3 Transnational crime gangs make fraud a global epidemic

Insurance fraud increasingly is becoming riddled with large transnational rings, and also is a terrorism-financing vehicle. Complex rings come from melting pots of nations, and often a ring may have members from several countries.

By Steve Barkhuizen

10 No-fault auto: worth saving?

No-fault auto insurance is driven by laudable goals. Auto insurers promptly pay fair medical costs of their own injured policyholders, regardless of who causes the vehicle crash. Convenience and fairness increase, pressure decreases.

By Walter Dartland and Peter Foley

16 Health reform may shift costs to property-casualty insurers

Fraudulent claims will accompany the inflow of 38 million new policyholders by mass-shifting of medical conditions and costs as doctors and other health providers try to recoup declining revenue in the traditional model.

By Dr. Rick Wakefield, JD, DC, PA

21 Benchmark study reveals SIUs are significant insurer contributors

For years insurers have sought to understand the norms for structuring, staffing, funding and measuring their special investigation units. Such guidelines haven’t been developed for a variety of reasons.

By Dennis Jay

28 TrendWatch: new developments about fraud in America

Politicians bribed by lure of large insurance payouts ... Stories, visuals bolster deterrent outreach messages ... Fatal case highlights challenges to arson forensics.

By Coalition Staff
Health reform may have an unexpected impact: As health insurers weed out expenses, healthcare providers may try to make up for lost income by dishonestly shifting claims to auto and workers compensation insurers. Cost-shifting could become one of the next big anti-fraud frontlines, writes national lecturer Dr. Rick Wakefield.

Can no-fault auto insurance survive amid rising claims and spiraling system costs in key states? Or should no-fault be scrapped and the policies used for spring mulch? JIFA asked leading Florida consumer advocate Walt Dartland to square off against Peter Foley with the American Insurance Association. Who wins? You make the call. Fraud is globalizing, like every larger industry seems to be doing, writes Steve Barkuizen with KPMG. A fraud ring headquartered in Dubai might recruit footsoldiers in Germany and Palestine, and managers in Nigeria. They might prowl for victims on three continents. Get used to it, with a twist. Terrorists are bilking insurers to finance their bomb-driven agendas.

Today’s fraud underworld is growing more cavernous, and angling to steal vaster sums of insurance money in a heartbeat. JIFA defines the newest fraud trends. But more important, JIFA experts are showing how to shrink that cavern down to size.

Sincerely,

Dennis Jay
Insurance fraud increasingly operates at
the level of organized transnational crime
rings. In some cases terrorists and even
national governments use insurance schemes to fund
illicit activities.

Insurance schemes are part of a modern global
crime nexus that steals an estimated $1 trillion per
year.¹ Criminal groups based in nations throughout
the globe are exploiting the interlinked nature
of modern trading, transportation, banking and
monetary systems that fluidly move people and
commerce throughout the global economy and
across international borders.

Growing symbiotic connections among crime
cartels such as drug cartels, terrorists, largescale
insurance fraud rings, cyberthieves, crime syndicates,
criminal state actors and other players seek
sophisticated ways to use each other’s networks and
skill sets for mutual profit in the subterranean global
criminal economy. Often they exploit porous, broken
or developing nations. Their growing infiltration
of lawful commerce threatens free markets and
financial systems critical to the stability of the
global economy.

There are no firm estimates on how much

**Abstract:** Insurance fraud increasingly is becoming riddled with large transnational rings, and also is
a terrorism-financing vehicle. Complex rings come from melting pots of nations, and often a ring may
have members from several countries. They effectively hide their operations behind networks of shell
companies, front companies and offshore financial centers. Russians are America’s top domestic crime
threat. In fact a Russian-dominated gang tried to steal $400 million in false injury claims from staged
crashes in New York. The Italian Mafia has been linked to staged crashes in Italy. An international
vehicle-fraud ring tried to fund Chechen separatists. Insurers must see the bigger global picture and
motives when dealing with claims. The aim should be to deprive complex rings the networks, resources
and funding needed to maintain their operations.
The U.S. is a natural target of schemers within this context. More than 7,000 U.S. insurers collect at least $1 trillion in premiums each year. This vast size contributes significantly to the cost of insurance fraud by providing more opportunities and bigger incentives.

Insurance fraud in the U.S. (excluding health insurance fraud) exceeds $40 billion per year. Healthcare fraud adds tens of billions more. Both sectors are frequent targets of transnational gangs, though firm data on the trend is unknown.

A global crime ring defrauded 70 U.S. insurers and made in excess of $11 million in false workers compensation claims. Ring members used a network of 19 fictitious medical clinics and stole the identities of thousands of victims to submit false claims. They used stolen doctors’ identities to create false medical reports. The final convictions were handed down in 2011.

The crime proceeds were laundered through Dubai, Armenia and the Philippines. Ring members hailed from Iran, Germany, The Philippines, Mexico and Armenia.

Some 102 members of another international crime group called Armenian Power were arrested in the U.S. for no-fault auto-insurance fraud, among other suspected crimes. The ring was closely tied to a so-called Thief-in-Law — a high level Russian criminal figure who offers protection, prosecutors say. The ring allegedly dealt directly with high-ranking Armenian/Russian crime figures abroad and in the U.S. Among other insurance scams, ring members allegedly owned Florida clinics that made phantom or needless treatments for supposed injuries from staged crashes.

Check fraud, kidnapping, extortion, illegal gambling and identity theft were among the other crimes the vast operation managed, the U.S. Justice Department alleges in a coordinated multi-state series of busts.

Another Armenian-American crime group with ties abroad made more than $100 million in bogus health-insurance claims against Medicare and other insurers. The operation ran a network of 118 clinics across 25 states. The group’s chief, Armen Kazarian, was the first Thief-in-Law convicted of racketeering.

“Consistently, we see [fraud rings] exploit shell companies, front companies, offshore financial centers, and free trade zones.”
in the U.S. and received 37 months in federal prison. The ring "puts the traditional Mafia to shame," said U.S. Attorney Preet Bharara. Insurance schemes in the U.S. may be orchestrated by shadowy overseas players. Florida is home to numerous insurance-fraud rings whose members originate from a melting pot of nations.

"These organizations are using part of this money for other things. It's been documented through investigations of this money leaving the county, leaving the state of Florida, whether it be back to Cuba, Mexico, the Cayman Islands, Costa Rica. So it's a lot bigger than what a lot of people understand, and the fact is that it's not just a staged crash and it's not just insurance fraud," Det. Ronnie Cooper, a special investigator with the Hillsboro, Fla. sheriff's office, said in testimony about organized crime to the Florida state legislature last year.

Russians are the top U.S. domestic organized crime threat, says the nonpartisan Congressional Research Service. In fact, a Russian-dominated ring in New York City tried to steal $400 million in false injury claims from setup and phantom car crashes.

"In the United States, Russian organized criminals are involved in long-established organized crime activities such as ... white-collar criminal activities including money laundering and fraud of various types," says an analysis by the federal Congressional Research Service.

"The types of fraud and scams that Russian criminals participate in cross industries from health care and strategic commodities (e.g., precious metals) fraud to credit card, insurance, securities and investment fraud." [italics added]

State-sponsored insurance crimes are an emerging threat as well. The cash-poor North Korean government allegedly has stolen hundreds of millions of dollars by scamming international insurers.

North Korea has orchestrated suspicious reinsurance scams involving disasters such as transportation accidents, floods and factory fires, according to experts. The reinsurance covers the state-owned insurers.

In one incident, a North Korean ferry sank off the coastal city of Wonsan, causing the death of 129 people. The North Koreans claimed that all passengers were automatically given insurance when they bought the tickets. The reinsurance claim amounted to $6 million. The North Koreans denied the insurers' own divers access to the wreck.

In another case, the regime's state insurance company may have exaggerated the damage caused by widespread flooding to steal monies. A photo issued by government officials purportedly showing victims wading in floodwaters was altered. Among the seeming disparities, the so-called flood victims were strangely dry. The Associated Press withdrew the image.

The UK has identified nearly 5,500 organized-crime groups comprising 37,000 people. They commit economic crimes such as insurance fraud in the UK. Overall, these diverse operations steal at least £24 billion a year.

As distinct from local urban street gangs, organized crime rings often maintain close ties with rings in other nations. Much of their work involves moving goods across the UK's borders. Overseas groups also are operating within the UK.

Organized fraud rings contribute heavily to a larger fraud picture in the UK. In general, undetected bogus claims fraud cost the UK an average of £2.1 billion a year, adding about £50 to every insurance policy, estimates the UK's central agency, the Insurance Fraud Bureau. The IFB coordinates action against organized insurance fraud, and currently is investigating cases valued at over £1.2 billion. General insurers in the UK identified 133,000 fraudulent claims in 2010. This equates to 2,500 claims a week.

Motor fraud is the most organized and costly. The
most common form of motor fraud in the UK involves staging fake accidents or luring innocent motorists to collide with the fraudsters by slamming on brakes at roundabouts and junctions. The fraudsters then exaggerate damage and injuries, and claim expensive medical treatment, vehicle storage and repair costs, loss of earnings and hired rental cars. Such claims can cost UK insurers up to £30,000 per claim.

Transnational gangs are involved in the lucrative trade. Staged crashes by organized crime steal £1 billion in the UK each year, says a report by the European Parliament in September 2013. In fact organized crime is the top concern of UK insurers. There is increasing concern in UK insurance anti-fraud circles about the use of so-called “accident management companies” (AMCs). In October 2011, for example, six men were convicted of submitting 120 false accident claims worth £2 million through a number of sham AMCs set up solely to submit the claims.

False claims worth £440,000 were submitted via AMCs in another conspiracy. None of the accidents happened. A gang of 26 men that staged and induced more than 92 accidents worth £1.6 million was arrested for staging car crashes and making fraudulent claims.

The Italian Mafia allegedly also has been linked to staged crashes. A Mafia clan in Southern Italy faked hundreds of wrecks a year to steal millions of Euros annually in false injury claims and car repairs, prosecutors charged in a massive bust in July 2013. Local insurers, doctors, lawyers and auto-repair shops allegedly were involved.

The stolen insurance money allowed the reputed local mob boss Guiseppe Giampa to buy guns and drugs, and pay his “employees.” Incredibly, Giampa turned informant on his own suspected insurance scheme.

Insurance fraud also funds terrorism. The absence of reliable government and other legitimate means of funding terror forces terrorists to resort to crime. Much involves white-collar crime, including insurance schemes. Terrorist activities require funding for weapons and bomb-making, and for training, travel and living expenses. The need for anonymity during planning of terrorist activities also requires deception such as false identities.

A Google search brings up hundreds of examples of diverse white-collar crimes that terrorists commit. For example, Imam Samudra, the so-called Bali Bomber, raised $150,000 by hacking bank accounts and credit lines.

It is logical that terror rings also might look to insurance fraud. The extent of fraud as a terrorism-funding vehicle, however, is unknown.

Two Germany-based al-Qaeda members plotted to fake the death of one plotter in a car crash in Egypt to collect more than $6.1 million in a massive life-insurance con. Most of the money would help fund al-Qaeda activities. The purported crash victim, a Palestinian, then would continue to Iraq as a suicide bomber. The main plotter was a reputed al-Qaeda recruiter in Europe and received seven years in prison in Germany. The Palestinian received six years.

“Hezbollah has also become well-integrated in the domain of transnational organized crime, deriving profits from a wide range of illicit enterprises.”

Members of a UK-based terror cell recently were caught in the early stages of plotting a bombing attack on London. They planned to use insurance money by faking injuries from setup crashes to help fund the alleged plot. “Whiplash for the sake of Allah,” one member said under wire tap. They pleaded guilty to terror-related charges.

Insurance-terror cases only occasionally surface publicly in the U.S. Law enforcement likely keeps such cases classified and behind closed doors due to national security concerns. The few cases that do go public paint chilling portraits of how terror groups are trying to exploit U.S. insurance systems.

Ahmed Hannon was convicted of insurance fraud and material support of terrorism in connection with his “economic jihad” scheme to defraud auto insurers with fake injuries for a minor auto crash. He provided fake invoices for medical bills, lost wages and rental-car costs.

Hor and Amera Akl torched a Jeep Cherokee
to collect more than $17,000 worth of insurance money as part of a scheme to help smuggle funds to Hezbollah.\textsuperscript{23}

An international vehicle-fraud ring helping fund Chechen separatists was broken up in Los Angeles. Owners of more than 200 vehicles lied to insurers that someone stole their vehicles. The vehicles were registered to Los Angeles residents and hidden in shipping containers destined for the Republic of Georgia. Upon arrival, they were sold for several times their value, and the money aided the Chechen rebels seeking a separate state from Russia.

The LAPD, FBI and Georgian authorities broke open the suspected scheme by uncovering 14 hidden late-model SUVs that had arrived in Georgia in shipping containers labeled “aid.”\textsuperscript{24}

The terror-funding connection in an earlier insurance case is largely circumstantial but noteworthy. Musa and Ahmad Jebril bought 13 houses and two apartment buildings in the Detroit area using false identities and documentation to secure mortgages.

The father-son team also opened bank accounts in the names of non-existent companies to handle incoming funds raised from renting the properties. They insured the buildings for more than their market value, vandalized them and submitted false insurance claims for the damages.

Their activities took place over a 15-year period, and their support for terrorist activities covered the same timeframe.

The Jebrils were convicted of 42 counts of fraud. They also were being investigated for promoting and supporting terrorism, and teaching radical Islamic anti-U.S. classes in their Michigan home. A fax was sent to CNN after the 1995 bombing in Riyadh, Saudi Arabia that killed four Americans. The fax praised the bombing and was traced to the Jebrils’ home.\textsuperscript{25}

Members of the terrorist group Jamaat Ul Fuqra raised more than $355,000 through workers compensation fraud to buy a terrorist-training compound in Colorado.\textsuperscript{26}

The group was organized in Pakistan by Sheikh Mubarak Ali Jilani Hasmi and established in the U.S. Fuqra’s training manuals contained instructions on how to commit forgery, counterfeiting and other deception. The suspects were convicted of the workers compensation and other fraud schemes that spanned more than seven years.

Fuqra was suspected of involvement in at least 13 murders and 16 bombings between 1980 and 2004. The first investigation was initiated by the FBI in 1983. It came in response to a murder and double firebombing in Detroit. The probe led to the discovery of a storage locker containing documents. Those investigations uncovered the workers-compensation scheme.

So why have insurance investigators not been completely wise to the terror-funding threat? Probably because the biggest misconception is that terrorist groups need millions of dollars to fund their activities.

“Part of the problem is that it takes so little to finance an operation,” says Gary LaFree, director of the University of Maryland’s National Consortium for the Study of Terrorism and Responses to Terrorism.\textsuperscript{27}

The 2005 London bombings cost only about £15,000 and the bombing of the USS Cole in 2000 cost around £5,000. Insurance fraud can easily raise this level of funding, given the cost of a typical crash for cash claim.

The FBI and other government agencies have pursued insurance fraud-terror links for some time. The threat of terrorism became America’s main security concern following the 9/11 attacks. Several laws have been enacted or modified since then, including US-Patriot Act, Border Security and Visa Entry Reform Act, and several federal fraud statutes, in an attempt to curb terrorist funding.\textsuperscript{28} Drug cartels have used life insurance to launder much of their criminal proceeds.

“Federal law-enforcement agencies discovered Colombian cartels were using drug proceeds to buy life-insurance policies, which were subsequently
About the author: Steve Barkhuizen is a Senior Manager (Forensic: Insurance) at KPMG, London and is an accomplished financial crime, fraud and sanctions practitioner. He specializes in insurance, with experience in the UK, Europe, Middle East, Asia and Africa. Before joining KPMG, Barkhuizen was a Financial Crime Manager at a UK general insurer. He developed the firm’s financial crime strategy and award-winning process for investigating and detecting automobile claims fraud (Personal Lines Claims Fraud Initiative of the Year: 2010 Insurance Fraud Awards).
endNOTES

3 ibid.
6 Federal Bureau of Investigation estimate.
8 Leader of Armenian Organized Crime Ring Sentenced in Manhattan Federal Court, news release, U.S. Department of Justice, February 8, 2013.
9 Legislative testimony ties PIP fraud to organized crime, WFSU, December 9, 2011.
11 Insurance Fraud By North Korea Outlined, Blaine Harden, Washington Post, June 18, 2009.
13 Fraud Linked to Flood Photo, Radio Free Asia, August 1, 2011.
26 The Fraud-Terror Link, Frank S. Perri, JD, CFE, CPA, Fraud Magazine, July/August 2010.
No-fault auto insurance is driven by laudable goals. Auto insurers promptly pay fair medical costs of their own injured policyholders, regardless of who causes the vehicle crash. In theory people get quick treatment without haggling and expensive lawsuits over who caused the accident. Convenience and fairness increase, upward pressure on premiums decreases.

No-fault systems are in place in 12 states today. Others such as Colorado and Georgia have opted out and returned to fault-based coverage. Each state must determine whether no-fault is a good fit.

My own state of Florida shows how many ways no-fault can be broken — and how many ways the system potentially can be fixed. It is a Petri dish that America should watch closely.

Auto premiums are so high and the system is so abused that some Florida insurers would rather repeal no-fault. But they would return to a failed insurance system, the same fault-based one that prompted Florida’s shift to no-fault in 1971.

Pressing the eject button is premature. Recent reforms and stepped-up enforcement are starting to show results. Let’s resist the impulse to bolt while system reforms are gathering momentum.

Consumer frustration is understandable. Florida drivers pay an average annual premium of $1,090, the 4th highest state in America. The bodily-injury limit is just $10,000.

Fraud is one of the largest no-fault cost drivers. Epidemics of organized staged-crash rings and sham clinics are looting Florida’s no-fault system. Crooked medical providers, attorneys and recruiters work in wolf packs. These profiteering pariahs are getting rich from large and inflated claims for phony whiplash from setup car wrecks. These criminal conspiracies form a significant financial drain on policyholders and auto insurers.

The average two-driver family in the Sunshine State thus pays a not-so-sunny “fraud tax” of nearly $100 in higher premiums a year, calculates the Insurance Information Institute. In fact, scams stole $658 million total in false no-fault claims in 2011. Fraud losses amount to as much as $1 billion annually.

Yes, the patient is ill. But that’s an unsound reason to amputate when antibiotic reforms are at work. Before declaring the patient incurable, we must first keep squeezing out the cancer cells of fraud.

Florida enacted sweeping no-fault reforms in 2012. They work to reduce many large non-fraud costs such as abusive lawsuits and excess medical treatment. Thwarting organized fraud rings also was a key goal. Among the anti-fraud fixes:

- State licensing requirements for clinics were greatly tightened. Greater oversight deals a serious blow to hundreds of unlicensed sham clinics operating in secret;
- Criminal clinics can be booted from the state’s no-fault system;
- Longer jail terms and larger fines went onto the
By Peter Foley

Presenters at a national conference on the state of auto insurance and accident claims concluded that the “present system is a dismal failure.” Interestingly, this observation was made in 1967 about the auto-insurance system, which was plagued with problems and inefficiencies.

The proposed solution was no-fault auto insurance. Nearly 50 years later we are finding that no-fault auto insurance can be a dismal failure as well. And consumers are paying the price.

No-fault was intended to streamline medical claims payments for people injured in auto accidents. Many of these victims lacked individual health coverage in the 1960s. This is much less of a problem today, especially now that health coverage is mandated under the Affordable Care Act.

As envisioned, no-fault victims receive compensation directly from their own insurer rather than asserting claims against others and, thereby, reduce disputes and litigation.

Medical costs up to a certain limit (except in Michigan, which has no limit) are covered, as are some fraction of wages if the victim cannot work. This is referred to as Personal Injury Protection, or PIP. The goal was to meet the immediate financial needs of the victim while allowing the victim to pursue bodily-injury coverage for pain and suffering under certain circumstances.

Stakeholders believed back then that efficiencies would be increased and insurance costs would be reduced, thereby benefiting consumers. By the 1970s, many states had adopted no-fault systems due to the attractiveness of these predicted benefits.

Unfortunately, in the decades since, no-fault systems have been consistently plagued by fraud, abuse and excessive litigation by parties who stand to profit at the expense of consumers.

The most significant drivers of fraud include staged accidents and claims for fake or prior injuries. In addition, unscrupulous medical providers are taking more than a fair share of the benefits through excessive or unnecessary treatment. Likewise, the system is strained by the often-fraudulent utilization of non-traditional treatments such as massage therapy, acupuncture and chiropractic care, combined with the lack of medical fee schedules.

As for high use of medical tests, the top five states with Personal Injury Protection claims involving at least one MRI were no-fault states. Forty percent or more of all PIP claimants studied in just three no-fault states (Florida, New York and New Jersey) received at least one MRI.

More than three-quarters of Michigan claimants in 2011 received hospital treatment, compared to the national average of 61 percent in 2007 (the last year for which data are available).

Meanwhile, litigation and attorney fees actually have increased. Ultimately, consumers bear these added and often unwarranted payouts in the form of higher insurance costs.

The end result has been increases in premiums and claims abuses, and little reduction of claims and lawsuits. The majority of states recognize no-fault’s

Con: Repealing no-fault lowers costs from fraud, abuse & litigation

System is riddled with excess expenses and fraud; several states seek repeal

Continued on pg. 13
books. They strengthen deterrence, can bankrupt wrongdoers and sweep them off the streets; and

- All passengers in crashes also must be listed on police-accident reports. This squeezes “jump-ins” who pretend they were crash victims in order to obtain false “injury” treatment.

- Assertive law enforcement also is reaping rewards. Florida is a much unfriendlier place for no-fault criminals. PIP fraud arrests rose by nearly a third, from 397 in 2011 to 577 last year, the state Division of Insurance Fraud reports. Some 802 PIP cases were presented for prosecution — a 152-percent surge.5

In one recent case, more than 100 members of a staged-crash ring operating in South Florida were arrested. Dozens of high-ranking ring members have pleaded guilty rather than face certain ruin in federal court. Similarly focused crackdowns are spreading to the Tampa area and other urban locales. Another crash-ring takedown involved 300 suspects last year.

Local action is having an impact as well. Fully 79 suspicious clinics disappeared within a month after Hillsborough County (Tampa area) started requiring local clinics to register with the county. And 32 more clinics shuttered the next month.6

Auto premiums for long-suffering Florida drivers finally are nudging downward, says a new report by the state Office of Insurance Regulation.7 Most drivers paid 13.2 percent less for the Personal Injury Protection (PIP) last year than 2012. PIP is the part of no-fault policies that fraudsters most exploit.

The premium drop means a 3-4 percent overall reduction in auto premiums. The reduction is small in premium dollars, but is a timely show of forward movement.

The results also compare favorably with 2011, when 86 percent of auto filings involved proposed increases in PIP premiums — the vast majority for double-digit increases.8

Still, drivers are justifiably sick of stubbornly high premiums. Residents may support repeal of no-fault if they perceive a bleak future with some of America’s highest auto premiums. Many Florida insurers believe high system costs have reached critical mass, and would gladly push for no-fault repeal. Let’s check Massachusetts for a counterprecedent. Staged-crash rings went largely unchecked in major cities around no-fault Massachusetts for years. Premiums were untenably high.

In a remarkable act of iron will, the state created squadrons of task forces that broke up carnivorous crash rings in every targeted city in 2003. Auto premiums in those communities soon dropped by as much as several hundred dollars.

Chiropractors began disappearing from the targeted locales in the ensuing 10 years. Attorney involvement in PIP claims also declined. Drivers in the target communities have saved as much as $262 in premiums annually ever since the clampdowns.

Concerted anti-fraud efforts may or may not have such a swift and pronounced impact in the Sunshine State. But the larger takeaway is that precedent for impact exists.

Michigan drivers are similarly afflicted with high no-fault premiums. Small wonder; the state doesn’t even have a fraud bureau — an agency that is crucial to coordinating and enforcing anti-fraud efforts. A bill creating an agency focused solely on auto-fraud and theft has been proposed. Given time, it could be a game changer.

The bedrock concept of no-fault in Florida remains promising. Why prematurely blow up one vast, Continued on pg. 14
inherent flaws, and have at-fault auto insurance or tort systems in place.

In fact, today, just 12 states (Florida, Hawaii, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Pennsylvania and Utah) still maintain some form of a no-fault system. Indeed, costs in no-fault states are higher and increasing faster than in fault-based tort states. Despite decreases in the frequency of automobile accidents and in costs to repair the damaged vehicles, the premiums for PIP and bodily-injury coverage in no-fault states were more than double fault-based states from 2008 to 2011, according to the Insurance Services Office, a leading source of information about property-casualty risk.

Questionable claims related to fake or exaggerated injuries also increased 116 percent in Florida compared to 28 percent nationally between 2008 and 2010, the National Crime Bureau estimates.

Questionable claims related to staged accidents increased 38 percent in New York compared to 21 percent nationally, NICB estimates.

Meanwhile, the average number of procedures per claim for non-traditional medical treatments continues to escalate. The average number of chiropractor visits in Michigan increased 88 percent from 2002 to 2011, according to the Insurance Research Council (IRC). Massage treatments related to PIP treatments in Florida nearly tripled between 2005 and 2010, and chiropractic manipulation jumped nearly 30 percent.

Due to Michigan’s unique unlimited PIP benefits coupled with no medical fee schedule, motorists there pay some of the nation’s highest average premiums — 20-25 percent higher than neighboring states. It’s no wonder, given that the average PIP medical claim rose more than 166 percent in the Great Lake State over the last decade. But let’s not forget about plaintiffs’ attorneys, since they are a key cost driver in the no-fault system. Thirty-nine percent of PIP claimants retain legal representation, the IRC has found. The average claimed loss in 2010 for neck or back sprains in New York City was nearly four times higher when an attorney was retained, the IRC also discovered. It’s no surprise then that nationwide, PIP-paid loss costs increased 31 percent from 2000 to 2012.

Florida has tried to address its no-fault problems by passing reforms in 2001, 2003, 2007 and 2012. The problems stem from phony medical clinics, frivolous lawsuits, inflated bills and staged auto accidents, among other things. Prior to the most recent reforms, upwards of $1 billion in estimated annual fraud were contained within the Sunshine State’s PIP system.

Florida may become the nation’s bellwether test of no-fault’s future, with repeal bills expected to be actively debated in 2014. Conversely, Colorado is an example of the successful return to a tort system. Just five years after switching from no-fault, insurance costs had decreased 35 percent with an average annual cost saving of $322 per car, according to a study by the governor’s office. This translates to $1 billion in annual statewide savings for policyholders.

There is ample evidence...
complex insurance system to install another vast, complex insurance system that already has failed?

Imposing the right reforms, providing enough resources and deploying relentless enforcement may well increase the odds of rate relief for long-suffering Florida drivers. We’re seeing small but tangible results. Numerous non-fraud reforms in the seminal 2012 law also are at work; they form a similarly large part of the solution.

So instead of prematurely consigning no-fault to the junkyard, let’s think practically: If no-fault proves incurably stuck in reverse, the system may have to go. If reforms push the accelerator pedal to deliver stability and rate relief, no-fault may deserve a welcome future in Florida. And nationally, the Sunshine State’s progress will be an equally welcome travel guide for motoring with an efficient insurance system that delivers high mileage for drivers and insurers alike.

## Pro: A system that still can work

1 Auto Insurance: Costs and Expenditures, Insurance Information Institute, 2013.


3 No-Fault Reforms So Far Have Had Little to No Impact On Rates, news release, Insurance Information Institute, September 28, 2012.


8 ibid


10 ibid

About the author: Walter Dartland is Executive Director of the Consumer Federation of the Southeast. He also is a founding member of the Coalition Against Insurance Fraud, former Florida deputy attorney general, and special counsel to the state Attorney General.
Con: Repealing no-fault lowers costs

that no-fault hasn’t fulfilled its promise. Efforts are underway in several states to repeal (e.g., Florida) or reform (e.g., Michigan) no-fault.

Since not all states are ready for repeal, no-fault reforms should include actions such as shuttering fraudulent medical clinics, reducing frivolous lawsuits, implementing medical fee schedules, capping attorney fees, and limiting treatments by non-traditional providers such as acupuncturists and massage therapists.

However, complete repeal is the best way to guarantee that unnecessary insurance costs attributed to fraud, abuse and excessive litigation are removed from the system to the benefit of consumers.

Ultimately, the insurance industry and policymakers in no-fault states owe it to consumers to provide a well-functioning 21st century auto-insurance system that protects policyholders — not scamners seeking to cash in on a failed system.

endNOTES


4 Move to ditch no-fault car insurance coming in senate, Miami Herald, October 13, 2013.


About the author: Peter Foley is Vice President, Claims Administration, for the American Insurance Association. He also chairs the Government Affairs Committee of the Coalition Against Insurance Fraud.
Health reform may shift costs to property-casualty insurers

Auto, workers comp insurers invite fraud because systems pay well and rely on trust

By Dr. Rick Wakefield, JD, DC, PA

The Affordable Care Act likely will have a large and unintended impact: The influx of 38 million new insureds combined with reduced health-insurer reimbursements will impel many medical providers to bill health claims to higher-paying automobile and workers compensation insurers.

Fraudulent claims will accompany this potential mass-shifting of medical conditions and costs as doctors and other health providers try to recoup declining revenue in the traditional healthcare system. This large-scale shifting will significantly change the landscape of claims as America’s new healthcare model phases in over the next few years.

Insurance-industry leadership must develop strategies and increase resources to deal with the projected escalation of medical fraud as the ACA’s impact ripples through the property-casualty industry. This argument is theoretical but consistent with the emerging medical environment under the ACA and past provider behavioral economics.

America’s $2.7-trillion healthcare system is an immense and complex economic engine. Over the past 75 years it has become a stable but growing 1/6 of the economy. A natural balancing act between costs and prices keeps the U.S. healthcare system

Abstract: Health reform likely will have an impact the law did not foresee: The inflow of 38 million new policyholders plus reduced health-insurer reimbursements will impel many medical providers to bill health claims to higher-paying automobile and workers compensation insurers. Fraudulent claims will accompany this potential mass-shifting of medical conditions and costs as doctors and other health providers try to recoup declining revenue in the traditional healthcare system. The property-casualty industry’s more-generous fee-for-service reimbursement system is the key driver. Insurer fraud investigators will play a growing role in this shift. Investigators must develop more strategies and skills — and gain adequate resources — for evaluating the accuracy of a provider’s claimed injury-event causation.
solvent. But the health-insurance system is not market-driven.

Private-sector health insurers have greatly tightened costs and reduced provider reimbursements under contract managed-care strategies.

Medicare and Medicaid also have significantly tightened cost controls and reimbursements to medical providers in recent years. Federal, state and local government healthcare programs account for 46 percent of national healthcare expenditures. Stepped-up anti-fraud efforts have imposed yet more pressure on Medicare and Medicaid providers. Affected are 41.3 million seniors (over 65) on Medicare and 43.2 million (ages 18-64) on Medicaid.

And now the private healthcare system under the ACA will see an influx of 38 million uninsured Americans of all ages. The ACA intends to improve access to America's healthcare system. The new law overhauls the current system to bring better care to more people while reducing costs. But this huge influx will throw the natural revenue system out of balance. It will impose considerably more pressure on medical providers operating within an expanded system of tight fee structures.

Among the only ways for healthcare providers to relieve these mounting pressures is to seek new forms of reimbursement at much higher rates than the healthcare system affords them.

The most easily accessible source is the property-casualty industry, with its largely uncontrolled fee-for-service reimbursement system. Automobile and workers compensation insurers are the most likely targets due to their involvement with high volumes of medical claims. Medical providers will develop often-sophisticated ways to shift growing numbers of medical conditions, costs and reimbursements onto property-casualty insurers. Considerable fraud will accompany these attempted shifts. Many providers will inflate costs and invent treatments as they escalate their search for financial stability and even survival.

The ultimate victims are consumers, who could pay higher auto premiums. Workers compensation premiums for honest businesses could rise. Patients also could be exposed to suspect, unneeded and possibly dangerous medical procedures as part of fraud schemes.

Property-casualty insurers are natural targets for cost- and condition-shifting for several reasons. The ability to bill property-casualty insurers at much higher levels than in healthcare is the key incentive. The property-casualty industry's more-generous fee-for-service reimbursement system is the driver.

Over the past decade we have seen medical providers openly and successfully charge more for auto-injury treatments. Michigan's no-fault auto system, for example, has an unlimited lifetime cap in payouts for bodily injuries from crashes.

The property-casualty industry's claim-payment system also is built heavily on trust in the judgment and honesty of medical providers.

Maximizing reimbursement while playing by the rules has been the mantra of medical providers working with property-casualty claims for decades.

The private healthcare industry abandoned this "trust" system in the 1990s with the wide introduction of managed care and pre-certification. Health-insurer defenses thus are becoming more hardened than in the property-casualty industry.

But auto and workers compensation insurers rely on medical providers to determine medical necessity, frequency and duration of treatment and diagnostic testing. Providers also oversee prescribing medicines such as painkillers, and durable medical equipment such as back braces.

Normally honest medical providers operating in the healthcare system will be the largest force of cost and condition shifting. They will try to increase reimbursements out of perceived survival necessity. These are the doctors, therapists, hospitals and clinics that we work with on a daily basis.

These providers are typically not larcenous or criminal personalities. They just want to balance
their books and make an honest living. Many of these providers will rationalize “gaming” the property-casualty system. Smaller false claims through so-called “soft fraud” will be their primary cost-shifting fraud vehicle. Harder, more-organized forms of fraud will occur as well.

Soft fraud is opportunistic but relatively common. It involves embellishing, enhancing legitimate claims, or even billing for occasional phantom injuries or conditions. This is dishonest, violates patient trust and creates a deception. For many providers, soft fraud may become the new norm, or model, for conducting healthcare business. Some providers also may gravitate from low-key, soft scams to habitual and systemic defrauding. Organized health-fraud rings may shift toward property-casualty as well if they perceive an easier and more lucrative target field.

Under the nation’s new healthcare model, income-strapped health providers can easily relate pre-existing conditions such as degenerative spinal arthritis to an auto accident. By changing the true causal relationship, the provider can markedly increase the reimbursement. Or claims for a shoulder condition might be fraudulently shifted to a workers compensation carrier under the guise that the patient injured his shoulder at the loading dock.

Doctors and allied vendors might be inclined to inflate damages by running up bills for X-rays, MRIs, and durable medical equipment such as back braces as well as medical treatment. Higher pain-management reimbursements, for example, could be charged to auto or workers compensation insurers.

Many of these procedures may be done without medical necessity. Healthcare providers could migrate these kinds of insurance costs to property-casualty carriers by:

- Shifting conditions (and causes) by claiming that pre-existing health conditions actually stem from auto-crash or workers compensation injuries;
- Increasing the length of treatment, thus increasing the time for workers compensation claimants to return to work;
- Increased frequency of procedures and visits, including potentially dangerous and medically unnecessary injections and surgeries;
- Double billing;
- Unbundling of treatments codes
- Billing for phantom procedures
- Inflated charges
- Upcoding to bill insurers for more-serious (and expensive) treatments than were needed
- Upcoding to inflate condition severity and case-management expenses
- Inappropriate balance billing (your health plan pays less than what your doctor or hospital charges and wants to be paid. Your healthcare provider may demand the balance from you)
- Enhanced special damages in liability cases
- Cloning of electronic medical records
- Billing for phantom treatments
- Increase used of addictive prescription drugs as a form of self-referral kickback

Medicare already has been subtly shifting the burden of proof to property-casualty carriers with “set asides.” These financial agreements allocate a portion of, for example, a workers-compensation settlement to pay for future medical services related to the workers-compensation injury, illness or disease. These funds must be depleted before Medicare will pay for treatment related to the workers-compensation injury, illness or disease.

Here, too, it happens when the provider can relate the underlying preexisting condition to an incident such as a work injury.

Medicare, then, would not reimburse for injuries and conditions that it believes could stem from auto or work-related injuries. Those property-casualty carriers would have to prove the pre-existing
condition is unrelated to the incident. This shifting of the burden of proof to the property-casualty insurers is unprecedented.

The mandated use of electronic medical records — the new digital world — also makes it easier to perpetrate property-casualty fraud undetected.

This type of medical record makes the fraud less personal and the claimed medical condition easier to invent, alter or counterfeit in volume. Cloning of records and scripting (pre-writing) of medical necessity justification makes EMRs a challenge for property-casualty insurers going forward.

The causal relationship of injury (or condition) to the event is the foundational principle of property-casualty claim reimbursement. We rely on medical providers to determine that the event, in fact, caused the injury or condition. But the property-casualty industry simply cannot absorb the shifted treatment costs for unrelated chronic diseases and injuries for 38 million new ACA insurance buyers.

Several assumptions will help drive the emerging new medical economics, especially in the anti-fraud sector. Property-casualty insurers should assume that:

- Providers first are advocates for their patients;
- Providers second are advocates for themselves and their business; and
- Providers are not advocates for the insurance industry.

Anti-fraud solutions range from grandly strategic to granular and tactical. Broadly, the property-casualty industry must rethink relying so freely on medical providers to determine injury and cause. Stricter oversight of providers will be essential for the emerging new medical model.

Insurer fraud investigators will play a growing role in helping stem this shift. Investigators must develop more strategies and skills — and gain adequate resources — for evaluating the accuracy of a provider’s claimed injury-event causation.

Among the other action steps for property-casualty insurers:

1) Closely scrutinize claim processes for areas that providers can exploit.

2) Place less emphasis on investigating smaller, isolated, one-off medical scams and focus more on recurring schemes that steal the most insurance money.

3) Place more investigative weight on providers instead of claims. If the one-off investigation, however, does reveal provider fraud patterns then fraud investigators should convert it into a major case investigation against the provider.

4) Provide more anti-fraud or compliance training of medical providers during the investigation process. Such training is common in health insurance because it is not possible to catch and prosecute all providers engaged in fraud. Training providers in fraud awareness and compliance does work. Insurers should increase funding for these training efforts.

5) Increase public outreach to consumers. Building consumer intolerance of fraud is core to anti-fraud efforts. Outreach should receive enough funding to deter would-be scammers. It also should empower policyholders to avoid being scammed, and report suspected cons.

Outreach campaigns should more than recoup their expenses in detected and deterred fraud.

6) Consider increasing use of Independent Medical Exams and peer-review panels for claims, plus serious analysis and aggressive handling of cost outliers. Increased defense and claim costs will be expensive but worth the price.

“Anti-fraud solutions range from grandly strategic to granular and tactical. Broadly, the property-casualty industry must rethink relying so freely on medical providers.”

7) Deploy and manage data systems and powerful analytics. Fraudulent claims must be detected and stopped before they are paid out. Chasing stolen money has a poor return. Predictive modeling can help speedily uncover the influx of cost-shifted fraud losses, in close to real time. More property-casualty insurers are adopting predictive analytics, and that pace needs to accelerate.

A good parallel is Medicare’s ineffective old pay-and-chase model. Medicare is shifting to an increasingly aggressive new model emphasizing predictive analytics and early detection in closer to real time. Results are beginning to show. This model should become more widely adopted by property-casualty insurers.

8) Managing and sifting Big Data should be
part of the mix. Combining large volumes of data with the power of advanced analytics will uncover many well-hidden clues to fraud. Information can be drawn and sifted from databases shared by insurers, regulators, law enforcement and others. Big Data and analytics form the leading edge of anti-fraud investigations.

9) Industry partners also must include needed data in the Aggregated Medical Database. This will help deal with fraud involving pre-existing conditions or chronic diseases. The expansion could include, for example, the patient’s medical history, and amounts charged to payers. The data could help insurers develop more standardized charges or usual charge data sets.

Since electronic medical records now are required, insurers should be able to directly import patient exams, notes and laboratory results into the carrier’s databases. Having the drug lists, medical history, test results and physicals as searchable data fields would greatly enhance insurer ability to deal with emerging fraud.

It is important to include the medical records from liability claims in the data acquisition. This may be one of the more challenging data problems.

Allowing the ICD-9 and CPT codes to go unmonitored and unchallenged is a problem for many carriers. Working together, new data systems and analytics can improve this weakness, but initial costs can be high.

The new ICD-10 diagnostic code set is rapidly approaching for property-casualty carriers. The thousands of new codes will give fraudsters new avenues of embezzlement and condition-shifting onto property-casualty insurers. But ICD-10 also will empower new avenues of detection. Who benefits most will be determined by the vision of the parties.

10) Continuous data monitoring for extraordinary outlier conditions and claims in diagnoses and treatments must be in place at the outset. Some of these data solutions are well underway by industry vendors such as Verisk. But most programs are in their infancy, and cooperative development with carriers is essential.

11) Adopt the tighter cost-controls such as those built into the ACA and Medicare. Property-casualty insurers might adopt those strategies to combat the increased costs and utilization. But that may require legislation and regulation, support by prosecutors and courts, increased insurer funding and changes in policy language. Still, shifting to a tighter cost-control paradigm should recoup costs for policyholders and insurers.

12) Consider auto-policy language changes in the definition section to link the definition of medical necessity to that of Medicare. Also, redefine “usual charges” to include the amount that health insurers normally reimburse medical providers.

In summary, the fraud ripple effect is an unintended consequence of the ACA and can rapidly damage the financial health of insurers and claimants.

Regulators will not view this cost- and condition-transferring favorably and may take punitive actions. Insurers must manage this process to minimize damage.

The problem’s magnitude is much like the “David and Goliath” chronicle. The healthcare insurance industry is enormous compared to the property-casualty industry. A relatively small altercation with “Goliath” may have serious implications for “David.”

Likely this will impose an increasingly serious financial burden that can no longer be shifted to consumers. A sense of urgency may be the most important insurer strategy to preserve competitiveness and serve their policyholders.

About the author: Dr. Rick Wakefield, JD, DC, PA is the President and Founder of International Healthcare Consultants, Inc., an Independent Review Organization and forensic consulting firm specializing in healthcare, insurance, science and law.

endNOTES

Benchmark study reveals
SIUs are significant insurer contributors

First-ever SIU study offers insights into anti-fraud metrics

By Dennis Jay

ew areas within insurance companies have made more strides in recent decades than fraud-fighting. Special investigation units have gone from gumshoe operations employing one or two retired detectives to sophisticated entities with ROIs that rival the most successful internal departments.

Along the way, SIUs have gained respect within their companies and become integral to conducting the business of insurance. Their rising influence is confirmed by a recent study by the Coalition Against Insurance Fraud.

Half of property-casualty companies won’t put a new product on the street until SIU analyzes the fraud-risk exposures, the study finds.

The growth of SIU staffing, resources and stature in recent years also comes with increased scrutiny and accountability to ensure fraud-fighting contributes its fair share to the company’s bottom line. Senior management in many companies has developed challenging SIU performance goals and standards, bringing SIUs under the umbrella of existing quality-assurance programs that have measured claims, underwriting, marketing and other departments for years.

The consensus among most property-casualty

Abstract: For years insurers have sought to understand the norms for structuring, staffing, funding and measuring their special investigation units. Such guidelines haven’t been developed because of the variance in how SIUs conduct operations and how they measure various metrics. The Coalition’s latest study sheds light on potential benchmarks, broken down by type of insurance, size and scope. Some of the results are surprising. More than a third of SIUs receive less than one percent of referrals from new claims receipts. On average, SIUs reject a quarter of all referrals. The majority of insurers spend more than $800 to investigate the average claim, and a majority of insurers spend less then $4 million a year to fund anti-fraud operations.
companies is that SIU is working well and is a significant contributor to corporate success. Still, questions exist about whether SIUs are structured and operating for optimal success. To wit, senior executives and SIU managers increasingly have asked:

- How does my SIU’s performance compare to the industry overall?
- What percentage of claims should be referred to SIU for more investigation?
- What is ideal SIU staffing?
- What is the industry standard for investigator caseload?

The answers to such questions have been educated guesses at best. The reality is, only now have industry benchmarks for anti-fraud activities been developed.

The Coalition’s latest research project answers many such questions about SIU. This comprehensive benchmarking study was completed in December, and has been in the works for more than two years.

**Measuring SIU value**

The Coalition’s Research Committee tasked a work group in 2011 to take on the challenging assignment of designing the study. The work group consisted of John Kloc of Sentry Insurance, Dave Rioux of Erie, Sean Zavala of Farmers and Doug Crandall of American Family.

The work group spent nearly a year surveying insurers to understand how they measure anti-fraud activities and what areas are most important to benchmark. This preliminary research was instrumental in designing the benchmarking survey. The final results will allow insurers to compare their results more accurately to property-casualty standards.

Key was to define terms so study participants could provide as uniform data as possible. For example, several months were spent determining how SIUs define a claim referral. Is it one claim, or features within a claim? Does a referral count if it is only “touched” by SIU and not opened for a full investigation? The key is to ensure apples are compared to apples.

The same goes for staff positions. Some companies have vastly different duties and responsibilities for SIU positions such as directors, managers and supervisors.

As for budgeting, one insurer might include NICB dues in an SIU budget while another does not. Comparing such differences can be meaningless unless the definitions are equaled out.

To assist in designing and implementing the benchmarking study, the Coalition hired the Ward Group, preeminent experts in insurance-industry benchmarking studies. The Ward Group has worked with more than 400 insurers on 2,000 studies involving diverse aspects of company operations.

The final survey covers more than 200 areas, from organizational structure, budget and areas of responsibility to workflow and caseload metrics. A total of 46 insurers returned surveys. The insurers represent a significant majority of property-casualty marketshare. There also is balanced distribution among personal- and-commercial lines, and among small, medium and large ones.

**Results and analysis**

1. **Referrals of new claims.** This is one of the most sought-after metrics in understanding whether insurer claims and technology produce an adequate
volume of referrals. The study asks for percent ranges — from less than one percent to more than five percent — instead of specific numbers. Overall, more insurers (37%) say they receive less than one percent of new claim receipts than any other category [see Figure 1].

The distribution among ranges is quite wide: More than a fifth of respondents reported they received between two and three percent of referrals. Perhaps the biggest surprise is the percentage of respondents (15%) who say they received more than five percent of referrals from claim receipts.

The results suggest insurers vary too much on this metric to create a benchmark.

The range distribution by line of business was wide for many lines [see Figure 2]. The study also found significant deviation of ranges among lines of business. The averages ranged from workers compensation premium fraud (0.6%) to other lines (3.2%).

Overall, the weighted average for all lines was 2.13 percent of new claims receipts. While this metric is an overall guideline, it should not be set in stone because of the wide range of responses. For future studies, the Coalition’s Research Committee is considering seeking specific percentages rather than ranges to calculate a more exact benchmark.

2. Referrals accepted for investigation. The percentage of referrals accepted for investigation also ranged widely. The spread ranged from 22 percent saying they accepted less than half of referrals to 39 percent who reported they accepted more than 90 percent [see Figure 3]. Personal-lines referrals were more likely to be rejected than in commercial lines, most likely because of the greater numbers relative to SIU capacity. A total of 36 percent of personal-lines carriers said they accepted less than half of referrals, while 50 percent of commercial-lines companies reported they accepted more than 90 percent. The stark difference is underscored by the fact that every commercial-lines insurer reported it accepted at least 50 percent of referrals.

Using weighted averages, the overall percentage of accepted referrals was 76 percent. Personal-lines SIUs accepted 69 percent while commercial lines accepted 83 percent.

Small carriers were more likely to accept referrals (82%) than were large carriers (74%), and regional insurers were more likely to accept referrals (82%) than national insurers (70%).
3. **Source of referrals.** Nearly three of every four referrals came from claims departments, as might be expected. Automated referrals by technology accounted for 15% of referrals [see Figure 4]. This is an important metric that likely will grow in the future as more insurers adopt wider use of technology to flag suspect claims and applications.

Large carriers and personal-lines insurers were more likely to receive referrals from automated systems. SIU activity accounts for eight percent of referrals.

4. **Cost per investigation.** Slightly more than half of respondents (51%) reported they spend more than $800 per investigation [see Figure 5]. Only 10 percent said they averaged $200-$400 per investigation. All companies averaged more than $200.

Three-quarters of large companies averaged more than $800 compared to 47 percent and 43 percent for small- and mid-sized companies, respectively. A total of 67 percent of commercial carriers average cost was more than $800 per investigation, while personal-lines carriers reported 47 percent.

5. **Cycle Time.** Cycle time involves the number of days from when a referral is accepted for investigation until the investigation is ended. For commercial lines the range cited most often by respondents (47%) was 31-60 days [see Figure 6]. Personal lines averaged 30 days or less.

A total of 86 percent of large companies reported an average cycle time of less than 60 days, while medium and small companies averaged 69 percent and 67 percent, respectively.

6. **Investigations per investigator per month.** Investigators averaged 12.7 investigations per month each. Investigators working personal-lines cases worked 11.4 cases monthly compared to their counterparts in commercial lines who handled 13.3.

7. **Anti-fraud training.** Internal education programs to promote fraud prevention and detection have become staples across the industry in recent years. Quality anti-fraud training is widely considered a vital component of anti-fraud programs. State regulatory requirements for continuing education have further spurred robust efforts.

Almost all insurers in the study report that their SIUs provided training for their own units and other departments. All participants said their SIUs provide anti-fraud training to claims staff as well. A relatively high percentage also trained underwriting (80%) and their agency or sales staff (57%). Other training findings include:

- 72 percent of SIUs delivered 1-5 hours of training per employee per year to the claims department
- 72 percent of SIU investigators received more than 10 hours of training per year on average
- 82 percent of large companies report giving SIU investigators more than six hours of training given per year

8. **Quality assurance and staff performance.** With SIUs growing in stature and sophistication in recent years, more and more have adopted internal
measurement programs to gauge SIU and staff effectiveness and productivity. Some 85 percent of insurers in the study adopted such programs in 2013.

A key component of QA programs is a review of closed files to determine how well procedures were followed and optimum outcomes achieved. Insurers with QA programs reviewed an average of 13 percent of cases. Reviews were mostly conducted monthly (44%) or quarterly (23%).

QA programs typically were implemented by the claims, SIU and internal-audit departments.

Typical review factors include communication, which typically includes report writing and communicating effectively with staff, law enforcement and others (98%), timeliness (98%) and quality of investigation (93%) [see Figure 7].

A variety of factors measure investigator performance. Quality of investigations and customer service were the most frequent factors employed.

9. Outsourcing of anti-fraud services. Almost all insurers reported outsourcing at least some anti-fraud work. Surveillance was the top function outsourced, followed by special services such as fire origin and cause, and investigation [see Figure 8].

Only seven percent of insurers use contractors for case management. Very few (2%) outsourced IT and regulatory compliance. A majority report they used outside surveillance contractors 80-100 percent of the time. National companies were more likely to outsource training (38%) compared to regional companies (10%).

10. Legal services. Insurers handled legal needs and requirements in varied ways, and most use a combination of in-house and outside counsel.

Among the findings:
- Small carriers were more likely to rely on outside counsel
- 89 percent of all carriers used outside counsel for conducting examinations under oath (EUOs)
- 48 percent used inside counsel for EUOs
- All large companies used internal and external counsel
- 15 percent used SIU personnel solely to conduct EUOs

11. Budgets. Annual SIU budgets ranged from less than $2 million (43%) to more than $10 million (17%) [see Figure 9]. Staffing and technology were the two areas where SIUs saw the largest increases from 2012 to 2013. Comparing budgets from company to company is challenging because SIU budgets have different components. Many (63%),
for example, did not include state-levied anti-fraud assessments, while half included vendor expenses and half didn’t.

**12. Fraud-mitigation expenses.** This is a sensitive subject for many insurers in how much their anti-fraud efforts save the company. Nearly eight of 10 companies tracked fraud-mitigation savings, but the factors used to measure this metric varied greatly. A total of 35 percent of small companies did not track fraud mitigation. Most-cited reasons for not tracking included discovery during civil proceedings, especially liability and bad-faith actions.

**13. Staffing.** Many insurers struggle with the question of staffing levels as SIUs have expanded in recent years. Various capacity models have emerged to help guide insurers in hiring enough SIU managers, investigators, analysts and administrators.

The Coalition’s study focused less on pure numbers because staffing greatly depends on line of business, region and level of outsourcing.

More-meaningful comparisons included the ratio of managers to employees, and distribution of positions overall within SIUs [see Figure 10].

Overall, the average ratio of employees to managers/supervisors was 6.7. However, the ratio ranged considerably with company size. Average ratio of small carriers was just 4.5 while large companies reported 7.3.

Other staffing metrics included:

- 13 percent of SIU employees were reported as managers, supervisors or team leaders
- Commercial-lines carriers indicated a higher percentage of analysts (16% of the SIU staff) compared to personal-lines carriers (4%)
oversee complex claims investigations not involving fraud compared to personal-lines carriers (38% versus 18%).

Other oversight included claim origin and cause, data analysis, medical-provider investigations and fraud-vulnerability assessments.

15. SIU structure. Anti-fraud units were structured in varied ways. Many are centralized within the company (42%), some are de-centralized (28%) and the same number report a combination (28%). Small- and mid-sized carriers were more likely to centralize than were larger carriers. Also, regional carriers were more likely to centralize than national carriers.

Units within SIU also vary. Most (61%) reported having no dedicated major-case unit, while two-thirds reported having a dedicated data-analytics unit. Most also lacked a dedicated public-records unit (72%) and only 20 percent of SIUs had a dedicated medical unit. Personal-lines carriers also were twice as likely to have a data-analysis unit than were commercial carriers.

A large majority of SIUs (83%) report to the claims department while 11 percent report to legal. Personal lines were more likely to report to claims (95%) than commercial carriers (63%). The heads of SIUs tend (64%) to report either to a vice president or senior vice president.

A third of SIU employees worked in headquarters while two-thirds worked in the field. The larger the company, the greater the percentage of employees who worked in the field.

Summary

This analysis is a small slice of data and analysis from the overall study. Companies that participated in this project received a customized confidential report comparing all data with the individual data they submitted, plus comparison by company size and line of business.

In followup interviews, insurers said the study results were helpful in understanding how they compare with other insurers, and in helping educate senior managers about overall SIU operations. The study also is spurring internal discussions on how to increase effectiveness and reduce weaknesses in their operations.

Some companies also are reviewing how they measure various aspects of their operations, and are considering adopting metrics most commonly used across the property-casualty industry.

Measuring “claims vs. features” as a workflow and performance metric is probably the most important issue. A future article will explore SIU metrics and suggest how to develop more uniformity across the property-casualty industry.

Overall, the SIU benchmarking study results provide an important snapshot that will help insurers monitor anti-fraud activity from year to year. The results also will allow fraud fighters, senior company managers, regulators and others to gauge insurer progress in combating insurance fraud.

About the author:
Dennis Jay is Executive Director of the Coalition Against Insurance Fraud.

endNOTES

1 Weighted averages were calculated for comparison purposes as follows: <1% = .5, 1-2% = 1.5, 2-3% = 2.5, 3-4% = 3.5, 4-5% = 4.5 and >5% = 5.5. The unknown here is the average of the actual percentage of answers greater than 5%.

2 Weighted averages were calculated for comparison purposes as follows: <50% = 45, 51-60% = 55, 61-70% = 65, 71-80% = 75, 81-90% = 85 and >90% = 95. The unknown here is the average of the actual percentage of answers less than 50%.
Politicians bribed by lure of large insurance payouts

The power of insurance money to corrupt politicians and even public employees has been spotlighted by several high-profile cases in recent months.

Former U.S. Arizona congressman Rick Renzi looted his family insurance agency of more than $400,000. He funneled client premiums into his election campaign, and for personal expenses such as airline tickets for family members. He tried to cover up the crime but received three years in federal prison.

More than 100 retired New York police and firefighters faked crippling psychiatric conditions stemming from 911 to steal as much as $400 million in false disability claims against Social Security, federal prosecutors charged in February. At least 33 doctors, retirees, consultants and others have been convicted. Most allegedly were retired New York cops and firefighters who claimed post-traumatic stress syndrome, anxiety, depression and other psychiatric illnesses. They were caught doing things such as mixed martial arts; manning a cannoli stand at a street festival; and piloting a helicopter.

Retired NYPD officer Thomas Hale and Raymond Lavallee coached the suspects how to fake the conditions, prosecutors allege. This included how to fail memory tests, how to dress and to have a plausible demeanor. Nearly every claim had identical phrases.

Congress is holding hearings on the scandal. The Social Security System should adopt successful investigative techniques private-sectors use, the Coalition urged a key House subcommittee in a written statement in February. Congress also should strengthen criminal and civil fraud penalties. And the federal Office of Inspector General should build stronger ties with state medical boards to ensure that licensees who defraud Social Security are disciplined, the Coalition urged. Foot doctor Peter Ajemian helped hundreds of Long Island Rail Road employees lie that they were seriously hurt so they could land cushy retirements courtesy of fraudulent taxpayer-funded disability payouts.

Ajemian falsely diagnosed at least 734 workers with crippling injuries so they could retire early. A staggering 75 percent of LIRR retirees received disability money between 1995 and 2011, prosecutors say. The U.S. Rail Road Retirement Board has cut off disability benefits to at least 600 retirees. The system-wide con could’ve stolen up to $1 billion in taxpayer money if it hadn’t been caught, officials say.

Maintenance foreman Fred Catalan, for example, retired with seeming injuries to his neck, shoulder and knees. But he was fit enough to receive his black belt in karate. He received up to 55 years in jail.
LIRR has created an internal compliance unit to work more closely with the federal government, and is launching more ethics training for managers and union employees. The commuter line also seeks stricter federal standards for reviewing employee disability claims and weeding out false ones.

The chief of the Hackensack, N.J. police department of Hackensack, N.J. forced an officer to lie on an accident report that his girlfriend had crashed his own SUV while avoiding a deer. In fact Ken Zisa’s girlfriend had crashed his Chevy Trailblazer into a utility pole. Zisa based his $11,000 insurance damage claim on the falsified report. He received five years in prison.

A broker bribed a New Jersey township mayor and the school district’s superintendent to keep lucrative and inflated insurance contracts. Carmine Inteso was mayor of Toms River. He took in hundreds of thousands of dollars from Maryland broker Frank Cotroneo, who provided coverage for several New Jersey municipalities. Cotroneo also bribed Michael Ritacco, superintendent of the Toms River school district, to keep workers comp contracts. They all were convicted.

A hospital owner allegedly bribed a California state legislator Ron Calderon $30,000 to help preserve a state law that kept the exec’s $500-million workers-compensation scheme going.

It’s the largest workers compensation fraud case in California history, officials say. The bribe protected a loophole in state law that allowed Michael Drobot to charge workers compensation insurers huge markups on spinal-implant devices, prosecutors say.

Drobot also paid tens of millions of dollars in kickbacks to doctors, chiros, recruiters and others who referred spinal patients to his hospital, prosecutors say.

And he owned a spinal-implant distributorship and charged insurers inflated rates for the devices.

Calderon accepted lavish dinners, golf excursions and plane trips on Drobot’s dime, prosecutors allege. Drobot has agreed to plead guilty. He’s cooperating and could receive up to 10 years in federal prison. Calderon is fighting the charges.

**Stories, visuals bolster deterrent outreach messages**

Armin Wand’s wife Sharon carried their infant daughter from their burning home. Wand tried to toss the child back into the inferno. The Wisconsin man’s three other kids died in the blaze he set to steal renter and life-insurance money.

Foreign-car specialist David Norman Juntunen took a client’s prized $200,000 Lamborghini on an unauthorized late-night joyride. He promptly wrecked the vehicle. Juntunen had lost his driver license due to DUIs. So he lied to his insurer that an employee drove, and had swerved to avoid an animal.

The tragedies and tales of America’s top insurance misfits are on full display with the Coalition’s electing the newest dishonorees into the Insurance Fraud Hall of Shame.

The No-Class of 2013 reveals the year’s most brazen, tragic or knuckleheaded insurance crimes. The Hall of Shame helps build consumer intolerance. It puts a human face on a crime that many consumers dismiss as harmless “white collar” pranks.

Retelling crime stories shows how everyday Americans pay a high and sometimes horrific price for fraud. Story-telling dates back to when the first cavemen sat around the campfire talking about the day’s woolly-mammoth hunt.

Well-humanized stories remain among the best ways to drive home messages. The Hall of Shame annually ranks among the Coalition’s Top 5 website...
features, according to internal analytics. It is a more-effective way of educating consumers about fraud than solely using emotionless statistics such as “Fraud costs us $80 billion a year.” Consider:

- Stories are 20 times more likely to be remembered than hard facts;
- 12 out of 13 people want stories from brands instead of traditional sales pitches;
- Human brains learn far better from specific examples than abstract information, even when they are merely text on a page (or screen);
- The human brain has been on a slower evolutionary trajectory than modern technology. Our brains still respond to content by looking for the story to make sense out of the experience; and
- 56 percent of people say that compelling storytelling motivates them to support nonprofits.

Strong anti-fraud visuals are a potent way to reinforce storytelling. Pictures interact with text to produce levels of comprehension and memory that can exceed what is produced by text alone, research shows.

Still, few anti-fraud organizations regularly use stories or visuals. The Coalition Against Insurance Fraud is working to have more courts require, as part of fraud sentences, convicted cons to publicly tell their story in person and in video. The deterrent goal is to better show consumers the penalties of getting caught.

The Michigan Insurance Fraud Awareness Coalition has posted a deposition of a woman describing how a staged-crash ring targeted her.

A court in Texas several years ago required a convicted chiro to go on camera and tell how getting caught ruined his life and business.

The explosion of smartphones, plus popular visually oriented sites such as Facebook, YouTube, Flickr and Instagram suggest that visual messaging of fraud is critical for anti-fraud messaging to have an impact on people’s attitudes toward this crime. This is especially true for younger Americans — tomorrow’s large insurance buyers.

Fraud fighters will be challenged to cut through the clutter of information and craft deterrent messages that motivate people to act. Liberal doses of storytelling and visuals drive messages home far better than numbers or plain text.

**Fatal case highlights challenges to arson forensics**

Arson forensics go on trial as a Cleveland woman tries to overturn her two life sentences in a fatal insurance plot by contending the arson science that convicted her was flawed.

Angela Garcia’s two infants burned to death when she torched her rental home for $40,000 worth of insurance money, the court ruled in January 2014.

Garcia received two life terms. The fire likely was accidentally set by a large unattended candle, she contended. An arson dog found no accelerant in the rubble. The home was demolished, and no evidence was collected for lab testing. But Garcia was charged when investigators learned she’d overvalued
Texas enacted a law in 2013 allowing Texas judges to overturn convictions upon a showing that forensic evidence used to get a conviction is bad science. And the prosecution cannot use the discredited evidence if the court orders another trial.8

Better understanding of “flashover” has changed many arson probes. Flashover is when the temperature at the ceiling in a room (with a fire in it) reaches a level sufficient to cause spontaneous combustion of everything in the room. Once flashover has occurred, all the traditional red flags of arson such as burn or accelerant pour are obscured and rendered meaningless.

“As the legal climate changes, there is greater need for fire investigators to adopt a rigorous scientific foundation for their investigations. It is time to bring real science to fire investigations,” fire expert David Harlow writes. “The problem is, many, if not most, fire investigators are making judgments of arson and fire origin and cause but have little to no scientific training.”9

her possessions on her renter insurance claim. Garcia’s conviction was based on outdated arson science, her appeal contends. More is known about what causes fires to spread more intensely or rapidly, based on how blazes start and the materials a home is made of. A national fire expert said the arson conclusions weren’t based on scientific reasoning. The cause and origin should be listed as undetermined, he said. A number of arson convictions have been overturned in the U.S. as arson science advances in sophistication.

“A review of Ms. Garcia’s case using the dictates of modern fire science shows that the conclusions of the original fire investigators as to the cause and origin of the fire were based upon flawed and outdated assumptions that were not tested by the scientific process, and that numerous potential accidental causes, including the home’s electrical system, were not properly considered or eliminated before the fire was deemed to be incendiary,” her attorney wrote in a motion.

Garcia’s case is among several in recent years to question scientific principles that once guided fire investigations — including the idea that multiple and independent points of a fire’s origin prove arson. Unlike DNA evidence, the proof collected in some arson investigations does not yield precise results.

Jimmy Hebshie was indicted for burning his Brockton, Mass. convenience store allegedly to collect insurance money. The evidence against him included a “V” shaped burn pattern and an alert from a canine trained to detect accelerants. Expert witness Lentini reviewed the case and found significant problems with the investigation. The federal court vacated Hebshie’s conviction in 2011, criticizing the fire investigator and the canine evidence.7

Some arson experts already had begun discrediting many assumptions employed in fire investigations, like using the amount of heat radiated by a fire to assess if an accelerant had been used.

Still, arson science has improved dramatically in 40 years. It is moving from art to science.

The profession is being modernized, in part by the the National Fire Protection Association’s adopting NFPA 921. It sets modern scientific standards for investigations.

The National Fire Protection Association also sets minimum requirements for the knowledge, skills and ability of fire investigators.

endNOTES


2 ibid.

3 Engage Your Audience With Stories, blog, marketing researcher Roger Dooley, December 8, 2010.

4 Psychological Power of Storytelling, Pamela Rutledge, PhD, MBA, Psychology Today, January 16, 2011.


8 Junk Science Causing Wrongful Convictions in Texas, DallasJustice.com.

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.

1012 14th Street, NW Suite 200
Washington, D.C. 20005

info@InsuranceFraud.org

facebook.com/insurancefraud twitter.com/insurance_fraud