Coalition Against Insurance Fraud

By the numbers: fraud stats

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People's Attitudes About Fraud

Consumers

Nearly one of four Americans say it's ok to defraud insurers, says a survey by the consulting firm Accenture Ltd. Some 8 percent say it's "quite acceptable" to bilk insurers, while 16 percent say it's "somewhat acceptable." About one in 10 people agree it's ok to submit claims for items that aren't lost or damaged, or for personal injuries that didn't occur. Two of five people are "not very likely" or "not likely at all" to report someone who ripped of an insurer. Click here for the complete study. *Accenture Ltd. (2003)*

Nearly one of 10 Americans would commit insurance fraud if they knew they could get away with it. Nearly three of 10 Americans (29 percent) wouldn't report insurance scams committed by someone they know. *Progressive Insurance (2001)*

More than one of three Americans say it's ok to exaggerate insurance claims to make up for the deductible (40 percent in 1997). *Insurance Research Council (2000)*

One of four Americans says it's ok to pad a claim to make up for premiums they've already paid. *Insurance Research Council (2000)*

One of three Americans says it's ok for employees to stay off work and receive workers compensation benefits because they feel pain, even though their doctor says it's ok to return to work. *Insurance Research Council (1999)*

Seven of 10 Americans say workers comp fraud is a widespread problem, and 45 percent say fraud is increasing. *Insurance Research Council (1999)*

One of five employed workers says they've been aware of fraud in their workplace. *Insurance Research Council (1999)*

Four of five Pennsylvanians reviewed their medical bills for accuracy in 1999 (seven of 10 in 1997). *Insurance Fraud Prevention Authority of Pennsylvania (1999)*

Nearly 16 percent of Pennsylvanians say they're willing to receive bogus workers comp payments (25 percent in 1997). *Insurance Fraud Prevention Authority of Pennsylvania (1999)*

Three of four Americans aren't willing to pay more for their auto coverage to allow bad-faith third-party lawsuits. *Insurance Research Council (2000)*

Physicians

Nearly one of three physicians say it's necessary to game the health care system to provide high quality medical care. *Journal of the American Medical Association (2000)*

More than one of three physicians says patients have asked physicians to deceive third-party payers to help the patients obtain coverage for medical services in the last year. *Journal of the American Medical Association (2000)*

One of 10 physicians has reported medical signs or symptoms a patient

didn't have in order to help the patient secure coverage for needed treatment or services in the last year. *Journal of the American Medical Association (2000)*

Fraud Losses & Costs

Personal Injury Protection (PIP)

More than one of every three bodily-injury claims from car crashes involve fraud. *Insurance Research Council (1996)*

17-20 cents of every dollar paid for bodily injury claims from auto policies involves fraud or claim buildup. *Insurance Research Council (1996).*

Fraud adds $5.2-$6.3 billion to the auto premiums that policyholders pay each year. *Insurance Research Council (1996)*

Claims for bodily injuries under the Personal Injury Protection portion of New York's no-fault auto coverage rose 79 percent between 1999 and 2000, compared to 25 percent in all no-fault states. *Insurance Research Council (2001)*

Insurers increased auto premiums up to 25 percent for New York City in 2001. *Insurance Information Institute (2001)*

The average PIP claim is $7,950 in New York State — 47 percent higher than the national average. *Insurance Information Institute (2001)*

Fraud costs each insured driver in New York State $75-$115 per year. *Insurance Information Institute (2001)*

PIP claims in New York State rose nearly one third in 2000, more than twice as fast as second-place Florida. *Insurance Information Institute (2001)*

The average PIP claim in New York State jumped 19 percent over the first nine months of 2000, and 64 percent between 1995 and 3Q 2000. This compares to a 33-percent increase for other states. *Insurance Information Institute (2001)*

Auto insurers in New York pay out nearly twice as much in PIP claims as they collect in premiums. For every $100 auto insurers received, they paid $177 in claims through 3Q 2000. *Insurance Information Institute (2001)*

Arson

Arson and suspected arson account for nearly 500,000 fires a year, or one of every four fires in the U.S. *National Fire Protection Association (1998)*

Only 2 percent of arson or suspect arson fires result in convictions. *National Fire Protection Association (1998)*

Arson and suspected arson are the largest causes of property damage in the U.S. *National Fire Protection Association (1998)*

Anti-Fraud Efforts

State Fraud Bureaus (2001-2002)

Criminal convictions increased 31 percent. *Coalition Against Insurance Fraud (2004)*

Cases presented for prosecution rose 14 percent. *Coalition Against Insurance Fraud (2004)*

Investigations initiated increased by nearly 18 percent. *Coalition Against Insurance Fraud (2004)*

Referrals of suspected fraudulent actions were up 4.5 percent. *Coalition Against Insurance Fraud (2004)*

Property-casualty insurers

Fraud is a serious problem, half of all property-casualty insurers say. *Insurance Research Council-Insurance Services Office (2002)*

The amount of fraud their company has experienced has increased over the last three years, more than one of three insurers say. Nearly half say fraud has stayed the same. *Insurance Research Council-Insurance Services Office (2002)*

About 11-30 cents — or more — of every claim dollar is lost to "soft" fraud (smalltime cheating by normally honest people), nearly half of property-casualty insurance companies say. Hardcore scams steal only a small fraction of that money. *Insurance Research Council-Insurance Services Office (2002)*

Only one of four insurers thoroughly investigate cheating on insurance applications. Even fewer insurers investigate insiders such as employees and agents who commit premium fraud. *Research Council-Insurance Services Office (2002)*

More than two of five property-casualty insurers have increased spending to fight fraud over the last three years. More than four of five insurers have formal anti-fraud programs. *Insurance Research Council-Insurance Services Office (2002)*

Nearly three of five insurers say their efforts to combat are only moderately effective, or lower. Research Council-Insurance Services Office (2002Fraud-control spending by property-casualty insurers rose from $200 million in 1992 to $650 million in 1996. *Insurance Research Council (1997)*

98 percent of property-casualty insurers have a fraud-control program, and most insurers have special investigation units. *Insurance Research Council (1997)*

Half of property-casualty insurers have broad, public-information programs directed against fraud. *Insurance Research Council (1997)*

Workers Compensation

Without workers compensation anti-fraud laws, claims would've been 10.4 percent higher in 1997, the average claim would've been 7.3 percent larger and system costs per worker would've been 18.5 percent higher. *National Council on Compensation Insurance (1999)*

Healthcare

In 1996, Congress funded an added $548 million over seven years for health-care fraud enforcement. *FBI (2001)*

Health insurers save $11 for every $1 they spend fighting fraud – an average of $5.5 million per company in 1998. *Health Insurance Association of America (1999).*

Federal convictions for health fraud, waste and abuse rose 57 percent between 1999 and 1998. *U.S. Department of Health and Human Services (2000)*

More than nine of 10 health insurers (95 percent) have anti-fraud training for employees, and nearly three of five (56 percent) have fraud hotlines.

Health Insurance Association of America (1999)

The FBI secured 560 convictions for healthcare fraud in 2001, a four-fold increase from 1992. The bureau also racked up 741 indictments in 2000, up from 615 in 1999. *FBI (2001)*

Medicare lost $11.9 billion to waste, fraud and mistakes in 2000, half of what was lost five years ago from improper payments to doctors and hospitals. U.S. *Department of Health and Human Services (2001)*

Fraud amounts to 10 percent of U.S. healthcare expenditures. *Government Accounting Office (1992), National Health Care Anti-Fraud Association (2001)*

Seniors and other taxpayers pay up to $1 billion a year in inflated drug prices due to potential fraud and loopholes in Medicare. The overpayments represented 1/5 of Medicare spending in 2000. *Government Accounting Office (2001)*

80 percent of healthcare fraud is by medical providers, 10 percent is by consumers and the balance is by other sources. *Health Insurance Association of America (1998)*

The U.S. government recovered more than $8 for every dollar spent fighting health care fraud and abuse by using the False Claims Act. *New Directions for Policy (2001)*

Identity Theft

Thieves stole the identities of 700,000 Americans last year. *The Privacy Clearinghouse (2000)*

Identity theft in general cost $745 million in 1997, up from $450 million in 1996. *U.S. Secret Service (1998)*

Abuse of Social Security numbers nearly tripled between 1998 and 1999, and four of every five calls to the Social Security Administration's fraud hotline involve identity theft. *Social Security Administration (1999)*

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