

Insurance Fraud

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Most people have probably heard of the term insurance fraud. It has been around ever since there was insurance. By definition, it is the intentional misrepresentation of facts and circumstances to obtain payment that would not otherwise be made. In the past, the presence of insurance fraud has generally been overlooked by the insurance industry. But in the past 10 to 20 years, worldwide interest in insurance fraud has increased greatly due to the continued growth of fraud cases and the rise in premiums it has brought to the industry.

In the property/casualty sector, it was estimated that \$30 billion were lost to insurance fraud in 2004 and 2005. These fraud cases could include staged auto accidents, fictitious injuries, non-work related injuries, misrepresentation of wage loss, etc. For example, Hurricane Katrina of 2005 may have resulted in an increase in insurance fraud. Homeowners made claims for lost items such as stereos or televisions sets they never owned. They also inflated claims for items actually lost. In addition, an increase in home arson coincided with the hurricane season, prompting suspicions that some of the arson may have been committed by flood victims without flood coverage.

While a large portion of insurance frauds are committed in the property/casualty sector of the insurance industry, other sectors are by no means unaffected. The healthcare sector is probably the single biggest victim to insurance fraud in the U.S. According to National Healthcare Anti-fraud Association, healthcare fraud costs Americans an estimate of \$54 billion annually, taking into account the increase in healthcare costs due to fraud. Combine this with other sectors such as commercial

business and life, the total cost of insurance fraud is astronomical. A study in 2001 by Conning and co. estimated that insurance fraud increases the average American household costs by over \$5000 per year when the rise in premiums, goods and services are taken into consideration.

The presence of insurance fraud received little attention until the 1980s. This is for a variety of reasons. First a foremost, many insurers felt that there was a fine line between investigating claims and harassing legitimate claimants. They were afraid that their investigations might lead to losing their business to their competitors. In addition, the need to comply with deadlines for paying claims imposed by many states made it difficult to adequately investigate suspicious claims. Gradually, the continued growth of fraud and the increase in insurance price have forced the insurers to put greater emphasis on fraud investigation as a means of controlling the escalating costs of insurance. Nowadays, most insurance companies have SIU's, or Special Investigation Units that engage in antifraud activities and about 40 states in the U.S. have set up 48 fraud bureaus. The increase in antifraud activity has resulted in an increase of fraud prosecutions. Successful prosecutions not only blocks future fraud by repeat offenders, but also act as a deterrent to others who may be contemplating fraud activities.

While antifraud activities have increased greatly in the past 20 years, there has been no clear evidence suggesting that insurance fraud has decreased. Because of the nature of insurance fraud, it is difficult to investigate and prosecute fraud cases. So just as insurance fraud has existed ever since there was insurance, it will likely remain that way into the foreseeable future. The most important thing is for the insurance industry to

remain committed to antifraud activities and keep the cost increases due to insurance fraud to a minimum.