

# Controlling Claim Fraud

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Daniel Finnegan, Ph.D.  
*President, Quality  
Planning Corporation*

Gail Simpson, Ph.D  
*Partner*  
*with*

**T**here is consensus in the insurance industry that a minimum of ten percent of claim dollars goes to pay fraudulent claims. In California, the State Legislature estimates fraud accounts for fifteen to twenty percent of claim payments. Even at the low estimate of ten percent, total losses to the industry exceed \$16 billion per year. Annual fraud losses are more than double total industry profits. It is not surprising, therefore, that the current soft market has brought increasing attention to the problem. The reduction of claim fraud represents a major area of opportunity for the improvement of financial performance.

In this article we outline a practical method by which the industry can mobilize its resources to minimize the cost of fraudulent claims. Using an example fact pattern of fraud, we show why current claim adjusting practices are inherently vulnerable. We then outline a step-by-step plan to build defenses that both deter and detect fraud. The emphasis throughout is on facing the real world—recognizing the legal, social, organizational, and resource constraints presented to the industry by the fraud problem.

The principles discussed here apply to all types of fraud in all lines. However, for the sake of brevity, we have limited our examples to staged auto accidents.

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## The Insurance Fraud Game

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**N**umerous manuals exist for lawyers and doctors on “how to play the insurance game.” The claim process is presented as a game in which the goal is to maximize claim payments, and the only rule is, “Don’t get caught!” The game metaphor is sometimes used in these manuals as a euphemism for the far more unpleasant term, *fraud*. All is fair in love, war, and insurance claims. We find the game metaphor useful for understanding the industry’s vulnerability. Our example fact pattern pits the insurance team against the fraud team.

It is important to emphasize that our example is merely a way to illustrate the broader principles of our method. Readers may reasonably disagree with any of the details. Our purpose encompasses a broader perspective: How can industry resources be mobilized to solve the total fraud problem? The general approach is not dependent on the details of how any one type of fraud is handled.

Our fact pattern is based on the “Casino Ring” recently broken up in Los Angeles. The Casino Ring is reported to have staged as many as 3,000 phony auto accidents, and to have collected more than \$50 million in false claims over a three-and-a-half-year period. According to state fraud officials, the Casino Ring stationed recruiters outside poker clubs in the Los Angeles area. Knowing that heavy losers at the table would be looking for quick cash, they paid recruits \$1,000 apiece for use of their identification and insurance policy information in staging accidents. Using this documentation the ring would then file a claim stating that the policyholder had broadsided another car containing three passengers. A member of the ring would recruit phony passengers for the car that was said to have been hit. Cooperative doctors and lawyers would then submit claims for injuries and property damage. The typical claim was for \$40,000, with a final settlement around \$20,000.

The Casino Ring was purported to have successfully defrauded all major insurers in the region. The ring was discovered only by accident, when a recruiter approached a poker club security guard. The guard notified authorities who then investigated.

How was it possible for a ring to stage 1,000 phony accidents a year and to successfully collect claims from all major insurers? The question is especially puzzling given the special investigation units (SIUs) many insurers have established in the Los Angeles area, helped by an increasingly active and formidable state insurance fraud bureau.

## Team Lineups

**T**he insurance team is composed of one bodily injury (BI) adjuster. On the fraud team are three claimants, one policyholder, two lawyers, and two medical clinics. Analysis of the teams' strengths and weaknesses reveal the gross extent of the mismatch.

The BI adjuster has three months of training and two years of experience. Given company productivity goals and quotas, the adjuster usually has less than seven hours on average to devote to any given claim. Of those seven hours, almost a third are taken up with paperwork and computer data entry. Nearly everything the adjuster knows about the claim comes from members of the opposing team. Adjusters spend most of their time at desks gathering information by mail or telephone. It is common for adjusters to have little or no face-to-face contact with policyholders and claimants.

Singling out an individual claim for analysis has the effect of overstating the strength of the insurance team. The BI adjuster has from 100 to 300 pending cases. The majority of these claims are completely legitimate. There are no obvious or simple ways to separate the legitimate claims from the fraudulent ones. Every hour the adjuster's phone rings with calls requiring immediate attention. Every day he receives a stack of letters from lawyers and claimants demanding immediate settlement. Every month the supervisor reviews the pending files and demands to know why more haven't been settled.

The fraud team has substantial strengths. The policyholder has admitted complete liability and his story is consistent with that of the claimants. There are no witnesses. The lawyers each have three years of training and ten years of experience backing them. The doctors each have eight years of training and many years of experience. The medical bills and records are full of complex jargon that is difficult for the adjuster to understand. All the claimants have soft-tissue injuries for which they received three months of treatment. Because no objective injuries are claimed, there can be no objective medical evidence to prove that the injuries were faked. Because the medical bill was not submitted until treatment was completed and a cure claimed, an independent medical examination showing no injury would prove nothing.

No matter how suspicious the adjuster may be of the claim, to deny payment without solid proof of fraud would involve substantial risks. Because the claimants offer to settle within policy limits, claim denial and proceeding to trial may require a waiver of policy limits. Potential losses suddenly multiply. Adjusters must anticipate the worst; claimants show up for trial accompanied by their hungry-looking children. Such claimants tell stories of how they have been unable to work because of the accident. Their testimony is completely corroborated by their doctors, who retail stories of great pain and suffering. The claimants say that they cannot feed their families; they are on the verge of being evicted from their homes. The insured has admitted complete fault, and yet the greedy and insensitive insurance company still refuses to pay.

This is the grim reality of disproportionate odds. The fraud game is like a showdown between the Forty-niners and the Saint Mary's Junior High School football team. Innocence and prayer may triumph in some of life's contests; but it's our belief that the insurance industry needs somewhat more earthy defenses in the fraud game.

## Current Industry Response

We recently presented similar, although much more specific, findings at a client's headquarters. Several executives raised the objection that our conclusions were exaggerated; things really aren't as black as we paint them. Thereafter, we visited claim offices with these executives. Together, we reviewed files, interviewed adjusters, and traced the history of claims that were later found to be fraudulent. The accusation that our findings were exaggerated, was summarily dropped. A consensus emerged that the current standard system for adjusting claims is indeed highly vulnerable to fraud. We urge those who question this view to conduct similar reviews of their own operations.

<b>The Fraud Game: Team Lineups</b>	
<i>The Insurance Team</i>	<i>The Fraud Team</i>
<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px; width: fit-content;"> <b>One Adjuster</b> </div> <ul style="list-style-type: none"> <li>■ 7 Hours Total Time</li> <li>■ 100+ Pending Claims</li> <li>■ 2 Years Experience</li> <li>■ Tight Dead-lines</li> </ul>	<div style="border: 1px solid black; padding: 5px; margin-bottom: 10px; width: fit-content;"> <b>Three Claimants</b> </div> <ul style="list-style-type: none"> <li>■ Consistent Story</li> <li>■ No Witnesses</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px; width: fit-content;"> <b>Policyholder</b> </div> <ul style="list-style-type: none"> <li>■ Support of Policy-holder</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px; width: fit-content;"> <b>Two Lawyers</b> </div> <ul style="list-style-type: none"> <li>■ 3 Years of Law School</li> <li>■ 10 Years Experience</li> </ul> <div style="border: 1px solid black; padding: 5px; margin-bottom: 10px; width: fit-content;"> <b>Two Medical Clinics</b> </div> <ul style="list-style-type: none"> <li>■ 8 Years Medical Training</li> <li>■ 10 Years Experience</li> </ul>

The primary response of most insurers to the problem of claim fraud has been the development and expansion of special investigation units or SIUs. Almost all major P&C insurers now have SIUs. Unfortunately, SIUs acting alone provide an inadequate response to claim fraud. At current staffing levels nationally, SIUs can only investigate about one-tenth of one percent of all claims submitted. Given the minimum fraud estimate of ten percent of all claims, this means that at most only one percent of all fraudulent claims could be subject to investigation by SIUs. The hundred-fold increase in SIU staffing necessary to close this gap would have the undesirable effect of transforming claim offices from

client service organizations into criminal investigation operations. Further, SIU investigations are costly on a per-claim basis. They don't solve the root causes of fraud and they are relatively ineffective against the "soft" fraud problems, such as minor claim buildup.

Later in this article we discuss the critical importance of SIUs. Nothing here should be interpreted as suggesting that SIUs have failed. On the contrary, the Casino Ring was finally broken up with the aid of several SIUs. This was but one of many victories that can be claimed by SIUs against organized fraud. What SIUs cannot do is compensate for a claim adjustment process that is in itself highly vulnerable to fraud.

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## Winning the Fraud Game

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The insurance industry has access to substantial resources that can be mobilized against fraud. These resources fall into four categories:

- A. Best Practices.** Adjusters can be armed with the best available practices in the deterrence, detection, and handling of fraud.
- B. Corporate Support.** Beyond SIUs, there are many ways in which individual insurers can support adjusters in controlling fraud.
- C. Industry Support.** The insurance industry as a whole, through industrywide organizations and information sharing, can and should bring their collective resources to bear against the fraud problem.

**D. Social Support.** Increased social awareness of the costs to consumers of fraud, combined with greatly enhanced legal sanctions against criminal fraud, are necessary to a long-term solution.

In this section we use the example of the Casino Ring to show how best practices and corporate, industry and social support can be mobilized to defeat fraud. Although specifics are limited to staged accidents in personal auto insurance cases, the principles presented apply equally well to other lines.

## A. Adjuster Best Practices

The adjustment procedures outlined in our analogy of the fraud game became standard industry practice in the 1950's. Although these methods have served the industry admirably in a variety of ways, they have no built-in provision against claim fraud. Fraud was neither a major nor a particularly visible problem in the 1950's: thus the industry standard is geared to a situation which no longer exists.

Despite the relatively defenseless position of the industry, we know of individual adjusters who quickly spot staged accidents and build air-tight grounds for the claim's denial in the course of their investigations. These adjusters overcome the odds to win the fraud game almost every time. Although such adjusters are rare, there is no reason why the techniques they have developed cannot become standard practice in the industry.

It is the task of individual insurers to identify optimum practices for claim adjusters, and to see that these practices are systematized and standardized for general use. This section discusses four tasks whereby an upgrading of current methods can effectively block claim fraud:

*Fraud Indicator Recognition*  
*Enhanced Interviewing Methods*  
*Accident Damage Analysis*  
*Medical Record Review*

**Fraud Indicator Recognition.** The claims that devolved from the Casino Ring should have raised the alarm of potential fraud in the minds of adjusters. All purported injuries were soft-tissue; there were three claimants in each car with nearly identical claims; medical bills were only submitted after months of treatment; there were no police reports of the accident; no claimants were ever hospitalized; and some of the individuals involved had long histories of association with questionable insurance claims.

Insurers commonly provide adjusters with laminated sheets prepared by the Insurance Crime Prevention Institute (ICPI), listing major indicators of fraud. In addition, some insurers have developed their own lists of red flags that signal possible fraud, and have trained adjusters to recognize them. All this is a good beginning. It is not, however, enough. Too often, training for adjusters is limited to the simple recognition of indicators. Adjusters receive little or no training on how to proceed once such indicators are actually encountered.

The value of fraud indicators can be made more effective in five ways:

- **Linkage to Investigative Methods.** Fraud indicator training should be coupled with training on how to handle suspicious claims. SIU investigators from multiple companies have reported to us that many potentially fraudulent claim referrals they receive cannot be successfully investigated because of late referrals, inappropriate prior investigations, or improper preparation by claim adjusters.
- **Comprehensive Coverage.** Fraud indicators should cover all types of fraud. The indicator lists currently used by most companies tend to concentrate on one or two fraud types and ignore the rest.

- **Regional Differentiation.** Because fraud patterns vary across the country, the indicators used should be adjusted accordingly.
- **Periodic Updates.** Fraud indicators should be periodically reviewed and updated. IRS studies show that tax fraud indicators deteriorate after about four years of use, as the fraud team modifies its methods in response to IRS actions. The P&C industry has been very slow in updating its indicators.
- **Documentation of Indicators.** As standard procedure, adjusters should document the existence of fraud indicators in claim files. The importance of documentation is discussed below.

If these procedures had been in place, almost every claim submitted by the Casino Ring would have been immediately recognized as potentially fraudulent, documented as such, and tagged for enhanced investigation.

**Enhanced Interviewing Methods.** Interviews of claimants and policyholders are a central part of adjusting any claim. These interviews can be enhanced to more than equalize the odds in the fraud game.

Alexander Pope wrote that “*He who tells a lie is not sensible to how great a task he undertakes; for he must be forced to invent twenty more to sustain that one.*” In fraudulent or exaggerated insurance claims, lies must be invented and agreed upon in advance by the conspirators, amounting to what can be considered a “script.” A good interviewer gets the respondents “off-script” and into discussions about details that were not agreed upon in advance. Comparison of off-script responses from claimants and the policyholder will inevitably uncover major discrepancies in their stories.

Claimants will often disagree about where they sat in the car, where they went after the accident, how long they stayed on the scene of the accident, and so on. Similarly, faked medical bills can be quickly exposed by a good interviewer. Bills claiming 20 TENS treatments are discredited if the claimant divulges that the doctor never attached electrodes during treatment. Entire claims have collapsed when the medical bill reported 30 hands-on treatments by a particular doctor, yet, during the interview, the patient misreported the doctor’s race and approximate age. No jury is going to believe that a claimant visited a physician 30 times without being able to remember what he or she looked like.

There are tested and proven interview protocols which demolish fraudulent claims. Many SIUs are currently using versions of these protocols. What is now needed is to make enhanced interviewing techniques part of standard claim adjustment practice. We should emphasize that these protocols are in no way hostile or even aggressive. The respondent is given no suggestion that the interviewer’s purpose is to detect fraud. Good investigation techniques give no hint that fraud is suspected until the case is proven. As a result, fraud control interview protocols can be incorporated into standard adjustment practice without any harm to customer relations.

In our experience, these basic interview techniques can be taught in as little as one day. A single day of training will not, of course, transform a novice adjuster into a savvy fraud investigator. But all adjusters can be taught to successfully use a specific, predefined interview protocol to improve their ability to detect and discredit fraud. As in all other endeavors, true expertise comes only with time.

Enhanced interviews require, on the average, about one-and-a-half hours of additional time per claim. If these interviews were used in ten percent of claims fitting fraud profiles, the average time per claim would be approximately nine minutes. This is a very low price to pay for a major barrier to fraud.

**Accident Damage Analysis.** To adjust physical damage claims, it is standard industry practice to require that claimant and insured autos be inspected. These inspections provide a major opportunity for the identification and denial of fraudulent claims. Most staged accident claims can be discredited by an inspection of the cars involved. One of three types of physical discrepancies inevitably come to light: the damage does not match across autos, the damage does not match accident descriptions, or the damage is insufficient to the reported speed at impact. In the Casino Ring, claims were reported in which the policyholder was said to have hit the claimant’s vehicle broadside at 30 miles an hour. Yet the policyholder’s car showed little or no damage. (Most passenger vehicle bumpers are rated to withstand impacts of three to five miles per hour. A thirty-mile-per-hour collision will destroy the front ends of most autos.) Moreover, the location

of the damage on the claimant's vehicle seldom matched the height of the policyholder's bumper. Paint transfers also did not match. Nor did the shape and area of the damage match the front end of the policyholder's vehicle.

None of this is subtle. Every staged accident we have ever seen has had obvious discrepancies in the physical damage. Although we know SIU investigators who report occasional exceptions to this pattern, the exceptions are rare. Most staged accidents could be exposed as fraudulent, if companies simply provided half a day of training for their adjusters on damage analysis and followed a policy of quickly obtaining good photos of the vehicles involved. Companies also need to establish guidelines on when to hire certified accident reconstructions, either to add authority to adjuster findings or to deal with unusual or complex accidents. Incidentally, the same procedures are an equally effective defense against overstatements of damage in genuine accidents and claims that attempt to include preexisting damage.

**Medical Record Review.** The practices described in this section so far would have detected and discredited the Casino Ring's fraudulent claims. However, many fraudulent claims are based on real accidents in which soft-tissue injuries are either completely faked or grossly exaggerated to inflate claim settlements.

Medical bill and record reviews can discredit unnecessary, unreasonable, or unrelated treatments presented in exaggerated medical bills. Adjusters do not require extensive training for such analyses, nor must they spend long periods of time reviewing files. We have identified 20 problems that are common to inflated soft-tissue medical bills. Each problem is accompanied by a recommended action on the part of the adjuster. For example, if the charge for an initial examination exceeds usual, customary, and reasonable standards, the adjuster must lower the reimbursement to the standard, and inform the parties involved why and how the adjustment was made. Standard letters can be used to provide the legal basis for the adjustment and allow a response. This is standard practice in health insurance, and yet it is a rarity in bodily injury auto claim adjustments.

Medical bill reviews can also detect and correct bills for unlicensed care, billing for treatments not provided, misuse of expensive diagnostics, unrelated treatments, greatly inflated levels of treatment, *a la carte* billing (also known as fragmentation of medical codes or unbundling), and billing for more expensive or elaborate treatments than those that were actually provided.

Soft-tissue medical record and bill review requires from 20 to 50 minutes of the adjuster's time per claimant. Necessary training takes approximately two days per adjuster, plus supervisor assistance through the first month.

The use of standard bill coding forms and standard letters prevents adjusters from substituting their own judgment for that of trained medical professionals. The bill evaluation procedures are based on the best legal and medical advice that is available. As with accident reconstructionists, companies should establish guidelines on when to obtain outside expert bill reviews or independent medical examinations.

**Summary.** Tested and proven adjustment practices exist that empower individual adjusters to detect and dispose of fraudulent claims. Making fraud control part of standard claim adjustment procedures will result in substantial savings for insurance companies.

<b>The Fraud Game: Team Building I</b>	
<b><i>The Insurance Team</i></b>	<b><i>The Fraud Team</i></b>
<b><i>Adjuster Tools</i></b>	
Fraud Indicators	Three Claimants
Investigative Interviews	Policyholder
One Adjuster	
Damage Analysis	Two Lawyers
Medical Bill Review	Two Medical Clinics

## B. Corporate Support

Individual adjusters cannot be expected to control fraud on their own. They must be backed by an integrated program of corporate support. In this section we discuss seven areas of necessary corporate support:

*Rewards for Fraud Control Practices*  
*Legal Backing*  
*Special Investigation Units*  
*Expert Support*  
*Expert Systems and Databases*  
*Quality Control Approach to Fraud Control*  
*Fraud Measurement and Monitoring*

**Rewards for Fraud Control Practices.** It is a truism of management science that you get the employee behavior you reward. If the insurance industry is to become serious about fraud control, it must reward adjuster vigilance. Too often, adjusters are subject to implicit or explicit production quotas that work to punish fraud control efforts. Given such quotas, an adjuster faces a dilemma when he spots indications of fraud in a claim: to pursue the potential fraud is likely to require additional time and therefore to lower his performance rating. Moreover, unless fraud indicators are clearly documented in the file, a supervisory review of the file is unlikely to reveal the reasons behind a seemingly sluggish investigation. Whatever the explicit intent, many adjuster evaluation systems actually serve to reward individuals who pay fraudulent claims while punishing those who put extra time and effort into fighting fraud.

Care must be taken in crafting a solution. It would be unwise to reward adjusters based on claims denied or payments reduced. Such a system would create legal and public relations nightmares. And it runs the risk of rewarding adjusters who deny legitimate claims.

It would be more effective to develop an evaluation procedure that measures adjuster productivity not only on the basis of the number of settlements, but also on the characteristics of those claims. Such a system could, for example, evaluate adjusters based on the number of settlement "points" accumulated per month. Complex claims and claims with fraud indicators would be assigned higher point values than simple claims. This type of evaluation system would have multiple benefits. It would:

- *Eliminate current incentives for adjusters to ignore fraud*
- *Promote awareness of fraud indicators and create incentives to document and pursue these indicators*
- *Provide adjusters with the time necessary to investigate potentially fraudulent claims*
- *Create a management tool to allocate adjuster time in the most cost-effective manner*

**Legal Backing.** Across companies, claim adjusters have a common complaint: they often feel that their company does not back them when they attempt to deny claims they believe to be fraudulent. This perception has led to widespread frustration and cynicism. More than a few adjusters have asked us why they should care about stopping fraud, if their superiors don't care about it?

When these complaints are explored, a more complex picture usually emerges. What generally happens is that the adjuster gathers merely circumstantial evidence that a claim is fraudulent. This evidence is then presented to the supervisor. When the entire file is reviewed, the supervisor may find that there are, indeed, good reasons to suspect fraud. However, because there is no proof to support the suspicions, the supervisor has no choice but to authorize payment of the claim. The problem isn't that supervisors don't care about fraud; it is rather that claim denials must be supported by strong evidence.

In the section above, we discussed how adjusters can marshal the necessary evidence of fraud. Once the evidence is collected, it is imperative that companies back their adjusters. Part of this support should include the development of guidelines for settling potentially fraudulent cases. Such guidelines would gear settlement choices to objective standards rather than to “gut feelings” about fraud. For instance:

- *No payment should be made for any provided medical care violating state medical licensing laws and regulations.*
- *Major inconsistencies in the physical damage evidence are grounds for denial of the entire claim, provided that the inconsistencies are supported by a certified accident reconstructionist.*
- *Evidence of excessive use of expensive medical diagnostics provides grounds for negotiation of the medical payments, but does not, by itself, justify denial of payment for that portion of the bill. The cost of excessive diagnostics should not be considered when evaluating pain-and-suffering general settlements.*

As with all claim practice guidelines, care and caution must be exercised in their development and use. They should be developed by the company’s best adjusters, based on the best available legal advice and reviewed with an eye toward customer relations, practicality and local conditions. Such guidelines can promote the fair and equitable treatment of all claimants, while reducing payments to fraudulent claims. At the same time they can amplify the influence of the company’s most experienced adjusters, in an environment where many adjusters are relatively new. But finally, guidelines are only guidelines; unique circumstances will always require unique responses.

Given these caveats, guidelines are crucial to successful fraud control.

- *Guidelines minimize risk of rigorous fraud control by building defensible legal positions.*
- *Guidelines mitigate the frustration and cynicism felt by many adjusters on the subject of fraud.*
- *Rigorously defended guidelines deter fraud as it becomes known that the company will not pay fraudulent claims.*

**Special Investigation Units.** Above we argued that SIUs cannot be the sole or even primary response to claim fraud. Nonetheless, SIUs are a key and necessary element of an integrated fraud control program. There are five areas in which adjusters cannot substitute for SIUs:

- ***Complex or unusual fraud.*** Adjusters cannot be trained to handle any but the most common types of fraud. Experienced fraud investigators will always be necessary for the more unusual or complex cases.
- ***Fraud rings.*** The very nature of their job requires that adjusters treat each claim individually. Organized response to suspected fraud rings requires both skills and resources beyond those of individual adjusters; it requires SIUs. This is particularly true when investigations involve law enforcement agencies, other insurance companies, or complicated legal issues.
- ***Training and information referral.*** SIUs should function as the organization’s center of expertise on fraud. They should coordinate exchanges of information with other companies and government police agencies. They should maintain up-to-date information on new fraud scams, suspected rings, fraud trends, related legal issues, and current investigation techniques.
- ***Fraud vulnerability monitoring.*** SIUs are a valuable resource to management for the evaluation of the company’s vulnerability to fraud. SIUs can conduct file reviews to learn if fraud indicators are being detected, if the necessary investigations are being made, and so on. One fraud investigation unit we have worked with develops and submits trial fraudulent claims as a systematic test of the adequacy of existing controls. “Postmortem’s” on claim handling are then conducted to evaluate the strengths and weaknesses of the process.

- **Legal Support.** For disputed claims that do go to trial, SIUs can play a key role in developing the case for fraud well beyond the level that would be possible for individual adjusters. SIUs can conduct skip-traces, investigate claimant backgrounds, conduct surveillance, and provide a myriad of other investigative services necessary to bolster a strong antifraud stance.

The track records of more than 100 existing SIUs show that these units need not expose companies to undue legal risks or to excessive litigation. The dangers of not properly supervising SIU operations have been amply demonstrated in a few, well-known examples, from which the lesson to the industry is clear: SIUs must always operate under strict corporate control.

One final comment on the role of SIUs: the best SIUs don't necessarily produce the most in immediate savings. We know of several SIUs that have very impressive performance numbers. They report savings-to-cost ratios well above ten to one. They obtain denials on over 90 percent of the claims they investigate. They have very low per-claim investigation costs. Their claims almost never go to trial.

These numbers tell us more about the failure of standard claim adjustment practices than about the success of any particular SIU. All five key functions for SIUs we outlined above tend to *reduce* immediate savings. The fast-and-easy savings should be achieved by claim adjusters. SIUs should be assigned the much harder task of investigating the 10 to 20 percent of fraudulent claims that cannot be resolved quickly or easily.

**Expert Support.** Depending on the types of fraud problems encountered locally, claim offices should supplement the services of accident reconstructionists, medical and legal experts, and SIUs by maintaining active relationships with other specialists such as handwriting analysts, skip-trace organizations, and private investigators.

These specialists are usually willing to conduct adjuster training sessions about how to most effectively use their services. Adjusters should be informed about relevant fraud indicators, necessary follow-up, and criteria about when to obtain outside support. As with any business expense, expert support costs should be rigorously monitored. Guidelines for use should be based on an ongoing analysis of costs versus savings.

**Expert Systems and Databases.** The insurance industry spends billions of dollars every year on computer information systems. These information systems should be enlisted in the battle to control fraud.

One of our clients recently commented that her company was "data rich and information poor." She pointed out that much of the data necessary for fraud control existed in company files and databases; but the data had not been translated into information which could be accessed by the right individuals at the right time for the purposes of fraud control. Our experience suggests that the problem applies to the industry as a whole.

Expert systems offer one method whereby this problem can be addressed. They can be designed to automatically identify fraud indicators and prompt additional investigations. Computer programs can detect across-claim suspicious patterns, such as the same phone numbers repeatedly being used by different claimants. Expert systems can also be used to detect unusual types of fraud in which adjusters are not routinely trained. Anomalous data, such as identical medical bills repeatedly issued by a single medical practitioner, can also be easily flagged.

Because fraud rings are in the business of mass-producing claims, they routinely reuse phony IDs, phone numbers, autos, witnesses, medical bills, X-rays, claimants, and so on. Expert systems can provide a valuable tool for both quickly spotting ring activity and identifying suspicious associated claims.

Medical bill review is a particularly fruitful area for expert systems. Soft-tissue treatment bills can generally be reviewed by hand, because 30 common bill codes make up over 90 percent of modalities billed. Trained adjusters quickly learn the codes and can respond without recourse to computerized systems. But medical bills covering treatments beyond physical therapy can involve over 7,000 billing codes, each of which may be modified by various special codes as well as thousands of diagnostic codes. Only a computer could efficiently evaluate this range of treatments. Expert medical bill

review systems exist today that contain millions of rules. These rules check for discrepancies ranging from removal of ovaries in male patients to use of veterinary codes.

Computerized fraud control systems can be a very profitable investment. Expert systems we built for the national food stamp program increased investigator fraud identification rates by 60 percent while cutting fraud investigation costs by 40 percent. An evaluation we conducted of 80 computerized fraud control systems found an average annual return on investment that was more than two to one. With the application of a few simple lessons learned from our evaluation, there is no reason why average effectiveness could not double.

**Quality Control Approach to Fraud Control.** The quality control model views fraud control as a claims administration issue—not exclusively as a legal issue. The question becomes how best to adjust claim so that payment of fraudulent claims is actually impossible. The approach relies on a systematic evaluation of the claim payment process to detect the source of defects and to eliminate them.

Every hour of every workday the P&C industry settles over 50,000 claims. This vast and constantly growing experience in claim adjustment can feed the industries knowledge base, leading to a much greater expertise in how to control fraud. The illustrations given above of how current best practices can be standardized to reduce fraud are only the introduction to this much larger potential.<sup>1</sup>

The quality control approach will arm adjusters with a continuously upgraded set of weapons against fraud.

**Fraud Measurement and Monitoring.** Until the industry has real numbers on the extent, costs, nature, and trends in fraud, the problem can only be fought in the dark. Without such monitoring individual companies will not be able to diagnose their problem correctly, tailor effective solutions, nor evaluate their progress.<sup>2</sup>

Difficulties in measuring fraud should by no means be minimized. A company will not get far if it simply includes a box on its claim form inviting the claimant to indicate whether or not the claim is fraudulent. Fraud can, nevertheless, be exposed. Criminologists, statisticians, and forensic auditors have developed an impressive array of methods for measuring hidden crimes.

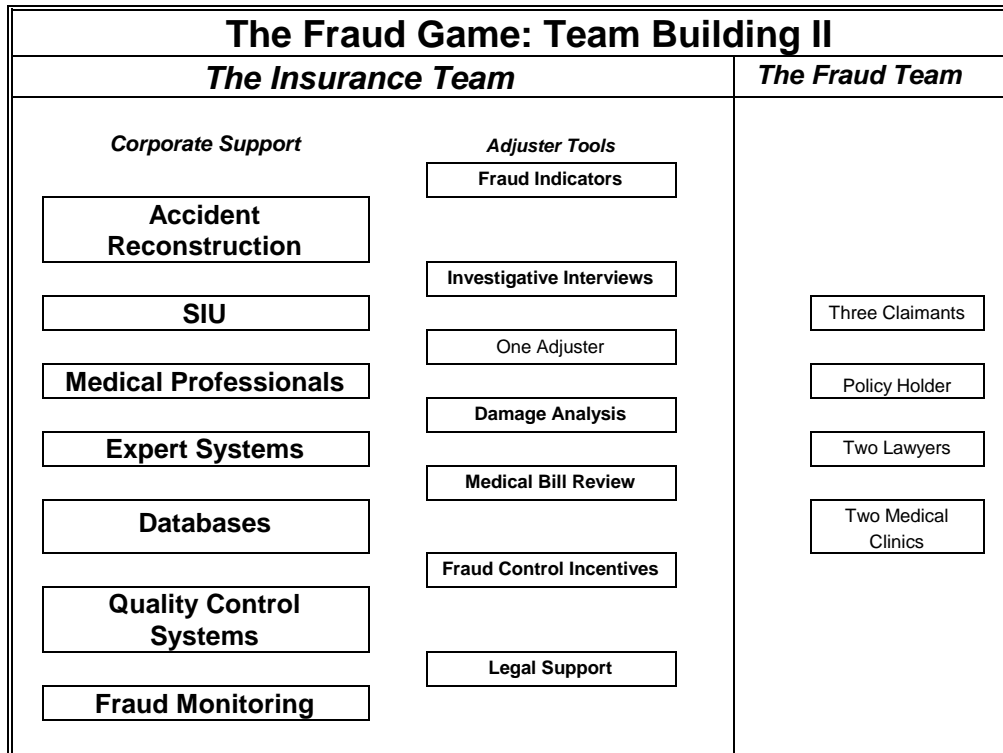
Fortunately, the measurement of fraud does not need to be organizationally or financially burdensome. Our company is currently building a fraud monitoring system for a major carrier. This system will estimate the frequency and severity of fraudulent claims, the success of current procedures in fraud identification, and the outcomes of alternative control methods. This system has been designed to indirectly aid adjusters by channeling resources to the types of fraud that are most prevalent and most costly for the company.

**Summary.** Implementation of these controls would effectively immunize any carrier against payment of claims for staged accidents. Such claims as those fabricated by the Casino Ring would be detected as potentially fraudulent at the time of their submission. Adjusters would have the tools, resources, motivation, and corporate backing to make success-

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<sup>1</sup> Multi-billion dollar fraud problems have actually been solved through use of quality control methods. When Ronald Reagan was elected President, the most pressing item on his domestic agenda was the elimination of "fraud, waste, and abuse." In the next decade, over a quarter of a billion dollars was spent on fraud research in social insurance programs; and the problem was finally solved. In the late 1970s welfare fraud accounted for about 25 cents out of every dollar paid. By last year the error rate average was down to about 6-7 cents on a dollar. Of this amount, only a fraction could be called fraud, the rest constituting a myriad of minor errors. These are not speculative numbers of the type often bandied about in conversations about insurance fraud. The welfare fraud estimates are based on tens of thousands of individual audits conducted by leading accounting firms and designed by leading statisticians. The welfare fraud problem was largely solved by following a path not so very different from the path we are outlining for the insurance industry.

<sup>2</sup> Before developing systematic procedures to measure and monitor social insurance and tax fraud, researchers in the field significantly mis-diagnosed the problem. Stereotypes such as the "black-welfare-Cadillac mother with 10 children" diverted efforts from the real areas of loss. Failing to identify trends early on, we were always in a reactive mode.



ful denials. The corporate SIU, with the support of expert systems, would identify the extent of the scam and begin to put its players out of business.

The advantages, however, go well beyond staged accidents. The same approach works equally well with all types of fraud in all lines. The quality assurance approach to fraud control involves defenses that are constantly tightened and improved. An ongoing fraud monitoring program would proactively identify emergent types of fraud and respond with cost-effective solutions.

### C. Industry Support

Fraud is an insurance industry epidemic, and not simply a disease affecting individual companies. As a result, collective, industrywide, action is necessary to any ultimate cure. There are five areas where collective action is necessary:

**Information Sharing.** Fraud thrives in the dark and dies in the light. Sharing of information across companies, limits the ability of fraud rings to repeat the identical scams on several insurers. Existing information exchanges include: the Index Bureaus for tracking bodily injury claims; databases maintained by the National Auto Theft Bureau (NATB), the Property Insurance Loss Register (PILR) for property and auto loss and theft; and CLUE, an Equifax product, for tracking an individual's claims history. State motor vehicle records are useful for tracing both individuals and autos.

**Industrywide Associations.** The Insurance Crime Prevention Institute (ICPI) is a nonprofit organization that assists member companies in the investigation of all types of insurance fraud. The National Auto Theft Bureau (NATB) provides expert support in areas specifically linked to auto theft. The International Association of Special Investigation Units (IASIU) is a rapidly growing forum for the exchange of information on insurance fraud and control methods, as is the annual fraud seminar sponsored by the American Insurance Services Group (AISG). We would like to see these organizations more closely coordinate their efforts in developing a coherent national agenda on insurance fraud control.

**Public Education.** Mothers Against Drunk Driving (MADD) provides a model of how public interest groups can focus attention on a social problem. The Insurance Information Institute (III) is currently exploring the possibilities for organizing a similar public interest campaign against insurance fraud, under the banner of ultimately lowering consumer costs.

**Fraud Research.** The task of separating legitimate and fraudulent claims would be greatly advanced if the industry would sponsor needed research on fraud-related topics. For example, much of the current accident research is irrelevant to staged accidents because it is limited to real accidents that involve substantial damage and injury. The industry's ability

to detect staged accidents would be promoted by more research on low-speed accidents and their bio-medical impact. More generally, industrywide research on fraud indicators, prevalence, costs, and remedies would provide the basis of long-term control.

**Political Agenda.** The insurance industry's considerable political resources should be mustered to promote laws, regulations, and enforcement mechanisms conducive to fraud control. Several possibilities are outlined in the following section.

## D. Social Support

Insurance fraud is not just an industry issue. In the end consumers bear the primary burden through higher insurance premiums. The law enforcement mechanism of society as a whole should be mobilized against the fraud problem. Such mobilization might include:

**Fraud Statutes.** At last count, 35 states have not enacted comprehensive insurance fraud statutes. Such statutes must be on the books in all states before the problem can be comprehensively addressed.

**Fraud Bureaus.** Three-quarters of all state departments of insurance do not have fraud units. The result is that fraud statute enforcement is at best fragmented and uneven. Until every state has vigorous insurance fraud enforcement

<b>The Fraud Game: Team Building III</b>			
<b><i>The Insurance Team</i></b>			<b><i>The Fraud Team</i></b>
<b><i>Industry &amp; Social Support</i></b>	<b><i>Corporate Support</i></b>	<b><i>Adjuster Tools</i></b>	
<b>Information Exchange</b>	<b>Fraud Monitoring</b>		
<b>Industry Associations</b>		<b>Fraud Indicators</b>	
<b>Public Education</b>	<b>Accident Reconstruction</b>	<b>Investigative Interviews</b>	<b>Three Claimants</b>
<b>Fraud Research</b>	<b>SIU</b>	<b>One Adjuster</b>	<b>Policyholder</b>
<b>Fraud Statutes</b>	<b>Medical Professionals</b>	<b>Damage Analysis</b>	<b>Two Lawyers</b>
<b>Fraud Bureaus</b>	<b>Expert Systems</b>	<b>Medical Bill Review</b>	<b>Two Medical Clinics</b>
<b>Legal Immunities</b>	<b>Databases</b>	<b>Fraud Control Incentives</b>	
<b>Insurance Reform</b>	<b>Quality Control Systems</b>	<b>Legal Support</b>	

capacity, fraud will prosper as a crime for which there is no punishment.

**Legal Immunities.** The exchange of information across companies to control fraud requires associated legal immunities. The fact that 20 states have not enacted the necessary immunity statutes continues to hamper fraud control efforts.

**Insurance Reform.** Incentives for auto fraud are created by the tort system. Eliminate the incentives and you will eliminate the fraud. No-fault insurance and limitations on pain-and-suffering damages would take the profit out of fraud. In the case of the Casino Ring, no-fault payments would have been limited to medical costs and physical damage.

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## Conclusion

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This article presented a program for comprehensive insurance fraud control. If such a program had been in place, the history of the Casino Ring would have been very different. Under a comprehensive fraud control program, the fraud ring would have been very quickly put out of business. Detection would not have hinged upon the honesty and courage of a single individual solicited by the players. Adjusters would have spotted discrepancies in accident reports and physical damage; and the claims would have been denied based on solid evidence of fraud. Information systems would have identified connections among the perpetrators. SIUs and State Fraud Bureaus would have been alerted early in the history of the scam. The ring would not have collected \$50 million in fraudulent claims. In fact, the ring would probably never have even been formed, because a no-fault statute would have taken the profit out of insurance fraud and potential perpetrators would have known that insurance fraud is a fast and sure path to jail.

If claim fraud can be controlled, why hasn't more been done? Three explanations are often forwarded by insurance executives: it would cost too much, aggressive fraud control would hurt customer relations and nothing can be done. All three issues deserve serious consideration.

**Costs.** The P&C industry is not currently in a financial position in which it can shoulder major new costs. However, none of the steps we suggest above involve major costs. The total program for a given carrier could be maintained for only a fraction of one-percent of premium. The resulting reductions in fraud would significantly improve profits.

Over the last decade, our company have participated in cost-benefit studies of over 100 fraud control systems. The large majority of these systems produced savings-to-cost ratios ranging from 2:1 to over 100:1. Obviously, fraud control is an extremely profitable investment.

**Consumer Relations.** Surveys have repeatedly shown that consumers want insurance companies to pursue more vigorous fraud control. To do so can only help public relations.

None of the measures suggested above would have any negative impact on honest claimants. In fact, most measures would be completely invisible to claimants. Enhanced interviewing is the only visible measure suggested here. And it has been designed to be entirely nonconfrontational. It makes no accusations and fraud is never mentioned. The best fraud investigations give no indication of suspicion until a tight case has been well documented.

**Pessimism.** Beyond the issues of cost and consumer relations, there is a much deeper reason claim fraud has not been systematically addressed: the industry's pessimism about the existence of any solutions. Most insurance executives regard fraud, like taxes and death, as unfortunate but inevitable. Even fraud investigators in SIUs seldom see any hope beyond winning small victories in an overwhelming sea of fraud. This pessimism creates a vicious cycle: in the belief that nothing can be done, nothing is done and the problem proliferates, in turn creating greater pessimism.

This article is aimed directly at this sense of resignation on the part of the insurance industry. Fraud is a solvable problem. We have attempted to show how the industry can mobilize its resources to eliminate organized fraud. In a companion article—"Controlling Claims Exaggeration"—we demonstrate how behavioral research provides the key to deterring "soft" fraud such as claim buildup. In "The Quality Control Approach to Fraud", we provide real-world examples of multi-billion-dollar claim fraud problems that have been solved by the application of quality control technology. Finally in "Measuring and Monitoring Fraud", we outline procedures by which both the industry as a whole and individual insurers can diagnose the fraud problem and scientifically monitor progress toward its elimination.



