

Fraud

You may not realize it, but each and every one of us is being ripped off—24 hours a day, 365 days a year.

Insurance industry estimates indicate that 10% or more of property-casualty insurance claims may be fraudulent. And fraud is the second-most-costly white-collar crime in America after tax evasion. These crimes add up to billions of dollars in fraudulent insurance claims every year. Even if you haven't suffered a direct loss, you are still a victim of insurance fraud and vehicle theft. Not only does fraud cause higher insurance premiums for all of us, but it also raises our taxes and inflates prices for consumer goods.

What is Insurance Fraud?

Fraud occurs when someone knowingly lies to obtain a benefit or advantage to which they are not otherwise entitled or someone knowingly denies a benefit that is due and to which someone is entitled. According to the law, the crime of insurance fraud can be prosecuted when:

The suspect had the intent to defraud. Insurance fraud is a "specific" intent crime. This means a prosecutor must prove that the person involved knowingly committed an act to defraud.

An act is completed. Simply making a misrepresentation (written or oral) to an insurer with knowledge that is untrue is sufficient.

The act and intent must come together. One without the other is not a crime.

Actual monetary loss is not necessary as long as the suspect has committed an act and had the intent to commit the crime.

Insurance fraud costs Americans approximately \$308.6 billion annually. Based on estimates by the National Insurance Crime Bureau (NICB), workers' compensation fraud is a \$30 billion problem annually in the United States.

Types of Insurance Fraud

Insurance fraud can be committed in various ways but at the core in every case is a "Material Misrepresentation," that is, a false statement made to gain a benefit under an insurance policy. Fraud can occur in personal and commercial lines but not limited to the following.

Worker's Compensation Fraud:

Applicant Fraud: An employee makes a false statement(s) during the course of a workers' compensation claim in order to get benefits, such as temporary total disability payments and/or medical benefits.

Employer Premium Fraud: An employer makes a false statement(s) in order to reduce workers' compensation premium. Employers who commit premium fraud have an unfair business advantage over their competitors since their reduced premiums allows them to place lower bids on projects than their competitors who are paying higher premiums.

Employer Dissuasion: An employer makes a false statement(s) in order to deny workers' compensation benefits to an employee or prevent an employee from filing a claim.

Claim Denial Fraud by Insurance Company:

An insurance company makes a false statement(s) in order to deny workers' compensation benefits to an employee or prevent an employee from filing a claim.

Medical /Health Care Provider Fraud:

A doctor, chiropractor or other health care professional who bills for service not rendered, "up code" (billing for services that were more expensive than those actual provided), and who participate in an organized ring by paying others to recruit patients. Medical Provider Fraud can occur under workers' compensation, auto insurance or any kind of health insurance policies.

Auto Insurance Fraud:

A person made a false statement(s) to an insurance company to obtain a benefit under an auto policy.

Key Elements to Prove Fraud

Misrepresentation: A false statement, omission, or misleading action was made.

Falsity: The statement was untrue.

Materiality: The false information was significant enough to influence a decision.

Knowledge/Intent: The person making the statement knew it was false or acted with reckless disregard for the truth, intending to deceive.

Intent to Induce Reliance: The speaker intended for the victim to act on the lie.

Justifiable Reliance: The victim reasonably believed the statement and acted upon it.

Resulting Damages: The victim suffered actual financial or other harm because of their reliance.

Penalty

Insurance Fraud is a penalty with a maximum penalty of 5 years in state prison and depending upon the type of fraud, a fine ranging from \$50,000 to 150,000. Actual Restitution will also be pursued and ordered as appropriate.

Key Aspects of Fraud Prosecution

Specialized Units: DAs often have dedicated units with specialized attorneys and investigators.

Scope of Crimes: They tackle deceptive advertising, false claims, mortgage scams, elder financial abuse, benefit fraud, and complex financial schemes.

Investigation & Collaboration: Units work with law enforcement (like DOI, FBI), other DAs, and state/federal agencies on complex cases, utilizing advanced tech for financial crimes.

Prosecution Process:

Evidence: Build cases with evidence, needing proof beyond a reasonable doubt.

Trial: Present evidence, question witnesses (direct/cross-examination), and make closing arguments.

Outcomes: Seek jail time, heavy fines, restitution, and civil penalties.

What is the #1 reason prosecutors choose not to prosecute?

Insufficient Evidence: If the prosecution lacks strong and admissible evidence to prove the defendant's guilt beyond a reasonable doubt, they may choose to dismiss the case. Without enough evidence, the likelihood of securing a conviction in court diminishes.

Limitations: District Attorneys can't handle all disputes; some are civil matters for private attorneys.

A District Attorney's (DA) office prosecutes a vast range of crimes, from misdemeanors to major felonies. A District Attorney (DA) is typically elected by voters serving as the chief prosecutor for that area, though in a few states (like AK, CT, NJ, DE) they are appointed. Normally they run on platforms

of prosecuting personal felonious crimes not insurance fraud. Insurance fraud is not a "sexy crime" and that conviction rate is not likely to win a DA reappointment upon reelection. Due to this a fraud prosecution could be very hard to obtain - especially if the DA declines prosecution. However, this should still be pursued as it could assist in lessening the value of a claim.

Combating insurance Fraud

Combating insurance fraud involves a multi-pronged approach:

Insurers use AI, data analytics, and specialized SIUs (Special Investigative Units).

Prevention through consumer education and vigilance (verify agents, don't sign blank forms, be wary of deals too good to be true).

Technology use (analytics, digital claims), and strong industry/government collaboration (special investigation units, state fraud bureaus, DOI, NICB) for detection and prosecution.

Reporting any suspected fraud to authorities to stop it early and protect everyone's costs.

Benefits of Reducing insurance fraud

The reduction of insurance fraud leads to benefits for consumers, businesses, and the economy.

Benefits to Consumers

- a. Lower Premiums.
- b. Faster Claim Resolution.
- c. Increased Availability of Coverage.

Benefits to Businesses and the Economy

- a. Lower Operating Costs: Businesses that provide insurance benefits to employees (e.g., health or workers' compensation).
- b. Efficient Resource Allocation: Insurers can operate more effectively, investing in better technology and services rather than spending excessive resources on fraud investigation and litigation.
- c. Market Stability: a reduction in fraud contributes to a more resilient and reliable overall economy.

Heffernan Claims Consulting – Combating Insurance Fraud

Our Claims Consultants have decades of experience, and our professionals ensure your claims are handled with precision, insight, and strategic guidance. We offer comprehensive Workers' Compensation, General Liability, Auto, and Property Consulting to guide you through every step of the claims process. From consulting to liaising with carriers, we ensure claims are managed efficiently, reducing costs and risks.

To combat insurance fraud effectively, leveraging the expertise and services described can be instrumental. Here's how Heffernan can utilize its claims expertise to address potential insurance fraud:

1. Customized Claims Management Strategy:

- a. Develop tailored strategies that include fraud detection measures. This can involve setting up specific protocols for identifying and investigating suspicious claims.

2. Carrier Liaison:

- a. Maintain open and direct communication with carriers to ensure that any red flags or suspicious activities are promptly addressed. This collaboration can help in identifying patterns of fraud across different claims.

3. Expert Support for Various Claims:

- a. Provide specialized support for General Liability, Auto, and Property claims to ensure thorough investigation and validation of claims. This includes verifying the legitimacy of claims and ensuring that all necessary documentation is accurate and complete.

4. Advocacy in Complex Claims Situations:

- a. Act as an advocate for clients in complex claims situations, ensuring that all aspects of the claim are scrutinized for potential fraud.

In conclusion, insurance fraud is a pervasive issue that affects us all, whether directly or indirectly. The financial burden of fraudulent claims is not limited to the insurance companies alone; it trickles down to consumers. Fraud manifests in various forms. Each type involves material misrepresentation, where false statements are made to gain undeserved benefits. The legal system does face challenges in prosecuting these crimes. Despite the challenges, combating insurance fraud is crucial. By integrating these strategies into the claims management process, Heffernan can effectively strive to combat insurance fraud while ensuring that legitimate claims are processed efficiently and fairly.

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