

# Fraud Management in Workers Compensation

Anne Engleman Workers Compensation Management Consultant  
Engleman Etcetera Pty. Ltd.

**T**ry this quick quiz:

The extent of Fraud in workers compensation is:

- a) Rampant
- b) Not really as big an issue as everyone thinks

Answer: Who knows?

This is one of the key issues in the area of fraud management in workers compensation in Australia: there is no consensus on the extent and impact of fraud in the workers compensation industry. There are numerous industry estimates but the bottom line is that it *appears* to be a drain on the system. But how much of a drain?

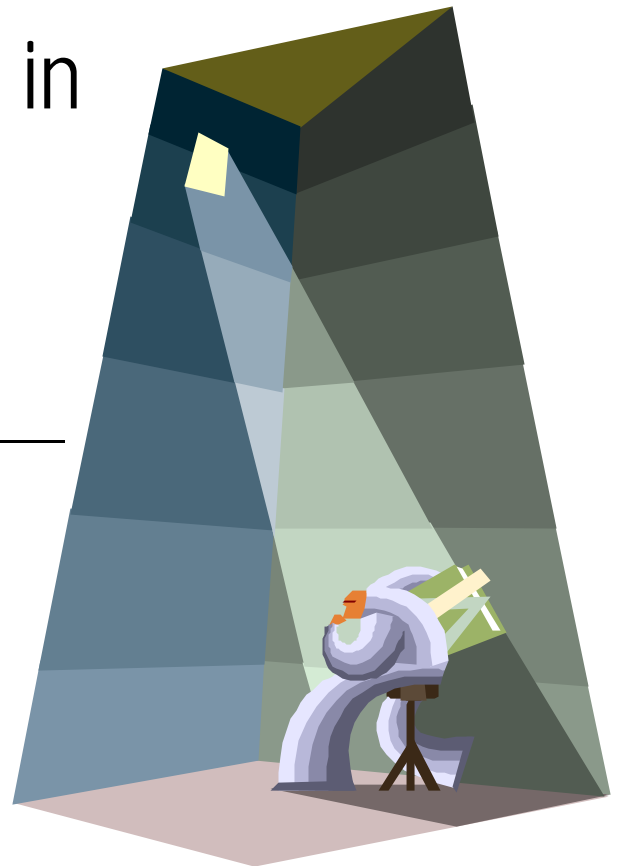
C. Susan Sendra Beger<sup>1</sup>, Senior Vice President, Disability Accounts, CNA quirkily conceptualizes the cost of insurance fraud:

*“if insurance fraud was a corporation it would rank in the top 25 of the Fortune500 companies.*

Rather than trying to ‘put a number’ on the cost of fraud, perhaps efforts are better spent on applying proactive strategies to prevent fraud from occurring in the first place.

This article considers strategic and technological developments in workers compensation fraud management which may lead to more effective resource allocation as well as more accurate identification and quantification of fraud.

As with most workers compensation initiatives in the last decade, a majority of information and research on fraud management comes from the US.



## THIS ARTICLE LOOKS AT:

- Types of fraud in Workers Compensation
- US Anti-Fraud Initiatives and their impact
- US Fraud Awareness Programs
- US Insurer Fraud Management Initiatives
- Australian Fraud Management Issues

## WHAT IS FRAUD?

**T**he precise legal definition of fraud in workers compensation varies from state to state within both the US and Australia; as do the penalties. In some states fraud is prosecuted under criminal law while in others remedies are sought under civil statutes.

Broadly, fraud requires knowledge, intent and materiality on the part of the perpetrator. It is a crime that affects the legitimate recipients of workers compensation via creating increased service costs in the system; resulting in higher premiums for employers and possibly leading to business closures due to employers' inability to pay higher premiums.

## TYPES OF FRAUD IN WORKERS COMPENSATION

Regardless of state or country differences, there are four main ‘perpetrator’ types<sup>ii</sup> of Workers Compensation fraud:

### Claimant Fraud

This includes malingering, receiving benefits while employed, non-work-related injury claims, multiple claims, relatives/dependents collecting benefits after the death of a claimant (known as ‘Survivor Fraud’).

### Provider Fraud

‘Providers’ include Medical, Rehabilitation, Legal and Investigation Providers. Examples include: kick-backs, self-referrals, up-coding (eg: coding a ‘standard’ 15 minute consultation as a ‘long’ 30 minute consultation), unbundling, product switching, under-utilization (eg: not providing comprehensive treatment which means the patient has to return frequently), over-utilisation (eg: providing more services than really necessary for recovery, colloquially known as sending the worker through the ‘Seven Doors of Rehab’); or worse, simply not providing ANY of the services billed for!

### Employer Fraud

Employer Fraud includes under-reporting payroll figures to reduce premium calculations, declaring themselves as independent contractors, misclassifying claims experience, misrepresenting business operations and/or locations, and ‘lowballing’ employment projections.

### Insurer Fraud

Insurer fraud generally includes internal fraud, although in the US insurer fraud is also described as underwriting without formal authorization. In Australia, insurers may commit fraud via illegally denying benefits.

## US ANTI-FRAUD EFFORTS

In the last decade, 33 US States enacted anti-fraud legislation. Measures included:

- Making workers compensation fraud a felony (as opposed to the lesser charge of misdemeanor).

- Requiring data sharing/reporting between private insurers and government agencies.
- Formation of Special Investigation Units (SIUs) to catch fraudulent individuals and organizations and bring them to justice.

## IMPACT OF US ANTI-FRAUD EFFORTS

Using econometric modeling techniques, the National Commission on Compensation Insurance (NCCI) calculated the following statistics in relation to the impact of US anti-fraud efforts:

**Covered Workers:** The percentage of workers covered by anti-fraud laws increased from 2.5% in 1989 to over 50% by 1997.

**Case frequency:** Case frequency reduced 5.5% on average in the first year after introduction of anti-fraud legislation. The impact in subsequent years was much lower incrementally but the NCCI comment that ‘impact of the law in reducing the case frequency is felt after many years’.

**Indemnity Costs:** Indemnity severity reduced 3.6% on average in the first year after legislation enactment, with the same long-term effect as mentioned above.

**Medical Costs:** The NCCI study did not show a statistically significant impact on medical costs following legislation enactment.

The NCCI qualified these findings with acknowledgement that ‘fraud prevention laws are often accompanied by other statutory reforms, often with similar cost control objectives as fraud prevention’. It should also be noted that the NCCI study only looked at the effects of the passage of anti-fraud legislation, as opposed to actual anti-fraud activity.

## US ANTI-FRAUD AWARENESS PROGRAMS

Anti-fraud public awareness programs are viewed as the most influential key to successful anti-fraud efforts.

In 1999, the Coalition Against Insurance Fraud iii,iv released the findings of a survey which reviewed the ‘outreach’ (awareness) materials of all US State Fraud Bureaus and the top 25 US Workers Compensation insurers (in terms of market share).

## Common Themes

The common themes and messages included:

- Educating insurance company employees such as claims personnel about fraud indicators.
- Educating employees of insured companies about the costs of fraud.
- Informing employees of the consequences of committing workers compensation fraud.
- Marketing material promoting insurer anti-fraud programs to prospective insured.

Not surprisingly, the survey found very little evidence of education on Premium fraud! Insurers are not inclined to 'bite the hand that feeds them'!

## Effective Awareness Campaigns

The Coalition Against Insurance Fraud conducted a study known as the "Four Faces Study" which looked at 'fraud tolerance' personality types. The Coalition recommended:

*'... that the insurance industry develop and fund an intensive, ongoing public information campaign to educate the public about insurance fraud, specifically convince the Realists that insurance fraud is not a victimless crime and communicate to the Conformists that fraud is not as widespread as they believe it to be. Moralists need messages reinforcing their low level of tolerance for this crime, and the Critics must be convinced that fraud is a major contributor to the rise in insurance premiums and that insurers are working hard to detect and deter fraud.'*

## Recommendations For Awareness Strategies

The 'Four Faces Study' also listed a number of recommendations for insurer and employer internal fraud management strategies. Some of these include:

- Profiling/verification of ALL claims (This is becoming increasingly easier and more cost effective with the development of internet applications).

## ATTITUDES TO FRAUD

In 1997, the Coalition Against Insurance Fraud conducted an interesting study on public attitudes to fraud. Known as the 'Four Faces' Study, it identified that only 31% of the population is likely to respond to strong messages which emphasise the consequences of fraud with images such as handcuffs, jail cells and stern judges, presented in intimidating colours such as red and black

The study was conducted by a national research company via a series of consumer focus group discussions and a telephone survey of 602 households across the United States. The following is an excerpt from the study:

Using cluster analysis, researchers found that 98 percent of the sample could be grouped into one of four subgroups depending on their levels of tolerance and certain perceptions of why people commit insurance fraud. For the purposes of this study, the subgroups are identified as Realists, Conformists, Moralists and Critics.



**The Realists** have a low tolerance for insurance fraud but realize it occurs. They may feel some behaviors are justified depending on the circumstances; they don't advocate strong punishment. This group represents 21.6 percent of the survey's respondents.



**The Conformists** are fairly tolerant of insurance fraud, largely because they believe many people do it, making it more acceptable. For that reason, they tend to believe in more moderate forms of punishment. This group makes up 26.4 percent of the survey's respondents.



**The Moralists** have the least tolerance of insurance fraud. They believe there's no excuse for this behavior and are the most willing to punish perpetrators severely. This is the largest group of respondents, 30.7 percent of the surveyed population.



**The Critics** have the highest tolerance for fraud and tend to blame the insurance industry for people's behaviors because they believe insurers don't conduct business fairly. They want little or no punishment for perpetrators. This group represents 21.2 percent of the survey's respondents.

Demographically, the four cluster groups varied only slightly.'

- Publicising the fact that profiling/verification occurs on ALL claims. This can generate customer confidence, increase customer intolerance for fraud and possibly promote better customer cooperation with fraud prevention activities.
- Widely ‘broadcasting’ insurer actions and resulting convictions on existing fraud cases so that consumers know the risk of committing fraud and what insurers are doing to protect their customers from the cost of the crime.

### Backlash on Claimant Fraud

There is a growing backlash from claimant advocates re: the focus of fraud prevention efforts on this group as opposed to employers. Advocates groups argue that workers are not seeing any of the benefits of reduced workers compensation costs for employers being passed on to them. The same issue is starting to gain attention in Australia.

To illustrate this issue, a recently released Quarterly Fraud Survey from the California Workers Compensation Institute (CWCI) indicated “Eighty-two percent of the documented referrals in 1999 targeted suspected claimant fraud, 7 percent focused on employers, 9 percent were directed at providers, and the remainder were divided between attorneys and “others”<sup>vi</sup>.

### Differing US and Australian Views

As pointed out by an Australian Insurer, there are significant differences between the US and Australian markets re: balancing the public interest and the protection of individual rights. In the US, public records are readily available via endorsed websites and even to restricted sites. Investigation practices of an obtrusive nature are allowed in the US but they carry accountability for those conducting them. In Australia, the balance is more to the rights of the individual. The appropriateness of either approach is probably reflective of the environment; ie: in the US fraud is viewed with almost ‘zero tolerance’ where as in Australia it is more of a ‘management situation’.

### US INSURER ANTI-FRAUD INITIATIVES

As plainly stated in a report on fraud by the US Insurance Information Institute<sup>vii</sup>: Insurance companies are not law enforcement agencies. As a result, an Insurer’s main defenses are resources

devoted to **detecting** fraud and (more importantly) resources devoted to **preventing** fraud.

Most US insurers have some form of Fraud Management program in place; ranging from a fraud reporting line that links to an outsourced or state Special Investigation Unit (SIU) up to a fully staffed internal SIU and a civil litigation unit devoted solely to fraud recovery.

According to the Insurance Information Institute, SIUs save insurers approximately \$10 for every dollar invested in them.

Methods of determining SIU success include measurement of:

- Return on investment
- Returns involving loss expenses and salvage profits
- Increases in prosecutions
- Claim reserve savings based on savings achieved after an investigation compared to the original anticipated cost of a claim.

The level of fraud program sophistication depends on state anti-fraud legislation requirements (eg: Anti-fraud initiatives are highly regulated in California and Massachusetts) as well as premium size and industry coverage. The following insurers are recognized as some of the leaders in the fight against workers compensation fraud.

### Fremont Compensation

Fremont Compensation<sup>viii</sup> in California played right into employer sentiment when the California anti-fraud legislation came into effect in 1991, with it’s ‘Fraud Doesn’t Work Here’ campaign. This featured billboard posters of a fraudulent worker behind jail cell bars. The company prides itself on its reputation for pursuing fraud ‘with the single minded intensity of a pit bull’.

Fremont tends to focus mainly on claimant and provider fraud and makes no bones about the fact that it will prosecute. The company touts the practice of contesting every suspicious claim; differentiating themselves from ‘many other insurers who settle for nuisance value’.

Fremont has obviously appealed to the ‘Moralist’ group (Four Faces Study) who is most intolerant of fraud and believes in harsh treatment for perpetrators.

Fremont nationally advertises its fraud program results and prides itself on 'fighting Fraud Creep' with its 'team of former prosecutors and police officers' (as opposed to ex-claims staff with a bent for investigation) and collaboration with local and national Fraud Bureaus as well as with other insurers.

### SCIF

The State Compensation Insurance Fund<sup>ix</sup> (SCIF) is another Californian insurer which widely publicises the results of its anti fraud efforts but seems to have a broader focus which covers not just claimants and providers but also addresses premium fraud.

SCIF was the first insurer to win a premium fraud case – which resulted in a \$3.7 million judgment and jail terms for the perpetrators.

SCIF has its both an internal SIU and an internal civil litigation unit devoted entirely to the recovery of damages in fraud related activities. This is reportedly unique in the CA market.

SCIF's internal fraud management system includes a hot line for fraud reporting, claim profiling software to identify suspicious claims and staff training on fraud indicators and the SCIF anti-fraud procedures.

### CWCI Antifraud Information & Resources

The California Workers Compensation Institute<sup>x</sup> (CWCI) conducts a quarterly Workers' Compensation 'Fraud Referral Survey' with Californian insurers, self-insurers and employers. The fraud survey encompasses three data sets. The largest data set counts overall referrals and includes data since 1992, and arrests and convictions since 1994. Two more recent data sets include information about referrals and arrests from referrals.

The CWCI is currently compiling information for a study known as '**The Red Flag Study**', to look at claimant fraud cases in which convictions were obtained. The objective is to identify which 'red flags' (if any) were present in the cases. ('Red Flags' are conditions which suggest that the fraudulent activity may be occurring; eg: an alleged injury occurs on a Monday morning; an accident is

unwitnessed; differing accident descriptions on claim forms and medical reports.)

### FRAUD DETECTION TECHNOLOGY

The use of 'profiling tools' in the Workers Compensation Fraud Management is a growing focus. The tools assess hundreds of claim characteristics to detect potential fraud.

The Utah Workers Compensation Fund (WCF)<sup>xi</sup> is a state fund which has been privatised. They have approximately 30,000 claims per year, with a premium base of \$100m/year.

WCF had a relatively strong fraud program in place, with savings of approx \$3m per year. However in 1995, they implemented the HNC Vericomp-Claimant<sup>xii</sup> system to monitor claimant fraud. This more than doubled the savings achieved via the Fraud Program (to a total of \$7m) (The extra \$4m in savings were attributed to the introduction of the Vericomp system.)

This translates to a saving of \$100/claim (includes medical only and indemnity claims) as a result of using Vericomp-Claimant.

Prior to implementation of the Vericomp-Claimant system the fraud alert mechanisms used at the WCF were like many other insurers: ad hoc and highly reliant on claims officers or the public reporting suspect claims. The mechanisms included toll free hotlines, claim officer identification and report to SIU and 'Red Flag Rules'.

The Vericomp-Claimant system implemented a weekly reassessment of ALL active claims. HNC points out that it is important to regularly re-assess because evidence of abuse may not initially show up.

At WCF, Vericomp-Claimant identifies approximately 1% of active cases for review each week (approx 300). The time impact on the claims officers is minimal. Each claims officer handles approximately 100 active claims and may need to review one or two a week (if that).

With the implementation of Vericomp-Claimant, WCF found that claims officers were actually more proactive and accurate in identifying fraud. Accuracy in identifying fraud cases is critical to controlling for administration costs. A 'profiling' tool like Vericomp means that resource allocation (time/money) is not wasted on the cases that are not relevant.

## Criticism of Profiling

Not everyone is 'sold' on the benefits of profiling technology. While it is useful to highlight potentially fraudulent claims, the people who commit fraud quickly figure out the profiling 'thresholds' and modify their behaviour to avoid detection. Some believe time/money is better spent on training claims officers to accurately detect and report potential fraud cases to the SIU.

Another potential flaw with profiling tools is that they can highlight too many 'false positives'. Their 'buzzers go off' too often, creating a large number of 'potential' fraud cases to investigate. Setting the 'trigger' threshold is not easy and may need to vary from jurisdiction to jurisdiction and from time to time, as circumstances change.

Cost is a further prohibitive factor to using fraud profiling systems. One of the top 12 Californian insurers estimated it would cost \$300-400K to implement fraud profiling Technology. The advent of Internet technology may help to reduce this cost in the future.

### FRAUD MANAGEMENT RESOURCE WEBSITES

#### USA

Coalition Against Insurance Fraud

[www.insurancefraud.org](http://www.insurancefraud.org)

Insurance Fraud Research Bureau

[www.insurancefraud.com](http://www.insurancefraud.com)

Fraud Defense Network

[www.frauddefense.com](http://www.frauddefense.com)

CWCI Antifraud Information and Resources

[www.cwci.org](http://www.cwci.org)

Barry Zalma's Fraud Site

[www.zalma.com](http://www.zalma.com)

#### AUSTRALIA

Corruption Prevention Forum

[www.lists.uts.edu.au/pipermail/cpf](http://www.lists.uts.edu.au/pipermail/cpf)

Workcover SA Fraud Pages

[www.workcover.com](http://www.workcover.com)

Victorian WorkCover Authority

[www.workcover.vic.gov.au](http://www.workcover.vic.gov.au)

## AUSTRALIAN ISSUES:

So, what is going on the Australian workers compensation fraud management arena?

### Limited Comparisons

Comparison between states is limited due to differing legislative arrangements across the states. These different arrangements have a strong bearing on how fraud is managed. Under privatised insurance arrangements (eg: WA), there is a significantly greater incentive for insurers to manage fraud, since it has a direct impact on their 'bottom line'. In Managed Fund environments (eg NSW, SA), insurers tend to expect a Regulatory Authority to undertake this role, since there is little commercial incentive to invest resources for fraud management.

### Resourcing is Expensive!

Conducting investigations and preparing for prosecution are labour intensive, high cost activities. Most Australian workers compensation insurers have not viewed internal Fraud & Investigation units as providing significant return on investment. Hence, the approach to fraud management has been reactive, ad hoc and outsourced for the most part. But this is changing.

Further, it is not in the interests of insurers to become too aggressive in their approach to fraud management, especially in the area of premium fraud. Prosecuting or fining customers is just not good business!

### Review of Investigation Referral Procedures

Similar to the US 'backlash' against claimant fraud investigation, there has been an increased focus on the issue of 'commercial stalking' which refers to the overuse (or unnecessary use) of investigation by insurers. Insurers are looking at self-regulation; reviewing their policies and procedures regarding when investigation is required. This will certainly create some savings as well as possibly improve the 'strike rate' with more targeted use of investigation.

It also suggests that investigation providers would be wise to review their training and quality control as well as business models. The days of Insurers referring cases for investigation as a way of

showing that ‘something’ is being done (usually for an employer’s benefit) are coming to an end.

### Investigation Providers’ Training and Service Quality

The current requirements to work as an investigator are considered inadequate by some insurers; “it’s not enough to just have a laptop, camera and an investigator’s license”. Talks are underway with several universities to raise the training standards to Graduate Certificate and Graduate Diploma level; eg: a Graduate Diploma in Insurance, majoring in Investigation. Subjects may include Risk Management, Insurance Contracts, Criminal Law, Surveillance techniques and Interview techniques.

### Proactive Management and Use of Technology

There are moves afoot within insurers and regulators to become more systematically proactive than reactive in their fraud management efforts. NSW, Victoria and South Australia WorkCover Authorities are using or looking at data mining/profiling technology. Several insurers are also looking at these tools. In many cases, they are building their own databases. Insurers and regulators are also recognizing that fraud management requires skill beyond normal claims handlers/technicians scope eg: hiring business analysts for profiling analysis.

### Not Much Public Awareness Programming

There is not a great deal of public awareness programming in the Australian market. The insurers seem to view this programming as the responsibility of the regulators or the industry associations, such as the Insurance Council of Australia (ICA).

WorkCover South Australia appears to be the most active in this area, with a newsletter and website devoted to publicising prosecutions. The Victorian and NSW WorkCover Authorities also publicise prosecutions via their websites. However, there apparently is little interest from the print media, especially in the metropolitan areas. Television media such as ‘60 Minutes’ and ‘Four Corners’ occasionally highlight fraudulent cases, but the general awareness of the community impact of fraud is not high.

The results of the Coalition Against Fraud research may assist Australian Investigation and Fraud Units with development of awareness strategies. Similarly, improved data collection should provide more accurate information to support awareness campaigns.

Creation of the ‘sentinel effect’ via awareness campaign is one of the most resource efficient methods of raising awareness. The sentinel effect occurs when people ‘think twice’ about committing a fraudulent act, because they are not quite sure of the actual degree of scrutiny. The same effect has been successful with Tax Evasion and Speed/Red Light camera campaigns.

### Next...

Imagine it is 5 years from now and the quiz at the beginning of this article is given again.

Chances are that the US and Australian markets STILL will not have a definitive answer on the *extent* of fraud. It is just too complex an issue to measure consistently across many legislative and jurisdictional variables.

What we WILL have is a much clearer idea of how to detect and address fraudulent activity in workers compensation.

What we WILL be able to quantify is the amount of money saved on investigation and litigation costs as a result of more targeted (and profitable) profiling and allocation of resources.

We WILL possibly start to see a greater awareness of the impact of fraud on all stakeholders, resulting in a move towards ‘zero tolerance’ for fraudulent activity from any perpetrator.

We will see.

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Contact: Anne Engleman, Engleman Etcetera Pty. Ltd.  
p. +61 2 9953 0464 f. +61 2 9953 0443  
anne@englemanetc.com.au

## Sources

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