



NATIONAL INSURANCE FRAUD FORUM

Discussions papers
on key issues

- Legislation & Regulation
- Public/Private Partnerships
- 21st Century Fraud Issues
- Public Awareness
- Measuring Fraud
& Quantifying Results

October 2000





NATIONAL INSURANCE FRAUD FORUM

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INTRODUCTION

Sponsored by the Coalition Against Insurance Fraud, the International Association of Special Investigation Units, and the National Insurance Crime Bureau, the National Insurance Fraud Forum was held in Washington, D.C. on June 5 - 7, 2000. Attending the forum were 100 leaders and experts in the field of insurance fraud. The attendees were representatives of private industry, law enforcement, state fraud bureaus, government regulators and professional organizations.

The purposes of the forum were to:

- ◆ Review the progress of the industry's approach to fraud fighting
- ◆ Examine five key areas which impact insurance fraud
- ◆ Develop strategies to address these key areas
- ◆ Publish a white paper highlighting these discussions and recommend a fraud-fighting agenda for the next five years

The five key areas suggested for discussion included the following:

- ◆ Legislation and Regulation
- ◆ Public Awareness
- ◆ Emerging Insurance Fraud Issues
- ◆ Public / Private Partnerships
- ◆ Measuring the Fraud Problem and Quantifying Results

The sponsoring organizations will issue annual reports on the progress of these issues. The National Insurance Fraud Forum will meet again in 2005 to set the anti-fraud agenda for the following five years.



LEGISLATION AND REGULATION

Discussion Summary

Fraud fighters from all parts of the United States met at the National Insurance Fraud Forum in Washington, D.C., June 5-7, 2000 to set a fraud-fighting agenda for the next five years. Their accomplishments included identifying key fraud fighting goals in dealing with legislation and regulation at the state and federal levels and proposing a list of specific developments on which to focus.

Proposed new statutes and regulations frequently threaten the industry's fraud fighting programs and the ability of fraud fighters to access information necessary to pursue insurance fraud offenders. A fundamental shift is occurring in government's approach to management and oversight of claims and investigative data. Traditionally, the business of insurance has been regulated by state governments. Insurance crimes, for the most part, have been state crimes. Accordingly, privacy protections and other restrictions on access to and use of data have been found in state laws and industry self-regulation.

Then came 1999 — and a new federal government preoccupation with privacy. The general approach has been to create new federal limitations, not to replace state limitations, but to set a nationwide floor of privacy protection. Several states are now trying to outdo each other in cutting off access to information about their citizens.

On the federal privacy front, there were three noteworthy developments in 1999.

First, Congress considered, but did not pass, extremely broad and extremely stringent new limitations on the use of personally identifiable information related to health care. Several of the bills introduced in Congress by Sen. Ted Kennedy (D-MA) and others would generally have prohibited use or disclosure of such basic fraud-fighting data as the fact that Joe Smith submitted claims for treatment by the XYZ Neck Pain Clinic. None of those bills passed. New federal regulations have been proposed, but not yet adopted.

Second, Congress enacted the Gramm-Leach-Bliley Act, also known as the financial

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services reform bill. A dispute over data access nearly derailed the bill. Congress established a general rule that insurance companies may not make customer information available to non-affiliates without first giving the customer the right to “opt out” of any such information sharing. Regulations to implement the new law, published May 24, 2000, allow information to be shared for fraud fighting.

The third development involved use of motor vehicle and driver license records. A Senate subcommittee approved legislation flatly prohibiting any state from giving any such information to NICB for any purpose, but NICB succeeded in carving out an exception for anti-fraud activities before the bill was signed into law.

Discussion Topics

The discussion group on legislation and regulation covered the following three major subjects in detail:

(1) Current federal privacy legislation & regulations affecting insurance industry access to and use of personally identifiable data.

(a) Restrictions on access to and use of health-related information.

The Kassebaum-Kennedy Act was passed in 1996 in part because Congress knew it could not cut Medicare & Medicaid fraud using paper records; it was clear that electronic data is essential.

Privacy advocates recognized that illegitimate use of medical records also is easier when the data is stored in electronic format.

Congress couldn't decide exactly what to do about privacy, so it gave HHS authority to implement privacy regulations.

HHS' statutory authority over health insurers and health care providers is clear, but it has no direct authority over property/casualty insurers — and admits it.

The proposed regulations cover almost any kind of information related to medical treatment: “Health information means any information . . . [that] relates . . . to . . . the provision of health care”

Patients will be allowed to “request broad restrictions on further . . . disclosures to particular persons.”

Disclosure is allowed for “law enforcement purposes” only if “pursuant to process,”

“for identifying purposes,” when “about a victim of crime or abuse,” for “national security” or “health care fraud.”

There is no specific exemption for covered entities to disclose information for use in fighting insurance fraud other than health care fraud.

The proposed rule may leave the mistaken impression that insurance claimants seeking reimbursement for medical expenses and payment for pain and suffering may try to prevent insurance company use of individually identifiable information to detect and deter insurance fraud.

NICB has proposed a one-sentence addition to the list of circumstances for which disclosure is permitted, which would avoid confusion and ensure that unscrupulous individuals do not seek to misuse the privacy standards.

HHS plans to finalize privacy regulations for health-related information later this year.

(b) Financial privacy provisions in the financial services reform bill.

New law allows banks to merge with insurers and other types of financial institutions, but Congress perceived a conflict between financial modernization and customers’ personal privacy.

Congress included new federal restrictions on access to financial data — established an “opt-out” system.

Final Federal Trade Commission regulations interpreting and implementing the privacy/data access provisions were published May 24, 2000.

The final FTC regulations adopted exemptions NICB supported to allow continued use of information to fight fraud.

(c) Restrictions on state disclosure of motor vehicle and driver records.

Congress included a provision in the Driver Privacy Protection Act of 1994 allowing every state to make driver records available to NICB, insurers and others to fight insurance fraud.

Congress amended the DPPA in 1999 to ban states from making driver records available for certain purposes unless the driver has first given permission — an opt-in system.

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NICB successfully lobbied to keep vehicle and driver records available for fraud fighting.

The U.S. Supreme Court rejected state claims that the DPPA unconstitutionally infringed on state authority.

(2) Future role of NAIC and the states in establishing and enforcing restrictions on insurance industry access to and use of data.

Seventeen states have adopted the NAIC's Insurance Information Privacy Protection Model Act.

Federal privacy legislation generally allows the states to adopt more stringent restrictions.

The states' financial privacy regulations will provide an indication of how strongly they desire uniformity.

(3) Prospects for adoption of additional privacy protection at the state and federal level.

Health-related information: new legislation to extend the HHS regulations to property/casualty carriers?

Financial information: unduly restrictive amendments to the Gramm-Leach-Bliley Act?

Motor vehicle records: new legislation eliminating exemptions from the prohibition on disclosure?

Privacy Commission: a comprehensive and detailed effort to overhaul state and federal privacy laws and industry practices?

Future Focus

As a result of those discussions, the Fraud Forum identified the following 10 areas on which to focus during the next five years:

(1) Globalization

The internet has opened new opportunities for fraud. Other nations have online privacy restrictions ranging from nothing to extremely strict (e.g., European Community standards). Regardless of how the state vs. federal issues (discussed below) settle out,

the U.S. needs to avoid being governed by the world's least common denominator (e.g., EC privacy restrictions).

(2) State vs. Federal Law

Which level of government is regulating what? Will the business of insurance soon fall under federal regulation (abrogation of McCarran-Ferguson)? Does the NAIC's Insurance Information Privacy Protection Model Act have a future? Will the states agree on the desirability of uniformity in enforcement and implementation of the FTC/financial privacy regs, the HHS health information standards and the DPPA?

(3) Industry Consolidation

New abilities to share information among affiliated companies was a key reason to update the statutes governing the securities industry and other financial services laws. The insurance industry needs to draw a hard line against the Shelby/Clinton efforts to restrict sharing among affiliated companies.

(4) Integrated Products

If insurers lose the ability to share information across product lines, they also may lose the ability to offer integrated products — once again, in conflict with the basic purposes of the GLBA.

(5) Professional Organizations

If states restrict the ability to fight fraud, they should also insist that doctors and lawyers be regulated more closely; the industry can in the meantime raise public awareness about what a failure professional self-regulation has been in insurance fraud.

(6) Privacy Advocates

Insurance industry needs to build bridges to the privacy advocacy groups that are driving developments in Congress.

(7) Congress

Members of Congress need to be educated about how fraud works and why data access is essential to fight it; the grassroots network — especially local law enforcement — needs to be primed and ready to go on a moment's notice.

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(8) State Legislators

State legislators need to be educated about how fraud works and why data access is essential to fight it; the grassroots network — especially local law enforcement — needs to be primed and ready to go on a moment's notice.

(9) Immunity

Need to monitor status and effectiveness of state immunity statutes and consider federal immunity provision.

(10) Unique Property Identifiers

Find better ways to track stolen property (HINs for vessels, more VINs on stolen automobile parts).



PUBLIC AWARENESS

Discussion Summary

Public awareness efforts to combat fraud are fragmented and inconsistent. Numerous industry groups have mounted a variety of campaigns. Some are extensive, well-funded and well-researched, while others are relatively limited. They tend to deploy different strategies, tactics and messages, which further dilutes the overall national impact on fraud reduction.

Thus we are faced with a crazy quilt of disparate efforts whose collective impact on fraud is unclear at best, and minimal at worst. Our challenge is to bring larger scale, more consistency and bigger impact to these efforts.

Recommendations

Develop a unified, long-term national public awareness campaign spearheaded by a diverse alliance of insurance and non-insurance groups.

The campaign should be phased, with Phase One relatively general that sensitizes the nation about the price everyone pays for fraud. Follow-up phases will target specific fraud crimes, narrower audience segments, regions and other variables.

Phase One goals

Soft fraud: Convince consumers and borderline criminals that fraud doesn't pay.

Hard fraud: Create a national environment of intolerance that makes it impossible for serious criminals to operate. Empower consumers to avoid being victimized by scams, and to aggressively report suspected fraud to authorities.

Primary Audiences: Average consumers who commit soft fraud and borderline criminals who can be dissuaded from committing hard fraud. The campaign also will target key audience segments such as immigrants, seniors, youth and others.

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Secondary Audiences: Legislators, regulators, insurance agents, various professional groups such as doctors, nurses, trial attorneys and others uniquely positioned to reduce fraud.

Messages: Messages will continually stress several clear, simple themes: insurance fraud is a crime, everyone pays a high price, getting caught has heavy consequences, and there is a strong likelihood of getting caught.

The campaign will last at least five years, with the exact length and scope of each phase to be determined. Phase One will launch broad national themes, with adjustments for state-level markets and fraud concerns.

The campaign will have a strong grassroots focus. Localized strategies can be effective because they are highly personalized and affordable. However, the campaign will retain a strong advertising component, so that strategies remain balanced.

The campaign will require a multi-million dollar annual commitment due to the high costs of big-ticket items such as advertising.

Large national insurers likely will be the primary campaign funders, though a long-term funding strategy must be developed, including support from non-insurance campaign members and other allies.

Managing the campaign will require considerable thought, involving significant questions such as whether to create a freestanding campaign hub group or work through an existing group.

Fraud trends must be continually monitored to possibly adjust campaign goals in mid-stream. Several of the largest trends include: seniors, immigrants, gender and consolidated financial services.

Tracking Progress

The campaign will conduct detailed research to set baseline goals, pretest campaign messages, check ongoing progress, measure changes in people's attitudes and behaviors, and determine impact on insurance fraud itself (if possible).

Introduction

You have probably witnessed the growth of public awareness as a pivotal tool for affecting the outcome of almost any event, issue or cause in America today. Whether

it is the battle to reduce emissions in cars, keep our kids free of drugs, keep guns in — or out of — people's hands, enforce the embargo against Cuba or debate the harvesting of old growth forests, the smartest players have lined up an aggressive team of savvy PR pros who are relentlessly chipping away at public opinion.

Public awareness can arm people with accurate facts and information, it fosters understanding and consensus, it ignites human passions, it stirs them to moral outrage when necessary, and moves people to take decisive action. Good public awareness can increase an organization's chances of long-term survival. Bad public awareness can bring you to your knees.

Many credit the awareness efforts by Mothers Against Drunk Driving with containing drunk driving by stirring up public outrage. When people died from poisoned Tylenol capsules in 1982, Johnson & Johnson's decisive recall of Tylenol was supported by a massive effort to inform the public. That outreach earned the company widespread praise as a good corporate citizen, and preserved the company's stock value from a potentially catastrophic hit.

Public awareness efforts by the Pennsylvania Insurance Fraud Prevention Authority show the impact outreach can have on fraud. After a two-year campaign in that state, the percentage of people who believe it's ok to inflate workers compensation claims dropped nearly 60 percent, and the percent of people likely to malingering after being injured fell 20 percent.

We in the fraud-fighting community are wrestling with how to mobilize public awareness campaigns to have a lasting national impact. If you spill a glass of mercury onto a table, notice how the mercury separates into dozens of beads — some beads are big some are small, some are thick and some are shallow. It's a crazy-quilt pattern that follows no set order or pattern.

This describes our fraud awareness efforts. There are numerous campaigns by companies, state alliances, regulators, fraud bureaus, associations and other groups. They all tend to be honest attempts to right a grievous wrong.

Yet these efforts often pursue diverse agendas and market goals. They often follow different strategies and use varied messages to get points across. Some are supported by excellent market research, and others follow instinct and gut reaction. Some are well-funded, others are seat of the pants. Some may have a real impact, and others will end up as sincere but little more than lip service.

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Cumulatively, the result is a diluted effort whose aggregate national impact on reducing fraud is unclear at best, and minimal at worst. Public outreach can be effective only if we can define the problems our outreach campaigns are supposed to address.

But the anti-fraud community is still struggling to even define exactly what fraud problems it most needs to solve.

And what problems they are. Fraud is a big, vast and complex crime. It's a white-collar crime and a blue-collar crime. It happens in boardrooms and trailer parks. It's committed by immigrants, elderly, CEOs, career criminals, dedicated churchgoers, doctors, lawyers, nurses and anyone else you can think of.

It's also committed against them.

It's a property-casualty crime, a life insurance crime and a health insurance crime. It's a problem of right and wrong attitudes, and a problem of right and wrong behaviors. And it's a whole lot more. Knowing all this, we must decide how public awareness can have the biggest impact on fraud problems.

Even once we've decided what outreach strategies will work, we have the age-old question of resources. How do we find enough resources to do the job right? By resources we mean financial capital — money. This also means human capital — the involvement of enough committed company employees, SIU's, agents, public relations professionals and others to make our awareness programs take off. And it means political capital, convincing leadership of involved organizations to place public awareness high enough on their anti-fraud agendas that our efforts will have a fighting chance.

A related challenge is one of scale and territorial reach. Do we launch a single integrated national outreach campaign, or do we seek customized programs for each state. Or maybe a little of both. Or something else altogether.

Similarly, who should lead these public outreach efforts? Any public awareness campaign will achieve more scale and credibility by involving a diverse range of insurance and non-insurance groups that have a vested interest in stopping insurance fraud.

To make progress, the public awareness effort must talk — and also listen. Far too many consumers tolerate insurance fraud, and believe wealthy insurers won't miss a few thousand dollars here and there. We need to better understand this mindset before we can respond effectively. Until the public sees fraud as a crime that affects everyone's well-being, then we'll continue fighting an uphill battle.

One document covering one day of discussions can hardly define all of the issues, let alone solve them. But we're now out of the starting gate. Over the next five years, our leadership and vision can set the direction of our anti-fraud awareness efforts for the 21st century.

The Problem: Bad Attitudes

The discussion groups agreed our root fraud problems stem from bad attitudes. Changing unacceptable fraud behavior first involves defining and changing unacceptable attitudes toward crime, insurers, law enforcement, each other, and more. The more public awareness makes people intolerant of insurance fraud, and of those who commit fraud, the greater will be our impact on fraud reduction.

Here are the key attitudes that public awareness must change:

Unacceptably large numbers of normally honest consumers still tolerate fraud, readily commit "soft" fraud themselves, and have relatively low sympathy for insurance companies being victimized by fraud;

The public views insurance fraud as a crime of easy money with little risk of getting caught, or of few serious consequences if they are caught;

People believe they are entitled to commit fraud after paying high premiums with no or few losses for many years;

Too many insurers are in denial about the scope of fraud and its impact on their bottom lines;

People lack a strong sense of outrage over insurance fraud as a crime, and view fraud as a victimless crime at worst;

Consumers can prevent themselves from becoming victims (self-empowerment).

The Solution: A National Campaign

Key recommendation: Develop a unified, long-term national public awareness campaign spearheaded by a diverse alliance of insurance and non-insurance groups.

Comment: A joint national campaign can deliver the large scale, funding and consistency of message needed to reverse the lax and often destructive public attitudes that allow fraud to remain one of America's most persistent and costly crime waves.

Key Goals

Opportunistic (soft) fraud: Convince consumers and borderline criminals that fraud doesn't pay.

Comment: Average consumers and borderline or low-level crooks can be influenced because insurance fraud may not yet be a deeply ingrained habit or lifestyle. Public awareness thus can seriously reduce their involvement in fraud. Note: The discussion groups believe the term "soft fraud" understates the seriousness of fraud.

Hard fraud: Create a national environment of intolerance that makes it impossible for serious criminals to operate.

Comment: Most hardened fraud criminals cannot be deterred by scare tactics, or by moral appeals such as shame and guilt. So instead of trying to change their behavior, the campaign will turn society against them. By building moral outrage over fraud's high costs to society, consumers will be more vigilant... legislators will pass tougher anti-fraud laws... regulators will obtain larger fraud-fighting budgets... courts will pass stiffer sentences... insurers will redouble their internal fraud-fighting efforts.

Hard fraud: Empower consumers to avoid being victimized by scams, and to aggressively report suspected fraud to authorities.

Comment: Consumers will receive practical how-to advice on topics such as spotting fraud, asking the right questions, and how to report suspected schemes.

Audiences

Initially, the campaign will primarily target general consumers who commit "soft" fraud such as lying on applications, and borderline criminals who can be dissuaded from committing "hard" fraud.

Messages

Phase One will continually stress several clear, simple and memorable messages:

- Insurance fraud is a crime (moral outrage)
- Everyone pays a high price (financial and personal costs)
- Getting caught has heavy consequences (fear and shame)
- There is a strong likelihood of getting caught (fear)

Phased Effort

The campaign should be phased: Phase One would be relatively general, and cast a wide net aimed at the general public and borderline crooks. It would inform and even alarm the public about insurance fraud in general by continually stressing several basic and memorable themes that, cumulatively, will build an overall climate of public intolerance for fraud.

Follow-up phases will target specific fraud crimes, narrower audiences, regions and other variables. The exact duration, scope and content of each phase will depend on the results of previous phases. This strategy paper, therefore, will discuss only Phase One activity.

Five-Year Commitment

The campaign must be sustained. It should last at least five years, but continue as long as insurance fraud remains a serious national problem. A shorter one-shot campaign may help reduce fraud temporarily, but fraud will quickly spike once the campaign's initial impact wears off. At least three factors support a sustained effort:

Message overload. Americans face a serious information overload. We are bombarded with hundreds of messages daily. Campaign messages thus must be continually repeated for the public to recognize, remember, believe and act on them.

Entrenched attitudes. Consumers' moral indifference to fraud and antipathy toward insurers are deeply entrenched. Changing ingrained attitudes at a national level will require a sustained effort.

Educate new generations. As millions of new immigrants and young consumers become insurance buyers, we must educate them early on to have zero tolerance toward fraud while their attitudes still are formative.

Align with Allies

The core strategy team should include respected non-insurance groups, and the broader campaign should expand to even more groups whose constituents are affected by fraud — as victims or perpetrators. These allies might include advocates for consumers, doctors, lawyers, seniors, immigrants, small businesses and others. Numerous benefits accrue:

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Greater credibility. The campaign will be more credible and generate greater visibility if it's driven by a large cross-section of respected advocacy groups representing diverse interests, constituents and politics.

Broader expertise. Non-insurance groups will lend astute insights into fraud-fighting strategies, especially how best to reach and influence their own constituents.

Larger Scale. We will achieve larger scale and impact when allied groups involve their own large constituencies, many of which number in the millions.

More funding. Many allies would be well-funded or have well-funded constituencies. By contributing to the campaign war chest, they would reduce the pressure on insurers to fund the entire effort.

Measure Results

The campaign will conduct detailed research to set baseline goals, pretest campaign messages, check ongoing progress, measure changes in people's attitudes and behaviors, and determine the campaign's impact on insurance fraud itself (if possible).

Grassroot's Focus

Grassroots strategies will form a large and possibly leading campaign strategy. Mass media advertising such as radio and TV ads can reinforce the grassroots efforts, but the high cost and lack of personalization make it doubtful that ads should play the lead role. When done well, grassroots is:

- *Highly personal.* Empowering consumers to protect themselves against fraud is most effective at the community levels. Consumers will be more receptive when we reach them in smaller, personalized settings with messages customized to their local issues and fraud concerns.
- *Affordable.* Grassroots programs also can be implemented at far lower cost than can mass-media advertising. Volunteers typically carry the messages into the community. Support materials such as videos and brochures can be developed at relatively low cost, yet with proper distribution they can attain continuous and widespread usage in our target communities.

The discussion groups recommended grassroots tactics such as carrying messages through community centers, senior centers, homebuyer fairs, consumer affairs coun-

cils, crime fairs and billboards. The exact mix of approaches will be determined during campaign planning.

Anti-Fraud Legislation

Public awareness can have a big impact on pending state and federal anti-fraud legislation, but fighting legislative battles bears considerable risks. The discussion groups urged caution about including a legislative component to the campaign because:

Legislation may sidetrack our core strategy of general anti-fraud education, a universal goal that serves as a common ground for all strategy team members. Campaign allies also may have opposing views on bills, which could polarize team members and cause internal dissension.

Implementation

Cost. A national campaign will require a multi-million dollar annual commitment in order to have a deep and lasting impact. Advertising alone will cost several million dollars, though it's doubtful the war chest will be large enough for a continuous full-scale national ad blitz. The budget also must recognize potential expenses such as advertising; PR, design and ad agencies; campaign administration; research; and costs of customizing campaign material and strategies for key states and audiences.

Funding. Large national insurers likely would be the primary campaign funders because of their size and stake in the outcome. But centralizing funding around one source is risky, so we will consider developing a long-term funding strategy that spreads funding among diverse sources that are reliable, consistent and committed year after year.

The campaign thus should explore the feasibility of additional funding sources such as federal grants, non-insurance corporations allied with the campaign, insurance department contributions, and direct mail and other mass-fundraising techniques.

Management Structure. Creating a viable management structure must be resolved before the campaign can move forward effectively. Should we create a freestanding campaign hub group, work through an existing organization, or a combination? What role does the campaign group play? Is it responsible for fundraising? Does it control the war chest? Decide which local efforts are funded? Does it create and control all

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campaign strategy?

Execution. The campaign overseers must determine who will execute programs. A PR agency? PR staff of campaign member organizations? A combination?



EMERGING ISSUES

Discussion Summary

Two separate “emerging issues” workshops were conducted over the course of two days. Each of the groups had spirited, open exchanges in each session. The result was a wide-ranging list of fraud fighting opportunities, problems and threats as we enter the new millennium. It was agreed that technology, globalization, and the changing nature of financial services are accelerating the speed and nature of change. This presents an enormous challenge to all involved in the fraud battle.

Each group independently summarized its discussions not with prioritization of the listed items, but with articulation of the need for more fundamental change in the fraud fighting process. Each group agreed that while it is imperative to be alert constantly for new schemes and techniques in committing fraud, it is also imperative that we balance this with a critical examination of how we are organizing and managing the anti-fraud forces.

The groups agreed that the top priority emerging issue is the need for the public, legislators and regulators, civic leaders, and insurance executives to reexamine their view of the role fraud plays in their day-to-day success or failure. Fraud can not be considered a victimless prank, a cost of doing business, an unpleasant but unavoidable part of our lives.

We must manage fraud not as a necessary expense but as a competitor for our personal, governmental and corporate assets.

This change in viewpoint is imperative if we are to win the short and long-term fraud war. We must know our competitors and deal with them aggressively and directly. This change in viewpoint will create the right atmosphere and drive consistent decision making. The number one priority is to develop an action plan to effect this change in perspective.

Recommendation

The workshops recommend the establishment of a working group within the Coalition Against Insurance Fraud's Emerging Issues Task Force to develop and execute an action plan to achieve this reassessment and redefinition of the fraud problem on the part of all involved parties.

The Challenge

"To me, a claims man is a surgeon — his desk is an operating table. And those pencils are scalpels and bone chisels. And those papers are not just forms and statistics and claims for compensation. They're alive; they're packed with drama, with twisted hopes and crooked dreams. A claims man, Walter, is a doctor and a bloodhound and a cop and a judge and a jury and a father confessor all in one."

—Edward G. Robinson as Claims Manager Keyes in *Double Indemnity*

The topic of this paper is "emerging issues" but we are continually reminded that there are constants in this ever-changing world of fraud and investigation. The tools and techniques may change but we still deal person to person in detecting and defeating fraud.

"Double Indemnity" was made in 1944 but the most powerful defense against insurance crime discovered to date remains the passion and the principles portrayed by Edward G. Robinson as Claims Manager Keyes.

However, time and technology do change the landscape where this battle takes place. The greed factor drives each new generation of insurance criminals to believe it is smarter than the previous generation and smarter than any investigator. The risk/reward scale still tilts heavily in its favor. It knows the risk of detection and punishment is far outweighed by the potential gain from insurance crime.

Despite the best efforts of an army of dedicated fraud fighters, new schemes are devised and old ones are revitalized in unique ways as quickly as barricades are established to detect and defeat the crime techniques of today.

The new millennium finds us much better equipped to detect and attack fraud, yet the basic story line of the 50-year-old "Double Indemnity," homicide disguised as accidental death to obtain insurance proceeds, is still a frequent headline today... although new cases usually have some 21st century trappings. Our challenge is to anticipate and thwart those with "twisted hopes and crooked dreams."

Can we identify the topics and issues that will monopolize our time over the next five years while also keeping a watchful eye on a horizon well beyond that time period? We all know that somehow time is accelerating — five years will flash past like a shooting star. We must run harder and faster than the insurance criminals do. Our vulnerability is great. Our strengths and our opportunities are many but so too are our weaknesses, our problems, and our threats.

What are the new generation of fraud rings, auto body shop scams, car theft/export, med/legal mills, viaticals, workers comp premium evasion.... The well-known list goes on and on? What are the problems and threats of new legislation, privacy, e-commerce, the Internet, globalization of our companies? What is the state of our fraud-fighting programs in the year 2000?

An Expert's Assessment

Here is one expert's assessment of fraud fighting at the millennium.

Peter Goldmann of the newsletter White Collar Crime Fighter interviewed Professor Malcolm Sparrow, a pre-eminent fraud expert from the JFK School of Government at Harvard University. Professor Sparrow's primary focus is health care fraud but his comments apply across the many lines of insurance.

Professor Sparrow declares that the number-one obstacle to effective fraud fighting is a widespread failure on the part of insurers, employers, politicians, and law enforcement to understand the complex nature of fraud.

He identifies six cornerstones of this complex obstacle:

- Unless fraud is detected close to the time committed, it will probably remain undetected forever.
- Performance indicators are highly misleading — is apparent increased fraud because of better detection or is it a true rise in fraud incidence? Should we measure fraud prevention or measure reaction to committed fraud? Some thump their chests about recoveries; some invest more in deterrence. This results in confusion when we try to assess or compare success measures reported by different agencies, states, or companies.
- The productivity/efficiency/fraud control balance equation generally is solved in favor of the proponents of processing efficiency. Small processing efficiencies are easily measurable and readily achieved. Large potential fraud control

savings are uncertain and hard to measure. Moreover, processing efficiencies can greatly increase the vulnerability to fraud.

- Today's controls will not detect tomorrow's fraud. The white-collar criminal is a true chameleon — ingenious in adjusting and adapting to survive in a hostile environment.
- There is widespread misplaced emphasis on detecting and investigating committed crimes, rather than on controlling, neutralizing, and deterring future crime. Despite some progress, the probability of detection and of criminal prosecution is still extremely small. The risk/reward ratio is still very attractive in insurance fraud — small risk with high reward. There is great potential in shifting the investment balance from heavily weighted identification of already committed crime — the “pay and chase” model — to more investment in detecting attempted fraud and defeating it.
- Today's fraud control systems mirror the production environment. Generally, our fraud fighting programs examine claims or transactions one at a time so we address only the least sophisticated fraud schemes.

Given all this, Professor Sparrow identifies two fatal flaws in our efforts:

- Because fraud control is dynamic and continuously evolving, a static set of “filters” has only short-term value.
- Sophisticated fraudsters study unsophisticated fraud control programs and easily design schemes to avoid detection.

The result of these flaws is that today's fraud programs detect primarily the casual, careless, and opportunistic scheme — the seasoned, sophisticated fraud perpetrator is generally successful.

Professor Sparrow points out that there are other factors impeding our success in defeating fraud:

- Insurers are socially acceptable fraud targets
- Fraud is not “self-revealing.” Claimants rarely see the bills and accompanying details of treatment, which are sent directly from the provider to the insurance carrier. Moreover, explanation of benefit material is cryptic, rarely reviewed, and easily misunderstood, if even seen by the claimant.

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- There exists great consumer respect of and confidence in the health care and the legal professions. The public trusts providers. Fraud discovery is a direct attack on the integrity of professions and their ability or inclination to police themselves. Both the legal and medical communities resist efforts to allocate greater resources to fraud prevention and investigation.
 - The public can be deceived and confused. Outright criminal fraud can be overshadowed and shielded by indignant rebuttals to challenges to “professional judgement” and “medical necessity” by insurance clerks. Unnecessary treatment, unnecessary testing and other abuses relating to the question of medical necessity also confuse the issues.

The Response

We need to examine our past critically and plan for the future carefully and boldly.

The Fraud Forum is one step in this long journey. Two separate workshops were held. In planning, the workshop team defined the following objective, constraint, and planned product.

Objective — Under the general topics of fraud schemes, fraud detection, fraud investigation, fraud case resolution, special investigation management, and legislation/regulation; identify, define, and assess the priority of newly developing issues classified as strengths, weaknesses, threats, problems, or opportunities.

Constraint — It was not the objective of the workshops to determine plans of action or solutions to address the identified threats or problems or to take advantage of the opportunities. Practical time limitations prohibited this.

Product — Prioritized list of specific topics for in-depth evaluation and examination by future ad hoc groups.

The goal in the workshops was to create full and open involvement while keeping each group focused. There was no time to devise solutions or action plans, no time for anecdotes or war stories. The goal was to generate a cascade of ideas — and then reach consensus about the top priority issues in each category. The intent is that these issues now become the focus of individual ad hoc committees of the Coalition’s task force on emerging issues.

Forum attendees had their choice of any one of the five two-hour workshops during the two time periods available. There was surprising consistency in the overall pro-

EMERGING ISSUES

file of the groups attending the two separate “Emerging Issues” workshops.

The demographics of the employers of the two “Emerging Issues” groups:

	<u>Workshop I</u>	<u>Workshop II</u>
State/Federal	4	3
Law Enforcement	5	2
For-profit	3	2
Insurance	9	8

This variety in background and perspective was invaluable in achieving a balanced assessment of the nature and the priority of developing issues.

The Emerging Issues

The following lists detail the specific issues raised by the two workshops.

1) Fraud Schemes

Emerging Problems

1. Money laundering
2. “Shell” insurance operations, domestic and foreign
3. Health care fraud — HMOs
4. Advanced commission schemes — nine-month promissory notes — promise of high commissions attractive to agents who may be duped into selling them
5. Managed care fraud
6. As companies seek to leverage cross marketing opportunities in providing financial services, they may start giving insurance away as a means to obtain the mortgage, banking and investment business of customers. Underwriting will become problematic and people will see the opportunity to secure coverage and commit fraud
7. Viatical fraud
8. Elderly and senior care fraud
9. Annuities as a vehicle for money laundering
10. Catastrophe fraud — contractors

11. Commerce — tracking transactions, phony IDs — the Internet

12. Identity theft

13. Distribution systems changing — agent less and less involved

Emerging Threats

1. Possible collapse of HMO managed care system

2. Excessive cost of prosecution due to international venues

3. Ease of doing business mindset opens up opportunities for those who commit fraud

Emerging Opportunities

1. Form new partnerships and alliances for technology, training etc.

2. Need to marry internal information exposure value on record vs. claim amount

3. Reinsurance needs to refine its approach to the fraud problem

4. International partnerships

2) Fraud Detection

Emerging Problems

1. Technology-driven systems for underwriting and claim evaluation

2. Lack of quality data for technology tools designed to fight fraud

3. Need new red flags for new types of schemes

4. Schemes that develop in foreign countries are hard to uncover.

5. SIU management needs new skill sets to deal with technology issues

6. Training must be changed to match up with new schemes

7. Still reactive not proactive

Emerging Threats

1. Systems issues, data integrity, failure to obtain basic information critical to investigation

2. Claims systems built to track claims only

3. Fewer adjusters — claims payments will be automated

4. Reactive systems to find fraud

Emerging Opportunities

1. Possibility of developing a universal data set.

2. Data mining systems

3. Rule-based decision-making systems that help prevent fraud by including all processes in the insurance business, not just the claims process.
4. Analysis of data — look for patterns, focus on activities other than just when a claim is made.
- 3) Fraud Investigation

Emerging Problems

1. Evidentiary problems — What will be used to prove the crime?
2. Privacy issues — What information will be available from the insurance and the banking realm?

4) Fraud Case Resolution

Emerging Problems

1. Multi-jurisdictional crimes
2. Insufficient laws written to cover insurance fraud here and abroad
3. Evidentiary requirements differ in every country.
4. Cost of doing business attitude an impediment to prosecution

Emerging Opportunities

1. Prosecution may be more favorable in some countries.

5) Special Investigation Management

Emerging Problems

1. Bank/Insurance mergers
2. Insurance companies chartering banks
3. Non-traditional partnerships, TPAs, self-insureds
4. Management of anti-fraud efforts expensive
5. State regulations extremely specific in nature limiting flexibility and innovation
6. Resources to fight fraud — public and private, scarce and diminishing
7. Global economy — Mergers and acquisitions will require we train everyone in the organization.
8. Need to become involved in product development so that we can give input before products are rolled out.
9. Manage processes not investigations or people
10. Manage fraud as a business problem and present it to management as such.

Emerging Threats

1. Need for SARs (special activity reports) anything over \$5,000 because of banking regulations and SEC oversight
2. New set of regulators (Treasury Department)
3. Outsourcing
4. Licensing

Emerging Opportunities

1. Management of processes instead of people to detect and control fraud
2. Partnering between P&C and Life
3. Involvement in e-commerce initiatives to include a fraud fighting perspective in process development
- 6) Fraud Legislation/Regulation

Emerging Problems

1. Federal and State regulations
2. 1033/1034 requirements (criminal background check of employees)
3. International regulations for multi-nationals
4. Lack of regulations for managed care industry
5. States require carriers must provide certain coverages or a certain percentage must be renewed, increasing a company's exposure to fraud in some segments.

Emerging Threats

1. Jury awards – completely unpredictable
2. Lobby groups inadvertently or intentionally undermining anti-fraud regulation
3. Too many levels of regulation — how many times must the data be reported, how many ways?
4. Privacy laws not well thought out when it comes to what the exceptions should be — who has legitimate business reasons for access?

Emerging Opportunities

1. Federal regulation as opposed to state — one set of rules countrywide
2. Federal immunity statutes
3. Lobbying activity to provide balanced input into legislative process domestically and internationally

EMERGING ISSUES

In the dynamic give-and-take sessions, there were other important ideas and themes, which did not necessarily become a bullet on the charts.

- Special investigation managers need to discover new ways to leverage technology to compensate for diminishing available human resources.
- Special investigation managers need to move to proactive identification of vulnerability and management of risk and away from the reactive management of individual suspected fraudulent claims.
- Special investigation managers must invest in better selling/marketing to broaden awareness of all types of fraud and the true fraud implication on the business of insurance.
- This selling/marketing must lead to a mindset change by senior management. Anti-fraud efforts should be seen as an essential part of the business of insurance by top management for good business reasons.
- Insurance fraud will be a refuge for criminals both domestically and internationally who face increasing pressure and reduced opportunity for other crimes - insurance fraud is easy, profitable and relatively painless in that it is prosecuted less often than other crimes.
- The elimination of the opportunity for abuse of certain entitlement systems is a threat to workers comp and other medical/disability insurance products.
- Insurance executives must begin to consider fraud and fraud fighting as a business opportunity and strategy not just a problem expense, fraud is a competing interest.
- Government, business and consumers need to adopt a holistic approach to the serious economic cancer of fraud which can be stimulated by federal program for the control of abuse and fraud in national programs as well as in private insurance

The workshops generated a wide-ranging, far-reaching, provocative set of issues. Each of the bulleted items and topics detailed above calls for analysis and action.

The workshop team distilled the material into a few basic themes, which follow and will shape our strategic and tactical planning in the years to come.

Broad Issues:

1. Financial De-regulation Implications

Mergers/Acquisitions and Bank Charters

- SEC rules and regulations
- New complex financial products
- New distribution channels

Possible shift in regulation — federal vs. state

- Insurance traditionally does not want federal oversight.
- Banking is already regulated federally.

Immunity provision — federal vs. state

2. Changing Nature of insurance business

Globalization — international companies/business

- International law enforcement/investigation
- Jurisdictional Issues
- Privacy Issues

Scheme: Shell companies

Growth/Market Share

- Underwriting is changing

Distribution Systems Changing

- E-commerce
- Regulatory
- Jurisdictional
- Privacy

Scheme: Agents

- Advanced commissions
- Premium finance
- Promissory Notes (9 month)

Products

Scheme:

- Life — viaticals
- Collapsing HMOs/Managed Care — affects guarantee funds, PIP
- Judicial regulation setting
- Disparate state regulations (51) — from micro-management to none.

3. Technology

- Proactive use for identification
- Tool for devising and committing crime as well as for detecting and defeating it
- Better decision-making tools
- E-commerce
- Evidentiary issues
- Electronic signatures

Scheme: Identity theft

4. Resources — Do we have enough/are we doing the right things?

- Right functions
- Right people
- Right job
- Right knowledge/skills
- Right tools — particularly public partners
- Right communication — w/public partners, internally, externally
- Outsourcing changes the resources
- State/federal prosecution investigation/prosecution resources

Overall Strategy

There is a well-defined litany of specific topics and issues that demand immediate and urgent attention. However, in order to achieve the fundamental change needed to effect real progress in reducing the tremendous negative drain of fraud on society, in order to create the environment in which we can deal successfully with the specific emerging issues defined in these workshops, we need a paradigm shift — a basic change in the way the fraud problem is viewed.

The public, legislators and regulators, civic leaders, and insurance executives all must

reexamine their view of the role fraud plays in their day-to-day success or failure. Fraud can not be considered a victimless prank, a cost of doing business, an unpleasant but unavoidable part of our lives.

*We must manage fraud not as a necessary expense
but as a competitor for our personal, governmental and corporate assets.*

This change in viewpoint is imperative if we are to win the fraud war. We must know our competitors and deal with them aggressively.



PUBLIC/PRIVATE PARTNERSHIPS

Discussion Summary

The purpose of these discussion groups was to identify successful public/private partnerships used to fight insurance fraud, and identify how they could be used to model future partnerships to meet the challenge of the millennium. Although such partnerships have been highly effective and are considered important to future successes in fighting fraud, there are legal issues that should be considered when using this approach.

The discussion groups identified a number of issues and developed recommendations that they felt could be resolved or reduce the impact of the fraud problem by either new public/private partnerships or expansion/enhancement of existing ones.

Some of the problems/issues identified in the discussion groups included lack of insurance fraud prosecutions as well as the use of all civil remedies available to punish insurance fraud offenders. Although advances have been made in information sharing between the public/private sector and immunity statutes have been broadened to encourage exchanges of insurance fraud information, better information sharing is required to effectively fight insurance fraud. Training and education of all stakeholders (insurance industry, law enforcement, consumers, and legislators) continues to be an issue that needs more attention. Funding for prosecutors, regulators and law enforcement involved in fighting insurance fraud is limited. A lot of focus has been placed on property/casualty and health insurance fraud, but the public sector has limited means to check duplicate/suspicious life insurance claims and the private sector has difficulty identifying the insurer in life insurance fraud cases. The insurance industry is faced with fraud reporting requirements to many agencies (prosecutors, law enforcement, regulatory agencies) which are costly, inefficient and duplicative.

The discussion groups made the following recommendations regarding public/private partnerships to fight insurance fraud:

-
- Educate and encourage use of civil litigation/remedies by the private sector in coordination with the public sector ensuring no negative impact for either party.
 - Encourage the sharing of information to increase use of license revocations, business closure, inspections of business and services of those involved in insurance fraud.
 - Use the Federal Health Care model to develop dedicated prosecutors and investigative resources to fight fraud.
 - Ensure appropriate representation on the Congressional Privacy Commission that is knowledgeable of both the public/private issues and educate the commission about privacy matters needed to fight insurance fraud.
 - Educate insurers and law enforcement concerning Department of Justice (DOJ) and Health and Human Services (HHS) guidelines for sharing of insurance fraud information between the public/private sector, and encourage similar guidelines in state jurisdictions.

Improve and explore avenues to improve sharing of insurance fraud information to include:

- Educating people regarding legal limits on information sharing.
- Encourage sharing of training and education programs about insurance fraud between the public and private sectors and among associations fighting insurance fraud.
- Share obtained public information between these sectors.
- Supply through public/private partnership peace officer standardized training, as well as training for prosecutors/judges and all fraud investigators.
- Explore developing the National Insurance Crime Training Academy (NICTA) concept through a strong public/private alliance.
- Create a life insurance claim database accessible by both the public and private sector.
- Work with NICB/ISO to develop one insurance fraud reporting system accepted by all agencies so carriers can efficiently report suspected fraud to one agency that will then distribute the information to all interested parties/agencies.

PUBLIC/PRIVATE PARTNERSHIPS

- Explore a system of “earmarking” a percentage of fines, penalties, restitution, asset seizure against those involved in insurance fraud to fund-dedicated prosecutors, investigators and task forces fighting insurance fraud.

Tracking Progress

Training/Education: Develop a baseline of insurance fraud training given to both the public and private sector through the associations involved.

Civil Remedies: Establish a baseline of civil litigation and other remedies by surveying the insurance carriers, regulatory and licensing agencies.



MEASURING FRAUD

Introduction

Americans live and die by numbers — whether it's political polls, the Dow Jones average, movie ratings or a baseball pitcher's latest earned run average. We have come to expect that all things can and should be measured quickly and easily. Business leaders in the 1980s tried to drive home the point by proclaiming that “if you can't measure it, you can't manage it.”

The obsession with measuring nearly every aspect of our lives presents a dilemma for the insurance fraud-fighting community. Simply put, insurance fraud is hard to measure accurately. The hidden nature of the crime — combined with other obstacles that will be discussed in this paper — have stymied efforts to develop easy and efficient methods of gauging the extent of fraud, and the effectiveness of specific solutions in curbing it.

Why Measure?

The most-common rationale often given for the need to measure fraud is a simple one: you need to know the extent of the problem to effectively solve it. Without knowing the size and scope of the problem, how can we know how much and where to deploy resources? The scarcity of money and staff to combat fraud suggests that efficient allocation of resources is vital in order to effectively deter and detect fraud.

A secondary rationale for a consistent measurement system is the need to understand the degree of impact various solutions have on the problem. If a baseline understanding of the problem is lacking, then how can the effectiveness of subsequent solutions be measured? This is especially true in determining whether anti-fraud activities have any impact on deterrence, which may be even harder to measure than the extent of the problem.

Another important reason for consistent measurement is public credibility.

Consumers and their legislators are more likely to buy into solutions if they are convinced a problem exists. Anecdotal evidence has helped convince a lot of people that insurance fraud is a problem that requires immediate and forceful remedies. However, cracks are beginning to form in this argument, casting doubt on whether insurance fraud is really as bad as insurers and others say. News articles now are investigating the fraud problem and are questioning how widespread it really is.

Legislators also question whether the problem is in proportion to the solutions advanced by the fraud-fighting community. Advocates for anti-fraud legislation have long said their jobs are much tougher without clear and convincing statistics about insurance fraud.

During the 2000 legislative session in New York, for example, a bill to specifically outlaw “running and capping” middlemen who coordinate fraud schemes was scuttled when the Assembly Majority Leader refused to call up the bill because he deemed this problem wasn't a significant one in the state.

Obstacles To Measuring

Insurance fraud means many different things to different people, and therein lies one of the biggest challenges in measuring fraud: There is no universally understood definition of insurance fraud.

From a strict legal sense, a fraud exists only when a court has deemed it so, either through criminal or civil rulings. While measuring court actions is relatively easy most of the time, the results may not be meaningful in gauging the fraud problem because only a small fraction of fraudulent acts ever end up in court.

Other possible areas to measure include:

- Prosecutions and civil cases brought to light
- Cases referred to prosecutors
- Criminal arrests and civil complaints
- Cases referred to law enforcement
- Claims denied or reduced
- Claims referred to SIUs
- Red flags triggered

Even with these criteria, not all fraudulent acts will be captured because some go undetected during the claims process while some suspected of fraud are established as valid.

Another obstacle is defining the type of fraud to measure. Most fraud estimates focus on claims fraud. Applications, underwriting or premium fraud go largely unmeasured. Fraud by insurers or company insiders also is rarely quantified.

Lines of insurance also define how and what gets measured or even estimated. Property/casualty insurance, specifically automobile and workers compensation, have received the greatest attention. Health insurance fraud has been estimated, although somewhat roughly, thanks to federal research of public health programs. Then again, the definitions remain unclear because government studies usually report the loss due to fraud and abuse, without defining either. Where does abuse end and fraud begin?

Research of life and disability insurance fraud is virtually nonexistent, yet there are signs that criminal activity is growing in both areas.

Not everyone in the anti-fraud community favors clear definitions and measurements, either. During the June 2000 National Insurance Fraud Forum, participants in one of two sessions that focused on this issue said some insurance investigators liked a “fuzzy” definition because it allows flexibility and prevents insurers from being buttonholed into “one-size-fits-all” solutions.

Some investigators also believe their performances could be misinterpreted by measurements that might not adequately apply to the structure of their operations or the type of fraud they investigate.

Finding adequate funding to install a consistent measurement system over time is another clear obstacle to measuring fraud.

Past Measurements

Attempts to measure insurance fraud have either been broad estimates, one-time snapshots, or narrowly focused on a single area, such as bodily injury fraud. The most-notable efforts include:

- Coalition Against Insurance Fraud. Publishes annual estimates for claims fraud in four areas of insurance (auto, homeowners, health and business). Estimates are based on extrapolations of previous industry and government estimates of fraud. Latest national estimate for claims fraud in the U.S. is \$79 billion.

MEASURING FRAUD

- National Insurance Crime Bureau. Estimates that insurance fraud totals \$18 billion to \$20 billion. Estimate focuses on property-casualty insurance, but news media and others often misinterpret this figure to include fraud across all lines.
- Conning & Company. Published a landmark study on insurance fraud in 1996 that estimated claims fraud at \$120 billion, mostly based on other estimates.
- U.S. Government Accounting Office (GAO). Published a 1992 study that estimated fraud and abuse in Medicare and Medicaid reached as much as \$100 billion annually.
- Insurance Research Council. Conducted a closed-claim study in 1995 of automobile bodily injury claims that concluded about 36 percent of those claims had signs of fraud or buildup. While 18 percent of the claims were suspected of being fraudulent, only one in five were thought to be planned as a staged or caused accident
- Automobile Insurers Bureau of Massachusetts. Conducted the original closed claim study in 1991 that found 11 percent of auto bodily injury liability claims were suspected of fraud, with an additional 21 percent judged to be buildup claims.
- Rand Corporation. Conducted a study of the Insurance Research Council data of bodily injury liability and no-fault claims that concluded that about 28 percent of all claims submitted by auto accident victims are exaggerated for the purpose of collecting insurance payments.
- U.S. Chamber of Commerce. Reported that 25 percent of all workers compensation claims are fraudulent.

The varying estimates are confusing and often contradictory, and the statistical methods do not always hold up to rigorous analysis. When examined by the public, media and legislators, these figures fail to definitively measure how large the fraud problem really is.

Measuring SIUs & Fraud Bureaus

The performance of special investigation units (SIUs) and state fraud bureaus also are often considered ripe for benchmarking, or at least consistent and continual measurement of various aspects of their operations and results.

SIUs

There's a common belief that most SIUs systematically measure their return on investment to their companies. A variety of measurements involving cases opened, files forwarded, referrals from claims department, savings based on reserves, cases referral to prosecution, etc. are used.

One large personal lines insurer, however, does not measure its SIU operation, contending that whatever the savings, an aggressive anti-fraud program is in the best interest of policyholders and is "the right thing to do." Other insurers downplay measurement for fear that such a system could be used against them in civil litigation that the company unfairly denies claims, perhaps even legitimate ones.

Some insurers have sophisticated systems of measurement that let them measure savings and understand the benefits of adding staff investigators versus the cost of outside contracted services.

Still, even with an outstanding system of measurement, a single insurer cannot measure itself against industry-wide standards, because none exist.

During the Fraud Forum, the two discussion groups were split on the idea of a uniform system of measurement to gauge performance of SIUs. The first group thought benchmarking would help management better compare performances from insurer to insurer. This would give management more confidence in the SIUs and thus attract more resources to anti-fraud activities. Benchmarking also could spotlight fraud units that excel, and highlight the reasons for the success, possibly encouraging more innovation and experimentation.

But the second discussion group wasn't convinced a uniform benchmarking system is now possible because carriers now use so many different measurement systems.

Designing a system that is valid across different lines of insurance was another obstacle. Can an SIU who mostly deals with workers comp cases be compared with one who investigates automobile insurance fraud? The differences between property/casualty insurance and health/disability/life are even starker, potentially making a benchmark even less-useful.

A third obstacle is the inability to measure the intangible benefits of SIUs. The mere creation of a fraud-fighting entity should help deter crime, yet actually measuring that

deterrence is nearly impossible. SIUs also provide functions other than investigating claims for the purposes of denials: Reviewing claims files that are quickly determined to be legitimate claims allows insurers to pay claimants promptly and close files quickly.

Fraud Bureaus

Fraud bureaus should use consistent and continual measurements, the participants agreed. Perhaps because of the culture and requirements of state government, developing a uniform system would be easier and less-demanding, especially since many of the current 45 units already capture data necessary to file annual reports to legislatures, governors and state insurance commissioners.

Fraud forum participants generally agreed that state agencies should be held accountable for their performance whether they are funded by tax dollars or by industry assessments. While measuring fraud bureaus is easier because only 45 exist, they still face some of the same problems as measuring SIUs.

The structure of fraud bureaus varies from state to state, as does their focus, funding and capabilities. Some deal with all types of insurance and insurance fraud, while others narrowly focus on workers comp or auto insurance.

Capabilities vary even more. A few state units have more than 100 investigators, full police powers and the ability to prosecute, while others employ just a handful (as few as four or five) investigators with few or no special powers.

The challenge is to develop a consistent and fair system that effectively compares the performances of all the state agencies, and gauges changes in performance, capabilities and structure from one year to the next.

Previous attempts to measure fraud bureaus have included the following data points:

- Number of employees
- Number of investigators
- Years of existence
- Where in state government is the agency housed
- Total budget, budget as a fraction of insurance lines covered premium
- Number of pending cases, arrests, cases referred to prosecution, cases prose-

cuted and convictions — criminal and civil.

To help provide a fair comparison, various ratios have been published, including number of cases per investigator, cases per capita and prosecutions per million of dollars of premium written in the state.

While such measurements are far from perfect, they do offer a fairer method of comparison from state to state. However, they still do not measure the intangibles that a fraud bureau brings to the table, especially deterrence.

Recommendations

Measuring Fraud

- Develop concise definitions of fraud for the purposes of uniform measurement, and promote the understanding and use of the definitions with industry, government, academia and the media. Terms might include “suspected fraud,” “referred fraud” or “convicted fraud,” depending on the action taken.
- Make clear the role of exaggerated or buildup claims as they relate to the definitions of fraud.
- Investigate the feasibility of developing methods of conducting closed claims studies in non-auto lines, including homeowners, workers compensation and health insurance.
- Investigate securing the aggregate reporting data insurers file annually with state insurance departments, to determine whether data could be extrapolated for measurement purposes.
- Develop methodologies for measuring the extent of fraud in the application process, especially in automobile and life insurance.
- In the interim until more accurate measurements can be ascertained, major anti-fraud organizations should seek agreement on more-consistent estimates, or perhaps resist publishing estimates that are not based on some level of scientifically valid empirical studies.

Measuring SIUs

- Publish a guidebook to assist insurers in measuring the performance of SIUs that would include case studies and the various measurement systems used by insurance companies. Provide an in-depth analysis of the benefits and draw-

backs of various systems. Underscore the importance that intangibles such as deterrence play in fraud prevention, and that the total worth of a special investigations unit cannot be calculated by dollar savings alone.

Measuring State Fraud Bureaus

- Continue publishing statistical studies that measure the state fraud bureau performances, and compare them from state to state, using a variety of ratios that help keep results in perspective. To better understand the capabilities of each bureau, such studies also should describe the bureaus' structures and discuss how they operate.

Conclusion

Measuring insurance fraud will never be easy, and likely will remain controversial. Reaching consensus on definitions and methods will be hard, especially when people focus narrowly on their own operations instead of keeping the big picture in mind.

But such consensus is essential if effective measurement programs are to help spotlight the damage caused by this crime, and ultimately convincing the public and decision-makers how much insurance fraud affects the U.S. economy and lives of Americans everywhere.

A unified, all-industry approach to measurement is needed if we expect to prove that the fraud-fighting community is serious about managing this responsibility diligently, and that, indeed, insurance fraud is a severe social and economic problem in the United States.



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NATIONAL
INSURANCE FRAUD
FORUM

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The mission of the National Insurance Crime Bureau is to combat fraud and theft for the benefit of its customers and the public through information analysis, forecasting, criminal investigation support, training and public awareness. Website: www.nicb.org

Founded in 1984 by a handful of insurance industry fraud investigators, the International Association of Special Investigation Units is a non-profit organization dedicated to:

- Promoting a coordinated effort within the industry to combat insurance fraud;
- Providing education and training for insurance investigators;
- Developing greater awareness of the insurance fraud problem;
- Encouraging high professional standards of conduct among insurance investigators; and
- Supporting legislation that acts as a deterrent to the crime of insurance fraud.

Website: www.iasiu.com

The Coalition Against Insurance Fraud is a national alliance of insurers, consumer groups and government organizations dedicated to fighting insurance fraud through public advocacy and public education. Our mission is to combine the influence and resources of consumers, government organizations and insurers to combat fraud as a means to restrain insurance costs for consumers and insurers by reducing the financial impact of fraud. Objectives include enacting new laws and regulations to help the fraud-fighting community, communicating the scope of the fraud problem and potential solutions to all major audiences, serving as a clearing-house of fraud information and conducting research.

Website: www.insurancefraud.org