggest.

**Link analysis.** Nearly half of insurers (45 percent) say they plan to expand their use of link analysis over the next 12-24 months. This is more than double their 2012 planned output, and is where the most insurers in the study forecast tech expansion. Link analysis can be effective in spotting seemingly obscure relationships among ring members. Workers compensation rings with dozens of attorneys, doctors and chiropractors, recruiters and fake injured car passengers are prime targets for link analysis.

**Predictive modeling.** Nearly 40 percent of insurers plan more investments in a platform that can help identify suspicious claims in closer to real time, and even project a scheme’s likelihood of occurring. The time-space continuum thus compacts. Much of the latest innovation and public attention has centered around predictive modeling and its great potential.

**Text mining (43 percent).** Insurers can unearth large volumes of unstructured data embedded throughout the enterprise. This trove of valuable case leads has been largely inaccessible using older analytics.

Scripted comments in claim notes, adjuster field notes and call-center logs can be identified via text mining. Claimants, for example, who all have the same medical-treatment records for purported crash injuries can be exposed.

**Data visualization (40 percent).** Insurers can rapidly spot shifts in tactics, targeted product lines and other variables. To avoid detection, many fraudsters continually change tactics by actively testing rules and thresholds. Fraud rings sometimes move to another region or product line when insurers and law enforcement place enough pressure against targeted cons.

When insurer law-enforcement pressure grew too effective against no-fault medical fraud rings in
South Florida, some moved operations to Georgia and Kentucky, which they perceived as easier targets. Data visualization enables insurers to rapidly recognize such shifts.

Building the business case

Technology also appears to be making a stronger business case for investing in anti-fraud analytics. One-quarter of insurers plan to expand their technology investments in the next 12-14 months. They appear to see a clear ROI. Only eight percent said lack of ROI was a challenge to implementing technology, compared to 36 percent in 2012.

Despite increases in suspicious activity, many insurers also face chronic shortages of SIU professionals and claims adjusters. Technology is helping offset these deficits, thus further bolstering the case for a strong ROI.

In fact, the perceived benefits of anti-fraud tech were higher across all categories compared to 2012.

Data is king

Data is the most-valuable commodity for anti-fraud technology. Modern analytics need quality, high-volume data to function optimally. It is fuel in the technology gas tank.

The term Big Data is the much-used watchword for the immense amount of data insurers can store and cull for interpreting by high-performance analytics. The volume of structured and unstructured data flowing into insurers has increased dramatically in the last few years. So has the variety of information. Insurers need high-performance analytics to manage the influx of Big Data and unearth hidden fraud patterns.

It follows that effective sources of data are important commodities in driving fraud investigations as well. Insurers listed these data sources:

- Industry fraud-watch lists (67 percent);
- Public records (45 percent);
- Unstructured data (38 percent);
- Third-party data aggregators (29 percent);
- Social media (14 percent); and
- Connected devices such as telematics (5 percent).
Mining social media and mobile devices such as smart phones are two of the more recent trends. Though their response rates were the lowest of surveyed data sources, these tools are relatively new and still catching on. Their upward trajectory likely will increase in the years ahead.

Social-media analytics automate searches for evidence across hundreds of social sites such as Facebook and Twitter, thus replacing slower manual searches.

These platforms can discover relationships among staged-crash ring members who deny to insurers that they know each other.

Workers compensation insurers also routinely mine postings on social media and mobile devices that might shed light on employees who may be faking workplace injuries to steal insurance money. Vacation photos of a surfing trip to Hawaii are incongruous with a claimed serious back injury at the loading dock.

Importantly, social searches also can validate injury claims.

**Hi IQ quotient**

The ability to adjust and self-learn as data pours in is a hallmark of evolved analytics. In this way, intelligent technology can continually identify shifts in tactics by fraudsters. It also can better define the structure and participants of criminal operations such as workers-compensation medical mills.

Increased intelligence also enables investigators to detect schemes earlier in the planning and execution stages, and even before planning begins.

Insurers must be nimble and continually adaptive in order to combat equally adaptive fraud criminals. Optimal technology involves crafting an integrated strategy of custom-bundled tech tools pinpointed to each insurer’s unique anti-fraud challenges.

The right mix will result in better fraud detection — and deterrence. Some medical fraud rings have warned operatives to avoid certain insurers with reputations for rigorously examining claims.

Yet for all of its high IQ, technology still depends on astute boots on the ground to stay relevant. Investigators, analysts and other anti-fraud professionals must interpret and make sense of the findings. And investigators, not analytics, are the ones who follow up case leads on the streets.

Properly chosen and mustered analytics managed by well-trained anti-fraud professionals will go a long way toward cutting insurer fraud losses. The benefits will lead to more-accurate pricing, a competitive edge and lower pressure on rates for policyholders.

**About the author:** Dennis Jay is executive director of the Coalition Against Insurance Fraud.
Coalition defends right to sue suspects in Illinois

An Illinois lower court’s mistakenly narrow ruling preventing a whistleblower from suing an allegedly crooked medical clinic will weaken the state’s whistleblower law and undermine anti-fraud efforts in the state, the Coalition argues in an amicus brief filed in early September in the state appellate court.

Physical therapist Jocelyn Zolna-Pitts believed the clinic where she worked was illegally overbilling insurers for sessions. She filed a civil suit. But the state’s whistleblower law didn’t intend for an individual to bring civil cases, the lower court ruled. Not so fast, the Coalition argues in supporting Zolna-Pitts.

The law’s clear wording and legislative intent allow private citizens to sue. Whistleblower laws such as Illinois’ were created to encourage concerned citizens to step forward with valuable information that could break open fraud operations, the Coalition says.

“If the allegations of the complaint prove true, the Plaintiff will have notified the government of a significant fraud that it otherwise failed to detect and prosecute – the very purpose and design of the Act,” the Coalition argues. “The countervailing judgement of the Circuit Court limits the types of fraudulent conduct that private plaintiffs could bring under the Act – running contrary to the text, structure, purpose, and history of the Act.”

Kentucky law barring soliciting of crash patients overturned

Fraud fighters recently were dealt a setback when a federal district court shot down a Kentucky law barring any solicitation of motorists for 30 days after the crash. Kentucky enacted the law in 2011 to halt fraud rings from steering innocent crash victims to medical mills for bogus crash treatment.

A recruiter for “1-866-GET-PAID” approached two Louisville crash passengers. State Farm denied the ensuing treatment claims. But the law violates the free-speech clause of the First Amendment, the federal district court ruled. The ruling also delayed until next year a legislative effort to clarify the law.

The decision collides with efforts by insurers to shut down ambulance chasers who illicitly pressure often-traumatized crash victims to visit a specific clinic that renders false and even medically dangerous treatment.

Anti-solicitation laws buy time for the crash victims to regroup and make better-informed and clear-headed decisions about where to obtain treatment.

Dishonest clinics often hire recruiters to show up at crash scenes or to research police accident
Some crash victims are unwitting pawns of medical mills. At least 20 states have laws banning solicitation of crash victims and recruiting for staged-crash schemes, or limiting outsider access to police crash reports.

A federal Texas ruling in June 2011, however, set a supportive precedent if the Kentucky decision is appealed.

The Texas law barred recruiters from contacting accident victims for 30 days after an accident. Two chiropractors challenged the law.

Protecting crash victims from solicitation by dishonest chiropractors during that 30-day period is a “substantial” state interest, the Fifth U.S. district appeals court in Texas ruled in upholding the statute. [Donald McKinley; Christopher Villasana v. Greg Abbott. U.S.; Court of Appeals for the Fifth Circuit; No. 10-50568]

Meanwhile, the Arkansas attorney general is taking aim at allegedly illicit recruiting. He is suing the suspected puppeteer of a ring that recruited crash victims from police reports.

Chiropractor Roger Pleasant’s suspected fraud ring members phoned victims day and night, the AG says. Recruiters also showed up at victims’ front doors.

Posing as agents, adjusters or employees of the at-fault party’s insurer, the recruiters tried to coerce victims into getting treatment at Pleasant’s clinic.

The treatment often was medically worthless and defrauded no-fault insurers. The AG is trying to shut down the suspected ring.

Journalists start fast probes of newly released Medicare data

Medicare’s transparency-driven release this spring of medical-provider billing data immediately spawned months of investigative news stories around the U.S.

The investigations are uncovering anomalous billings by local medical providers and patterns of state sanctions.

The data trove covers more than 880,000 health care providers in all 50 states, the District of Columbia and Puerto Rico. Collectively, the providers received $77 billion in Medicare payments in 2012.

Releasing the data could help uncover fraud and help consumers better understand pricing, consumer advocates say. But patients could jump to the wrong conclusions, countered other medical groups such as the American Medical Association, which opposed the release.

Regardless, reporters were among first responders.

A doctor who treats degenerative eye diseases in seniors received $21 million from Medicare in 2012, Bloomberg wrote. That is twice the amount received by the next ophthalmologist.

The San Francisco member station of NPR identified an emergency-medicine doctor in Southern California who averaged 30 of the most complex office visits per patient in 2012.

The state medical board also had placed him on probation in 2006 for “repeated negligent acts, incompetence, making false statements and inadequate record keeping,” the station alleges. His probation was extended last year after he was accused of violating the terms of his prior sanction.

The Chicago Tribune delved into a neurosurgeon who was indicted earlier this year. He allegedly
over-billed for the most complex office visits and indiscriminately prescribed controlled substances. The doctor billed for these visits more than 75 percent of the time in 2012, the Tribune said. The doctor disputes the allegations.

In Texas, 10 of the 77 medical providers in the state who almost exclusively billed for the most-expensive office visits in 2012 “have been fined or otherwise sanctioned by the Texas Medical Board,” said the Dallas Morning News. A Laredo doctor was sanctioned three times, most recently in 2013, the news outlet said.

**Spinal implants challenged in lawsuits against surgeons**

Medically worthless screws and rods were implanted in patients, causing excruciating pain. These are among the charges in a flurry of lawsuits and other actions aimed at a $500-million criminal health-insurance scheme based in Southern California. The suits are notable as ongoing collateral from one of the largest insurance schemes in recent history. The actions also have drawn attention for the gruesome allegations and claimed danger to the victims’ lives.

At stake are so-called spinal-fusion surgeries. Doctors implanted substandard rods and screws in patients’ backs, supposedly to relieve pain, officials say. An elderly machinist allegedly handcrafted the devices. They were substandard, below surgical grade and dangerous, suits allege.

Medical providers fraudulently overbilled insurers for the devices and treatments, lawsuits allege. A firm called Spinal Solutions is embroiled for allegedly distributing the devices to medical providers.

Some doctors also took kickbacks, including cash, sports memorabilia, prostitutes and private plane rides. Middlemen and hospitals profited by inflating the screw costs, according to a Sacramento lawsuit.

The latest action widens the scandal surrounding a Corona del Mar hospital executive who pleaded guilty in April to paying doctors to bring in patients. Michael Drobot also bribed former state Sen. Ronald Calderon to craft legislation that helped keep huge insurance payments flowing.

The lawsuit says the knockoff spinal implants threaten patients’ lives because they could contract an infection. Some allegedly fraudulent screws cost $300 to make but were billed at as much as $12,500 each.

In a related move against the suspected ring, the California medical board cited Dr. Jack Akmakjian in April for allegedly injecting unsafe amounts of steroids in patients and over-prescribing drugs involving the mammoth scheme.
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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