Rutgers Law School
Center for Risk and Responsibility

Misinformation About Insurance Fraud

"**Insurance Fraud Costs the U.S. $308.6 Billion Annually**," according to the Coalition Against Insurance Fraud.

That figure is indefensible.

- The methodology used to reach that figure is unsound.
- Fraud by insurance companies is not considered in the calculation.

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Contents

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"**Insurance Fraud Costs the U.S. $308.6 Billion Annually**," according to the Coalition Against Insurance Fraud in a 2022 Report, "The Impact of Insurance Fraud on the U.S. Economy" (the Report).[1]

The Coalition, insurance industry sources, and the news media frequently cite the $308.6 billion figure as an accurate description of the amount of insurance fraud in the United States.

That figure is indefensible.

The Report

In 1995 the Coalition estimated the amount of property/casualty insurance fraud in America at $80 billion. To update that figure, the Coalition commissioned the Colorado State University Global White Collar Crime Task Force (the Task Force) to research the issue and prepare a report. Other insurance industry sources advised the Task Force and reviewed the Report, including the American Property & Casualty Insurance Association, the Insurance Information Institute, the International Association of Special Investigation Units, and the National Insurance Crime Bureau.

The Task Force decided not to conduct any independent quantitative or qualitative research on the amount of insurance fraud.

To broaden the scope of the earlier estimate, fraud in eight lines of insurance business are included in the Task Force's report:

1) Property and Casualty
2) Workers' Compensation
3) Premium Fraud
4) Healthcare
5) Medicare and Medicaid
6) Life Insurance
7) Disability Insurance
8) Auto Theft

The methodology used in the Report is unsound.

The Report's $308.6 billion figure is based on faulty research methodology. The authors of the Report failed to do any original quantitative or qualitative research. Instead, they relied on existing sources. The sources used are limited and the Report's reliance on them is unsound.

The Report's analysis of property/casualty insurance fraud illustrates its unsound and inconsistent methodology.

In the late 1980s, the Insurance Information Institute interviewed insurance company claims adjusters who opined that fraud accounted for about 10% of the property/casualty insurance industry's incurred losses and loss adjustment expenses each year.

The Report deems 10% as a "credible percentage" to still use as the average percentage of fraud in claims, even though the methodology of the III study is not explained.[2] This use is inconsistent with other decisions in the Report, where it refuses to rely on a prior study "without knowing the details of the survey instruments, the research protocols, the sample, etc."[3]

In part, the Report regards this number as credible because it accords with the Task Force's own "independent private consultation research studies" and with other studies that reach conclusions similar to the III's 10% figure.[4] For example, it relies on an undated Federal Bureau of Investigation report on insurance fraud. However, the FBI report is not limited to fraud by policyholders and service providers but also includes types of fraud within the insurance industry, such as embezzlement by insurance agents and unjustified commissions by insurers and reinsurers.[5]

A leading independent researcher has described the 10% figure as "conventional wisdom . . . [that] appears to be more folk wisdom than fact."[6]

Relying on that "credible percentage," the report calculated the total cost of property and casualty fraud by simple arithmetic, multiplying insurance companies' loss costs of $450.8 billion by 10%, to arrive at a figure of $45 billion.[7]

The fraud estimate is based on an unjustified assumption: The incidence of fraud, as a percentage of loss costs, has not changed since the late 1980s.

Not only is the 10% figure unsound, its use in the Report is so simplistic as to render it meaningless. The use of the figure assumes that here have been no changes in society that may have influenced the incidence of fraud in more than a quarter of a century—no changes in technology, social attitudes, preventive mechanisms, or otherwise. The Report notes that in 1995 the internet was in its infancy and states that its development since then "substantially contributes to new forms of global insurance fraud."[8] But it does not address the widespread use of internet sources, fraud algorithms, Big Data, video, and other technological advances that have aided in the prevention and discovery of insurance fraud.

Moreover, the assumption that the incidence of fraud has not changed also leads to a striking conclusion: *The thirty-year campaign against insurance fraud by the Coalition and its partners has not decreased the incidence of insurance fraud.*

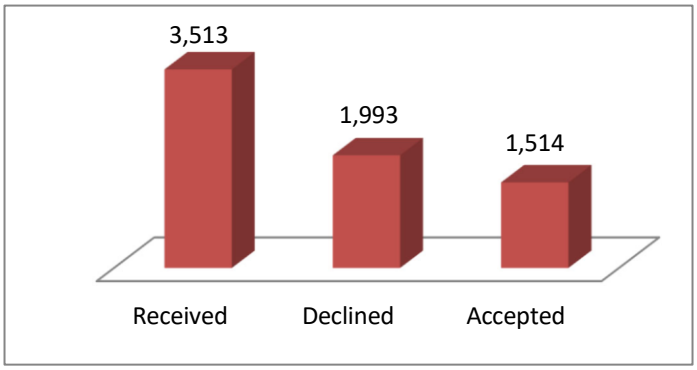
The Report does not consider evidence from state anti-fraud agencies that indicates the amount of fraud likely is far lower than the stated figure.

The Coalition's claim of $45 billion in property/casualty fraud is based on the conclusion from the III's decades-old survey that fraud accounts for about 10% of the property/casualty insurance industry's loss costs. The Report does not consider evidence from state anti-fraud agencies that indicate the percentage likely is far lower than that because "this research was not available consistently for every state."[9] This approach conflicts with other parts of the Report; in estimating workers' compensation fraud, the Report uses a study of California and extrapolates to every other state.[10]

Statutes in many states require insurance companies to report suspected cases of insurance fraud to a state agency or to prosecutors for investigation and potential prosecution. For example, Massachusetts insurers who have "reason to believe that an insurance transaction may be fraudulent" must report the incident to the state's Insurance Fraud Bureau. Although the details of the III survey are not stated, the 10% number in that survey probably results from the same or a similar standard—whether there was "reason to believe" that fraud had occurred.

But the data from the states show that when insurance companies report fraud, only a small number of the referrals merit prosecution or even extensive investigation. Table 1 shows the fraud cases referred to the Massachusetts Insurance Fraud Bureau by insurance companies and those that the Bureau accepted or declined to accept in 2022, the latest data available.[11] *The bureau only "accepted for further investigation" 43% of the cases insurance companies referred.*

Table 1

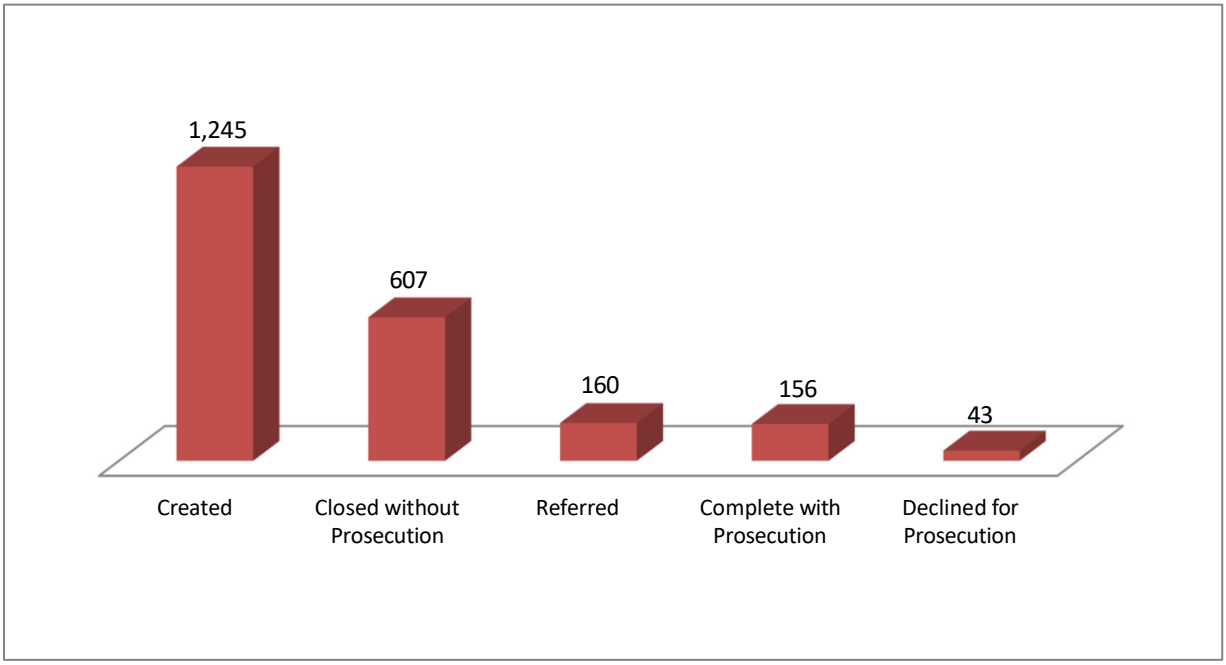


And more: Table 2 shows statistics from 2022 on

- how many cases the Bureau created for investigation
- how many of those cases were closed without being referred to prosecutors
- how many cases were referred to prosecutors
- how many of the referrals were accepted or declined by prosecutors

Only 13% of cases investigated by the bureau were referred to prosecutors.

Table 2



Allegations of fraud by insurance companies may not be accepted by the Bureau or not referred for prosecution for a number of reasons. In some cases there may be fraud but proof is simply not available. But the overall numbers are striking: *Where insurance companies had "reason to believe" that fraud had been committed, the Fraud Bureau pursued less than half of the cases and only about 1 in 20 were referred for prosecution (1,514 of 3,513 and 160 of 3,513, respectively).*

The Report does not consider the best academic research—or any academic research—on the amount of insurance fraud.

The statistics from state agencies cast considerable doubt on the Report's estimate. This doubt is strengthened by academic research on insurance fraud. In a symposium issue on insurance fraud in the *Journal of Risk and Insurance*, Dr. Richard A. Derrig wrote:

> Surveys routinely ask how much fraud is there, and is it getting better or worse, without providing working definitions or requiring any empirical

> backup to the opinions solicited. Even expert opinions solicited in evaluating random samples of claim files can provide suspected fraud and abuse at most as opposed to definitive identification.[12]

(Until his death in 2018, Dr. Derrig was the nation's leading expert on insurance fraud. He served as Senior Vice President of the Automobile Insurers Bureau of Massachusetts and Vice President of Research of the Insurance Fraud Bureau of Massachusetts.)

In a ten-year study of the work of the Massachusetts Insurance Fraud Bureau, Derrig concluded

> 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.[13]

"The true level of criminal fraud would be less than one-half of 1 percent"—far from the Report's figure of 10%.

Another leading researcher, Dr. Sharon Tennyson of Cornell University, came to a similar conclusion:

> Conventional wisdom often estimates the prevalence of insurance claims fraud at about 10 percent of claims or 10 percent of claims costs. *This statistic appears to be more folk wisdom than fact.*[14]

The Report does not mention or rely on this research or any other academic work on insurance fraud.[15]

The Report's analysis of fraud in other lines of business also demonstrates errors.

Similar methodological errors occur in the Report's discussion of other lines of insurance business. As with property/casualty insurance, in each instance the Report errs in favor of larger estimates of fraud. Examples are the sections on fraud in workers compensation, disability insurance, and auto theft.

Workers Compensation

In estimating workers compensation premium fraud, the Report takes research on workers compensation in California and extrapolates to the entire United States.[16] As noted above, in other areas the Report rejects the use of state-by-state data because of variations among the states—variations that are common in workers compensation systems and fraud enforcement.

Disability Insurance

The Report focuses on Social Security Disability Insurance fraud within the general area of disability insurance. The data from the Social Security Administration are detailed and reliable, while other data on disability insurance suffer from a "wide variety of definitions, parameters, costs, and statistics."[17] It adopts the SSA's figure on improper overpayments as the measure of fraud.

This is untenable. The SSA's definition of improper payments includes "a beneficiary's incorrect report." "Incorrect" could include a simple mistake by a beneficiary or family member, which is far from fraud. For example, SSA notes as "incorrect reports" errors such as a beneficiary, parent, or spouse neglecting to report in a timely manner an increase in wages or in-kind support such as food or shelter from relatives.[18]

Auto Theft

Auto theft can constitute insurance fraud when an owner misrepresents their vehicle as stolen and then files an insurance claim for its value. That is not the type of behavior the Report uses to compute its $7.4 billion estimate of insurance fraud, however.

> [The Task Force] fully discloses that the final formula that was used for purposes of this study to derive a new cost of auto theft is not the most ideal to accurately measure this line of business. . . Specifically, the [Task Force] would like to note that the FBI statistic, although they clearly define their data as "auto theft", measures auto theft as a whole and does not necessarily differentiate between auto theft as a crime and auto theft resulting from insurance fraud. . .
>
> Absent provable involvement of the insured in the theft, however, auto theft is not insurance fraud but an insurance crime for which virtually all automobile insurance policies extend coverage.[19]

Using this definition of auto theft to estimate insurance fraud is absurd. A teenager steals a car parked on the street. A thug carjacks a vehicle. The vehicles are never recovered so the owners file insurance claims. Neither of these are insurance fraud but both of them are counted in the Report as insurance fraud.

The Report claims that it includes thefts that are not fraud within its calculation of fraud "to assist [the] efforts of law enforcement and shed additional light on the problem of automobile thefts in our nation."[20] But the stated purpose of the Report is to "provide more substantial support for a new defined cost of insurance fraud,"[21] and the inclusion of unrelated auto theft fails that purpose. Perhaps not coincidentally, this error also increases the overall estimate of insurance fraud.

The Coalition Against Insurance Fraud claims to be concerned about all types of fraud but there is no calculation of fraud by insurance companies in the Report.

The Report claims to provide "an accurate picture of the current cost of fraud in the United States."[22] Yet it does not mention or consider at all the incidence of fraud by insurance companies against their policyholders—for example, by fraudulent denial of valid claims.

The Report completely ignores fraud by insurance companies.

The Report lays out the types of fraud included in its calculations. Its definitions only include potential frauds *against* insurers and almost never includes fraud *by* insurers. The Report's definition of "disability fraud," for example, includes "making a false statement, providing incorrect information, or withholding information to collect benefits." It does not include a pattern of denial of valid claims by an insurance company, as occurred in the Unum Provident scandal discussed below.

In none of these or the other categories does the Report consider that fraudulent claims denials and other insurer-side fraud might exist. The Report makes a minimal reference to fraud by agents, such as selling fake policies or not forwarding premium payments to the company, but such items do not enter into the calculation of fraud. This failure is egregious, considering the Coalition's claim to be concerned with all types of fraud, the findings of insurer-side fraud by courts and regulators, and reports of fraud by whistle-blowers and others.

The Report ignores well-known instances of insurance fraud by insurers.

Examples of insurance fraud by policyholders and service providers routinely are publicized by the Coalition and its insurance partners. The Report and the Coalition's other publicity efforts ignore the many instances of fraud by insurance companies. For example:

- Individual litigation over insurer "bad faith" is common, often including behavior that could be described as fraudulent. One recent example is *Stein v. Farmers Insurance Company of Arizona*.[23] Barbara Stein was injured in an auto accident and filed a claim with Farmers, her insurance company. Farmers failed to fully investigate the claim for nearly two years and never evaluated Stein's claim of traumatic brain injury. A Farmers claims adjuster testified that in settling a claim with a Farmers policyholder such as Stein, he generally starts "at the low end of the range," may not pay out a claim for ten or fifteen years, and may not pay at all until the policyholder is ready to sign a release, even if she suffers severe injuries, believes Farmers' offer is too low, and is under financial pressure. The court upheld a jury award against Farmers for $3.5 million, including punitive damages, because Farmers' "reasons for denying or delaying payment of the claim [were] frivolous or unfounded" and the company did not "attempt[ ] in good faith to effectuate prompt, fair and equitable settlements" of Stein's claims.

- A Washington Post investigation reported that in the wake of Hurricane Ian, some Florida insurance companies aggressively sought to limit payouts to policyholders by altering the work of licensed adjusters. Some policyholders and their families had their Hurricane Ian claims reduced by 45 to 97 percent. The American Policyholder Association, a nonprofit insurance industry watchdog group, claimed to find "compelling evidence of what appears to be multiple instances of systematic criminal fraud perpetrated to cheat policyholders out of fair insurance claims."[24]

- The "Unum Provident Scandal," extending from the mid-1990s into the next decade, included a pattern of denial of valid claims for disability insurance. NBC's *Dateline* and CBS's *Sixty Minutes* featured stories on Unum's practices, and courts excoriated the insurer's practices that "bordered on outright fraud" and involved "unscrupulous tactics." Unum was fined by many state regulators; the California Department of Insurance reported violations of state law in nearly one-third of the cases it sampled.[25]

Conclusion

Insurance fraud happens, it is wrong, and it should be prevented, investigated, and punished.

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—here, the prevention of insurance fraud.[26] The first step in any successful social marketing campaign is to convince the public of the enormity of the problem, and that is one of the purposes of the Report.

But inadequate or biased research leading to indefensible assertions doesn't help. The Coalition Against Insurance Fraud's report on *The Impact of Insurance Fraud on the U.S. Economy* lacks credibility because of its many errors. The Report concludes with a call for more research leading to "a consistent picture of the cost of insurance fraud." The Report itself falls well short of that standard and should not be relied on.

Notes

[1] Available at https://insurancefraud.org/wp-content/uploads/The-Impact-of-Insurance-Fraud-on-the-U.S.-Economy-Report-2022-8.26.2022-1.pdf
[2] Report at 8-9.
[3] Report at 30.
[4] Report at 9.
[5] Insurance Fraud, available at https://www.fbi.gov/stats-services/publications/insurance-fraud (no date). See Kenneth S. Klein, The Case for Pausing an Immediate Embrace of the Social Inflation Argument for Legal System Reforms, *Journal of Insurance Regulation*, 2023-24, Vol. 42, No. 1, 1-30.
[6] Sharon Tennyson, Moral, Social, and Economic Dimensions of Insurance Claims Fraud, *Social Research*, 2008, Vol. 75, No. 4, 1181, 1184.
[7] The Report calculates the amount of fraud by using both loss expenses (the amount paid in claims) and loss adjustment expenses (the administrative cost of paying those claims), although it states several times that it is using only loss adjustment expenses. (Report at 10-11)

This lack of attention to detail occurs throughout the Report. For example, referring to an III study as performed either "in the late 1980s" or "in 1980" (pages 8-9); referring to "life insurance fraud" where it means "Medicare and Medicaid fraud" (page 28); and, in the section on property/casualty insurance, stating that it addresses auto and home theft statistics in a separate section even though that separate section only addresses auto theft (pages 8, 33).

Errors such as these raise questions about the rigor of the process.
[8] Report summary page.
[9] Report at 9-10.
[10] Report at 18-19.
[11] Insurance Fraud Bureau of Massachusetts, Annual Report, 2022, available at https://archives.lib.state.ma.us/items/e177cab8-ede2-49e5-9799-5625d44c1f61/full
[12] Richard A. Derrig, Insurance Fraud, *Journal of Risk and Insurance*, Sep., 2002, Vol. 69, No. 3 Sept. 2002, 271-287, 274.
[13] Derrig at 275.
[14] Tennyson, *supra*. See also Jing Ai et al., A Robust Unsupervised Method for Fraud Rate Estimation, *Journal of Risk and Insurance*, 2013, Vol. 80, No. 1, 121-143.
[15] Other useful works include James Davey, A Smart(er) Approach to Insurance Fraud, *Connecticut Insurance Law Journal*, 2020, Vol. 27, No. 1, 34; Richard A. Derrig, Daniel J. Johnston & Elizabeth A. Sprinkel, Auto Insurance Fraud: Measurements and Efforts to Combat It, *Risk Management and Insurance Review*, 2006, Vol. 9, No. 2, 109-130; Stijn Viaene & Guido Dedene, Insurance Fraud: Issues and Challenges, *The Geneva Papers on Risk and Insurance*, 2024, Vol. 29, No. 2, 313–333.
[16] Report at 18.
[17] Report at 31.
[18] Social Security Administration, Major Causes of SSI Improper Payments, available at https://www.ssa.gov/improperpayments/SSI_majorCauses.html .
[19] Report at 36, 38.

[20] Report at 38.
[21] Report Overview.
[22] Report at 5.
[23] 2023 WL 6970161 (9th Cir. 2023).
[24] Insurers Slashed Hurricane Ian Payouts Far Below Damage Estimates, Documents and Insiders Reveal, Brianna Sacks, *Washington Post*, March 11, 2023.
[25] John H. Langbein, Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials Under ERISA, *Northwestern University Law Review*, 2007, Vol.101, No. 3, 1315, 1317-1321.
[26] Jay M. Feinman, *Delay, Deny, Defend: Why Insurance Companies Don't Pay Claims and What You Can Do About It* Ch. 10, 2010, www.delaydenydefend.com .