Social marketing: tackling small-time crime

Social marketing is an effective fraud deterrent for consumers who commit “small crimes” of insurance fraud. It’s capable of arming state fraud bureaus with a needed tool to reduce the billions of dollars in fraud losses a year.

By Ralph W. Burnham

Fraud bureaus show resilience as resources dwindle

State insurance fraud bureaus are facing a difficult period, with many units shedding jobs and losing budget money. As a result, their investigative resources are being stretched thinner.

By Dennis Jay

Deducting fraudulent waivers of deductibles

Insurers face potentially significant risks of loss from fraudulent and tortious waivers of insurance deductibles and co-payments. Auto-body shops and roofers are among the leading offenders.

By Brian Stimson and Matt Montaigne

Laws solicit jail for soliciting crash fraud

Auto insurers face huge losses to fake injury claims stemming from staged and real car crashes. So-called runners (or recruiters) play a key role in luring real and bogus crash victims to shady clinics for illicit treatment.

By Howard Goldblatt

TrendWatch: new developments about fraud in America

Court decisions are helping and potentially hindering fraud fighters... New research shows that medical ID theft is alive and well... Communicators need to gear their anti-fraud messaging to mobile-phone users.

By Coalition Staff
From Darwin, Nietzsche and any modern CEO, we know that thriving as a species demands that we adapt or perish. It’s why cavemen became modern humans, and the brontosaurus is a museum display. For the fraud fighter species, three important “R”s of success are shared in this issue of JIFA: research...resources...and resilience. One state agency poured rigorous research into consumer psychology when developing anti-fraud TV & radio spots. The spots are measurably convincing more Pennsylvania consumers not to commit fraud. Public outreach works when applied science is applied well.

A resource crunch is afoot among state fraud bureaus, reveals a study by the Coalition. Some bureaus are being stretched to the limit. But overall, fraud units show impressive resilience in keeping their anti-fraud numbers up. Speaking of resilience, adaptable fraud fighters are enacting creative new laws to deflate cunningly shifting tactics of clinics that recruit crash victims for phony injury claims, another article tells us.

JIFA shows an honest, at times disturbing, but always forward-reaching view of today’s fraudscape. The current articles reinforce our keen vision as a highly adaptive crime-fighting species: Some day consumers will visit their museum to see quaint relics...An extinct insurance cheater is on display, right next to the brontosaurus.

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Abstract: Growing evidence suggests that social marketing aimed at dishonest insurance consumers who commit “small crimes” of insurance fraud is an effective fraud deterrent, one capable of arming state fraud bureaus with a needed tool to reduce the billions of dollars a year in fraud-related claim losses and expenses now victimizing insurers and consumers. At least one-third of fraud suspects prosecuted in Pennsylvania are everyday insurance consumers without a serious criminal history, while two-thirds are offenders who commit simple frauds with little or no financial gain. It is important to reduce these small-time crimes. They bring added claim losses and expenses to insurers while diverting insurer and law-enforcement resources from the pursuit of more serious, high-dollar fraud crimes. Initial measurement of social marketing’s impact on Pennsylvania consumers found a two-percent reduction in likely offenders over an 18-month campaign, with change coming at an investment of just $18 per person. In contrast, the per-person cost of funding the prosecution and conviction of an offender exceeds $20,000. Other state fraud bureaus find themselves confronted with a fraud problem similar to that of Pennsylvania. They have expressed interest in using the Pennsylvania Insurance Fraud Prevention Authority’s social-marketing material, but lack funds to adopt Pennsylvania’s TV and radio ads for use in their states. If social marketing continues to be shown effective in removing fraudulent claim losses and expenses from Pennsylvania’s fraud-cost equation, a logical next step for insurers would be to fund a similar program at the national level.

By Ralph W. Burnham

Insurance fraud is a crime that costs billions of dollars a year. The flames of fraud consume the lifeblood of insurance. This ultimately harms consumers by driving up premiums. It damages insurers by reducing their profitability and ability to compete in today’s ever-changing insurance markets.

How much insurance fraud escapes detection each year is unknown, but the lure of unlawful financial gain is clear. There is plenty of money to steal, and Pennsylvania is no exception. Total national insurance premium volume reached $1.6 trillion in 2010, and Pennsylvania was the fifth-largest state with $83 billion in premiums. In 2010, paid claim losses were $1.1 trillion nationally, including $62 billion in Pennsylvania.

Social marketing: tackling small-time crime

Applying science to public outreach convinces people not to commit fraud
The Pennsylvania Insurance Fraud Prevention Authority came into existence in 1995, statutorily created to direct funding of anti-fraud efforts in the state. The Authority pursues a two-pronged strategy by funding:

- State law-enforcement agencies’ criminal prosecutions of insurance fraud; and
- Public outreach fraud-awareness campaigns to help deter fraud.

For Fiscal Year 2011-2012, the Authority is investing $2 million in public outreach and $10.3 million in the prosecution programs of 12 state and local law-enforcement agencies.

Why public outreach?

The Authority’s mission, as branded into our website, is to Help people Stop, think and then not commit Fraud.

Most fraud offenders are opportunists looking to make a quick dollar at insurer expense. When successful, they inflict claim losses and claim expenses on insurers. Frustratingly, even when fraud cheats are caught and denied payment by insurers, insurers still bear and pay the expenses of having handled the fraudulent claim.

Both claim losses and claim expenses are factors in the setting of insurance rates and premiums charged insurance consumers. Only by removing both fraudulent claim losses, and the expenses of fraudulent claims from rate-making, can insurers and honest consumers be fully protected. Public outreach makes this possible.

Uncertain fraud data

The large obstacle to knowing if public outreach is an effective fraud deterrent is the lack of fraud data. The Authority has data only regarding insurance fraud that has been reported to law enforcement. The data are uncertain as to undetected fraud, and to fraud that is detected but not reported to law enforcement. We saw that only the reporting of suspected fraud increased significantly after December 2007.

Law enforcement’s statistics do, however, tell us that at least one-third of defendants are first-time offenders, as shown by rehabilitation (ARD) rates, which is a court disposition typically extended only to offenders with no criminal history. And, as shown by imprisonment rates, the most serious insurance-fraud crimes are committed by less than 20 percent of people arrested.

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Small-time crime: Since 2008, closer examination of arrests confirms that Pennsylvania’s insurance-fraud problem is disproportionately one of small crimes. These are first-time offenders who had opportunistically engaged in simple auto insurance fraud schemes, with little or no monetary gain. In 2011, auto insurance frauds accounted for 51 percent of reported frauds and 71 percent of arrests. Approximately two-thirds of suspects arrested in 2011 received no money from their fraudulent claims.

Some 84 percent of arrests in 2011 came from five common auto-insurance fraud areas:

- 22 percent – fraudulent auto physical-damage claims;
- 20 percent – fraudulent claims filed on insurance purchased after an accident while driving uninsured;
- 18 percent – fraudulent claims of stolen vehicles;
- 14 percent – fraudulent claims of personal injury from accidents; and
- 10 percent – Using fraudulent insurance to register motor vehicles.

Due to the limitations of crime metrics, the Authority uses consumer-attitude research
to measure results of its public outreach fraud-awareness campaigns in attacking Pennsylvania’s problem with first-time opportunistic offenders. Consumer surveys, as current snapshots of people’s attitudes and behaviors, provide the Authority with reliable gauges of the impact of public outreach.

The Authority’s public-outreach efforts have evolved in three distinct phases. Each phase used data-driven research to reliably guide campaign planning, and provide credible post-campaign metrics to measure success.

Phase 1: First campaign

The Authority adopted two goals for its inaugural public-outreach campaign in 1997: a) deter bogus claims for workers compensation and damage to vehicles; and b) decrease consumer tolerance of fraud by warning that this crime drives up everyone’s insurance costs.

The Authority first conducted a behavioral study of consumer attitudes about insurance fraud. The results helped both guide the design of billboards, posters, television and radio ads, and shape media-relations efforts.

The Authority’s 1997 pre-campaign consumer survey showed that 55.6 percent of Pennsylvanians were “somewhat likely” or “very likely” to commit insurance fraud under certain circumstances.

A repeat of the survey in 1999 showed a similar rate for potential offenders.

The Authority also measured people’s recall of the ads after the campaign. The highest consumer recall (57 percent) involved a TV spot aimed at workers compensation fraud. But fewer consumers remembered billboard advertising (39.6 percent) or radio ads (15 percent). Television ads became the Authority’s preferred outreach medium for their ability to reach consumers and be recalled.

Phase 2: Social marketing arrives

Despite introducing insurance fraud into the vocabulary of everyday Pennsylvanians, fully 58 percent of consumers remained likely to commit insurance fraud under certain conditions. So that all-important behavioral needle hadn’t moved much.

Further consumer research in 2001 modeled potential offender fraud behavior, suggesting appropriate fraud-prevention messages. Likely offenders who were motivated by financial necessity were responsive to often-repeated emotional and visual ads emphasizing the harms that offenders inflict on their families and other loved ones.

Focus groups refined the Authority’s next round of TV ads in what became social marketing — the use of traditional paid media to change the attitudes and behaviors of a target group of likely fraud offenders. Emotionally charged ads aired from 2003 through 2007 in the Philadelphia, Pittsburgh and central-state areas of Pennsylvania. They sought to convince people that committing fraud was not worth the steep price.

- In one ad, a sister and brother sat at a kitchen table, discussing their father’s recent fraud arrest. The young boy angrily calls his father a “liar;”
- Another ad showed a teenage girl riding in...
a car with her father on the way to school. She was angry and embarrassed that he’d been arrested for insurance fraud. She was stone-faced and silent despite her father’s efforts to talk to her; and

- A third ad showed a woman being arrested for insurance fraud at her workplace, in front of co-workers.

In followup campaign research, fully 75 percent of consumers remembered the ads. Emotional, family-focused messaging clearly had a strong impact.

**Phase 3: Creating baselines**

The Authority took another important step in 2009, creating long-term baseline research for measuring the impact of our campaigns consistently from one year to the next. We retained the Harrisburg-based social-marketing firm The Partnership of Packer, Oesterling & Smith in 2008 to develop the next-generation campaign.

A pre-campaign telephone survey of 1,000 consumers in December 2008 found that:

- 69 percent of consumers were unlikely to commit five types of fraud listed in the survey;
- Only 17 percent knew what acts comprised insurance fraud, or that it is a felony;
- Only 12 percent viewed fraud as a serious crime; and
- Only three percent strongly believed cheaters would be caught.

The Authority’s previous campaigns had made solid progress in expanding consumer understanding, and appeared to have reduced our number of potential offenders. But large gaps still needed closing.

Further in-depth interviews with consumers, insurance experts and law enforcement helped refine the Authority’s newest messages. Talking to influencers face-to-face gained our media team useful insights that supplemented the hard data.

From a mountain of research, the Authority in July 2009 launched new TV ads for an 18-month campaign. The results then would be measured. That initial campaign had three goals:

“Really? He told me he injured his back Friday... on the loading dock.”

- Weekend Warrior anti-fraud advertisement
Increase people's general knowledge of fraud; Convince people to view insurance fraud as a serious crime with serious consequences; and Educate people that fraud offenders will get caught.

A “storybook” of new television and radio commercials depicted common fraud schemes by average consumers. Among the spots:

**Bad Day** portrays a young woman who has just had an auto accident while driving uninsured. Her boyfriend urges her to buy insurance and then illegally file a claim.

**Weekend Warrior** portrays a warehouse worker who innocently tells his boss that a co-worker's injury came from a weekend basketball game, not a loading-dock accident.

**Lost and Found** is the story of a woman outraged that her husband had been so naïve as to falsely claim auto theft just to get out of a too-expensive loan.

A wide-ranging public relations campaign reinforced the TV ads. The effort included rebranding the authority's website to have a stronger consumer focus.

After the campaign, the first repeat baseline survey in October and November 2010 showed that:

- Consumers who “strongly agree” that insurance fraud is one of the most serious crimes increased 33 percent;
- Consumers who realize insurance fraud is a felony and a lie told to unlawfully steal from an insurer increased 18 percent;
- Consumers who believe insurers use sophisticated technology to detect fraud increased 19 percent; and
- Consumers shown by survey results to be likely offenders decreased two percent.

Let’s focus on this last data point. It is an important metric that offers the tantalizing prospect of measuring a healthy ROI from social marketing.

The campaign cost slightly more than $18 per person to convince likely fraudsters to avoid committing this crime... Compare that with the Authority's average cost of $21,000 to $25,000 to prosecute and convict each insurance-fraud offender.

**Continued evolution**

The initial campaign’s storybook of ads continues to expand as the Authority’s social marketing creates new ways to reach consumers and measure their responses.

The Authority has bought banner ads on the websites of cable providers, radio stations, weather sites and retailers. The ads direct consumer traffic to the Authority's website when visitors click on them.

These websites also allow direct targeting of specific anti-fraud messages to certain geographic areas of Pennsylvania.

For example, the **Beware the Buck** and Winter **Weather** campaigns seek to warn against one frequent scheme: buying auto coverage after an accident, then lying that the accident happened after the coverage took effect.

The Authority also is pushing out anti-fraud messages via Facebook at facebook.com/PAIFPA and Twitter as user @PAIFPA.

**Need for pilot campaigns**

Insurers suffer claim losses and expenses when cons slip through the system or insurers lack grounds to deny questionable claims.

Keeping these claims from ever occurring should prove a positive bottom-line improvement. Each insurer should ask itself: How much fraud-related...
loss do we incur each year just from questionable claims?

Social marketing works in Pennsylvania. Consumers are shifting from being likely fraud offenders to unlikely ones. They are also more aware that this crime is a social ill. This marketing is an effective, cost-efficient investment by Pennsylvania’s insurers.

It also helps build support for anti-fraud legislation by drawing public attention to the fraud problem, as seen in Pennsylvania’s recent passage of a broadened immunity law for insurers and their fraud investigators.

Other state fraud bureaus have asked if they could adapt the Authority’s ads. The Authority offers these ads free of charge to save colleagues tens of thousands of dollars in creative and production costs. But despite their interest, most fraud bureaus lack the budgets to rebrand Pennsylvania ads for use in their state or buy time on TV and radio stations.

Social marketing will work effectively in other states with fraud problems similar to Pennsylvania’s. It is a tempting thought because it would bring consistent anti-fraud outreach to all states. But it also would require pilot campaigns to prove the concept.

Insurance fraud is big; we must think bigger.

What is your opinion of this topic? Visit insurancefraud.org/JIFA.htm
For fast access, scan this code using a smartphone

About the author: Ralph Burnham is executive director of the Pennsylvania Insurance Fraud Prevention Authority.

endNOTES


3 The Pennsylvania Insurance Fraud Prevention Authority was created in 1995 to determine the size and nature of Pennsylvania’s insurance fraud problem, advise the Commonwealth’s governor and General Assembly of that problem, and then administer funds entrusted by insurers to the Commonwealth, initially set at $8 million a year. The Authority’s mission is to support insurance-fraud prosecution and prevention. The Authority is directed by a seven-member board of directors. The board includes four legislative appointees as representatives of insurers, a consumer representative appointed by the governor, and two members of law enforcement. The Authority is not a criminal law enforcement agency. The Authority operates independently of the state’s government, but is a component of government because it is statutorily required to bear all expenses of the Commonwealth’s primary insurance-fraud prosecution agency in the state Attorney General’s Insurance Fraud Section.

4 In Pennsylvania, only auto insurers are required by law to report suspected insurance fraud to law enforcement (75 Pa. CS § 1817).
Fraud bureaus show resilience as resources dwindle

Numbers remain solid despite dropping budgets and growing caseloads

By Dennis Jay

Cash-strapped state governments have shed jobs at a pace not seen in modern U.S. history since the economy ran aground more than three years ago. More than 400,000 jobs have evaporated since 2008. Anyone from bureaucrats in state capitols to police, teachers and local fire fighters have been jettisoned, according to the Center on Budget and Policy Priorities.

Like molting salamanders, that job-shedding includes state fraud bureaus. Employment in these crime-fighting agencies has fallen nine percent during each of the last two years, confirms a 2011 survey of 44 fraud bureaus by the Coalition Against Insurance Fraud. The full report will be released this spring.

Budgets also are being pared, but the news is mixed. Though the overall squeeze on budgets and staff continues, the pressure has eased somewhat in the last year.

Most forms of insurance fraud in the survey also rose last year even as overall resources to fight this crime dwindle, the directors said in the Coalition’s survey.

Abstract: State insurance fraud bureaus are facing a difficult period, with many units shedding jobs and losing budget money. As a result, their investigative resources are being stretched thinner. There is a tipping point at which a bureau’s ability to adequately do its job is materially affected. The downturned economy likely has played a role. Governors and legislators in some states thus are replenishing depleted coffers by cutting budgets of state agencies such as fraud bureaus. There are some tentative signs, however, that falloffs in resources are easing somewhat. Several forms of fraud also are increasing, with crooked agents registering the largest increases. Despite difficult times, fraud bureaus as a whole are generating solid crime-fighting numbers that reveal a great deal of resilience in the face of tighter finances. The Coalition’s fraud-bureau survey next year will show whether these crime-fighting agencies face even tougher times, or have begun turning the corner in the quest for adequate resources.
Perhaps not coincidentally, the fraud surge overlaps the weak economic recovery. Many factors such as stepped-up insurer investigations or greater focus on a given kind of fraud crime can influence spikes in fraud data. But the overlap with the troubled economy still is too pronounced to ignore as a major contributor.

Even so, most fraud bureaus continue registering solid crime-fighting numbers that reveal a high degree of resilience and efficiency despite unusually difficult times, the findings suggest.

But the chemical mix of downgraded resources, a stagnant economy and rising fraud are stretching the anti-fraud safety net thinner. In many states, the continued economic pressures threaten to compromise the ability of more fraud bureaus to fully do their jobs. At some tipping point, the fraud fight could be materially affected, leaving more areas of the nation more vulnerable to upsurges in fraud crimes that otherwise would be caught and prosecuted.

**Staff decreases slowing**

Fraud-bureau staff had increased every year between 1995 and 2009, the year the Coalition began compiling data. Many fraud bureaus were created during that timespan as a counterweight to an insurance-crime problem that more states finally began to recognize was expensive and aggressively spreading.

State coffers were more flush with money in the late-1990s, America’s economy was healthier, and states were more prepared to invest greater resources in the fraud fight. Today all but nine states have one form of fraud bureau or another. States with no fraud bureau (multi-line or line-specific) include Alabama, Indiana, Maine, Michigan, Oregon, Tennessee, Vermont, Wisconsin and Wyoming.

Fraud-bureau employment today, however, has drifted back to the lower levels before the recent buildup began in the middle of the last decade.

Overall staff levels declined nine percent last year from 1,470 to 1,343 after a similar drop from 2009 to 2010. Investigators, administrative staff, analysts and lawyers all have been pared.

But job losses appear to be slowing: Though 13 percent of directors reported staff losses last year, nearly a quarter of fraud bureaus (23 percent) reported losing positions in 2009 from the previous fiscal year.

States also told directors not to fill open positions last year. By contrast, nearly half of the fraud bureaus said they had unfilled positions in 2010.

Whatever the sources of job loss, the net impact is that fewer people are showing up for work at fraud bureaus — and in some cases, a lot fewer.

**Budgets reductions easing**

Budgets have experienced similar downshifts, falling 10 percent overall from 2010 to 2011. Some cash-strapped states even reduced fraud-bureau budgets at midyear when shortfalls in the state general funds grew especially acute.

Though much like staffing levels, budget declines have eased somewhat over the last three years. Only 16 percent of fraud bureaus saw budget cuts since the beginning the 2011 fiscal year, compared to 39 percent in 2009.

Fraud bureaus that rely on general state revenues and allocations from insurance departments also suffered larger declines than bureaus relying on annual assessments of insurers.

Assessments absorb no taxpayer funds. This approach supposedly provides a larger degree of funding stability, and helps armor against general cutbacks and sudden raids.
Still, even assessment pools have shrunk somewhat. This is especially true of bureaus whose funding is pegged to insurer premium volume. Assessment funds have dropped as premiums declined during the height of the recession, which saw fewer homes, cars and workers to insure.

Nor has assessment funding guaranteed immunity from raids. Most notorious were Virginia and Louisiana, which in 2009 and 2010 diverted insurer money that was legislatively reserved for fraud bureaus.

State budget raids also appear to be easing. Several states have raided fraud-bureau budgets to replenish depleted general coffers over the last three years.

Seven bureaus reported raids in 2010, but only one bureau saw funds redirected last year.

Resources down, caseloads up

The mantra of doing more with less also has proved true. Recessions impose a double whammy: Anti-fraud resources decline, but the downturned economy ignites more fraud by people who are anxious to recoup money when their finances crumble.

Hard-up consumers or greedy opportunists may lodge bogus claims. Businesses also play the fraud lottery, especially small businesses that may have weaker cushions against economic slide than larger firms.

So no small surprise that cases referred to fraud bureaus for investigation rose six percent from 132,779 to 140,992 in 2010.

As a result, most investigative staffs saw larger caseloads. But fewer cases were opened last year simply because many bureaus lacked the resources. Total cases opened for investigation thus fell three percent in 2010, from 44,822 to 43,501.

The more immediate statistic involves arrests. This is a touchstone figure that can help gauge crime-fighting activity. Fraud bureaus reported a 10-percent decline in arrests over the last two years: 5,016 busts were logged in 2009, with a drop to 4,471 in 2010.

Similarly, criminal convictions declined eight percent, from 5,186 to 4,758 during that same period. The fact that fraud bureaus saw more convictions than arrests likely reflects the large number of investigations in previous years that have come to fruition and are being prosecuted.

Fewer recent arrests plus clearing out of earlier cases is a warning signal that the pipeline of active cases may continue depleting. Convictions thus could decline in several states, and overall, during the next several years if the case pipeline keeps clearing out.

Civil actions stable

Civil and administrative actions against insurance cheaters can be a convenient and effective crime-fighting tool. Such actions require a lower burden of proof than criminal convictions, and thus often absorb fewer resources.

But despite their promise, civil actions by fraud bureaus have remained only steady at about 1,750 actions in 2009 and 2010. In fact, civil actions remain well under the highs of 2005 to 2007, when they averaged more than 3,600 annually.

Despite the dropoff, civil actions still bear monitoring as a potential trend in future years, especially if the economy remains stagnant.

Fraud bureaus will need to continue seeking budget-friendly ways to maintain pressure on fraud schemes.
Core fraud crimes rising

Fraud directors also were asked about trends in the streets. Bottom line: Many common forms of fraud continue increasing during the unsteady economy, the directors say. The results closely mirror previous years, with a couple of exceptions.

Crooked agents remain the biggest problem area by far. More than half of fraud bureaus (55 percent) said cases involving insurance agents had risen in 2011. This was easily the biggest spike among all crime categories. A common agent crime involves stealing client premiums without securing the requested coverage. In many cases, crooked agents use the money to prop up their struggling businesses.

Staged auto crashes logged the next-highest increase, with 45 percent of fraud bureaus seeing jumps. Setup wrecks for bogus injury claims steal hundreds of millions of dollars a year, and possibly more. Gangs operate primarily in urban areas, where dense populations provide cover for large volumes of claimed crash injuries.

False claims involving auto insurance came in third with a 38-percent increase. Hard-up or plain greedy drivers may torch their SUVs for insurance money, or try to reduce their auto premiums by lying about where they garage their vehicles.

Thirty-six percent of fraud bureaus reported increases in false claims involving medical coverage in 2011. Fake health plans, especially, have spread over the last three years. It is no coincidence that bogus health coverage tends to spike during economic downturns. Financially stressed consumers and small businesses are vulnerable to deceptive sales pitches.

Home and business arsons also edged upward last year, but far less than the substantial increases from 2009 through 2010. Hard-pressed homeowners facing foreclosure, for example, might torch their homes in an illicit gambit to have insurance pay off their mortgage.

Bogus workers compensation injury claims also grew, but at a similarly slowed pace. This tracks with previous economic declines. Job layoffs mean fewer workers to report claims. Many workers also may hesitate to jeopardize their jobs by filing questionable claims.

Future is uncertain

In followup discussions with the Coalition late last year, many directors anecdotally expressed deep concern about whether their outlook for resources would improve anytime soon.

Several bureaus already live on the edge with minimal resources, which materially reduces their ability to combat this crime. Arizona's fraud bureau lost most of its staff during a state budget-cutting effort in FY 2008. Hard-up states also have raided fraud-bureau budgets in efforts to fill depleted general coffers.

Despite facing continued economic pressure, fraud units on balance continue producing solid crime-fighting numbers. They consistently show effective results when well-funded, functioning and fully loaded. Often this means paring non-essential functions to keep core investigative operations going strong. But how far can you stretch a rubber band before it starts breaking?

The Coalition's 2011-2012 survey will shed more light on whether fraud bureaus begin rebuilding the resources needed to sustain a forceful anti-crime presence throughout the nation.

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About the author: Dennis Jay is executive director of the Coalition Against Insurance Fraud.
Deducting fraudulent waivers of deductibles

Insurers have effective remedies but must better recognize their fraud exposures

By Brian Stimson and Matt Montaigne

Waivers of deductibles, co-payments and similar cost-sharing obligations by third-party service providers present fraud risks for insurers. Providers such as roofers and auto-body shops typically offer to waive such obligations to induce their insured customers to use their services. Obviously, insureds are more likely to select a provider if they do not have to pay their deductibles or co-payments.

While insurers almost always find such waivers objectionable, the fraud does not occur until after the provision of the service, when the provider submits a bill to the insurer that inflates the cost of the service. The inflated bill enables the provider to obtain a single payment from the insurer, which is equal to the combined amount the provider would have received from the insurer and insured if the insured had paid the deductible or co-payment.

The inflated bill defrauds the insurer because it misrepresents the provider’s total charge for the services. The insurer is induced to pay the total charge for the services, as opposed to the percentage of the total charge the insurer agreed to pay under the policy.

Abstract: Insurers face potentially significant risks of loss from fraudulent and tortious waivers of insurance deductibles and co-payments. Auto-body shops and roofers are among the leading offenders. Many states have enacted statutes imposing criminal penalties for fraudulent waivers. State statutes also allow insurance companies to sue service providers for damages, injunctive relief and other remedies. Both state and federal remedies are available. But many insurers don’t realize the magnitude of their fraud and abuse exposures, and thus do not actively exercise their available remedies. Full deployment of these remedies has great potential to reduce improper or unnecessary outflows of money, which are raising rates for consumers, exposing them to unsafe repairs, and reducing insurer income.
Amazingly, some insureds do not even need the service furnished by the provider. In such cases, the provider offers to waive the deductible, and promises to represent the insured in negotiations with the insurer for coverage of the service. After furnishing the service, the provider submits an inflated bill for its total charges, as if the services were necessary and covered by the policy.

If the service provider bills only its usual and customary charges, then many state regulators will allow the provider to forego collecting the deductible from the insured. But the state courts may still construe the waiver as a tortious interference with the insurer’s contract with the insured. In other words, even if the service provider does not violate an affirmative statutory or regulatory prohibition, it may still commit a business tort that injures the insurer by eliminating a cost-control mechanism.

Health-care payers have litigated these fraudulent and tortious practices with health-care providers for years, resulting in numerous published legal opinions.

**Risk hard to quantify**

Auto and home insurers are affected by the same practices, but the dearth of published legal opinions involving such insurers suggests they have not litigated extensively with service providers. The fraud risk for auto and home insurers is also difficult to quantify because there are no comprehensive analyses of industry-wide data on fraudulent and tortious waivers of deductibles. Nonetheless, the news reports of such waivers — and the state legislative response to such reports — suggests that the fraud risk for auto and home insurers is significant.

This article a) outlines relevant legal principles developed in the health-care fraud context; b) highlights representative state laws targeting fraudulent and tortious waivers of insurance deductibles; and c) provides a roadmap of civil legal remedies for auto and home insurers seeking to deter fraudulent and tortious waivers.

**Waiver statutes impose stiff penalties**

The federal government is the nation’s largest health-care payer, and has long prohibited health-care providers from waiving deductibles and co-payments for beneficiaries of programs such as Medicare. Liability attaches to the waiver itself, before the provider submits an inflated bill. The prohibition is enforced by the government, and liability can result in stiff criminal sentences.

Many states have adopted similar statutory protections for private health-care payers. In Colorado, for example, a provider submitting “a fee...which is higher than the fee he has agreed to accept from the insured patient with the understanding of waiving the required deductible or co-payment” commits the Class-One petty offense of health-insurance fraud. Under the same Colorado statute, waiving the deductible or co-payment interferes “with contractual obligations...between the insured and the insurer relating to such payments...” Violations thus can support actions by insurers against providers for tortious interference with insurance contracts.

When private health-care payers pursue statutory and common law remedies under
disagree on the ethics of the practice, with proponents asserting that waivers cause no harm if the shop’s reduced profit is acceptable to its owner. Opponents argue that the practice is unprofessional, creates an uneven playing field, and drives profits out of the industry by conditioning customers to expect more for less. The body shops opposing the practice often have contracted with insurers to participate in direct-repair programs (“DRPOPs”), and have thus agreed to collect deductibles. Another factor driving waivers of deductibles has been the tornadoes and severe storms across the Eastern and Southern states, which have deluged homeowners with rain, hail, wind and “storm chasers.” Storm chasers are contractors who canvass damaged areas after the storm, signing up customers for roofing or other repair work. In Texas alone, the number of potentially fraudulent repair claims sent to the National Insurance Crime Bureau for investigation increased 321 percent, from 2008 to 2010. NICB attributes the increase partly to fraudulent storm chasers. Unfortunately, this is more than a financial issue. Dishonest roofers who bring in business through fraudulent waivers also may perform shoddy work. This can expose homeowners to headaches and the added cost of repairing the work.

Anti-waiver statutes plentiful as tools

Many states have long-standing statutes against waivers of deductibles by auto- or home-repair providers. For example, South Carolina adopted a statute in 2002 that made it an unfair trade practice for an auto glass-repair business to waive all or part of an insurance deductible as consideration for selecting the business. The prohibition is enforced by the state Attorney General. The existence of such an obligation was the central legal issue in both Aetna Health, Inc. v. Carabasi Chiropractic Center, Inc. and Garcia v. Health Net of New Jersey, Inc., where the payers sued the providers for statutory insurance fraud and tortious interference based on coinsurance waivers.

In Aetna Health, the New Jersey Appellate Division found that the payer stated a claim for statutory insurance fraud by alleging that the provider waived the enrollee’s coinsurance, failed to disclose the waiver, and inflated its charges. The payer stated a claim for tortious interference by alleging the waiver, the also court ruled. Two years later, the Appellate Division granted summary judgment to the providers in Garcia. The court reasoned that the payer could not prove scienter or malice because there was no evidence that the providers were obligated to collect the enrollee’s coinsurance.

Must approve obligation

Together, Garcia and Aetna Health stand for the proposition that an insurer must plead and prove a third-party provider’s obligation to collect the deductible, co-payment or coinsurance in order to prevail on a claim against the provider for a fraudulent or tortious waiver.

Garcia and Aetna Health are consistent with Kennedy v. Connecticut General Life Insurance Company, where the U.S. Court of Appeals for the Seventh Circuit found that the health-care insurer was not obligated to pay the health-care provider because the provider waived the insured’s co-payment.

Under the policy language, the insurer was not obligated to pay charges the provider did not require the insured to pay, the Seventh Circuit reasoned. Because the provider effectively waived his third-party contractual right to the co-payment from the insured by promising that he would only seek payment from the insurer, neither the insured nor the insurer had a legal obligation under the policy to pay the provider.

Waivers of deductibles also have become a flashpoint in the home- and auto-repair industries. This is due partly to the recession, which has prompted auto-body shops to waive deductibles in order to stimulate business. The shops themselves
General, with assistance from government prosecutors across the state. Any person who suffers an ascertainable loss of money or property from a violation of the prohibition may bring an action for damages, with the ability to recover treble damages for willful violations.

Florida took a slightly different approach in 2003. It enacted a statute extending the felony offense of criminal insurance fraud to service providers who, as a “general business practice,” bill their usual and customary charges to insurers after agreeing with the insured to waive the deductible or co-payment.

Waivers of deductibles are illegal only when the provider charges the insurer more than the cost of the repair in order to recover the deductible, reasons the Deputy Director of the Florida Department of Financial Services (which administers the statute). If the service provider does not collect the deductible or overcharge the insurer, then the practice does not violate the statute. This distinction is important because violators are subject to mandatory civil penalties, and the insurer acquires a statutory cause of action against the violator upon a conviction or plea of guilty or nolo contendere.

Other states have passed legislation recently, in an apparent response to news reports of fraudulent and tortious waivers of deductibles. Georgia, for example, adopted legislation in 2011 that amended its Fair Business Practices Act (FBPA) to prohibit roofers from representing homeowners in connection with insurance claims. The amendment also made it a misdemeanor to knowingly “advertise or promise to pay or rebate all or any portion of any insurance deductible as an inducement to the sale of goods or services.” The latter reform is critical for insurers because only the state and individuals can sue under the FBPA. Georgia’s criminalizing of advertisements and promises to pay insurance deductibles provides insurers with redress through state prosecutors.

Shortly after the new legislation became effective, Georgia’s insurance commissioner investigated roofers who allegedly were waiving insurance deductibles. The targets of the investigation included a roofer advertising that “(s)torm victims pay zero deductible.” The commissioner rented a house, dispatched undercover agents to pose as homeowners, and installed hidden cameras to record the roofers’ conduct. The cameras revealed that the roofers damaged the roof, attributed the damage to hail, and offered to pay any insurance deductible as an inducement to purchase the repair work. Three roofers were arrested. They face various criminal charges, including felony insurance fraud.

State investigations and legislation targeting fraudulent waivers of home and auto insurance deductibles — together with news reports of such waivers — reflect a significant fraud risk. Yet there are few published decisions regarding waivers of auto or home deductibles. Nor are there any comprehensive analyses of industry-wide data concerning fraudulent and tortious waivers.

The absence of published decisions and comprehensive studies suggests that insurers do not fully appreciate their fraud exposure, the range of available civil legal remedies, or the deterrent benefits that would undoubtedly flow from vigorously pursuing civil legal remedies against the most egregious of providers.
Varied legal remedies available

Insurers aggrieved by waivers of deductibles may bring statutory fraud or anti-waiver claims against third-party service providers. Depending on the circumstances, insurers also may bring state common-law claims for fraud, tortious interference and unjust enrichment. Insurers can recover damages, injunctive relief, restitution, and attorney fees and costs.

Statutory fraud — broad relief: Some states, such as New Jersey and Georgia, have adopted fraud statutes that specifically protect insurers. New Jersey's statute has been construed to prohibit fraudulent cost-sharing waivers, and it also authorizes civil actions. Under the Garcia case, however, the statute applies only if the provider is obligated to collect the cost-sharing amount from the insured. Georgia's insurance-fraud statute is purely criminal, but also can be enforced by insurers through civil actions under the state RICO Act. Other states, such as South Carolina, expressly define waivers of insurance deductibles or co-payments as prohibited, unfair business practices giving rise to civil actions. South Carolina's prohibition applies only to auto-glass companies.

Regardless of the requirements for liability, state statutory claims usually are advantageous for insurers because they authorize broad relief. Minnesota's statute, which empowers insurers to sue auto glass companies, is representative. Prevailing insurers in Minnesota are entitled to receive damages and costs, including the costs of investigations and attorney fees. Insurers also may obtain equitable relief (e.g., injunctions) as determined by the court.

The federal RICO Act authorizes equally broad relief. To prevail on a federal RICO claim, an insurer probably has to plead and prove that the provider was obligated to charge and collect the deductible or co-payment. If the provider was obligated, and used the interstate mail or telecommunications system to perpetrate the fraud, then the provider's federal mail or wire-fraud violations might serve as the predicate racketeering activity for the insurer's RICO claim against the provider. A prevailing insurer can obtain treble damages and attorney fees, as well as injunctive relief.

State common law: Insurers also can seek redress from fraudulent and tortious waivers of deductibles through common law.

If an insurer believes that a third-party service provider has submitted an inflated bill, the insurer always can bring a garden-variety fraud claim. Such a claim typically requires these elements: a) knowingly false representation; b) made with the intent to induce action by the plaintiff; c) justifiable reliance by the plaintiff; and d) damages.

The insurer also can sue for tortious interference with its contractual relationship with the insured.

The insurer’s theory is that by waiving the deductible, service providers have induced insureds to forego paying their deductibles, and therefore have interfered with the insureds' obligation under the policy to pay. The failure to pay the deductible is a material breach by the insured because the policy’s deductible requirement is a cornerstone of the insurer’s efforts to control costs for all insureds.

Finally, the insurer can sue for unjust enrichment. The insurer’s theory is that the service provider received an improper benefit through the insurer's inflated payment, which the service provider must disgorge in equity and good conscience.

Conclusion

Fraudulent and tortious waivers of insurance deductibles and co-payments by service providers
such as auto-body shops and roofers present significant fraud risks for auto and home insurers. Many states have responded by enacting legislation empowering insurers to bring civil actions against service providers for damages, injunctive relief, attorney’s fees and costs.

But insurers must better appreciate the extent of their fraud exposure, and the available remedies for fraud they do uncover. By vigorously pursuing both statutory and common-law remedies against the most egregious of service providers, insurers can deter fraudulent and tortious conduct, and thereby manage premiums for their insureds.

Want to share your thoughts about this article? Visit insurancefraud.org/JIFA.htm
For fast access, scan this code using a smartphone.

endNOTES

1 The term “health care payer” encompasses insurers for individuals and group health plans, self-funded health plans subject to the Employee Retirement Income Security Act (ERISA), and government health plans.

2 42 U.S.C. § 1320a-7(b)(2)(B) (criminalizing the offering or paying of kickbacks or rebates in order to induce persons to purchase items and services reimbursable under a federal health care program); Special Fraud Alert, 59 Fed. Reg. 65,374 (Dec. 19, 1994) (“Routine waiver of deductibles and co-payments by charge-based providers, practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.”)

3 Colo. Rev. Stat. § 18-13-119(3)(b); See, e.g., O.C.G.A. § 43-1-19.1(a) (classifying the waiving or advertising of the waiving of a deductible or co-payment as a deceptive or misleading practice which justifies the denial or revocation of a state medical license); Tex. Ins. Code Ann. § 1204.055(b) (declaring that physician or health care provider may not waive a deductible or co-payment by acceptance of an assignment of health care benefits).


7 Id.


10 Id.


11 Ibid.

12 May storms beastly, Columbus Dispatch, 2011 WLNR 12361009 (June 21, 2011); Spring Hailstorms Bring Roof Damage And, Just As Bad For Owners, Unscrupulous Roofers, Ft. Worth Star-Telegram, 2011 WLNR 1155912 (June 10, 2011); Scammers Targeting Storm Victims, Birmingham News, 2011 WLNR 8898450 (May 3, 2011); Authorities Warn About Offers To Do Storm Repairs, Morning Call (July 11, 2010); see also Scan Example, available at http://freeroofscam. org/examples/ (last visited Jan. 2, 2012).

13 2011 WLNR 1155912. In Texas, a provider commits a crime if a) the provider advertises or promises to provide the service and to pay all or part of the deductible; b) the consumer pays for the service using insurance proceeds; and c) the provider knowingly charges an amount for the service that exceeds the provider’s usual and customary charge by an amount equal to all or part of the deductible. Tex. Bus. & Com. Code §27.02. A service provider that waives the deductible does not commit a punishable offense under §27.01 until and unless it submits a bill to the insurer that exceeds the provider’s usual and customary charge by an amount equal to all or part of the insurance deductible. Tex. Atty. Gen. Op. JM-1154.

14 2011 WLNR 1155912.

15 See Authorities warn about offers to

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do storm repairs, Allentown Morning Call, 2010 WLNR 14099447 (July 11, 2010).

27 Indeed, the authors found only two decisions involving waivers of auto insurance deductibles. Alpine Glass, Inc. v. Ill. Farmers Ins. Co., No. 06-CV-1148, 2006 WL 3486996, at *2-6 (D.Minn. Dec. 6, 2006) (granting auto glass company’s motion to dismiss insurer’s counterclaim for violation of anti-incentive statute); Action Auto Glass v. Auto Glass Specialists, No. 1:00-cv-756, 2001 WL 1699205, *1 (W.D. Mich. Aug. 21, 2001) (granting summary judgment in favor of plaintiff auto body shop on unfair trade practices claim against competitor that publicly criticized business practice of providing coupons to customers for their deductibles). The authors found only one news report of a jury verdict involving waivers of auto insurance deductibles: A California jury awarded $163,387 to Farmers Insurance Exchange on a fraud claim against an auto body shop that improperly waived deductibles under circumstances where the shop did not repair the vehicle in accordance with the amount of the claim accepted by Farmers. Farmers Wins Landmark Body Shop Fraud Lawsuit, Auto Body Repair News, available at: http://abrn.searchautoparts.com/abrn/article/articleDetail.jsp?id=445217 (Jul. 30, 2007, last visited Jan. 5, 2012).

28 Minn. Stat. § 325F.783 (“[n]o person who provides retail auto glass products or services paid for ... by an insurer ... may waive ... all or any part of an ... insurance deductible ... .”)

29 Minn. Stat. § 8.31(3a).

30 Id.

31 The decision of the Central District of Illinois in OSF Healthcare Sys. v. Banno, No.1:08-cv 01096, ECF No. 29 (C.D. Ill. Sept. 24, 2008), 42 (Dec. 10, 2008) (adopting report of magistrate in part), and 61 (Mar. 30, 2009) (final order on motion to dismiss following re-pleading), is instructive for insurers. The plaintiff in OSF Healthcare was a health-care provider that agreed to discount its rates in return for the exclusive right to provide health care to Caterpillar’s employees. Id. at ECF 29, pg. 4. The plaintiff sued the defendant, a non-contracted provider, after the defendant routinely waived Caterpillar employees’ coinsurance. Id. at pg. 6. The plaintiff then brought a federal civil RICO action, alleging predicate acts of mail and wire fraud. Id. The defendant moved to dismiss on the ground that he had no legal duty to collect the coinsurance. Id. at ECF 61, pg. 3. The court denied the motion, finding that the plaintiff pled a legal duty on the part of the defendant to charge and collect co-insurance by virtue of Caterpillar’s express instruction to do so. Id.

32 18 U.S.C. § 1964(a), (c).

33 See Aetna Health, 2006 WL 66460, at *2; Oxford Health Ins., 2010 WL 3068027, at *5 (alleging common law fraud through a practice of submitting misleading bills).


35 While one court has accepted this theory in the health care context, two others have rejected it on the ground that the insurer did not expect to receive a benefit when making the inflated payment for the service. See Oxford Health Ins., 2010 WL 3068027, *8-9 Aetna Health, 2006 WL 66460, at *1; Garcia, 2007 WL 5253484, at *14, 2009 WL 3849685, at *4.
Recruiting tactics for crash rings evolving, but new laws are heading them off

Abstract: Auto insurers face huge losses to fake injury claims stemming from staged and real car crashes. So-called runners (or recruiters) play a key role in bringing in real and bogus crash victims to shady clinics for illicit treatment. States have responded with a variety of laws to crack down on runners over the years. One prominent recent legislative trend works to thwart soliciting real crash victims for treatment. Limiting access to police reports or simply making soliciting a specific crime are two legislative approaches. Such statutes make it easier for prosecutors to convict runners than traditional anti-runner laws, which tend to require that prosecutors prove a direct link between the recruiting and a fraud. Ultimately, fraud fighters and insurance schemers both are agile and continuously adapt to each other’s tactics. Fraud fighters must adapt faster and better if America is to turn the corner on this crime.
Recruiters frequently show up at authentic crash scenes and try to steer real victims to shady clinics... Painfully injured patients who are lured to these clinics may receive shoddy treatment.

Solicitation wave washes over

Clamping down on solicitation works to thwart evolving tactics by crash rings.

Recruiters frequently show up at authentic crash scenes and try to steer real victims to shady clinics. The recruiters may simply hand out business cards onsite, or hound victims by knocking on their doors or persistently telephoning them.

Painfully injured patients who are lured to these clinics may receive shoddy treatment. Legitimate medical care takes time, which only slows down the clinic’s factory-line production of fraudulent injury claims. Clinics also fraudulently convince slightly injured victims that they need expensive treatment for injuries that are more serious than they actually are.

One legislative approach criminalizes the mere act of soliciting crash victims, whether or not fraud is intended. These measures usually ban solicitation for a defined time-period after the crash — typically 30 or 60 days.

This breathing room allows often-traumatized victims to regroup and work with the auto insurer to find the proper medical care for their needs. By the time the blackout period has ended, many victims also have settled claims or received legitimate medical care. This elbows crooked clinics out of the transaction.

Equally important, criminalizing just the act of soliciting is easier to prove in court without having to prove the act was in furtherance of fraud. Advertising, blast faxes, face-to-face hounding and other tactics are concrete evidence, less-complex and easier to land a conviction.

Nebraska had a bill in 2011 limiting solicitation for a full 90 days after crashes. But the bill died because the state chiropractic board developed a regulation forbidding chiropractors to use coercion or fraud to get crash passengers to have treatments at their clinics.

Legislators believed that reigning in only dishonest and unethical chiropractors fully resolved crooked soliciting. Fraud fighters contend that a new law should be passed to penalize other crooked medical providers and their recruiters. The state chiropractic lobby agrees, and says it would support a more-inclusive bill if one is introduced in 2012.

Supreme Court upholds Texas law

In 2009, Texas passed a 30-day ban against soliciting patients specifically by phone or in-person. Fraud fighters, led by the Texas Committee on Insurance Fraud, had won a hard-fought two-year battle in the statehouse. But the new law faced a constitutional challenge almost immediately. A chiropractor sued to overturn the law before it even could take effect. He claimed the measure violated his First-Amendment right to advertise for clients.

A federal appeals court upheld the law, so the persistent chiropractor went to the U.S. Supreme Court. His appeal was denied.

The Texas law finally took effect. The decision also cemented in place a precedent that may help armor anti-solicitation measures against similar
challenges in other states. Passage in a large and visible state such as Texas also may draw attention to solicitation abuses in other states, and to the Texas model as a potentially effective remedy.

“It was a long, drawn-out battle that took six years, two legislative sessions and two decisive court decisions,” said Mark Hanna, of the Texas Committee. “We hope this law will be a model for legislation across the country. It feels good to put the nail in what should have been outlawed long ago: chasing ambulances for profit.”

The new law may already have had a purgative effect in Texas. Some insurance-fraud investigators say they have seen chiropractors moving out of Texas to nearby states that don’t have anti-solicitation laws.

A broad anti-solicitation bill also is inching through the New Jersey legislature as part of a comprehensive auto-reform bill. The measure died last year, and the anti-fraud community is pushing for passage in 2012.

**Cashing in on crash reports**

Limiting access to police crash reports is another promising anti-solicitation strategy. Such measures temporarily prohibit the general public from obtaining the reports, usually for 30 or 60 days after a wreck. Only the victims, their representatives or legitimate journalists can view the reports during that period.

These measures work to curb a common tactic by insurance swindlers: Recruiters go to local police stations each day and obtain the latest crash reports. They goldmine the reports for names, addresses and phones of crash victims. Then they try to hound the victims into receiving treatment at a specific clinic.

Typically the clinic is shady or an outright sham. What legitimate clinic needs to obtain patients using crash reports, or to relentlessly badger victims? Victims also face potentially substandard medical treatment. Good medicine takes time, increases expenses and reduces illicit profits. Illicit medicine has little concern for the patients’ welfare, and may involve shortcuts and useless treatment that largely ignore the medical needs of real injuries. Blocking access protects patient privacy, as well. Why should a third party uninvolved with the crash need to view sensitive personal information in the report?

Even if the injury treatment is legitimate, the crash victims often are unprepared to make clear-headed treatment choices so soon after the wreck. They need time to regroup and work with their insurer to properly evaluate their treatment options or settle the claim.

**Florida** was the first state to block unfettered mining of crash reports. The Sunshine State sealed off the reports for 60 days, except for victims, their lawyers and other insiders to the accident. Lawmakers in other states have pushed bills modeled after the Florida law, but enactment has been slow to take hold. Well-connected and influential opposition in several states has come from an unexpected source: Law enforcement.

**Maryland**, for example, passed a law similar to Florida’s. But it was quickly repealed the next year. Among the reasons, local police decided that arbitrating who could access the reports would be a bureaucratic burden.

A bill in Connecticut was never even introduced.
Law enforcement considered restricting crash reports as a financial threat. Local governments and police departments sell crash reports to help fund their operations. Reducing that funding would further pressure already tight budgets in a down economy.

The police rose up in Indiana as well. Fraud fighters were moving a bill in 2011, only to have the state police quash it. The Indiana state police have a multi-year contract with a vendor to sell the crash reports. They contended that limiting access would violate the contract under Indiana law. The state constitution clearly says contracts are inviolate and cannot be altered by a state law, the police successfully argued to the statehouse.

Arkansas lawmakers pursued two crash-report bills in 2011. One bill restricted access for 90 days but failed. A 60-day cloak then was introduced, but it also died when the legislature adjourned for the year without acting on it. Apparently, law enforcement wasn’t involved in stifling this bill.

Georgia is one success story amid the losses. The Peach State enacted a crash-report ban in 2011 — with an unusual twist: Anyone can obtain the reports, but the documents cannot be used for commercial purposes.

Thus, medical providers can legally treat crash victims if the providers have an ongoing relationship with them. But providers cannot solicit crash reports involving new patients. The problem, however, is enforcement. How do you monitor commercial usage of reports?

Running down runners

Anti-runner measures still remain part of today’s legislative mix as well. They can be powerful anti-fraud weapons despite their potential drawbacks.

Connecticut made it a crime to hire or act as a runner for staged-crash rings. But in a new twist, the statute penalizes the mere act of recruiting phony crash victims. Like soliciting of real passengers, prosecuting for recruiting fake ones requires proving a fraud tie-in. Recruiting itself is enough to convict — a much easier task.

The measure tracks a guideline crafted by the anti-fraud task force of the National Association of Insurance Commissioners. The guideline was one of the first efforts to take that approach.

But there also might be an unintended impact.
Recruiters could face felony charges for trying to land patients for legitimate treatment and honest insurance claims. The legislature and courts will have to sort that out.

**Michigan** has expensive problems with staged-crash rings, and is working to build out its anti-fraud infrastructure. To this end, the Michigan governor recently signed into law a traditional anti-runner bill with language requiring a fraud tie-in.

Michigan will join 15 other states targeting runners. The measure is similar to the Coalition's model law, and actually originated from the model.

The insurance department is confident the bill will clear the legislature. The Senate has added language saying that the insurance department believes it is essential that the bill be enacted into law. The core language is similar to the Coalition's model bill.

**New York** remains a question mark year after year. Staged-crash rings are rampant in **New York City**, and have spread to cities upstate. Anti-runner bills have circulated in the statehouse for several years, but they continually fail. In-fighting, inertia, lack of will and other factors help explain this gap despite a strong consensus that such laws are needed.

**Adapt faster and better**

Targeting automobile crash rings has been a major issue of many state legislatures for years, given the volume of stolen insurance money and damage to passengers.

Shyster medical clinics are persistent and greedy, so remedial bills likely will be proposed for years to come.

Combating crash gangs is a never-ending cycle of adapt-and-change. Clinics constantly adopt costly new evasive tactics when fraud fighters hammer them with new fraud laws, regulations or investigative strategies.

Both sides play the crash game well. Fraud fighters therefore must keep adapting faster and better than dishonest crash clinics. With auto insurance, it’s the road better hoed.

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**About the author:** Howard Goldblatt is director of government affairs for the Coalition Against Insurance Fraud.

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**endNOTES**

1 172 NAC 29-009.03.
4 SB 84, Indiana Legislature (2011).
5 HB 1044 and HB 2211, Arkansas Legislature (2011).
6 53-24-53(c) Georgia Code Annotated.
7 CGS 53-340a.
9 Arizona: 20-463(G); District of Columbia: 22:3225.02; Idaho: See 41-291(13) and 41-293; Massachusetts: Chap. 266:111C; Minnesota: 609.612 and see 481.03; Nevada: 686A.2815(7) and (8); Utah: 31A:31-102.
11 Texas Penal Code 38.12(d).
12 Title 23 Sec. 316.066.
13 Kentucky Statutes 21A:300.
14 53-24-53(c) Georgia Code Annotated.
16 Florida Statutes Title 46 Sec. 817.234 and Title 23 Sec. 316.066.
Recent Legislation, staged crashes

Recent court decisions are helping shape the anti-fraud landscape, including two state rulings with potential precedent-setting impact beyond their own borders.

Access by West Virginia auto-insurer investigators to vital claimant medical records was limited. The path was cleared for Texas fraud fighters to better chase down dishonest clinics that lure auto crash victims for bogus injury treatment (see “Laws Solicit Jail” feature story). And the Vatican was absolved of complicity in a massive insider looting of life insurers.

Here are the details...

The privacy of a claimant’s medical records overrules the insurer’s need to access those files. That was impact of a ruling by West Virginia’s highest court. A claimant had refused to let State Farm see her medical records during a personal-injury lawsuit stemming from an auto-injury claim. The auto policy had contractually allowed the insurer access to the records.

But the West Virginia Supreme Court imposed wide limits on document disclosure, and required that the claimant’s medical records be destroyed.

Investigations by auto insurers in the state would be greatly hampered without access to medical records that could provide vital evidence about claimed crash injuries, fraud fighters contended in an amicus brief.

State Farm appealed to the U.S. Supreme Court (State Farm Mutual Automobile Insurance Company v. Bedell). But the nation’s highest court in late November 2011 chose not to hear the case, thus locking the West Virginia precedent in place.

Even healthcare probes could be limited if other courts adopt the precedent. A large fraud ring recently was charged with a suspected $300-million Medicare scheme. One doctor allegedly billed for more than 24 hours of psychotherapy treatments a day, and another doctor allegedly billed for treating dead people. If the precedent spread to federal courts, for example, investigations into this kind of suspected fraud could be significantly hampered.

The Texas ruling upholding a 30-day ban on soliciting crash victims sets in motion an important anti-fraud law in the state. Fraud fighters thus retain an effective tactic for combatting illicit and widespread luring of victims for thousands of dollars in bogus injury treatment.

A federal decision in Mississippi closed a long chapter in one of the largest cases of insider looting of insurers in U.S. history.

The court in February dismissed, with prejudice, a lawsuit by five state insurance commissioners accusing the Vatican of complicity in Martin Frankel’s massive $200-million theft from several small, ailing life insurers he had secretly bought.

The commissioners of Mississippi, Tennessee, Missouri, Oklahoma and Arkansas sued the Vatican in 2002. They charged that Msgr. Emilio Colagiovanni and the Holy See helped Frankel illicitly buy the insurers.

Frankel created a sham foundation that he claimed the late Pope John Paul II had personally
authorized. Frankel used those bogus credentials to help hide his ownership of the insurers. He received nearly 17 years in federal prison in 2006.

Dale v. Colagiovanni was dismissed in February by the U.S. District Court for the Southern District of Mississippi.

Pirating of patient data

Pirating of sensitive patient medical data appears to be increasing. This raises the specter that many healthcare firms are soft targets for swindlers who steal the data for costly and potentially life-threatening medical identity theft schemes.

That’s one implication of a report released by the Ponemon Institute in December 2011.

“Many hospitals and healthcare organizations in this study believe they have insufficient security and privacy budgets, and affected patients are not always receiving the privacy care they are promised,” the report says. “The growing use of unsecured mobile devices and the rising rate of employee mistakes compound the problem.”

Ponemon found that:

❖ Data breaches nationally soared 32 percent last year. Employee negligence and lack of oversight were the prime causes;

❖ Twenty-nine percent of respondents say their data breaches led to cases of identity theft. That is a 26-percent increase over the previous year;

❖ Nearly every organization surveyed had experienced at least one data breach in the last year.

❖ Once a breach is uncovered, 83 percent of hospitals say it takes one to two months to notify affected patients; and

❖ The main causes of data breaches were lost or stolen computing devices, unintended release of information by contractors, and slip-ups by employees.

Medical identity thievery has spread in recent years despite widespread public attention. In fact it remains the fastest-growing form of identity theft, many experts contend.

One-third of healthcare firms have caught a patient using someone else’s identity to receive treatment, says a 2011 report by the consulting firm PwC, titled “Old Data Learns New Tricks,” by the consulting firm PwC. Nearly 1.5 million Americans have been victimized, Ponemon says in another report released in March 2011.

Data breaches across all industries cost each victim organization an average of $6.75 million, Ponemon also estimates.

Much of identity theft involves employees stealing patient information from hospitals, clinics and other healthcare outlets. They sell the data to fraud rings, which lodge thousands of dollars in bogus medical claims.

Thieves also obtain treatment for themselves. Unpaid medical bills can ruin the victim’s credit. Incompatible medicine and blood types also could end up in a victim’s medical records, creating potentially life-threatening exposures. In two prominent cases:

Brandon Sharp applied for a mortgage, only to discover several collection notices and damaged credit. He was shocked to find he owed thousands of dollars for emergency medical care someone else had rung up in his name.

Andorie Sachs received a call that her newborn baby had tested positive for drugs. Social-services workers then showed up at her front door and threatened to take away her four children. The woman hadn’t given birth in years.

Consumers losing health insurance in a sluggish economy could help drive many ID thefts. Electronic
data-sharing required by HIPPA also could enlarge the problem in the years ahead.

“The digitization of patient health information is inevitable, and so are the risks of compromising patient privacy,” says the PwC report.

Looking at new technology

Hand-sized mobile phones are having an outsized impact on how Americans meet, socialize and form many of their opinions. They also have great potential to expand the ability of fraud fighters to educate the public.

Mobile devices are among the newest online freeways to information. The devices are becoming more people’s primary sources of information, attitudes and connection with others. Tens of millions of consumers are regular mobile users. In the process, communicators are creating new outreach playbooks on how to reach them.

Considerable research about this societal riptide is rapidly emerging. Among the revelations:

Mobile devices are the most-important source of breaking news for a large portion of users. Most people will use phones instead desktop computers to access the Internet within a few years. Facebook says 200 million people access its site every day using mobile phones. Baby Boomers are among the trend’s growth drivers; mobiles are not solely a youth movement.

Communicators are quickly adopting new strategies for grabbing the attention of busy mobile users. Some organizations have launched entire outreach campaigns geared for them.

Generally, the small screen requires short, punchy messages with few words that get straight to the point.

Mobile-friendly versions of organizations’ websites also are being developed. Uncluttered screens hold sway. That means larger type, and fewer detailed content features. Fancy graphics or special effects are eliminated. Navigation is simplified so users can quickly reach key information on the go.

Another tactic gaining steam is the so-called QR code. They are matrix barcodes that mobile users quickly scan with their phones. That dials up the QR sponsor’s homepage or other online consumer feature. QR codes are being printed onto publications, marketing material, brochures and other message platforms. They are popular because they are free and easy to create.

The Virginia State Police are using QR codes on new consumer anti-fraud brochures. The Coalition is migrating codes to much of its outreach material.

Communicators also are rethinking how to grab the attention of mobile-dependent reporters. News releases are brief — one or two paragraphs and a link. Same with story pitches.

Connecting with mobile users will be an increasingly important facet of public outreach well into the future.

Fraud fighters are being challenged to connect as well. The goal: convince consumers to hang up on fraud; it’s a lousy signal wherever they go.
The Coalition Against Insurance Fraud is a national alliance of insurers, consumer groups and government agencies combatting all forms of insurance fraud through legislation, public education and research.

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