Division of Investigative & Forensic Services
Best Practices Report 2018

What is Insurance Fraud and How Much Does it Cost?

The National Association of Insurance Commissioners (NAIC) reports that insurance fraud occurs when an insurance company, agent, adjuster or consumer commits a deliberate deception to obtain an illegitimate gain. It can occur during the process of buying, using, selling or underwriting insurance. Insurance fraud may fall into different categories from individuals committing fraud against consumers to individuals committing fraud against insurance companies and often, "rings" of individuals participate in fraud schemes that have become more sophisticated over time.

As far back as 2001, Florida has been combating Personal Injury Protection Fraud specifically in South Florida. A typical scheme benefits a crooked attorney, a runner and a doctor. The runner offers to help the accident victim receive treatment. Once the insurance company releases payment, the victim may be offered little or no money from the payout. Personal injury lawyers who file a fraudulent claim against the victim's insurance provider often obtain a sizable share from the cash payment. In Florida's current property and casualty climate, the misuse of Assignment of Benefits (AOB) is causing many fraud fighters and politicians alike to join to protect Florida homeowners. Simply put, an AOB gives a third-party authority to file a claim, make repair decisions and collect insurance payments without your involvement. AOBs have "become a vehicle for fraud and claim build-up by some vendors, escalating the scope and cost of remediation or repairs beyond actual damage. It is important to understand that complex fraud plots often involve multiple industries rather than solely insurance. An insurance investigation, for instance, might reveal evidence of financial fraud in the banking arena or payroll fraud in small and large businesses and as recently reported in a Tallahassee, Florida case, the alleged murder of a local resident so his wife could receive his life insurance proceeds.

https://www.tallahassee.com/story/news/2018/10/19/mike-williams-murder-denise-williams-brian-winchester-chery-williams-lake-seminole-alligators/1687512002/

Unfortunately, insurance fraud costs grow annually and are paid by insurance consumers in the form of higher insurance premiums. NAIC statistics estimate that insurance fraud cost is approximately $100 billion annually, and it affects every type of coverage, i.e., health, auto, commercial, or property insurance. To put this in perspective, fraud costs every Floridian $100.00 a year for every $1,000.00 of their homeowner's or auto insurance premium, with 10 percent of all property casualty premiums collected to pay for the costs to prevent, detect, investigate, and prosecute fraud (*Insurance Information Institute, September 2017*). Industry statistics show 84 % of insurance companies say fraud cases they investigate involve high profile fraud schemes such as identity theft (49 %), and/or computer, cyber hacking and claims (34 %) (*LexisNexis, June 2016*).

Nationwide, 48 states plus the District of Columbia have laws that identify insurance fraud as a specific crime; with Virginia and Oregon being the only states without an insurance-fraud statute. Currently 43 states and the District of Columbia require insurance companies to report suspected fraud to a state fraud unit or some other law enforcement or regulatory agency (*Coalition Against Insurance Fraud, October 2015*), the majority of which have specific bureaus assigned to dealing with workers' compensation fraud solely or multiple lines of insurance.

2017 Florida Legislature Mandates Report on Insurance Fraud

In 2017, the Florida legislature mandated the Division of Investigative and Forensic Services (DIFS) create and submit a report on or before December 31, 2018, detailing best practices for the detection, investigation, prevention, and reporting of insurance fraud and other fraudulent insurance acts. The report must be updated as necessary but at least every 2 years and must provide:

- Information on the best practices for the establishment of anti-fraud investigative units within insurers;
- Information regarding the appropriate level of staffing and resources for anti-fraud investigative units within insurers;
- Information on appropriate anti-fraud education and training of insurer personnel;
- Information on the best practices and methods for detecting and investigating insurance fraud and other fraudulent insurance acts;
- Information on the best practices for reporting insurance fraud and other fraudulent insurance acts to the Division of Investigative and Forensic Services and to other law enforcement agencies;
- Information detailing statistics and data relating to insurance fraud which insurers should maintain; and

- Other information as determined by the Division of Investigative and Forensic Services.

The Legislative intent was to create a report to identify best practices to detect, investigate and report insurance fraud. Much has been accomplished through the efforts of DIFS and its partners. DIFS held several workgroups inviting insurance industry professionals, state regulators and compliance partners to discuss these issues. The workgroup participants provided ideas and feedback regarding best practices specifically associated with the detection, reporting and investigating insurance fraud and participated in discussions with DIFS regarding anti-fraud unit establishment, training and education.

After meaningful dialog, a solid foundation for best practices has been identified through these workgroups. As with any research, many areas surrounding insurance fraud and the mission of this report are not finalized. While each insurance carrier determines the specific criteria used in their business model, the workgroups agreed on several preventive measures needed to ensure the anti-fraud best practices are being utilized. Members of the workgroup agreed the development of this report is beneficial in the continued effort to address insurance fraud issues within the State of Florida.

Procedure to Identify, Prevent and Detect Insurance Fraud

One of the most important issues facing insurance carriers and investigators is the development and implementation of a fraud control policy developed to serve as a consistent guide toward effective fraud prevention, identification and detection. Staff and investigations can only be expected to comply with procedure if it is clearly set out in a document which details procedures to be followed. Where no such document exists, it is often difficult to prove that external parties have followed specific procedures. Indeed, the lack of clear guidelines is often the first excuse suspected offenders will use when questioned concerning fraudulent acts.

When addressing internal organizational procedures, it is less cumbersome when determining if employees are following protocol. However; companies should consider the following when developing or modifying existing procedures;

- Number of policies in effect
- Number of claims received
- Number of suspected fraudulent claims detected
- Need for staff to efficiently authenticate claims received
- Need for fraud detecting software or simply utilize “red flag” indicators
- Need for two (2) tier reviews for fraud referrals to ensure substance and validity
- Anti-fraud unit at the level staff needed to thoroughly investigate suspected fraudulent claims.
- Anti-fraud unit oversight.

- Guidelines for exchange of information between administration, legal and anti-fraud units.
- Guidelines for anti-fraud units to report claim information and accurately document for future usage.

Using Big Data to Fight Fraud

With the growing complexity of fraud, insurers need to put in place forward-looking fraud detection techniques that efficiently analyze data and help minimize fraud loss. Insurers tend to collect large amounts of structured, semi-structured and unstructured data which are seldom evaluated in fraud investigation operations. Combining analysis of data along with the existing fraud detection techniques enable insurers to enhance productivity of underwriting and claims processes and maintain a competitive advantage. As insurers move to analytics to detect fraud, specific policies should be considered regarding how data is compiled. The use of technological tools with sophisticated computer analytics can make certain that programs are evaluated for accuracy and fairness.

Information on the best practices and methods for detecting and investigating insurance fraud and other fraudulent insurance acts;

- The use of red flag indicators which include, but are not limited to;
    - Excessive prior claims history
    - Financial distress
    - Policy inception
    - Coverage inquiry
    - Insured is overly pushy for a quick settlement
    - Losses include total contents of business/home including items of little or no value
    - Handwritten receipts
    - Property/Vehicle is not available for inspection
    - Vehicle has unusual amount of aftermarket equipment

Best Practices for establishing an Anti-Fraud unit

Like any other staffing question there is no “one size fits all” solution here. When companies set standards based on premium volume or the number of policies in force (PIFs), certainly clear consideration should be given to the housing, scope, exposure and cost of the unit.

Some companies may consider “outsourcing” their Anti-Fraud Units. There are both pros and cons for doing so, but best practices must still be in place by the insurer to make certain

investigations are conducted properly and fairly. It is critical that the coordination of outsourcing resources should never be a direct or indirect excuse for an insurer acting improperly. Written agreements and standards of the insurers expectations for outsourced fraud detection, reviewable by regulators, are advisable and should be audited and verified on a regular basis either annually or at most bi-annually. Another consideration would be to mandate fraud investigators, be physically based in the area of coverage versus simply working remotely from a computer. There are certainly benefits to having anti-fraud units physically housed within an area of high exposure. Although this mandate may be difficult for some insurers, the benefit to the insurer could possibly outweigh the inconvenience.

Things to consider:

- Statistical data, including number of policies, number of claims received, and estimated loss due to perceived fraud and abuse.
- Determine the need for centralized coverage of anti-fraud personnel.
- Status of the claims screening process to determine its effectiveness and identify areas for improvement
- Cost of internal versus external anti-fraud unit (third party)
- Lines communication between Anti-fraud units and internal departments.
- Flexibility to expand and/or reduce unit as needed for efficiency
- Anti-fraud unit oversight

Some companies may choose to mandate a certain number of investigators (direct employees or outsourced) per "x" number of PIF or claims filed. Anti-fraud training should be considered when establishing a well-rounded unit. In addition to anti-fraud unit personnel, training should be afforded to other applicable personnel. This should include claims representatives, underwriters, policy handlers, call center staff, and legal staff. Additional training could be provided by DIFS to address online referral submission. Finally, new employee anti-fraud training with at least 2 hours of fraud training should continue. This process while already in place needs to include a tracking mechanism to ensure compliance.

Routine Education and Training to Stay Ahead of Insurance Fraud

Florida continues to be a leader in insurance fraud education and training of insurance professionals. A great education and information sharing program occurs with frequent regional anti-fraud intelligence meetings. These meetings are coordinated with both law enforcement and non-law enforcement partners. Specifically, the National Insurance Crime Bureau (NICB) and Florida property and casualty taskforce hosts intelligence meetings on a regular basis. This affords a tremendous opportunity for fraud-fighters to come together and share information.

To be successful, it is recommended anti-fraud personnel have a general understanding of:

- All insurance policy contracts within the company
- Rules applied by the court for interpretation of insurance contracts
- Insurers policy applications, method of submission, and types of misrepresentation
- Florida state statute 626.989 and other statutes associated with insurance fraud
- Florida Office of Insurance Regulation standards
- Insurance fraud investigative techniques
- Interview techniques
- Internal early warning systems
- Emergence of new fraud schemes, the detection and components
- Insurance fraud criminal statutes and the elements necessary for prosecution

Florida Department of Financial Services (DFS) Leadership in Standardizing Fraud Reporting Techniques

Florida is in discussions with anti-fraud professionals to consider a standardized national reporting form.

Steps to Reporting Insurance Fraud

Information on the best practices for reporting insurance fraud and other fraudulent insurance acts to the Division of Investigative and Forensic Services and to other law enforcement agencies can be submitted through several avenues. The DIFS fraud hotline is an option for many to report insurance fraud. Contacting the local DIFS field office is also an option for those wanting to report fraud. This method is most preferred by reporters when they are uncertain what is needed to submit a referral or if their complaint includes an insurance fraud violation. The most common way to report acts of insurance fraud is through the DIFS insurance fraud online reporting gateway. This gateway can be utilized by anyone and is often the most convenient way to submit suspected fraud information, as well as attach documents for review.

At any rate, reporters of insurance fraud should consider the following when reporting acts of fraud:

- Understand the DIFS insurance fraud reporting gateway
- Develop complete and comprehensive records that clearly indicate the suspicion of insurance fraud
- Indicate a lie, misrepresentation or omission that is material to the claim is insurance fraud (Letter of Materiality)
- Include a custodian of records affidavit
- Avoid stating the claim was fraudulent unless the fraudulent activity was proven in court or admitted by the insured/claimant

- Be as concise as possible while providing the necessary information
- Do not copy & paste entire report/findings
- Limit acronyms
- Provide the name of subject company/target/clinic
- Provide identifiers for the subject (DOB, SSN, address, etc.)
- Was the claim paid
- Did insured provided statement?
- Was a confession obtained?
- Include EUO's or recorded statements.
- Be specific as to what they contain.
- Provide supporting documents upon request.
- Attend local intelligence and information sharing meetings
- Develop working relationship with local DIFS field office personnel

Statutes and Rules Relating to the Reporting of Suspected Fraud

Section 626.9891, Florida Statutes, authorizes the Department of Financial Services, Division of Investigative and Forensic Services (DIFS) to adopt rules relating to Insurer Special Investigative Units (SIUs) and Anti-Fraud Plans. These rules are set forth in Ch. 69D-2, F.A.C.

Rules 69D-2.003(1) and 2.004(1), F.A.C., specifically require each insurer to file, as applicable, with the Division a detailed description of its Anti-Fraud Plan, which filing must also include an acknowledgment that the insurer shall report all suspected fraudulent insurance acts directly to the Division.

To eliminate the reporting of duplicate suspected fraudulent insurance acts, it shall be the policy of the Division, consistent with the procedures established in Ch. 69D-2, F.A.C., that:

> *(1) An insurer subject to subsection 626.9891(2), F.S., shall file with the Division a completed insurer anti-fraud plan and shall submit the plan electronically via the Division's website at www.myfloridacfo.com. The completed plan shall be submitted on Form DFS-L1-1689, http://www.flrules.org/Gateway/reference.asp?No=Ref-09343, Anti-Fraud Plan (Rev. 03/18), which is hereby incorporated by reference and available on the Division's website. The insurer's filing of the information required on Form DFS-L1-1689 shall constitute an adequately detailed description of its designated anti-fraud unit as required by subsection 626.9891(2), F.S. An insurer that elects to contract with others to investigate and report possible fraudulent insurance acts pursuant to subparagraph 626.9891(2)(a)2., F.S., shall also electronically file a copy of the executed contract with the Division.*
> *(2)(a) Insurers or other entities or persons subject to mandatory reporting requirements of subsection 626.989(6), F.S., shall report suspected fraudulent acts electronically on Form DFS-L1-1691, http://www.flrules.org/Gateway/reference.asp?No=Ref-09344, Suspected Fraud*

Referral Form (Rev. 03/18), on the Division's website at www.myfloridacfo.com or via an electronic reporting interface that is linked to the Division (e.g. the National Insurance Crime Bureau or ISO sites).
Insurers shall electronically provide the following regarding reporting suspected fraudulent activity:
1. An acknowledgment that all reports of suspected insurance fraud shall contain information that clearly defines and supports the allegation of suspicious activity.
2. An acknowledgment that the insurer or anti-fraud investigative unit shall record the date that suspected fraudulent activity is detected, and shall record the date that reports of such suspected insurance fraud are sent directly to the Division.
(b) Insurers shall include the acknowledgements set forth in subparagraphs (2)(a)1. and 2., electronically on Form DFS-L1-1689, the Anti-Fraud Plan.
(3) The filing of the information required herein is not intended to constitute a waiver of an insurer's privilege, trade secret, confidentiality or any proprietary interest in its anti-fraud investigative unit, its anti-fraud investigative unit description, or its anti-fraud investigative unit policies and procedures.

Further, Section 627.736(4)(i), Florida Statutes, provides that "[a]ll claims denied for suspected fraudulent insurance acts shall be reported to the Division of Investigative and Forensic Services.

Section 626.989(4)(c), Florida Statutes, grants civil immunity, in the absence of fraud or bad faith, for providing the aforementioned required reports of suspected fraudulent insurance acts.
(5) Each insurer is required to report data related to fraud for each identified line of business written by the insurer during the prior calendar year. The data shall be reported to the department by March 1, 2019, and annually thereafter, and must include, at a minimum:
(a) The number of policies in effect;
(b) The amount of premiums written for policies;
(c) The number of claims received;
(d) The number of claims referred to the anti-fraud investigative unit;
(e) The number of other insurance fraud matters referred to the anti-fraud investigative unit that were not claim related;
(f) The number of claims investigated or accepted by the anti-fraud investigative unit;
(g) The number of other insurance fraud matters investigated or accepted by the anti-fraud investigative unit that were not claim related;
(h) The number of cases referred to the Division of Investigative and Forensic Services;
(i) The number of cases referred to other law enforcement agencies;
(j) The number of cases referred to other entities; and
(k) The estimated dollar amount or range of damages on cases referred to the Division of Investigative and Forensic Services or other agencies.
(6) In addition to providing information required under subsections (2), (4), and (5), each insurer writing workers' compensation insurance shall also report the following information to the department, on or before March 1, 2019, and annually thereafter:
(a) The estimated dollar amount of losses attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

(b) The estimated dollar amount of recoveries attributable to workers' compensation fraud delineated by the type of fraud, including claimant, employer, provider, agent, or other type.
(c) The number of cases referred to the Division of Investigative and Forensic Services, delineated by the type of fraud, including claimant, employer, provider, agent, or other type.

The Future of the Fight Against Fraud

There is not a more dedicated group of public servants than those who attack insurance fraud at the source, with a mission to reduce costs for all insurance consumers and stop those who take advantage of, often vulnerable, Floridians. As fraud schemes continue to become more sophisticated, fraud fighters must continue to use every available tool to stay ahead, but as with so many initiatives, it takes human ingenuity and increased financial resources to be successful. Insurance fraud investigators are specially trained professionals who can "smell" fraudulent activity and have the drive to stop it. Florida's DIFS is a leader with a force of 141 sworn law enforcement officers whose primary duty is to investigate insurance fraud crimes within the state of Florida. The goal is for DIFS, intelligence and industry personnel to continue working together to identify new and existing trends related to insurance fraud. Organizations such as Florida Insurance Fraud Education Committee (FIFEC), National Association of Insurance Commissioners (NAIC) and the National Coalition on Insurance Fraud are a few resources used to educate and share information on state and national platforms. Current monthly and quarterly meetings held with resources such as the National Insurance Crime Bureau (NICB) and Florida Property & Casualty Taskforce have proven to useful to personnel investigating acts of fraud. The forward thinking developed during these events are critical to the overall success of the investigation of complex cases and organized criminal organizations.

In addition to intelligence sharing, members of these groups understand the benefits of working together on investigative taskforces such as DIFS's Disaster Fraud Action Strike Team (DFAST), Palm Beach County Sober Home Taskforce and the Greater Palm Beach Health Care Taskforce. These taskforces include state and federal officers, insurance industry personnel and local resources. Due to the effort from the taskforce members and others, undercover operations are made possible, additional resources are made available and violators are caught and brought to justice.