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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
34 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0034

Paul R. LePage
GOVERNOR

Eric A. Cioppa
Superintendent

Senator Rodney L. Whittemore
Representative Wesley E. Richardson
Joint Standing Committee on Insurance and Financial Services
100 State House Station
Augusta, ME 04333

June 25, 2012

Re: Report of Fraudulent Insurance Acts for Calendar Year 2011

Dear Senator Whittemore, Representative Richardson, and members of the Committee:

This letter and accompanying information constitutes the Maine Bureau of Insurance's Annual Report on Insurance Fraud to the Joint Standing Committee on Insurance and Financial Services. The data contained in this report is based upon annual survey information which insurers are required to report to the Bureau pursuant to 24-A M.R.S.A. §2186 and Maine Insurance Rule Chapter 920.

The number of suspected fraudulent insurance claims reported in 2011 represents an eleven percent decrease from 2010. The Automobile insurance line of business has consistently had the highest number of reported suspected fraudulent claims. Workers' Compensation and Property insurance both had an increase in the number of reported claims in 2011. Companies reported in excess of eight million dollars not paid out on cases of suspected fraudulent insurance acts in Maine.

The other tables in this report provide aggregate data by line of insurance in which claimants, legal providers, medical providers, or others may have engaged in fraudulent activity; cases in which acts were reported or referred to law enforcement agencies; and the amount of money not paid out on suspected fraudulent acts. The Bureau will continue to collect information on suspected fraudulent insurance acts in an effort to better understand the extent of insurance fraud and abuse in Maine. If you have any questions concerning this report, do not hesitate to contact me.

Respectfully submitted,

Eric Cioppa
Superintendent

cc: Members of Insurance and Financial Services Committee; Anne L. Head, Commissioner; Colleen McCarthy Reid, Legislative Analyst



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Maine Fraud and Abuse 2011 Annual Report

The total number of suspected fraudulent claims decreased from 1,693 in 2010 to 1,503 in 2011. This decrease was primarily due to a lower number of reported claims for Automobile insurance, Health insurance, and Other Lines. The Other Lines category is used for such lines of insurance as disability, mortgage guaranty, and fidelity. There was an increase in the reported number of Workers' Compensation and Property insurance claims. Table 1 shows the number of suspected fraudulent claims reported by line of insurance for the most recent five-year period.

For all tables in this report, the number of claims may not equal the number of cases of fraudulent activity, as one case may involve more than one fraudulent claim. For example, an insurer may have reported that one medical provider submitted several claims which were fraudulent.

Table 1: Number of Suspected Fraudulent Claims Reported by Line of Insurance					
	2011	2010	2009	2008	2007
Automobile	468	505	708	674	973
Property	360	255	485	303	280
Workers' Compensation	303	263	211	276	350
Health	251	361	141	195	260
General Liability	56	56	54	66	109
Life	13	25	27	27	24
Inland Marine	7	6	8	8	7
Other Lines	45	222	106	78	90
Total	1,503	1,693	1,740	1,627	2,093

Table 2 shows the number of suspected fraudulent claims by type of insurance. Personal Lines includes personal auto or homeowners insurance, while Commercial Lines include commercial general liability, workers' compensation, and mortgage insurance.

Table 2: Number of Suspected Fraudulent Claims Reported by Type of Insurance					
	2011	2010	2009	2008	2007
Personal Lines	800	900	819	939	1,196
Commercial Lines	684	773	501	656	764

The following tables, Table 3 through Table 6, display the types of suspected fraudulent insurance acts, broken down by who committed the fraud (i.e., claimant, legal provider, medical provider, or other).

Table 3 shows the number of reported cases in which a claimant may have committed a fraudulent insurance act. In 2011, the number of reported cases was higher than in 2010 in all but two categories. The reported data reflects an increase of over 40 percent in the number of Faked Property Damage claims. The Other category was used for cases involving a variety of acts such as suspected backdating of policies, suspicious fires, and theft.

Table 3: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which the Claimant May Have:					
	2011	2010	2009	2008	2007
Faked/Exaggerated Injury	444	401	355	521	423
Faked Property Damage	322	228	286	212	315
Inflated Financial Loss	86	67	112	127	151
Staged Accident/Injury	66	55	55	130	45
Been Known to File Suspect Claims—Including Faking, Exaggerating, or Extending Total or Partial Disability	24	32	102	237	190
Other	130	237	266	232	234

In 2011, for the second consecutive year, there were no reported cases of suspected fraudulent insurance acts committed by legal providers. The number of reported cases involving legal providers has been minimal throughout the five-year period.

Table 4: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which the Legal Provider May Have:					
	2011	2010	2009	2008	2007
Hired or Paid Cappers/Chasers to Recruit Clients	0	0	0	3	0
Charged Fees Inconsistent with Services Provided	0	0	1	0	0
Other	0	0	0	0	1

In 2011, there was a significant increase in the number of reported cases of suspicious medical billing and services conducted by medical providers. Insurers reported increases in suspected cases of Billing for Services Not Provided, Upcoding or Billing for Excessive Treatments, Unbundling Services, and Other. The Other category was used for such instances as misrepresentation of diagnosis as well as billing issues such as billing with an incorrect modifier, billing of excessive services, or billing for services outside of normal business hours.

	2011	2010	2009	2008	2007
Billed for Services Not Provided	19	9	6	6	2
Upcoded or Billed for Excessive Treatments	17	5	6	8	5
Unbundled Services	16	0	7	1	0
Provided an Inaccurate/Incomplete History	0	0	6	20	1
Fabricated Services	2	0	5	3	0
Operated Without a License	0	0	5	1	1
Received Compensation for Referral to Medical or Legal Providers	0	0	0	0	0
Hired or Paid Cappers/Chasers to Recruit Clients	0	0	0	0	0
Other	25	3	6	6	7

Table 6 shows the number of reported cases in which a person or entity (other than a claimant, medical provider, or legal provider) may have been involved in different types of suspected fraudulent insurance acts. In 2011, there was a significant decrease in the number of reported cases in the Other category. The reduction is due to one large company breaking out, for the first time in 2011, its data into specific categories in Tables 3 through 6. In previous years, the carrier combined all data into the Other category in Table 6.

	2011	2010	2009	2008	2007
Provided an Inaccurate/Incomplete History, or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance Premium	25	47	25	15	236
Charged Inconsistent with Services Provided	1	2	1	2	1
Fabricated Services	1	2	0	2	0
Received/Paid Compensation for Referral	0	0	1	0	0
Other	5	184	367	14	9

Note: The large reduction from 2007 to 2008 in the Provided an Inaccurate/Incomplete History, or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance

Premium category is primarily due to an auto insurer underwriting significantly fewer high hazard policies.

The number of cases of suspected fraudulent insurance acts reported or referred to law enforcement or other agencies increased by over 16 percent from 2010 to 2011. This is attributed to increases in the number of cases reported to the National Insurance Crime Bureau; to Other Law Enforcement--including local law enforcement, Sheriff's Office, State Police, and the Fire Marshal's Office; and to the U.S. Attorney's Office.

	2011	2010	2009	2008	2007
National Insurance Crime Bureau	170	161	226	254	209
Other Law Enforcement	58	24	78	34	44
Workers' Compensation Board Fraud & Abuse Unit	15	15	11	23	36
County Attorney's Office	11	19	5	4	7
Other, Including U.S. Postal Authorities	11	11	10	10	3
U.S. Attorney's Office	8	4	2	15	1
Totals	273	234	332	340	300

Note: These totals do not match the total number of reported fraudulent insurance acts because not every act is referred to a law enforcement agency.

Table 8 shows the amount of money that was not paid on cases of suspected fraudulent insurance acts. This represents money that may have been paid had the suspected fraud not been detected. The amount of money not paid on suspected insurance fraudulent acts increased by nearly three percent from 2010 to 2011. Three companies reported \$500,000 or more in amounts not paid on cases of suspected fraudulent insurance acts, and those companies combined for more than 52 percent of the total.

2011	2010	2009	2008	2007
\$8,022,902	\$7,800,461	\$6,352,899	\$9,731,510	\$7,956,277

Notes: 1. Two insurance groups reported suspected cases of fraudulent insurance activity, but do not track and report the amount of money not paid on those cases. The Bureau is continuing to work with companies to promote uniform reporting of the data. 2. Amounts for 2010 were reduced for one insurer because it was determined that the suspected fraudulent activity affected a third party and not the insurer.