Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It

Chapter 10: Insurance Fraud and Other Frauds

Parents embarrass their teenage children in many ways—it's almost part of the job description—but a television commercial produced by the Pennsylvania Insurance Fraud Prevention Authority portrayed a new one. A despondent father is driving his silent, seething teenage daughter to school where she faces humiliation by her classmates. The cause for her distress? Her father has been arrested for insurance fraud. The commercial is part of a vigorous campaign to convince the public and lawmakers that the problem in insurance is not unjustified delay, denial, and defense of claims by insurance companies but unjustified claims for payment by fraudsters.

The insurance industry has developed a vocabulary of types of fraud in insurance claims. Hard fraud involves faking a loss, such as staging an auto accident or setting fire to one's own house in order to collect insurance money. Soft fraud involves fudging an insurance claim by exaggerating injuries or the value of property destroyed or stolen. The colorful lexicon of types of fraud, includes "fibbers" and "padders" who exaggerate claims, the "swoop and squat" (the vehicle you are following is suddenly passed by another vehicle that "swoops" in front of it, causing the vehicle in front of you to stop abruptly, or "squat," so that you can't avoid colliding with it), and the "drive down" (a driver waves on another driver, indicating it's OK to proceed, and then intentionally hits the passing car).

The umbrella group Coalition Against Insurance Fraud (CAIF) defines insurance fraud as "when someone intentionally deceives another about an insurance matter to receive money or other benefits not rightfully theirs."[i] This definition is broad enough to include fraud by insurance companies that delay, deny, defend, but that is not the target of the insurance fraud campaign. At the urging of the insurance lobby, many states have enacted statutes that require companies to report whenever they have "reason to believe" that a "fraudulent insurance act" has been committed. The statutes have been carefully drafted to apply only to false statements made by applicants for insurance or policyholders or victims who present claims to companies, or the doctors who treat them and the lawyers who represent them, however, not to insurance companies that defraud their customers.[ii] It could hardly be otherwise; a prosecutor for the Insurance Fraud Division of the Massachusetts Attorney General's office reportedly said that investigating fraud by companies would present a conflict of interest with the division's primary role in helping the companies pursue fraud by their customers.[iii]

The campaign against insurance fraud is an example of social marketing, the use of the techniques of marketing, advertising, and public relations where what is being sold is an idea or a behavior rather than a product. From campaigns to stop smoking or littering, to promote the use of condoms or seat belts, and to prevent forest fires or AIDS, social marketing campaigns

have become increasingly sophisticated, and the insurance fraud campaign is one of the best. Like others, it employs a multi-pronged strategy, including advertising to shape public sentiment and rewriting laws. Unlike some of the others, the insurance fraud campaign produces direct benefits for its sponsors in the insurance industry; Smokey the Bear has no pecuniary interest in stopping forest fires, and increased use of condoms is aimed at preventing the spread of sexually transmitted diseases and not at increasing the profits of condom manufacturers.

The insurance fraud campaign merges two stories, named by Professor Tom Baker as "the immoral insured" and the "depravity of those who threaten the public interest."[iv] Quoting insurance adjusters, Baker tells the story of the immoral insured: "The normally decent, law-abiding American . . . , if left to his own devices, has a little larceny in his soul . . . And really, people can't see it as anybody's money. The insurance company and the federal government—people like that—they are fair game where the public is concerned." This threatens the public interest, at least as defined by insurance companies, because it takes away money that rightfully belongs to the policyholders and justified claimants. "We have an obligation to the public and to our policy holders to detect fraud and resist fraudulent claims," say adjusters.

The immorality of insureds is alleged to increase in times of stress. Talking about Hurricane Andrew, one adjuster said, "I don't want to sound too cynical, but most people, when they see money laying on the ground, will pick it up."[v] After the attacks on the World Trade Center on September 11, 2001, insurance companies were as concerned about fraud as about paying claims. The trade journal *Claims* reported that "officials are gearing for a possible wave of insurance fraud that will inflate the event's financial cost, according to the Coalition Against Insurance Fraud. 'Disasters inevitably attract scam artists who try to exploit emergency conditions for profit,' said Dennis Jay, the coalition's executive director. 'The only question is how much insurance fraud will occur, and how much it will cost policyholders.'"[vi] And in response to the subprime mortgage crisis of 2008, as if the nation was not facing enough problems, CAIF warned of "a spike in home arsons by desperate homeowners looking for insurance fraud to bail them out of foreclosure."[vii]

The first step in any successful social marketing campaign is to convince the public of the enormity of the problem, and that has been a principal focus of the insurance fraud campaign. The claims are dramatic: If all insurance fraud was conducted by a single corporation, it would rank in the top 25 of the Fortune 500. The total amount lost to fraud every year is $4.8 billion to $6.8 billion in auto insurance and $30 billion overall. Fraud is the second most costly white collar crime, trailing only tax evasion. Eleven to thirty cents or more of every claim dollar is lost to soft fraud ("small time cheating by normally honest people," as CAIF describes it). More than one third of people hurt in auto accidents exaggerate their injuries. Ten percent or more of the insurance industry's claims payments and expenses annually are attributable to fraud. Arson and suspected arson account for nearly 500,000 fires a year, or one of every four fires in the U.S.[viii]

Like the claims for sugarless gum ("four out of five dentists recommend . . .") or headache medicines ("the number one pain reliever"), these claims are promulgated by those with something to sell. The figures are generated by the insurance companies themselves, who have an interest in creating an environment that gives more credibility to companies' aggressive investigation and frequent denial of claims and that makes victims more reluctant to file claims lest they be accused of fraud. Within the companies, the figures come from employees who have an interest in alleging fraud. Adjusters are expected to identify questionable or difficult claims as

fraud and to refer them to the company's Special Investigations Unit. The questionable claim becomes evidence of criminality, particularly as the suspicious claims are reported to the National Insurance Crime Bureau, even if the claim is eventually paid and no evidence of fraud is ever proven. Indeed, the more aggressive the pursuit of fraud, the more likely that it will produce behavior that can be labeled as fraud. An aggressive investigation may frustrate and delay the claimant who needs the money to pay for medical bills or repairs to a house, so she may give up and settle the claim or even walk away from it; that behavior then becomes evidence of the fraud that was initially alleged.

There is no doubt that insurance fraud occurs, that it is wrong, and that it should be prevented, investigated, and punished. But the social marketing of insurance fraud likely has exaggerated the problem and therefore has been used to justify an excessive response. For example, the Insurance Research Council came up with the figures of $4.8 to $6.8 billion in excess payments and fraud in 10% or more of claims. But a more reliable study tells a different story.[ix] The Massachusetts Insurance Fraud Bureau is a quasi-governmental agency with investigative authority that is controlled by the insurance industry and receives referrals of fraud from insurance companies. Over a ten-year period, 17,274 cases of fraud were reported by companies to the Bureau. Then the winnowing began. Only 6,684 referrals were accepted by the bureau, yielding 3,349 cases to be investigated. Of those, only 552 were referred to law enforcement authorities for possible prosecution. Combining completed prosecutions and cases still pending at the conclusion of the study, 368 of the original 17,274 referrals actually involved criminal fraud. Therefore, Richard Derrig, author of the ten-year study and the Bureau's vice president for research, concludes, "It demonstrates that the ratio of suspected fraud (not abuse) by industry personnel and the public to provable fraud is on the order of 25 to 1. Even if the unsupported suspected fraud estimate of 10 percent were accurate, the true level of criminal fraud would be less than one-half of 1 percent."

The extent to which insurance fraud is believed to be a major problem because it has been marketed as a major problem is apparent when insurance fraud is compared to another form of non-violent theft with significant social consequences: shoplifting. The National Association for Shoplifting Prevention, an advocacy group like the CAIF, labels shoplifting "our nation's 'silent crime'. Parents don't want to believe it, schools don't address it, retailers don't want to talk about it, police don't want to respond to it, courts don't want to deal with it and the people who do the shoplifting either rationalize it as 'no big deal' or are too ashamed or too afraid to admit it."[x] That group claims that shoplifting happens 550,000 times each day, resulting in $13 billion worth of goods stolen each year. Like the insurance fraud numbers, these statistics are hard to verify and may be exaggerated. According to the FBI, law enforcement agencies reported 978,978 incidents of shoplifting in 2007, only two days worth of the association's figures; even if the incidence of unreported crime is much higher, it is hard to imagine that it is more than two hundred times higher. Whether shoplifting is more of a social problem than insurance fraud or less, it is a silent crime because it has been less effectively marketed; there are few television commercials about shoplifting, and no legislatively-mandated enforcement mechanisms leading to high-visibility criminal prosecutions as there are with insurance fraud.

Insurance fraud, whatever its scale, is not new, nor is the campaign against it. What may be the first American insurance fraud predated the founding of the nation itself. John Lancey, a

young sea captain, unwisely succumbed to the persuasion of his father-in-law to scuttle an old sailing vessel on its way to the American colonies; when the scheme was revealed by a crew member, Lancey was hanged on June 7, 1754.[xi] Lancey and other ship scuttlers were followed by a colorful succession of "professional litigants, 'fakirs,' false witnesses, shyster lawyers, tricky doctors, ambulance-chasers, and runners."[xii] "Firebug gangs" burned properties for the insurance proceeds, ghoulish schemers produced charred body parts to claim that insured relatives and friends had been killed in fires, and "floppers" looked for cracks in sidewalks on which to conveniently trip.

The targets of insurance fraud organized against the practice from early days. Accident insurers and streetcar companies formed the Alliance Against Accident Fraud in 1905; the Alliance created a rogues gallery of 50,000 alleged swindlers, lobbied Congress, and urged bar associations and medical associations to discipline and prosecute "the ambulance chaser and the shyster lawyer." (Efforts to cleanse the bar of lawyers who, lacking "character," were likely to participate in fraudulent personal injury cases often had an ethnic tinge; while the Philadelphia bar was conducting a study of ambulance chasing, the study's leader, lion of the bar and ethics expert Henry Drinker castigated the "Russian Jew boys" who practiced law "merely following the methods their fathers had been using in selling shoe-strings and other merchandise."[xiii]) When its sponsors concluded that the Alliance was insufficiently effective, the National Bureau of Casualty and Surety Underwriters formed a Claims Bureau that put former FBI agents in secret offices around the country to "checkmate the lone wolves " and "to smoke out the ambulance chasers and fake claim syndicates." In 1971 insurance companies formed what was essentially their own national police force to investigate fraud, the Insurance Crime Prevention Institute.

The modern campaign against insurance fraud took shape in the early 1990s. In 1992 the National Insurance Crime Bureau was formed by the merger of the National Automobile Theft Bureau and the Insurance Crime Prevention Institute. The NICB would grow to include more than a thousand insurance companies, rental car companies, parking services providers, utility companies, and other transportation-related firms. The next year the Coalition Against Insurance Fraud was founded with many of the same players, including the NICB as a charter member and insurance companies, the NAIC, enforcement groups such as the National District Attorneys Association, and, somewhat oddly, consumer organizations including the Consumer Federation of America.

The campaign against insurance fraud was being reorganized at the same time McKinsey & Company was redesigning the claims process at Allstate and other companies. An increased effort to label, identify, and sanction fraud was a significant part of McKinsey's strategy. (Strangely enough, in the early stages of its work for Allstate, in addition to studying closed claim files, it conducted interviews at several other insurance companies to "gain insight" about how they approached potentially fraudulent claims; strangely, because the other companies were of course Allstate's competitors rather than its collaborators.) Its general conclusions were that "Fraud was investigated less frequently than it should have been," "The 'discovery' rate for fraud is very low," and "Proactive fraud detection and handling of suspected claims should reduce fraudulent activity and positively impact claim costs."[xiv] That is, investigating more fraud would lead to paying out less in claims. As a result, McKinsey recommended changes in the processing of auto bodily injury claims and homeowners property damage claims to encourage adjusters to

treat more claims as fraudulent and refer them to the Special Investigations Unit (SIU) for more aggressive handling. For example, the new first step in investigation of a Minor Impact, Soft Tissue auto claim would be to "identify and transfer fraud files to SIU."

Arnold Schlossberg Jr., a retired Army major general and the Defense Department's drug czar, took the helm of the NICB and bemoaned the previous lack of a unified approach to insurance fraud. "What we need now is a team approach involving our industry, law enforcement agencies, and other sectors to begin dealing with this problem in a coordinated and systematic way." The team approach would focus on enforcement and social marketing. As Sean Mooney, senior vice president of the Insurance Information Institute, put it, enforcement can shape public perceptions, "particularly if the arrest is done right—leading the suspect away on the evening news . . . The insurance industry can acquire some of the fearful respect presently enjoyed by the Internal Revenue Service . . . There's no way we want to drag little old ladies in North Dakota off to jail. We just want to put the fear into them that we could."[xv]

That fearful respect was to be gained through a three-part campaign. The first part was largely internal to insurance companies. In a modern version of the Alliance Against Insurance Fraud's rogues gallery, companies would create national databanks of insurance fraud claims in order to compile statistics and to share information on individual claimants. The second part was the public campaign, marketing insurance fraud as a crisis. CAIF was unabashed about the strategy and its role in it. Media reports on insurance fraud doubled in the five years after the Coalition's creation, and "The media didn't make that happen by itself. Sources first had to convince them insurance fraud was a story worth covering, then supply the information for the story." The techniques are sophisticated. "It also helps to increase the comfort level if the press office compiles what Dan Johnston, President, Insurance Fraud Bureau of Massachusetts, refers to as a 'one-stop shopping' packet for the media, which allows for greater control of the story and the message. The goal is create a package so complete that the reporter or producer never has to leave his or her desk."[xvi] The third part was to partner with legislatures and law enforcement agencies to create new laws that could be used to pursue ostensibly fraudulent claims and to aggressively pursue the claimants.

Coordinating enforcement efforts and public relations requires a close working relationship between the enforcers and the marketers. CAIF touts Allstate as a master of the technique. "When the company identifies a case with media potential, they bring in the lawyers as early as possible to work with the special investigation unit and determine how they're going to conduct the investigation. When it gets to a point where everybody is satisfied that the evidence is as good as it's going to get, Ed [Moran, a former prosecutor now working for Allstate] asks the lawyers to analyze the facts, exactly what they have seen and the law itself. He encourages them to take calculated risks, possibly into new legal areas, while also looking for cases that give the most bang for the buck . . . At that point, Allstate's corporate communications people are brought in on the case, get an explanation of the case and asked for advice on getting the best media play." And the bottom line: "Allstate also measures the effects of filing of these actions and has seen claim counts go down."[xvii]

A peculiar instance of the insurance industry's marketing of insurance fraud as a great social problem is its involvement in raising the profile of arson as a matter of public and law enforcement concern. Arson is clearly a serious problem; the FBI Uniform Crime Reports counted

57,224 incidents of arson in 2007, of which 10,995 involved single-family homes and 15,105 involved motor vehicles. How arson became a matter of federal concern and why the FBI collects these figures, however, is part of the insurance fraud story.

In the 1970s the insurance industry began a campaign to raise public consciousness of arson.[xviii] State Farm, the largest property insurer, was a leader in the campaign to make arson a matter of public concern. Insurance critics question State Farm's interest in the subject. As a highly regarded insurer with many top-level customers insuring single-family homes, it may have had less of a problem with arson than other companies; State Farm's benefit from a campaign against arson would be more indirect, in a broader consciousness about insurance fraud and more skepticism of insurance claims. Nevertheless, from 1970 to 1990, it engaged in a two-pronged program, to have its own adjusters focus more on suspicious fires and to increase the awareness of the public and the efforts of law enforcement officials about arson. As a company report proudly noted, "State Farm people helped draw up a blueprint for a coordinated nationwide attack on arson that has produced action on many fronts." Some of the efforts were modest but of great publicity value, such as providing arson-sniffing dogs to local fire investigators. But as part of the industry's broader program, those efforts helped shape the law and perception of arson.

At the time there was no consensus among federal law enforcement officials that arson was a serious national problem, nor that federal prosecution of arson-related crimes was warranted. The FBI did not consider arson to belong in the most serious class of crimes that were included in its Uniform Crime Reports. Even though arson might be a lucrative source of income for some criminals, the Internal Revenue Service did not monitor the situation and the Postal Service, which investigated mail fraud of which insurance fraud through arson could be a part, did not regard it as a crime of great magnitude.

Nevertheless, the industry pressed the issue. Even after congressional hearings on the matter, the FBI refused to categorize arson as a Class I crime, so in 1982 Congress enacted a statute ordering it to do so. Other legislative action followed. At the federal level, the Violent Crime Control and Law Enforcement Act of 1994 made insurance fraud that affects interstate commerce a federal crime. The Bureau of Alcohol, Tobacco and Firearms joined the campaign by creating arson task forces with federal and local officials in twenty-three cities. That move ultimately may have saved the Bureau's existence; when the Reagan administration subsequently attempted to dismantle the Bureau, insurance groups and fire prevention associations testified on its behalf.

The close cooperation between insurance companies and the federal government is illustrated in a 2006 case from Indiana, in which a private investigator from the National Insurance Crime Bureau was as much a member of the investigative and prosecution team as the FBI agents involved.[xix] Joseph Jaskolski, the NICB investigator, was the primary moving force behind the investigation and prosecution, assisted the FBI agent assigned to the case in conducting the investigation, had access to secret grand jury information, accompanied the FBI agent on interviews of witnesses and inspections, assisted in reviewing documents, escorted witnesses at the grand jury proceeding, and worked with the United States Attorney at trial.

The insurance industry's campaign also resulted in anti-fraud legislation in every state.[xx] Although the details vary, most follow some or all elements of CAIF's Model Insurance Fraud Act. All states now make insurance fraud a crime, with two-thirds of the states treating it as a

felony. About the same number require that the state establish some form of insurance fraud bureau, as if Wal-Mart and Macy's had successfully lobbied for legislation requiring the state attorney general to set up a special shoplifting division. In nearly every state these statutes have created a mixed regime of private and public attack on insurance fraud. Three-fourths of the states have a specialized insurance fraud agency within the insurance department or the attorney general's office, and a few rely on less formal relationships between insurance companies and prosecutors, even to the point of having the companies pay private investigators to work with public officials.

Massachusetts is unique in having a statutorily created Insurance Fraud Bureau, a quasi-governmental agency that is controlled by private insurance companies. The Massachusetts IFB is not unique, however, in touting its results in terms of savings for the companies. In a 2006 report, publicly demonstrating the link between the insurance fraud campaign and insurance company profits, it announced "Good News! . . . For the second year, available statistics show a major reduction of total claim dollars and the number of injury claims reported."

Many states, such as New York, require insurance companies to set up full-time Special Investigations Units staffed by investigators with law enforcement or other experience to cooperate with state enforcement agencies, to make sure that all insurance companies participate in the campaign. Companies are also required to report suspected fraud to state law enforcement authorities. Suspected fraud is defined broadly to include any claim in which there is "reason to believe" that a claim may be fraudulent; to make it easier for companies to report, they are given special immunity from criminal prosecution and lawsuits by policyholders who are falsely accused of fraud.[xxi] The breadth of the mandate results in insurance companies reporting many claims as fraudulent that are obviously not fraudulent. In 2008, insurance companies referred 23,054 cases of suspected fraud to the state's Fraud Bureau. During the same year 1,367 cases were deemed worth an investigation and prosecutors obtained convictions in 402 cases, some begun in previous years.[xxii] The winnowing of spurious allegations to real cases of fraud is not cheap; nationwide, each conviction for insurance fraud costs an average of $60,907 for the fraud bureau on top of the ordinary expenses of the criminal process.

The attack on insurance fraud also becomes an attack on lawyers who represent accident victims seeking compensation from insurance companies. Philadelphia District Attorney Lynne Abraham warned victims' attorneys that her office was interested in "deterring attorneys from considering taking any case which has that faint, but unmistakable, odor of fraud, which gets stronger and stronger the closer one digs."[xxiii]

Even more ominous was the Florida prosecution of attorneys Marvin Marks and his son and law partner Gary for representing their clients in settlement negotiations against insurance companies.[xxiv] On March 10, 1989, Florida Insurance Commissioner Tom Gallagher and his agents raided the Marks law firm's North Miami offices, seizing 253 confidential client files. Within the week the Florida Supreme Court suspended the Marks from the practice of law and the state attorney general initiated proceedings for the forfeiture of all of the firm's assets under the Florida Racketeer-Influenced Corrupt Organizations Act. Eventually the attorney general's office and the insurance department indicted the firm, three of its lawyers, and two doctors who had examined clients of the firm. The key allegation of the indictment was that the firm had been a tough bargainer, not revealing all relevant medical information when representing its clients. Under

that theory, failing to report all available medical information was fraudulent under the insurance fraud statute. All available information: Even the failure to reveal the report of one doctor who had found a client's disability to be minor when four other doctors had certified her as 45 percent disabled. But the duty to disclose was a one-way street, because insurance companies could conceal all the information they wanted; in one of the cases for which Marks was charged, the defendant's insurance company withheld a statement that confirmed that its insured was negligent.

Ultimately the Florida Supreme Court upheld the dismissal of the charges against the lawyers, relying on the obligation of a lawyer to represent his client, which requires in negotiation that sometime the attorney not tell all he knows. Thirteen years after the dramatic raid on the Marks law firm offices, the case ended with a final decision of the Florida Supreme Court. But the message had been sent to victims' lawyers: The firm and its lawyers had spent millions of dollars in their defense, and the firm was unable to reopen.

Whatever its effects on the incidence of actual fraud, the social marketing of insurance fraud as a major problem has been very successful. The Insurance Research Council periodically surveys public attitudes towards insurance fraud, and its most recent survey reported that while one in three adults believe it is acceptable to exaggerate an insurance claim in at least some circumstances, the rate has been steadily declining. Perhaps more important, 78 percent stated that they were very or somewhat concerned about insurance fraud, and 92 percent had been persuaded by the industry's campaign that "insurance fraud leads to higher rates for everyone" and that "persons who commit insurance fraud should be prosecuted to the fullest extent of the law."[xxv] In another poll, more than half of the respondents believed it was more likely that an individual would commit insurance fraud than that an insurance company would deny a valid claim, and only one-fourth thought the opposite.[xxvi] But in a perverse twist, the campaign against insurance fraud may breed fraud as it infiltrates the claim process. As risk management consultant Thomas Laffey notes, "The claims-and loss-settlement process has become a battleground for many policyholders. It breeds an environment that, not surprisingly, encourages fraudulent activity. I am convinced that if the insurance industry treats its policyholders in an honorable manner, fraudulent claims activity will be significantly reduced." Forty percent of those surveyed in one study believed that fraudulent acts were in response to not being treated with respect by the industry.[xxvii]

Laffey is correct; the insurance fraud story has become integral to the claims process. Attention to the potential for insurance fraud in the claims process involves three steps. The claims adjuster is on the frontline, using a variety of tools to identify potential fraud. When potential cases are found, the results are sometimes used in the adjusting process and sometimes the cases are referred to the company's Special Investigations Unit for more careful scrutiny. Claims in which litigation is threatened or brought, particularly litigation alleging bad faith denial of the claim, then involve the use of even more sophisticated experts who specializing in proving fraud and refuting claims of bad faith.

The attention to fraud throughout the claim process turns the adjuster's role on its head. In a perversion of the insurance adjuster's proper role as keeper of the promise of indemnity and security made by the company to its policyholder, the adjuster becomes the policyholder's or claimant's adversary, acts more like a cop than a good neighbor, and treats victims as suspects.

An Allstate Best Practices Manual accurately represents the conflict in its statement of basic principles. On the one hand, it directs adjusters, "When in doubt, you should honor a questionable claim rather than refuse payment of a possibly legitimate one . . . Reducing fraud does not eliminate your responsibility for good faith and fair dealing." On the other hand, it also informs them, "To maximize your success in identifying, investigating and handling fraudulent claims, you should incorporate fraud control techniques into your regular claim handling procedures."[xxviii]

The first step for adjusters in detecting fraud, however, is not to treat claimants as if they were guilty of fraud, at least not directly. Presenting an attitude of service, not suspicion, is the best tactic: "Interrogation with a smile."[xxix] Adjusters are trained initially to be empathetic about the claimant's loss, to engage in open ended discussion, and only after a rapport has been established to get into more detailed questioning. Often much of the information that will later be used to justify an allegation of fraud is gleaned from the initial call when the adjuster oozes support while looking for fraud.

Insurance companies and trade groups develop lists of "red flags" that allegedly indicate the potential for fraud. Adjusters are instructed to be alert for the presence of red flags in a claim and to send the claim to the SIU if there are too many red flags. Red flags are often weighted with points, and accumulating a certain number of points requires that the claim be treated as fraud. This is a logical system if the red flags actually are indicators of fraud, but the systems are set up so that many legitimate claims are flagged as well. State Farm, for example, had a system in which indicators had a point value of one to ten. Scoring a five or above was a reason for further inquiry into possible fraud, and scoring ten mandated a full investigation.[xxx] An insured who was unemployed rated a four; an insured who was hard to reach (perhaps because he works long hours) also rated a four. If the car involved in an accident had been involved in a previous collision, the car scored a seven; if it had mechanical problems, four. A rear end accident rated a five; if the victim of an accident was "overly pushy for settlement"—say, by demanding what is owed to him under the insurance policy—the behavior rated a three. Allstate's SIU Segment Training, prepared as part of its Claims Core Process Redesign, used a scale with 100 points requiring referral to the SIU.[xxxi] Consistent with its attack on MIST victims, a minor impact accident immediately scores 20 points. If the claimant had a bodily injury claim requiring more than emergency room treatment in the past three years, 40 points. In a bit of a catch-22, unrelated claimants who have the same doctor and same attorney, 50 points; the same doctor but not the same attorney, 25 points; and the same attorney but not the same doctor, 25 points. The NICB list of red flags includes three or more occupants in the claimant's vehicle, subjective injuries such as headaches and muscle spasms, the claimants' submitting medical bills from the same doctor or medical facility, and an older vehicle.

The red flag systems also have flexibility—a category for "other reasons" with an open point value. If an adjuster is busy and wants to move the case to the SIU, or if the adjuster or office has a goal of the number of claims to be sent to the SIU and is just short, other reasons might appear in the investigation to push the claim over the top.

Professor Aviva Abramovsky explains how these red flags turn everyday events into evidence of criminality and deter accident victims from pursuing the compensation which is owed them.[xxxii] Imagine a family of five involved in an accident in the old, reliable, family car. After the

accident, they all seek treatment from their family doctor and are diagnosed with neck and back injuries. This entirely typical story contains multiple red flags of fraud—multiple occupants, older car, neck and back injuries, same doctor—so an adjuster would be likely to refer it for potential criminal investigation. For this family and all future injury victims, Professor Abramovsky writes, "Awareness of these criteria, or even awareness of frequent insurance fraud prosecutions, forces the family to include the potential for criminal investigation alongside the denial of claim benefits when determining whether to go forward on a contested claim. Under such circumstances, they might well decide not to file a claim at all, thus relieving the insurance company of its promise to pay made in exchange for collected premiums."

The red flag systems are valuable to companies, but the improvement of computer technology and the increasing sophistication of databases has enhanced the ability to label claims as potential frauds.[xxxiii] Rules-based analysis, data mining, and predictive modeling are among the techniques the use of which is spreading. MetLife Auto & Home, for example, decided to increase the number of claims referred for fraud, so it partnered with Computer Sciences Corporation (the producer of Colossus) to create an automated system. Its Fraud Evaluator scores the potential for fraud beginning at the first notice of loss. The company can set parameters for what it considers to be fraud, giving it considerable flexibility in deciding which and how many cases will be referred to the SIU. The program's search engine compares the elements of a claim against external databases, looking for doctors whose treatments are suspect among other things. Then it analyzes all the information to see how closely the elements of a claim match other claims that are believed to be frauds and creates a score, and all scores above a certain point are sent to the SIU. The system produced the desired results, a doubling of claims sent for investigation for fraud.

In 2003 Erie Insurance of Pennsylvania also implemented a data mining and predictive modeling system, even creating graphical representations of the links among data, giving adjusters a picture of potential fraud, and drawing on years of claims data to model potentially fraudulent claims. The results were to increase the number of claims identified by the system as potentially fraudulent and, as the system became more developed, to grow that proportion. Human use of red flags is still used, though, in a mix of computer and human to label the largest number of claims as frauds. Erie's vice president, Dave Rioux, commented that computer systems "will never capture all of the questionable claims because the vast majority can only be captured by real human intelligence and gut feelings that something is not right about the claim."

Many of these systems draw on databases of ISO, formerly the Insurance Services Office. ISO ClaimSearch collects data from many insurance companies and other organizations into a single data base that insurers can use to investigate claims. It contains information on more than 600 million claims, with more than 210,000 new reports submitted daily. When an insurer submits a claim—the system is used by companies with over 90% of the property/casualty business—ClaimSearch reports on other claims filed by the same individuals or businesses, searching for matches by name or similar name, address, Social Security number, vehicle identification number, driver's license number, tax identification number, and other parties to the loss. ISO also has its own claim scoring system, on a thousand-point scale, to model claims of suspected fraud.[xxxiv]

The vast databases and sophisticated systems give the appearance of certainty in the detection of fraud. Despite the appearance of precision, insurance experts admit that they are inexact, and

inexact in favor of the insurance companies. Erie Insurance's Rioux criticizes rule-based systems, less sophisticated than more modern predictive modeling systems, as particularly prone to false positives—cases in which the system found evidence of fraud where there was none. "These claims met all the conditions but clearly were not fraud by any stretch of the imagination," he noted. But even the more sophisticated systems depend on the data they are fed. The databases and modeling rely on historical determinations of fraud, but those determinations are suspect. Few of the alleged frauds actually result in criminal convictions, so the systems depend on the companies' own determinations of what is fraud. The alleged victim of the alleged crime—the insurance company—becomes the prosecutor, judge, and reporter of results, results that essentially require the accused to prove his innocence. The companies define the problem and then measure future cases against their definition. Disputes over the amount of a claim may be referred to the SIU, and then reported to state or federal agencies as evidence of fraud; even if no fraud is ever proven against the claimant the database record remains. Likewise, if claims are referred to SIUs and the hardball tactics there coerce a claimant into giving up, that is evidence of fraud as well. And because of the comprehensiveness of the databases, the doctors and lawyers involved have now been linked to potential frauds, too, and can be flagged by the system in the future.

A bias in favor of finding fraud is in insurance companies' financial interest. They reinforce that interest by giving employees incentives or pressures to find allegations of fraud. From the early stages of Allstate's CCPR and State Farm's ACE, adjusters and claims offices were directed to find fraud and rewarded when they did and punished when they did not. ACE's quality indicators included the percentage of cases referred to the SIU and the percentage pursued by SIU. A State Farm report on the "anti-fraud results" of a California-based SIU noted "the substantial BI [auto bodily injury claims] savings and the 29% closure rate with no payment when we 'play hard ball,'" results that were described as "spectacular."[xxxv] Shannon Brady Kmatz, former Allstate adjuster and later a whistleblower, testified that Allstate's Albuquerque claims office had an SIU referral goal of 6 percent of claims; when it hit that goal—the highest in the Western region—the goal was raised for the next year to 7 percent. There is no reason to suppose, of course, that the incidence of fraud increased by that rate in one year. She stated, "People making claims were to be viewed with suspicion. They were all thought to be potentially someone who would cheat Allstate in some way." Individual employees' Performance Development Summaries—their annual ratings—included specific goals for SIU referrals. Farmers Insurance did the same. Personnel evaluations listed a "critical" "expected result" as "surplus enhancement" by "increase referrals to Investigations by 10%;" the surplus to be enhanced was, of course, the company's profit. Employees who did not measure up were warned. One form includes the ominous statement: "You have submitted 2 investigation referrals in 1998. This is an area you need to improve on."

As with other elements of the claims process redesign, even when the particulars change the principles stay the same. A 2004 survey of participants in an Insurance Fraud Management Conference revealed that 97 percent of company representatives believed it would be useful to benchmark their SIU referral rate with that of the industry as a whole, and 69 percent were willing to share referral rate data with their competitors to set the benchmarks.[xxxvi] Eighty percent of companies calculate savings made through anti-fraud programs, and some of the rest have a

particular reason; as the SIU of a large company wrote in response to a 2003 survey: "We believe that tracking the outcome (of investigations), or dollars denied due to fraud, creates an unacceptable and unnecessary risk of civil litigation . . . In the best-case scenario, this creates the perception that SIU investigators are compensated for denying claims and at worst it creates actual bias by the SIU investigator."[xxxvii] Although it is in the company's interest to increase the "dollars denied due to fraud," it is not in the company's interest to get caught at it.

The result of the campaign against insurance fraud and its integration into claims processing is predictable: Allegations of fraud will be used against policyholders as another means to delay, deny, defend. Cloteal and Alfred Cameron, Dallas homeowners insured by Texas Farmers Insurance Company, found that out.[xxxviii] Neither was home the night their house burned, and it was clear that arson was the cause of the fire. Farmers initially paid them for temporary living expenses but then Tony Poncio, Farmers' branch claims manager, denied the claim, concluding that it was arson committed by them for insurance fraud. There were red flags: The fire was clearly arson, and the Camerons were not home at the time. They had only $3,000 in savings and had some credit card debts, and a fire marshal said Alfred had gambling debts, so they may have had a financial motive for fraud. Several years earlier they had filed a claim for fire loss to rental property they owned and for thefts of their cars. Their Farmers policy had been in effect for only three months before the fire. The house was for sale at the time of the fire, and the amount of the insurance policy was greater than the sale price.

Unfortunately for the Camerons (and ultimately for Farmers), the insurance company reflexively used the red flags as the basis for denying the claim without following the basic rule of claims practices, to investigate fully and fairly. Neither of the Camerons could have set the fire; Alfred was at a casino with a friend at the time and Cloteal stayed at her daughter's apartment to help her pack because she was moving. But Poncio did not interview either the friend or the daughter, because "there was nothing else to look into about it." Their financial condition was not precarious; their annual income was $90,000, they were current on their credit cards, there was no evidence of gambling debts except for the off-hand remark of the fire marshal, the casinos where he played did not even grant credit, and they were financially secure enough to get a mortgage to purchase a new house. There was no evidence that their previous insurance claims involved fraud and Farmers made no effort to even get the claims files to find the facts. They already had a buyer for the house and suffered a financial and personal loss by the fire; unlike the typical arsonist, they had not removed family photographs or other items of sentimental value before the fire. As the Camerons' expert in claims practices testified at the trial, Farmers performed the kind of investigation where the outcome is determined in advance. The jury agreed; in a verdict upheld by the appellate court, it concluded that Farmers had broken its promise to act in good faith and deal fairly with the Camerons and had violated the Texas insurance laws.

John Asmus, a claims adjuster for Shelter Mutual Insurance Company in Missouri, summed up the attitude that insurance fraud is rampant and a basis for denying claims when he told Jonathan Hensley, "You might as well get a lawyer because Shelter was not going to pay the house off."[xxxix] Jonathan and his wife Juanita had purchased a one-story brick home near Steele, Missouri, but a year and a half later separated and ultimately filed for divorce. Jonathan remained in the house and one Sunday afternoon, while Jonathan was out celebrating his birthday with

friends, a fire began on top of the stove that destroyed the kitchen and dining room and spread smoke damage throughout the house. Jonathan stayed that night at his girlfriend's house, and at 5:45 a.m. the next day, the house caught fire again, this time burning nearly all of the house to the ground. Over the next two days the fire department returned three times to put out rekindles of the fire.

Asmus met with Jonathan and gave him an initial check of $2,000 to purchase clothes and other necessary items. Shelter hired Chris Silman to investigate the cause of the fire. Asmus also contacted Cendant Mortgage Corporation, which held the mortgage on the house, to determine the balance owed on the loan, but Shelter never paid off Cendant as the insurance policy indicated it should. When Jonathan asked why, Asmus gave his regrettable reply.

Jonathan did get a lawyer. Jonathan, Juanita, Shelter, and Cendant eventually settled the claim under the homeowners insurance policy for $83,100 under coverage on the dwelling, but the settlement preserved Jonathan's right to sue Shelter for other amounts. He sued on the policy and under Missouri's statute that punished "vexatious refusal to pay" an insurance claim. The jury awarded him $58,170 for the personal property, $15,000 for additional living expense, $4,700 for debris removal, $500 for fire department services, $22,367 for interest, and, under the statute, an additional $15,713 for penalty, and $43,477 for attorney fees.

In upholding the jury's verdict the Court of Appeals pointed to many elements of Shelter's conduct that constituted vexatious refusal to pay. Up to the date of the trial, it refused to pay Cendant even after it acknowledged that it owed Cendant the money. As a result, interest continued to accrue and Cendant threatened Jonathan with foreclosure. When Asmus told Jonathan to get a lawyer, that statement effectively constituted a denial of the claim. By law, when an insurance company denies a claim it has to give reasons, but Asmus gave no explanation for denial of the claim. Most importantly for the allegation of fraud, Shelter's investigation was inadequate. Shelter suspected that Jonathan had set the fire, but it failed to fully investigate the situation and ignored evidence to the contrary. Shelter knew Jonathan had an alibi but never attempted to corroborate it. Shelter relied on reports of a suspicious dark pickup truck driving away from the house the morning of the second fire, but it failed to consider that Jonathan's neighbors shared a driveway and drove a dark red pickup. Silman, Shelter's fire expert, took five debris samples from the house; only one of them tested positive for accelerant, but Silman failed to pin down where that sample came from and actually kept changing his story as to its source, moving from the storage room next to the garage (where Jonathan kept a can of gasoline for his lawn mower), to the area of the front door, to the center of the master bedroom, to the wall between the bedroom and living room. Shelter said Jonathan's bad debts made the claim suspicious, but he had no such debts; in fact, at the time of the fire he made $85,000 a year, had forty to fifty thousand dollars in his 401(k), and owed no debts other than the Cendant mortgage on the house and a loan on his truck. Finally, whatever evidence Shelter had against Jonathan applied equally to Juanita, but it arbitrarily chose to exonerate her and focus on him.

Jonathan Hensley's case is distinctive only because of the frankness of adjuster John Asmus: "You might as well get a lawyer because Shelter was not going to pay the house off." The attitude is shocking but the openness is refreshing. Insurance fraud is a problem, but whether fraud against insurance companies or by insurance companies is the bigger problem is open to question.

[i] William C. Lesch and Bruce Byars, "Consumer Insurance Fraud in the U.S. Property-Casualty Industry," *Journal of Financial Crime* 15, no. 4 (2008): 411, 413.

[ii] N.Y. McKinney's Penal Law § 176.05.

[iii] Brief of Amici Curiae The Massachusetts Academy of Trial Attorneys and The Massachusetts Bar Association, Commonwealth v. Ellis, No. SJC-07846 (Mass. December 2, 1998), 1998 WL 35031552, at 38 & n.5. See Abramovsky

[iv] Tom Baker, "Constructing the Insurance Relationship: Sales Stories, Claims Stories, and Insurance Contract Damages," *Texas Law Review* 72 (1994): 1395, 1411.

[v] Tom Baker and Karen McElrath, "Insurance Claims Discrimination," in *Insurance Redlining*, ed. Gregory D. Squires (Washington: Urban Institute Press, 1997), 141.

[vi] "Insurers Devise Anti-Fraud Plan," *Claims*, November 2001, 14.

[vii] Coalition Against Insurance Fraud, Annual Report 2007.

[viii] Figures are from the Coalition Against Insurance Fraud, Insurance Information Institute, and Insurance Research Council.

[ix] Richard A. Derrig, "Insurance Fraud," *Journal of Risk and Insurance* 69, no. 3 (2002): 271.

[x] <http://www.shopliftingprevention.org/TheIssue.htm > (March 13, 2009).

[xi] For this and subsequent history see Dornstein, *Accidentally on Purpose*.

[xii] Edward A. Purcell Jr., "The Class Action Fairness Act in Perspective: The Old and New in Federal Jurisdictional Reform," *University of Pennsylvania Law Review* 156 (2008): 1823.

[xiii] Jerold S. Auerbach, *Unequal Justice: Lawyers and Social Change in Modern America* (New York: Oxford University Press, 1976), 127.

[xiv] SIU Segment Training, Allstate Insurance Co., July 1995.

[xv] Christopher Dauer, "Team Approach Sought to Stem Fraud," *National Underwriter*, December 14 1992.

[xvi] Coalition Against Insurance Fraud, "Communicating the Anti-Fraud Message," http://www.insurancefraud.org/communicating_fraud.htm.

[xvii] Id.

[xviii] See John Panneton, "Federalizing Fires: The Evolving Federal Response to Arson Related Crimes," *American Criminal Law Review* 23 (1985): 151.

[xix] Daniels v. Liberty Mut. Ins. Co., 2006 WL 3239994 (N.D. Ind. 2006).

[xx] Aviva Abramovsky, "An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards," *Journal of Criminal Law & Criminology* 98, no. 2nd (2008): 363, 2d ed E. Hoyt, David B. Mustard, and Lawrence S. Powell, "The Effectiveness Of State Legislation in Mitigating Moral Hazard: Evidence from Insurance Fraud," *Journal of Law & Economics* 49 (2006): 427.

[xxi] McKinney's Insurance Law §§ 405-409.

[xxii] <http://www.ins.state.ny.us/acrobat/fd07ar2g.pdf>. Figures include all types of insurance fraud, including workers compensation, disability and medical.

[xxiii] Abramovsky, "An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards," 389.

[xxiv] Abramovsky, "An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards," 396.

[xxv] <http://www.ircweb.org/news/200307242.htm> (December 23, 2008)

[xxvi] P. Hans and Nicole Vadino, "Whipped by Whiplash? The Challenges of Jury Communication in Lawsuits Involving Connective Tissue Injury," *Tennessee Law Review* 67 (1999-2000): 569.

[xxvii] Lesch and Byars, "Consumer Insurance Fraud in the U.S. Property-Casualty Industry."

[xxviii] Allstate Best Practices Guide, Identifying & Handling Potentially Fraudulent First Party Casualty Claims (1992, 1994)

[xxix] Richard V. Ericson, Aaron Doyle, and Barry Dean, *Insurance as Governance* (Toronto: University of Toronto Press, 2003), 319.

[xxx] State Farm, The Indicator (Summer 1983).

[xxxi] Allstate Insur. Co., SIU Segment Training, n.d.

[xxxii] Abramovsky, "An Unholy Alliance: Perceptions of Influence in Insurance Fraud Prosecutions and the Need for Real Safeguards," 392.

[xxxiii] Regis Hyle, "Running up the Flag," *Claims*, April 2007, 38 Maria Woehr, "Uncovering Crooked Claims," *Insurance & Technology*, July 1 2006.

[xxxiv] <http://www.iso.com/Products/ISO-ClaimSearch/ISO-ClaimSearch-improve-claims-processing-and-prevent-fraud.html>; Lesch and Byars, "Consumer Insurance Fraud in the U.S. Property-Casualty Industry."

[xxxv] Memorandum, Savings report on Westlake Anti-Fraud Results, January 24, 1984.

[xxxvi] Fraud measurement survey, http://www.insurancefraud.org/fraud_measurement.htm.

[xxxvii] "Study on SIU Performance Measurement," Coalition Against Insurance Fraud, <http://www.insurancefraud.org/downloads/siu_study.pdf>, June 2003.

[xxxviii] Texas Farmers Ins. Co. v. Cameron, 24 S.W.2d 386 (Tex. App. 2000).

[xxxix] Hensley v. Shelter Mut. Ins. Co., 210 S.W.2d 455 (Mo. App. 2007).