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A Phenomenological Study of the Barriers and Challenges Facing Insurance Fraud Investigators

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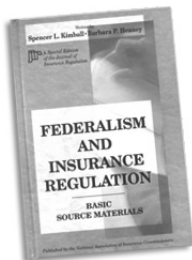
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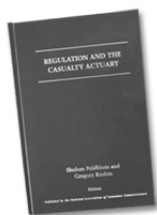
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A Phenomenological Study of the Barriers and Challenges Facing Insurance Fraud Investigators

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Abstract

Insurance fraud is a serious problem that has significant societal, humanitarian and financial impacts. There is a lack of consistency in approaching this issue. This study's purpose is to explore and discover insurance fraud investigators' lived experiences of fighting insurance fraud using interpretive qualitative phenomenology. The data analyses and interpretation resulted in multiple themes emerging regarding the strategies, barriers, trends and environmental factors that affect insurance fraud. The findings will be useful to those operating in this industry as these strategies and barriers can be applied immediately toward preventative efforts. In addition, the results will be useful to others in parallel investigative industries as it is demonstrated that insurance fraud offenders operate in many other criminal circles.

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Introduction

The U.S. Department of Justice declared fraud, a category of white-collar crime, the No. 2 crime issue facing the United States, second only to violent incidents (Sparrow, 2008). Recent research suggests that insurance fraud schemes are currently the preferred criminal method of organized crime rings, drug cartels and terrorist cells (Morales and Hurtado, 2012; Sukharenko, 2004). Organized crime rings and terrorist cells have targeted insurance fraud as the preferred crime to fund their groups because they are drawn to the high reward and low risk of these offenses (Tennyson, 2008). Yet, despite these alarming facts, there is an immense void in data and studies performed in this area, so much so that it inhibits the knowledge base and causes increased challenges for fraud fighters (Lesch and Brinkmann, 2011).

Sparrow (2008) argues that fraud is a relatively invisible crime, one that is difficult to detect and quantify, making it one of the most worthy areas for further study. Insurance fraud is a problem because studies have revealed that it presents significant financial, societal and humanitarian costs (Palasinski, 2009). For example, automobile insurance fraud is historically one of the most costly fraud scandals in the history of the United States, costing the average household \$950 per year (Coalition Against Insurance Fraud, 2012). It is estimated that 10% to 20% of all automobile insurance claims filed are fraudulent. Coupled with the fact that automobile premiums in the United States total \$110 billion, this would correlate to an approximate insurance fraud issue of \$11 billion annually (Boyer, 2007; Miyazaki, 2009). Equally alarming is the fact that the majority of the public is unaware of these alarming statistics (Boyer, 2007).

Additionally, fraudulent medical billing practices have been shown to result in significant abuse to patients (Parver and Goren, 2011; Taylor, 2003). Research has revealed how questionable medical facilities will inflate billing (upcoding) in order to increase the reimbursement that they receive from the insurance carriers. This upcoding procedure often results in patients being subject to highly painful procedures, such as invasive testing, unnecessary surgeries and extreme physical manipulations. This can result in severe injury, including paraplegia and death (Qureshi, Sartor, Xirasagar, Ying and Bennett, 2011; Parver and Goren, 2011; Taylor, 2003).

Despite insurance fraud's broad reaching impact, research has revealed alarming statistics concerning the public's opinion toward this crime. According to Wilson (2009), approximately 24% of the population believes that it is acceptable to exaggerate the value of an insurance claim, and 11% believe that it is acceptable to submit a claim for items or damages not actually lost. Furthermore, 30% agree that fraudulent activity will increase during an economic downturn, and 49% believe that they would not be caught if they filed a fraudulent claim. Miyazaki (2009) postulates that public acceptance is due to the negative perception of insurance companies and how the publication of their high profits helps to justify

consumer fraudulent activity. For this reason, there seems to be a lack of social pressure to enact, enforce, investigate and prosecute insurance fraud-related issues.

Given these alarming facts, little is known about the insurance fraud problem. Furthermore, it is not known what preventative insurance fraud strategies are currently working and which approaches are the most effective (Furlan, Vasilecas and Bajec, 2011). The Coalition Against Insurance Fraud (2012) reports that because there is no single agency or organization that collects fraud data, each insurance company and agency must devise its own reporting information, which is inconsistent and often inconclusive. As argued by Furlan et al. (2011), there is a large void in data collection and studies performed in the area of white-collar crime, to the extent that it hinders the knowledge base and causes increased challenges for fraud fighters. As such, the purpose of this interpretive phenomenological study is to explore insurance fraud using interview data collected from fraud experts on the challenges, barriers and strategies that affect insurance fraud preventative measures.

Background

The body of literature on insurance fraud has indicated that this unique form of white-collar crime is trending in a dangerous direction (Bales and Fox, 2010; Boyer, 2007). Law enforcement and criminal justice agencies have placed fraud-related crimes at the top of the list of current potential threats to our society (Sparrow, 2008). Studies have revealed that there are significant financial, societal and humanitarian costs of fraud, yet there is little research being performed to assist fraud professionals with prevention strategies (Furlan et al., 2011; Holtfreter and Blomberg, 2005).

It is not known what preventative insurance fraud strategies are currently working and which approaches are the most effective. A comprehensive literature review revealed that all research appears to fall under eight main categories: numerical strategies; prosecution; bad faith; behavioral theories; training; patient abuse; economic impact; and large-scale fraud. All of these areas of research, separately, are highly applicable, yet a gap exists bridging all of their findings into a global synthesis of information that can be applied in a broader context for preventative strategies. This is an ideal environment for phenomenological analysis, which will reveal barriers and strategies to prevent insurance fraud from an expert sample and seek to bridge the gap in this knowledge base.

Consequently, an additional problem of insurance fraud investigators appears to be successfully melding pertinent research with theory in order to help explain and diagnose the insurance fraud problem. Studies have shown that many agencies and companies are using statistical databases as the primary method of fraud prevention, yet these have been deemed somewhat ineffective given they lack a personal, human-based component (Morales and Hurtado, 2012; Morley, Ball and Ormerod, 2006). These facts support the theoretical conceptualization of this

analysis, whereby postulating that capable guardians, a tenet of routine activities theory, will serve to reduce the opportunity to commit crime and intervene in the spatiotemporal continuum of the offense.

Cohen and Felson (1979) proposed the routine activities theory in 1979 in an attempt to explore the environmental factors of crime. They argued that environmental factors significantly contribute to the nature and frequency of crime. The foundation of routine activities theory proposes that three critical elements must be present in order for crime to occur: suitable targets, capable guardians and motivated offenders (Cohen and Felson, 1979; Conradt, 2012). When all three components are in alignment, then a space-time continuum exists, and crime is the result (Boakye, 2009). This paper will serve to fill the gap between current research and the applicability of theory into insurance fraud prevention strategies, an approach that has previously been given little academic attention.

Methodology

This qualitative, phenomenological study's purpose is to interview key experts in the field of insurance fraud, and identify significant themes and patterns of barriers and strategies that would assist with insurance fraud prevention. It is established in the literature that preventative strategies do effectively reduce insurance fraud, yet it is not known which preventative insurance fraud strategies are currently working and which approaches are the most effective (Furlan et al., 2011). The body of literature revealed that the impact of insurance fraud is difficult to quantify, predicated by the fact that many agencies and insurance companies have different methods they use to measure insurance fraud. This leads to inconsistent data on the fraud problem (Jay, 2012). Furthermore, fraud is viewed as a relatively invisible crime, making it difficult to accurately assess its impact (Derrig et al., 2006).

Research suggests that because of this crime's financial impact, many insurance companies have developed some form of preventative strategy (Bales and Fox, 2010). However, studies also have revealed that these current preventative approaches are generic, ineffective and easy for the opportunistic criminal to penetrate (Palasinski, 2009; Wilson, 2009). These findings would suggest that current preventative strategies need to be updated based on the current status of the insurance fraud problem, thus adding to the need for a study focusing on gaining the lived experiences of contemporary fraud fighters.

Additionally, while there have been prior studies performed in the insurance fraud area, a gap exists in understanding the true essence of the insurance fraud issue—a gap that is best explored by interpretive, inductive phenomenological inquiry. Approaching the research problem using an interpretive worldview will be the most effective approach at answering the research questions; research using this paradigm involves the search for subjective meaning of an experience,

whereby these meanings are varied and multiple, and requires the researcher to look for complex views instead of narrow, objective perspectives (Glicken, 2003; Moerrer-Urdahl and Creswell, 2007). Interpretivism is ideal for this study as it can generate new theories or patterns of meaning, instead of the postpositivism approach, which would commence with a theory (Crotty, 1998).

To address the insurance fraud problem, the current study follows Moustakas' (1994) methods of phenomenological inquiry, whereby researchers focus on the lived experiences of the participants. The research questions that were formulated adhere to Moustakas' parameters for phenomenological inquiry and were developed to provide a detailed description of the essence of the investigators lived experience in the fraud arena (Baltimore and Crase, 2009; Laverty, 2003). The primary research question is: What barriers and challenges are reported by insurance fraud investigators in helping fight insurance fraud? The secondary research questions are:

1. What preventative tactics have insurance fraud investigators used, and have they been effective?
2. What do insurance fraud investigators report as the main trends in insurance fraud in today's environment?
3. What are the perceptions of insurance fraud investigators as to the legal, political and social environmental factors that promote or inhibit fighting insurance fraud?

The phenomenological format was deemed the most effective method for collecting information to answer the research questions posed. Capturing and analyzing information through in-depth interviews from top insurance fraud professionals yielded data that was highly effective at getting to the core of this problem. Moustakas' data analysis approach and ATLAS.ti, a data analysis software package, were both used to analyze the interviews. Moustakas' (1994) multi-step methodology involves bracketing biases, developing a list of non-repetitive statements, grouping significant statements into themes, scanning the data for themes and sub-themes, synthesizing these themes, and then providing structural descriptions.

For purposes of this study, three insurance fraud experts were asked to participate in field testing, completing the field test interview and then commenting on the accuracy and overall validity of the format and research questions. The three field test participants were chosen to participate in a field test of the research instrument using the same purposive sampling procedure as the study sample. The testers made several small inquiries and suggestions, but consensus at the conclusion of the process was that all six questions in the original instrument would accurately satisfy the study's goals and purpose. Therefore, no modifications of the instrument were needed. The reliability and validity of the study was strengthened by the integration of this field test into the framework of the research.

Next, a non-probability purposeful sampling procedure was used to select 15 insurance fraud experts from the overall membership of 150 from a professional investigative organization based on the inclusion criteria listed below. The expert panel of insurance fraud professionals was identified using the following purposive criteria: employed in the insurance fraud industry for at least 10 years, are active with industry associations, have held or currently hold an investigative position, and regularly publish or present fraud related information.

The sole data collection instrument for this study included six semi-structured open-ended questions. The interview protocol was designed and formatted based on recommendations from seminal researchers such as Polkinghorne (1989) and Moustakas (1994). A newly created instrument is essential in phenomenological inquiry as it can be tailored to focus on the specific issues and themes of the topic under study (Creswell, 2007; Glicksen, 2003). As recommended by Creswell (2009), conducting an in-depth literature review of the topic will help determine which areas to focus on and specifically which questions to ask. The instrument was developed based on these recommended protocols. The six interview questions were as follows:

1. What do you perceive as the main trends in insurance fraud today?
2. Do you feel that the legal/political/social/ environment promote strategies to fight insurance fraud? Why or why not?
3. Do you feel that insurance fraud is increasing or decreasing in severity and frequency? Why or why not?
4. What is your perception on the current barriers to preventing insurance fraud?
5. What current strategies are you personally using to fight insurance fraud? Do you feel that they are working? Why or why not?
6. What frustrations do you feel as a professional in this field attempting to fight fraud?

Fifteen investigators participated in the study; 11 were male, and four were female. Participants ranged from 36 to 58 years of age, with an average age of 46.2 years. Table 1 provides a summation of the demographics of the sample. The years of experience ranged from 10 to 30 years, with an average of 18.7 years. The education level ranged from associate degree to master's degree to juris doctorate.

**Table 1:
Sample Demographics**

Participant	Title	Years Experience	Education
1	Partner/CPA	17	MBA
2	CEO	20	BA
3	Investigator	20	AAS
4	Investigator	18	BS
5	Vice President	18	BA
6	Manager	21	BA
7	Investigator	18	BA
8	Manager	19	BS
9	Investigator	18	BS
10	Analyst	17	MBA
11	Investigator	15	AAS
12	Attorney	10	JD
13	Manager	25	BA
14	Partner	30	AAS
15	Investigator	15	MS

As discussed by Baltimore and Crase (2009), and Moustakas (1994), the process of data collection for qualitative, phenomenological studies involves in-depth interviews with a sample population. The sole method of data collection for this study was 15 face-to-face semi-structured interviews. An interview instrument was used as a guide when interviewing, but as suggested by Moustakas (1994), the structure of the inquiry was flexible to allow new ideas and discoverable data to emerge regarding this phenomenon (Gearing, 2004; Raffanti, 2008). This flexibility undoubtedly added to the rich data that resulted from the interviews (Moerrer-Urdahl and Creswell, 2007). In addition, a list of additional probing questions was developed in the event that the interview became stalled.

Once the sample was identified and direct phone contact was made, the face-to-face interviews were scheduled with each participant. Each interview was conducted in a private office setting, free from distraction (Ritzman, Sanger, Snow and Stremlau, 2010). At the beginning of the meeting, a hard copy of the informed consent form was reviewed with the participant, and answers to any pending questions were provided. All 15 participants willfully agreed to participate and immediately signed the informed consent form and an additional form consenting to audiotaping of the interview.¹ The interviews lasted from 30 minutes to one hour, with the average interview lasting approximately 45 minutes.²

1. Each interview was recorded using a Sony ICD-PX720 digital audio recorder.

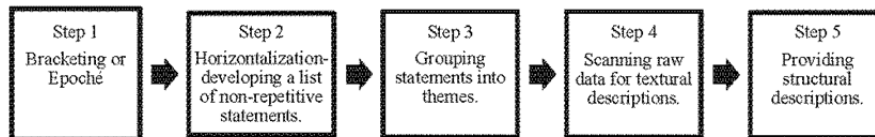
2. Upon completion of the audio session, the electronic file was downloaded to the researcher's password-protected laptop computer for data analysis.

Data analysis took place after all 15 interviews were conducted. Each audiotaped interview was transcribed and then compared to the audio tape to ensure accuracy.³ The interview audio and text files were stored on a password-protected laptop computer and backed up on a flash drive that was kept in a locked safe. Each participant was assigned a number at the face-to-face interview, which would serve as the sole identifying feature of that sample member.

Moustakas' data analysis procedure was followed during the data interpretation phase of this study. As outlined in Figure 1, the first step in Moustakas' (1994) methodology involves Epoché, or bracketing, which involves setting aside biases or preconceived notions in order to fully explore the fraud phenomenon (Gearing, 2004; Raffanti, 2008). The second step involves horizontalization, listing every significant statement and giving it equal weight. ATLAS.ti was used to assist with the development of these significant statements for further analysis by using the open coding function. The third step is to group significant statements into themes (Baltimore and Crase, 2009; Ritzman et al., 2010).

Both the coding function within ATLAS.ti and the reports function were used to further reduce overlapping themes. The fourth step involves writing textural descriptions of the experiences, or the *what*. This phase was completed using the in-depth statements secured from the sample of fraud fighters, which allowed for a more profound understanding of the emerging themes. The final stage involves providing a structural description of how these barriers and challenges can be used toward preventative efforts to make them more successful. The final themes were synthesized, and a presentation of the material, in both table and discussion format, was developed (Gearing, 2004; Ritzman et al., 2010).

Figure 1:
Moustakas' Data Analysis Approach*



*Adapted from *Phenomenological Research Methods*, by Moustakas, C. (1994). Thousand Oaks, CA: SAGE Publications, Inc.

3. As Gilstrap (2007) and Moustakas (1994) presented, the researcher is the key instrument in phenomenological, qualitative analysis. The researcher listened to each taped interview and then transcribed them each verbatim. The researcher decided to transcribe the interviews without the assistance of outside resources in order to become more immersed in the data, as Moustakas suggested.

The qualitative reliability protocol that Leedy and Ormrod (2010) and Creswell (2009) established served as the foundation for this study. The recommendations these researchers made were followed to insure the study was reliable according to qualitative standards.⁴

Qualitative validity involves checking for the accuracy of the findings by employing certain procedures (Babbie, 2004; Giorgi, 2006). Many researchers view validity as one of the strengths of qualitative research as it seeks to determine whether the findings are accurate from the perspective of the researcher and the participant (Creswell, 2009; Crotty, 1998). Internal validity becomes an issue in research when a panel of participants contains one or more strong personalities that may serve to sway the other panel members and skew results (Lewis, 2009; Glicken, 2003).

This is one of the key advantages of the format employed in this study: All interviews were performed separately, with no participant interaction. Researchers such as Creswell (2007) recommend several strategies to increase the validity of a study: triangulation, member checking and clarification of bias. Creswell (2007), Glicken (2003), and Bordens and Abbott (2008) all recommend the use of these multiple strategies to insure validity in a qualitative methodology. The validity strategies that Creswell (2007) recommended were integrated within this study and served as the foundation to insure qualitative validity.⁵

4. Specifically, the exact procedure that was used to obtain the data for this study was outlined and documented, systematically, for future replication. Secondly, the author transcribed all of the interviews; no outside source was used for this function, which allowed for the review of the interviews multiple times to ensure accuracy. Finally, the author manually coded the data, but also ensured that there was no drift in meaning by using ATLAS.ti, a qualitative analysis software package. Thus, by following these well-established protocols on qualitative reliability, the study would be deemed reliable and consistent (Creswell, 2009; Golafshani, 2003; Leedy and Ormrod, 2010).

5. These strategies include triangulation, member checking and clarification of bias. Triangulation involves using multiple sources of data to develop and build a coherent justification for the themes (Leedy and Ormrod, 2010). Triangulation was used within this study as themes were established based on the converging of multiple perspectives from the participants, each adding his or her own separate insights into this phenomenon. Member checking as a qualitative validity strategy involves taking the final themes back to the participants to determine if they are accurate or require modification (Creswell, 2007; Babbie, 2004). After the final themes were developed, the author contacted each participant via email and presented the study's final product (i.e., themes and coding) and then asked for comments. All participants concurred that the final product was accurate, thus fulfilling the requirements for this validation strategy. Clarification of bias was also used (Creswell, 2007; Gearing, 2004) as the author's bias was acknowledged throughout the study.

Results and Analyses

The primary research question explored in this study was: What barriers and challenges do insurance fraud investigators report in helping fight insurance fraud? The analysis revealed the following six themes: 1) no political and judicial support; 2) financial barriers; 3) fraud is difficult to quantify; 4) fraud is a social problem; 5) claims staff changes; and 6) companies are their own worst enemy. Table 2 provides a summation of these main themes in the left-hand column and then the appropriate sub-themes in the right-hand column. As the table illustrates, only Theme 6—*Companies are Their Own Worst Enemy*—had sub-themes. The three sub-themes for Theme 6, as illustrated in Table 2, were: 1) insurance carriers pay and do not fight; 2) hiring practices; and 3) promote profits.

All 15 of the participants in the sample reported that a lack of political or judicial support was one of the biggest barriers to insurance fraud prevention. They said that fraud fighting must start at the end of the line (prosecution) in order for the front-line efforts to be successful and effective. Participant 4 and Participant 5 said that weak laws and enforcement was “huge,” remarking that the only way to get people to stop committing insurance fraud is to have harsher penalties. Participant 6 described fraud punishment as a “slap on the wrist.” Participant 7 called it a “joke.”

Many of the participants said that in those few cases that do go to court, there was a significant inconsistency in the interpretation of laws, regulations and court decisions. Participant 12 said that this was a huge frustration and barrier. “One judge in one court could rule one way,” Participant 12 said, “and a judge in another court would say the exact opposite.” Added Participant 13, “This inconsistency creates significant confusion, decreases confidence and causes unsettled feelings among the insurance carriers, which would make them reluctant to proceed with an expensive case down the line.”

Table 2:
Themes and Sub-themes of the Primary Research Question: What Barriers and Challenges are Reported by Insurance Fraud Investigators in Helping Fight Insurance Fraud?

Themes	Sub-themes
a) No Political or Judicial Support	
b) Financial Barriers	
c) Fraud is Difficult to Quantify	
d) Fraud is a Social Problem	
e) Claims Staff Changes	
f) Companies are Their Own Worst Enemy	a) Insurance Carriers Pay and Do Not Fight
	b) Hiring Practices
	c) Promote Profits

A Phenomenological Study...

Lack of political support was seen as a major barrier for the sample. Participant 3 thought that politics was one of the root causes of the lack of prosecutorial support, remarking that politicians have their own agendas and that insurance fraud is not a “glamorous” crime, like drugs or terrorism. Others felt that the high turnover rate in many public offices was one of the major barriers in getting cases prosecuted. Participant 11 discussed how it takes years to educate a new assistant district attorney.

“Just when you have them up to speed and ready to roll, they move on, and you start all over again,” Participant 11 said.

The consensus from the sample was that all carriers, law enforcement agencies and public agencies are in dire need of additional resources to devote to this fraud-fighting endeavor.

Participant 1 remarked, “Nobody wants to put money into it.”

“Everybody has to do more with less,” added Participant 4.

Many of the participants said that competition over limited resources is the downfall of every fraud unit, as fraud gets little attention and is usually passed over in favor of other units and departments. Participant 11 discussed how special investigative units (SIUs) are “an expendable unit; companies ebb and flow, and SIUs get cut because of this.”

Further frustration was felt by many of the participants who are staffed in SIUs that have cut their support structure, such as databases, technological items and other seemingly “basic” fraud fighting essentials. Participant 13 discussed how his company has cut its database usage, which presents additional challenges and time constraints for his field investigations.

“It is totally counterproductive and ineffective,” he said.

Each company and agency appears to have its own way to measure fraud: as an occurrence, as a savings and as a disposition. The result is a significant disparity in the results that are published.

As Participant 2 argues, “Without these impact-generating statistics, fraud will never get the attention that it deserves.”

Added Participant 3, “There is absolutely no rhyme or reason to fraud reporting. If you were to ask 10 different fraud fighters, you would get 10 different answers on how they measure fraud.”

All of the participants said that fraud was a larger social issue, one whereby the public generally “accepts” insurance fraud as a normal part of insurance operations. Participant 7 said that there is a public barrier; there is the feeling that it is OK to commit fraud because premiums are paid and, therefore, people are owed.

“This definitely has to change,” Participant 7 said. “You have to show people that there are damaging effects of fraud, both financial and physical, in order for change to come.”

Many of the participants spoke of what they termed “entitlement theory.” Participant 5, Participant 11 and Participant 12 all discussed how many people are unemployed or underemployed; yet, these people still want the cars and the toys, so they turn to fraud, and fraud “becomes part of their income.”

A lack of understanding of the insurance fraud problem was a constant theme that emerged in the interviews. Many of the participants, such as Participant 8, discussed how people “have no problem lying on their policy or trying to collect when it is not advantageous to their company and society.”

Participant 6 furthered this contention, stating, “People don’t understand how insurance works. They don’t understand that all of their money is pooled together for the greater good, to cover all losses. People don’t care and don’t want to care.”

An overwhelming theme was how claims adjusters are not adjusters anymore; their positions have been downscaled to processors. Participant 4 discussed how there has been an evolution of the claims adjuster job, explaining how senior claims adjusters used to make good money.

“It was a career,” Participant 4 said.

Participant 3 remarked, “Companies fire these people and hire two college kids for the price of this experienced adjuster. The problem with this is that these new reps wouldn’t know a fraud if it hit them in the head.”

Participant 11 and Participant 14 also expanded on this notion and discussed how the claims adjuster job is now “watered down.”

As Participant 8 noted, “Now they go six months and switch companies. They are all processors now.”

Many participants reported that one of the biggest barriers to fraud prevention was their own companies. Participant 3 discussed how his own company engaged in fraudulent activity by altering policy information of an executive; the company justified this as a way to “take care of our own.” Many participants were frustrated at the lack of seriousness that fraud has at the upper levels within a company, citing specific examples of how they constantly have to *sell* fraud to their executives. This main theme was further coded into three sub-themes: 1) insurance carriers pay and do not fight; 2) hiring practices; and 3) promotion of profits.

Participants said that insurance carriers too often choose to take the “easy” road and pay claims instead of fighting them.

“It’s a smart business decision in my opinion, but it sets a bad precedent,” Participant 1 said. “It sends a message to the criminals that they can go ahead and defraud them as they will pay.”

Participant 3 further disclosed, “The insurance carriers are in a hurry to settle these claims. Now with that mentality, you are going to create your own fraud.”

Several participants discussed how many companies view lost fraud dollars as part of a business loss. They do not want, or need, to fight fraud because they simply write it off as a cost of doing business.

Participant 11 and Participant 15 explained how people without any prior SIU, field or law enforcement experience are now managing SIUs. Participant 11 and Participant 15 said these people “simply don’t understand what we are faced with in the field.”

Participant 6 remarked how these non-field managers are being asked to approve and authorize certain portions of an SIU investigation, and without any practical experience, “they are making the wrong decisions.”

As discussed in the theme regarding claims staff issues, many participants were frustrated with the claims staff hiring issues, explaining how companies are hiring claims processors and not adjusters. Many participants said that the first contact between the insurance company and the policyholder or claimant was a key opportunity to set the stage for the file. Participant 3 said that a great deal of fraud begins if an adjuster starts the relationship (sometimes at the very first call) treating an insured or claimant poorly.

Participant 5 said that when this occurs, the policyholder or claimant thinks that the company is trying to get one over on them, and they start to think of ways that they “can even it out, get my piece of the pie,” which begins the fraud cycle.

Another hiring trend emerged from the interviews involving the outsourcing of SIUs. A majority of the participants discussed how external service providers were replacing internal SIU investigators and staff. Participant 9 discussed how the internal, company-paid investigator is going to do a stellar job as he or she has a stake in the company and the result. As compared to the external service provider who is only contracted and could have 10 other clients that he or she has to please. “You get lost in the shuffle,” Participant 2 remarked.

An overwhelming majority of the participants said that one of the most significant reasons that companies are their own worst enemy, was in their presentation of profits. Participant 3 explained how people have no respect for big companies anymore.

“People hear how executives are stealing,” Participant 3 said. “They hear about ABC president who made \$2 million last year, and, at the same time, they deny my grandmother for her visit to her general practitioner.”

Participant 8 disclosed how people perceive the insurance companies as “big and bad,” and “it is perfectly acceptable to rip them off.” Participant 10 further confirmed this perception and discussed how companies throw lavish parties, publish outrageous profits and salaries, and showcase private jets for executives.

The secondary research question explored in this study was: What preventative tactics have insurance fraud investigators used, and have they been effective? All of the themes that emerged from this probing question were directly correlated to the preceding theme pertaining to barriers. The analysis revealed the following four themes: 1) fix the social problem; 2) more focused and specialized staff; 3) technology; and 4) networking. Table 3 provides a summation of these main themes in the left-hand column and then the appropriate sub-themes in the right-hand column. As Table 3 illustrates, only Theme 2—*More Focused and Specialized Staff*—had three sub-themes: 1) claims representatives; 2) SIUs; and 3) synergy.

Fixing the broader social problem pertaining to insurance fraud was seen as the most effective strategy to help fight fraud. Many participants viewed fraud as a global social issue that required a specific approach, one that would change the public perception about the crime and make it less appealing to the criminal element. Participant 5 and Participant 13 discussed how cheating is more acceptable in an economic crisis, as people try to get their “piece of the pie” from nontraditional work avenues, such as fraud. They further added that the social

phenomenon of “entitlement” breeds crime and fraud as people are competing for limited resources.

**Table 3:
Themes and Sub-themes of the Secondary Research Question: What Preventative Tactics Have Been Used by Insurance Fraud Investigators, and Have They Been Effective?**

Themes	Sub-Themes
a) Fix the Social Problem	
b) More Focused and Specialized Staff	a) Claims Representatives b) SIUs c) Synergy
c) Technology	
d) Networking	

The in-depth interviews revealed several strategies, such as focusing on increasing training and public awareness of the growing fraud problem and its wide-reaching impact.

“If fraud was more publically known, people would definitely be more apprehensive to commit fraud,” Participant 1 said.

Participant 2 further added, “People are smart. If they don’t know the damaging effects of fraud, they are going to continue to do it. They need to know its impact.”

Participant 5 offered, “If you truly want to make a difference, you aren’t going to do it solving cases. It’s going to be done by changing people’s perception of this crime.”

Participants viewed public outreach campaigns in different venues as an effective solution, one that provides a nice “bang for your buck.” Some of those common strategies would be billboards, television spots, radio and even social networking avenues. Participants remarked that anything to get the word out to the public was effective.

As one of the participants said, “You need to create a presence and let people know you are watching.”

Several participants spoke of policy education as a key component in a fraud-fighting strategy. These companies focus on educating their policyholders before an accident occurs as to what their policy covers and does not cover. This created a sense of *one* with the policyholder, instead of the adversarial relationship that is often the case after the loss occurs. Participant 4 explained how people do not understand how insurance works.

“They get what they opted and paid for,” Participant 4 said. “If we try and explain this after their house burned down, we look like we are ‘nickel-and-diming’ them. Then the relationship changes for the worse.”

Participants discussed the need for a more focused and specialized claims and SIU staff as one of their main strategies. Furthermore, they argued that a

synergistic claims-SIU relationship was needed in order for fraud-fighting efforts to be truly effective. This main theme was further coded into three sub-themes 1) claims representatives; 2) SIUs; and 3) synergy. Many participants discussed how the claims adjuster position has seemingly transitioned from a claims adjuster job to a claims processor job, reducing the need for cognitive intervention by the claims staff. As a result, many participants use or recommend the use of a claims specialist or liaison that would be able to address SIU issues and act as a “gatekeeper” to the SIU staff.

As Participant 2 noted: “The claims folks are so overworked, they don’t have time to do anything but pay claims. They get an SIU case, and we can’t even get ahold of them to get additional authorization on a file. It is very frustrating.”

Participant 11 and Participant 15 explained that when a file is transferred to the SIU, the representative still has to maintain the file for regulatory compliance by sending the appropriate letters and documents. When they are pressed for time with other duties, these letters can be forgotten. Once that occurs and a file is out of compliance, then the fraud is a moot point, and they have to pay the claim.

A consistent theme emerged from the interviews regarding the need for a specialized SIU staff, one that has specific focus and duties. Participant 2 was alarmed at the trend toward “desk” claims managers with no SIU background managing SIUs.

“You need people with SIU or law enforcement experience,” Participant 2 said. “Without it, they just don’t understand the problem.”

A majority of the sample has had great results with use of an SIU analyst—a non-field employee who would review databases, red flags, computer programs and files, looking for patterns and clues. Many participants thought that this analyst position was the most effective method to deal with diminishing SIU budgets and other current SIU challenges.

Participant 7 and Participant 8 both remarked, “We see a huge return on investment with our analyst.”

Participant 13 added, “Our analyst is pouring over hundreds of claims and pulling the ones they feel should be investigated based on our guidelines, our indicators. We are hitting the ball out of the park with this approach.”

Participants viewed the relationship between the claims department and the SIU as a significant factor in the success or failure of any fraud-fighting strategy. Participant 2 noted that it is important to see the global, long-term perspective on a claim.

“You need to ask them (claims), ‘What are you looking to prove?’” Participant 2 said.

Participant 3 explained that this five- to 10-minute conversation with the claims representative was a key component to their SIU file handling and helped to focus efforts and create that sense that claims and SIUs are working together.

Other strategies to increase synergy and communication involved training and awareness programs. Almost all of the participants said that training sessions helped to significantly improve claims and SIU relations, but many warned that these could not be too long and/or too frequent.

“If you are not staying in touch with these folks (claims), you are never going to detect what is going on,” Participant 9 said “You need this strong partnership.”

Technology was a recurring theme throughout all participant interviews.

“Most of the effective systems are the use of red flags or indicator systems to provide notification of a potentially questionable claim,” Participant 11 said.

Participant 8 reiterated the need to be technologically savvy to fight fraud noting that while big companies “always have a good infrastructure to fight this stuff,” smaller companies are at a strong disadvantage as they don’t have the resources to support this. One common strategy that reoccurred from the participants was the use of predictive analytics, whereby carriers would use programs that incorporate math and science into fraud identification.

“This is big, one of the most effective tools we have used in a while,” Participant 10 said.

Even though technology is a vital factor in strategic fraud fighting, almost all participants warned that the sole use of technology, without human intervention, is essentially ineffective.

“Someone should always look at the data,” Participant 3 said.

Participant 4 believed that the information coming out of the system is not sufficient to deny a claim or conduct a prosecution.

“These are more of a set of indicators saying that a human needs to get involved here, to look things over and then make a determination,” Participant 4 said.

Many participants, such as Participant 5 and Participant 7, discussed how a “two-pronged approach” is an effective fraud strategy. Under this strategy, an indicator system filters through all incoming claims (first prong), and then an SIU analyst of claims liaison reviews these files (second prong).

“No matter how far along we are, humans have different capabilities than a computer,” Participant 15 said, “and, at some point, this information needs to go through a human filter.”

In an era of reduced budgets, participants viewed networking as a cost-effective method to increase communication and to help develop a cost-saving fraud strategy.

“Learning what others are doing helps to see the big picture, where to focus efforts and where to let things go,” Participant 4 said.

Participant 7 and Participant 9 discussed a recent case that made print media that involved multiple carriers and agencies. They said it was a huge success because everyone saw that, and they reiterated how more media exposure of insurance fraud is needed so that the public sees there is an organized front fighting it. Participant 9, an employee of a smaller carrier, discussed how almost all of the referrals coming into its SIU came from intelligence shared from other SIUs and law enforcement agencies.

Participants also agreed that one of the most effective ways to network was to attend seminars and meetings put on by professional fraud fighting groups. Participant 10 discussed how the small registration fees for these meetings, averaging \$15 to \$40, was well worth the investment.

“You get that back 100 times over with the intelligence shared, the networking and the contact lists from these meetings,” Participant 10 said.

Consensus among participants was that attending these seminars was the most cost-effective and efficient method to network in this era of limited corporate budgets.

The third research question explored in this study was: What do insurance fraud investigators report as the main trends in insurance fraud in today’s environment? The analysis revealed the following four themes: 1) increase in soft/opportunistic fraud; 2) increase in no- fault fraud; 3) fraud is becoming more dangerous and sophisticated; and 4) the bad economy contributes to fraud. Table 4 provides a summation of these main themes in the left-hand column and then the appropriate sub-themes in the right-hand column. As the table illustrates, Theme 1—*Increase in Soft/Opportunistic Fraud*— had two sub-themes: 1) work loss exaggeration; and 2) more average people involved. Theme 2—*Increase in No-Fault Fraud*—also had two sub-themes: 1) medical provider fraud; and 2) coding.

Fraud fighters reported a remarkable increase in the incidents of soft and opportunistic fraud; that is, people who were involved in legitimate accidents and incidents, and chose to take advantage of the opportunity by engaging in fraudulent activity. The two sub-themes that emerged were the increase in work loss exaggeration and the involvement of seemingly average people in fraud.

**Table 4:
Themes and Sub-themes of the Third Research Question: What Do Insurance Fraud Investigators Report as the Main Trends in Insurance Fraud in Today’s Environment?**

Themes	Sub-themes
a) Increase in Soft/Opportunistic Fraud	a) Work Loss Exaggeration b) More Average People Involved
b) Increase in No-Fault Fraud	a) Medical Provider Fraud b) Coding
c) Fraud is Becoming More Dangerous and Sophisticated	
d) The Bad Economy Contributes to Fraud	

“We have seen a significant increase in work-loss claims,” Participant 2 said. “This is a huge opportunity for fraudsters.”

Participant 13 has seen a drastic increase in work-loss claims around the summer months.

“They [claimants] look to see Dr. Summeroff,” Participant 13 said. “We have seen spouses taking turns going out every other summer so they can save thousands in day care. This becomes part of their normal routine.”

One of the participants, who is a forensic accountant specializing in these claims, discussed how in self-employed situations, there is a huge increase in the number of claimants not reporting full income amounts on their tax returns, or they file a completely fraudulent tax return.

Many participants saw a remarkable increase in the average person being involved in fraud—that is, the nontraditional claimant, such as soccer moms, teachers, pastors and police officers. Participants described this person as engaging in fraud as an income generator; they may have a spouse that lost a job or possibly faced a reduced salary. Instead of lowering their lifestyle to fit this new economic situation, they supplement their income with fraud.

“I believe that more and more everyday, run-of-the-mill people are becoming involved in this,” Participant 2 said. “These people are not out looking to make a claim. Something happens to them. They get hit by a car. They slip and fall. They decide to take advantage of this opportunity—one that may not present itself again.”

Participant 9 provided an accurate summation that a majority of the group agreed with. He explained how people are trying to get a piece of the pie because they feel that they have been shorted by losing their job or by not getting money that they believe they were entitled to.

“These people are hard to catch,” Participant 9 said. “They fly under the radar if you’re not looking for them.”

Many of the interview responses mentioned an increase in no-fault fraud. Many participants thought that body shop fraud was still occurring but that it was being overwhelmingly replaced by a significant increase in the severity and frequency of no-fault fraud. Two sub-themes emerged from interviews: 1) medical provider fraud; and 2) coding.

Participants viewed medical provider fraud as one of the most significant trends in the current state of the environment. Participant 7 disclosed how criminals conducting medical fraud “are getting more bang for their buck. There is no risk, and they get millions, and if they get caught, they don’t get jail; they get probation.” Participant 8 disclosed how large, broad-based provider fraud is on the rise at the corporate and business level. “You are seeing huge criminal enterprises set up, medical mills, to deceive the companies,” Participant 8 said. “These all have organized crime connections.”

Several participants discussed a recent case that the FBI and multiple other agencies investigated involving a \$450 million exposure. It was all medical fraud related and all organized medical rings.

Participant 12 provided a possible explanation for this drastic increase. She noted a sharp increase in the fraudulent procurement of policies via the internet. The scam involves a fraudster procuring a policy over the Internet and then sending a counterfeit check for the premium. The claimant stages a loss, and the claims department starts to pay out on it. Then the bank notifies the carrier that the check is counterfeit. By that time, it is too late, and the carrier has already made payments.

Participants saw incorrect coding, upcoding, billing for services not rendered and exaggerated coding from providers in their billing to carriers as major trends in the last year. Participants said that this was disturbing as many doctors are held “on a pedestal” and expected to act with integrity.

“People would be shocked to know that doctors do this stuff,” Participant 2 said.

Some explained this recent trend by discussing how the cost of treating patients has risen dramatically. Participant 15 mentioned how the drastic rise in insurance premiums has caused doctors to have to “bill more to get more.”

Participant 12 discussed how her organization has seen a spike in billing for “no-code” items, or procedures that do not have a specific no-fault code. She further explained how traditionally inflated electromyogram (EMG) and nerve conduction velocity testing was the main fraud trend in years past, but currently she sees procedures such as injections, western medicine bills for no-code procedures such as moxibustion, and MRI supplemental readings and procedures.

Participant 8 and Participant 9 explained how doctors now bill for highly expensive surgical procedures that are difficult to refute, such as manipulation under anesthesia. Under this treatment, the patient is placed under anesthesia.

“How can the patient testify what he went through?” Participant 8 asked. “Without this evidence, these cases are impossible to refute.”

A recent trend emerged that fraud was becoming more dangerous and sophisticated, more so now than in years past. “I am aware of some investigators that have been on surveillance and have been approached by people with weapons and asked to leave the location,” Participant 7 said. He further offered a summation of a recent case whereby an investigator was working on recovering stolen vehicles in Mexico and was assassinated because the organized crime group he targeted took it “personally” that he was taking their cars back.

Many participants discussed how the majority of the large-scale fraud rings are using fraud as a source of funding, citing examples where money is being traced to well-known organized crime families and terrorist groups, such as al-Qaida. “These people come to this country, and they find fraud is easy” Participant 6 said. “There is no risk, and they can make millions. It is a no-brainer that they migrate to this crime.”

Another parallel theme surfaced regarding the increasing physical danger to patients involved in these medical fraud scams. Participant 14 discussed a commonly billed EMG test, which is extremely painful for patients, yet fraud rings subject their patients to these without any compassion. Several participants noted how fraud rings are now using children as part of their accident rings to add more legitimacy. Participant 9 explained how kids are getting their knees cut for inflated surgical bills. “It’s absolutely disgusting and painful for them, and just to inflate the billing,” Participant 9 said. “It’s getting more and more common.”

Many participants reported that many medical clinics have “no hit lists” in their back rooms. These are detailed schematics of insurance carriers that outline detailed information about the company, the adjusters, billing procedures and other sensitive material.

Participant 11 discussed how one requirement for proving fraud in New York is the filing of a written instrument. Claimants and attorneys are circumventing this by sending in blank forms, such as NF-2 forms (no-fault medical forms) and then calling in to the claims adjuster with the information. The sample reports that

when the claimants use this “call-in” method, a carrier cannot prove that a written instrument was submitted, and, therefore, a fraud denial is more difficult.

Participant 5 explained how there is an “absolute, direct relationship between what is happening economically and our quarterly and annual fraud referral numbers.” Participant 4 stated, “As the economy drops, the opportunistic seems to take more opportunity.” Some participants discussed how many self-employed claimants are significantly under-reporting their income in order to recoup lost income from the economy. Participant 3 said that unemployment and lack of corporate loyalty was to blame. “There is so much joblessness. Everyone wants a piece of the pie,” Participant 3 said. “A company will now dump you in a heartbeat, and then you are looking for options, and insurance fraud is a very easy option.”

Participant 11 and Participant 14 discussed how they were seeing a trend in dealerships offering enticing financial deals toward customers and then qualifying them for vehicles purchases. These customers would not traditionally have been able to buy a car as they have extremely poor credit and are already in dire financial state, yet they were being approved by the dealerships.

Participant 14 pointed out how several local dealers push unqualified people into leases; the dealers know the potential owners aren’t going to upkeep the car, maintain it or even stay current on the payments, yet they allow the purchase. As the Coalition Against Insurance Fraud (2014) discussed, when these individuals fall behind on their payments, they often turn to fraudulent activity, such as staging a theft or arranging a total loss to the vehicle in order to get rid of the car and avoid car payments.

The fourth research question explored in this study was: What are the perceptions of insurance fraud investigators as to the legal, political and social environmental factors that promote or inhibit fighting insurance fraud? The analysis revealed the following three themes: 1) lack of legal support; 2) lack of political support; and 3) social acceptance. Table 5 provides a summation of these three main themes in the left-hand column and then the appropriate sub-themes in the right-hand column. As Table 5 shows, Theme 1—*Lack of Legal Support*—has two sub-themes: 1) prosecutors/judges fail to be aggressive; and 2) lack of strong laws. Theme 2—*Lack of Political Support*—also has two sub-themes: 1) politicians have alternative agendas; and 2) politicians do not understand the problem. Theme 3—*Social Acceptance*—has two sub-themes: 1) companies are seen as the *big pocketbook*; and 2) entitlement.

**Table 5:
Themes and Sub-themes for the Fourth Research Question: What are the Perceptions of Insurance Fraud Investigators as to the Legal, Political and Social Environmental Factors that Promote or Inhibit Fighting Insurance Fraud?**

Themes	Sub-themes
a) Lack of Legal Support	a) Prosecutors/Judges Fail to Be Aggressive b) Lack of Strong Laws
b) Lack of Political Support	a) Politicians Have Alternative Agendas b) Politicians Do Not Understand the Problem
c) Social Acceptance	a) Companies are Seen as the <i>Big Pocketbook</i> b) Entitlement

Participants believed the legal environment did not support their fraud fighting efforts. Consensus among the panel showed that this lack of support was primarily due to two factors: 1) prosecutors and judges fail to be aggressive in their approaches; and 2) there is a lack of strong laws to support fraud fighting issues. Participants agreed that this lack of support results in a cycle of criminality as offenders see this and migrate toward this unprosecuted crime.

Participants noted a general lack of support from the prosecutorial/judicial level, citing specific cases where fraud was evident and clearly and easily prosecutable, but it was never pursued. Participant 1 and Participant 13 suggested that because insurance fraud is not a “sexy” crime, it doesn’t get the attention that it deserves. Participant 2 said, “There is zero deterrent for criminals to see, ‘This is what we mean when we talk about risk.’ There is no risk. They could steal millions and not even get jail time. What message does that send?” Participant 7, who specializes in medical fraud, explained how his carrier uses the 2005 *State Farm Mut. Auto. Ins. Co. v. Mallela* court decision to help prosecute fraudulent medical facilities. “You have to know your venue, know who the judge is and which way he/she sways,” he said. Participant 4 provided a specific case in which fraudsters were arrested and convicted, yet because the punishment was so weak, they were back at it within months of their release.

Participants expressed frustration that there is a lack of laws that would assist them in pursuing fraudsters, laws that would punish and deter criminality. Participant 2, Participant 6 and Participant 15 discussed how there is a lack of lobbying efforts and how this has a detrimental effect on fraud legislation. The sample illustrated how Florida has passed aggressive legislation with the support of lobbying groups.

“Florida’s fraud rates are declining rapidly,” Participant 15 said. “They have good politics there, here [New York], they are not good.”

Participant 8 and Participant 9 disclosed how our legislative support is “weak,” and pointed out that even when there are laws pending, they get watered down to the point they are completely ineffective.

Several participants, one who is currently a fraud attorney, discussed how there is a huge inconsistency in the method that the courts use to handle fraud cases.

“They are incredibly inconsistent” Participant 11 said.

As a former police officer, Participant 4 said that this lack of support could be rooted in the reporting requirements of police departments. He explained how insurance fraud is an FBI Part 2 crime, taking a “back seat” to the Part 1 crimes, which gain all of the glamour and attention

Taking the preceding theme one step further, the interviews revealed that coupled with a lack of prosecutorial support is an overwhelming lack of political support. The interviews revealed two main sub-themes: 1) politicians have alternative agendas, and 2) politicians do not understand the problem.

“I have not seen a strong effort for politicians to push fraud,” Participant 2 said. “I think it is because they have a lot of other agendas, donors and affiliations/relationships that bring them money and support at election time.” Participant 3 and Participant 7, both former law enforcement officers, discussed how fraud is low on the “totem pole” of priorities for politicians, as they are focusing on areas where they will get more positive public relations, like DWI [driving while intoxicated] cases.

“Until the fraud industry gets a good lobbying channel, the politicians will never change their mind, Participant 6 said.” Participant 4 discussed how there will be a lack of political understanding of the problem until there is public outcry, something never present in fraud. He further explained that there is no outcry or public demand for action primarily because the public accepts this crime; there is no public pressure to push for these laws.

Participant 6 discussed how politicians don’t truly understand how insurance companies operate: very close to the bottom line. He further explained how a few years ago, there was a no-fault legislative senate seminar in which several senators alluded to the fact that all carriers have to do is hire more claims representatives to solve the fraud problem. “They told us to go hire a bunch of people?” Participant 6 asked. “That is no solution; that showed me that they really have no clue what is going on here.”

Participant 5 discussed a case in which a judge presiding over a fraud case called him wanting to ask how he felt about jail time for a fraudster. “I find it extremely odd he would even ask me this question,” Participant 5 said.

Participants saw social acceptance of the fraud problem as a major issue preventing effective fraud fighting endeavors. Participants said that fraud has become more engrained in our culture and would take a significant effort to change this paradigm. The expert panel felt that there were two main sources of this acceptance: 1) insurance companies are seen as the *big pocketbook*; and 2) entitlement.

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Participants overwhelmingly believed that there is a public perception that insurance companies have unlimited capital, and that mentality breeds an overall justification of fraud as a crime. “People just don’t care,” Participant 8 said. “They think the insurance companies make a ton of money, and their small fraud isn’t hurting anything.”

Some cite the insurance companies themselves as the culprits for this mentality, illustrating how many companies showcase high profits, high salaries and company perks. “People see this,” Participant 14 said, “and they think the company is like a cash cow. They have money falling all over the place, when, in fact, this is far from the truth.”

The sample felt that fraud was a broader, social issue; one that requires a cognitive alteration of people’s perspectives of fraud and one that shows that fraud is a socially damaging endeavor. Participant 5 and Participant 9 discussed how the “entitlement phenomenon,” as presented in recent media circles, rings true when trying to explain fraud behavior. Participant 5 said we live in a society where cheating is acceptable. “Everyone wants to get ahead, but they don’t want to work hard and go to Harvard,” Participant 5 said. “Instead, they get hit by a car, and that is their lottery ticket.”

A few of the experts discussed how fraudsters come to view their fraudulent activity as part of their lifestyles. Participant 9 worked several undercover medical stings in his career, and he noted how the medical facilities made him feel like “part of a family.” He discussed how the average claimant does not usually have a “rich” social circle, but when they start treatment at these facilities, they are treated like royalty. They look at it like “a day at the spa.” “It becomes a social event for these folks, part of their way of life,” Participant 9 said. “They start baking breads for the doctors. They get to know your grandkids.”

Several participants offered that this social problem cannot be fixed without public support. Participant 12 and Participant 13 discussed how drunk driving and seat belts were not a major issue until the media, politicians and lawmakers made a conscious decision that it was going to the front burner. This support changed the public’s perception of these offenses.

“That is what was needed to stop it from occurring, public buy-in,” Participant 12 said. Participant 13 further explained, “It all comes back to No. 1. Everyone wants to make a buck, but nobody wants to work anymore to get it.”

Conclusions and Recommendations

In this study, four main research questions were explored by using the research instrument to guide the interviews. Because of the data analysis, themes and sub-themes emerged from the participants. Regarding the first research question on barriers, the main themes that emerged were: 1) no political or judicial support; 2) financial barriers; 3) fraud is difficult to quantify; 4) fraud is a social problem; 5) claims staff changes; and 6) companies are their own worst enemy. Theme 6 had three sub-themes: 1) insurance carriers pay and do not fight; 2) hiring practices; and 3) promote profits. Regarding the second research question, the following strategies were identified: 1) fix the social problem; and 2) more focused and specialized staff, which includes claims representatives, SIUs, synergy, technology and networking.

The third research question on trends revealed: 1) an increase in soft/opportunistic fraud, which included the sub-themes of work loss exaggeration and more average people committing fraud; 2) an increase in no-fault fraud, which included the sub-themes of medical provider and coding fraud; 3) fraud is becoming more dangerous and sophisticated; and 4) the bad economy contributes to fraud. The fourth and final research question on legal/social/political environment revealed: 1) a lack of legal support; 2) social acceptance; and 3) a lack of political support, all having multiple sub-themes.

The results of this study add significant knowledge to the field of fighting insurance fraud. Specific barriers and strategies were uncovered, which will assist fraud fighters with effective preventative efforts. Specific strategies were revealed that can be immediately implemented in a preventative strategy.

Some interesting findings include the importance of the human component and the impact of the changing workforce on identifying and managing fraud. While it has been known that numerical strategies are highly effective, all participants agreed that there needs to be a strong human component in order to be truly impactful. In addition, participants agreed that personnel changes that have occurred in claims departments, SIUs and management ranks have caused a decline in the awareness of fraud identification. In addition, the study revealed that fraud is part of larger social problem, and that an increase in public awareness and outreach is vital in order to change this mindset.

This study provided significant insights into the fraud phenomenon. It is evident, however, that further research is needed in order to add further knowledge into this field of study. Potential follow-up studies could include a replication of this qualitative inquiry that focuses on a different sample population—possibly fraud managers, front-line claims representatives, law enforcement fraud investigators, and prosecutors or fraud attorneys.

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Cummins, J. David and Richard A. Derrig, eds., 1989. *Financial Models of Insurance Solvency*, Norwell, Mass.: Kluwer Academic Publishers.

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