Annual Anti-Fraud Training

2022

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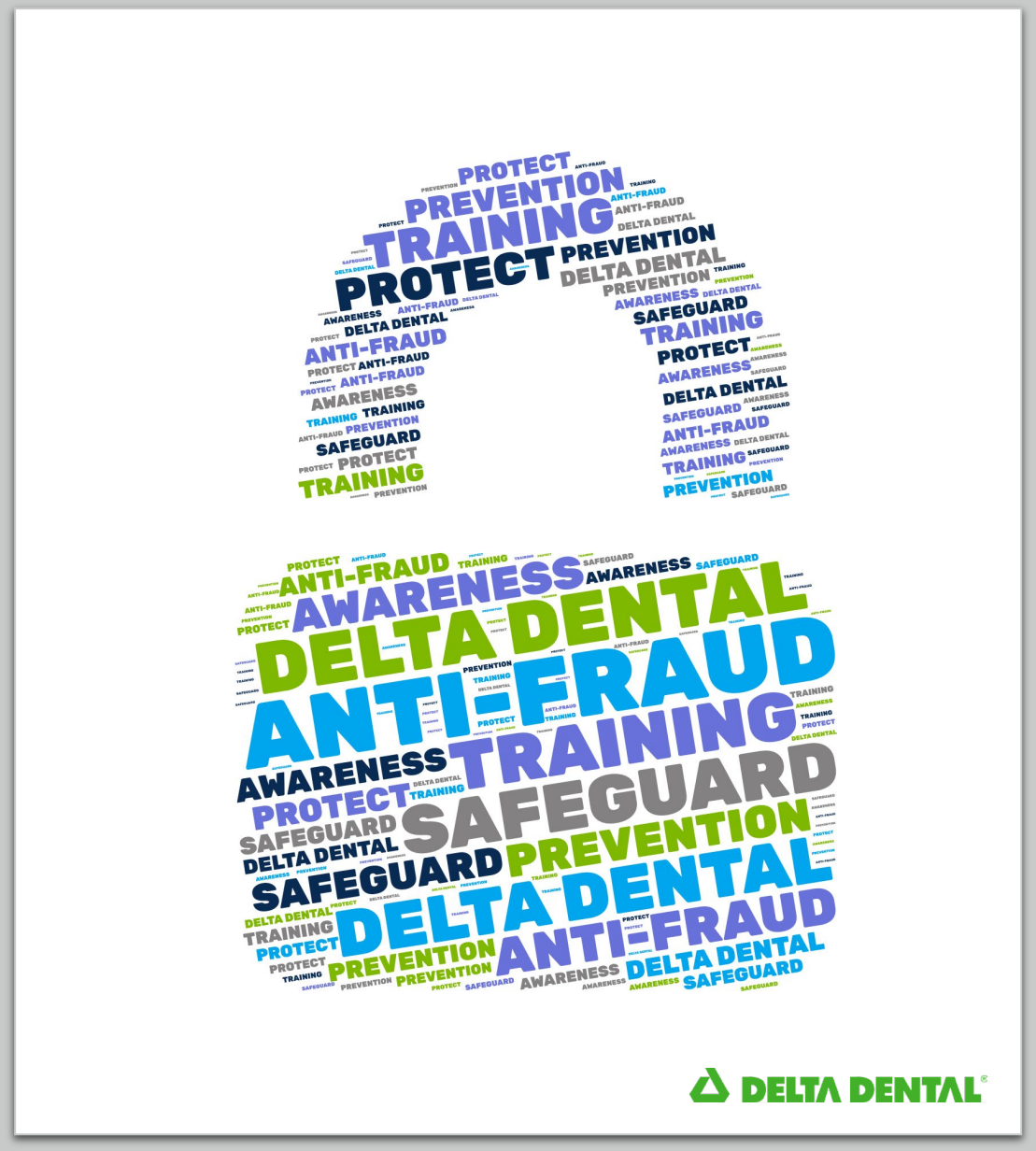
What's in the Training Course?

This two (2) hour course qualifies for the state of Maryland as well as all sixteen additional states requiring annual insurance anti-fraud training.

This Annual Fraud Training course encompasses the requirements of the State of Maryland in addition to other states that also require Agents to complete Annual Insurance Anti-Fraud training.

The course materials include sections that provide the definitions of insurance fraud, recent trends, red flags and indicators, efforts to reduce fraud, investigation tips, company SIU referral processes and a section on how technology and fraud work for and against an insurance company.



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Insurance Fraud
OVERVIEW
Section One

Insurance Fraud

As defined by the National Health Care Anti-Fraud Association

According to the National Health Care Anti-Fraud Association (NHCAA) Health Care Insurance fraud is one of the third largest a deliberate deception perpetrated against or by an insurance company or agent for the purpose of financial gain.

Fraud may be committed at different points in the transaction by applicants, policyholders, third-party claimants, or professionals who provide services to claimants.

Insurance agents and company employees may also commit insurance fraud.

Overview of Insurance Fraud

While fraud is constantly evolving and affects all types of insurance, the most common in terms of frequency and average cost are:

- Automobile insurance fraud which is widely believed to be most affected by fraud
- Workers' compensation fraud committed by both employees and employers especially during economic downturns and high-risk industries; and
- Health insurance and medical fraud which can be costly, both financially and in actual loss of lives, due to the complexity and massiveness of the healthcare system.

Overview of Insurance Fraud

Insurance crimes also range in severity, from slightly exaggerating claims to deliberately causing incidents or damage.

Common frauds include “padding,” or inflating claims; misrepresenting facts on an insurance application; submitting claims for injuries or damage that never occurred; and staging accidents.

Insurance Fraud Statistics

30.8%

of Insurance Orgs claim that fraud cases they examine involve at least two industries

28.6%

of Insurance Companies associate the increases in fraud with difficult economic times

20.3%

of Homeowners cite fraud as their biggest concern when hiring contractors

13%

of Business Owners are concerned their employees could commit workers' compensation fraud

10%

of Policy buyers don't provide or omit important data on their insurance application

3 to 10%

of total health expenditures amount to fraud each year

(1) Coalition Against Insurance Fraud, https://insurancefraud.org/

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Why Do People Commit Insurance Fraud

According to the Coalition Against Insurance Fraud, the causes vary, but are usually centered on greed, and on holes in the protections against fraud.

Often, those who commit insurance fraud view it as a low-risk, lucrative enterprise.

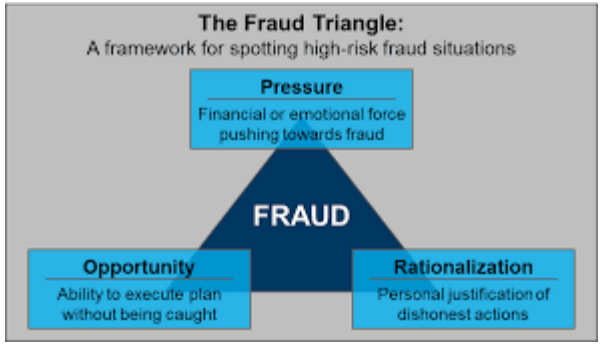
Compared to those for other crimes, court sentences for insurance fraud can be lenient, reducing the risk of extended punishment.

Fraudsters realize insurers fight fraud, but also realize some insurance companies pay suspicious claims anyway, as settling such claims is often cheaper than legal action.

Fraud Triangle

The fraud triangle is a framework commonly used in auditing to explain the reason behind an individual's decision to commit fraud. The fraud triangle outlines three components that contribute to increasing the risk of fraud:

1) Pressure
2) Opportunity
3) Rationalization



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Insurance Fraud
TRENDS
Section Two

Life & Health Insurance Fraud

Like other lines of insurance, there are various ways to commit fraud. This section will provide details of the common trends within the life and health care industries. Fraud in this context is not limited to criminal activity, but is expanded to include misrepresentations and omissions, whether malicious or less than complete disclosure.

In life insurance especially, scams faking death, murdering policyholders, underwriting fraud, making fraudulent loans, selling stranger-owned life insurance and schemes by agents and brokers are all ways fraud has been committed .

Life insurers report that underwriting scams from the most-severe form of fraud against them.

Organized ring activity in life insurance also appears to be a widespread concern with fraud by diverse ethnic gangs.

Health Insurance Fraud

The high cost of medical insurance fraud continues unbated, raising premiums and reducing coverage for insureds in need. Whether no-fault auto insurance, health coverage or workers'-compensation systems, the pernicious effect of medical fraud is felt by insureds and insurers alike.

Schemes such as pharmacists dividing prescriptions into small packages to claim extra fees, drug companies, organizing price cartels, doctors over claiming treatments and cost, to patients making fraudulent insurance claims are all examples of fraud that occurs in the health care industry.

Health Care Medical Fraud

Health care fraud occurs when an individual, a group of people or a company knowingly mis-represents or mis-states something about the type, the scope or the nature of the medical treatment or service provided, in a manner that could result in unauthorized payments being made.

Health care fraud may be perpetrated against all types of health insurers and health insurance companies, including Medicare, Medicaid, workers' compensation insurers, automobile insurers and other private entities.

Fraud, Waste & Abuse Defined

Fraud

Fraud is defined as the wrongful or criminal deception intended to result in financial or personal gain. Fraud includes false representation of fact, making false statements, or by concealment of information.

Waste

Waste is defined as the thoughtless or careless expenditure, mismanagement, or abuse of resources to the detriment (or potential detriment) of the insurance carrier or government. Waste also includes incurring unnecessary costs resulting from inefficient or ineffective practices, systems or controls.

Abuse

Abuse is defined as excessive or improper use of a thing, or to use something in a manner contrary to the natural or legal rules for its use. Abuse can occur in financial or non-financial settings.

Health Care Fraud

Healthcare fraud is the intentional deception or misrepresentation could result in some authorized benefit to them or to others.

THE INTENT BEHIND THE ACTION!

Health Care Abuse

Health care abuse involves actions that are inconsistent with sound fiscal, business or accepted behavioral healthcare practices and result in an unnecessary cost or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for healthcare.

Who is Committing Fraud?

Insured/Claimant Fraud

Using someone else's insurance ID card to receive health care, supplies or equipment.

Agreeing to let a healthcare provider bill you for services you didn't receive

Misrepresenting a health condition to obtain services

Changing/altering a prescription

Filing false claims

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Provider Fraud

Most medical providers and medical services are honest and work hard to improve their patients' health. However, a few are participating in illegal actions for personal/financial gain.

The image on this page illustrates the many areas where health care/medical fraud is being committed.

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Medical/Dental Provider Fraud

Common Medical Provider Schemes

- Billing for services not rendered or rendered or goods not provided.
- Falsifying certificates of medical necessity and billing for services not medically necessary
- Falsifying plans of treatment or medical records to justify payments.
- Misrepresenting diagnoses or procedures to maximize payments.
- Misrepresenting charges or entitlements to payments in cost reports.
- Soliciting “kickbacks” for the provision of various services or goods.

Provider Fraud

Billing for more expensive services or procedures than were actually provided or performed, commonly known as “upcoding” – i.e., falsely billing for a higher-priced treatment than was actually provided (which often requires the accompanying “inflation” of the patient’s diagnosis code to a more serious condition consistent with the false procedure code.)

Misrepresenting non-covered treatments as medically necessary covered treatments for purposes of obtaining insurance payments (i.e., “nose jobs” are billed to patients’ insurers as deviated-septum repairs.)

Waiving patient co-pays or deductibles and over-billing the insurance carrier or benefit plan.

Billing a patient more than the co-pay amount for services that were prepaid or paid in full by the benefit plan under the terms of a managed care contract.

Associate Fraud

Most insurance adjusters are honest and ethical, but a growing number of adjusters are bilking their customers.

Adjuster may refer the insured's injury to a dishonest medical facility for a kickback. The insured may receive unnecessary or inappropriate treatment.

Adjuster may file false and inflated claims against the insureds policy. Sometimes they'll also try to convince the insured to join the scheme.

Adjuster may use their position of trust to access the insureds personal information such as a Social Security number and other personal data for scams involving identity theft.

Underwriting / Premium Fraud

Underwriting and application fraud, also known as premium fraud, occurs when someone purposely conceals or misrepresents information when obtaining insurance coverage, typically to get a lower premium. One of the most common forms is data misrepresentation; a life insurance applicant may not list all the health-related issues, or an agent may intentionally not enter specific health concerns on the application.

Underwriting Fraud

Mobility and “ease of doing business” initiatives have resulted in insurance companies implementing “straight-through underwriting processing” projects.

At a time when insurers are looking to cut expenses, this is often a recipe for disaster and has unfortunately resulted in increased application fraud risk.

This particular type of fraud affects all lines of business.

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Underwriting Fraud

Underwriting and application fraud, also known premium fraud, occurs when someone purposely conceals or misrepresents information when obtaining insurance coverage, typically to get a lower premium. Some of the common forms is data misrepresents are:

- Failure to disclose doctor visits, hospital stays, medical tests
- Occupation
- Employment History
- Assets/Financial Status
- Age
- Income
- History of Tobacco Usage
- History of Alcohol Usage
- Existence of Other Life Insurance Policies
- Dangerous Hobbies or Traits

Paramed Examiner Fraud

- A Paramed is a trained medical professional who completes the medical portion of consumers application for life, health, disability and long-term care policies.
- Paramed examiners may work in collusion with the insured or in collusion with an agent to falsify medical tests and insured's vitals.

Medical Misrepresentation

- Untrue or incomplete medical information provided on an insurance application.
- Falsifying or altering medical records – very common with todays' editing tools and applications.

Wet-Ink Policies

Wet-Ink policies are new life insurance policies that are sold immediately after being issued– before the ink is dry. These policies were applied for by the insured who intended to sell them immediately after they were issued. The applicants committed fraud on the application by claiming they need life insurance for estate planning purposes, and that a relative would be the beneficiary.

Wet-Ink is common when healthy seniors are solicited by insurance agents who sign them up for new insurance with the intent to sell these policies. The applicants/insured's do not pay any premiums or are reimbursed for the first premium.

Clean Sheeting

Occurs when a person with a life-threatening illness applies for new life insurance and does not disclose the truth about his/her health.

Dirty Sheeting

Occurs when a healthy person viaticates a life insurance policy. The healthy person provides false medical information to indicate that he or she has a life-threatening illness.

Agent Fraud

Most insurance agents are honest and ethical, but a growing number of agents are bilking their customers.

Dishonest agents steal their customers' premiums and do not buy the requested policies. They cover up the thefts by issuing fake policies or other evidence of coverage.

Customers often discover the scam only when they make a claim, and the insurer says there is no coverage.

Dishonest agents will also secretly slip unwanted coverage into a policy to boost their own commissions. They may also convince policyholders – especially seniors – to cash out their life policies and buy a new policy with no accumulated value.

Premium Diversion

Premium diversion is the embezzlement of insurance premiums. It is the most common type of insurance fraud. Generally, an insurance agent fails to send premiums to the underwriter and instead keeps the money for personal use. Another common premium diversion scheme involve selling insurance without a license, collecting premiums and then not paying claims.

Fee Churning

In fee churning, a series of intermediaries take commissions through reinsurance agreements. The initial premium is reduced by repeated commissions until there is no longer money to pay claims. The company left to pay the claims is often a business the conspirators have set up to fail. When viewed alone, each transaction appears to be legitimate, only after the cumulative effect is considered does fraud emerge.

Commission Rebating

Life insurance agents principally derive their compensation through commissions. For a new business sale, the largest percentage of the commission is generally paid out with the first-year commission, sometimes in excess of 100% of the policy premium. Renewal premiums typically are magnitudes smaller than the first-year sale, in the region of 5% to 10%.

The rebating scenario occurs when an agent gives the applicant a portion of his first-year commission as an incentive to complete the life insurance sale. This practice is illegal in 48 states and technically only permissible in Florida and California; however, carriers will not knowingly accept business written under this arrangement. Product pricing parameters in general do not take into account changes in lapse and mortality patterns when there is an external inducement to purchase a policy.

Commission Rebating

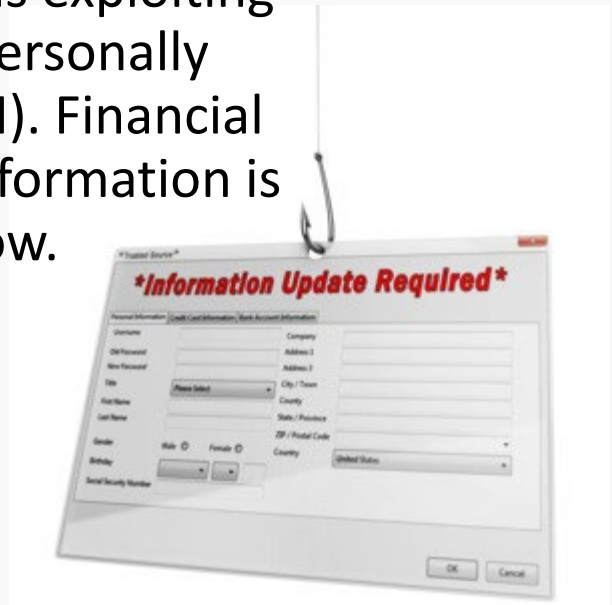
Of more concern to companies is the sale generated purely to kick back the commission in excess of 100% of the premium. In this scenario an agent can recruit an accomplice to serve as a straw buyer.

After the underwriting is complete, the agent fronts the first-year premium to effect coverage and then receives a commission equivalent to the premium paid plus 20% override in some instances. Since there was never any intent to keep the policy in force, carriers do not have a chance to recoup underwriting expenses as these policies lapse in short order.

Identity Theft / Identity Fraud

According to the FTC's "Consumer Sentinel Network Data Book," the most common categories for fraud complaints in 2020 were imposter scams, debt collection and identity theft. Credit card fraud was most prevalent in identity theft cases.

With COVID-19, cybercriminals are targeting Americans who are working at home. The federal Trade Commission advises consumers to be wary of cybercriminals exploiting coronavirus fears to steal personally identifiable information (PII). Financial information and medical information is especially sensitive right now.



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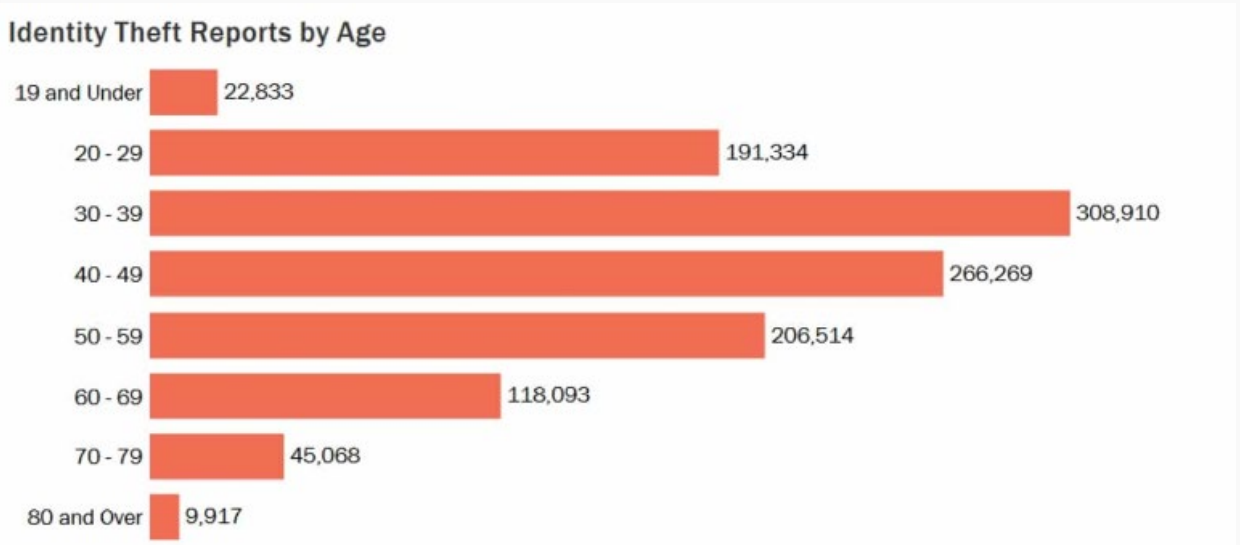
Identity Theft / Identity Fraud

Identity theft & Identify fraud are terms used to refer to crimes in which someone unlawfully obtains and uses another person's personal data in some way that involves fraud or deception – typically for economic gain.



Source: FCC

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Identity Theft / Identity Fraud

According to a 2019 Internet Security Threat Report by Symantec, cybercriminals are diversifying their targets and using stealthier methods to commit identity theft ar
fraud.

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Account Takeovers

Account takeover fraud (ATO) is a form of identity theft in which the fraudster gains access to a victim's bank or credit card accounts – through a data breach, malware or phishing – and uses them to make unauthorized transactions.

By posing as the real customer, fraudsters can change account details, make purchases, withdraw funds and leverage the stolen information to access other accounts.

ATO is becoming more noteworthy because it offers a better return on the investment to fraudsters. Being able to overtake someone's account is more lucrative than stealing an individual's physical credit card.

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Account Takeovers

3.4 billion	79%
Fake accounts created by cyber-criminals using an unsuspecting person's name and information.	Increase over 2018 for unauthorized mortgages, personal care, credit card and student loans.

According to a recent Forrester report, ATO attacks caused at least $6.5 billion to $7 billion in annual losses across financial services, insurance, eCommerce and other industries. In addition to financial loss, organizations face loss of customer trust and their customers' sensitive data.

Account takeover fraud does not have to start with highly secured information such as a social security number or PIN number, fraudsters can potentially take over accounts from information that is everywhere – email addresses, a full name, a birthdate or any piece of information that can be described as identifying information to a person.

Account Takeovers Example

Attacker visits target website and tests authentication flow for weaknesses including ; account name or password guessing, account lockout timings, password resets, and more.

Attacker uses public data dumps and account farming techniques to determine users.

Using password dictionaries, the attacker is able to gather a percentage of user accounts.

Gathered accounts are either sold or their contents like credit cards and personal data are harvested.

Account Takeovers

ATO is a profitable scheme for fraudsters because the benefit to risk ratio is to their advantage. For the consumer it spells disaster. When a user has one account that has been compromised, all other accounts that the individual has become vulnerable as well. People tend to use the same password for various accounts. If a credit card account has been taken over by a perpetrator and the user has the same password for bank accounts, Venmo accounts, or investment accounts, those accounts are now at risk as well.

Javelin Research found that fraudsters are fast in their efforts to take over accounts. The company's 2020 research on identity fraud reports that 40% of takeovers happen within 24 hours of a criminal's access to a victim's account.

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Life Expectancy Schemes

A viatical company informs investors that the life expectancy of an insured is short (i.e., 12 months) when it has data to show that life expectancy may be 60 months or longer.

This so called viatical company provides false medical and life insurance reports for so-called viators who did not exist.

STOLI / IOLI / SPIN-LIFE

Premium Financed

STOLI – Stranger Owned Life Insurance)

IOLI – Investor-Owned Life Insurance,

SPIN-LIFE (Speculated Initiated Life Insurance)

- Wealthy seniors are solicited to apply for new life insurance and the settlement company arranges for premiums to be financed until the policy no longer is contestable.
- This is a tactic to get around laws that require owners and beneficiaries to have an insurable interest when applying for new life insurance. Insurable interest, if applied to automobile insurance, would mean John cannot get insurance for Joe's Rolls Royce, if John doesn't know Joe and would lose nothing if the car was stolen or totaled.

Steps Involved in a Life Settlement

1. Policy holder needs to find an investor interested in buying the life insurance.

2. Once found, the policy holder & the buyer decide on a price for the sale.

3. Policy owner gets the cash for the sale & the buyer becomes owner of the policy.

4. The buyer is now responsible to pay the insureds premium for the life of the policy.

5. When the insured passes away, the buyer gets all of the proceeds from the policy.

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Foreign Death Claims

A foreign death claim is when an insured dies outside of the United States. Before a life insurance claim is paid the insurer requires proof of the insured's death.

When a U.S. citizen dies abroad the death is reported to the U.S. embassy or consulate.

Such claims may be presented by beneficiaries residing in the United States to recover the proceeds of a policy obtained in the United States by a relative who unexpectedly died while on a trip back to his or her native land, usually after the expiration of the contestable period.

Foreign Death Claims

U.S. Consular Officers should follow these procedures to avoid fraud:

- Confirm the death, identity, and U.S. citizenship of the deceased.
- Attempt to locate and notify the next-of-kin.
- Coordinate with the legal representative regarding the disposition of the remains and the personal effects of the deceased.
- Provide guidance on forwarding funds to cover costs.
- Serve as provisional conservator of the estate if there is no legal representative in the country.
- Prepare documents for the disposition of the remains in accordance with instructions from the next-of-kin or legal representative.
- Oversee the performance of the disposition of the remains and the distribution of the effects of the deceased.
- Send signed copies of the Consular Report of Death of an U.S. Citizen Abroad to the next-of-kin or legal representative for possible use it settling estate matters in the United States.

Foreign Death Claim Challenges

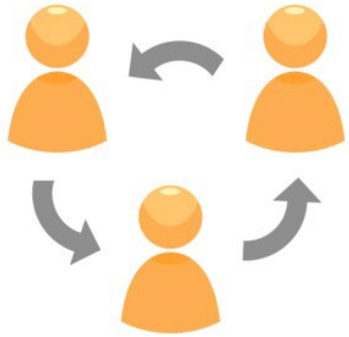
- Foreign countries have their own laws, and the U.S. laws and regulations have no meaning to those countries.
- We must understand their processes, laws, regulations, their culture and possibly their language when it comes to death in that country.

Examples:

- Publishing deaths or obituaries in Haiti is not common practice.
- In Saudi Arabi and other Arabic countries, once embalming is done there is no chance for an autopsy.
- In Mexico they allow a medical examiner to sign-off on a death either by viewing the body or by reviewing the deceased's medical records only.

Organized Fraud Rings

Organized Crime groups have been identified targeting life insurance policies whereas they may take part in illegal activities such as food stamp fraud and theft which then generate funds to be utilized in the purchasing of life insurance policies on individuals that they do not have insurable interest with.



The motive is to obtain a life insurance policy and collect on the benefits, not for the typical income replacement, but wealth building, including houses, cars, jewelry and wedding gifts.

Policies are bought, traded or given as dowries and wedding gifts. In some cases, the insured may not be aware the policy exists.

Premium payments are sometimes shared amongst multiple people.

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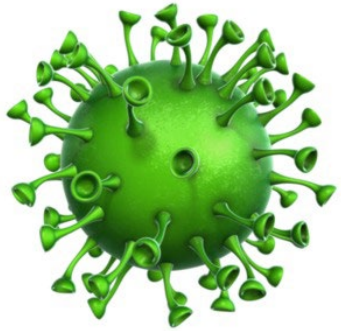
Insurance Fraud
PANDEMIC IMPACT
Section Three

The Pandemic & COVID-19

COVID-19 is the disease caused by SARS-CoV-2, the coronavirus that emerged in December 2019.



The virus is known as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). The disease it causes is called coronavirus disease 2019 (COVID-19). In March 2020, the World Health Organization (WHO) declared the COVID-19 outbreak a pandemic.

The Pandemic & COVID-19

The DOJ warns us to be on high alert for COVID-19 related fraud such as:

- COVID-19 vaccine fraud schemes. Never share your personal or health information with anyone other than known and trusted medical professionals.
- Unsolicited requests for your Medicare information, even if they are accompanied by offers of “free” COVID-19 tests or supplies or an email or call by someone claiming to be a representative from Medicare or the Department of Health and Human Services.
- COVID-19 vaccines are free. If anyone charges you for help signing up or the shot itself, it’s a scam.

Insurance Fraud

Consumer complaints against insurers also surged during these times. Insurers came out of the “Great Recession” with plans to cut staffing and outsource services. They also deployed new algorithms for everything from better appropriate fraud detection to inappropriate premium-optimization schemes. The race was on to return to high corporate profits.

Forward-thinking fraud fighters are already planning for a similar scam surge. As we faced a lengthy new norm of business shutdowns, dwindling personal savings, and a free-falling economy, then many decent Americans may cheat their insurer for a fast cash infusion.

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False & Fictitious Claims

False claims may seem like a justifiable lifeline against bankruptcy, losing their home or business, and throwing their family or employees onto the streets.

Insurers equally owe a high duty to policyholders in these increasingly financially difficult times. Insurers need adequate staffing to handle and investigate claims, reach correct coverage decisions. Importantly, they must balance their own need for financial returns in a fair and equitable manner.

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Automobile Fraud Scams

The criminal element likely will seek to cash in as well. Organized rings might put the word out that they're in business. Why not stage collisions with your unwanted late-model SUV and another vehicle? Your vehicle is totaled, giving you a nice income boost from fake injury claims.

Organized crash rings may launch waves of fake whiplash claims, testing how insurer anti-fraud systems copes during the pandemic. The onrush of telemedicine to substitute for in-person medical exams could allow rings to mass-produce whiplash claims.

Many staged crashes could be launched by individual drivers and small-business owners looking for a quick "collision by collusion" to cover expenses or bills. associates may be hard to detect. This would raise the question of whether insurers are properly staffed with investigators to identify such scams. Failing to do so may help drive up auto premiums for years to come.

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Home-owner Fraud Scams

Arson. Homeowners may torch their homes if mortgages become un-payable. Targeted torching of garages, kitchens or other smaller home areas might offer an income boost without raising suspicions that burning your entire home might arouse.

Since 2008, many Americans, feeling a new economic well-being, also have purchased – and perhaps over-mortgaged – second homes, which may now be viewed as a disposable luxury no longer needed.

Thefts/Burglary. Staged thefts or mysterious losses could generate income, including jewelry claims, electronic audio and video systems claims, and other lifestyle luxuries could be the first to go and could swiftly mount.

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Recreational Vehicles / Boats / Jewelry Fraud Scams

The high economical times give many consumers spending money to buy luxury toys. Boats, motorcycles, RVs, snowboards, expensive watches, jewelry, audio and video systems and other lifestyle items. These luxuries could be the first to go. Setup thefts, boat sinkings, fires and other mysterious losses could swiftly mount.

Sudden increases in policy limits by homeowners without the income, lifestyle or possessions to support the coverage could be among the flags. Homes may burn just days or weeks after new policy limits take effect, or just before a foreclosure is scheduled.

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Business / Commercial Fraud Scams

With thousands of business already shuttered indefinitely and watching their profits evaporate, some anxious owners will look for ways out as bankruptcy approaches. Firms that may have less-than-stellar business interruption coverage may be especially amendable to making a fast insurance claim for financial gain.

Arsons have been identified as part of the business scammer's playbook. Also, we have seen an increase in staged inventory thefts, delivery hijackings, water damage or inventory spoilation claims.

Thefts have increased. Businesses with unaffordable vehicle fleets have been identified as reporting sudden thefts or collisions, especially smaller businesses with most through expensive delivery trucks or vans. Staged crashes/losses could generate income, including bloated injury claims. (1)

(1) Coalition Against Insurance Fraud, https://insurancefraud.org/

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Worker's Compensation Premium Fraud Scams

Financial stress could impel more businesses to lowball their payroll and staff size. Permanent and part-time layoffs regretfully will increase – possibly for months to come.

Falsified layoffs thus could seem more-plausible to workers' comp insurers amid turmoil, and thus easier to disguise and get away with.

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Workers' Compensation Fraud Scams

Fake injuries. Impending layoffs could invite anxious employees to set up fake or inflate workplace injuries just ahead of the pink slip. They can fabricate new injuries – or take care of pre-existing non-work injuries such as that wrenched knee that never fully healed after last fall's weekend soccer game.

Expect an onslaught, as well, of potential claims never before seen in workers' compensation. With employees ordered to work remotely from home, what is the new definition of "workplace injury"? May an employee who trips on their rug at home while trying to get to a phone call or computer screen now claim they were injured "on the job"? Such claims, no doubt, will arise. Most will have no witnesses, surveillance cameras or other independent proof to determine if they are legitimate.

Exploiting workers' comp could be especially appealing if an employee's loaded comp coverage is better than their personal health plan. A big unknown will be how America's health insurers themselves weather this crisis and their financial viability in a post-COVID economy.

Medical & Injury Scams

Closed clinics may make inflated claims for real and phantom treatments to keep revenue flowing. Billing records may need to be carefully reviewed in comparison to mandatory closures, travel restrictions, or other similar COVID-19-related impacts to determine if services were actually rendered. Medical providers teetering on the edge of failure will be equally tempted to create an outflow of false claims, up-charges for treatments, or generate income from unnecessary or duplicative services.

As with fake whiplash claims, telemedicine could be exploited to mass-produce false claims. With calls for telemedicine to be expanded rapidly, expect an equal rise in those seeking to commit scams as new systems may be rolled out before adequate safeguards are in place.

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Medical & Injury Scams

Numerous purely health-insurance scams surfaced within days and weeks of the pandemic. There was a first wave of fake “corona insurance”. Scammers have gone after private insurance and Medical beneficiaries, selling bogus testing kits and miracle cures to steal seniors’ Medicare information and other personal identifiers.

Such cons may accelerate as the criminal element latches onto new ideas for defrauding anxious Americans. Look too for the loosened oversight rules on healthcare plans enacted last year. With no accompanying funding to states to investigate fraud, this could be a potentially fertile ground for scammers to exploit consumers who need healthcare coverage at a cheaper price.

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Investigating Suspected or Fraudulent Claims

As companies strive to adjust to the altered state created by the COVID-19 pandemic, actors with ill intent will do the same, looking for ways to leverage the disruption and havoc the coronavirus has caused.

All of this at a time when companies under economic stress may decide to cut non-revenue-generating compliance and audit functions, weaking some of the internal defense systems already in place for protection just at a time when risk oversight need to be scaled up.

As COVID related claims increase, investigations need to increase at the same time. We need to adapt to new means of investigations, depending heavily on analytics and data, but also by maintaining your field investigative staff.

Investigating Suspected or Fraudulent Claims

In today's world, we have multitudes of technology that investigators and adjusters can use to perform their job duties. However, there is still a great need for our external staff members and third-party partners/vendors to investigate claims in person.

Distance Investigating. The isolation of so many investigators, adjuster and claims staff may complicate investigations that normally require personnel on-site visits, such as vehicle crash screens, home fires, hospitalizations of injured parties.

How will both insurers and outsourcing companies adapt if fewer investigators and adjusters are available for crucial onsite work? Will this require more claimant phone interviews and reliance on photos or videos in place of onsite legwork? Will tech-savvy policyholders increase their use of altered damage photos for personal gain?

Investigating Suspected or Fraudulent Claims

Are insurer and vendor partners prepared for sudden claim surges? Will they have staff and other resources to handle increased claim volume while dealing with potential quarantined staff working remotely instead of on the field? Do vendors have credible continuity and disaster plans to keep investigations flowing during emergencies? Do they have policies in place for their safety from disease?

Many good companies provide the option of outsourcing these services, but those high-quality vendors may be quickly overworked. Should that occur, be aware of new companies springing up that may not be as qualified or ethical.

Investigating Suspected or Fraudulent Claims

Insurers also could face a reputational challenge. They must show compassion in rapidly paying claims of anxious policyholders – even suspect claims – while still showing vigilance against fraud.

Battles are already on the horizon concerning claims for business interruption coverage. Many business owners feel they may be entitled to coverage. Major insurance organizations are warning that things such as COVID-19 are excluded. In some states, lawmakers are calling for legislation requiring mandatory payments by insurers regardless of policy language.

Investigating Suspected or Fraudulent Claims

An insurer's reputation can be quickly boosted or damaged by its COVID-19 response. Much depends on how people perceive their insurer treats them during times of urgent personal need. Many insurers rapidly pay claims upfront during natural disasters, then chase the suspect ones, insurer decision-makers will need a thoughtful strategy to strike the right balance.

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Investigating Suspected or Fraudulent Claims

Consideration should also be made toward insureds/claimant's new home/work environment, that is, most are homebound and have increased challenges that come with that new structure.

Many parents had to adjust their lives to watch and or teach their school aged children while also maintaining their "normal" day jobs. This has caused increased challenges from a time management perspective, but also from the perspective if a field visit is necessary. Very often, the entire family will be home which will cause increased challenges if in-depth conversations, such as statements, need to be taken.

It is recommended to ask for a private area free of other family members to discuss any sensitive topics. This may not be possible, but it is worth the effort. A private area could also mean outside on a picnic table or other non-traditional meeting area.

Investigating Suspected or Fraudulent Claims

Fraud fighters must avoid the appearance of being hard-hearted and mistrustful while Americans go through such great personal struggles.

The anti-fraud community is mobilizing to prevent a potential pandemic of claim fraud. With the right planning and vigilance, fraud fighters also will succeed. We must work cooperatively to make sure insurers, consumers, and everyone involved in the insurance process is held to the highest ethical and moral standards.

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Mental Health & Stress

As the number of cases of COVID-19 increase, so does the associated anxiety and stress. Consider the following steps.

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Psychology of COVID

In dealing with clients/consumers, we need to be mindful of this stressed and panicked psychological state that the public is in and thus consider this in the daily tasks that we undertake. Insureds and claimants in that state will have less threshold for tolerance for additional negative news, such as a reduced claim or a settlement or adjustment lower than expected.

Last year, this conversation may have been cordial, but in this current environment, this same individual might be more difficult than they would normally be. There isn't a method to overcome a public that may be more difficult to deal with then in the past, except for the adjuster to be aware of this as they approach their daily work. "Softer" approaches will be more effective than a "hard" approach.

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Stay Safe
Nutrition
Fitness
Positivity
You
Mind
Virtual
Balance
Wellness
Stay Connected
Focus
Health
Prioritize
Body


Insurance Fraud
EFFORTS TO REDUCE
Section Four

Efforts to Reduce Insurance Fraud

It takes a concerted team effort to fight back against insurance criminals. No individual, organization or agency has the resources to single-handedly stop them.

By combining the resources and expertise of thousands of insurers, law enforcement agencies, state fraud bureaus and the National Insurance Crime Bureau (NICB), insurance fraud can be detected, deterred and stopped, thus helping protect American consumers' pocketbooks.

- Continuous Education
- Fraud Bureaus
- Laws/Legislation
- Utilization of Data Analytics
- Technology

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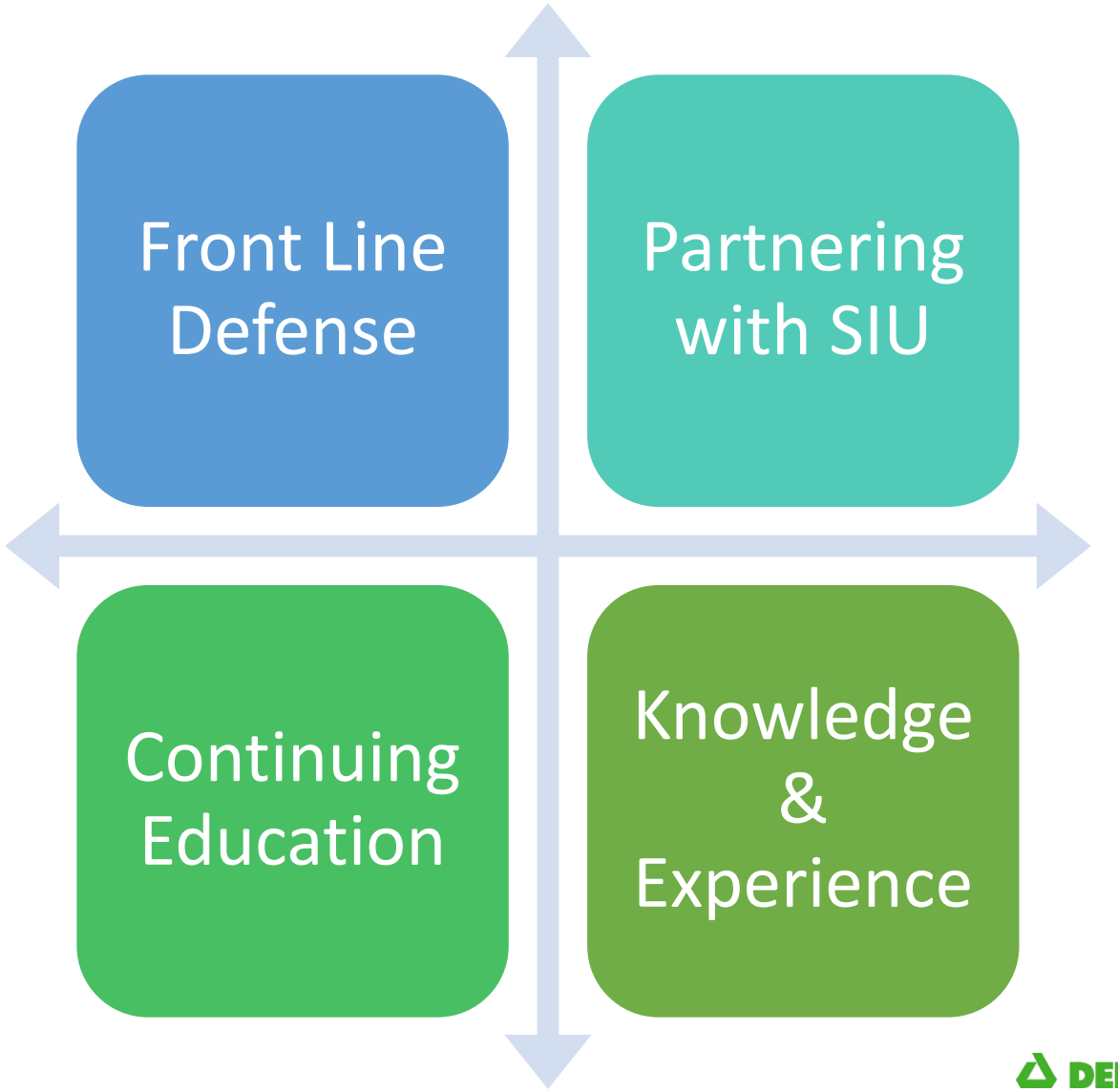
Agents Role



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SIU Professionals Role

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Be Tough on Fraud

It is important for insurance for companies to be able to detect fraud scenarios and make an example of those that are caught in order to deter future fraudulent activities. If an insurance company comes off as tough on fraud, there may not be very many honest, upstanding individuals willing to switch over to “the dark side”.

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Implement Efficient Processes

In order to be tough on fraud, you must be able to detect it in the first place. This requires well though-out underwriting and claims management processes. Everyone from top and mid-level managers to claim handlers, the finance department and sales representatives needs to be onboard with making the fight against fraud a priority.

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Consumer Awareness

State fraud bureaus along with the Coalition Against Insurance Fraud and insurance companies are developing consumer awareness campaigns via television & radio advertisements, road-side billboards and pamphlets within policy or claim mailings. (1)

(1) Coalition Against Insurance Fraud, https://insurancefraud.org/

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Insurance Fraud is Real

Putting a human face on fraud and its victims is an effective way to break through and reach people at a deeper level.

This involves telling true-life stories about fraud crimes. Profiling fraudsters, their underhanded motives, and how they harm honest American families reveals the humanity behind the cold and often opaque fraud data.

Stories capture people's attention and foster a visceral understanding that adds greater meaning to fraud data. This can also help energize broader societal opposition to this crime.

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Insurance Fraud Hall of Shame 2021

Mask up fast and hide while you can; a new set of viral spreaders have arrived. Let's un-welcome the newest members of the ***Insurance Fraud Hall of Shame.***

The No-Class of 2021 was chosen by the Coalition Against Insurance Fraud. The ***Shamers*** are this year's most notorious convicted insurance fraud criminals.

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Insurance Fraud is Real:

#1

Freeway reign of error: Truckers framed for setup crashes

Wreck ring stalks truckers with dangerous freeway collisions; passengers lie they have whiplash

Federal prosecutors methodically dismantled the “wreck ring” in court. Most members now have criminal records. The Louisiana State Police played an invaluable role in the successful investigations.

The perpetrator will spend up to five years in federal prison when he’s sentenced. As he discovered to his dismay, insurance fraud was a freeway straight to jail.

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Insurance Fraud is Real:

#2

Hookah arson hoax ruins historic old neighborhood

Businesses closed, people lose homes as hookah bar owners ignite gasoline fire that shoots out of control

The federal judge shared the community's outrage after the brothers who committed the fraud were convicted. They each were handed nine years in prison, and must somehow repay $22 million. One showed little remorse in court. He merely called their ruinous insurance scheme a "mistake."

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Insurance Fraud is Real:

#3

Father drives autistic kids off pier for life-insurance payday

Straps helpless kids into back seat, sets up murders to look like accident

His intentions were clear during a recorded call to an insurer. He is heard in the background speaking.

“May God compensate us for the kids. …” he said. “May God give us better than them.”

The federal judge compensated him with 212 years in prison.

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Insurance Fraud
POTENTIAL INDICATORS
Section Five

Indicators of Insurance Fraud

While the presence of indicators or warning signs does not necessarily indicate any fraud or abuse has occurred, it is essential that claims professionals be familiar with such indicators.

Understand what the indicators are. Recognize them in a claim or application file. React by following company procedures.

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Indicators of Insurance Fraud

General Indicators

- Physical address is not disclosed
- Address provided is not valid
- Subject moves with uncommon frequency
- Subject uses other people's telephone numbers
- Subject's SS#, name, or other pertinent information doesn't match
- Tips or rumors received from co-workers, neighbor of family
- Recent claims in the family or from co-workers
- Claim filed several days, weeks or months after alleged loss
- Recent increase in coverage
- High number of other recent claims
- Social security disability claims made
- Multiple means of coverage for loss exist

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Indicators of Insurance Fraud

General Indicators

- Subject has a criminal history, appears unethical, depressed or lazy
- Subject advises he is a victim of the insurance company
- Family history of claims
- Subject has dangerous hobbies
- Subject retains attorney immediately
- Attorney well known in the involvement of suspicious claims
- First Notice of Claims is from attorney
- Subject is threatening or abusive
- Subject might be evasive, repeating questions
- Subject is non-cooperative
- Claimants have strong knowledge of claims process and terminology

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Indicators of Insurance Fraud

General Indicators

- Subject never home for calls, asleep, just left, etc.
- Subject demands payment right away
- Subject calls constantly to get paid
- Subject's demands are out of line with the type or degree of loss
- Subject in a hurry to settle claim
- Injuries are subjective, soft tissue, sprains, headaches
- Psychological claims for stress and anxiety
- Claim is from previous injury
- Excessive recovery time

Indicators of Insurance Fraud

Dental Insurance Indicators

- Billing for services not rendered
- Providing and billing for unnecessary services while representing the services as necessary
- Concealing other insurance coverage
- Unbundling services
- Billing for more expensive services than provided
- Failing to collect patient copayments
- Changing dates of service to circumvent calendar year maximums and time limitations
- Providers with the same last name as the covered person, or the rendering provider is also the patient

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Indicators of Insurance Fraud

Dental Insurance Indicators

- Provider credentials do not fit the diagnosis or services
- Reports of EOBs containing services not rendered.
- The use of Non-dental terminology or misspelled words
- An unusual number of duplicate bills
- Attempts to bypass standard claim submission procedures
- A pattern of submitted claims for procedures that cannot be repeated, like extraction of a tooth already removed
- Expenses incurred close together or billing on the same day for treatments that are usually spaced apart

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Indicators of Insurance Fraud

Life Insurance Indicators

- Name – Variations used
- DOB/Social Security # - might be 1 digit off
- Address – Use Post Office Box or multiple addresses
- Employment – Unverifiable, self-employed, owner/manager
- Income/Net Worth – inflate
- Beneficiary – No insurable interest
- Health – fabricate records, perfect health, non-smokers etc.
- Payer Account Info – bad account or wrong routing number
- Intent to sell policy? – Answer NO
- Forced documents / signatures

Indicators of Insurance Fraud

Life Insurance Indicators

- Is the policy's effective date close to the date of death?
- Is the deceased not well known by relatives?
- Did the deceased live alone?
- Are there many small policies with coverage's that are available in mass offerings, i.e., in magazines and mail-in and television advertisements?
- Are the agent's loss ratios unusually skewed, considering the size of the market and the types of people insured?
- Were numerous life insurance policies purchased on the deceased?
- Were different carries used in securing coverage for no apparent reason?
- Is the coverage amount excessive considering the social position of the deceased?
- Was the death certificate obtained by the beneficiary?
- Was the claim made shortly after the expiration of the contestability period?

Indicators of Insurance Fraud

Medical Fraud Indicators

- A single medical provider with a high percentage of claimants with attorneys, especially if the same attorney.
- Consistent improper billing practices, such as unbundling, up-coding/double billing.
- Medical claim is extensive, but collision is minor with little physical damage to vehicles.
- Medical records consist of “template” style reports or consist of “canned” notes.
- Medical records show different handwriting on same dates of services, patient gender or names is wrong or not noted.
- Medical records show different inks on same dates of service or the same ink and handwriting covering a lengthy period of time.
- Medical treatment starts after attorney representation.
- No emergency room treatment or emergency response on extensive injury claim.
- Records provided are photocopies of originals.

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Indicators of Insurance Fraud

Medical Fraud Indicators

- The claimant submits no transportation bills or is confirmed elsewhere on the same day that medical treatment is billed.
- The insurer receives a demand from an attorney for referral to a specific medical provider.
- The medical bills show excessive early referrals for psychiatric testing when accident involved trauma only.
- The medical provider holds bills and submits them all at one time, especially if submitted through an attorney, indicating possible collusion.
- The medical provider is reluctant to communicate with the insurer, but initiates calls to a claimant attorney.
- The medical provider refers claimants unnecessarily to specific medical specialists.
- The medical reports show excessive referrals to specific providers, yet there is no apparent serious injury.

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Indicators of Insurance Fraud

Medical Insurance Fraud

- There are three or more occupants in the struck vehicle; all of them report similar subjective injuries; treated by the same medical provider.
- There are conflicting medical reports.
- There are missing dates of services or there are non-sequential notes or lot numbers on invoices.
- Unexpected high costs (special supplies, home therapies, diagnostic testing) being very early for a minor injury, soft tissue, and subjective findings.
- When medical reports are requested, insurer is advised the records are lost, stolen or burned.

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Indicators of Insurance Fraud

General Indicators of Application Fraud

- Unsolicited, new walk-in business not referred by existing policyholder.
- Applicant walks into agent's office at noon or end of day when agent and staff might be rushed.
- Applicant neither works nor resides near the agency.
- Applicant's given address is inconsistent with employee/income.
- Applicant gives post office box as an address.
- Applicant has lived at current address less than six months.
- Applicant has no telephone number or provides a mobile/cellular phone number.
- Applicant cannot provide driver's license or other identification nor has a temporary, recently issued, or out-of-state driver's license.

Indicators of Insurance Fraud

General Indicators of Application Fraud

- Applicant wants to pay premium in cash.
- Applicant pays minimum required amount of premium.
- Applicant suggests price is no object when applying for coverage.
- Applicant's income is not compatible with the value of vehicle to be insured.
- Applicant is never available to meet in person and supplies all information by telephone.
- Applicant is unemployed or self-employed in transient occupation. (e.g., roofing, asphalt)
- Applicant is unusually familiar with insurance terms or procedures.
- Application is not signed in agent's view. (e.g., mailed in)

Suspect Something is WRONG, Investigate It!

Detecting a case of fraud is an admirable achievement, however this should never prevent a claims professional from referring suspicious cases to the SIU or an outside investigation firm.

To report fraudulent activities, please call our toll-free hotline:

800-526-1852

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