

Risk Control

Managing Workers' Compensation Fraud

Scope of the Problem

Insurance fraud occurs every day in every state. While most experts agree that the actual financial impact of insurance fraud is not easy to calculate, the Insurance Information Institute estimates that **all** property/casualty insurance fraud cost insurers \$30 billion annually. Of this, workers' compensation fraud accounts for approximately 25 percent or \$7.2 billion a year, according to the National Insurance Crime Bureau (NICB). The NICB characterizes workers' compensation fraud as the "fastest growing segment of insurance fraud" in the nation. As one company executive put it, "If workers' comp fraud were a legitimate business, it would rank among Fortune 500 companies." And, workers' compensation fraud is not just a cost borne by insurers. Insurance fraud costs everyone – insurers, employers, workers, consumers, and shareholders.

The Many Faces of Fraud

Workers' compensation fraud has many faces. The NICB says that those who commit insurance fraud range from organized fraud rings, to doctors, lawyers, and business owners, to employees and ordinary people who buy insurance. While workers' compensation fraud can be "perpetrated by any participant in the system," most studies indicate that the three parties primarily driving the cost of workers' comp fraud are employers, medical providers, and employees. Employer or premium fraud can come in the guise of underreported payroll or misclassification of workers, to reduce the company's workers' compensation insurance premium burden. Medical or service fraud can come in the guise of upcoding (billing for more expensive procedures than were actually provided) and treatment over-utilization, to pad service reimbursement. And, employee or claimant fraud can come in the guise of an accident or injury that is not workers' compensation related, is "staged," or is prolonged, in order to derive benefits to which the employee is not otherwise entitled.

Of the many faces of fraud, this article addresses employee claimant fraud, which is said to comprise about 20 percent of all workers' compensation claims paid. When a claimant files a fraudulent workers' compensation claim and that claim is paid, several things may happen:

- The company's loss experience record will look greater than it legitimately should be.
- The company's workers' compensation insurance premium may rise, as a result of the fraudulent claim.
- As a consequence of the premium increase, net revenue could be impacted. In turn, this could mean that some companies may need to generate more product/more service, to cover the cost. Or, a consumer price increase might need to occur. Or, worker wages might need to be cut back, and
- Shareholders may find themselves with diminishing equity returns

Costs also can be borne in the guise of production delays and retraining, and, for co-workers, there may be the need to increase work schedules to meet production demands. In all events, the company may find itself lagging behind the competition. Additionally, workers' compensation fraud only adds to the burden of an already expensive system. Fraud, medical costs and attorney fees are said to be some of the major reasons that "the system fails both employees and employers." So, should it matter? You bet it should.

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Public Attitudes Toward Fraud

Most workers who file workers' compensation claims have honest work-related injuries and do not abuse the system. Those who do abuse the system and file fraudulent claims may be reflective of a general "insurance fraud" attitude described in two surveys, one conducted by the Insurance Research Council (IRC) and the other conducted by Progressive Insurance. According to the IRC survey on the American public's attitudes on insurance fraud in general, 35 percent of respondents thought it was acceptable to pad an insurance claim. Younger respondents were more likely than older respondents to say that it is all right to pad a claim.

The IRC survey found that around 34 percent of employee respondents said it was "almost always acceptable" to "malingering" or stay out of work and collect workers' compensation benefits when they still felt some pain, although their doctors authorized their return to work. According to an IRC spokesperson, this attitude could be attributed to skepticism about medical decisions or the worker's personal assessment of pain and the ability to perform job duties. Five percent of respondents thought it acceptable to collect workers' compensation benefits for injuries which occurred at home, or to continue to collect benefits when fully recovered, or work at another job while collecting benefits. About 21 percent of respondents said they were aware of workers' compensation fraud schemes at their workplaces. Seventy-one percent of respondents agreed or somewhat agreed that insurers should pay to prosecute workers' compensation fraud cases. Lessons from the surveys suggest opportunities for states, the insurance industry, and employers to educate employees and the public on who really pays for fraud: we all do.

Insurance Fraud is Against the Law - States Take Charge

State government and regulating agencies also are involved in fighting the war against workers' compensation fraud. Almost every state has passed laws which define fraud and raise the level of insurance fraud from a misdemeanor to a felony. Felony offenses may include the filing of fraudulent claims and assisting others to make fraudulent claims or statements. Workers' comp fraud is subject to prosecution, usually through the district or state attorneys general offices. Judgments may include fines, community service, probation, prison sentencing, and court-ordered restitution to insurers, employers, and workers' compensation boards. Many states also have passed or are proposing legislation for increased penalties for those who entice people to file fraudulent claims.

Many states mandate that insurers and self-insured employers report fraudulent transactions to the state fraud units/bureaus. Many states offer special telephone numbers, including 1-800 hotlines, for reporting suspected workers' compensation fraud. Some states also offer websites for online reporting of fraud. Study data suggest that fraud bureaus with 1-800 telephone hotlines receive a greater number of reports per capita than fraud bureaus that do not provide a dedicated telephone.

States may provide immunity from civil liability to those who report fraud, in the absence of fraud, malice or bad faith. Immunity laws differ in their protections but, in varying degrees, they attempt to shield business and insurers from civil lawsuits when reporting suspected fraud. Some states provide narrow protections, such as extending immunity only when reporting to the fraud bureau. Others are broader and may cover reporting to any law enforcement agency. Businesses should understand the fraud laws, including immunity provisions, in their states. Referral levels also appear to be impacted by immunity laws. In some states, employers also can bring lawsuits against employees who are convicted of filing fraudulent claims.

Most states, if not all, are involved in public awareness initiatives to fight the war against insurance fraud, including through outreach materials (often available on-line) and seminars. Use of public outreach awareness campaigns are said to have a significant impact on public attitudes and behaviors regarding workers' compensation claims. After a two-year public awareness campaign by the Pennsylvania Insurance Prevention Authority, the percentage of people who believed it was acceptable to inflate workers' compensation claims dropped nearly 60 percent and the percentage of people likely to malingering after being injured fell to 20 percent. States also are using database networks to trace down offenders who collect benefits from one employer while working for another. Business

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groups, the Chambers of Commerce, and leagues of cities also are among others involved in supporting legislation against insurance fraud.

Insurers Fight Back

Many insurance companies have special fraud units who help both in educating companies on workers' compensation anti-fraud programs and in investigating fraud. Many offer zero-tolerance training programs and outreach materials, including posters, to help companies in the fight against claimant fraud. Many also offer 1-800 hotlines so companies can report fraud. Once the fraud is reported, specially trained investigators will determine what additional investigation is necessary. They also work with state fraud units and prosecutors to help bring fraud cases to prosecution. Civil and criminal penalties for insurance fraud have increased since the insurance industry stepped up its fight against fraud.

What Companies Can Do

According to the NICB, a good workers' compensation program starts with a "well-orchestrated safety management program," to help accidents from occurring in the first place. But, once they do occur, a diligent post injury management program, including return-to-work, plays a key success role in managing injured employees and the company's workers' compensation loss experience. Providers also play a key role in this. Providers who specialize in work-related injuries also can better oversee and encourage the employee's recovery and return to work. Experts suggest that medical providers also make good partners in anti-fraud efforts by recognizing and raising "red flags" to employers, including identifying malingering.

The NICB also suggests that all business adopt a zero-tolerance for fraud program. Along this line, the Pennsylvania Insurance Department, in its paper "Combating Insurance Fraud," suggests several anti-fraud "best practices," which include not just a corporate culture of "zero tolerance," but also responsibility and accountability for an antifraud plan at the senior corporate officer level. The plan includes working with insurers and law enforcement in pursuing criminal and civil prosecution of fraudulent. Some experts also suggest that companies hold exit interviews to discourage post-termination claims.

Know the red flags

While states and special investigative units can help to investigate fraud, the actual uncovering of the fraud in the first place is not always an easy task. Experts, however, say that businesses should be aware of the "red flag" indicators of fraud, "where past experience shows a greater likelihood of fraud." While fraud indicators do not necessarily mean fraud has occurred, they may prompt a closer review of a claim. Some indicators include:

- Accidents/injuries that are reported to have occurred late Friday or early Monday morning. The injury may have come from a non-work related activity, including a weekend activity.
- An injured worker who is reluctant/ refuses to accept treatment from a medical provider or other health care professional
- The physician's diagnosis is not consistent with the treatment, or worker takes off more days than accident would seem to warrant
- Accident is not witnessed or reportedly occurred in an area where the employee would not normally be.
- Accident is not promptly reported.
- An injured worker who is seasonal and about to conclude the job.
- Claim occurs just before a layoff, strike or the end of an employee's probationary period to ensure against discontinuation of wage.
- Worker is observed in work or recreational activities inconsistent with the reported injury.
- Injured worker has a history of short-term employment.
- Injured worker complains of non-work-related health problems to co-workers before filing a claim.
- Injured employee on workers' compensation disability can never be reached or provides a beeper number as his main number.

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The Coalition Against Insurance Fraud also says it is important to pay attention to employee complaints and concerns about working conditions. “The strongest predictor of fraud,” says the Coalition, “is a chronically disgruntled work force.”

Under no circumstances should a company accuse an employee of fraudulent claim filing. Most claims are legitimate and employees will need the support of their companies to help them through the post injury management process. Making a false accusation can potentially raise claims of harassment and defamation, among others. Suspected fraud simply should be reported to your insurance carrier or your state fraud unit, following your company’s fraud reporting process.

Investigate Accidents, Report to Bureau and Insurance Company

Companies should handle all reports of injuries, including potentially fraudulent claims, through their normal injury reporting and accident investigation process. This includes documenting all incidents of reported injury. Companies also should have a fraud –reporting process where employees and supervisors may report suspicious fraud to management. In no case should anyone in the company make any accusations. All occasions of suspected fraud should be reported through the company’s fraud-reporting process to the insurer or the insurers’ special investigative unit immediately. The special investigative unit will coordinate the investigation with the company, and, when appropriate, the state’s insurance fraud bureau/unit and state prosecutors. The National Insurance Crime Bureau also as a toll-free telephone hotline: 1-800-TEL-NICB.

Educate employees on workers’ compensation and anti-fraud laws

Experts say companies can make a significant difference in fraud through education and treating employees fairly. Studies indicate that educating employees on the purpose and program benefits of the workers’ compensation system helps to decrease system abuse. A study by Intracorp found that injured employees who did not understand the workers’ compensation system were more likely to seek an attorney and more likely to malingering than those who were educated by their employer about the system. Companies also should have a policy on the need for prompt reporting of work-related injuries, so that benefits for legitimate work-related injuries may be processed under the system promptly. However, employees also should be educated on your zero-tolerance for fraud, including that it is against the law to commit claimant fraud and that such fraud can be prosecuted. Studies suggest that educating on prosecution is key in discouraging the filing of fraudulent claims. Many companies use anti-fraud posters to help reinforce this message. Companies also should communicate that the cost of fraud is not free: everyone is affected; everyone pays. It is borne by the company and its employees, including those who are suffer legitimate workplace injuries or illness. The Coalition Against Insurance Fraud suggests that when employees understand that companies and employees pay for fraud (higher premiums can eat into salary increases), and also know that the company investigates suspicious fraud, they are less likely to defraud the workers’ compensation system.

Everyone in the company can take an active role in the fight against fraud by knowing the red flag indicators and reporting suspected fraud to company management through the company’s fraud-reporting process.

The company’s positions on workers’ compensation and injury management should be communicated as part of new hire orientation and to all employees on an annual basis. The policy should clearly help employees understand that, while it is their right to seek workers’ compensation for legitimate work-related injuries/accidents, fraud is illegal and is paid out of everyone’s pocket.

Closing Comments: Meeting the Challenge

Changing the attitudes and behaviors about fraud are key in the fight against fraud. Heightened efforts to educate on, and prosecute fraud are making a difference. Surveys show that the public is less accepting of fraudulent practices than in the past. A commitment to safety management, post injury management, including return to work programs, and an anti-fraud, zero tolerance program, together, can help make a difference to the workers’ compensation experience of employers, insurers, state boards, and employees alike. It just makes good cents!

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“To me, a claims man is a surgeon – his desk is an operating table. And those pencils are scalpels and bone-chisels. And those papers are not just forms and statistics and claims for compensation. They’re alive; they’re packed with drama, with twisted hopes and crooked dreams. A claims man, Walter, is a doctor and a bloodhound and a cop... all in one.”

Edward G. Robinson as Claims Manager Keyes
Double Indemnity, 1944

In 1944, Double Indemnity portrayed the story of a homicide disguised as an accidental death, to obtain a large insurance payout. Although the movie was filmed nearly 65 years ago, fraud investigators continue to be challenged by and investigate those with “twisted hopes and crooked dreams.” “The most powerful defense against insurance crime discovered to date,” says the Coalition against Insurance Fraud, “remains the passion and the principles portrayed by Edward G. Robinson as Claims Manager Keyes.”

See our article “Investigating Workers’ Compensation Fraud,” and learn how Travelers own special claims investigators, their passion and principles, are involved in the war against fraud, including working with companies to help uncover and investigate suspected fraud.

For more information, visit our Web site at travelers.com/riskcontrol, contact your Risk Control consultant or email Ask-Risk-Control@travelers.com.



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