INTRODUCTION

INSURANCE FRAUD IS EPIDEMIC

The cost of insurance fraud to the insurance-buying public continues to rise year after year. There is no certain number, because most attempts at insurance fraud succeed. Estimates in the United States range from $87 billion to more than $300 billion annually.

Insurers and government-backed pseudo-insurers can only estimate the extent they lose to fraudulent claims. Lack of sufficient investigation and prosecution of insurance criminals is endemic. Most insurance fraud criminals are not detected until they become greedy, and the fraud becomes so obvious it cannot be ignored.

When insurers and governments mount a serious effort to reduce insurance fraud, the number of claims presented to insurers and pseudo-insurers drops logarithmically.

Insurance fraud is not limited to the United States. In Britain, fraud costs the British economy at least £14 billion, as stated in a report commissioned by the Association of Chief Police Officers (ACPO) published in March 2007.¹ A report noted that in 2011, detected insurance fraud amounted to £983 million.² Since the amount of fraud actually detected is a small portion of what was actually found, even in the UK the £14 billion is a conservative number.

In the United States, a similar study by Aite Group speaks of a new report³ that provides an overview of the North American P&C insurance fraud battlefield, including its history and evolution. Based on Aite Group interviews with North American P&C industry stakeholders and industry fraud-prevention organizations from July 2012 to March 2013, the report states the cost of fraud, details fraud types and their perpetrators, and describes anti-fraud solutions being developed and deployed.

Aite Group concluded that insurance fraud impacts not only every insurance company but virtually every consumer and taxpayer worldwide, and shows no sign of easing. Aite Group estimated that claims fraud in the U.S. P&C industry alone cost carriers $64

¹. http://www.endfraud.co.uk/.
billion in 2012 and will reach $80 billion by 2015. P&C carriers are just now beginning to focus their fraud management strategies and investments on solutions that enable fraud detection as early in the claims process as possible, before claims payments are made and valuable investigative opportunities are lost.

As the industry attempts to keep pace with fraudsters’ varied, ever-shifting tactics, it must deploy more innovative, effective anti-fraud technologies or risk dire losses. Vendors and organizations mentioned in the Aite Group report include the Coalition Against Insurance Fraud (CAIF), CSC, Detica NetReveal, Equifax, Experian, FICO, IBM, Innovation Group, Insurance Bureau of Canada (IBC), ISO/Verisk, KPMG, LexisNexis, Mattersight, Mitchell, the National Insurance Crime Bureau (NICB), SAP, SAS, and TransUnion.

Insurance fraud is an equal-opportunity crime committed by people of every race, religion, and national origin. Insurers who do not exercise serious anti-fraud efforts often complain that local district attorneys and police agencies give insurance fraud a low priority. In response, police and prosecutors complain that the insurers do nothing that police and prosecutors can use to prosecute perpetrators.

This book is written to make it clear to insurers, police, and prosecutors that it is necessary to start working together to reduce the extent of insurance fraud. If they do not work together, the crime will continue to metastasize until it will be impossible to write insurance at a profit or for a price anyone can afford. And with the increase in fraud against insurers and government-based programs like Medicare and Medicaid, the tax burden of those who pay taxes to support those programs will be insufferable.

Both insurers and police agencies have good reason to complain. Insurers are almost universally ignored by police agencies when they report the crime. When insurance criminals are caught in the act, they are seldom arrested, even less often prosecuted, and almost never punished seriously.

Police and prosecutors, on the other hand, must deal with insurers who are not equipped to perform an adequate criminal investigation. Insurer employees seldom have police or prosecutorial experience; they are in business to provide those who buy insurance the benefits promised by the policy. When faced with fraud, employees of insurers are qualified to conduct only the investigation necessary to protect the insurer from civil litigation by a fraud perpetrator.

If prosecution of insurance fraud is to be successful, insurers, prosecutors, and police agencies must work together as a team. To do so, insurers must train their staff to recognize the elements of both the crime of insurance fraud and the civil tort of insurance fraud. Well-trained insurance personnel, while collecting information about a potential fraud, will know the type and quality of information that either a prosecutor or a civil defense lawyer will need in order to prove that fraud was attempted.

Some estimates indicate that more money is spent fighting fraud than is saved. Others show that every dollar spent by insurers to defeat fraud saves the insurer as much as seven
dollars in fraudulent claims. Although insurance fraud is a crime in almost every jurisdiction in the United States, it is the only crime where the victim is required to perform the investigation from its own funds and to pay special taxes to support investigation and prosecution by public agencies. Departments of Insurance across the country continue to add taxes on insurers and the insurance-buying public to pay for the state’s portion of the fight against insurance fraud.

Insurers are compelled by statute and regulation to maintain Special Fraud Investigation Units, publish and fulfill a detailed anti-fraud program, and train all of their anti-fraud personnel. Compliance by insurers is less than consistent across the industry. Some have effective fraud units, while others simply identify one employee as their anti-fraud director, although his or her work is almost totally adjusting claims and not investigating fraud.

Departments of Insurance audit insurers regularly to be sure that each works hard to train its people to investigate and seek prosecution of fraud perpetrators. Insurers that fail to do so can be fined by the state Department of Insurance for not doing the work (which is traditionally the duty of the state) to investigate and prosecute crime. In addition, adding insult to the injury, courts and juries can assess punitive and exemplary damages against insurers who, under compulsion of the Departments of Insurance, accuse their insureds of fraud. If the insurer fails to prove the fraud, and the police agencies, including the Departments of Insurance, fail to prosecute, following the direction of the Departments of Insurance is dangerous because the immunity provisions of anti-fraud statutes are anemic and are limited to only the report of the suspected crime.

Similar businesses in the financial sector, which are also regular victims of fraud and other crimes, are not taxed or compelled to investigate crimes committed against them. No state agency or person demands that a local or national bank pay for prosecuting embezzlers. No state agency or person demands that convenience store owners pay for prosecuting people who hold up 7-11 stores. No regulator requires stockbrokers to investigate money laundering or fraudulent transactions.

The imposition upon the insurance industry—and the attendant cost passed to the insurance consumer—is unique. Insurers are treated differently from all other businesses in the United States. George Orwell was right when, to paraphrase what he wrote in Animal Farm, “All businesses are equal; some are more equal than others.” Clearly, insurers are less equal with regard to crimes perpetrated against them than are other businesses. They are the only business required to pay for special investigators and prosecutors to investigate crimes against them. They are the only business required, by statute, to investigate crimes against them and produce the evidence to the prosecutors. Without the power and immunity available to police agencies, insurers are faced with a classic “Catch-22,” where they are damned and fined if they don’t comply with the statutes and regulations and are damned with punitive damages and cost of defending bad-faith suits if they do comply.
DO INSURERS GET THEIR MONEY’S WORTH FROM FIGHTING FRAUD?

The answer is yes and no. The more difficult question to answer is how to quantify the savings, if any.

A report from the Insurance Services Office (ISO) commented:

- Insurers consider fraud “a serious problem” but their companies’ anti-fraud efforts only “moderately effective”:
  - 68% say their companies’ anti-fraud programs address claims fraud “thoroughly”;
  - 19% say they address premium fraud “thoroughly”; and
  - 25% say they address application fraud “thoroughly.”
- Slightly more than one-third (37%) think the amount of fraud their companies have experienced has increased over the past three years.
- Forty-two percent think that 21% or more of total claims contain “soft” fraud; only 6% think that 21% or more of claims contain “hard” fraud. They agree that fraud is most prevalent in the private passenger auto and workers’ compensation lines of business.
- Eighty-two percent of the 353 insurers responding to the survey say they have an anti-fraud program at their companies.
- One hundred percent of the large insurers, 91% of the medium insurers, and 64% of the small insurers have an anti-fraud program.
- Sixty-three percent of the companies say that the state or states in which their companies do business require an anti-fraud plan.
- However, only 13% of insurers doing business in these states consider state requirements and guidelines “very useful.”

Because less than one-third of respondents answered questions about their companies’ expenditures, estimates of industrywide spending on anti-fraud efforts are not reliable. The response rate suggests that insurers are unable to isolate anti-fraud expenditures in their budgets or unwilling to share what figures they have with other insurers and the general public.

The Coalition Against Insurance Fraud reported that:

- More than one of every three bodily-injury claims from car crashes involves fraud. Insurance Research Council (IRC) (1996).
- 17–20 cents of every dollar paid for bodily injury claims from auto policies involves fraud or claim buildup. IRC (1996).
- Fraud adds $5.2–$6.3 billion to the auto premiums that policyholders pay each year. IRC (1996).
• Claims for bodily injuries under the Personal Injury Protection (PIP) portion of New York’s no-fault auto coverage rose 79% between 1999 and 2000, compared to 25% in all no-fault states. IRC (2001). Since then, reports indicate that New York PIP losses are growing to an insufferable amount.
• Insurers increased auto premiums up to 25% for New York City in 2001. IRC (2001).
• The average PIP claim is $7,950 in New York state—47% higher than the national average. Insurance Information Institute (III) (2001). Fraud costs each insured driver in New York State $75–$115 per year. III (2001).
• PIP claims in New York state rose nearly one-third in 2000, more than twice as fast as second-place Florida. III (2001).
• The average PIP claim in New York state jumped 19% over the first nine months of 2000 and 64% between 1995 and the third quarter of 2000. This compares to a 33% increase for other states. III (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 the third quarter of 2000. III (2001).

It also reported that:

• Criminal convictions increased 31%. Coalition Against Insurance Fraud (CAIF) (2004).
• Cases presented for prosecution rose 14%. CAIF (2004).
• Investigations initiated increased by nearly 18%. CAIF (2004).
• Referrals of suspected fraudulent actions were up 4.5%.

In addition, the IRC in 2013 reported that 24% of Americans believe it is acceptable to increase an insurance claim by a small amount to make up for deductibles they are required to pay. That is lower than the 33% found in 2002, according to new findings from an online IRC public opinion study. Additionally, 18% believe it is acceptable to increase a claim to make up for premiums paid in previous years when they had no claims—the lowest percentage since the question was first asked in a 1981 in-home survey.

Younger respondents, especially young men, were much more likely to view claim padding as acceptable. For example, among males age 18–34, 23% agree it is all right to increase claim amounts to make up for premiums, compared with just 5% of their older male counterparts and just 8% of females aged 18–34.

The IRC study Insurance Fraud: A Public View, 2013 Edition also found that 86% of Americans agree with the statement “insurance fraud leads to higher rates for everyone,” while 10% agree that “insurance fraud doesn’t hurt anyone.”

Respondents showed support for fraud-fighting efforts. Two-thirds (66%) approved of legislation to limit attorney and medical provider access to police accident reports for
the purposes of soliciting new clients or patients, a marked increase from 2002. Eight in 10 were willing to participate in claim processes that could help insurers detect and prevent fraud, such as examinations under oath (85%) or independent medical exams (80%). Eighty-two percent agreed that persons who commit insurance fraud should be prosecuted to the fullest extent of the law, although the consequences favored for specific fraud activities were generally less severe than in 2002.

The 2012 results are from an online survey conducted in June 2012 among 2,005 adults countrywide. Survey results were weighted by known demographic distributions to ensure that the final results were representative of the total U.S. adult population. For more detailed information on the methodology and findings from this study or previous IRC studies of insurance fraud attitudes, contact David Corum at (484) 831-9046, or by e-mail at irc@TheInstitutes.org. Copies of the study are available for $300 for an electronic version or $400 for a printed copy. Visit IRC’s website at www.insurance-research.org for more information.

**ARRESTS AND PROSECUTIONS**

The average docket of new cases also has stayed flat since 2001.

Convictions—the bottom line for insurance fraud-fighting—may spike in the next few years as growing investigations mature into full-blown prosecutions, reported the coalition’s executive director.

In California alone, more than $51.2 billion in premiums was collected for property and casualty insurance and losses of more than $27.6 billion were incurred in 2010. If only 3% of the losses were fraudulent, California fraud would have cost more than $828 million. This enormous annual number should have resulted in thousands of investigations, arrests, and convictions in California alone but did not.  

**Convictions**

California continues to convict more insurance swindlers than any other state—one of every three convictions in the United States. The Golden State’s Fraud Division logged a record 1,546 convictions, which could not have put a dent in the potential $828 million in fraudulent property and casualty claims. California is still well ahead of runners-up Florida, New York, and New Jersey. The Coalition’s report concludes that:

though fraud bureaus show encouraging gains on several important fronts, fraud fighters should be wary of too much celebration. The sobering truth is that America’s fraud problem may be much larger than people realize. . . .

The amount of money potentially taken by fraud perpetrators, between 3% and 10% of premium, is beyond the imagination of the common man. Billions of dollars are taken every year from the insurance-buying public, and little is being done to stop it.

**What Do the Results Really Show?**

Insurance fraud prosecutions and investigations are, compared to other felonies, anemic. What the reports do not tell is that most of those convicted were sentenced to probation. Few made full restitution, and those who served time were few and far between. Insurance criminals are laughing at the insurance industry, the police agencies, the fraud divisions, and the prosecutors. If they are one of the few criminally convicted, they face an average sentence of only five years’ probation and 60 days in jail. Jail time is usually served on weekends so that the convicted fraud perpetrators can still ply their trade on weekdays.

Contrary to the belief of many prosecutors, even though people are seldom physically injured by insurance fraud, it is a major crime, with a statutory maximum punishment in most states of five years in state prison. In addition, staged auto accidents and arson-for-profit schemes often result in real injuries and the death of the innocent. The amount of money is so massive that organized crime figures from every part of the world are joining in, with the usual vicious activities that organized crime brings.

Specialists who know insurance and insurance fraud are those who investigate it. It is, at least in California and those states that have criminal insurance fraud statutes, a rather simple crime to prove—the type of case a prosecutor would want to file and try to a jury.

Instead, as an ex-prosecutor said to me, “Insurance fraud is a crime prosecutors run away from because the cases are usually heavy with documentary evidence and are complex.”

Consider the public outcry if gangs of bank robbers took $300 billion from U.S. banks every year. Would the public stand for groups of criminal stockbrokers looting their 401(k) and other pension plans? What would happen if a motorcycle gang stole $300 billion every year from convenience stores across the country? There would be calls for the heads of the police and prosecutors who failed to stop the crime spree. Yet, when the public is told that a group of criminals steals $300 billion every year from the insurance industry, the response is either a yawn or a cheer for the criminals who make Bernie Madoff seem an amateur.
I have heard the following odd responses from prosecutors to whom insurance fraud cases were presented:

- “A confession on the record with five corroborating witnesses is not enough to support a fraud prosecution.”
- “An insurance company can’t be a victim of a crime.”
- “You have a good case but I don’t have time to prepare an indictment or take the case to a grand jury.”
- “Juries don’t like insurance companies.”
- “Are you bringing this case because you don’t want to pay a legitimate claim?”
- “I don’t understand what the claimant did wrong.”
- “I don’t see a crime.”
- “I didn’t know crimes existed in the Insurance Code.”

**WHAT INSURANCE PEOPLE MUST DO TO CHANGE THE STATISTICS**

It is the obligation of all whose work it is to protect insurers against insurance fraud to do something to change the situation. Methods that are available to reduce the effect of insurance fraud include the following:

- Lobby local, state, and federal police agencies to change the system so that:
  - all the insurance tax money must go to all kinds of insurance fraud at the discretion of the Commissioner of Insurance;
  - prosecutors must be assigned to the Fraud Bureau or Fraud Division, whose only job must be to prosecute insurance fraud; and
  - when the local district attorney does not file a criminal complaint, the fraud investigator or lawyer for the insurer must complain, loudly.

- Insurers and their staff should work within the system and take the following steps:
  - Report every suspected fraudulent claim to the Fraud Division.
  - Follow up with the Fraud Division after receiving the letter saying it won’t investigate.
  - Supplement the Suspected Fraudulent Claim (SFC) report with investigation results and transcripts of examinations under oath.
  - Develop a personal relationship with investigators at the Fraud Division.
  - Develop a personal relationship with supervising investigators at the Fraud Division.
  - When the Fraud Division refers a case to a prosecutor, determine the identity of the prosecutor and establish a relationship.
• Make it clear to the prosecutor that you represent an interested and proactive victim.
• Make it clear to the prosecutor that your insurance company is upset that it is the victim of a crime.
• Make it clear to the prosecutor that you will make available to him or her anything needed or required.
• Make it clear to the prosecutor that you, and other employees of the insurance company, will be available to testify at the trial.

If the claim is in California and 60 days pass after the case is referred to the district attorney by the Fraud Division, the insurer should demand compliance with the requirements of California Insurance Code § 1872.4 that provides, in relevant part, as follows:

If prosecution by the district attorney concerned is not begun within 60 days of the receipt of the commissioner's report, the district attorney shall inform the commissioner and the insurer as to the reasons for the lack of prosecution regarding the reported violations. [Italics added]

Outside of California, look for similar statutes in the state where the claim was presented or simply complain to the district attorney or state's attorney. Remember, a prosecutor is a public servant who is obligated to work with and on behalf of the victim of the crime. As a victim of a crime, the insurer has the right to speak with and complain to prosecutorial agencies.

The letter demanding an explanation for why prosecution has not been filed should go to the elected district attorney and the commissioner of insurance. He or she will refer the letter for response to a head deputy. Often they will be ashamed to tell the insurer that the only reason for the failure is that other cases always have priority over insurance fraud.

The district attorney of every county must be made aware that he or she is obligated to inform the insurance company why the crime is not being prosecuted. With enough letters and complaints, insurance fraud will be recognized by prosecutors as a serious crime. It often takes the embarrassment of the individual prosecutor before it is possible to increase the number of prosecutions and the speed with which they are brought to trial.

It is also the obligation of everyone involved in the effort to hinder insurance fraud to make the public aware of the problems insurance fraud causes them. To do so, each person involved in that attempt can take the following steps:
1. Write articles for your local newspapers.
2. Telephone local reporters and complain that they don’t cover the crime.
3. Call talk radio and explain the expense of insurance fraud.
4. Volunteer for your company’s speaker’s bureau and give talks on insurance fraud to every Rotary, Lions, Elks Lodge, or other service organization meeting.
5. Appear at the trial of every insurance fraud case.
6. Demand restitution when an insurance fraud perpetrator is convicted.
7. Refuse to pay fraudulent claims regardless of the costs of defense.
8. When sued by people who are believed to have presented fraudulent claims, insist on a jury trial.

Remember Pogo, who was reported to have said “We have met the enemy and he is us”? People involved in the business of insurance should do nothing to make the crime easier to succeed and do everything possible to defeat each attempt at insurance fraud.

To defeat insurance fraud, it must be prosecuted, and the courts must give the criminals the maximum sentence allowed by law. Medicare and Medicaid fraud, in the last few years, have been investigated and prosecuted with more vigor than in the past. Those health-care providers are receiving close to maximum sentences in federal prison. With the advent of the Affordable Care Act (“Obamacare”), the prosecution of Medicare and Medicaid fraud increased in its first two years but seems to be slowing down as the new law becomes active, since it automatically reduces the funding for fraud investigation as the statute matures.

THE ORPHAN CHILD OF THE CRIMINAL JUSTICE SYSTEM

For insurance fraud to be prosecuted, the insurer must complete a thorough investigation that can be presented to a prosecutor, because police, federal investigators, prosecutors, and even fraud division investigators will do nothing until the case is presented to them in detail by an insurer. Every person involved in the business of insurance must understand that insurance fraud is the orphan child of the criminal justice system. Insurance fraud will never be totally defeated. It will be reduced and made unprofitable to the perpetrators when the public and prosecutors recognize it as a serious problem that affects their own financial condition.

Everyone involved in the business of insurance and everyone who buys insurance must make it clear that they are angry with what is happening to their insurance premium dollar. When I, and everyone who has ever purchased a policy of insurance, hear that $300 out of every $1,000 we pay goes to a criminal, we should all want to scream out
the window, as did the character in the movie *Network*—“I’m mad as Hell, and I’m not going to take this anymore!”

**Knowledge of Insurance Is Required to Adequately Investigate Insurance Fraud**

Before insurance fraud can be conquered, it is important to understand what insurance is and how it works. Politicians continue to misunderstand insurance. Insurance is not a right awarded by the Constitution to every resident of the United States. It is a contract between an insurer and a person or corporation called the insured. Insurance is only a “contract whereby one undertakes to indemnify another against loss, damage, or liability arising from a contingent or unknown event.”

That is all insurance is: a contract.

It is a special type of contract by which the insurer agrees to indemnify the insured against a loss, damage to property, or liability as long as the event for which indemnity is sought is contingent or unknown at the time the insurance was acquired. A condition preexisting the contract is not contingent or unknown. One should not be able to buy insurance against the fire loss of a home after it burns down. A person should not be able to buy medical care insurance to treat cancer only after the disease is diagnosed. Auto liability insurance purchased after an accident is not insurance and should not indemnify the insured for injuries suffered.

Insurance fraud exists because its perpetrators wish to profit by failing to comply with the definition quoted above. Those who perpetrate insurance fraud intend to create the loss, damage, or liability rather than join the pool of those who have no losses but wish to protect themselves against contingent or unknown events.

Because politicians and the public they serve do not understand what insurance is; because they do not understand what promises the insurers and insureds make to each other; and because premiums are paid annually but claims are rare, insurers are disliked. Insurance fraud in North America and Europe is rampant and almost universally unpunished.

The purpose of this book is to provide information to those who are engaged in the effort to reduce insurance fraud. It will explain the elements of the crime and the tort to claims personnel. It will provide information for the lawyers representing insurers so they can adequately advise their clients who are victims of the crime of insurance fraud. It will provide information for the prosecutors and their investigators about what is required to prove the crime.

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We include the full text of decisions from courts of appeal and supreme courts across the country. This allows claims personnel and their lawyers to guard against errors they might make that would cause a defeat or a not-guilty verdict.

The effort to reduce insurance fraud requires the assistance of both civil and criminal courts. With the help of this book, fraud investigators, insurance adjusters, insurance attorneys or special investigation units, and insurance management will have the information they need to deal with state investigators and prosecutors.