



Insurance Fraud Costs the U.S. \$308.6 Billion Annually

Why is this study important? Insurance fraud is the crime we all pay for, whether through higher premiums, law enforcement expenses, court costs, and in medical care. The actual cost of insurance fraud on American citizens is impossible to measure accurately. This report seeks to use the best available data and resources to accurately estimate the economic damage insurance fraud causes every year in our nation. It is intended to inform consumers and to guide insurers, law enforcement, insurance regulators, and legislators in the need to work together to protect consumers from insurance fraud crimes.

Why is the figure so high? In 1995 the Coalition Against Insurance Fraud announced an \$80 billion estimate of insurance fraud in America. That number became the most-cited insurance fraud statistic in the U.S. And while the 1995 estimate addressed only property & casualty insurance, this report addresses all lines of insurance. The 1995 estimate was also never updated or adjusted for inflation. Applying an inflation calculator alone increases the \$80 billion figure to \$155 billion. The remaining additional \$156 billion in estimated insurance fraud includes the additional lines of insurance, notably healthcare, workers compensation, and life & disability insurance. Also, in 1995 the internet was in its infancy. Today, the World Wide Web substantially contributes to new forms of global insurance fraud that impacted the U.S. that did not previously exist.

How was this study conducted? The Coalition Against Insurance Fraud provides this study. When the decision was made to do the first update in 27 years to the 1995 figure, the Coalition sought input and assistance from key strategic partners who advised, peer-reviewed, and analyzed this report. These partners include the International Association of Special Investigation Units, the National Insurance Crime Bureau, the American Property & Casualty Insurance Association, and the Insurance Information Institute. To ensure a thorough and independent report, all data collection, analysis, and the study document were prepared by the Colorado State University Global White Collar Crime Task Force led by Dr. Michael Skiba. The team of PhD candidates at CSU compiled data from the most reliable sources available for each line of insurance. Such sources include the FBI, respected trade associations, and regulatory reporting filings. As the study notes, far better data collection is needed by insurers and governmental agencies to better analyze and quantify the actual cost of insurance fraud on the American economy.

For more information: Please refer to the Coalition Against Insurance Fraud website: www.insurancefraud.org or contact the Coalition's Executive Director Matthew J. Smith, Esq. via matthew@insurancefraud.org or by calling (202) 393-7332.



**THE IMPACT OF
INSURANCE
FRAUD ON THE
U.S. ECONOMY
2022**



**Coalition Against
Insurance Fraud**



CSU GLOBAL

THE IMPACT OF INSURANCE FRAUD ON THE U.S. ECONOMY

A report from the Coalition Against Insurance Fraud



**Coalition Against
Insurance Fraud**

In partnership with



Study Conducted by:



Colorado State University Global
White Collar Crime Task Force
2022

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OVERVIEW

The Coalition Against Insurance Fraud was created in 1993 and remains the nation's only consumer advocacy organization devoted to educating and protecting American citizens from the cost and damage of insurance fraud. The Coalition consists of more than 260 organizations committed to the fight against insurance fraud. These organizations include federal and state agencies, insurance regulators, legislative and insurance trade associations, state attorneys general, prosecutors, law enforcement agencies, the majority of America's leading insurance carriers across all lines of insurance, and select companies and law firms assisting in fighting insurance fraud.

In approximately 1995, the Coalition released an estimate of the cost of insurance fraud in the United States as being \$80 billion every year. Unlike other large economic figures, such as the national debt, the estimate of the cost of insurance fraud is an annualized number, meaning the financial counter resets at zero and begins anew every January 1st. The \$80 billion impact for many years has remained the most often cited insurance fraud statistic across the nation. Released 27 years ago, the figure has not been updated nor adjusted for inflation or the advent of new forms of insurance fraud. The time has come to both update and provide more substantial support for a new defined cost of insurance fraud that accurately reflects the United States in the 2nd decade of this new millennium.

The Coalition extends its deepest appreciation for the support and contribution of our partners in this study: the **International Association of Special Insurance Investigators, the American Property & Casualty Insurance Association, the National Insurance Crime Bureau, and the Insurance Information Institute.** This study also would not have been possible without the support of our members who support the work done by the Coalition every day. Finally, credit for the work behind this study goes fully to Dr. Michael Skiba and the research team at the Colorado State University Global White Collar Crime Task Force. We commend their tireless dedication, hard work, and excellent analysis upon which this study is firmly based.



**Coalition Against
Insurance Fraud**

ADVOCACY • INFORMATION • OUTREACH

I. Introduction to the Study and the Fraud Problem

Insurance fraud is one of the most costly and damaging forms of fraud crimes in the United States and globally. Fraud takes many forms; as scammers change their methods daily to find new gaps and vulnerabilities. Insurance fraud results in monetary damage but also causes humanitarian harm. In the area of medical fraud, patients are often put at great risk and subjected to unnecessary treatments and procedures as a result of unscrupulous providers attempting to inflate medical billing charges. Thus, insurance fraud is widespread and has a dangerous impact on our society as a whole.

The purpose of this study is to develop a new cost estimate of the economic impact of insurance fraud in the United States. Being released in 2022, the estimate represents the current state of fraud and is intended to assist policymakers, companies, agencies, government entities, and the public to gain a clearer understanding of the true nature and scope of the insurance fraud problem. There are no prior studies that have focused on this level of depth in developing a cost estimate of insurance fraud, therefore this research endeavor is a truly ground-breaking project. Having a current cost estimate will undoubtedly assist with creating increased awareness of the fraud problem which will aid the allocation of resources for more highly focused counter-fraud strategies.

Colorado State University Global's White Collar Crime Task Force (WCCTF) is the research arm spearheading this study, working on behalf of the Coalition Against Insurance Fraud. The Coalition appreciates the support and assistance of our partners in this study, the International Association of Special Investigation Units (IASIU), the American Property & Casualty Insurance Association (APCIA), the National Insurance Crime Bureau (NICB) and the Insurance Information Institute (III). Many other insurance carriers, government agencies, non-profit organizations, industry groups, and individual fraud fighters have all assisted with the development of this project. The WCCTF consists of dozens of CSUG staff, Ph.D. faculty, researchers, and assistants, but the primary lead investigators for the purposes of this study were Dr. Greg Koehle, Landon Palmer, and Allison Blackburn.

This research publication will consist of the following sections:

- I. Introduction of the study and the insurance fraud problem.
- II. Previous \$80 billion cost of fraud estimate explained.
- III. Methodology of the study.
- IV. Shortcomings and limitations of the study.

- V. Line of business (LOB) analysis.
 - a. Current and existing research on the cost of fraud of specific LOBs.
 - b. Research calculations on the updated cost for the specific LOBs.
 - c. Compilation of the LOBs into a final 2022 cost estimate
- VI. Statement on auto theft.
- VII. Recommendations for future studies.
- VIII. Conclusion.
- IX. Appendix.
- X. References.

II. Explanation of the Previous \$80 Billion Cost of Fraud Estimate

The Coalition circulates an estimate of the current cost of fraud as \$80 billion annually, which is the most widely used and popular statistic on insurance fraud cited in multiple channels daily. Many industry professionals opine that this number is an incredibly conservative figure and thus the inception of this 2022 study was to develop an entirely new and up-to-date cost of insurance fraud in the United States. The Coalition estimates that the \$80 billion figure was developed in or around 1995. As a basic first step in estimating a new cost of fraud, the WCCTF started with the baseline of \$80 billion in 1995 and converted that amount into “present-day” dollars.

Using a standard Consumer Price Index (CPI) conversion of \$80 billion in 1995 to January 2022 results in an 81.5% inflation rate, which would convert into a 2022 cost of fraud in the United States at \$145 billion! It is the goal of the WCCTF and this study to compile a new statistic in a highly methodological manner to present an accurate 2022 cost of insurance fraud.

III. Methodology

The WCCTF considered multiple methodological approaches as the foundation of this study. Consideration was made to conduct the research using a quantitative methodology, which would involve developing a research instrument in the form of a survey, which would then be circulated in the insurance industry. The benefit of this methodology would be real-time results directly from the industry. The WCCTF explored this option but discovered that this approach would be problematic due to data privacy concerns. Due to privacy issues with the release of claims, policy, and fraud information, gathering specific data from carriers and industry groups via a survey would be incredibly challenging, and yield sub-par data sets. After contacting several carriers which had data set sources, it was clearly understood by the WCCTF that the carriers were very resistant to releasing any data outside of their respective corporate environments, thus making this quantitative methodology, not a viable research option.

A qualitative methodology was also considered, whereby the researchers would perform in-depth interviews with industry professionals on fraud cost and measurement. This would be a very beneficial approach as direct contact and feedback would be gathered. However, the WCCTF realized that this approach would also result in the same data and information privacy challenges and therefore would not be an ideal structure for this research endeavor.

The WCCTF pondered many other research approaches and considered those options along with the timeframe and resources for this study and thought using available data sets would be the best option. The WCCTF conducted initial exploratory searches for several months for available data and existing research on insurance fraud and realized that there are many data sets, studies, and publications that have already been performed that can be utilized as the core data points for this current study. Therefore, the WCCTF decided that the structure of this study will consist of locating, reviewing, and analyzing currently available research and data sources, in other words, the WCCTF will not be collecting any “new” data as part of this study.

In each of the Line of Business (LOB) sections, the WCCTF will address the reasoning behind the choice to utilize specific data as connected to that line of business. The WCCTF considered and reviewed hundreds of sources to serve this study, but the final data was chosen based on those sources that were aligned with organizations that had the highest degree of creditability in the industry and used the most accurate and effective method of data collection.

The WCCTF searched for data within five years of this study date (2016 or newer) to accurately represent the most current state of the insurance problem. This five-year range provides robust data as it includes pre-covid data (2016-2020) and covid data (2020-present). When data was used that was considered somewhat “dated,” the WCCTF extrapolated the data and metrics and applied a CPI conversion to reflect today’s cost. This CPI conversion will be explained in detail within the appropriate sections of the study where it was utilized.

The next phase of the preparation was to identify the lines of business that would be included in the cost of insurance fraud analysis. After lengthy discussions with the Coalition and other stakeholders, it was determined that this study would focus on the following lines of business:

- | | |
|--------------------------|--------------------------|
| 1) Property and Casualty | 5) Medicare and Medicaid |
| 2) Workers’ Compensation | 6) Life Insurance |
| 3) Premium Fraud | 7) Disability Insurance |
| 4) Healthcare | 8) Auto Theft |

IV. Shortcomings and Limitations of the Study

The WCCTF will be using existing research and data as the core elements of this study, and accordingly, as with any credible research, there are limitations and shortcomings. Considering that existing data is being used, the research results are therefore limited in certain areas as this research was already gathered under pre-set parameters. Therefore, the team cannot act fluidly and alter data gathering parameters as the study unfolds, the team must analyze the data that was already captured, which presents inference and results limitations. However, even with these shortcomings and limitations, the research team is confident that the results will be credible, sound, and provide an accurate picture of the current cost of fraud in the United States.

Compiling one cost of insurance fraud for the entire insurance industry across multiple LOB’s will create a new and fresh picture of the state of insurance fraud. However, it is understood that each specific insurance company, insurance-related organization, government agency, industry group, etc. has its own unique place in the insurance industry. Thus, due to the many unique organizations that exist, certain sections and LOB’s of this study may not be applicable. It is recommended that insurance organizations use this study as a baseline and then if needed, modify the findings revealed in this study to their unique situations.

V. Insurance Fraud by Line of Business Analysis

Property and Casualty Insurance Fraud

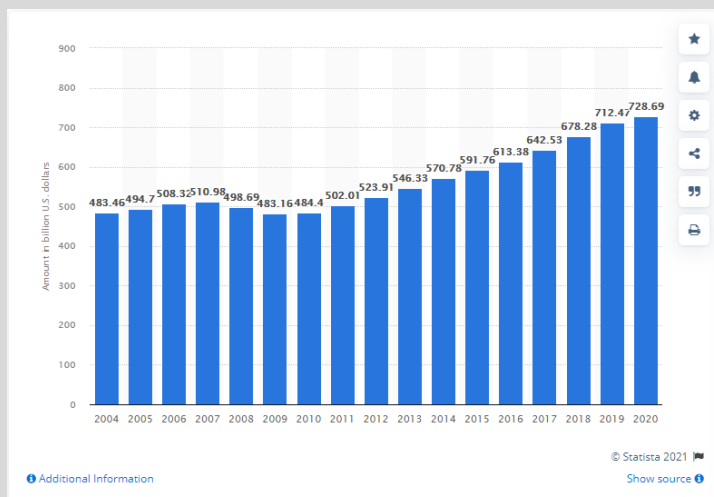
a) Introduction to the problem:

Property and casualty insurance is defined as a type of insurance that provides protection for two main areas. First, it protects items that the insured owns. Secondly, it provides liability coverage as protection for an insured if the insured is found culpable in an accident and causes property damage or personal injury to another person.

Property insurance is referred to as a “first-party” coverage in that it provides for losses related to a policyholder’s property, whereas casualty, or liability, insurance is referred to as a “third-party” coverage, implying it protects a policyholder against the claims of others. Property and casualty insurance can be written to apply to automobiles, homes, and businesses. There are three basic types of property loss: 1) loss of or damage to the article itself, 2) loss of income from the use of the article, and 3) any extra expense incurred due to the loss of the article. Casualty insurance, which covers liability losses, are losses that occur as a result of the insured’s interactions with others or their property. To be liable, the individual must be guilty of negligence or the failure to use proper care. There are generally three types of liability insurance: 1) general liability, 2) professional liability, and 3) product liability.

The following three visuals reveal interesting statistics on the property and casualty industry in the United States.

The following graph shows direct premiums of property and casualty insurance in the United States from 2004 to 2020 (in billion U.S. dollars).



Source: Statista 2021

The following table shows a high-level property and casualty insurance industry income analysis of 2016-2020 in billion U.S. dollars.

Property/Casualty Insurance Industry Income Analysis, 2016-2020
(\$ billions)

	2016	2017	2018	2019	2020
Net premiums written	\$534.0	\$558.4	\$618.3	\$639.5	\$655.5
Percent change	2.6%	4.6%	10.7%	3.4%	2.5%
Premiums earned	\$529.2	\$546.4	\$599.7	\$627.3	\$642.7
Losses and loss adjustment expenses incurred	382.5	414.7	428.3	445.6	450.8
Other underwriting expenses	148.0	151.1	167.7	172.5	179.3
Policyholder dividends	2.9	3.3	3.7	4.9	7.7
Net underwriting gain/loss	-2.4	-20.8	2.6	7.8	11.9
Net investment income	47.5	49.7	57.0	56.3	53.4
Miscellaneous income/loss	-2.4	-9.0	-2.4	-2.5	-1.9
Operating income	43.1	20.2	57.3	60.5	59.0
Realized capital gain	8.5	19.6	10.7	11.0	10.4
Federal income tax	7.3	-0.8	7.2	8.5	8.7
Net income after taxes	44.3	40.6	60.8	63.1	60.7

Source: NAIC data, sourced from S&P Global Market Intelligence; Insurance Information Institute.

Source: Insurance Information Institute. (2021). *Facts + Statistics: Industry overview*.
<https://www.iii.org/fact-statistic/facts-statistics-industry-overview>

The following table shows the direct written premiums of the top 10 property and casualty carriers in the U.S. in billion U.S. dollars.

Top 10 Writers Of Property/Casualty Insurance By Direct Premiums Written, 2020
(\$000)

Rank	Group/company	Direct premiums written (1)	Market share (2)
1	State Farm	\$66,153,063	9.1%
2	Berkshire Hathaway Inc.	46,358,896	6.4
3	Progressive Corp.	41,737,283	5.7
4	Allstate Corp.	39,210,020	5.4
5	Liberty Mutual	36,172,570	5.0
6	Travelers Companies Inc.	28,786,741	4.0
7	USAA Insurance Group	24,621,246	3.4
8	Chubb Ltd.	24,199,582	3.3
9	Farmers Insurance Group of Companies	20,083,339	2.8
10	Nationwide Mutual Group	18,499,967	2.5

(1) Before reinsurance transactions, includes state funds.
(2) Based on U.S. total, includes territories.

Source: NAIC data, sourced from S&P Global Market Intelligence; Insurance Information Institute.

Source: Insurance Information Institute. (2021). *Facts + Statistics: Industry overview*.
<https://www.iii.org/fact-statistic/facts-statistics-industry-overview>

- b) Existing data pertaining to property and casualty fraud costs.

In addressing the current cost of fraud in the property and casualty line of business, multiple sources were considered to assist with locating a new monetary amount. Considering the structure of this study was one whereby the research team was not gathering new data through qualitative or quantitative methods, an extensive search was performed to secure as many potential sources of existing data and monetary estimates on the cost of property and casualty fraud that have already been performed. The research indicated that there is inconsistency with the definition of what specific lines of business are included in property and casualty insurance. Therefore, to provide an accurate metric on the current cost of property and casualty fraud, the research team took great effort in clearly investigating what specific lines of business were used in any research study or publication that helped calculate the current cost. This was done to ensure that there was not an overlap in lines of business that would potentially skew the final data.

Accordingly, there were two lines of business that are oftentimes included in property-casualty fraud; auto theft and workers' compensation. For purposes of this study, those two lines of business will be analyzed separately to create a more accurate and precise final figure on the cost of fraud. The research team removed those two lines of business from this property and casualty cost and will focus on those separately to provide a more accurate metric.

Auto theft is a type of fraud that is traditionally included in property and casualty fraud and for the purposes of this study, the research team decided to analyze auto and home theft as an entirely separate line of business. Therefore, there will be no auto and home theft statistics included in this cost estimate for property and casualty fraud. Workers' compensation fraud is sometimes included in property and casualty fraud; however, for the purposes of this study, the research team focused on workers' compensation as an entirely separate line of business. Therefore, there will be no workers' compensation cost included in this property and casualty metric.

Regarding existing research and cost estimates for property and casualty fraud, several sources were identified. The Federal Bureau of Investigations (n.d.) estimates that insurance fraud (non-health) is estimated at more than \$40 billion annually. *The Insurance Information Institute (III.org) makes the following statement on its website:

“In the late 1980s, the Insurance Information Institute interviewed claims adjusters and concluded that fraud accounted for about 10 percent of the property/casualty (PC) insurance industry's incurred losses and loss adjustment expenses each year. Using that measure, in 2019 and 2020 P/C fraud would amount to \$38 billion each year. The figure can fluctuate based on line of business, economic conditions, and other factors.”

*The III did not specify exactly how they derived at this figure, but the WCCTF estimates that they first took 2019 and 2020 incurred losses (Loss & LAE) and then multiplied that figure by 10% (average percentage claim fraud). The chart below is a visual representation of how the WCCTF believes they arrived at the \$38 billion figure.

Year	Loss & LAE	Fraud (10%)	Incurred Losses*	Fraud (IL)*
2016	382.5	38.25	323.595	32.3595
2017	414.7	41.47	350.8362	35.08362
2018	428.3	42.83	362.3418	36.23418
2019	445.6	44.56	376.9776	37.69776
2020	450.8	45.08	381.3768	38.13768

As quoted by the III (above) they explain that they used the 10% average percentage claim fraud as it was based on a study that they performed in 1980 by interviewing claim adjusters from the industry. The WCCTF found that the 10% the III utilized for the percentage of fraud in claims was also consistent with independent private consultation research studies the WCCTF has performed and is also a percentage that is widely cited as credible by many leading anti-fraud organizations, such as the ACFE, and the Coalition; thus, the WCCTF deemed 10% as a credible percentage to use as the average percentage of fraud in claims as a basis for this current 2022 study.

Casualty fraud, which is a component of property and casualty fraud, was studied in 2015 by the Insurance Research Council (2015) which estimated that casualty fraud accounted for between 15% and 17% of total claims payments for auto insurance bodily injury in 2012. The study estimated that between \$5.6 billion and \$7.7 billion was fraudulently added to paid claims for auto insurance bodily injury payments in 2012. Using a standard formula CPI index and adjusting for inflation, the new cost of casualty fraud in current dollars would be estimated between \$6.8 and \$9.3 billion. All of the data and figures that resulted from the previously stated analysis will be used as a baseline as the study unfolds.

*The \$40 billion statistics from the FBI was deemed one of the most credible to estimate insurance fraud as they are one of the premier law enforcement agencies in the world and accordingly maintain a robust research platform and have a vast network to gather credible and accurate data. The WCCTF located research by several state

insurance organizations, but due to the fact that this research was not available consistently for every state, this was deemed as an unviable source.

*The Insurance Information Institute was chosen as the second most reliable, credible, and effective data source as the III is one of the most well-respected members of the insurance industry. Since 1960, the III has been one of the most trusted sources of data for consumers, the media, and professionals in the insurance industry and at its core organizational function researches and publishes information, statistics, and data on the insurance industry.

*The 2012 study that the Insurance Research Council performed was chosen as the primary data source as the IRC has been providing the property and casualty industry with robust research since its inception in 1977, and along with the III is considered one of the top insurance research organizations. The WCCTF found little to no studies specifically focused on casualty fraud and therefore this somewhat dated 2012 study by the IRC was seen as the most effective data source for the purposes of this study.

c) Research teams' calculation on the updated cost of property and casualty fraud.

The WCCTF considered the results developed in section b above but also wanted to explore opportunities to develop an entirely new metric. Regarding a reasonable methodology to calculate the current cost of property and casualty fraud, the WCCTF concluded that an accurate formula would be to begin with the Loss Adjustment Expense (LAE) for each year and then extract 10% of that LAE figure to arrive at a new estimated cost of property and casualty fraud. The Actuarial Standards Board (2022) defines the Loss Adjustment Expense as the “cost of investigating, administering, determining coverage for, settling, or defending claims even if it is ultimately determined that the claim is invalid.” It is also known as “claims adjustment expense.” Accordingly, the WCCTF utilized the LAE as circulated by the III (Insurance Information Institute, 2021, Facts + Statistics: Industry overview) and then calculated the new cost of fraud by multiplying LAE by 10%.

Figure 1 shows a visual of the 2016-2020 property and casualty industry metrics for the U.S. The LAE that is the focus of this analysis is seen in the 4th row, titled: “Losses and loss adjustment expense incurred.”

The final cost of property and casualty fraud was assessed from 2016 to 2020 by using the LAE for each year and then multiplying that number by 10%. The results can be viewed in two formats in Figures 2 and 3.

Figure 1

Property/Casualty Insurance Industry Income Analysis, 2016-2020
(\$ billions)

	2016	2017	2018	2019	2020
Net premiums written	\$534.0	\$558.4	\$618.3	\$639.5	\$655.5
Percent change	2.6%	4.6%	10.7%	3.4%	2.5%
Premiums earned	\$529.2	\$546.4	\$599.7	\$627.3	\$642.7
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Other underwriting expenses	148.0	151.1	167.7	172.5	179.3
Policyholder dividends	2.9	3.3	3.7	4.9	7.7
Net underwriting gain/loss	-2.4	-20.8	2.6	7.8	11.9
Net investment income	47.5	49.7	57.0	56.3	53.4
Miscellaneous income/loss	-2.4	-9.0	-2.4	-2.5	-1.9
Operating income	43.1	20.2	57.3	60.5	59.0
Realized capital gain	8.5	19.6	10.7	11.0	10.4
Federal income tax	7.3	-0.8	7.2	8.5	8.7
Net Income after taxes	44.3	40.6	60.8	63.1	60.7

Source: NAIC data, sourced from S&P Global Market Intelligence; Insurance Information Institute.

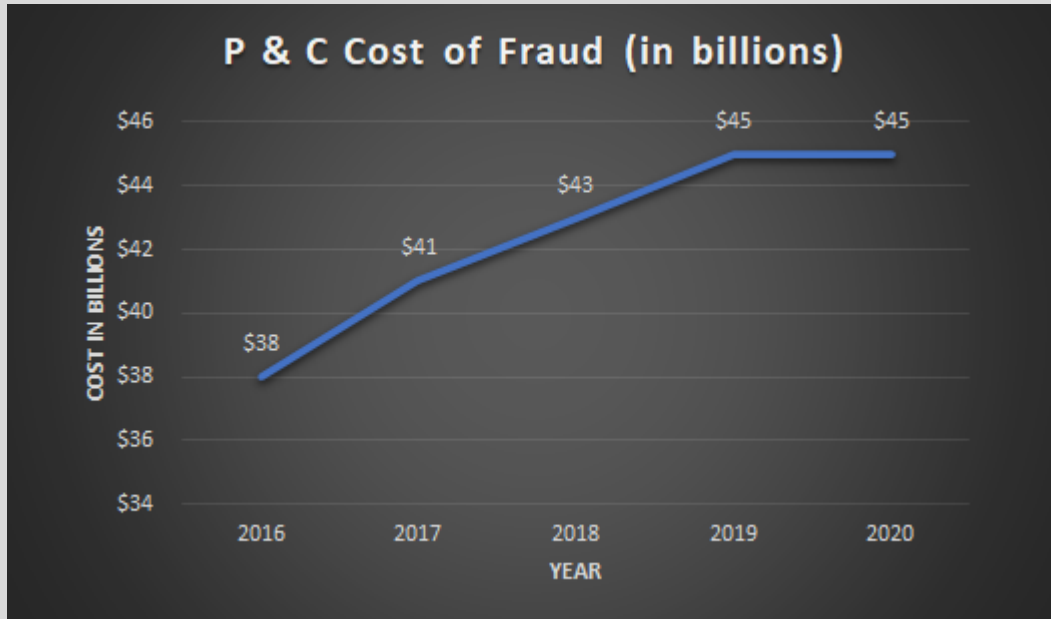
Source: Insurance Information Institute. (2021). *Facts + Statistics: Industry overview*.
<https://www.iii.org/fact-statistic/facts-statistics-industry-overview>

Figure 2: Cost of Property and Casualty Fraud 2016-2020 (in table format).

YEAR	LAE (in billions)	FRAUD (10%)	COST (in billions)
2020	450.8	10%	\$45
2019	445.6	10%	\$45
2018	428.3	10%	\$43
2017	414.7	10%	\$41
2016	382.5	10%	\$38

Figure 3: Cost of Property and Casualty Fraud 2016-2020 (in graph format).

In conclusion, as indicated in a visual format in Figures 2 and 3 above, the WCCTF estimates that the current cost of property and casualty fraud in the United States is \$45 Billion. When we consider the costs as revealed in section b from the FBI (\$40 billion), III (\$38 billion), and the IRC (between \$5.6 and \$7.7 in casualty fraud), the current estimate of \$45 billion appears credible and reliable.



Statement of No-fault

No fault insurance is required in twelve US states: Delaware, Florida, Hawaii, Kansas, Massachusetts, Michigan, Minnesota, New Jersey, New York, North Dakota, Oregon, and Utah. In addition, no-fault policies are optional, but can be purchased in seven other states: Arkansas, Kentucky, Maryland, South Dakota, Texas, Virginia, Washington, and the District of Columbia.

There is no doubt that fraud exists in claims submitted under no-fault coverage, whether in the form of staged accidents, medical provider fraud, or other schemes, there is significant fraud exposure and the potential for serious financial loss. During the initial data research phase of this study, it became immediately apparent to the CSUG team that there is an overall lack of distinct reporting and recording of no-fault insurance fraud in the United States. Most no-fault states include no-fault fraud as part of their property and casualty metric, however, no-fault is not specifically defined and calculated as a separate line item in that property and casualty metric in almost all instances. Therefore, given the structure of the method that organizations currently

record and report fraud, and specifically how there is a lack of specific fraud recording of no-fault fraud, it is not possible to develop a separate cost of no-fault insurance fraud in the United States. However, it may be safely assumed that no-fault fraud is included as part of the property and casualty final cost.

One of this study's key take-aways and recommendations is that no-fault states specifically define and record no-fault insurance fraud as an entirely separate form of fraud. Having an accurate and separate measurement of no-fault fraud will provide insights into the cost of fraud that is ultimately passed on to the consumer.

Statement of the property and casualty metric.

The goal of this study is to increase awareness of the insurance fraud problem by circulating a new and impactful cost of fraud and also serve as a starting point to create specific calls to action for all involved in anti-fraud efforts to take additional steps to modify and enhance our existing fraud reporting. As identified in the “Statement of No-Fault” text above, there are significant gaps in the reporting of property and casualty fraud. During all phases of research and data gathering in regards to property and casualty fraud, it was extremely challenging to determine what specific data was gathered when the research team located a data source. In almost all of the instances, the term “property and casualty” was used very regularly in data sources and articles, but there was never any specific breakdown of what specific coverages were included. These gaps in reporting are significant opportunity areas for the insurance industry to develop new protocols. As stated earlier, no-fault fraud needs an entirely separate line item for reporting and the same is true for all forms of auto insurance fraud. Most carriers and states capture auto insurance fraud as part of their property and casualty measurement, and accordingly, auto insurance fraud is included in the present study under the property and casualty figure. This study has identified a significant gap in reporting related to auto insurance fraud; the research team recommends that companies and states specifically define what exactly is included in their definition of property and casualty statistics and record and report by the type of coverage, such as no-fault (1st party coverage), auto property and casualty, fire property and casualty, casualty (3rd party), etc... as this will provide deeper insights into the impact of each specific area.

Workers' Compensation

a) Introduction to the problem:

Workers' compensation insurance is accident coverage that is paid by employers. If an employee is injured on the job, the employee may receive benefits to cover medical bills, rehabilitation costs, and lost wages. Some policies even provide a death benefit.

Workers' compensation insurance only applies if the employee is injured while performing the duties of the actual job. Workers' compensation systems vary from state to state, thus there are many different systems in place in the United States, creating challenges in regard to measurement, research, and collaboration.

Workers' compensation fraud is defined as "a completely fabricated injury, or a legitimate injury that is exaggerated by an employee to claim additional money." There are many legal definitions of workers' compensation fraud, but the most widely used definition (*Insurance Council of Texas, 2022*) states:

"Workers' compensation fraud occurs when someone willfully makes a false statement or conceals information in order to receive workers' compensation benefits or prevents someone from receiving benefits to which they might be entitled."

Some examples of workers' compensation schemes may include, overstating injuries or limitations, concealing records that could be detrimental to a claim, claiming an injury sustained on the job when it occurred elsewhere, and working "under the table" while collecting temporary disability benefits.

One of the most challenging aspects of workers' compensation fraud is that it is not considered a high-profile crime; most individuals are not even aware that workers' compensation scams are even a crime. Fraudulent workers' compensation claims are very damaging to businesses as they create a negative impact on a company's bottom line, revenue, and culture. Workers' compensation fraud is not limited to employees, there is also a significant amount of fraud that occurs from employers themselves in the form of misclassifying workers and other policy misrepresentations to reduce the premium amount that the employer actually pays to the insurer. Medical provider fraud is the third area of fraud in workers' compensation. This occurs when unscrupulous medical providers overbill and bill for services not rendered.

According to the Bureau of Labor Statistics (2022), it costs employers an average of \$957 per year per worker to provide legally required workers' compensation coverage, which accounts for about 1.2 % of the total average employee compensation costs incurred by employers. The average cost is \$915 per worker in the private sector and \$1,186 per worker in state and local governments. When we look at the disturbing trajectory of fraud in workers' compensation, we also see an emerging, highly disturbing pattern. As an example, Texas reported 99,850 workers' compensation claims in 2020, a significant increase from 73,628 in 2019 (*Texas Department of Insurance, 2022*).

There are instances when a company feels justified to issue a workers' compensation denial. Research shows (*Business Insurance, 2018*) that claim denial rates increased from 5.8% to 6.9% between 2013 and 2017.

The top 10 most common reasons for claim denial were:

- No medical evidence of injury.
- No injury per statutory definition.
- Reservation of rights, which is an insurer's notification to an insured that coverage for a claim may not apply.
- Pre-existing condition.
- Idiopathic condition
- Intoxication or drug-related violation.
- Non-work-related stress.
- Failure to report an accident promptly.
- The injured person doesn't meet the statutory definition of an employee.
- Misrepresentation.

Below are several interesting visuals on workers' compensation insurance as published by the Insurance Information Institute (III). These provide some framework for this challenging line of business.

Figure 4 below shows interesting statistics on workers' compensation insurance dating from 2011-2020. It is interesting to note the pivot point starting in 2019 when the Net Written Premiums began to decline from a steady growth since 2011.

Workers Compensation Insurance, 2011-2020
[Export To Excel](#)
 (\$000)

Year	Net premiums written (2)	Annual percent change	Combined ratio (1)			
			Calendar year (3)	Annual point change (4)	Accident year (5)	Annual point change
2011	\$35,664,230	12.7%	117.6	15 pts.	110	-4 pts.
2012	38,947,491	9.2	110.4	-7.2	102	-8
2013	41,147,216	5.6	103.0	-7.4	95	-7
2014	43,753,885	6.3	101.9	-1.2	90	-5
2015	45,355,102	3.7	95.5	-6.4	88	-2
2016	45,619,831	0.6	95.6	0.1	88	0
2017	45,047,380	-1.3	92.2	-3.4	91	3
2018	48,614,131	7.9	86.3	-5.8	93	2
2019	47,142,191	-3.0	88.3	2.0	97	4
2020	42,500,412	-9.8	90.2	1.9	100 (6)	3

(1) After dividends to policyholders. A drop in the combined ratio represents an improvement, an increase represents a deterioration.
 (2) After reinsurance transactions, excludes state funds.
 (3) Calendar year data are from S&P Global Market Intelligence.
 (4) Calculated from unrounded data.
 (5) Accident year data are from the National Council on Compensation Insurance (NCCI).
 (6) Estimated by NCCI.

Source: NAIC data, sourced from S&P Global Market Intelligence, Insurance Information Institute; ©National Council on Compensation Insurance.

Source: Insurance Information Institute. (2021). Facts + Statistics: Workplace Safety/Workers Comp. <https://www.iii.org/fact-statistic/facts-statistics-workplace-safety-workers-comp>

Figure 5 below shows the 2020 top 10 workers' compensation insurance carriers by Direct Premiums Written. As seen below, these 10 carriers comprised 47.6% of the entire market share of workers' compensation premiums.

Top 10 Writers Of Workers' Compensation Insurance By Direct Premiums Written, 2020

(\$000)

Rank	Group/company	Direct premiums written (1)	Market share (2)
1	Travelers Companies Inc.	\$3,737,454	7.3%
2	Hartford Financial Services	2,992,054	5.9
3	Zurich Insurance Group	2,495,405	4.9
4	Chubb Ltd.	2,294,598	4.5
5	Liberty Mutual	2,140,149	4.2
6	Berkshire Hathaway Inc.	1,998,778	3.9
7	AmTrust Financial	1,956,224	3.8
8	Accident Fund Group	1,668,319	3.3
9	New York State Insurance Fund Workers' Compensation Fund	1,610,727	3.2
10	Old Republic International Corp.	1,301,262	2.6

(1) Before reinsurance transactions, includes state funds.
 (2) Based on U.S. total, includes territories.

Source: NAIC data, sourced from S&P Global Market Intelligence, Insurance Information Institute.

Source: Insurance Information Institute. (2021). Facts + Statistics: Workplace Safety/Workers Comp. <https://www.iii.org/fact-statistic/facts-statistics-workplace-safety-workers-comp>

Figure 6 below shows the coverage and costs of workers compensation benefits in 2018. This chart provides a nice indicator of the significant money that is involved in this type of coverage.

Workers Compensation Benefits, Coverage And Costs, 2018

	2018	Percent change, 2014-2018
Covered workers (000)	142,618	7.2%
Covered wages (\$ billions)	\$8,177	19.6
Workers compensation benefits paid (\$ billions)	62.9	-1.2
Medical benefits	31.3	-3.4
Cash benefits	31.6	1.1
Employer costs for workers compensation (\$ billions)	98.6	5.0

Source: Workers Compensation: Benefits, Coverage, and Costs, October 2020, National Academy of Social Insurance.

Source: Insurance Information Institute. (2021). Facts + Statistics: Workplace Safety/Workers Comp. <https://www.iii.org/fact-statistic/facts-statistics-workplace-safety-workers-comp>

Figure 7 below shows the top 10 occupations that had the highest number of injuries and illnesses in 2019. From an underwriting and counter fraud standpoint, these occupations could serve as a basis for red flag development and/or higher risk assessment.

Top 10 Private Industry Occupations With The Largest Number Of Injuries And Illnesses, 2019 (1)

Rank	Occupation	Number	Percent of total
1	Laborers (2)	64,160	7.2%
2	Truck drivers, heavy and tractor-trailer	47,990	5.4
3	Nursing assistants	27,590	3.1
4	Stockers and order fillers	27,390	3.1
5	Retail salespersons	24,870	2.8
6	Light truck drivers	23,070	2.6
7	General maintenance and repair workers	21,490	2.4
8	Registered nurses	20,150	2.3
9	Construction laborers	19,790	2.2
10	Janitors and cleaners	18,680	2.1
Total, top 10		295,180	33.2%
Total, all occupations		888,220	100.0%

(1) Nonfatal injuries and illnesses involving days off from work for private industries; excludes farms with fewer than 11 employees.
 (2) Laborers and freight, stock and material movers.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Source: Insurance Information Institute. (2021). *Facts + Statistics: Workplace Safety/Workers Comp.*
<https://www.iii.org/fact-statistic/facts-statistics-workplace-safety-workers-comp>

b) Existing data pertaining to workers’ compensation fraud cost.

The WCCTF conducted a thorough review searching for existing research available on workers’ compensation fraud costs. The WCCTF uncovered an extremely credible research study being performed by the Coalition Against Insurance Fraud’s Workers’ Compensation Fraud Committee. *The WCCTF spoke directly to the committee and the researchers of the study and reviewed all aspects of the project, including the methodology and metrics, and deemed that this study was credible and accurately represented the current state of workers’ compensation fraud. Accordingly, the WCCTF determined that this 2022 Coalition study will serve as the main resource of workers’ compensation fraud costs for purposes of this current 2022 study.

*The workers’ compensation statistic that the Coalition Against Insurance Fraud publishes was deemed as the most credible source as the Coalition has been supporting the insurance industry with research, advocacy, and support since its inception in 1993. The Coalition is one of the most well-respected in the anti-fraud community and provides robust services to consumers, the media, and insurance organizations.

The following excerpt is from the Coalition's Workers' Compensation Task force and its research:

The Coalition's Workers Compensation Fraud Task force continues its work of calculating a new figure that quantifies the amount of comp fraud taking place in the U.S. Led by Co-Chairs, Dominic Dugo, and Gene Donnelly, the pair has assembled a multi-disciplinary collective of experts in the field of WC to tackle the assignment of updating the decades-old \$7B estimate. Excluding self-insureds, the committee has come up with a preliminary estimate of \$34B in WC fraud divided between premium and claim fraud. The committee examined a number of recent studies and reports to ascertain the value of premium fraud. They also reached out to a number of experts and academics to capture the cost of claim fraud. Dr. Michael Skiba, PhD and Department Chair of Criminal Justice at Colorado State University Global, estimated a 16% fraud rate in the claim volume based on research with dozens of carriers. Based on the 2020 written premium, and using the 16% number, the estimated amount of fraud in WC claims is \$9B and \$25B of premium fraud. The Committee wants anyone with relevant expertise or access to authoritative reports/information on fraud in the WC system to share any information that may better inform their working estimate of \$34B. If you have questions about the committee's methodology or would like to participate in the effort to update the WC figure, please contact Dominic Dugo at Dominic@insurancefraud.org.

- c) Research teams' calculation on the updated cost of workers' compensation fraud.

The 2022 Coalition research project focused on two areas of workers' compensation fraud to determine their final figure; premium fraud and claim fraud. In analyzing workers' compensation claimant fraud it was determined using a base of 2020 written premiums and multiplying that metric by a 16% fraud rate. A.M. Best provides a direct written premium in 2020 of \$56,225,576,000, which served as the baseline premium metric. Prior studies performed by the WCCTF resulted in strong indications that 16% of all workers' compensation claims are suspicious, thus the use of the 16% figure in this cost formula. Once written premiums (\$56,225,576,000) were multiplied by the 16%, the final result was \$8,996,092,160, appropriately rounded to \$9 billion as the final cost of workers' compensation claimant fraud in 2020.

Workers' compensation premium fraud was determined by first developing a cost of fraud in the state of California and then using census data to predict the cost of fraud countrywide. The baseline used was a \$3 billion estimate that was derived by Frank Neuhauser of the University of California Berkeley who performed a study on the Underground Economy and Payroll Fraud. The Coalition's Workers' Compensation Task Force used the \$3 billion figure and then assumed California's population is 12%

of the total United States population (based on 2019 Census Data), the formula was developed to determine the final cost. According to the United States Census data, in 2019, the U.S. population was 328 million and California was 39.5 million; thus, California occupies 12% of the total U.S. population.

\$3 billion (fraud in California) x 8.3 (California is 12% of the USA population), translates into a metric of 100 divided by 12 = 8.3. Thus $\$3,000,000,000 \times 8.3 = \24.9 billion premium fraud in the United States.

The WCCTF, therefore, concludes that workers' compensation claimant fraud totaled \$9 billion plus \$25 billion in premium fraud, for a grand total of \$34 billion in workers' compensation fraud in the United States.

Premium Fraud

a) Introduction to the problem:

Premium fraud also referred to as premium leakage, is a very significant area of insurance fraud, but is very difficult to assess due to the difficulties when trying to determine policy misrepresentation on policies. Premium fraud can occur at almost all points in the policy process, from signing up for a new auto policy to making policy changes to an existing policy. Policyholders are motivated to misrepresent policy information since premiums can cost less or more depending on facts that are provided in the policy application; thus, enticing policyholders to misrepresent certain facts on their policies in favor of lower premiums. During the initial policy application process, an insured has the opportunity to misrepresent almost every item covered, such as drivers, vehicle use, garaging locations, etc. After the policy is in force, the policyholder can also engage in activity and fail to disclose it to the insurance company for fear of raising their premium. Some of these activities would include moving to a higher premium area, allowing a new driver to operate a vehicle, increasing the mileage driven of a covered vehicle, etc. In addition to this challenge, insurers themselves are pressured to write policies due to the highly competitive market in that they operate. This pressure could result in insurers writing a bad risk, which will bring in premiums at the onset but will be extremely costly to the insurer in the long term due to the high propensity for fraud in these higher-risk policies.

There are many indicators and common red flags related to premium fraud; the following are examples of some of these red-flag indicators:

Residency.

- Policy zip code and policyholder area code are in different areas.

- Insured is employed a significant number of miles from the policy address.
- Accident is more than a few miles from the policy address.
- Insured is reluctant to meet appraiser/adjuster/investigator at the policy address and prefers a work location, coffee shop, and the like. This may indicate that he/she does not reside there.
- Insured agrees to meet the appraiser/adjuster/investigator at residence address but needs more than a reasonable amount of time to get to the location. Again, this may indicate that the policyholder does not reside at the address.
- Insured uses a PO box as his or her primary mailing address.
- Insured cannot produce documents that show his or her name and the policy address—documents such as utility bills, pay stubs, tax returns, or credit card bills.

Vehicle mileage driven.

- Insured is reluctant to release mileage information via phone or in person.
- Insured avoids appraiser/sales agent/investigator physically viewing the vehicle.
- CARFAX or other database check reveals a significant number of miles in a short period of time. This may indicate potential commercial use.
- Accidents occurs with multiple passengers that are not related or acquainted with the insured. This may indicate that the insured uses the vehicle for commercial or livery use, and potentially the mileage is misrepresented.

Other miscellaneous premium red flags would be as follows:

- Insured pays cash for the premium.
- If insured pays via check, the checks are starter checks.
- Re-employment, the insured is very vague about his/her job duties.
- Premiums seem very high for the insured's socioeconomic status.

Red flags indicators that can be communicated to first notice of loss report taker:

- Insured provides a PO box.

- Multiple people making the loss report.
- Agent documentation indicates that the insured had a higher-than-normal number of inquiries to the agent prior to loss.
- Insured is hesitant to release personal information and is generally uncooperative.
- Insured is overly aggressive for a settlement and could also threaten contacting supervisors, state consumer bureaus, attorneys, etc.
- Insured seems unusually familiar with insurance terms.
- Multiple recent changes in policy coverage, including the coverage that specifically affects the claim being reported.

(Skiba, 2017)

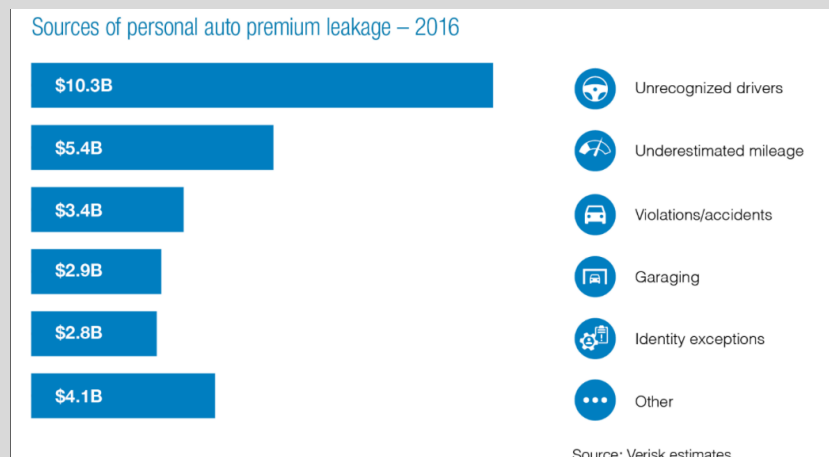
b) Existing data pertaining to premium fraud cost.

The WCCTF performed an in-depth search canvassing for current research on premium fraud. After performing this comprehensive search, it was discovered that there is little to no research performed in the area of premium fraud. The WCCTF’s extensive search resulted in one study that was performed in 2017 on premium fraud that was deemed credible and will serve as the foundation for this LOB in this 2022 study. Premium fraud in auto insurance was the focus of a study performed by Verisk in 2017, which estimated that \$29 billion was lost due to premium fraud. *Their calculation included unrecognized drivers, underestimated mileage, violations, garaging, and identity exceptions. Significant growth in the use of technology platforms to write policies (non-face-to-face) makes it easier for an insured to misrepresent items on their policy. As seen below in Figure 8, their study revealed the following sources of leakage.

Figure 8: Sources of Personal Auto Premium Leakage

Source: Verisk, 2017.

Due to the lack of other research uncovered during the investigation of this LOB, and the credibility of this study, the 2017 Verisk study will be the



primary source of information for this current 2022 study.

*As noted, the Verisk 2017 study was deemed the most effective for the purposes of this research project. The WCCTF reviewed the Verisk study parameters (copied below) and accordingly, approved of this methodology as a credible source of data. “Two Verisk research initiatives support the majority of findings for this Innovation Paper. The 2016 Verisk Auto Insurance Premium Leakage Survey explored insurers’ concerns, programs, and plans regarding premium leakage. The response represented 58% of private passenger auto insurance premiums. Verisk also conducted a client analysis for 82 insurers split evenly between standard and nonstandard. The research combined Verisk’s RISK:check® predictive analytics model that identifies potentially fraudulent applications with additional data from more than 3 million policies (2.1 million standard, 1 million nonstandard).”

c) Research teams’ calculation on the updated cost of premium fraud.

The 2017 Verisk study will serve as the basis for premium fraud for the purposes of this study. The Verisk study concluded that in 2017 the cost of premium fraud was \$29 billion. If we use a standard Consumer Price Index (CPI) conversion of \$29 billion from 2017 to January 2022, we receive a new 2022 cost of fraud of \$31.6 billion.

The WCCTF sought a second source to cross-check the final \$31.6 billion estimate derived using the Verisk foundational estimate. To establish a second metric, the WCCTF used a formula based on the estimated percentage of premium fraud as established by Reinsurance Group of America (RGA) and then divided that percentage into the 2020 net written premium for the U.S. A global study performed by RGA in 2017 assessed premium fraud at a rate of 5.9 percent *(Reinsurance Group of America, 2017, *Global Claims Fraud Survey*). Considering the total net written premium for 2020 (\$655.5 billion-Figure 9) we derived a formula of \$655.5 billion x 5.9 %, which resulted in a figure of \$38.7 billion. When we cross-check this figure of \$38.7 billion with the Verisk figure of \$31.6 billion, we can ascertain that both costs are of course different, but they are within the same range for the WCCTF to be comfortable releasing a new estimated figure based on these two numbers.

Figure 9: Total Net Written Premium 2016-2020 (in billions).

	2016	2017	2018	2019	2020
Net premiums written	\$534.0	\$558.4	\$618.3	\$639.5	\$655.5
Percent change	2.6%	4.6%	10.7%	3.4%	2.5%
Premiums earned	\$529.2	\$546.4	\$599.7	\$627.3	\$642.7
Losses and loss adjustment expenses incurred	382.5	414.7	428.3	445.6	450.8
Other underwriting expenses	148.0	151.1	167.7	172.5	179.3
Policyholder dividends	2.9	3.3	3.7	4.9	7.7
Net underwriting gain/loss	-2.4	-20.8	2.6	7.8	11.9
Net investment income	47.5	49.7	57.0	56.3	53.4
Miscellaneous income/loss	-2.4	-9.0	-2.4	-2.5	-1.9
Operating income	43.1	20.2	57.3	60.5	59.0
Realized capital gain	8.5	19.6	10.7	11.0	10.4
Federal income tax	7.3	-0.8	7.2	8.5	8.7
Net income after taxes	44.3	40.6	60.8	63.1	60.7

Source: NAIC data, sourced from S&P Global Market Intelligence; Insurance Information Institute.

Source: NAIC data, sourced from S & P Global Market Intelligence; Insurance Information Institute.

Regarding the final cost of premium fraud in the U.S., if we take the two figures of \$31.6 and \$38.7 billion, and then average these two numbers together, the new figure for the cost of auto premium fraud in the United States is \$35.1 billion.

*The RGA study metric of 5.9% was based on premium fraud in the Americas and did not isolate The United States from the final 5.9% figure. Despite this shortcoming, the WCCTF felt that the 5.9% was still the most accurate measure to serve as a baseline for this project. Regarding the methodology, the RGA conducted an online survey in September and October 2017 of 27 insurance carriers.

Healthcare Fraud

a) Introduction to the problem:

According to the Centers for Medicare and Medicaid Services (2020, *CMS Office of the Actuary Releases 2019 National Health Expenditures*), healthcare spending in 2019 made up nearly 18% of the country's Gross Domestic Product, totaling \$3.8 trillion. Nearly all of this spending was paid for by insurance. Health insurance has grown in utilization and popularity across America for the last 100 years when insurance became

more widespread following World War I. In 2010, the federal government passed groundbreaking legislation in the Affordable Care Act. This regulation aimed to give access to insurance to people that may not have had it prior, and as a result, a large percentage of Americans are currently covered by health insurance, and most of our \$3.8 trillion annual GDP is paid by health insurance. In a post-Affordable Care Act, post-Medicaid Expansion America, the United States Census Bureau (2020), estimates that 92% of people in the U.S. have some form of health insurance. Using those two figures, an estimated \$3.5 trillion in healthcare costs are paid by insurance annually. Altogether, this makes healthcare a unique and attractive target for fraud, both because of a large amount of dollars available, and because so much of the spending is paid by insurance rather than by the individual receiving services.

Insurance fraud schemes can take many forms in healthcare. These schemes are found in all areas of healthcare, including hospitals, pharmacies, clinics/doctor's offices, long-term care facilities, home health services, pharmaceuticals, medical devices, and durable medical supplies. In some cases, providers bill for services that were never rendered, which can include billing for services to patients who are deceased, or who have never seen the provider submitting the claim. Other schemes involve "upcoding," or submitting a claim for a service more complex and with a higher reimbursement rate than the service that was rendered. Upcoding can include billing for a high quality of medication or supplies, or by inflating complexity. Most provider visits include an evaluation and management of service. This service can be reimbursed at multiple rates depending on how complex the patient's care is and how difficult evaluating the patient and managing their condition is. Determining the correct level of complexity is highly subjective, and creates an environment where providers often determine what level is appropriate on their own. This level of autonomy creates a large opportunity for fraud.

More complex schemes involve the practice of "unbundling," where a provider will bill for each component of a service individually rather than submit a single billing code that covers all services, as required by some insurance companies. Often a billable service will include lab work, follow-up, visits, or other auxiliary services that are supposed to be included in a single rate. Fraud can be committed by submitting claims for all of the services individually rather than accounting for the included services in the initial code. Insurances, including both Medicare and Medicaid as well as most commercial plans, require that a service be medically necessary to be reimbursed. The provider submitting the claim is often key in determining whether or not the service is necessary. This allows the provider who will directly benefit from additional services to manipulate the situation to fraudulently bill by making false statements about a

patient's condition to show medical necessity, including fabricating diagnoses and misrepresenting the patient's true conditions.

Healthcare fraud can also be committed by the patient. Medical identity theft has been becoming more and more common, with uninsured or underinsured persons presenting to a healthcare provider a name, identification, and insurance information for a different person. Occasionally, fraud is committed through willing "card sharing" rather than identity theft. This occurs when a willing person shares their health insurance information with a family member or friend and helps them impersonate the insured person when seeking care to get the insurance company to pay for the care provided to a non-covered person.

b) Existing data pertaining to healthcare fraud cost.

No major commercial health insurance companies report fraud estimates, and national organizations that do gather this information do not publicly publish it and declined WCCTF requests for this information. The WCCTF approached approximately 10 carriers and received denials for access to the information they gathered. The WCCTF located three separate sources of data that were deemed credible for this study. The National Healthcare Anti-Fraud Association (2019), *is a premier organization in healthcare fraud and estimates that between 3%-10% of health insurance spending is lost to fraud nationwide; if we assume the higher 10% metric, fraud costs in health care could surmount to \$300 billion. The WCCTF then used CMS's 2020 data which shows \$3.8 trillion in total healthcare spending and 2019 United States Census data showing 92% of people in the United States carried health insurance, and calculated as follows: \$3.8 trillion x 92% = \$3.5 trillion is paid annually for health insurance claims. CMS data (as explained in detail in the next job section on Medicare and Medicaid) shows that Medicare and Medicaid spending in 2020 totaled \$1.5 trillion, meaning the remaining \$2 trillion was paid by commercial insurance plans.

*The NHAFA is seen as the leading healthcare fraud fighting organization in the United States healthcare industry. They were founded in 1985 and are a private-public partnership that is comprised of over 100 insurance carriers, law enforcement, and regulatory agencies. Also affiliated with the NHAFA is the NHCAA Institute for HealthCare Fraud Prevention, which was established in 2000 and is a separate educational organization that provides both education and training to anti-fraud healthcare personnel. Accordingly, the WCCTF deems the NHAFA as a highly credible and reliable source of healthcare research and data.

c) Research teams' calculation on the updated cost of life insurance fraud.

As outlined above, considering the limitations of available statistics (both publicly and directly from private health carriers) on health care fraud, the WCCTF felt that the most accurate method to derive a healthcare fraud metric would be to utilize the data secured from the NHAFA on fraud percentage (3%) and CMS on total health care spending (\$3.5 trillion). The WCCTF applied the estimated 3% of dollars spent to be lost to fraud as established by the NHAFA to the \$3.5 trillion healthcare expenditures as established by the CMS. This would suggest total healthcare claims fraud costs all insurers, including Medicare and Medicaid, $\$3.5 \text{ trillion} \times 3\% = \105 billion annually.

To arrive at an accurate metric on healthcare spending, we must extract from that \$105 billion, the amount of fraud in relation to Medicare and Medicaid fraud. Referring to the next line of business section on Medicare and Medicaid, we derived a final figure (averaging AARP and USGOA data) of \$68.7 billion dollars to Medicare and Medicaid fraud. Subtracting Medicare and Medicaid fraud from the total figure leads us to conclude that fraud costs \$36.3 billion per year ($\$105 \text{ billion} - \68.7 billion).

Medicare and Medicaid

a) Introduction to the problem:

Medicare and Medicaid are government programs that pay healthcare expenses for vulnerable populations. Medicare is a federal program focused on elderly and disabled persons. This is a population that would have less access to traditional health insurance because private health insurance is often provided through an employer, and individuals in these populations tend to either be retired or unable to work because of their disability. Medicare recipients pay an insurance premium and often have other out-of-pocket costs such as deductibles and coinsurance. The premium is subsidized by government funds and the provider network and pricing agreements are managed by the government.

Medicaid is a state-run program that provides access to families living near the poverty level. Medicaid recipients generally do not pay a premium or out-of-pocket costs. All costs are paid by the government, which also manages the provider network.

Medicare and Medicaid fraud has a lot in common with traditional healthcare insurance fraud. Fraud schemes can include billing for services not rendered, upcoding, unbundling, and providing unnecessary services. Differences are reflected in the nature of the services provided and the nature of the recipients. Medicare and Medicaid recipients are more vulnerable to fraud than the general population. Elderly and

disabled persons are at higher risk of being fraud victims because they are generally less involved in the decisions behind their care and may not be as likely to pay close attention to their bills or may struggle to understand their bills. Since Medicaid recipients often do not have any cost-sharing, they are less likely to pay attention to any aspect of billing, making them a larger target. The Department of Health and Human Services Office of Inspector General considers some services providers to be at higher risk for committing fraud. Hospitals and physicians are generally considered lower risk, with Home Health Agencies and Durable Medical Equipment providers being considered high risk. Because they are more likely to be dealing with life limiting diseases and decreased functionality, Medicare and Medicaid patients are more likely to receive services from high-risk providers than the population covered by traditional insurance. The government also spreads more resources on investigating and pursuing fraud over private, commercial, insurance companies. This suggests that Medicare and Medicaid would experience more fraud than commercial insurance companies.

b) Existing data pertaining to Medicare & Medicaid fraud cost.

The WCCTF conducted an exhaustive search canvassing for metrics on Medicare and Medicaid fraud and found an incredibly wide range and inconsistent results, such as metrics of \$60 billion annually from the University of Southern California Center for Elder Justice (2021) to \$134 billion from the Center for Medicare and Medicaid Services (2020) and even groups such as the Center for to the National Conference of State Legislatures (2022) concluded that fraud in Medicare and Medicaid is nearly impossible to measure. The CMS was seen as a very credible source by the WCCTF, but after deep analysis into the \$134 billion figure they derived at, it was decided to refrain from including the metric in the final analysis. CMS themselves estimated \$134 billion (2020), annually in improper Medicare and Medicaid claims, however, they point out that not all improper claims were necessarily fraud. The WCCTF arrived at the \$134 billion figure by adding up the 2020 Improper Payments from FFS, Part C, Part D, Medicaid, and CHIP dollars from the chart in the citation above from the CMS website. This \$134 billion number includes waste and abuse, which may be unintentional, such as a misunderstanding or a disagreement about when there is an honest, good-faith question regarding medically necessary. This figure also follows Office of Management and Budget Office guidance that any claim unsupported by documentation is assumed to be improper rather than undetermined. It was therefore decided to refrain from including the CMS number of \$134 billion as part of this study.

The WCCTF scoured for other sources and located two other highly credible sources that will be utilized for this line of business. The American Association of Retired

Persons (AARP), referencing United States General Attorney Jeff Sessions, estimates that CMS pays \$1,000 in fraud claims per member, or roughly \$60 billion (2018). *

The United States Government Accountability Office (USGOA) puts the number a little higher, at \$77.4 billion (2019). *The WCCTF derived at \$77.4 billion by referring to the report, which states \$36.2 billion for Medicare Fee-for-service/FFE and another \$41.2 billion for Medicaid, which summed together, total \$77.4 billion.

*AARP is the nation's largest non-profit organization representing individuals over 50. Having roughly 40 million members in the United States, it is considered the most credible and robust organization focusing on matters of that age group. Accordingly, this organization is known to provide highly detailed and accurate research and reporting on topics related to individuals over 50, such as Medicare and Medicaid.

*The United States Government Accountability Office is a legislative branch government agency that provides auditing, evaluation, and investigative services for the United States Congress. Their primary function is to investigate and monitor federal spending and performance. As they are the top agency in the United States that monitors federal spending, they are an ideal resource to provide data and research for this study.

c) Research teams' calculation on the updated cost of life insurance fraud.

The WCCTF calculated a final number for Medicare and Medicaid fraud by taking an average of the AARP (\$60 billion), and the USGOA (\$77.4 billion) figure, $\$60 \text{ billion} + \$77.4 \text{ billion} = \$137.4 \text{ billion}$ divided by 2 = \$68.7 billion. Although some sources do not consider Medicaid to be insurance as there is technically no risk sharing, the general population considers it to be a form of insurance, and it functions from a billing perspective similarly to Medicare and other commercial insurers. Therefore, the WCCTF believes Medicare and Medicaid fraud should both be included in the total amount.

Life Insurance Fraud

a) Introduction to the Problem:

Life insurance fraud is deliberate deception committed by an insured or insurance agent to gain a financial advantage. Applicants, policyholders, third-party claimants, and professionals who provide services are all potential fraud sources. Misrepresenting life insurance policy information, tampering with another person's policy, and fake deaths, are among the common frauds. Life Insurance fraud is one of the most serious

problems facing insurers, insurance consumers, and regulators. Its existence not only increases the cost of insurance but also threatens the financial strength of insurers and negatively affects the availability of insurance. Insurance fraud encompasses a wide range of illicit practices and illegal acts involving intentional deception or misrepresentation. Some of the most common forms of life insurance fraud include:

- Lying on an application. This involves adjusting, or even withholding valuable information, such as any medical conditions.
- Forgery. A common scheme is when someone other than the policyholder will change a beneficiary.
- Fake policy. Fake agents sell fake policies that do not exist and pocket the money.
- Faked death. In these instances, people try to collect for someone who is still alive or never existed.
- Murder. When a beneficiary plans to kill a policyholder and pocket the payout.
- Pocketing premium. An agent pockets the premium payment instead of forwarding it to the company.

Life insurance policies also involve a contestability period, that is, the time frame in which an insurer can deny a claim for material misrepresentation and fraud. This period varies by state, but it is generally one to two years. Research by the Reinsurance Group of America (2017) reveals that 20% of life insurance policies are rescinded by insurance companies.

b) Existing data pertaining to life insurance fraud cost.

The WCCTF performed a robust search looking for current data on life insurance fraud and unfortunately, very limited information was revealed. The WCCTF searched every potential platform in search of research on life insurance fraud statistics including open source, direct industry contacts with the III, NAIC, FBI, the Coalition, ACFE, IASIU, and academic libraries. As a result of that exhaustive search only one study that was conducted in 2017 by the Reinsurance Group of America (RGA) was found. All other sources that were located that focused on life insurance fraud made reference to the 2017 RGA study, confirming that the RGA study was the only research study completed focused on life insurance fraud.

To understand the life insurance fraud problem the RGA surveyed 25 insurance carriers, conducted informational interviews among insurance carriers, held information gathering discussions at the 2016 RGA Annual Fraud Conference, and conducted their internal research of the claims experience. Based on that method, the RGA reported that they estimate life insurance fraud to cost approximately \$10-20 billion each year.

The RGA further states that 1%-3% of all life insurance claims are either investigated for fraud or misrepresentation, or they are denied outright.

c) Research teams' calculation on the updated cost of life insurance fraud.

In considering the research revealed in section b above, it was determined that a new figure for the cost of life insurance fraud would be necessary. Although the 2017 RGA study added insights and was the most cited in terms of life fraud, the methodology was based on several survey instruments, and even though this could be a very credible source of information, without knowing the details of the survey instruments, the research protocols, the sample, etc., the WCCTF felt that a new cost was needed.

To arrive at a new formula for life insurance fraud, the WCCTF looked for data on the total life insurance benefits and claims paid in past years. A very credible and accurate source was uncovered when the WCCTF located data published by the III. *(Insurance Information Institute, 2021, Insurance Fact Book Payouts)*. As seen by Figure 10 below, a recent study by the Insurance Information Institute (III) showed life insurance benefits and claims reached \$747.4 billion in 2020. The amount includes death benefits from life insurance, annuity payments, disability payments, and other payouts. It is interesting to note when analyzing data in this form that life insurance benefits have slowly declined since 2018.

Figure 10: Life Insurance Benefits and Claims 2016-2020

	2016	2017	2018	2019	2020
Death benefits	\$73,996,171	\$74,942,626	\$77,076,010	\$76,038,700	\$87,670,442
Matured endowments, excluding annual pure endowments	420,287	437,591	381,587	423,780	467,154
Annuity benefits	74,769,738	77,043,317	78,392,309	82,348,469	86,023,032
Disability, accident and health benefits (1)	120,056,048	126,785,757	131,440,728	140,558,797	137,585,722
Coupons, pure endowment and similar benefits	19,509	19,406	11,216	4,327	4,297
Surrender benefits, withdrawals for life contracts	265,095,216	308,928,842	350,278,913	339,640,132	323,350,563
Group conversions	30,872	25,719	26,702	25,499	13,980
Interest and adjustments on deposit type contracts	9,407,551	8,348,035	9,539,457	10,044,578	9,815,812
Payments on supplementary contracts with life contingencies	2,062,662	2,106,523	2,152,431	2,413,542	2,414,306
Increase in aggregate reserve	123,731,601	98,004,358	133,760,428	110,529,379	100,020,756
Total benefits and claims	\$669,589,655	\$696,642,288	\$783,059,441	\$762,027,202	\$747,366,061

Source: Insurance Information Institute, 2021, Insurance Fact Book Payouts.

Key fraud organizations such as NICB, III, the Coalition, NAIC, and IASIU, widely circulated the figure of 10% as the key percentage of claims that are fraudulent. Accordingly, the WCCTF will propose a new cost of life insurance fraud using the total benefits and claims payout as indicated by the III in Figure 10 above and then use the metric that 10% of all life claims are fraudulent as a baseline. Using this formula, if the life insurance benefits and claims payout was \$747.4 billion in 2020, and we estimate that approximately 10% of that figure was fraudulent we would derive at a new cost of

\$747.4 billion x 10% = \$74.7 billion. Therefore, the 2020 estimate of life insurance fraud in the United States is \$74.7 billion.

The increasing number of life insurance frauds not only increases costs for the companies but also leads to inflated premiums, which is felt by consumers. Therefore, it is necessary to have a proper risk management framework to curtail or minimize life insurance fraud. A life insurance company's commitment to fraud control will be met by identifying the opportunities for fraud and implementing risk avoidance, its prevention, and procedures for its minimization in the day-to-day system of operations.

*As already noted in the property and casualty line of business section earlier, the Insurance Information Institute was chosen as the most reliable, credible, and effective data source as the III is one of the most well-respected members of the insurance industry. Since 1960, the III has been one of the most trusted sources of data for consumers, the media, and professionals in the insurance industry and at its core organizational function researches and publishes information, statistics, and data on the insurance industry.

Disability Insurance Fraud

a) Introduction to the Problem:


Disability fraud involves making a false statement, providing incorrect information, or withholding information to collect benefits (individual or group). There are many forms of disability fraud, including; faking a medical issue to be declared disabled, continuing to collect payments after the individual has recovered, receiving benefits while working another job, usually "off the books", exaggerating a medical condition to meet the disability threshold for collection and inflating income on a Social Security Benefits application to increase payout.

In reviewing the current literature related to disability fraud, there appear to be many inconsistencies in its definition and measurement. Some sources include disability in workers' compensation fraud, some consider it an entirely separate line of business, and yet others define it separately, but segment it as being fraud against private carriers and the Social Security Administration. It is also readily labelled "improper payments" by the Social Security Administration. Due to these inconsistencies and the wide variety of definitions, parameters, costs, and statistics being circulated, the WCCTF decided to focus on Social Security Disability fraud as the primary area of study as these statistics are well defined in the literature.

b) Existing data pertaining to premium fraud cost.

The Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI) programs offer assistance to individuals that are disabled. SSDI pays a benefit to an injured party or family member if you are an eligible worker and have paid Social Security taxes on your income. SSDI will reimburse individuals with disabilities who have limited income. The table below (Figure 11) shows the highlights of the difference between SSDI and SSI (*Social Security Administration, 2022*).

Social Security Disability Insurance	Supplemental Security Income
Payments come from the Social Security trust funds and are based on a person's earnings.	Payments come from the general treasury fund, NOT the Social Security trust funds. SSI payments are not based on a person's earnings.
An insurance that workers earn by paying Social Security taxes on their wages.	A needs-based public assistance program that does not require a person to have work history.
Pays benefits to disabled individuals who are unable to work, regardless of their income and resources.	Pays disabled individuals who are unable to work AND have limited income and resources.
Benefits for workers and for adults disabled since childhood. Must meet insured status requirements.	Benefits for children and adults in financial need. Must have limited income and limited resources.



Securing today and tomorrow

SocialSecurity.gov

Figure 11: Comparison of SSDI vs. SSI

Source: Social Security Administration, 2022.

As previously mentioned, the WCCTF will focus on Social Security Disability fraud, or Improper Payments, as the focal point for developing a cost current 2022 cost of disability fraud. The WCCTF performed an exhaustive search for credible and accurate data pertaining to disability insurance and located

several interesting sources but decided for the purposes of this study to utilize data from the most seminal organization in this area, the Social Security Administration (SSA). As the SSA is the top branch of the United States government that oversees life insurance and therefore the data and research they publish is an ideal fit for purposes of this study.

The Social Security Administration (SSA) considers payments to be improper, "...if they result from a mistake in computing the payment, its failure to obtain or act on available information, a beneficiary's failure to report an event, or a beneficiary's incorrect report". The SSA considers improper payments to comprise of both under and overpayments; underpayments when they mis-calculate benefits, and overpayments when they pay someone more than they are due. The SSA estimated that in 2019, a total of \$7.9 billion was paid in total improper payments (*Social Security Administration, 2020*).

c) Research teams' calculation on the updated cost of life insurance fraud.

As the SSA data is incredibly reliable, robust, and accurate, the WCCTF focused on data published by the SSA as the basis to develop the new cost of disability fraud in

the United States. The SSA estimated that in 2019, \$7.9 billion was paid in improper payments, that is, both overpayments and underpayments (defined in section b above). As underpayments are payments that the SSA makes as a result of improper calculation, and potentially an error on behalf of the SSA, it was decided that because these types of payments are not necessarily fraudulent, the WCCTF will refrain from including underpayments in the final cost of disability fraud. In other words, the WCCTF will only focus on overpayments as these payments can be precipitated by insured and beneficiary misrepresentation and fraud. We conclude that our new cost of disability insurance fraud will be based on SSA overpayments. As published by the SSA in their Fiscal Year 2020 Agency Report, they estimate that it made \$6.6 billion in overpayments in 2019 (*Social Security Administration, 2020*).

Accordingly, if we use a standard Consumer Price Index (CPI) conversion of \$6.6 billion in 2019 to January 2022, we receive an 81.5% inflation rate, which would convert into a 2022 cost of disability fraud in the United States as \$7.4 billion!

Auto Theft*

a) Introduction to the problem:

The FBI's Uniform Crime Report (UCR) defines motor vehicle theft as the theft or attempted theft of a motor vehicle. A motor vehicle is formally defined as a self-propelled vehicle that runs on land surfaces and not on rails and could include sport utility vehicles, automobiles, trucks, buses, motorcycles, motor scooters, all-terrain vehicles (ATV), and snowmobiles. The following are not considered motor vehicles according to the UCR; farm equipment, construction vehicles (bulldozers, etc.), airplanes, and boats (*Federal Bureau of Investigation, 2020*). It is interesting to note that the UCR considers the taking of a motor vehicle for temporary use by persons having lawful access as being **excluded** from this definition of auto theft.

Auto theft is always evolving, thus creating a very challenging atmosphere for companies and agencies that are tasked with investigating these crimes. Auto thieves are very savvy at pivoting to new and sophisticated methods for theft, including smart keys, cloning vehicles, and using false identities to purchase high-end luxury vehicles.

b) Existing data pertaining to premium fraud cost.

The research team explored all possible sources for accurate statistics and metrics on auto theft and as a result, several key sources were identified. The National Insurance Crime Bureau (NICB) maintains an accurate database on auto theft as it affects the general consumer population and specific industry members of NICB. Additional theft data was also discovered that is maintained by the Insurance Information Institute (III).

The NICB and III data are very accurate and meaningful and were considered as part of this analysis, however, the data gathered and maintained by the FBI was used as the primary source for this current research study for the following reasons. The FBI defines auto theft as a key component in their robust UCR measurement and has been maintaining auto theft records for many decades; thus, the FBI was considered one of the primary sources of auto theft data for this study. In reviewing the 2019 and 2020 UCR in detail, some key highlights are:

2019

- Total thefts nationwide: 724,872.
- The rate of motor vehicle theft was 219.9 per 100,000 inhabitants.
- Of all the classifications of motor vehicles as defined by the UCR (in the above paragraph), automobiles ranked the highest at 74.5% of the total.
- The average value of auto theft was \$8,886.

2020

- The average dollar loss per theft was \$9,166.
- 810,400 vehicles were stolen, the highest yearly number of vehicles stolen since 2008 (959,059). See Figure 12.
- The number of thefts increased 11.8 % from 724,872 in 2019.
- The rate of motor vehicle theft was 246 per 100,000 inhabitants, the highest rate since 2009 (259).

(Federal Bureau of Investigation, 2020)

Figure 12: Motor Vehicle Theft Rates 2011-2020

Source: U.S. Department of Justice, Federal Bureau of Investigation, Uniform Crime Reports.

Year	Vehicles stolen	Percent change
2011	716,508	-3.1%
2012	723,186	0.9
2013	700,288	-3.2
2014	686,803	-1.9
2015	713,063	3.8
2016	767,290	7.6
2017	772,943	0.7
2018	751,904	-2.7
2019	724,872	-3.6
2020	810,400	11.8

Source: U.S. Department of Justice, Federal Bureau of Investigation, Uniform Crime Reports.

Figure 13: Motor Vehicle Theft-States with the Highest and Fewest

Top 10 States With The Most And The Fewest Number Of Motor Vehicle Thefts, 2020

Most motor vehicle thefts			Fewest motor vehicle thefts		
Rank	State	Vehicles stolen	Rank	State	Vehicles stolen
1	California	168,323	1	Vermont	264
2	Texas	84,276	2	Maine	862
3	Florida	38,271	3	Wyoming	964
4	Colorado	30,452	4	New Hampshire	1,044
5	Washington	27,399	5	Rhode Island	1,509
6	Georgia	25,506	6	Delaware	1,665
7	Missouri	24,189	7	Idaho	1,767
8	Illinois	21,332	8	Alaska	1,969
9	Tennessee	21,098	9	North Dakota	2,074
10	North Carolina	20,520	10	West Virginia	2,271

Source: U.S. Department of Justice, Federal Bureau of Investigation, Uniform Crime Reports.

Source: U.S. Department of Justice, Federal Bureau of Investigation, Uniform Crime Reports.

Figure 14: 2020 Top 10 Most Stolen Vehicles

Top 10 Most Frequently Stolen Vehicles, 2020

All model years (†)			2020 model year vehicles only		
Rank	Model	Thefts	Most common model year stolen	Rank	Model
1	Ford Pick-up (Full size)	44,014	2006	1	Nissan Altima
2	Chevrolet Pick-up (Full size)	40,968	2004	2	Chevrolet Pick-Up (Full size)
3	Honda Civic	34,144	2000	3	Toyota Corolla
4	Honda Accord	30,814	1997	4	Chevrolet Malibu
5	Toyota Camry	16,915	2019	5	Ram Pick-Up (Full size)
6	Nissan Altima	14,668	2020	6	Toyota Camry
7	GMC Pick-up (Full size)	13,016	2005	7	Hyundai Elantra
8	Toyota Corolla	12,515	2020	8	Jeep Cherokee/Grand Cherokee
9	Honda CR-V	12,309	2000	9	Ford Pick-Up (Full size)
10	Dodge Pick-up (Full size)	11,991	2001	10	Dodge Charger

(†) Includes all model years for each vehicle.

Source: NICB, 2020, NICB Releases Annual “Hot Wheels” report: America’s Top Ten Most Stolen Vehicles. <https://www.nicb.org/news/news-releases/nicb-releases-annual-hot-wheels-report-americas-top-ten-most-stolen-vehicles>

Auto theft was on the rise in 2020, with a total of 810,400 thefts occurring. NICB estimates in 2020 that 1 car was stolen every 36 seconds (NICB calculated this statistic based on 880,595 thefts occurring). Auto theft over the past five years (2016-2020) remained around 800,000, but the five-year peak in 2020 was attributed to several factors, most notably, the pandemic, economic downturn, owner complacency, loss of juvenile outreach programs, and public safety budgetary and resource limitations. When we analyze geographic regions, the west coast (California, Oregon, Nevada, and Washington) and mid and southwest (Colorado, New Mexico, Missouri, and Kansas) had the highest rates of car theft in 2020 (*Federal Bureau of Investigation, 2020; Insurance Information Institute, 2021*).

Considering the information presented above regarding the measurement of auto theft, the WCCTF fully discloses that the final formula that was used for purposes of this study to derive a new cost of auto theft is not the most ideal to accurately measure this line of business. Of all of the lines of business studied in this research project, this line of business is seen as the one that has the most significant limitations regarding gathering. Specifically, the WCCTF would like to note that the FBI statistic, although they clearly define their data as “auto theft”, measures auto theft as a whole and does not necessarily differentiate between auto theft as a crime and auto theft resulting from insurance fraud. Therefore, it is noted that this measurement does have limitations, however, the WCCTF felt that even with these limitations, the final figure that was derived at should be included in this study.

c) Research teams’ calculation on the updated cost of auto theft.

The WCCTF considered all of the data that was uncovered by researching the NICB, III and FBI statistics, but the metric as circulated by the FBI will be used as the primary source of auto theft cost for this 2022 study. As stated, and defined earlier in this section, the FBI maintains very accurate and robust data pertaining to auto theft statistics in the United States. Therefore, the cost as calculated and communicated by the FBI will be utilized for this study. Accordingly, the FBI estimates that the total cost of motor vehicle theft in the United States for 2020 is \$7.4 billion (*Federal Bureau of Investigation, 2020; Insurance Information Institute, 2021*). Therefore, \$7.4 billion will be the current cost estimate of auto theft for purposes of this study.

VI. Compilation of LOBs into a final 2022 estimate of insurance fraud cost

This section will consist of compiling all of the LOBs into one final estimate of the cost of insurance fraud in the United States as of 2022.

- Property and Casualty Fraud. The WCCTF estimates that the current cost of Property and Casualty fraud in the United States is \$45 Billion.
- Workers’ Compensation Fraud. The WCCTF estimates that workers’ compensation fraud totals \$34 billion in the United States.
- Premium Avoidance or Misclassification. The WCCTF estimates premium fraud in the United States is \$35.1 billion.
- Healthcare Fraud. The WCCTF estimates healthcare fraud in the United States is \$36.3 billion.
- Medicaid and Medicare Fraud. The WCCTF estimates Medicaid and Medicare fraud in the United States is \$68.7 billion.
- Life Insurance Fraud. The WCCTF estimates that life insurance fraud in the United States is currently \$74.7 billion.
- Disability Fraud. The WCCTF estimates that the current cost of disability fraud in the United States is \$7.4 billion.
- Auto Theft. The WCCTF estimates auto theft in the United States is \$7.4 billion. *

FINAL ESTIMATE OF THE COST OF INSURANCE FRAUD IN THE UNITED STATES:

(All numbers are in billions and figures are as of 2022)

Property & Casualty	\$45B
Workers’ Compensation	\$34B
Premium Avoidance	\$35.1B
Healthcare	\$36.3B
Medicare and Medicaid Fraud	\$68.7B
Life	\$74.7B
Disability	\$7.4B
Auto Theft*	\$7.4B

\$308.6 Billion Annually

VII. Statement on Auto Theft

This report includes auto theft in the analysis of the updated estimate of the cost of insurance fraud in the United States. At the current time, auto thefts in the United States are reported to be on the rise. These thefts directly impact insurers through

increased claims, investigations of the theft, and policy payments where appropriate. Auto thefts also harm consumers. Obviously, those directly impacted are harmed but so too are all consumers who pay for auto theft crimes through higher premiums. Absent provable involvement of the insured in the theft, however, auto theft is not insurance fraud but an insurance crime for which virtually all automobile insurance policies extend coverage. The Coalition recognizes the extensive and excellent work being done by our partner, the National Insurance Crime Bureau, law enforcement agencies and others to fight back on the crime of automobile thefts. We include the information in this report, and the cost in our estimate of insurance fraud cost in the United States to assist those efforts and shed additional light on the problem of automobile thefts in our nation.

VIII. Recommendations for future study

The WCCTF is honored to embark on such an incredibly insightful journey exploring the world of insurance fraud and investigating the many different aspects of this unique form of white-collar crime. Throughout the study, the WCCTF saw opportunities for further research and investigation for others seeking to dive deeper into estimating the cost of insurance fraud. Specifically, the WCCTF would recommend researching each of these LOB's through an entirely separate study, or studies, to take a deep dive into the intricate areas of each LOB. Focusing initially on one specific LOB would prove fruitful as this would allow the team to myopically explore a survey instrument, develop committees, and create a highly focused methodology. Additionally, the WCCTF recommends a research group be created dedicated to gathering and compiling fraud measurements across all LOB's on a regular and ongoing basis. Having a consistent picture of the cost of insurance fraud would assist with the allocation of current and hopefully increased resources in this endeavor.

IX. Conclusion

This report has quite literally been a quarter-century in the making. It is doubtful anyone associated with creation of the original \$80 billion estimate of the cost of insurance fraud would have foreseen their work creating the most cited anti-fraud statistic in the United States. Federal and state agencies, courts – both federal and state, regulators, legislators, insurers, national and international media and academic research all routinely cite to that original figure.

In 2021 the Coalition Against Insurance Fraud embarked on this project to provide each of these important stakeholders, and more importantly America's consumers, with a far more accurate and up-to-date estimate of the cost of insurance fraud on our

nation's economy. This report is the result of that endeavor. We again wish to express our great appreciation to those who partnered with us on this task: the National Insurance Crime Bureau, the International Association of Special Investigation Units, the American Property & Casualty Insurance Association, and the Insurance Information Institute. Our greatest appreciation, however, goes to the incredible team at the Colorado State University Global White Collar Crime Task Force, led by Dr. J. Michael Skiba. Their dedication, spirit and untold hours of work form the foundation upon which this vital report is based.

X. Appendix

Recommendation for the measurement of fraud

Many inquiries were received from the Coalition members requesting a recommendation as to how to accurately measure fraud. As a result of this demand, the WCCTF directs those seeking more information to an excerpt from Dr. J. Michael Skiba's book entitled "The Psychology of Fraud".

In that book, an entire chapter is devoted to addressing this exact topic. The WCCTF hopes that this appendix section will serve as a guide for insurance companies to assist with the development of an effective measurement formula to integrate into their respective organizations. The data that insurance companies gather and maintain concerning fraud is incredibly valuable as it provides incredible insights as to the nature of fraud occurring within their respective organizations. However, this data is also extremely useful to consumers as it is the backbone of showcasing the damaging effect of fraud. In addition, legislators and the legal environment can also benefit from this data as they can also use it to make highly strategic and effective decisions about fraud and prevention.

To review the Appendix in full please visit this site:

<https://insurancefraud.org/wp-content/uploads/Appendix-THE-IMPACT-OF-INSURANCE-FRAUD-ON-THE-U.S.-ECONOMY.pdf>

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PHOTOS:

- <https://www.iii.org/fact-statistic/facts-statistics-workplace-safety-workers-comp>
- <https://www.iii.org/article/background-on-insurance-fraud>
- [rga-2017-global-claims-fraud-survey-white-paper---final \(1\).pdf](https://www.rgare.com/knowledge-center/media/articles/rga-2017-global-claims-fraud-survey-white-paper-final-1.pdf)
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About the Coalition

The Coalition Against Insurance Fraud is America's only anti-fraud alliance speaking for consumers, insurance companies, government agencies and others. Through its unique work, the Coalition empowers consumers to fight back, helps fraud fighters to better detect this crime and deters more people from committing fraud.

The Coalition supports this mission with a large and continually expanding armory of practical tools: Information, research and data, services, and insight, as a leading voice in the anti-fraud community. Formed in 1993, the Coalition is made up of more than 260 member organizations and they unite to fight all forms of insurance scams regardless of who commits the fraud.

Technical review and oversight of the this report were provided by the Coalition's Research Committee:

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Coalition Against Insurance Fraud

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