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◆ INTRODUCTION

The insurance industry is an essential part of the financial services sector, a fundamental pillar of the economy and vital for the society and the well-being of its citizens. Insurance promotes the efficient spreading of risks and financial losses and, therefore, is at the core of the risk and financial management strategies of businesses and people. The presence of insurance fraud, estimated at more than \$100 billion, not only imposes costs on insurance companies and threatens their competitiveness and future viability, but it is also financially damaging to consumers and detrimental to the economy and society as a whole.

Particularly disconcerting is an observed trend of suspected cases of fraud increasing in the years following the great financial crisis, recording a 56% jump between 2008 and 2012, as persisting adverse economic conditions may be fueling insurance fraud.¹ As such, insurance fraud is a key concern for state insurance regulators, whose antifraud activities, coordinated by the NAIC, aim to primarily protect consumers and support insurers' financial health.

◆ DEFINITION AND CLASSIFICATION OF INSURANCE FRAUD

Insurance fraud is a complex, multi-sided phenomenon with an elastic definition based on severity and intent. Insurance fraud occurs when an insurance company, agent, adjuster, policyholder, third-party claimant or service provider commits a deliberate deception in order to obtain an illegitimate financial gain. Knowingly lying for the purpose of receiving or denying benefits can occur during the process of buying, using, selling or underwriting insurance. Furthermore, depending on the specific issues involved, fraud may be "soft" and could be addressed administratively or "hard" and handled as a criminal matter.

It is important to note that, irrespective of the casual attitude of some people toward fraud (i.e., thinking their actions do not really constitute a criminal act), existing federal and state statutes unambiguously criminalize insurance fraud. So-called soft fraud commonly involves "claim padding"; e.g., inflating damages of legitimate claims or misrepresenting facts on insurance applications. Hard fraud generally involves premeditated criminal acts such as fabricating claims, faking accidents or selling fake insurance. Hard fraud is more often committed by criminal rings conspiring with medical doctors, lawyers and dishonest agents to intentionally defraud insurers and consumers.

Insurance fraud can also be categorized as external or internal depending on the party committing the fraud. Exter-

nal fraud is committed by individual consumers of insurance as applicants, policyholders and claimants commonly involving submitting fictitious claims, providing false statements, billing insurance for unnecessary or made-up services or multiple times for the same service.² Internal fraud, on the other hand, is perpetrated by insurance industry insiders, such as company officials, employees, agents and brokers. Internal fraud may involve the selling of insurance without a license, diversion of premiums to insurance company employees' personal accounts, and obstructing regulatory investigations.³ But, by far, the most egregious type of internal fraud is selling unnecessary or fake insurance to unsuspecting consumers who end up paying for unneeded or nonexistent coverage.

The elderly and the poor are the most vulnerable segments of the population to insurance fraud as skyrocketing medical costs and limited economic opportunities make them more susceptible to "too-good-to-be-true" offers. Senior citizens are particularly targeted by fraudsters because they tend to suffer in greater numbers than the general population from dementia and other types of cognitive impairment that can affect their ability to make sound financial decisions.

Additionally, insurance fraud can take place both at the underwriting and the claim phase. Underwriting fraud could be perpetrated at the initial sale or the renewal of the contract and may include the dissimulation of important information, the deliberate concealment of existing contracts covering the same risks and coverage for fictitious risks. Claim fraud is what most people think of when they speak about insurance fraud.

While fraud is constantly evolving and affects all types of insurance, the most common in terms of frequency and average cost are the following: automobile insurance, which is widely believed to be most affected by fraud; workers' compensation, with fraud committed by employees and employers especially during economic downturns and in high-risk industries; and health insurance and medical fraud, which can be particularly costly, both financially and in actual loss of lives, due to the complexity and massiveness of the healthcare system.⁴

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¹ National Insurance Crime Bureau. 2013. "U.S. Questionable Claims Referrals: 2010, 2011, 2012." NCIB Forecast Report, May 10, 2013.

² Viaene, Stijn and Dedene, Guido. 2004. "Insurance Fraud: Issues and Challenges." *The Geneva Papers on Risk and Insurance* Vol. 29 No. 2 (April 2004), 313-333.

³ Ibid.

⁴ Ibid.

◆ **INSURANCE FRAUD IN A SOCIOLOGICAL AND ECONOMIC CONTEXT**

Insurance fraud is variously considered as a sociological-moral problem and an economic-contractual problem. Public attitudes toward insurance fraud can directly influence the occurrence and severity of fraud. If insurance fraud is generally viewed as a “victimless crime” and as a high reward/low risk proposition, fraudulent claims would constitute a relatively high percentage of total insurance claims.

According to a public opinion study by the Insurance Research Council (IRC) in 2013, 18% of consumers believe it is morally acceptable to inflate a claim to offset paid premiums considered outrageously high and, therefore, unjust.⁵ At the same time, it is encouraging this is the lowest percentage since the first IRC survey in 1981. Also, 24% of policyholders believe it is acceptable to increase an insurance claim by a small amount to make up for deductibles they are required to pay. However, the number is significantly lower than the 33% found in a 2002 IRC telephone survey.⁶

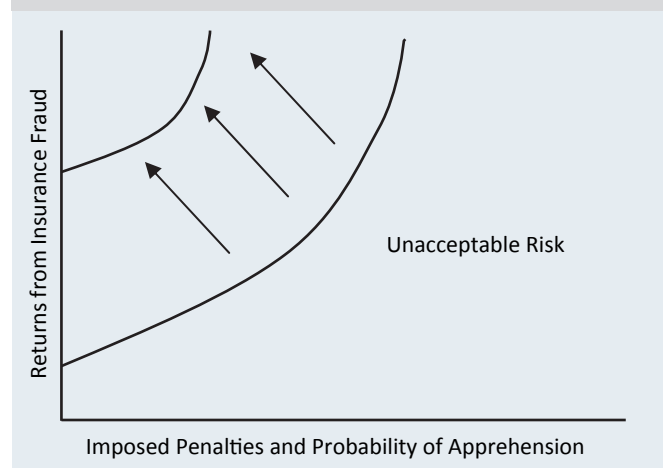
The study also found 86% of insurance consumers believe insurance fraud leads to higher rates for everyone, while only 10% think fraud does not really impact premiums and, therefore, does not hurt anyone.⁷

The occurrence of insurance fraud depends mainly on three factors: motive/incentive; opportunity; and rationalization. People are motivated to commit insurance fraud for a variety of reasons (e.g., financial gain). But motive itself is not enough; potential offenders need to have the opportunity to commit fraud. People tend to be more likely to get involved in fraud activities when they feel the likelihood of detection is relatively small. Furthermore, people who may commit insurance fraud try to find reasons to rationalize and justify it.⁸

The benefits accrued from insurance fraud tend to attract potential offenders with different attitudes toward fraud and preferences for risk. In the fight against fraud it is essential to break down fraud to its most basic elements. Abstracting from issues of morality, the decision to commit fraud can be modeled as an outcome of the calculation between the expected marginal benefit and the probability of apprehension, punishment and marginal fines imposed. Therefore, the extent of involvement in any insurance fraud activities can be viewed as being inversely related to punishment costs and directly related to expected returns.⁹

At some low-cost level of soft fraud, the risk for detection and, therefore, punishment is near zero. At higher levels of criminality, as the costs from fraud rise, both the penalties

FIGURE 1: SIMPLE ECONOMICS OF INSURANCE FRAUD



and the risk of apprehension increase (Figure 1). Moving along the curve in the graphical illustration, the deterrence effect of the imposed penalties (e.g., jail time and/or fines) increases in multiples of the expected returns as both the state and the insurance industry are willing to incur higher costs to audit, verify claims and pursue offenders. After the probability of being apprehended is practically 100% and the penalties are very severe, the expected returns are never high enough to justify fraud by the offender.

The shape of the curve and its steepening shows how an offender may rationalize fraud and the effectiveness of deterrence. In this graph, the goal of both the state authorities and insurance companies is to enlarge the area to the right of the curve where the risks are unacceptable and the returns are not worth the price. This is accomplished by moving the curve to the left, essentially by improving deterrence and devising more effective fraud-detection methods.

◆ **THE IMPACT OF INSURANCE FRAUD**

While insurance fraud has been present from the early days of the insurance industry, with the notorious “railway spine” personal injury cases of the 1870s,¹⁰ it has grown to a much more pervasive and costly problem, conceivably reaching into

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⁵ Insurance Research Council. 2013. “Insurance Fraud: A Public View, 2013 Edition.” IRC Public Opinion Study, March 2013.

⁶ Ibid.

⁷ Ibid.

⁸ International Association of Insurance Supervisors. 2006. “Guidance paper on Preventing, Detecting and Remedying Insurance Fraud.” Guidance Paper No. 12, October 2006.

⁹ Benson, Bruce and Zimmerman, Paul, Editors. 2010. “Handbook on the Economics of Crime.” Edward Elgar Publishing.

¹⁰ Derrig, Richard, A. 2002. “Insurance Fraud.” *The Journal of Risk and Insurance*, 2002, Vol. 69, No. 3, 271–287.

INSURANCE FRAUD (CONTINUED)

the hundreds of billions of dollars annually. The Coalition Against Insurance Fraud (CAIF) estimates close to \$80 billion in fraudulent claims are made annually in the U.S. covering all lines of insurance. The CAIF cautions, though, that this is a conservative figure because much of the insurance fraud remains undetected and, therefore, goes unreported.

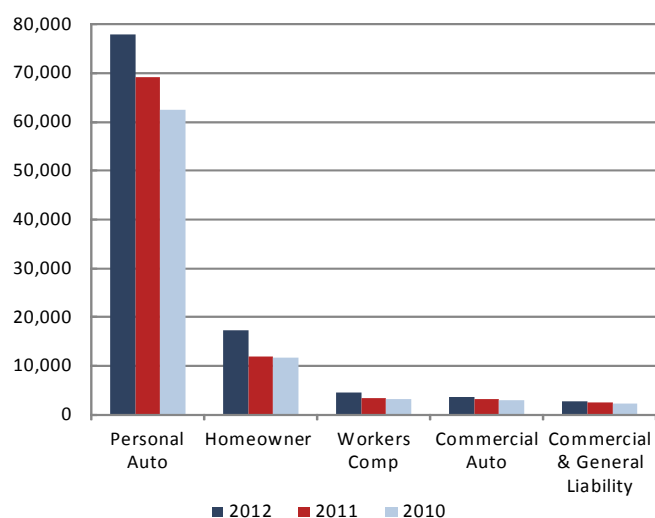
According to the Federal Bureau of Investigation (FBI), health insurance fraud is estimated to be about 3% to 10% of total healthcare expenditures. The U.S. Department of Health and Human Services has estimated healthcare fraud in 2010 amounted to between \$77 billion and \$259 billion.¹¹ State and federal authorities have reported a rise in health insurance fraud involving fraudulent billing, deceptive sales practices and identity theft following the passage and enactment of the federal Affordable Care Act (ACA) in 2010.

Most cases involve senior citizens who are offered supplemental coverage they do not need by agents who fraudulently assert such coverage is required. Other fraudsters falsely present themselves as navigators, charging fees as high as \$100 to assist people with navigating the new health insurance landscape.¹² According to the Transactional Records Access Clearinghouse (TRAC), which tracks federal statistics, the U.S. Department of Justice reported that federal filings for healthcare fraud cases rose 3% during fiscal year 2013.¹³

Insurance fraud is generally estimated at about 10% of the property/casualty insurance industry's incurred losses and loss adjustment expenses each year. Based on this estimate, property/casualty insurance fraud amounted to approximately \$33 billion a year in the period between 2008 and 2012. Rate evasion by misrepresenting facts on an auto insurance application (e.g., using a false Social Security number to avoid higher premiums due to bad credit scores, providing a false address or providing false automobile usage information) is estimated at about \$16 billion a year.¹⁴ In addition, according to a November 2008 study by the Insurance Research Council, auto insurance fraud accounted for \$4.8 billion to \$6.8 billion of all auto injury claim payments in 2007.¹⁵

According to the 2013 Insurance Fraud Survey conducted by the provider of predictive analytics, FICO, and the Property Casualty Insurers Association of America (PCI) and included responses from 143 insurers throughout the U.S., about 31% of the property/casualty insurers estimate that up to 20% of total claims are direct results of fraud. In the same survey, another 35% of U.S. insurers said fraud accounted for up to 10% of their total claims costs. Furthermore, 57% of insurers said they anticipate a rise in losses due to fraud losses on personal insurance lines—policies designed to

FIGURE 2: TOP FIVE QUESTIONABLE CLAIMS BY POLICY TYPE (2010-2012)



Source: National Insurance Crime Bureau.

protect individuals and families—with only 5% of insurers expecting a decline in fraud losses on personal lines.¹⁶

The National Insurance Crime Bureau (NICB) reported questionable claims (QCs)—i.e., claims that NICB member insurance companies refer to NICB for closer review and investigation based on one or more indicators of possible fraud—have been rising in the past few years. There was a 9% increase in QCs between 2010 and 2011 (from 91,652 QCs to 100,201 QCs) and a 16% increase in QCs between 2011 and 2012 to 116,171 QCs.¹⁷

The top five QC categories by type of insurance (Figure 2) were 1) personal automobile, with 78,024 claims in 2012, up 13% from 2011; 2) homeowners personal property, with 17,183 QCs, up 45%; 3) workers' compensation, with 4,459 QCs in 2012, up 29% from a year ago; 4) commercial automobile, with 3,554 QCs in 2012, a jump of 15% from 2011;

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¹¹ Insurance Information Institute. 2014. "Insurance Fraud." www.iii.org, March 2014.

¹² Ibid.

¹³ Transactional Records Access Clearinghouse. 2014. "Prosecutions of Health Care Fraud Law Reach New High in FY 2013." TRAC Report, Jan. 14, 2014.

¹⁴ Insurance Information Institute. 2014. "Insurance Fraud." www.iii.org, March 2014.

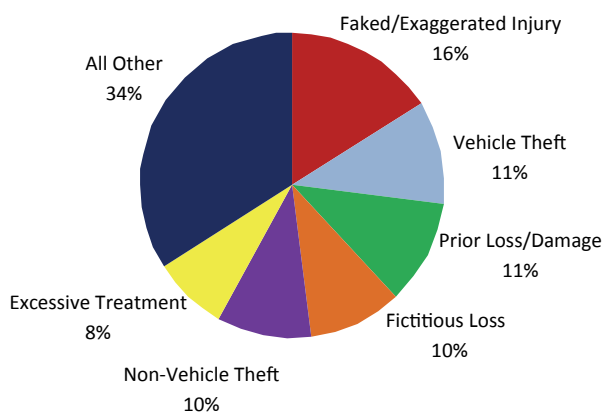
¹⁵ Insurance Research Council. 2008. "Fraud and Buildup in Auto Insurance Claims: 2008 Edition." IRC.

¹⁶ FICO. 2013. "One in Three North American Insurers Feels Inadequately Protected Against Fraud, According to FICO Survey." FICO News Release, Sept. 10, 2013.

¹⁷ National Insurance Crime Bureau. 2013. "U.S. Questionable Claims Referrals: 2010, 2011, 2012." NICB Forecast Report, May 10, 2013.

INSURANCE FRAUD (CONTINUED)

FIGURE 3: TOP PRIMARY REASONS FOR QUESTIONABLE CLAIMS



Source: National Insurance Crime Bureau.

and 5) commercial and general liability, with 2,650 QCs in 2012, an increase of 3% from the previous year.¹⁸

The primary reasons insurers referred questionable claims to NICB for fraud in 2012 (Figure 3) were faked/exaggerated injury (16% of total QCs), questionable vehicle theft (11% of total QCs), prior loss/damage (11% of total QCs), fictitious loss (10% of total QCs), suspicious non-vehicle theft/loss (10% of total QCs) and excessive treatment (8% of total QCs).¹⁹

The rise in insurance fraud is mostly attributed to the increasing sophistication of the criminal schemes and the adverse economic conditions particularly afflicting the elderly and certain low-growth geographic locales and low-income communities. In terms of specific insurance lines, approximately 61% of insurers expect an increase in criminal auto fraud, and 55% see a rise in workers' compensation fraud rings. As for individual policyholder opportunistic fraud, about 58% of insurers forecast a rise in personal property fraud, 69% see more workers' compensation fraud and 56% expect an increase in personal automobile insurance fraud.²⁰

◆ REGULATORY AND LEGAL ANTIFRAUD ACTION

Insurance fraud did not receive much attention until the 1980s, when rising premiums and the increasing involvement of organized crime urged the drafting and enactment of stronger antifraud legislation. The state regulatory response to insurance fraud, as coordinated through the NAIC, is multifaceted, involving consumer education and information, investigation, reporting and prevention, and corrective action.

State insurance departments combat insurance fraud through special bureaus that are charged with detecting, investigating and preventing insurance scams. Forty-two states and the District of Columbia have enacted legislation to set up fraud bureaus. The first state fraud bureau was created in North Carolina in 1976. Most fraud bureaus get their funding through direct assessment on insurance companies domiciled in their state. A number of state fraud bureaus have more limited powers than others, and some states have more than one bureau to address fraud in different lines of insurance. Most state fraud bureaus have jurisdiction to investigate fraud in all lines of insurance, while some are only authorized to deal exclusively with fraud in automobile insurance or in workers' compensation. Thirty-five state bureaus have authority to investigate healthcare fraud. In addition to many state fraud bureaus possessing full police powers, about half also have civil authority to impose fines.²¹

State fraud bureaus generally initiate independent inquiries and conduct independent investigations on suspected fraudulent insurance acts. They also review reports or complaints of alleged fraudulent insurance activities from federal, state and local law enforcement and regulatory agencies, persons engaged in the business of insurance, and the public to determine whether the reports require further investigation and to conduct these investigations. In addition, state fraud bureaus regularly conduct independent examinations of alleged fraudulent insurance acts and undertake independent studies to determine the extent of fraudulent insurance acts.²²

State insurance regulators also invite the public to report tips about suspected fraudulent acts. Consumers may directly contact the appropriate state insurance department to report suspected fraud or may utilize the NAIC Online Fraud Reporting System (OFRS) to report suspected fraud to one or more states. Through this system, consumers have one central, online portal to report suspected fraud to one or more states. State insurance departments also use the OFRS to receive reports of suspected fraud from insurance companies. In 2010, state fraud bureaus received more than 132,000 case referrals from insurance companies, consumers and other law enforcement agencies. About 45,000 cas-

(Continued on page 21)

¹⁸ Ibid.

¹⁹ Ibid.

²⁰ FICO. 2013. "One in Three North American Insurers Feels Inadequately Protected Against Fraud, According to FICO Survey." FICO News Release, Sept. 10, 2013.

²¹ Coalition Against Insurance Fraud. 2011. "Study of State Insurance Fraud Agencies, 2011."

²² Ibid.

es were opened for investigation, resulting into more than 4,200 arrests and 2,000 civil actions.

State insurance regulators also work with insurance companies and their special investigation units (SIUs) to address suspected fraud. The SIUs are dedicated divisions of insurance companies created for the purpose of investigating insurance fraud and usually consist of former law enforcement or claims employees turned investigators, many of which receive additional training by such agencies as the FBI, the federal Bureau of Alcohol, Tobacco, Firearms and Explosives (ATF) and state fraud bureaus.

Insurance companies' SIUs must comply with all applicable sections of the NAIC *Insurance Fraud Prevention Model Act* (#680) as adopted by the states. The NAIC *Antifraud Plan Guideline* (#1690) establishes standards for SIUs and state fraud bureaus regarding the preparation of an antifraud plan that meets the mandated requirements for submitting a plan with a state insurance department. Twenty states currently require antifraud plans be prepared for inspection by the state insurance department. By conducting an audit or inspection, or by reviewing an insurer's antifraud plan in conjunction with a market conduct examination, state insurance regulators help ensure an insurance company is following its submitted antifraud plan. Most national fraud-fighting agencies believe it is a good practice for all insurers, regardless of whether it is state-mandated, to develop an internal insurance antifraud plan. Flexibility should be allowed for each insurer to develop a plan that meets its individual needs and still meets state compliance standards.

State insurance regulators' antifraud efforts are primarily guided and coordinated by the NAIC Antifraud (D) Task Force. The mission of this Task Force is to serve the public interest by assisting the state insurance supervisory officials, individually and collectively, to promote the public

interest through the detection, monitoring and appropriate referral for investigation of insurance crime, both by and against consumers. The Task Force assists the insurance regulatory community through the maintenance and improvement of electronic databases regarding fraudulent insurance activities and provides a liaison function between insurance regulators, federal, state, local and international law enforcement and other specific antifraud organizations.

◆ CONCLUSION

The issue of insurance fraud is a key concern for state insurance regulators as they focus on strategies to best combat it at all levels, and critical for insurers trying to keep costs down and consumers who ultimately pay for it. As described in this article, insurance fraud is not only an insurance problem but also one with wider social and economic implications. Fraud not only threatens the financial position of insurance companies but also affects their value chain, spreading the risks and costs involved far and wide across society and the economy as a whole.

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