Insurance Fraud (June 2008)

Insurance fraud is making an insurance claim or increasing the amount of a claim by deceiving or misrepresenting the nature or value of the loss. It is a form of theft by deception.

How It Happens

Insurance fraud can be either “hard fraud” or “soft fraud.” Hard fraud occurs when someone deliberately fakes an accident, injury, theft, arson, or other loss to collect money illegally from insurance companies. These thieves often act alone but, increasingly, large organized crime rings have begun to stage large schemes that steal millions of dollars. Soft fraud includes the actions of normally honest persons who have told “little white lies” to their insurance companies to cover the costs of deductibles or premiums. Many people view this as harmless number fudging, but soft fraud is a crime and helps raise everyone’s insurance costs.

Overall, insurance fraud comes in many varieties. Just as there are many different types of insurance, someone has attempted or found methods for defrauding each for profit.

Automobile Fraud - One type of automobile fraud is the “caused” accident. Caused accidents are cases where there were real injuries or damages to property, but they were not caused by an accident at all. Rather, they were the result of intentional acts to collect for bodily injuries or property damages from their own policies or from others’ liability insurance. In the case of a staged accident, there are often no real injuries or damages because the accidents are farces enacted to collect money.

Some of the more common types of caused or staged accidents include the “swoop and squat,” the “drive down,” and the “paper accident.” A “swoop and squat” accident occurs when a vehicle is passed by another vehicle that suddenly moves back into the overtaken vehicle’s lane, or “swoops” in front of it. This appears to cause the driver of the overtaken vehicle to engage in an abrupt braking maneuver (or “squat”) that causes the driver of the vehicle trailing it to collide with the rear of the “squatting” vehicle. Commonly, the drivers of both the “swoop” and the “squat” car planned the accident. It is likely that the “swoop” car will never be seen again and the driver of the “squat” car plans to submit vehicle damage and personal injury claims to the innocent driver’s insurer, often for multiple occupants of the “squat” car. A “drive down” occurs when a driver waves on another driver, ostensibly indicating that it is acceptable for that vehicle to proceed, and then, as the other vehicle passes, the driver who waved him on intentionally hits the passing car causing damage and a potential liability claim. Finally, a “paper” accident is an auto accident that exists only on paper. In these fraud schemes, no accidents have taken place and the claims are usually only property damage claims. The damaged vehicles also are often sitting in an auto body shop waiting for claims handlers to inspect their damages, which allegedly occurred from the auto accidents the insured described in their claims, rather than an accident that just occurred on the street.

Arson Fraud - Arson fraud is the willful and malicious burning of property of value for profit derived from subsequent insurance claims. The end result is that the owner is issued the replacement value of the real estate or associated property from the insurance company.
**Workers Compensation Fraud** - Workers’ compensation fraud is the deliberate, material misrepresentation of facts regarding a work-related injury or the exaggeration of the extent of a minor injury to collect workers’ compensation benefits. In actuality, these employees are often quite healthy and are caught working a second job or performing activities beyond what their claimed injury would allow in order to generate additional income.⁵

**Health-Care Fraud** - Health care fraud can take several forms, typically as a company fraud (e.g., a “medical mill”) or a personal fraud (e.g., a “slip and fall”). A “medical mill” is an unethical medical practitioner or provider who works in concert with scheming patients to create fictitious, accident-related injuries to collect fraudulent disability, workers’ compensation, and personal injury claims. These providers usually work through middlemen who recruit patients for their scams as well as doctors who may bill insurers for multiple office visits that never took place. A “slip and fall” incident occurs when a corrupt attorney reports his client was seriously injured after falling on commercial property and demands that the business’ insurance company be notified. The business owner has no prior knowledge of anyone falling and has never seen the claimant. In many cases, the claimant never entered the business at all. The fall was either staged or fabricated and there was no real injury to the claimant. These con artists often target small businesses due to the increased probability that a settlement will occur.⁸

**Costs and Statistics**

Insurance fraud has the potential for very high rewards and very low risk. Even the most conservative estimates show that insurance fraud has been growing in recent years, and due to the difficulty in detection, no single agency knows the exact extent of insurance fraud. Below are some examples of the cost of insurance fraud:

- The Coalition Against Insurance Fraud (CAIF) estimates the annual cost to the U.S. economy from insurance fraud is $80 billion yearly.⁷

- The Insurance Information Institute (III) estimates that for the year 2004, property/casualty insurance fraud cost insurers $30 billion.⁸ High estimates of fraud losses are attached to health insurance and auto insurance fraud specifically. For instance, it is estimated by Blue Cross and Blue Shield that medical insurance fraud cost approximately $85 billion in 2003, or 5% of health care spending. Additionally, a 2006 report states that one in 10 bodily injury liability claims in the state of California in the year 2002 were fraudulent, resulting in $319 to $432 million (or 11-15% of claims) in losses;⁹ considering that these losses are for the state of California only, aggregate estimates for the U.S. are much higher.¹⁰

- Additionally, specialized circumstances, such as natural disasters, present an opportunity for insurance fraud. CAIF reports that 1.6 million claims were filed in response to Hurricane Katrina, resulting in $34.4 billion in insured losses.¹¹

- According to a 2006 report on occupational fraud, the Association of Certified Fraud Examiners (ACFE), estimates the cost of occupational fraud and abuse at approximately 5% of the U.S. Gross Domestic Product (or $652 billion). Of the frauds reported, asset misappropriation was the most common type of fraud, representing 91.5% of all cases. Corruption occurred in 30.8% of the cases, while fraudulent statements were the least reported frauds (10.6%) but were the most costly with a median loss of $2 million.¹²

- CAIF reports that from 2001 to 2002 convictions for fraud cases increased 31%, cases presented for prosecution increased 14%, investigations initiated increased nearly 18%, and referrals of suspected fraudulent actions rose by 4.5%.¹³

In the past, those individuals who committed insurance fraud, especially those who perpetrated “soft” frauds, were rarely prosecuted. Overworked law enforcement agencies found it necessary to utilize their limited resources and investigation time to prosecute more dangerous criminals. Thus, fraud perpetrators
felt fairly safe from prosecution. Still today, many perpetrators believe that the worst that is likely to happen even if they are detected is that the insurers they attempt to defraud simply will not pay them.

Unfortunately, the attitude of offenders is encouraged by the attitude of the public. Many people view insurance fraud as a “victimless” crime, particularly because it is committed against a lifeless, faceless entity, the insurance company. Cited by both CAIF and III, a 2003 study conducted by Accenture, along with a 2004 follow-up, collected responses from over 1,000 U.S. adults and illustrates the views of the U.S. public concerning the seriousness of insurance fraud:

- Nearly one in four U.S. adults stated that overstating the value of claims to insurance companies is acceptable, and more than one in ten believes that it is acceptable to submit claims for items that were not actually lost or damaged.  

- In 2003, twenty-four percent of the respondents stated that they believe that the reason individuals commit insurance fraud is because insurance premiums are too high; the 2004 follow-up reveals that this number has now increased to one in three respondents.

- Nearly one quarter of respondents believes that insurance fraud is committed in order to maintain insurance deductibles; this number is up from twenty percent in 2003.

- A majority of respondents (66%) believe that a weaker economy contributes to an increase in fraud cases. Forty-nine percent, however, report that people commit fraud simply because they can get away with it, and this number increased to fifty-six percent in 2004.

Consumers are victimized by insurance fraud, because everyone has to pay higher costs that result from insurance fraud. According to research cited by CAIF, the Insurance Research Council estimates that fraud adds $5.2 to $6.3 billion to the auto premiums that policyholders pay annually. It is believed that fraud costs each insured driver in New York State alone $75 to $115 per year in increased premiums, resulting in a hidden tax on consumers for auto insurance premiums. The Insurance Information Institute claims that of every claim dollar, at least 10 cents goes to fraud, while the Insurance Research Council (IRC) claims 17 to 20 cents on the dollar is paid for fraudulent bodily injury claims against auto policies.

Furthermore, in a recent study conducted by the IRC, it was found that reported losses in auto injury claims are escalating in spite of the fact that the rate of serious auto injuries has been decreasing. It seems as though the costs of insurance fraud to the public will only be increasing with time.

**Examples/ Case Studies**

Insurance fraud has become one of the most prevalent and costly forms of white collar crime in the nation. Below are some recent examples of the damages caused by insurance fraud:

- Two elderly women Helen Golay and Olga Rutterschmidt have recently been convicted of conspiracy to commit murder. In addition to the conspiracy charges Golay was convicted on the actual murder charges as well. Prosecutors allege that the women selected their two victims from the homeless population of Hollywood. The women put the two men up in apartments and then took out several insurance policies on the men, naming the two women as beneficiaries. It is then alleged that the two women arranged for the two men to be killed in hit and run accidents, collecting over $2 million in insurance money. A key witness in the case was another homeless man who said that the two offered him benefits, a place to stay, and money, however the man grew suspicious and left when he was pressured by Golay and Rutterschmidt for personal information and to sign documents.

- Elesha Martin was recently convicted on three counts of arson and one count of insurance fraud. Martin would take out renters insurance on a house and would eventually set fire to the property in order to file a claim with her insurance agency. Martin carried out this scheme on three separate occasions collecting claims totaling over $130,000 on each property. Martin was sentenced to 20
years in the Arkansas Department of Corrections with the possibility of 7 years being suspended if Martin makes restitutions.27

• Dr. Jorge A. Martinez has been sentenced to life imprisonment for his involvement in health care fraud. Martinez ran “pain management” clinics in Ohio, treating patients with weekly injections and narcotic prescriptions during visits which lasted only a few minutes, claiming thousands of dollars in insurance reimbursements for each visit. Martinez submitted over $60 million in claims, stating that he was performing complex nerve blocking treatments when, in fact, he was performing low cost trigger point injections; he was paid over $12 million by Medicaid, Medicare and the Ohio Bureau of Workers’ Compensation for the treatments. Two of the doctor’s patients died from OxyContin overdoses as a result of his practices. Dr. Martinez is the first person to be convicted under the “health care fraud resulting in death” statute.28

• Ronald Evano was sentenced to more than 5 years in prison and was ordered to pay $340,000 in restitutions for his role in a fraud scheme in which he and his wife Mary Evano would purposely eat glass in order to defraud restaurants, grocery stores, insurers, hospitals and doctors. The couple would claim that the glass was in food they had eaten at restaurants and grocery stores. The couple would then collect payments from insurance companies to pay their hospital bills, however instead of paying the bills they would pocket the money. 29

TheResponse/CurrentEfforts

The push is on to make insurance fraud a felony in all states. Currently, the statutes in about half of the states specifically classify insurance fraud and attempted insurance fraud as felonies. In most states, however, insurance investigators and law enforcement are relying on other types of fraud statutes to address the problem. At the federal level, insurance fraud may be prosecuted under the mail fraud or wire fraud statutes, the Racketeer Influenced and Corrupt Organizations Act (RICO), or other federal criminal statutes. Most state level prosecutions are brought under theft, forgery, or bribery statutes. States also utilize laws that address misrepresentation, communications fraud, and unlawful business solicitation and financial transactions. In recent years, some states have also passed laws making it a crime to commit vehicle arson, make false statements on insurance applications, and file fraudulent claims. However, identifying insurance fraud specifically in state laws is very beneficial, as states with strong anti-fraud programs also have lower insurance rates for consumers.

Attempts to punish insurance fraud are multi-faceted. They include joint efforts by insurance companies, insurance industry associations, the media, and law enforcement. Insurance companies have always made a moderate attempt to curb insurance fraud at the policy underwriting stage but they have been reluctant to commit to a strong fight against insurance fraud for fear of repercussions from allegedly violating antitrust laws or of being sued for unfair or bad faith claims practices. Nevertheless, many insurance companies have developed special investigation units with advanced fraud detection computer programs to identify questionable claims and attempt to stop the payment of fraudulent claims. The insurance industry also has the backing of numerous industry associations which support the anti-fraud campaign by offering training to insurance company personnel, maintaining databases of information for companies’ use when underwriting policies or investigating claims, and assisting in the investigation of suspicious claims.

In addition, the insurance industry has presented information by television, radio, newspaper, and billboards to help get its anti-fraud message across to the public. Many insurance companies have also installed confidential telephone hotlines to encourage the reporting of suspicious activity. Finally, several states are now required to establish state anti-fraud bureaus for the purpose of identifying fraudulent acts, collecting information on repeat offenders, and investigating cases of suspected fraud. As of 2004, 43 states have instated fraud bureaus to help combat the epidemic of insurance fraud.30
“For More Information” Links

- Association of Certified Fraud Examiners - http://www.cfenet.com
- The Coalition Against Insurance Fraud - http://www.insurancefraud.org
- Insurance Fraud Prevention Authority - http://www.helpstopfraud.org
- Insurance Information Institute - http://www.iii.org

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Endnotes


