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During her insurance career, Linda founded two insurance agencies, served as a faculty member for the National Alliance and a number of insurance agent associations, and established herself as a national insurance CE provider. In 2011, Linda retired from the front lines of the agency workforce to devote her energies to full-time freelance writing and insurance course development. Her client list includes A.D. Banker & Company, WebCE, Hanover Insurance Company, HUB International, and Enterprise Holdings. Linda also develops and presents training seminars, workshops, and webinars and is a regular contributor to the *Customer Service Focus* column in *Rough Notes* magazine.

The Pervasiveness of Insurance Fraud

If you talk to professionals in our industry about insurance fraud, they'll tell you insurance fraud is linked directly to the lousy economy. They'll also tell you the majority of insurance fraud is perpetrated by criminals and greedy policyholders.

What they won't tell you, however, is that insurance fraud results in the loss of more than $100 *billion* in the United States in any given year. Neither will they tell you that all types of fraud have become a global problem. Occupational fraud perpetrated by employees against their employers, investment fraud (i.e., Ponzi schemes), drug diversion, insider trading, identity theft, bankruptcy fraud, credit card fraud--and, oh yeah, insurance fraud--are devouring business profits and inflating the costs of products and services at an alarming rate.

In 2012, I was contracted by a client to write an insurance CE course about insurance fraud. After having worked in the insurance industry for over 30 years, I thought I'd been exposed to more than my fair share of insurance fraud, for example:

- The client who staged the theft and torching of his car because he bought a lemon from a sleazy pay-by-the-week used car dealership that wouldn't repair the car (it had 150,000 miles on the odometer when the client bought it)
- The producer who repeatedly withheld or misrepresented underwriting information on insurance applications solely for the purpose of securing P&C insurance for ineligible applicants
- The insurance company that regularly denied coverage for auto physical damage claims from third-party claimants that really should have been paid

Upon completing my research, talking with Dennis Jay, director of the Coalition Against Insurance Fraud, and interviewing the manager of the SIU at a major insurance company, I reassessed my level of expertise with respect to insurance fraud. I reached this conclusion: I'm a babe in the woods when it comes to insurance fraud and so, probably, are you.

Did you know that nearly 25% of Americans believe it's perfectly acceptable to defraud insurance companies? Did you know that more than 33% of Americans believe exaggerating insurance claims to avoid their policy deductibles is also perfectly acceptable? And 33% of Americans believe it's perfectly acceptable to continue receiving workers' compensation benefits if they're in pain--even if they feel well enough to return to work.

Okay, so you knew those things ... and you're not as naïve as I was. But I'll be you didn't know that people between the ages of 18 and 24 are **three times** more likely to pad an insurance

claim than people over age 40 are. And that anyone who cheated on a high school exam two or more times is **three times** more likely to pad an insurance claim than someone who didn't cheat on high school exams. Fraud is linked directly to integrity--or a lack thereof.

I'm not pulling these numbers and facts out of the air. You can find these and other statistics, along with excellent information, on the website of the Coalition Against Insurance Fraud, the insurance industry's premier weapon against the crime of insurance fraud. You might also be interested to know that, according to the Association of Certified Fraud Examiners (ACFE) and the Association of British Insurers (ABI), people who commit insurance fraud have a number of personality traits in common.

Yep, it takes a certain kind of individual to commit insurance fraud ... or any type of fraud, for that matter. Exploiters are devoid of any type of ethics or integrity and create entirely fraudulent schemes for the sole purpose of securing personal gain. Essentially, they're thieves who justify behavior that gets them what they want--whether it's money, power, or influence. Game-players exaggerate or pad legitimate claims because they believe doing so is just part of the game between insurance companies and policyholders. Revenge-seekers exaggerate legitimate claims because they want to get back at an insurance company, or the insurance industry in general, because of a previous unsatisfactory insurance claims experience. And the last type of insurance fraudster hesitates before committing fraud, doing so tentatively and only when persuaded by someone else.

Although fraud is seemingly easy to commit, four elements are required before a scammer can **successfully** perpetrate insurance fraud. These elements are like the ingredients in a cake: if the baker leaves out the eggs, flour, or sugar--or fails to use the right oven temperature, the cake will be a flop.

The first element of fraud is opportunity: a fraudster must either recognize opportunity or create one. Soft fraud is the recognition and use of an opportunity that already exists, such as the padding or exaggeration of a legitimate insurance claim. Hard fraud is the creation of opportunity, such as faking a workplace injury. (Once upon a time, soft fraud was responsible for the majority of dollars lost to insurance fraud...)

The second element, the condition that prompts a scammer to commit insurance fraud, is motivation. It's been widely documented that fraudsters are predisposed to behaving in certain ways or being challenged by certain conditions, such as:

- Living beyond their means
- Having financial or family problems
- Having drug or alcohol problems
- Possessing a "wheeler-dealer" attitude
- Being highly irritable, suspicious, or defensive
- Having control issues or being unwilling to share responsibilities
- Refusing to go on vacation
- Having unusually close relationships with clients and/or vendors

Although a person exhibiting one or more of the "red flag" traits listed above may not ever commit insurance fraud and may, in reality, be an honest and honorable person, the red flag behaviors exemplify people who are more apt to be motivated to commit any type of fraud.

The National Insurance Crime Bureau (NICB), to which insurers report insurance fraud, asserts that tax evasion is the only type of white-collar crime more costly than insurance fraud. The NICB estimates indicate that *at least* 10% of all P&C insurance claims involve some sort of fraud.

The third and fourth elements of fraud are justification and ability. Fraudsters must be able to justify their behavior: if their consciences get the better of them, they won't be successful. They must also have the ability to carry out their schemes. This means they must possess the knowledge, skill, and expertise to accomplish all the mechanics of their scams. The higher the fraudster's level of education, and the more tenure he has, the more sophisticated and costly his scam will be.

A 500-page textbook couldn't contain all the examples of insurance fraud that have been committed to date; therefore, I'm only going to touch on a couple of types of insurance fraud--and that's because they're so alarming. It's also worth mentioning that, in light of the tragedy wrought by Hurricane Sandy, disaster fraud always becomes an issue after natural and manmade disasters. If you want more details about the types of insurance fraud being perpetrated today, complete with true stories and tips for prevention, visit this page of the Coalition Against Insurance Fraud's website: (http://www.insurancefraud.org/fraud-why-worry.htm#1).

Healthcare fraud is by far the most profitable type of insurance fraud in the current international economy. It crosses all lines of insurance--from stolen workers' compensation benefits, to phony Medicare billings, to padded and counterfeit no-fault auto injury claims, to drug diversion. Hospitals, medical suppliers, doctors and other healthcare providers, organized crime rings, and Joe Policyholder all devise fraudulent methods of bilking healthcare systems worldwide of billions and billions of dollars.

PIP and no-fault laws exacerbate the problem (just ask Florida), as do people who are unfamiliar with how healthcare fraud is committed. The four most common types of healthcare fraud are:

- Submitting claims for bills and services that weren't provided
- Submitting claims and bills for services that were inflated or deliberately inaccurate
- Providing false or misleading information on insurance applications
- Using a health insurance ID card belonging to someone else for the purpose of receiving healthcare benefits to which a person isn't entitled

Among the reasons for the proliferation of healthcare fraud is the fact that most consumers and insurance professionals simply aren't reviewing documents that correspond to medical treatment and the payment of insurance benefits for those services. Whenever a health insurer issues a claim payment, it issues an Explanation of Benefits (EOB). The EOB should *always* be compared to the original bill issued at the time of service. Signs that healthcare fraud is being committed include:

- Double or triple billings for the same service or treatment
- Unnecessary testing
- Unlicensed personnel performing duties only a licensed person should be performing
- Providers who require many appointments when treatment can be performed in fewer, or even at one, appointments

- Nursing homes, hospitals, and other facilities that
    - Issue bills for services after patients have died or been discharged
    - Provide generic medications when doctors prescribed specific named brands
    - Bill for additional visits that never took place

The icing on the cake of healthcare fraud is the role it plays in drug diversion. According to *Prescription for Peril*, a report issued by the Coalition Against Insurance Fraud, healthcare fraud actually finances drug diversion!

> *Prescription drug diversion is one of the defining drug crimes in America today. It has few equals for sheer size, speed of growth, resistance to deterrence, harm to people from so many strata of society, and large costs to insurers. Overdoses, deaths, and injuries continue growing at an alarming rate.* ***Insurance fraud is the main financier and enabler of drug diversion. Even so, few health insurers understand the pivotal role insurance fraud plays in the diversion epidemic that costs insurers up to $72.5 billion a year.***

The DEA defines drug diversion as being the illegal process of diverting pharmaceuticals from their lawful purpose into drug trafficking. A person doesn't have to take drugs or be a drug dealer to participate in, or enable, drug diversion. A teenager selling his mother's prescription painkillers is committing drug diversion--as is a person being treated by several different doctors for the purpose of obtaining a larger quantity or variety of medications than one doctor alone would prescribe.

The CDC reports that 100 Americans die *every day* from prescription drug overdoses. In fact, more drug deaths are caused by prescription painkillers than by all the overdose deaths of heroin and cocaine combined. More than **two million people** reported using prescription painkillers for non-medical use in one recent calendar year.

It's also important to be aware that organized crime rings are becoming increasingly more involved in all types of fraud, but especially in healthcare fraud. The crime rings utilize physicians, chiropractors, lawyers, accountants, and runners (people who are paid to recruit patients--which is illegal in many states) who work as a team to submit phony insurance billings to insurers.

One crime ring taken down in California not too long ago involved nearly 40 fraudsters who recruited patients from across the country. Unnecessary and dangerous surgeries were routinely performed for the sole purpose of putting money in the fraudsters' pockets--over $100 million!

Some of the red flags indicating a crime ring may be involved in insurance fraud include any attorney, physician, or person who seeks out individuals and promises any type of payment in exchange for the treatment of injuries--especially those sustained in car accidents or at work.

As insurance professionals, we should be alert to the warning signs that insurance fraud may be taking place and do our part to stop making it so darned easy to commit. Every American foots a portion of the "bill" for insurance fraud. Between increased insurance premiums and other inflated costs related to the crime, every single household spends approximately $1,000 per year.

Personally, I'd prefer to donate my $1,000 to an animal shelter (or buy an iPad) rather than line the pockets of criminals ... or people who only think of themselves. What would you rather spend your $1,000 on?