Annual Report of Insurance Fraud and Abuse for 2014

Prepared by the Maine Bureau of Insurance
June 2015

Paul R. LePage
Governor

Anne L. Head
Commissioner

Eric A. Cioppa
Superintendent

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

RECEIVED JUN 18 2015

Paul R. LePage
GOVERNOR

Eric A. Cioppa
Superintendent

June 17, 2015

Senator Rodney L. Whittemore, Chair
Representative Henry E. M. Beck, Chair
Joint Standing Committee on Insurance and Financial Services
100 State House Station
Augusta, ME 04333

Re: Report of Fraudulent Insurance Acts for Calendar Year 2014

Dear Senator Whittemore, Representative Beck, 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 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

Table of Contents

Annual Report of Insurance Fraud and Abuse for 2014

With regard to tables in this report, the number of claims may not equal the number of cases of fraudulent activity, because one case may involve more than one fraudulent claim.

Table 1 shows the number of suspected fraudulent claims reported by line of insurance for the most recent five-year period. The total number of suspected fraudulent claims increased from 1,440 in 2013 to 1,826 in 2014. This increase was due primarily to an increase in Health claims which were 82% higher than in 2013. The Property, Life, Inland Marine and Other Lines categories all reflect a decrease in the reported number of claims. The Other Lines category includes *Disability* and *Professional Liability* claims.

Number of Suspected Fraudulent Claims Reported by Line and Type of Insurance

Table 1 shows the number of suspected fraudulent claims reported by line of insurance for the most recent five-year period.

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

	2014	2013	2012	2011	2010
Automobile	350	326	333	468	505
Property	185	216	228	360	255
Workers' Compensation	297	271	366	303	263
Health	881	484	229	251	361
General Liability	68	65	67	56	56
Life	6	18	9	13	25
Inland Marine	1	6	25	7	6
Other Lines	38	54	25	45	222
Total	**1,826**	**1,440**	**1,282**	**1,503**	**1,693**

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

Table 2: Number of Suspected Fraudulent Claims Reported by Type of Insurance

	2014	2013	2012	2011	2010
Personal Lines	776	550	540	800	900
Commercial Lines	1,036	894	743	684	773

Number of Suspected Fraudulent Insurance Acts by Type of Act

Tables 3 through 6 display the types of suspected fraudulent insurance acts, broken down by specific types of fraudulent acts.

Table 3 illustrates the number of reported cases in which a claimant may have committed a fraudulent insurance act. In 2014, the number of reported cases was lower than in 2013 for three of the six categories. The reported data reflects an increase of 17 percent in the number of *Faked/Exaggerated Injury* claims and an 8 percent increase in the *Staged Accident/Injury* category. The *Other* category was used for cases involving a variety of acts such as *Counterfeit Fraud, Vandalism, Misrepresented Circumstances* and *Theft*.

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

	2014	2013	2012	2011	2010
Faked/Exaggerated Injury	457	392	367	444	401
Faked Property Damage	191	196	231	322	228
Inflated Financial Loss	84	92	142	86	67
Staged Accident/Injury	70	65	82	66	55
Been Known to File Suspect Claims—Including Faking, Exaggerating, or Extending Total or Partial Disability	38	20	69	24	32
Other	103	140	126	130	237

Table 4 shows there were no reported cases of suspected fraudulent insurance acts committed by legal providers in 2014. This total has not changed since 2010.

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

	2014	2013	2012	2011	2010
Hired or Paid Cappers/Chasers to Recruit Clients	0	0	0	0	0
Charged Fees Inconsistent with Services Provided	0	0	0	0	0
Other	0	0	0	0	0

Table 5 shows the number of cases in which a medical provider submitted suspected fraudulent claims. For 2014 there was an overall increase in the number of reported suspected fraudulent insurance acts by medical providers. In the categories *Received Compensation for Referral to Medical or Legal Providers, Operated Without a License, Provided an Inaccurate/Incomplete History, Billed for Services Not Provided* and *Other*, the 2014 data reflects a significant increase over 2013 results. The *Other* line included *Performing Unnecessary Procedures, Failure to Provide Medically Necessary Services, Failure to Submit Documentation to Support Billed Services* and *Improper Coding*. Three categories – *Upcoded or Billed for Excessive Treatments, Unbundled Services and Fabricated Services* – reflected slight decreases from 2013. There was no change reported in the *Hired or Paid Cappers/Chasers to Recruit Clients* category in the last five years.

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

	2014	2013	2012	2011	2010
Billed for Services Not Provided	29	22	22	19	9
Upcoded or Billed for Excessive Treatments	5	16	31	17	5
Unbundled Services	1	5	6	16	0
Provided an Inaccurate/Incomplete History	2	0	6	0	0
Fabricated Services	0	2	6	2	0
Operated Without a License	5	0	0	0	0
Received Compensation for Referral to Medical or Legal Providers	14	0	0	0	0
Hired or Paid Cappers/Chasers to Recruit Clients	0	0	0	0	0
Other	254	12	8	25	3

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 2014 the reported claims rose in the category *Provided an Inaccurate/Incomplete History or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance Premium* as well as among cases in the *Other* line. Two categories decreased: *Charged Inconsistent with Services Provided* and *Fabricated Services.*

Table 6: Number of Cases of Suspected Fraudulent Insurance Acts Reported in Which an Other Person or Entity May Have:					
	2014	2013	2012	2011	2010
Provided an Inaccurate/Incomplete History, or Submitted False or Inaccurate Information to Obtain an Insurance Policy or to Reduce an Insurance Premium	48	41	19	25	47
Charged Inconsistent with Services Provided	1	2	0	1	2
Fabricated Services	0	4	1	1	2
Received/Paid Compensation for Referral	0	0	0	0	0
Other	13	6	5	5	184

Number of Suspected Fraudulent Cases Reported/Referred to Law Enforcement & Others

Table 7 shows the total number of cases of suspected fraudulent insurance acts reported or referred to law enforcement or other agencies, which decreased by 13 percent from 2013 to 2014. This is attributed to decreases in the number of cases reported to the National Insurance Crime Bureau, the Workers' Compensation Board Fraud & Abuse Unit, the District Attorney's Offices and to Other entities, including U.S. Postal Authorities.

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

	2014	2013	2012	2011	2010
National Insurance Crime Bureau	149	156	143	170	161
Other Law Enforcement	24	17	68	58	24
Workers' Compensation Board Fraud & Abuse Unit	5	25	11	15	15
District Attorney's Offices	22	25	1	11	19
Other, Including U.S. Postal Authorities	16	28	26	11	11
U.S. Attorney's Office	2	0	2	8	4
Totals	**218**	**251**	**241**	**273**	**234**

Note: Not all cases of suspected insurance fraud are referred to a law enforcement agency.

Amount of Money NOT Paid On Cases of Suspected Fraudulent Insurance Acts

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 $2.4 million from 2013 to 2014.

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

2014	2013	2012	2011	2010
$6,201,110.12	$8,563,087.77	$7,304,489.61	$8,022,902	$7,800,461