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STATE OF MAINE
DEPARTMENT OF PROFESSIONAL
AND FINANCIAL REGULATION
BUREAU OF INSURANCE
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AUGUSTA, MAINE
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GOVERNOR

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Superintendent

June 3, 2013

Senator Geoffrey M. Gratwick
Representative Sharon Anglin Treat
Joint Standing Committee on Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Re: Report of Fraudulent Insurance Acts for Calendar Year 2012

Dear Senator Gratwick, Representative Treat, and members of the Committee:

This letter and accompanying information constitutes the Maine Bureau of Insurance 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 2012 represents a 15% percent decrease from 2011. Although the automobile line of business has consistently had the highest number of reported suspected claims, the workers' compensation line had more suspected claims in 2012. The reported amount of money *not* paid out on cases of suspected fraudulent insurance acts in Maine decreased to $7.3 million in 2012 from just over $8 million in 2011.

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 questions concerning this report, do not hesitate to contact me.

Respectfully submitted,

Eric Cioppa
Superintendent

cc: Colleen McCarthy Reid, Legislative Analyst; Anne L. Head, Commissioner

Maine Fraud and Abuse 2012 Annual Report

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.

The total number of suspected fraudulent claims decreased from 1,503 in 2011 to 1,282 in 2012. This decrease was primarily due to a lower number of reported claims for Automobile insurance and Property insurance. The Workers' Compensation, Inland Marine and General Liability insurance categories all reflect an increase in the reported number of claims. Table 1 shows the number of suspected fraudulent claims reported by line of insurance for the most recent six-year period.

Table 1: Number of Suspected Fraudulent Claims Reported by Line of Insurance

	2012	2011	2010	2009	2008	2007
Automobile	333	468	505	708	674	973
Property	228	360	255	485	303	280
Workers' Compensation	366	303	263	211	276	350
Health	229	251	361	141	195	260
General Liability	67	56	56	54	66	109
Life	9	13	25	27	27	24
Inland Marine	25	7	6	8	8	7
Other Lines	25	45	222	106	78	90
Total	**1,282**	**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

	2012	2011	2010	2009	2008	2007
Personal Lines	540	800	900	819	939	1,196
Commercial Lines	743	684	773	501	656	764

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

Table 3 illustrates the number of reported cases in which a claimant may have committed a fraudulent insurance act. In 2012, the number of reported cases was lower than in 2011 in all but three categories. The reported data reflects a decrease of 28 percent in the number of Faked Property Damage claims and 17 percent in Faked/Exaggerated Injury. The 'Other' category was used for cases involving a variety of acts such as suspicious fires, false or exaggerated reports and theft.

Table 3: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which the Claimant May Have:

	2012	2011	2010	2009	2008	2007
Faked/Exaggerated Injury	367	444	401	355	521	423
Faked Property Damage	231	322	228	286	212	315
Inflated Financial Loss	142	86	67	112	127	151
Staged Accident/Injury	82	66	55	55	130	45
Been Known to File Suspect Claims—Including Faking, Exaggerating, or Extending Total or Partial Disability	69	24	32	102	237	190
Other	126	130	237	266	232	234

Table 4 shows there were no reported cases of suspected fraudulent insurance acts committed by legal providers in 2012. This total has not changed since 2010. The number of reported cases involving legal providers has been minimal throughout the tabulated period.

Table 4: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which the Legal Provider May Have:

	2012	2011	2010	2009	2008	2007
Hired or Paid Cappers/Chasers to Recruit Clients	0	0	0	0	3	0
Charged Fees Inconsistent with Services Provided	0	0	0	1	0	0
Other	0	0	0	0	0	1

There was a significant increase in the number of reported cases of suspected fraudulent insurance acts in which a medical provider may have Upcoded or Billed for Excessive Treatments and Providing an Inaccurate/Incomplete History. Insurers also reported increases in suspected cases of Billing for Services Not Provided and Fabricated Services (See Table 5). The 'Other' category was used for such instances as anonymous unsubstantiated referrals, billing issues for uncovered services, cosmetic, unproven or unsafe, billing with an incorrect modifier. The 'Other' category showed a significant decrease in reported cases from 2011.

Table 5: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which the Medical Provider May Have:

	2012	2011	2010	2009	2008	2007
Billed for Services Not Provided	22	19	9	6	6	2
Upcoded or Billed for Excessive Treatments	31	17	5	6	8	5
Unbundled Services	6	16	0	7	1	0
Provided an Inaccurate/Incomplete History	6	0	0	6	20	1
Fabricated Services	6	2	0	5	3	0
Operated Without a License	0	0	0	5	1	1
Received Compensation for Referral to Medical or Legal Providers	0	0	0	0	0	0
Hired or Paid Cappers/Chasers to Recruit Clients	0	0	0	0	0	0
Other	8	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. The reported claims have remained the same or have decreased slightly when compared to those of 2011.

Table 6: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which an Other Person or Entity May Have:

	2012	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	19	25	47	25	15	236
Charged Inconsistent with Services Provided	0	1	2	1	2	1
Fabricated Services	1	1	2	0	2	0
Received/Paid Compensation for Referral	0	0	0	1	0	0
Other	5	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. 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.

The total number of cases of suspected fraudulent insurance acts reported or referred to law enforcement or other agencies decreased by 12 percent from 2011 to 2012. This is attributed to decreases in the number of cases reported to the National Insurance Crime Bureau; the District Attorney's Offices, the Workers' Compensation Board's Fraud & Abuse Unit and to the U.S. Attorney's Office.

Table 7: Number of Cases of Suspected Fraudulent Insurance Acts Reported/Referred to Law Enforcement and Other Agencies

	2012	2011	2010	2009	2008	2007
National Insurance Crime Bureau	143	170	161	226	254	209
Other Law Enforcement	68	58	24	78	34	44
Workers' Compensation Board Fraud & Abuse Unit	11	15	15	11	23	36
District Attorney's Offices	1	11	19	5	4	7
Other, Including U.S. Postal Authorities	26	11	11	10	10	3
U.S. Attorney's Office	2	8	4	2	15	1
Totals	**241**	**273**	**234**	**332**	**340**	**300**

Note: These totals do not match the total number of reported fraudulent insurance claims because not every claim 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 decreased by nearly nine percent from 2011 to 2012.

Table 8: Amount of Money NOT Paid on Cases of Suspected Fraudulent Insurance Acts

2012	2011	2010	2009	2008	2007
$7,304,489.61	$8,022,902	$7,800,461	$6,352,899	$9,731,510	$7,956,277