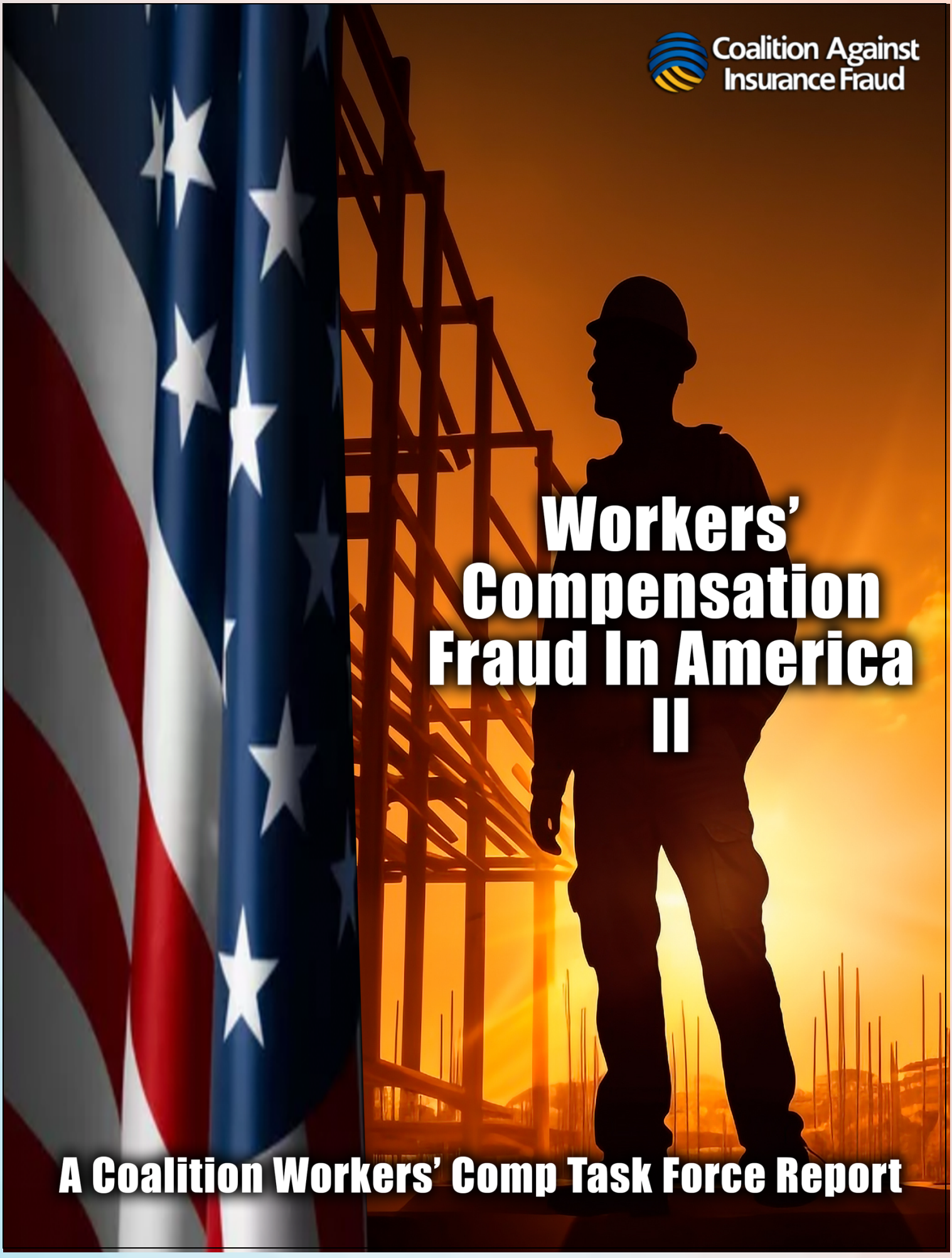

Coalition Against Insurance Fraud
Workers' Compensation Fraud In America II
A Coalition Workers' Comp Task Force Report

Since 1993, the Coalition Against Insurance Fraud has been a leader in bringing together public and private interests to protect American consumers and insurers from all aspects of insurance fraud. Seeking to identify and stop fraud in America's workplace is one of the most important endeavors the Coalition can embark upon.

With this in mind, the Coalition formed in March 2021, its first-ever Task Force to examine WC Fraud in America. At the outset, led by Gene Donnelly, Assistant Vice President of SIU for Zenith Insurance, and Dominic Dugo, Coalition Outreach Coordinator and Retired Chief Deputy District Attorney of San Diego County, they were joined by 14 insurance experts from throughout the nation. In July 2022, after meeting for 15 months, the Task force published a report "Workers' Compensation Fraud in America" which put WC fraud at $34B a year!

The Task Force continues to meet monthly and has grown to 25 experts with over 500 years of insurance fraud experience combined. Our newest report released today provides a detailed analysis of (1) Premium, (2) Claimant, and (3) Provider Fraud within the WC system. Topics include fraud red flags; explaining the crimes; prevention strategies; how to investigate and prosecute these cases; and the impact WC fraud has on consumers, the government, and insurers.

In the first quarter of 2024, the Task force will release three 1-hour PowerPoint presentations to coincide with the Claimant, Premium and Provider fraud discussion in this report. These materials will provide excellent training materials for staff assigned to the anti-fraud effort.

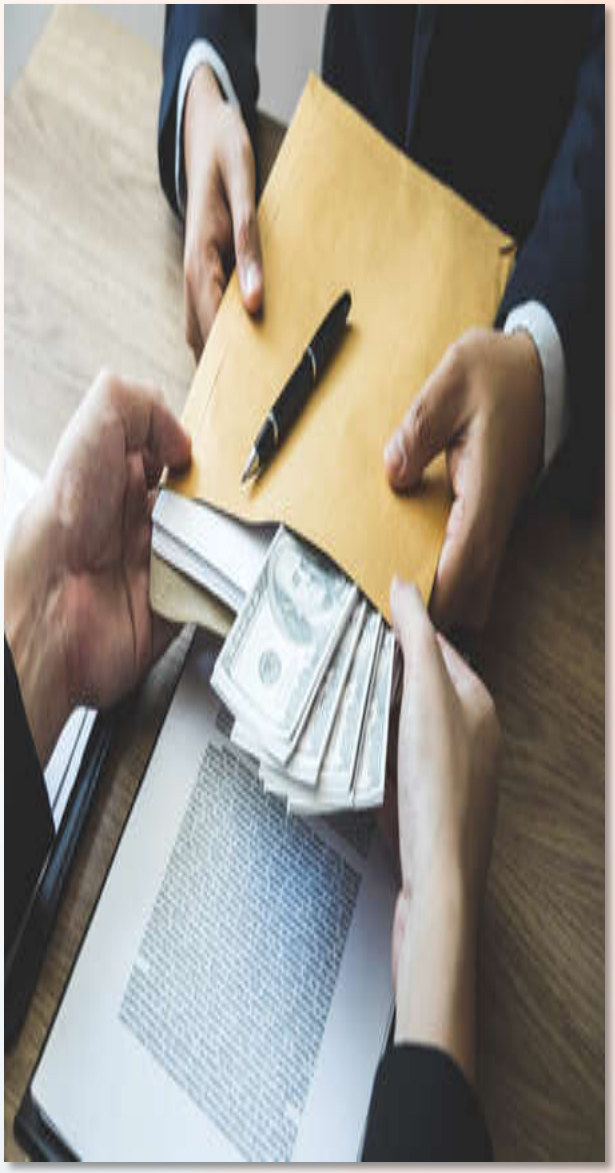
Workers deserve fair and full compensation from their employers. Employers deserve to pay fair premiums and have a duty to fairly and honestly secure coverage for their employees. Medical and legal providers need to be properly compensated for their services while honestly and fairly treating their patients, clients, and the WC system. This report is intended to help make sure those goals are achieved.

The Coalition wishes to thank and recognize these anti-fraud leaders whose efforts are set forth in this report.

WC TASK FORCE MEMBERS

Dominic Dugo, chair-Coalition Against Insurance Fraud; **Gene Donnelly**, vice chair-Zenith Insurance; **Nina Burnett**, AF Group; **Jay Bobrowsky**, State Compensation Insurance Fund, CA; **Christopher Jelinek**, Chubb; **Steve Walden**, CNA; **Matthew Smith**, Esq., Coalition Against Insurance Fraud; **Michael Grenon**, Employers; **Patrick Sidorchuk**, FFVA Mutual; **Chris Welch**, Florida department of Financial Services; **Andrew Enochs** & **Jeffrey Cirino**, FRISS; **Jennifer Cunningham**, Ohio Bureau of WC; **Lina Valencia-Ignatius**, Pinnacol; **Geoff Keah**, AmTrust; **Joe Benevides**, HEMIC; **Jessica Silver**, NYSIF; **Christopher Sloan**, PA Insurance Fraud Prevention Authority; **Chris McDade**, Social Discovery; **Matthew Capece**, United brotherhood of Carpenters and Joiners of America; **Ronnie Hurst**, WCF; **Christine Scaparro**, Liberty Mutual; **Andrew Pauley**, NAMIC; **William Bertt**, PMA Companies and **Robert Buchanan**, Zurich

(1) WORKERS' COMPENSATION PREMIUM FRAUD



I. Introduction
   - Good Intentions

II. Crime of Premium Fraud
   - Math Behind Premium Calculations
   - Misclassification Work, Credit
   - Underreporting
   - Experience Modification
   - Labor Brokers-Shell Companies

III. Impact
   - Financial Implications
   - Harm to Employers
   - State Budgets

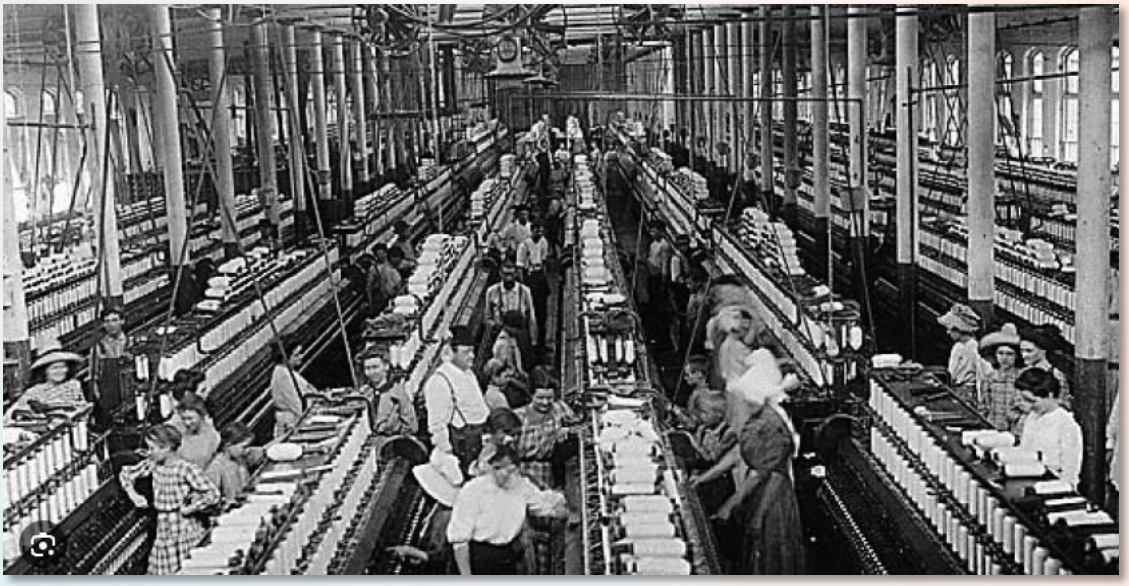
IV. Prevention
   - Path Forward
   - Underwriting-Auditing
   - Public Outreach
   - Cooperation Among Carriers
   - Certificates of Insurance
   - State and local Governments
   - Grant Funding
   - Training Prosecutors
   - Legislative Opportunities

V. Conclusion Team Approach

I.
Introduction

This paper explains how WC premium fraud is perpetrated; the connection it has to related crimes of tax evasion and wage theft; and strategies to attack these insidious crimes. WC fraud not only harms employees who may have suffered an uninsured injury but also negatively impacts both the economy and honest employers. In a 2022 report, the Coalition Against Insurance Fraud found that WC premium fraud costs insurers $25B annually. Matthew J. Smith, Esq., the Coalition's Executive Director, said, *"Premium fraud is a serious problem throughout the nation. The schemes are deeply unfair to honest employers who play by the rules, leading to higher WC premiums that unfortunately get passed along to honest consumers at higher prices."*

Good Intentions



During the American Industrial Revolution, labor was often subjected to abysmal working conditions that, by today's standards, would be deemed appalling. As a means to combat these egregious working conditions, WC insurance was established. This system provided a consistent remedy for injuries sustained by employees, which proved more effective than the expensive torts and civil litigation of the time.

In the present day, WC coverage has become mandatory in all states except Texas. However, mandatory costs often attract measures designed to cheat the system, resulting in employers gaining an unfair advantage by committing various schemes in order to pocket more profits as they pay less than their fair share into the WC system. The impact of such fraudulent behavior extends beyond the realm of insurance and often includes companion crimes such as tax evasion and wage theft.

II.

Crime of Premium Fraud

To understand premium fraud, it is imperative to know the components of a WC premium and how it is calculated. The initial element is the rate, which is contingent upon the level of risk associated with the business classification or description. The base rates are established to sufficiently cover the average loss experienced by a business operating within a particular classification. Understandably, higher risk operations will warrant higher rates. The second element, and the primary focus of many premium fraud schemes, is the amount of the employer's payroll. Premiums are calculated, in part, per $100 of total payroll, which means businesses with large payrolls can expect to pay higher premiums. The third element is an Experience Modification Rate (EMR), also referred to as ER Mod, EMOD, or XMOD, which is developed by comparing the claims experience of an individual employer with that of the average similar business. An EMR tailors the cost of WC in accordance with a business's performance and incentivizes reducing claims through safety and loss prevention measures. The final assessed premium is calculated by plugging each of these elements into a formula that looks like:

"Rate x (Payroll/$100) x EMR = WC Premium"

At its core, the crime of premium fraud is no different than any other fraud in that it is a criminal act, with a deceptive precursor, designed to elicit some type of unwarranted gain, either financial or personal. The argument can be made that those who commit premium fraud actually gain both. They gain WC for their employees without paying in full and they are able to pocket a larger percentage of profit by lying to their insurance company in return for a lower premium. How the fraud is committed depends on what elements the fraudsters reasonably believe they can lie about and get away with. The most common premium fraud schemes are discussed below.

Misclassification of Work Performed

Unscrupulous employers sometimes resort to misrepresenting the type of work performed by their employees to their insurers. This is considered premium fraud by misclassification. For instance, a company may falsely declare its tree trimmers as landscapers or claim that half of its construction workers are clerical staff. By unlawfully transferring workers to a classification with lower rates, the employer aims to lower premiums. Recently, Delta Group, a national insurance investigative agency, conducted an investigation into a food manufacturer that reported 104 workers on its WC policy, with 98 allegedly working in a clerical capacity. However, upon conducting a spot visit, Frank Sztuk, a 40-year veteran of antifraud measures and the Senior Vice President of Delta Group, along with other investigators, discovered that the majority of the workers were actually involved in food-production operations on the production floor, with only one person working in a clerical role. Loss to the carrier exceeded one million dollars.

Falsifying Pay Rate for Premium Credit

In states that have a (Contracting) Classification Premium Adjustment Program (CPAP), another type of misclassification scheme can be found. Under this program, employers who can provide proper documentation showing their employees are paid at a rate higher than the state average may be eligible for a premium credit on their WC policy. These laws are based on the assumption that higher-paid employees are generally more experienced and skilled, and therefore less prone to injuries than their lower-paid counterparts and allows for a lower rate to be applied to higher-paid employees. Unfortunately, employers often exploit this law by falsifying the hourly rates paid to their employees. This crime has been identified in California and could also be happening in the other states where this program exists.

Typically, a dishonest employer may report that their roofers or carpenters earn $50 per hour, whereas in reality, these employees only receive $15 per hour. The deliberate misclassification can result in a fraudulent reduction in rates for employees working in high-risk operations.

Actual payroll reporting - rate of $15
$20 per hour x 40 hours = $800 x 5 employees = $4,000 in total payroll
$4000/$100 = 40 x RATE = 40 x $15. = $600 in premium

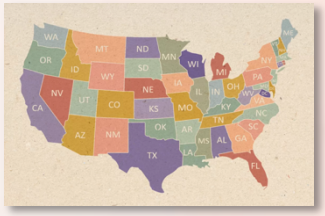
Fraudulent payroll reporting - approved for a lower rate of $12
$40 per hour x 20 hours = $800 x 5 employees = $4,000 in total payroll
$4000/$100 = 40 x RATE = 40 x $12 = $480 in premium

Underreporting

The most prevalent form of premium fraud involves the intentional misrepresentation of payroll exposures. The primary tactic involves employers deliberately underreporting their payroll to insurers. For example, a dishonest employer with an annual payroll of $600K may falsely claim only $200K to the insurer to reduce their WC premiums. To conceal payroll, employers may use tactics such as paying employees in cash, obscuring employees through shell companies, keeping two sets of books or falsifying records used during insurance premium audits. Recently, we have seen an increase in companies paying employees under the table with cash utilizing check-cashing services, gift cards, or mobile cash apps. These schemes are particularly prevalent in the construction industry. By hiding payroll, fraudsters not only pay lower premiums, but also evade payroll taxes.

Misclassification as Independent Contractors

Another type of payroll fraud that is cause for concern involves the misclassification of independent contractors. To be an independent contractor, a worker must be involved in an independent trade and be free from direction or control in the performance of their work. Unlike employees, independent contractors are not subject to WC coverage and are not entitled to employee benefits such as healthcare and retirement. *"Pretending"* employees are independent contractors is a serious issue that denies workers' rights and protections under federal and state labor standards and promotes wage theft. In this scheme, employers may instruct their employees to identify as independent contractors in order to keep more of their take-home pay, when in fact the employer is the one reaping the benefit of one less reported employee. In some instances, employees may not even be aware that their employer has identified them as independent contractors until an injury is reported.



States have varying definitions of employment, but it is common for them to take into consideration the degree of control over the worker. In general, a worker is an employee if the employer controls what the worker does and how they do it, and a worker is an independent contractor if the employer only controls what they do.

If a claim is submitted for a worker identified by the employer as an independent contractor, it is necessary for the claims representative to conduct a thorough case-by-case evaluation of the evidence. However, this process may result in a delay in providing the injured worker with proper medical coverage, potentially leading to permanent impairments.

Moreover, in the absence of coordination between the claims and underwriting teams, insurance carriers may inadvertently cover claims for employees even if the policy does not accurately reflect the relevant payrolls. Therefore, it is essential that any statutory claims identified by a claims representative be promptly conveyed to the underwriting and auditing departments, in order to enable closer scrutiny for signs of possible premium fraud.

Experience Modification

A third type of premium fraud involves EMR evasion. EMR is a surcharge applied to each business, which helps to offset profitability issues based on their claims experience. The EMR is more impacted by claim frequency rather than a single severe claim, as the base rates for classifications are developed based on the average frequency for that class. As the frequency of claims rises, the likelihood of more than one severe claim also increases, thereby endangering the profitability of insuring the risk. Another critical aspect of EMR is that it follows the business irrespective of the insurance carrier. Additionally, some larger construction companies use EMRs as a criterion to determine who is awarded their contracts. Therefore, there is a genuine incentive to maintain a credit rated EMR.

Employers who seek to evade the higher costs associated with WC due to a high EMR may resort to illegitimate practices such as failing to report injuries to the insurance provider and paying for claims out of pocket. Such practices are typically only effective until a catastrophic claim arises, after which point the employer may lack the financial means or willingness to cover the cost of the claim. Insurance carriers must take note of policies where a certain level of claim frequency would be expected, but only see severe claims, as this may indicate attempts at deception.

In addition to underreporting injuries, businesses may also attempt to avoid a high EMR by establishing a new business entity with new ownership, a new Federal Employer Identification Number (FEIN), and a new filing with the Secretary of State, while retaining the same workforce. These so-called *"ghost policies"* further complicate efforts to identify the beneficial owner of the business. It is worth noting that such practices are not limited to EMR evasion but are also used to evade outstanding debts or audits.

If an insurance carrier can track employees from one business to another and suspects fraudulent behavior, it is likely that the business is not new, but rather a reformed entity. Investigators should strive to identify the beneficial owner, rather than relying solely on the owner listed on paper.

Labor Brokers

A prevalent form of fraud, which is also present in the construction industry, involves the use of subcontracted labor brokers. These entities hire employees and offer their services to other employers in need of temporary labor. Labor brokers may operate as paper contractors or may have their own WC. Specialty subcontractors, such as those in interior systems, flooring, and electrical work, frequently augment their workforce through the use of labor brokers.[1] Such subcontractors often require labor brokers to have their own WC policy to avoid primary contractor liability

Labor brokers offer savings on labor costs by misclassifying employees as independent contractors or paying them off the books and failing to report payroll. Labor brokers and specialty subcontractors often operate as joint employers, with both entities exercising control over the employees. However, law enforcement efforts tend to focus on the labor broker, leaving the specialty subcontractor free to hire another labor broker or the same one under a different corporation or shell company identity.

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[1] David Borum & Geoffrey Branch, *How Construction Cons Steal Workers' Comp Premiums: It's a Shell Game*, Journal of Insurance Fraud in America, April 25, 2017, *reprinted by* Property Casualty 360, available at, https://www.propertycasualty360.com/2017/04/25/how-construction-cons-steal-workers-comp-premiums.

Shell Companies

One common tactic used in WC fraud involves the creation of a shell company. It begins by incorporating new Limited Liability Companies (LLCs), which are then registered with the Secretary of State, providing a veneer of legitimacy to the shell company. On paper, the shell company may not be owned by actual individuals, further shielding the beneficial owner. The fabricated company is used to obtain WC insurance and certificates of insurance which can

then be illegally leased to labor brokers or subcontractors. An insurance provider may believe it is covering only a few employees, but it could actually be insuring hundreds of workers.

These fraud schemes, alarmingly successful, have been found at university job sites, military bases, hospitals, high-rise apartments, government office buildings, airports, and other large construction projects managed by major construction companies. They can operate across multiple states or even internationally. Typically, when an insurance carrier suspects fraud, these businesses will move on to the next insurer or establish a new business entity to continue their fraudulent practices.

"With the economy in a downturn due to the pandemic, many businesses are looking for ways to cut expenses and misrepresent job classifications or not list all their employees. These are common mechanisms to commit fraud," observes Sztuk of Delta Group. Ultimately, premium fraud involves dishonesty or misrepresentations about risk exposure and classification, payroll totals, losses sustained, and beneficial ownership of a business. This enables wrongdoers to acquire WC coverage illegally at less than the appropriate rate. Suspects include, but are not limited to: business owners, insurance brokers, bookkeepers, supervisors, and office personnel. Certain industries that are labor-intensive or cash-intensive, such as agriculture, janitorial and construction are often the most affected.

III.
THE IMPACT

Financial Implications

Premium fraud is a significant economic crime that has a profound impact on society. WC premiums represent a considerable expense for businesses, which when combined with payroll tax requirements, can lead to additional costs of up to 60% to 70% of payroll. By misclassifying operations, underreporting payrolls, changing businesses, or using shell companies, fraudsters can illegally lower their premiums, as well as evade taxes, further contributing to the underground economy. The underground economy is a large and secretive employment sector that is rife with fraud and corruption, where workers are denied health insurance and WC benefits, and generally have fewer legal protections.[2] The construction industry is a significant contributor to premium fraud, with up to 20.5 percent of its workers who should be treated as employees being misclassified as independent contractors or paid off the books (5). In the United States, the underground economy has been estimated at between $2T and $2.8T. Tax evasion results in a loss between $700B and $1T a year.[3]

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[2] https://www.investopedia.com/articles/markets/032916/how-big-underground-economy-america.asp

[3] https://www.investopedia.com/articles/markets/032916/how-big-underground-economy-america.asp
Washington Center for Equitable Growth, article by Corey Husak, 2021. US Treasury Secretary Janet Yellen puts tax evasion at $700 billion a year. See also the *LA Times*, April 13, 2021 article by Laura Davison which states that IRS Commissioner Chuck Retting puts tax evasion at $1 trillion a year in the United States.

Employers engaged in premium fraud and payroll tax evasion can reduce their costs illegally and underbid honest competitors, with an average steal of one out of every seven contracts. *"Scofflaw contractors intentionally misclassify employees as independent contractors … or simply pay them off-the-books by check or cash with no reporting to state or federal taxing authorities or WC insurers,"* says Matthew Capece, Representative of the General President of the United Brotherhood of Carpenters & Joiners of America. *"This results in crooked contractors skimming 16.7% to 48.1% off their labor costs,"* adds Capece, an expert in wage theft and premium fraud in the construction industry.

"Premium fraud cheats honest policyholders and creates an unfair business advantage for the perpetrator. This creates a bidding advantage for lower product and servicing offerings due to their reduced operating costs," notes Sam King, a 30-year veteran insurance fraud fighter. *"Underfunded claims cause classification rate increases for all businesses. Overall rate hikes cause states to become less competitive in attracting and retaining businesses,"* says King.

Being hit by both unfair competition and increased rates due to the cost of fraud can make it challenging for honest businesses to compete, putting them at risk of closing their doors. Within the construction industry, this is particularly true, which only perpetuates the pervasive nature of premium fraud in that sector. Insurance companies are beginning to understand that by taking steps to address premium fraud, they are protecting honest policyholders, further safeguarding the integrity of their book.

Harm to the Employees

Premium fraud has a profoundly detrimental impact on employees across various fronts. Workers are susceptible to severe injuries resulting from falls or other painful incidents, only to realize that they lack WC coverage. The absence of prompt medical benefits, as stipulated by WC insurance, can further hinder their return to work in a timely manner due to the unavailability of medical treatment. This, in turn, deprives employees of the opportunity to earn a livelihood and may even cause lasting medical conditions.

It is rare for premium fraud to be an isolated offense committed by employers. Frequently, additional crimes such as state and federal tax fraud, wage theft, immigration violations, labor trafficking, wire fraud, mail fraud, money laundering, and racketeering are involved.[4] Losses from premium tax scams also have dire consequences, depriving state and local governments of crucial tax dollars needed to provide adequate services to taxpayers, especially at a time when many jurisdictions are grappling with funding challenges.

[4] *See, e.g.,* Press Release, Dept. of Justice, U.S. Attorney's Office Middle District of Florida, *Two Men Plead Guilty to Fraudulent Scheme to Evade Payroll Taxes and WC Requirements in the Construction Industry,* (March 30, 2021) (hereinafter "Two Men Plead Guilty"), available at, https://www.justice.gov/usao-mdfl/pr/two-men-plead-guilty-fraudulent-scheme-evade-payroll-taxes-and-workers-compensation (This case is an example of a WC premium fraud scheme where shell companies were used also involving federal offences. The defendants pleaded guilty to wire fraud and tax fraud. The estimated payroll taxes owed on the $22,793,748 of checks cashed was $5,766,286. The WC insurers should have charged a premium of $3,600,000, instead of what they charged--$15,206 to $31,268 per policy year.)

When an employer conceals payroll information, they not only withhold it from insurance providers, but they may also do the same to labor and employment regulatory agencies. This lack of transparency in wage oversight exposes employees, generally low-wage workers, immigrant workers, and workers with less education and fewer resources to potential wage theft. There have been allegations of dishonest contractors paying their workers $20 per hour, while billing labor rates of $25 per hour, and simultaneously charging upper-tier contractors $45 per hour. According to the Economic Policy Institute, wage theft costs the US workers as much as $50B per year - a number far higher than all robberies, burglaries, and motor vehicle thefts combined.[5]

Impact to State Budgets

For states that rely on state coffers from insurance premiums on a regular basis, the consequences of fraudulent activities can be profound. A case in point is the Tennessee Bureau of WC, which estimated that fraudulent practices in the construction industry caused a colossal loss of $296 million in premiums in 2016.[6] It is worth noting that the state imposes a 4.4 percent assessment on premiums for administering various programs such as the subsequent injury and uninsured employers fund, the Tennessee Occupational Safety and Health Administration, among others. The effect of such fraudulent activities has been a yearly loss of $13M on these programs.

IV.
Prevention

The Path Forward

Addressing premium fraud and the related crimes of tax evasion, and wage theft, in a meaningful manner demands a multifaceted approach that engages diverse stakeholders. In light of the fragmented legal and regulatory landscape to systemic trends within the insurance industry, the environment that enables and sustains premium fraud remains pervasive.

Insurance is currently undergoing a technological transformation that prioritizes user experience and positive ratings. This customer-centric approach has resulted in a more streamlined application and policy management process, featuring fewer human interactions and more self-serve options. Advertisements proudly tout the ability to secure an insurance quote in mere minutes, even for WC, a coverage that is limitless.

Unfortunately, this allows some employers the opportunity to take advantage of lenient underwriting practices, solely to obtain a certificate of insurance, which remains the most common form of proof of coverage. After using the certificate to get paid, these dishonest employers can keep the policy in force until the time of an annual audit or until the carrier suspects foul play. Often, this does not stop them as they can easily switch carriers to continue their deceptive practices.

Experienced fraudsters are familiar with the state funds and carriers that are more susceptible to their scams. In some cases, they may hold multiple policies under different ownership or business names, thereby compounding the complexities of detecting and combating premium fraud.

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[5] https://inthesetimes.com/article/wage-theft-union-labor-biden-iupat

[6] Tenn. Bureau of Workers' Compensation, Annual Report on Employer Coverage Compliance, 6 (February 1, 2019), available at https://www.tn.gov/content/dam/tn/workforce/documents/injuries/2019ComplianceAnnualReport.pdf; and Tenn. Bureau of Workers' Compensation Employee Misclassification Advisory Committee, The Use of Criminal Prosecution to Reduce Misclassification, Avoidance of Workers' Compensation Coverage and Premium Fraud (Dec, 12, 2019).

Underwriting, Auditing, And More

Carriers can apply underwriting measures into their policies to mitigate the occurrence of premium fraud. When adding a new account, insurers should meticulously review businesses with high EMRs or those with a high frequency of losses. These can be indicative of a policy being *"rented out for a certificate of insurance."* Conversely, a business with fewer claims than expected should undergo thorough vetting to determine if it is a possible brokered policy.

If a policyholder had a claim frequency issue, and after switching to another carrier suddenly has no claims, this can indicate the owner is no longer reporting claims for injured workers as they may have resorted to paying for minor injuries out of pocket while only reporting severe and costly claims. Subsequently, insurers should perform an underwriting inspection after a policy is on the books to validate operations, payroll, locations, and ownership.

The audit at the end of the policy term provides a crucial opportunity for carriers to identify premium fraud. A robust audit practice that empowers auditors to investigate suspicious activities is invaluable for identifying cases of underreporting and misclassification. It is imperative that carriers avoid waiving audits for specific classifications, including roofing, janitorial, siding, or any other classes that are susceptible to premium fraud.

However, if an audit is waived for a customer, underwriters must closely monitor the policyholder until an audit can be conducted. In certain instances, some carriers mandate an in-person audit for customers who avoided a prior year audit or issued a significant number of certificates in the previous year, as this can be indicative of policy brokering. While pictures may be worth a thousand words, there is nothing quite as informative as an in-person inspection.

In addition to the vital roles played by auditing and underwriting, other teams within an insurance company can prove instrumental in detecting fraudulent activity. Although auditors and underwriters are often the primary gatekeepers tasked with identifying premium fraud, it is not uncommon for claim representatives to also detect suspicious activity.

Consequently, it is imperative that the claims discipline is trained to recognize the signs of premium fraud and understand its impact on injured workers. This may involve encouraging them to ask more probing questions in cases where an injured worker is paid in cash or there are allegations of independent contractor misclassification. Comprehensive training programs within an insurance carrier should strive to highlight success stories drawn from a variety of sources, including both claims and underwriting.

Public Outreach

Policyholders constitute critical stakeholders that can contribute significantly to the eradication of premium fraud. Dishonest employers in the industry pose an unfair competition to their honest counterparts and jeopardize the interests of policyholders. In order to safeguard the interests of the latter, insurance carriers can offer educational resources to industry groups or organizations to assist them in identifying *"bad actors"* within their industry. Public outreach initiatives focused on education and awareness have been shown to be highly effective in explaining the deleterious impacts of premium fraud.

Research indicates that successful public information campaigns tend to leverage a variety of communication channels and strategies, including but not limited to TV commercials, social media, press releases, and news stories. Additionally, providing avenues for members of the public to report possible premium fraud sends a strong message that insurance carriers and regulatory offices take fraud seriously and are committed to addressing it. Implementing an anonymous hotline or an easily accessible reporting feature on the carrier's website can facilitate the reporting process and foster greater transparency and accountability in the industry.

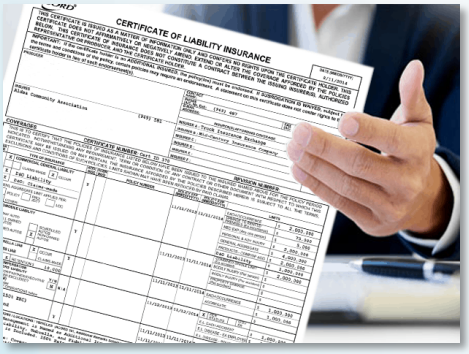
Cooperation Among Insurance Carriers

The insurance industry can benefit from greater collaboration among carriers, especially in states without monopolistic WC carriers. In monopolistic states, the single carrier has the ability to drive change more effectively. However, in states with multiple carriers, they are typically seen as competitors and are hesitant to share strategy information with each other. This lack of collaboration leads to a black-box approach to addressing premium fraud, with carriers adopting varied approaches to fraud prevention.

While sharing information between carriers is not common due to competitive reasons and antitrust concerns, there is an opportunity for carriers to take advantage of emerging technology. Third party vendors tout the ability to leverage known existing claims information by the use of artificial intelligence (AI). Incoming claims can be quickly triaged and flagged with fraud indicators as a means to cut down on the tedious review process. Having this information readily available will speed up the investigative process as well as the handling of legitimate claims.

Another additional opportunity exists with a tool similar to how insurers track claims by claimant and vehicle. When you buy a car, you can check the car's accident history. As of now, there does not exist a tool where information on businesses with a history of underreporting or non-compliance with audits is available to insurance carriers. Sharing this information can prevent subsequent carriers from being cheated by the same bad actors.

Certificates of Insurance and Blockchain Technologies



Certificates of insurance are still widely used in the construction industry, but the current process and technology for them are outdated and pose a risk of premium fraud. The traditional use of physical certificates has been replaced by PDFs sent via email, but they are not interactive and lack real-time validity. Relying solely on certificates for proof of coverage is concerning, as they can be used even if the policy has been canceled. Also, they provide limited information about the classification, payrolls, or ownership which provides justifiable deniability for contractors who knowingly hire dishonest employers.

For carriers who rely on certificates, there are a few actions that can help prevent premium fraud. Incorporating payroll and classification information into certificates would hold employers accountable for hiring contractors who deliberately underreport payroll or misclassify their operations. Moreover, the number of certificates issued could offer valuable insights to insurance carriers regarding the size of the businesses they are underwriting. The possibility of fraudulent insurance agents issuing certificates further underscores the limited visibility of insurance carriers with respect to the number of certificates issued versus the amount of payroll recorded on the policy.

To prevent premium fraud, insurance carriers can incorporate payroll and classification information into certificates to hold contractors accountable for hiring dishonest employers. Using blockchain technology can also add credibility and real-time verification to the process of providing proof of insurance. Blockchain consortiums can create a decentralized and scalable approach to managing certificates, allowing multiple stakeholders to participate in the network and validate certificates. However, the cost and cooperation necessary for this solution can be a challenge. Alternative solutions include incorporating a QR code on issued certificates or using state databases to verify coverage. The carriers who have begun to implement this are trailblazers, and it is not currently the norm.

State and Local Governments

Many states have regulatory agencies whose jurisdiction overlap on matters related to premium fraud. Similarly, municipalities may further restrict illicit business and trade within their local jurisdiction. States that have a higher degree of cooperation between these shared stakeholders will no doubt be ahead of the game when it comes to fighting fraud. Labor departments, licensing boards, and business regulatory agencies all share a common interest in protecting the rights of both employers and employees as well as the consumer. There are numerous examples around the country of agencies working together to address premium fraud, wage theft, and tax evasion. Here are a few:

The New York State Joint Task Force on Employee Misclassification and Wage Theft: This task force brings together several state agencies, including the Department of Labor, the WC Board, and the Department of Taxation and Finance, to combat employee misclassification and wage theft. The task force investigates and prosecutes employers who misclassify employees as independent contractors to avoid paying taxes and WC premiums.

The Pennsylvania Employee Misclassification Coordinated Enforcement Initiative: This initiative is a collaboration between several state agencies, including the Departments of Labor and Revenue, the Attorney General's Office, and the Department of State, to combat employee misclassification. The initiative focuses on educating employers about their legal obligations and conducting audits and investigations to identify employers who are misclassifying employees.

The California Labor and Workforce Development Agency: This agency oversees several departments and boards, including the Department of Industrial Relations, the Employment Development Department, and the Department of Fair Employment and Housing. These departments and boards work together to enforce labor laws, including those related to wage theft, premium fraud, and tax evasion.

Insurance fraud is a serious crime that can result in significant financial losses for insurers and policyholders alike. Many states have enacted robust laws to address various types of insurance fraud, including premium fraud. Here are some examples of state laws that address premium fraud:

New York Penal Law Section 176.15: This law prohibits fraudulent insurance acts, including schemes to wrongfully take, obtain, or withhold, or attempts to wrongfully take, obtain or withhold property in excess value of one thousand dollars.

Florida Statutes Section 626.9541: This law prohibits knowingly making a false or fraudulent written or oral statement or representation on, or relative to, an application or negotiation for an insurance policy for the purpose of obtaining a fee, commission, money, or other benefit from any insurer, agent, broker, or individual.

Texas Insurance Code Section 35.02: This law prohibits false or fraudulent insurance applications or statements, including misrepresentations of facts to obtain lower premiums.

Colorado State Statute 18-5-211: This law defines insurance fraud as intentionally providing false or withheld information in an application, request, or modification of an insurance policy, resulting in the issuance of the policy.

Illinois Compiled Statutes Section 720 ILCS 5/17-10: This law prohibits insurance fraud, including submitting false or misleading information to obtain lower premiums.

Nationally, states have varying approaches to addressing premium fraud. How aggressively a state wants to fight this costly crime is largely determined by its respective legislative body. When dealing with the creation of new laws, it is important to remember that a prohibition against premium fraud works best when accompanied with an imposed penalty sufficient to achieve deterrence. States should consider criminal and civil penalties that increase as the dollar amount of the fraud increases.

Grant Funding

As state budgets become increasingly strained, funding for prosecutors who specialize in targeting insurance and premium fraud cases is at risk. Unfortunately, too few prosecutors are currently pursuing premium fraud cases, particularly in states where such offenses are only penalized as misdemeanors or minor criminal offenses. Given the complexity of these cases, prosecutors may lack sufficient incentives to prioritize them in their caseloads.

One promising solution to this issue is the provision of grant funding for insurance fraud prosecutors. With dedicated funding, states would be able to ensure that they have access to prosecutors with specialized expertise in trying and successfully prosecuting premium fraud, tax evasion, and wage theft cases. These professionals would be well-equipped to guide the creation of search warrants for records unique to premium fraud cases, including those from businesses, insurance agencies, accountants, financial institutions, internet providers, and cell phone carriers. They would also be more familiar with the voluminous review process in comparing insurance carrier information against state payroll and tax records for discrepancies.

Training for Prosecutors

Prosecuting premium fraud requires a specific knowledge base to adequately understand how the crime is committed. This can be intimidating to those less familiar with the specific elements and schemes involved with the crime. By providing training, including case studies of successful prosecutions of premium fraud, wage theft, and tax evasion, prosecutorial authorities and those charged with investigating premium fraud can take great strides to ensure those committing and aiding this crime are not only arrested, but successfully prosecuted.

Additional Legislative Opportunities

The definition of 'employee' is a critical issue affecting premium fraud across the United States. Courts across the country are actively deciding cases that clarify the distinction between employees and independent contractors, particularly with the rapid growth of the gig economy. This debate often pits employee associations against business councils, with each group facing different pressures and motivations.

Establishing a consistent definition of employee versus independent contractor is essential to combating premium fraud. A cohesive approach to worker classification would help businesses and employees better understand their rights and obligations, while also allowing regulators to better enforce labor laws. Moreover, clear definitions could help prevent disputes and litigation related to worker classification, which could ultimately reduce instances of premium fraud nationwide.

V.
Conclusion:

The Team Approach

Premium fraud poses a significant national issue, amounting to a staggering annual cost of $25B. This fraudulent activity not only harms workers but also undermines the administration of WC systems, insurers, and law-abiding employers. Furthermore, premium fraud often coincides with other criminal acts such as tax fraud, wage theft, money laundering, mail and wire fraud, labor trafficking, conspiracy, and other organized schemes to defraud.

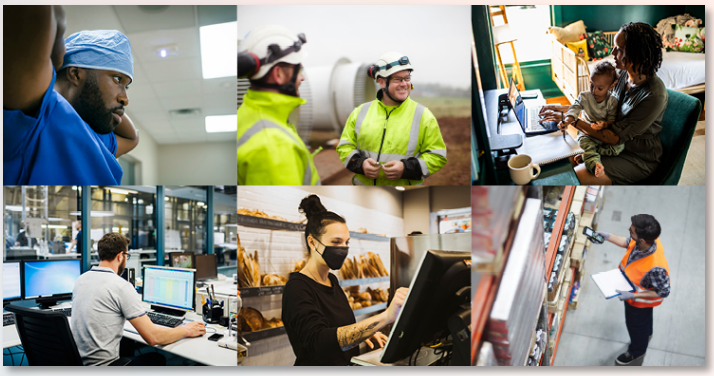
However, there are viable solutions to this pressing problem. A collaborative team approach to fighting premium fraud is paramount. Criminal and civil laws must be crafted to include specific prohibitions against cheating the system with stern penalties for those found to be in violation. Adequate training and funding should be provided to law enforcement agencies and prosecutors who are charged with bringing fraudsters and co-conspirators to justice. Regulatory agencies must maintain the resources necessary to create and enforce rules which effectively balance the interests of insurance industry stakeholders as well as the consumers they serve. Insurance carriers have to create an internal anti-fraud culture whereby potential fraudulent activity can be identified, investigated, and reported as applicable. Finally, the public must be given reminders on the costly effects of premium fraud, ways to recognize it, and methods to report it.

As part of a team, all of the aforementioned players have a significant individual role in curbing fraudulent activity. As is the case in team sports, performance is negatively affected if all players are not putting in maximum effort while working together toward the same goal. Fraudsters are aware of where weak links are located and exploit that area as a path of least resistance.

Therefore, it is crucial that as a team, we adapt and improve our tactics to prevent further losses to insurers, prevent worker suffering, and avoid punishing honest employers who adhere to the law. The current situation is untenable, and swift action is necessary to address this pervasive problem.

(2) WORKERS' COMPENSATION CLAIMANT FRAUD

I.
Introduction



Claimant Fraud is a $9B dollar per year problem in the United States. This crime adversely affects everyone from citizens, employees, businesses, and the economy in general. claimant fraud is a systemic problem that requires a specific understanding to appropriately recognize, investigate, and identify it in the workplace.

This document and associated training materials will provide the information and tools to address claimant fraud in the workplace. By understanding the problem of WC Claimant Fraud in America, we can develop specific Best Practices and training programs to make an immediate impact on fraud. Through proactive steps we can reduce the rate of claimant fraud, protect local and national economies, and make the workplace a safer environment.

II.
Impact of Claimant Fraud

Claimant Fraud involves making a false or fraudulent material statement for the purpose of obtaining or denying any WC benefit. Suspects are usually employees, although it could also include insurance company staff. WC is designed to provide a worker injured on the job with medical services and related benefits.

Overall Cost of Insurance Fraud

- $34B Annually (this $34B figure is broken down to $9B in claimant fraud and $25B in premium fraud)
- Impact on Employee Morale
- Increase Cost of Good & Services
- Increased WC Insurance Premiums

Please see the report from the Coalition Against Insurance Fraud on the *"Impact of Insurance Fraud on The U.S. Economy"* at the following link:
https://insurancefraud.org/wp-content/uploads/The-Impact-of-Insurance-Fraud-on-the-U.S.-Economy-Report-2022-8.26.2022.pdf

III.
Types of Claimant Fraud

WC Claimant Fraud includes any fraudulent activity or deceptive behavior that attempts to manipulate the WC system for personal gain. Some common types of claimant fraud are as follows:

False Statements
An employee may provide false information regarding the circumstances of their injury, such as the location, cause, or timing.

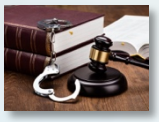
Working While Collecting WC Benefits
An employee can commit fraud by working a second job while receiving Temporary Total Disability benefits and not reporting the work and wages to their WC carrier. Commonly referred to as "Double Dipping".

Denial of Prior Injury
An employee might have an old, pre-existing injury that they report as a new work injury.

Fake or Non-work Injury
An employee can commit fraud by intentionally reporting a work-related injury when their injury occurred elsewhere.
An employee may fake or stage an injury and report it as a work injury.

Exaggerated Claim (Malingering)
Malingering is a deliberate act of exaggerating work-related injuries to receive financial benefits or extended time off work otherwise not entitled to. This is achieved by misrepresenting the severity of a reported injury to take advantage of the WC system.

Red Flags of Malingering
Delays in seeking medical treatment or missing scheduled medical appointments.
Inconsistent symptoms of injury or reported symptoms that do not align with objective medical findings.
General lack of cooperation during medical evaluations including symptom magnification. Misrepresentation or discrepancies in prior claim history or medical history.
Reported limitations are inconsistent with observed daily activities.



Impact of Malingering

- *Civil & Criminal Implications:* Malingering is insurance fraud and subject to civil and criminal penalties including fines and imprisonment.
- Financial impact to employers and insurers resulting in increased premiums, reduced resources, and increased costs to consumers.
- *Workplace morale and trust:* Malingering directly impacts the relationships and morale between employer and employee through a loss of trust and increased burden on fellow employees.
- Resources diverted away from focusing on legitimate claims and employees in need of assistance.

Implement detailed Investigation Best Practices to conduct thorough and timely claims investigations.

- *Medical Management:* Ensure Nurse Case Managers or qualified medical professionals are conducting thorough medical assessments to determine the nature and extent of all injuries including expected end of healing time.
- *Fraud Awareness Training:* Ensure the entire staff is aware of Red Flags and impact of Malingering.
- Create clear Fraud Best Practices to ensure suspected fraud is reported to internal resources.
- Law Enforcement & Compliance relationships. Report all suspected fraud to Local, State and Federal Law Enforcement, if warranted.

IV.
WC Fraud *"Red Flags"*

WC insurance is designed to protect employees who are injured on the job. However, some individuals and companies take advantage of this system by committing fraud. Insurance fraud is a serious problem that can be costly for insurers and harmful to honest policyholders. To combat fraud, insurers use various methods to detect and prevent it. One of the most important tools in this effort is the identification of fraud indicators. These indicators are warning signs that suggest a claim may be fraudulent. By recognizing these indicators, insurers can take appropriate action to investigate and prevent fraudulent claims. Below are some of the most common claimant fraud indicators and how insurers can use them to combat fraud.

- **Employee has an extensive WC claims history**.
    - Run various ISO searches to get the complete claims picture: i.e., name, name/address, SSN, name/DOB, address only, DL#, phone #, family members, roommates.

- **Employees perform seasonal work that is about to end.**
    - Review policy, search the internet to find company webpage to see what all they do.

- **Employees are disgruntled or facing an imminent firing or layoff.**
    - Obtain/review personnel file to review for any recent performance issues.

- **First notice of injury is after an employee is laid off, terminated, or resigns.**

- **Employee is non-compliant with treatment and refuses to return to work in any capacity (i.e., modified duty).**
    - Review claim file notes. Is there a particular reason for non-compliance with treatment?

- **Co-workers provide information regarding the legitimacy of the reported injury.**
    - Consider an AOE/COE investigation, speaking with all potential witnesses or anyone that might have knowledge about the loss. Secure statements early!

- **Anonymous sources provide *"tips"* regarding the legitimacy of the reported work injury and/or the individuals activity level.**
    - Do you have a case management system, or something that can retain/flag *"private"* or *"confidential"* SIU notes? Again, secure statements early. Set expectations regarding their statements/testimony remaining anonymous.

- **Social media posting indicates the employee having a higher level of activity than is told to the medical professions and insurance carrier.**
    - Consider retaining an outside firm to conduct Social Media searches. Searching through your own accounts can be subject to discovery. Be able to preserve what you find.

- **First notice of injury comes from the employee's attorney.**
    - Structure your statements ahead of time. It never hurts to inquire why someone didn't file a claim themselves.

- **Employee does not report the injury immediately.**

Members of NICB can obtain complete WC *"Red Flag"* indicators using the following link:
https://www.nicb.org/members/document-downloads

V.
WC SIU Referral Types

Many insurance companies have established Special Investigation Units (SIU) that investigate suspicious claims. These SIUs receive referrals from various sources, such as claims adjusters, fraud hotlines, and law enforcement agencies. The different types of WC SIU referrals and how they are used to identify and prevent fraud in the WC system. Will be discussed. By understanding these referrals, we can better understand how SIUs investigate fraud to protect honest policyholders and keep insurance premiums affordable.

Adjusters/Examiners

Adjusters/Examiners are our frontline defense. It is important to foster relationships with claims staff as this is where the bulk of referrals come from. You should also have a robust case management system that can delineate which offices you receive referrals from. This can help identify offices that may need additional training.

Insured/Employee/Co-workers/Anonymous Tips

These are usually of a more sensitive nature, and often the caller wants some degree of anonymity. Consider having these notes labeled as *"Confidential"* or otherwise only viewable to SIU.

Analytics

Linear business rules only go so far. Consider adopting a comprehensive data analytics platform that can connect real time links that would otherwise take an individual a substantial amount of time.

Background/Database/ Surveillance and Large Loss Investigations

Having a good analytics platform goes hand in hand with comprehensive background database access. What used to take weeks of an investigator's time physically going to court houses, performing neighborhood searches, etc., can now be accomplished at the click of a mouse.

Industry Alerts/FOREWarn Alerts/Targeted Taskforce

Industry Alerts/FOREWarn Alerts: If your carrier is a member of NICB, you can receive FOREWarn alerts. They are aggregated intel reports from multiple carriers regarding individuals, businesses, etc.

Contacted by State Fraud Bureau/DOI

Contact from State Fraud Bureau/DOI: Relationships with DOI personnel are vital to an SIU operations success. Knowing the right investigative contacts can help expedite having your cases opened in a timely manner.

VI.
Investigative Guidelines

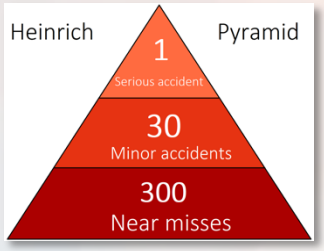
Employer Investigations

WC fraud is a crime of opportunity. One key to reducing claimant fraud is having a robust Employer Accident Investigation Program. Investigations should not target fraud. Investigations should focus on claims, accidents, near misses and unsafe acts. If we consistently follow accident investigation Best Practices, the fraud will be identified.

The goal of any employer and Employer Accident Investigation Program is rooted in safety and prevention. Employers must understand accidents, why they occurred and take corrective action to prevent recurrence. The main purpose of an accident investigation is to determine the facts surrounding the accident and to prevent future accidents.

Employers must develop thorough and consistent accident investigation protocols to identify risk, determine the root cause of an accident and create a culture of safety and accountability.

Accident Triangle



The accident triangle, also known as Heinrich's triangle or Bird's triangle, is a theory of industrial accident prevention. It shows a relationship between serious accidents, minor accidents, near misses and unsafe acts. This idea proposes that if the number of minor accidents is reduced then there will be a corresponding fall in the number of serious accidents.

Employers must investigate all accidents and unsafe acts that occur. This philosophy will make the workplace safer, improve existing accident investigation Best Practices and identify the *"root cause"* of the accident to eliminate hazards. These actions will help reduce future accidents and remove the opportunity for a fraudulent act to occur.

The loss location contains valuable information that is essential to any investigation. The loss location must be secured to preserve the scene, protect valuable evidence and to prevent further injury. It is essential to keep unauthorized personnel out of the loss location until the facts have been gathered and documented.

Examples of information to gather at the loss location include:

- ***The Environment:*** Liquid on floor, lighting, or the presence of vapors
- ***Equipment & Tools:*** Guarding and noted defects
- ***Materials:*** Size, shape, and weight
- **Safety Equipment or lack of Safety Equipment**
- **Identify any CCTV video cameras that may have captured the accident**

Witnesses

Once the injured worker's medical needs have been taken care of, it is vital to identify all witnesses to the accident. These witnesses would include direct witnesses and peripheral witnesses. Direct witnesses would be those that were involved in the accident or who witnessed the accident. Peripheral witnesses are individuals that may not have been at the scene. These would include employees or personnel with technical knowledge or expertise about the conditions that may have contributed to the accident. All witness interviews and statements should be conducted as soon as possible, one witness at a time, in a private location, conducted in a professional manner while looking for facts.

The injured worker should immediately (or as soon as practicable) complete an incident report describing the accident and loss location in detail. All direct and peripheral witnesses should provide witness statements. The employer Supervisor should complete a detailed incident report summarizing all aspects of the investigation completed.

Questions to ask during the investigation might include the following.

What was the employee doing at the time of the accident?

1. Was the employee qualified to perform this operation?
2. Were company procedures being followed?
3. Is the job or process new?
4. Were proper tools or safety equipment being used?
5. Was the proper supervision being provided?
6. Had the employee received training on this operation prior to the accident?
7. Where did the accident take place?
8. What was the physical condition of the area when the accident occurred (for example, was the temperature of the area hot or cold; if outside, was it wet or muddy, was debris in the way or was the area clear)?
9. Were there any witnesses to the accident?

10. What immediate or temporary action could have prevented the accident?
11. What long-term or permanent action could have prevented the accident?

The accident investigation should look to confirm (3) main points:

1. Direct Cause: Identify the final action that caused the injury or damage to occur. A slip injury due to liquid on the floor. A lifting injury due to incorrect lifting techniques.
2. Indirect Cause: This is the result of the Direct Cause, such as unsafe acts or unsafe conditions.
3. Root Cause: This is the accident factor that if eliminated, would have prevented the occurrence. The leaky pipe that resulted in pooling water on the floor. The lack of appropriate lifting training.

The completed accident investigation should highlight how an accident occurred. Did the accident occur due to a breakdown in safety culture, equipment & facilities, management systems or an unsafe act or condition? Any breakdown in company procedures, training, supervision or material or equipment design will lead to poor working conditions or unsafe acts or practices. Without a consistent Employer Accident Investigation Program in-place there will be an increase in mishaps, injuries, and opportunistic fraud.

The accident investigation must result in the following:

Elimination of the identified hazard
Replacement of dangerous materials or techniques
Improved engineering controls
Effective PPE
Implementation of needed training
Updated Employer Best Practices

VII.
Successful WC SIU Investigative Program

A successful SIU Investigative Program should include the following components:

Teamwork

To be effective, an investigative program requires a collaborative effort among various parties. These parties may include claim adjusters, examiners, supervisors, loss control/underwriting, insured employers & employees, Agents/Brokers, SIU's, industry resources, investigative vendors, Law Enforcement, and defense counsel. Businesses should also implement a zero-tolerance workplace policy for fraud and develop an environment that encourages employees to report their concerns.

By working together, these parties can leverage their unique perspectives and expertise to identify potential fraud and take appropriate action. For example, claim adjusters can review claimants' medical records and conduct interviews to determine the validity of claims, while investigative vendors can conduct field surveillance and desktop investigations to gather additional evidence.

Investigation Best Practices

To ensure a successful program, it is essential to follow investigation best practices to ensure a thorough and fair process. These may include:

Timeliness requirements: Claims should be investigated promptly to prevent fraudulent activity from continuing.
Documentation requirements: Investigators should document all aspects of the investigation, including database and background requirements, the investigative plan of action, investigation

updates and a comprehensive report summarizing the investigation's findings. Include all relevant information, supporting evidence and a clear conclusion based on the evidence gathered.
Experienced WC Investigators: Use of experienced Investigators who are trained in WC laws and investigative techniques.
Conduct Interviews: Interview the injured employee, witnesses, supervisors, and any other relevant individuals. Ask open-ended questions to gather accurate and detailed information. To the extent possible, ensure confidentiality of all parties.
Preserve Evidence: Ensure that all evidence is preserved and secured. This includes physical evidence, such as equipment involved in the incident, as well as digital evidence like surveillance footage or electronic records.
Collaborate with stakeholders: Communicate with the injured employee's supervisor, HR department, and legal counsel to ensure a comprehensive investigation. Obtain their input and address any concerns or questions they may have.
Investigative vendor management: Companies should identify, and vet qualified investigative vendors, set quality and pricing expectations, and implement an ongoing quality assurance program. Ensure all investigative vendors follow all privacy laws and are properly licensed and insured.
Law enforcement referral requirements: Suspected fraudulent claims should be referred to state fraud bureaus / law enforcement for further investigation and to follow all state statute requirements.

By following these best practices, companies can ensure that investigations are thorough, timely, well-documented, and that any fraudulent activity is identified and addressed appropriately.

Case Management

Proper case management is a critical component of a successful WC investigative program.

This may involve:

Securing investigative evidence: Investigators should take steps to secure any evidence obtained during an investigation, such as video footage or witness statements.
Documenting investigative plans and reports: All aspects of the investigation, including the plan of action and findings, should be documented in detail.
Capturing investigative impact/savings: Companies should keep track of the impact that the investigation has on their bottom line, such as by identifying fraudulent claims that were denied, mitigated, or prevented.
Retention of documents/evidence/reports: Investigators should retain all relevant documents, evidence, and reports in case they are needed in the future and in compliance with mandated retention policies.

By managing cases effectively, companies can ensure that they are well-positioned to identify and prevent fraudulent activity and to respond appropriately if fraud is suspected.

Investigation Vendor Management

Investigation vendor management is another crucial component of a successful WC investigative program.

This may involve:

Identifying and vetting qualified/competent investigative vendors: Companies should carefully vet vendors to ensure that they have the necessary expertise and experience to conduct investigations effectively.
Understanding state laws pertaining to surveillance: Different states have different laws governing surveillance activities, and companies must ensure that they comply with all relevant regulations.
Quality and pricing expectations: Companies should set clear expectations for the quality of work and pricing that they expect from investigative vendors.
***Securing indemnification agreements, vendor insurance, and licensing*:** Vendors should be required to have appropriate insurance and licensing and to provide indemnification agreements that protect the company from potential liability.
***Ongoing quality assurance program*:** Companies should implement an ongoing quality assurance program to ensure that investigative vendors are meeting their expectations and delivering high-quality work.

Utilizing Investigative Evidence Obtained

After conducting a thorough investigation, the evidence obtained should be used to make informed claim decisions about the WC claim.

The following parties can benefit from the investigative evidence.

Claims Examiner: The claims examiner is responsible for making an informed claim decision on whether to approve a claim. The evidence collected during the investigation can help the examiner determine the validity of the claim and make a more informed decision.

Defense Counsel: If a claim is in litigation, the defense counsel can use the investigative evidence to build their case and defend against fraudulent claims.

***Treating Doctor/IME/FCE*:** The evidence collected can be used to help the treating doctor or independent medical examiner (IME) make a more accurate assessment of the claimant's condition. If necessary, functional capacity evaluations (FCEs) can be used to determine if the claimant can return to work.

Independent Adjusters: Independent adjusters can use the evidence collected during an investigation to assess the claim and make a recommendation on whether to approve the claim.

Investigative Experts: Finally, investigative experts can be brought in to provide additional analysis and support. For example, a forensic accountant could be used to examine financial records, a medical expert could be used to review medical reports, or a biomechanical expert can review both the accident and resultant injuries to determine if one could have caused the other.

Thus, a successful WC investigative program requires a team effort and adherence to best practices for investigation and case management. Through teamwork and utilizing industry resources, investigators can conduct timely and effective investigations that lead to informed decisions about the claims. By following best practices for documentation, vendor management, and evidence utilization, investigators can ensure that they are protecting their clients from fraudulent claims and minimizing unnecessary costs associated with WC claims.

How to Conduct Investigations

1. Verify the injured worker's personal identifying information (PII).
2. Run ISO ClaimSearch for claims history, prior injuries, and patterns of claims.
3. Database search to determine business ownership, properties, professional licenses.
4. Background check, including criminal and civil records, to determine if there are any prior convictions or financial stress.
5. Social Media Search (deep web search) used to determine activity, concurrent employment, hobbies, patterns, gym membership, golf handicap, participation in organized physical activities, i.e., 10k race, mini triathlon, "road runners," cycling etc. May discover events a claimant may be attending and utilize this information when assigning surveillance.
6. Medical Canvass conducted to determine previous treatment for injuries. This may be specialized (orthopedic, physical therapy, chiropractor) or general (ER, Med Express, family doctor).
7. Pharmacy Canvass conducted to see medical provider(s) who may be writing the prescriptions, i.e., orthopedic, podiatrist.
8. This can be helpful with surveillance and/or when subpoenaing medical records. Note: Most pharmacies have a national database.
9. Field Investigation/Onsite Investigation.
   - Loss location investigation
   - Claimant Statements
   - Witness Statements

Surveillance utilized to determine daily activities, a *"day in the life"* of an individual. Also utilized when you know an injured worker should be at a specific place at a specific time, medical appointment, depositions, IME, physical therapy, etc.). Identifying and obtaining public & private surveillance footage.

Preserving evidence spoliation.
Installing surveillance equipment at the workplace.

VIII.
Common Motives for Committing WC Fraud

There are several reasons why an employee may attempt to commit WC fraud. It may be a scenario where an employee sees an opportunity when a legitimate incident occurs, and they take advantage of it. They utilize this opportunity to build a claim with the goal of collecting Temporary Total Disability (TTD) benefits and not having to work. Other scenarios include *"planned"* incidents, and/or filing a claim for an incident that did not occur. This may be a staged work injury or a fictional incident and injury.

The motives for WC fraud usually fall into one or more of the following categories.

Seasonal Employment that is ending.
Lack of usable paid time off (PTO).
No daycare services during the summer months.
Financial stress/Early retirement.
Recent performance issues.
Recent job reclassification.
Disgruntled employee.
See co-workers filing claims.
No health insurance to pay for personal injury / condition.
Work for unreported income while collecting TTD.

Understanding the motives of the fraud can be helpful in identifying, investigating, and potentially preventing suspect claims.

VIII.

WC Fraud Awareness Training

WC fraud is a serious issue that can have significant consequences for both employers and employees. To raise awareness about this fraud and promote prevention, it is important to provide training to employers and employees as follows.

1. Introduction to WC System
   Explain the purpose of WC insurance and the importance of providing benefits to injured employees
2. Definition of WC Fraud
   Define that WC fraud is any intentional act or misrepresentation designed to deceive or manipulate the system for personal gain.
   Highlight the different forms of fraud including working while receiving benefits, exaggerating symptoms, faking an accident, non-work injury, and misreporting prior injuries.
3. Consequences of WC Fraud
   Discuss the legal, financial, and reputational consequences of committing fraud.
   Explain that WC fraud increases insurance costs for employers, reduces jobs and benefits for employees and leads to higher prices of consumer goods.
4. Recognizing Red Flags
   Employers and employees should recognize the common indicators or red flags of WC fraud.

Employers and employees should be encouraged to report any suspicious activity regarding suspected fraud.

5. Reporting Procedures
   Reporting procedures should be clearly outlined for employees.
   Employees should be assured that there are protections in place against retaliation for reporting suspicious work-related injuries.
6. Prevention Tips
   There should be well thought out Best Practices in place for preventing WC fraud including promoting workplace safety and prompt reporting of all injuries.
   Emphasize the importance of accurate documentation and consequences of providing false information.
7. Role of Management & Supervisors
   The role of Managers and Supervisors is to promote a culture of safety, integrity and discouraging workplace fraud.
   Managers and Supervisors should lead by example.
8. Conclusion & Resources
   The key points of fraud awareness training should be covered during annual training.
   Training on WC fraud should be delivered to all new hire employees.
   All employees should be provided with additional resources such as contact information for fraud hotlines, online reporting portals or specific contact information at the employer's location to report suspected fraud.

To effectively detect, investigate, and defeat WC fraud, it is essential for organizations to understand the scope of complexity of emerging trends and exposures. This includes focused and timely fraud awareness training to address claimant fraud.

IX.
Conclusion

Insurance fraud is a systemic and ongoing problem costing businesses and consumers $308.6B per year in the United States with claimant fraud accounting for $9B of that total. There is a moral obligation of employers, employees, carriers, businesses, consumers, and law enforcement to take immediate action to combat insurance fraud at its core. This claimant fraud analysis provides a road map for employers, employees, and carriers to increase fraud awareness and put into action sound Fraud Best Practices to reduce claimant fraud while making the workplace a safe environment.

(3) WORKERS' COMPENSATION PROVIDER FRAUD

I. Introduction
II. Impact
    Injured workers
    Insurance companies
III. Detection
    Claims Adjusting and Fraud Detection
    Types of Investigations within Special Investigations Unit (SIU)
    Internal Data
    External Data
    Automated Fraud Detection Technology
    Model Oversight
IV. Prevention
    Executive Buy-in
    Insured Buy-in
    Increased scrutiny of high-risk claims and providers
    Education and outreach for injured workers/providers
    Reporting suspicious activities or claims
V. Remedies
    Administrative
    Civil
    Criminal
    Authority of law enforcement
    Penalties
    Civil actions pursued by insurance companies.
    Governmental groups/legislation
VI. Conclusion

I.
Introduction

Provider fraud refers to fraudulent activities committed by healthcare providers in the WC system. This may include, but is not limited to, medical professionals such as doctors, physical therapists, and chiropractors who engage in fraudulent activities such as submitting false medical bills, exaggerating the extent of injuries, or providing unnecessary treatments. This results in significant financial losses for insurance companies and can also harm injured workers who receive unnecessary or harmful medical treatments, and prolonging recovery.

The impact of provider fraud continues to emerge as one of the most critical areas requiring resources and an effective anti-fraud plan. The schemes continue to develop and manifest in regional areas across the country. It is important for all team members who have responsibilities for approving or paying medical expenses to establish effective training and recognition for irregularities and have a plan to address these issues when identified. Not addressing this problem impacts bottom-line operating costs, profitability and risks the potential of patient harm through the various schemes encountered.

Provider Fraud Schemes

While far from an all-inclusive list, below are examples of provider fraud. The schemes can, and will change, as unscrupulous providers seek to back injured workers into a treatment plan to suit the provider's billing direction.

Billing for services not rendered – provider bills for a service or product not actually provided/delivered.
Overbilling – provider bills for a more costly service than what was performed.
Misrepresentation – provider misrepresents who provided the care or what care was received.
Boiler Plate or Cloned Billing – consistently bills the same procedure codes regardless of diagnoses or length of treatment across their entire patient base.
Canned treatment notes-injured worker's treatment notes do not change from visit-to-visit.
Unbundling – practice of billing individual services typically performed together as a bundle, to increase the overall reimbursement rate.
Unlicensed Providers – providing treatment by unlicensed staff and billing as if licensed.

II.
Impact

Injured Workers

Provider fraud has a negative impact on injured workers as the focus of treatment is maximizing a provider's profits and less about patient care. Injured workers may be subjected to unnecessary medical treatment, procedures, tests, or medications, which could have adverse effects on their health, and can potentially cause serious harm. For example, in California, some doctors were paid illegal kickbacks for patient referrals, which led to unnecessary spinal surgeries. As a result, some injured workers suffered serious complications and long-term health problems.

Unnecessary medical or phantom treatment can result in delay in care for injured workers who genuinely need medical attention. In some cases, any delay in care could negatively impact the injured worker's health, as some conditions require immediate treatment.

Lastly, provider fraud can lead to loss of trust in the general healthcare system if patients never get better and continue to receive treatment. Patients may become skeptical of providers and may be less likely to seek medical attention in the future. Injured workers may also become frustrated and angry at the claim process because the claim professional or SIU is continually scrutinizing the claim due to the questionable billing of medical services and/or prolonged length of treatment. In short, injured workers may not receive the prompt treatment they need to heal and return to the workforce.

Insurance Companies

Healthcare fraud impacts insurance companies in many ways. It influences the cost of both healthcare and WC premium rates by increasing the overall costs to entities obtaining coverage, such as corporations, small businesses, and individual consumers. It raises not only premiums for healthcare coverage, but it also increases deductibles which trickles down to inflated costs to the consumer. This in turn may lead to larger, more complicated diagnoses and more costly treatments as individuals try to avoid proactive treatments due to the increased costs of having medical insurance and increased out of pocket expenses.

III.
Detection

Claims Adjusting and Fraud Detection

Claims Representatives serve a complex role investigating claims and administering benefits, while also providing customer service and applying administrative law. Several competing responsibilities including caseload volume, urgent deliverables, and new assignments, leaves less time and attention for Claims Representatives to focus on fraud. However, Claims Representatives and other frontline staff may be an insurer's best defense to identify risky claims and policies before becoming too costly.

A key component of success for detecting suspect fraud is anti-fraud training and awareness. SIU's have a critical role in providing training and awareness in efforts to maximize detection on the claims level. Many states require mandated annual anti-fraud training for integral employees to combat fraud. The definition of integral staff should include key personnel in other business areas such as Claims who are well-positioned to identify fraud. Training is invaluable as it is not only an opportunity to educate those closest to the claims, but it can also encourage proactive strategy. Each company should develop a training program in support of their business model to optimize defense against fraudsters.

Claims staff should recognize indicators of fraud when reviewing medical treatment, associated medical equipment and modification requests for treating injured workers. The National Insurance Crime Bureau (NICB) is a not-for-profit organization based in the United States that works to combat insurance fraud and vehicle theft. The NICB collaborates with law enforcement agencies, insurance companies, and other organizations to address fraudulent activities related to insurance claims and stolen vehicles.

NICB states "Definable Inconsistency" is a set of circumstance and/or facts outside of the norm of usual behavior, procedures, or findings that may not rise to the level of a Red Flag Indicator (NICB Anti-Fraud Program Guide pg. 24). When suspected fraud is identified, claims staff should consult their SIU for guidance and referral for investigations.

Referral processes to SIU should involve a simplified process. SIU should keep the Claims, Legal, and Medical staff in the loop regarding the progress of the investigation whenever possible.

As part of the claims process, a key component relates to medical billing review. All medical bills go through either an automated or manual review for appropriateness and repricing to State guidelines. Medical Bill Review teams review bills that have likely been flagged for manual review based on anomalies detected by automated adjusted billing review software programs that are designed to reduce the need to touch all medical bills evaluated by insurance carriers. Many of the programs include fraud indicators which allow for manual flag entries designed to cause a bill to be pulled from an automatic payment status for review.

Provider Fraud Red Flags – Below is a list of some of the potential red flags that claims adjusters should look for.

- Injured worker does not recall having received the billed service.
- Provider's medical reports read almost identically even though they are for different patients with different conditions.
- Much higher healthcare costs than expected for the allowed injury type.
- Frequency of treatments or duration of treatment period is greater than expected for allowed injury type, especially for older (non-catastrophic) claims.
- Frequent billing in older (non-catastrophic injury) claims.
- Larger volume of prescription drugs billed than expected for the allowed injury.
- Billing for treatment on consecutive dates of service for minor allowed conditions.
- No change in treatment regimen or no measurable improvement after an extended period.
- Same doctor(s) and attorney(s) are repeatedly associated with the same questionable claims.
- Unexplained sudden increase in a provider's billing and payment levels.
- Provider services are billed (for non-emergency care) for dates of service on weekends or holidays or on dates when the patient was hospitalized.
- Provider bills for dates of service within time periods for which the provider had previously billed and received payment.
- Provider bills for dates of service after the effective date for change of physician of record.
- Medical documentation does not support billed service.
- Frequent delays in the submission of requested records.
- Great distances between the provider and injured worker.
- Submission of bills with non-industrial diagnosis codes. Bills resubmitted with codes. changed to an allowed diagnosis
- Billed procedures are inconsistent with allowed conditions or industrial conditions.
- Billed procedures are identified by the American Medical Association as being for *"one or more areas"* billed with multiple units of service.
- Billed procedures are for evaluation and management codes only.
- Provider is actively billing multiple claims for an injured worker.
- Day or date of service is inconsistent with the type of provider.
- Provider billed for services that were not likely to have been performed

Types of Provider Fraud Investigations

Creating a specialized unit dedicated to the investigation of Medical Provider Fraud within the SIU is the most effective method to combat this crime. Alternatively, a carrier must have the ability to pull a team together from existing resources as the schemes and scope of the suspected fraudulent activity is diverse and often involves many conspirators. Since many people are involved in a claim (claims examiners, nurses, lawyers, bill reviewers, SIU investigators) it is easy for the *"big picture"* to get lost in the shuffle. The schemers rely on this! For this reason, carriers should involve staff from the departments listed above with support from IT analytics personnel to uncover potential fraud as soon as anomalies are detected, and rules can be put in place to halt or at least delay the processing of suspect claims.

When potential provider fraud is identified, an Investigative Plan should be formulated. The plan will outline the steps needed to collect the evidence necessary to determine if the allegation has merit. Often, the first step is to gather background information on the specific procedure or device which is being billed to understand the norms. Provider fraud investigations could include review of data to establish patterns, research on the procedure codes being billed, interviews with claimants to determine who provided the services which have been billed and validating whether services which were billed were actually received.

Claimants who are represented by an attorney cannot be interviewed unless specifically authorized, which can make investigations more complicated. The investigator may need to confer with a medical expert in the same field as the provider being investigated to determine accepted standards of care and protocols or to conduct a review of medical records. In some instances, a clinic inspection is required to determine if the provider has the equipment necessary to perform the services billed. An Investigative Plan will help keep you focused and assist in evaluating whether findings support a criminal referral, civil/administrative remedy, or no action.

Internal Data

There are numerous internal data sources to support investigations related to medical provider fraud. Claim history can provide records of claims filed by medical providers which could show a pattern of questionable claims or identifying information. Insurance companies collect a range of data during the underwriting process, including information about the policyholder's business, which could be important if it is related to the questionable activity. Insurance companies also keep records of payments made to policyholders and/or providers which could be relevant if involved in questionable activity. Additionally, internal data include access to background records and social media for investigating providers who might be involved with questionable activity. Insurance companies also use advanced analytics to analyze internal data to detect outliers in billing patterns.

External Data Sources

Carriers also use external data sources to investigate medical provider fraud. Some of those include industry databases such as LexisNexis, Experian, NICB, and public records from the Secretary of States and licensing boards. There are also billing and coding guidelines that can be used to detect, confirm, or validate proper billing. Medical billing and coding guidelines are essential for accurate and compliant billing practices. The guidelines help ensure that healthcare services are properly documented, coded, and billed. Examples include Current Procedural Terminology (CPT) Coding: CPT codes are used to describe medical procedures and services. These codes are published by the American Medical Association (AMA) and provide a standardized way to report medical services.

Additionally, NICB is responsible for the Aggregated Medical Database (AMD) that is hosted and maintained by Verisk. The AMD is composed of medical claim data submitted by property and casualty carriers across the US who are NICB members. The data is aggregated and de-personalized to protect patient privacy and carrier confidentiality. Verisk, a data analytics firm, conducts analysis of the aggregated data to identify aberrant provider biller behavior. These findings are then shared with member companies to provide leads for further investigation. The database contains information on medical procedures, diagnosis and treatment as well as information about the healthcare providers who performed those services. Before AMD, there was no centralized medical billing database for the P&C insurance industry. However, only member companies have access to the alerts generated from the AMD. Since membership fees can change over time, it is recommended to directly contact the NICB for the most up-to-date information regarding membership costs.

Automated Fraud Detection Technology

Fighting WC fraud has traditionally been a manual operation within many companies, making fraud mitigation a time consuming and error prone process. A great number of insurance companies use outdated internal systems and/or rely on manual processes such as the knowledge of workers and business rules for fraud detection.

Companies with automated fraud detection solutions are usually more effective at proactively detecting fraudulent behavior or fraud schemes. By directly detecting claims that need further attention or require active follow-up, companies are increasing chances of detecting fraud and are limiting false positives to a minimum.

The leading insurance companies actively work on managing fraud and risks within their portfolio. These companies are using proactive measures to remove fraudsters from their portfolio and actively prevent new (potential) fraudsters from entering.

Insurers have the ability to deploy Artificial Intelligence (AI) techniques such as predictive analytics to analyze data and predict future outcomes based on historical patterns and trends. This is a more proactive approach that involves uncovering fraud patterns and anomalies by analyzing historical data.

For example, if a particular type of injury is consistently overreported or if a certain healthcare provider is associated with an unusually high number of claims or higher billing rates by CPT code, these could be indicators of fraud. Once identified, predictive analytics can be used to apply these insights in real time with new claims that are received. This allows investigators to focus on more precise referrals and prioritize their efforts and time.

Fraud claim scoring is a process used by insurers to evaluate the likelihood of a claim being fraudulent. The scoring of claims consists of a combination of expert rules, AI models, text mining models (unstructured data), and network analysis with a vast array of internal and external data sources. These resources allow the algorithm to learn and adapt as new data becomes available. The more data the algorithm has access to, the more accurate the predictions become. For example, an efficient model will analyze various data points associated with a claim, such as the type of injury, the history of the claimant, and the healthcare provider. The algorithm assigns a score to each claim, which represents the level of risk of fraud associated with the claim. Claims with higher scores are prioritized for further investigation and reviewed by fraud investigators, while claims with lower scores may be processed more quickly with straight-through processing by the adjuster.

Model Oversight

Any model used should be constantly validated and reviewed for potential bias. In the insurance field, this is particularly important as AI-powered decisions can have serious financial and legal consequences. While there is no specific oversight agency for AI technology used in insurance fraud detection in the United States, there is a movement from several states to create legislation to address oversight and transparency requirements on insurance companies that use predictive models and algorithms. Colorado passed a law in 2021 that prohibits insurers using any big data systems from unfairly discriminating based on race, color, national or ethnic origin, religion, sex, sexual orientation, disability, gender identity or gender expression. In order to show compliance, insurers must show the Division of Insurance how they are testing their data and tools to ensure they do not result in unfair discrimination.

In addition, the National Association of Insurance Commissioners (NAIC) formed the Innovation Cybersecurity and Technology Committee to explore emerging issues related to insurers leveraging new technologies, such as AI. This committee developed regulatory principles on AI that were adopted by the full NAIC membership at the 2020. Beginning in 2021, the Working Group began surveying insurers by line of business to learn how AI and machine learning techniques are currently being used and what governance and risk management controls are in place.

In other regions, the European Commission's High Level Expert Group on AI has produced an Ethics Guideline for Trustworthy AI. The basic elements of this guideline provide sound techniques when deciding to use AI technology.

IV.
Prevention

Executive Buy-in

Senior management should strive to set up an organization that constantly learns and improves its fraud detection capabilities. For example, implementing a fraud detection program that stimulates employees to fight fraud while still providing customer satisfaction would help. This way, fraud can be fought more effectively, by being part of the DNA of the entire organization. By making it a goal that fraud, waste and abuse will not be tolerated will allow staff to follow suit. Advertise the importance to all staff.

Insured Buy-in

Insurance companies should have a strategy to communicate and collaborate with policyholders on claims where questionable medical providers are actively billing. Sometimes policyholders influence claim decisions based on their perceived business needs or the push to resolve claims quicker. It may appear easier to resolve claims through nuisance settlements than to incur additional expenses related to investigating the questionable schemes.

Getting buy-in from the policyholder is an important aspect of detecting WC fraud. Here are some steps that can help get the buy-in.

Education on the importance of detecting fraud: Explain to the policyholder that detecting fraud is crucial for keeping WC costs low and ensuring that legitimate claims are paid. Fraudulent claims can result in increased premiums.
Highlight the risks of fraudulent claims: Help the policyholder understand that fraudulent claims can lead to legal penalties, loss of reputation, and increased insurance premiums. Explain how detecting fraud can help prevent these negative consequences.
Provide training to the policyholder's employees: Educate the employees on what constitutes WC fraud; how it impacts them; how to report it; and how to prevent it. This can help reduce the likelihood of fraudulent claims in the first place.
Provide regular updates: Keep the policyholder informed on the progress of detecting and preventing fraud. Regular updates on successes can help build trust and demonstrate the value of detecting fraud.
Emphasize the importance of confidentiality: Assure the policyholder that any reports of suspected fraud will be kept confidential and shared only with those needing to know. This can help alleviate concerns about retaliation or other negative consequences.

Increased scrutiny of high-risk claims and providers

It is vitally important to have thorough compliance programs in place, establish edits, and schedule standardized reports to review and scan for anomalies in billing practices. With the vast amount of data available to all carriers, these programs should be easy to create.

Education and outreach programs for Injured Workers/Providers

Education and outreach programs for injured workers identifying trends in medical provider fraud and knowing how these schemes/trends affect the bottom line. Show employees and physicians the benefit of returning an injured worker to work as soon as they are able versus the long-term adverse effects from remaining out of work. Literature could be sent to injured workers, with every payment or correspondence, advertising the need to report issues.

Make it easy to report suspicious activities or claims

Advertise on the company website / provide literature / correspondence, regarding the need to refer to all suspicious activity. Provide a Hotline and allow anonymity for someone to refer cases for investigation and ensure you have a follow up system to investigate the reported activity.

V.
Remedies

Administrative

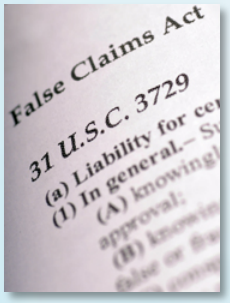
Each state should have established protocols to enforce laws through civil and administrative authority. Research may be required to determine the appropriate source to seek when considering civil actions. Use of this potential option can be effective with monetary recovery for violations that may be otherwise deficient to launch a criminal investigation.

In addition to fraud, waste and abuse that occurs from provider overbilling can have significant impact on medical spend for a carrier. Early identification of improper billing and proactive efforts to curb payments allow a carrier to prevent money being lost while further investigation is conducted. These remedies may fully address the issue or may result in further evidence that intentional fraud is occurring. Administrative actions that can be taken to address questionable billing include the following.

> ***Notification letter:*** A provider is put on notice that billing is being reviewed and explains why bills are being rejected. Allows the provider a chance to respond and set forth justification for the claim.
> ***Peer to peer meeting***: The carrier's Medical Director or other clinical resource engages in a discussion with the provider regarding the potential overutilization or questionable medical necessity of services being provided. Facilitates consensus on payment policy.
> ***Provider flagging:*** This allows for manual review of provider claims to ensure submitted documentation meets payment requirements. May include a request for medical records to gather further information to validate a claim before payment.
> ***Utilization management:*** Allows carriers to review proposed procedures or services and determine medical necessity prior to the service being provided to the injured worker. If prior authorization is not obtained, the bill may be rejected.
> ***Recovery:*** Audit or review of procedures finds documentation that does not support a claim as billed based on either CPT codes used or medical necessity. Carrier pursues repayment.

Investigation may identify that a provider's conduct is unethical, but not necessarily a violation of law. In those instances, a referral to a state medical licensing department may be warranted.

Civil



Medical providers that violate Civil False Claims Acts are subject to civil litigation which may include recovery of up to three times the amount of damages sustained by the Government as a result of the false claims, plus financial penalties per false claim filed.

An effective strategy for combating provider fraud is through civil affirmative litigation. This involves filing a lawsuit against the provider(s) in question seeking damages or relief for the fraudulent activity. The goals of litigation are to protect the interests of the patients, insurers, and insureds; to hold the provider accountable for their actions; recover damages that were incurred as a result of the fraud; and deter future fraud.

Examples of affirmative litigation include *Qui Tam* lawsuits. This is a type of whistleblower lawsuit that allows individuals or insurers to file a lawsuit on behalf of the government against a fraudulent medical provider(s). Usually, suits are filed under seal allowing the government an opportunity to review and pursue these matters. If the government decides not to pursue, the case is removed from under seal and pursued by the insurer or individual.

Remedies include monetary damages, injunctive relief, civil penalties, and billing guidelines. Monetary damages may be awarded to compensate the plaintiff for any losses incurred as a result of the fraud. Injunctive relief involves a court order requiring the provider to stop engaging in fraudulent activity.

Affirmative litigation is a complex and challenging area in the industry. However, it can be a powerful tool for holding providers responsible for fraudulent activity and deterring the same in the future.

Criminal

When considering criminal prosecution at the state or county level, research should be completed to determine fraud statutes applicable to the case and developing additional information for what agency may accept the case.

When considering criminal action, the prosecuting authority can prosecute criminal cases and serve both civil and administrative functions at the state level. Many states have a Department of Insurance with a fraud bureau and function as a criminal investigation and prosecution authority at the state level.

The next option would be to engage the local county, district or city prosecuting attorney's office. Developing an understanding of how to present a criminal case is critical to success. Each jurisdiction may have different procedures for accepting investigations. At the local or district level, a report of a suspect fraud case may require filing with a local police department for review. Consult the local prosecutor and/or law enforcement agency to determine jurisdiction and the proper procedures.

For case review, understanding fraud statutes and identifying the elements of a crime are key to success. The elements must be met. This is accomplished through identifying evidence and witnesses who can testify to direct evidence in the case. A detailed and complete report synopsis will assist with review before a prosecuting authority.

Many resources exist to locate the many levels of criminal and civil prosecution authorities in each state.

Federal prosecution: The U.S. Dept. of Justice has made prosecution of health care fraud a priority due to the enormous dollars at stake and the threat to patient safety. The strike force model allows prosecutors and multi-agency investigative personnel to combine resources to address the most egregious cases involving health care fraud and illegal distribution of prescription drugs. There are currently 16 strike forces across the United States which allows for collaborative investigations between the FBI, U.S. Dept. of Health and Human Services Office of Inspector General, Drug Enforcement Administration and other federal agencies. Federal prosecutors will prioritize high dollar fraud schemes; schemes where patient harm is likely; illegal prescription drug distribution; and fraud rings operating in multiple states. Federal prosecutors may include losses sustained by carriers when seeking restitution.

The federal statutes most commonly used to charge health care fraud are:

18 USC §1347 Health Care Fraud
18 USC § 63 Mail Fraud
18 USC §1343 Wire Fraud
31 U.S.C. § 3729-3733 False Claims
42 U.S.C. § 1320a-7b(b)] Anti-Kickback Statute

Other federal statutes could be employed if the fraud involves misbranding of prescription drugs or illegal distribution of controlled substances.

Authority of law enforcement agencies

Law enforcement agencies ranging from the U.S. Department of Justice, Attorney General, State's Attorney Generals, State Departments of Insurance, District, County and City levels, each have enforcement powers provided by statute provided at various levels that fall within the scope of authority.

Penalties for Provider Fraud

Criminal fraud convictions bring the serious possibility of jail or prison. Though sentences differ widely, a misdemeanor conviction can lead up to one year in a local jail, while a felony conviction can lead to multiple years in prison.

The penalty range varies from federal and state statutes. In general, federal, and state statutes cover a wide range of crimes including False Claims Acts, Anti-Kickback, healthcare fraud, physician self-referral, Stark Law, etc. Criminal convictions for serious offenses can range from significant fines as high as $250K, restitution and generally a 3 to 5-year sentence for a single count felony conviction.

Civil remedies can be substantial through federal, state, and civil tort actions. Fines can be assessed per each violation and can result in fines or judgements for triple damages.

Governmental groups/legislation

One of the most effective ways legislation can impact medical provider fraud is through increasing penalties. The threat of severe penalties and punishment can serve as a powerful deterrent to provider(s) who are considering engaging in fraudulent activities. Legislation can establish stronger fines, imprisonment, exclusion from participating in the WC system and losing the ability to practice medicine.

Another way legislation can impact provider fraud is through increased oversight and monitoring. Laws can require more robust monitoring and reporting programs to detect fraud. Additional oversight could deter someone from committing fraud.

Legislation can encourage government agencies to investigate and prosecute medical fraud through additional grant funding.

Finally, legislation can help improve transparency and accountability in the healthcare industry. By requiring providers to disclose information about their business practices, financial relationships and conflict of interest, legislation can ensure providers are acting in the best interests of their patient

VI.
Conclusion

The prospect of provider fraud can be an overwhelming problem for an insurance carrier with devastating impacts to the bottom line. That is why a detailed comprehensive approach to combating this type of fraud is so critical. Insurers need to be vigilant in not only the detection of the variety of provider fraud schemes, but ensuring they have the appropriate preventative measures in place. The fight against provider fraud must start from the top of an organization by funding and supporting a vibrant Anti-Fraud program and ensuring they are teamed with other departments (Medical, Legal, Claims, Bill Review, Analytics) so that schemes can be detected early, and roadblocks be put in place to thwart future fraud attempts. Once these best practices are established, a carrier will have the best opportunity to combat provider fraud.

As evidenced by this report, Provider Fraud in the WC system is not only costly to employers and insurance carriers, but also to injured workers and hurts honest providers by causing delays in treatment approval or payment for services through increased scrutiny of all providers.

Proven acts of fraud by medical providers should result in harsh civil or criminal penalties so that those found *"guilty"* are removed from the WC system. This will ensure that providers who defraud the system can do no more harm and will help to discourage other providers from going down this path.

The Coalition Against Insurance Fraud Task Force report seeks to provide a detailed analysis of WC fraud in America. The crimes are explained; strategies are identified; and action plans are suggested to combat this crime. While WC fraud is a significant problem at $34B a year, historically, it has not been at the forefront in the battle against insurance fraud.

WC fraud has serious negative impacts upon employers, employees, providers, consumers, and our overall community. Since we are all negatively impacted by WC fraud, we must implement well-thought-out training programs and action plans to reduce this costly crime. By working effectively together, we can hope to significantly reduce WC fraud in the future.

Coalition Against Insurance Fraud