Testimony

U.S. Senate Committee on Commerce, Science & Transportation
Subcommittee on Consumer Protection, Product Safety, Insurance & Data Security

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by
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Mr. Chairman, members of the Committee. My name is Dennis Jay and I am executive director of the Coalition Against Insurance Fraud. I commend you for holding this hearing and shedding light on an issue that affects virtually every consumer and every business in the United States.

The Coalition Against Insurance Fraud was founded 24 years ago as a national, broad-based alliance of major stakeholders in the fight against fraud — specifically consumers, government agencies and insurance companies. More than 150 mostly national organizations belong to our coalition.

Our mission is to help unite the forces working to combat fraud while focusing on legislative advocacy in the states, empowering consumers and conducting meaningful and useful research. The Coalition seeks to curb fraud in all lines of insurance no matter who may be a victim or a perpetrator.

We have successfully helped enact anti-fraud legislation in more than 20 states with what we call "balanced bills." This means they not only include criminal and civil penalties for defrauding insurers, but also include sanctions against people in the insurance industry who defraud consumers.

Fraud is committed by organized fraud rings, by professionals such as medical providers, lawyers and insurance agents, by home contractors and auto body shops as well as everyday Americans — our neighbors, friends and co-workers. Our research suggests this is an equal-opportunity crime committed by people of all ages, income levels, races, gender sand education levels. Most Americans admit to knowing someone who has committed insurance fraud.

Today, we would like to provide background on the impact and cost of insurance fraud in the United States and give you an update of the state of the fraud fight in property/ casualty insurance.

Fraud involving automobile insurance, homeowners coverage and commercial insurance continues to be a drain on consumers, businesses and society in general. No one knows the total cost of insurance fraud because of the hidden nature of the crime. The data the Coalition analyzes from insurers, government agencies and others suggest insurance fraud costs tens of billions of dollars each year. This expense creates hardships for low and middle-income consumers who are forced to pay an annual "fraud tax" on premiums for car and home insurance — as well as a built-in cost on every good and service.

Additionally, some scams injure and even kill innocent consumers. Businesses also suffer when they can ill-afford workers compensation insurance because of rising premiums due to fraud. Left unchecked, this can also cause an ever-increasing spiral as others become more tempted to commit insurance fraud as premiums continue to climb.

Types of insurance fraud.

Insurance fraud is one of the most eclectic crimes in America. Types of fraud include:

Automobile — staged crashes. Perpetrators can include runners, who coordinate the scams, drivers, passengers, lawyers and medical providers. Scammers intentionally cause cars to collide — sometimes with innocent motorists — to file fake damage and medical claims. This type of fraud is most severe in states that have no-fault automobile insurance. Lives are jeopardized when innocent motorists are maneuvered into car crashes staged by crime rings to collect large injury payouts from auto insurers. A family of three burned to death when a setup crash went awry after their car was hit by two large trucks on a California freeway. A grandmother in Queens, N.Y. died when her car went out of control after she was maneuvered into a staged crash. One organized ring in New York City collected more than $279 million in false claims through a network of chiropractors, lawyers and staged crash coordinators.[1]

In many cases, medical clinics in these scams are secretly owned by organized rings, employ a licensed physician to front for them and offer no real medical services. The tactics by many of these organized fraud rings can change quickly as insurers and government investigators focus on their scams. One day they may be involved in bogus chiropractic care; and the next they are billing for questionable medical procedures or useless nerve testing.[2] Additionally, motorists with real injuries may be subject to useless template treatment that does nothing to alleviate their injuries, and may enhance their injury.

Automobile — padding/false claim. This usually occurs by a consumer, a body shop or glass-repairs facility that pads damage on an existing automobile claim, or submits a bill for unnecessary work or work not done in connection with an auto accident. In some cases, body shops will intentionally inflict more damage after the vehicle has been towed to their facility in order to increase their profits. Repairs may be substandard or haphazard, placing unsafe vehicles back on the road.

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[1] *"Colossal crash ring in permanent reverse,"* http://www.insurancefraud.org/article.htm?RecID=3453, December 23, 2015

[2] *Scammers evolve tactics for medical equipment, sham clinics, nerve tests*, Robert A. Stern and James A. McKenney, *Journal of Insurance Fraud in America*, April 2017.

Automobile — give-up. Give-ups involve falsely reporting a vehicle stolen when it actually is hidden, shipped overseas, repossessed, dumped in a body of water, buried or burned. Perpetrators can include car owners and the people they hire to get rid of their vehicles. This crime is more severe during economic downturns when people feel they can no longer afford monthly auto payments or they are "underwater" on their loans. One factor that seems to encourage this fraud is longer loan terms (five and six years), when the loan balance is greater than the value of the vehicle. High gas prices also are a factor, especially of gas guzzlers, such as SUVs. Give-ups and can include motorcycles, recreational vehicles, boats and even farm equipment.

Automobile — underwriting. Underwriting fraud in auto insurance includes lying on an application to reduce premium or gain coverage that one wouldn't otherwise be qualified to obtain. Deceptions can include untruths about driving record, miles driven, where the car is garaged, and number and age of drivers in household. Auto underwriting fraud is also called rate evasion. This type of fraud causes the insurance rates of honest people to increase in order to subsidize either the increased risk presented or the accidents of the people who cheat.

Rate evasion has increased in recent years as more people purchase insurance online rather than by telephone or in person through an insurance agent. One version of this scam is the "crash and buy" scheme. Motorists who fail to purchase auto insurance get in accidents and then buy coverage and lie, claiming the accident occurred post-purchase.

Business — arson. Owners or operators who burn down or hire someone to torch a business, which is usually failing, for profit. Arson is more frequent during economic downturns. Cases have included building owners of occupied houses and apartments. In some cases, fire has spread to adjacent businesses and homes that also destroy these structures, placing lives and jobs at risk. This type of insurance fraud spans all socio-

economic levels. Sadly, every year first-responders such as fire fighters die from battling intentionally-set fires.

Business — padding/faking. This type of fraud includes inflating a legitimate claim, or faking a theft or damage claim on a business. A classic case is inflating the value of inventory after a fire or flood.

Contractor fraud. Home contractors can defraud both insurers and consumers, from doing shoddy work to stealing claims payments. During natural disasters, unlicensed contractors from out of state are especially prone to committing fraud. Documented cases include contractors causing added damage to roofs and siding to billing the insurer for repair work.

Drug diversion. The opioid crisis affects property/casualty insurance as well as health insurers. Drug diversion includes the prescribing, distribution, selling, acquiring or using legal prescription drugs for illegal or illicit purposes. It is committed when patients addicted to painkillers and other prescription drugs illegally receive drugs from doctors, pharmacists, and street dealers. Physicians and pharmacists commit drug diversion when they knowingly prescribe and dispense painkilling drugs for no legitimate medical reason. Property/casualty insurers face these scams when they reimburse claimants and medical providers who treat auto accident victims, premises liability and workplace injuries.

Homeowners — arson. This includes burning a home that is either owned or rented to profit from claimed payments. Perpetrators can include home and business owners and the people they hire to commit the arson. Organized rings in major urban centers also have bought run-down homes, over-insured them and then set them on fire. One ring in South Florida was caught after photos of the same singed furniture kept showing up in claims for different house fires.[3]

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[3] *"Smoking Out Insurance-Arson Rings Earns Laura Uriarte Prosecutor Of Year Award," news release, January 12, 2017.*

Homeowners — padding/faking. This includes inflating a legitimate theft or damage claim on a home or apartment. Sometimes fake receipts are used to inflate claims. Another common scheme is reporting a false burglary claim.

Fraud by insurance agents. Dishonest insurance agents and brokers defraud consumers by failing to remit their premiums to insurers, and sometimes by selling fake policies backed by no insurer. This type of fraud can leave consumers in financial ruin if they experience a major loss, such as a home or business fire or a large liability lawsuit.

Fraud by insurance company employees. Most criminal cases include claims-check diversion by claims adjusters who collude with a legitimate or fake claimant. Company employees also manufacture claims, manipulating the claims system. There also have been rare cases of insurance executives who loot companies and jeopardize the ability to pay claims. Some fake companies also have sold bogus coverage and have no wherewithal to pay claims. Often these criminals use the names of legitimate insurers to fool insurance buyers.

Liability — false claim. Grocery stores, restaurants, other businesses and homeowners face false claims by people who fake injury on their property. “Slip and falls” can result in large payouts to injured victims and their lawyers. In some cases, people have falsely claimed they found rodents, glass and severed fingers in food ordered in restaurants.

Fraud by public adjusters. Unlike adjusters who work for insurance companies, public adjusters are allowed to represent claimants in many states. They are paid a percentage of the final claims payment. Thus they have an incentive to illegally inflate the claims payment as high as possible, sometimes illegally by manufacturing losses. Crooked public adjusters can collude with attorneys and contractors to increase losses cause by water damage, fire and other perils.

Workers compensation fraud by workers. This fraud includes workers who fake injuries, refuse to go back to work after they heal, or have a side job while still collecting benefits. It is often encouraged by lawyers and medical providers who profit the more severe the injury and the longer the employee is off the job. During the 2008-2010 recession, solicitors were stationed outside of unemployment offices to encourage recently laid-off workers to file false injury claims.

Workers compensation fraud by employers. These scams occur when a business lies about how many employees it has, the types of jobs workers do, and their overall workers compensation claims experience. It is especially prevalent in the construction industry, where builders may employ undocumented workers off the books. Large businesses can saves hundreds of thousands of dollars in annual workers compensation premiums by committing underwriting fraud. The money they save can be used to underbid their honest competitors on construction bids. Organized rings also help businesses commit fraud by "renting" them shell corporations to use to buy coverage and fool insurers[4]. Employee leasing schemes and the practice of declaring employees as independent contractors both are prevalent in workers compensation rate-evasion fraud.

Workers compensation fraud by medical providers. The no-fault system of treating and compensating injured workers has generally worked well since its creation in the early 20th century. However, the no-fault aspect of the system appears to be an open invitation for dishonest medical providers to exploit injured workers and plunder the system. Schemes includes billing for services not rendered or needed, including chiropractic care, diagnostic tests and prescription drugs. In California alone, medical fraud in the workers compensation system costs multiple billions of dollars each year.

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[4] *"Shell games: How construction cons steal workers-comp premiums,"* by David M. Borum and Geoffrey R. Branch, *Journal of Insurance Fraud in America,* February 2017

Anti-fraud efforts by industry

During the last 20 years, property/casualty insurers have helped counter the growing fraud threat by establishing investigation units, and investing in training and technology. In 2016, nearly three-quarters of insurers were deemed to be fully engaged in using anti-fraud technology to better and more quickly detect fraud.[5] Property/ casualty insurers also support organizations that provide training and credentialing programs for investigators and claims personnel.

Increasingly, insurers have resorted to civil lawsuits against medical providers to return payments from fraudulent claims, and to send a message that fraud won't be tolerated.[6]

The sharing of claims data among property/casualty insurers has proven to be instrumental in detecting suspected fraud, especially by organized rings. Property/ casualty insurers also participate in the successful Healthcare Fraud Prevention Partnership (HFPP).[7] This collaborative effort is a forum for Medicare, Medicaid, Tri-care, private health plans and others to share intelligence about schemes by medical providers who cost taxpayers and insurance buyers tens of billions of dollars each year. Government health programs and private health plans are allowed to pool and access data on suspect medical providers. This effort has uncovered dozens of schemes, and has so far saved nearly $300 million.

However, property/casualty insurers are not allowed to share or access HFPP data because of restrictions of the Health Insurance Portability and Accountability Act (HIPAA). The Coalition views this restriction as a lost opportunity: Research shows that many medical providers who defraud property/casualty insurers also file false claims against government programs, and vice versa.

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[5] *"The State of Insurance Fraud Technology,"* Coalition Against Insurance Fraud, November, 2016.

[6] *Insurer success in suing fraudsters expected to increase civil actions,"* Duane Morris Health Law, February 17, 2015

[7] Healthcare Fraud Prevention Partnership website, https://hfpp.cms.gov/

Anti-fraud efforts of government

During the last 20 years, state governments have responded positively to what they see as the growing threat of insurance fraud. All states but two (Oregon and Virginia[8]) have enacted specific insurance fraud statutes to define fraudulent acts and set penalties. Additionally, 38 states and the District of Columbia have established specific agencies to investigate and prosecute insurance fraud. Most of these state agencies have police powers, and several employ prosecutors to exclusively deal with insurance fraud cases.

In many states, such as California, Florida, New Jersey and New York, insurance fraud bureaus are full law-enforcement agencies with hundreds of investigators employed in their units.

Together, state insurance fraud bureaus receive some 150,000 referrals each year about incidents of insurance fraud. Referrals are received from insurers, consumers and other law-enforcement agencies.

There is a high level of collaboration and cooperation among these state agencies and insurers in investigating and prosecuting fraud. A total of 43 states require insurers to report cases of suspected fraud. Several also require insurers to sponsor internal investigation units and provide training.

At least a half-dozen fraud bureaus also sponsor advisory committees to gain feedback and intelligence from stakeholders in the state, and to discuss ongoing anti-fraud efforts. The Coalition Against Insurance Fraud currently serves on five of those advisory panels.

[8] While Virginia does not have a specific insurance fraud statute, it does have an insurance fraud bureau housed within the state police.

In addition to referring cases for criminal prosecution, several fraud bureaus also have authority to take lower-level cases on an administrative and civil basis.[9]

Other efforts to counter fraud

Efforts by insurers and government agencies to detect, investigate and prosecute insurance fraud is vital to curbing these costly crimes. However, after more than 20 years of increasing efforts to combat fraud, it's clear our nation will never arrest or convict its way out of insurance fraud.

No one knows what percentage of insurance fraud is detected. Informal surveys of insurers suggest it may be anywhere from 20 to 50 percent. Only a small percentage of those cases is ever opened for investigation by law enforcement agencies, and even a smaller percentage is ever adjudicated.

In recent years, more efforts have focused on prevention and deterrence. Public outreach messages help convince otherwise honest consumers that they will a high price for cheating on insurance.[10]

Research by the Coalition Against Insurance Fraud and others suggests that this strategy is helping to reduce fraudulent claims and encourage consumers to report fraud. The Coalition also has adopted a strategy of communicating directly with consumers through social media about insurance fraud issues, especially about schemes that target consumers, such as staged accidents, fake airbags, contractor fraud,

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[9] *"Un-civil civil penalties can thwart fraudsters,"* by Howard Goldblatt, April 20, 2017, https://www.insurancefraud.org/blog/apr-2017/un-civil-civil-penalties-can-thwart

[10] *Social-marketing campaigns taking on small-time crimes*, by Virginia Roth and Bernard Host, *Journal of Insurance Fraud in America*, January 2016. https://www.insurancefraud.org/jifa/jan-2016/social-marketing-campaigns-taking-o

dishonest insurance agents and medical ID theft. The use of Facebook,[11]Twitter[12] and other social-media outlets helps educate consumers about fraud, empowers them to avoid being scammed, and reduces their tolerance of this crime. Users of social media sometimes brag about the fraud they have committed and solicit others for help in executing scams.

At a time when the acceptance of unethical behavior seems to be increasing in our nation, it is important to have strategies in place that will counter this negative trend.

In conclusion

Insurers, state governments and the federal government are light years away from where they were just twenty years ago in seeking to curb insurance fraud in the U.S. However, we still have a long way to go before we turn the corner on this crime. The Coalition Against Insurance Fraud is confident, however, that through continued collaboration, and though efforts to deter and encourage vigilance by all stakeholders, we will continue down the path of reducing the high costs of insurance fraud.

[11] https://www.facebook.com/insurancefraud

[12] https://twitter.com/insurance_fraud