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Poor Economy Means More Work For DI Special Investigation Units

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Desperate times often lead to desperate measures.

During difficult financial times, employees know that losing their jobs through layoffs, attrition, shutdowns and closures is a strong possibility. The uncertainty of today's economic climate, coupled with the burden of having limited personal resources and savings to draw from in the event of becoming unemployed, may lead some employees to file fraudulent disability claims.

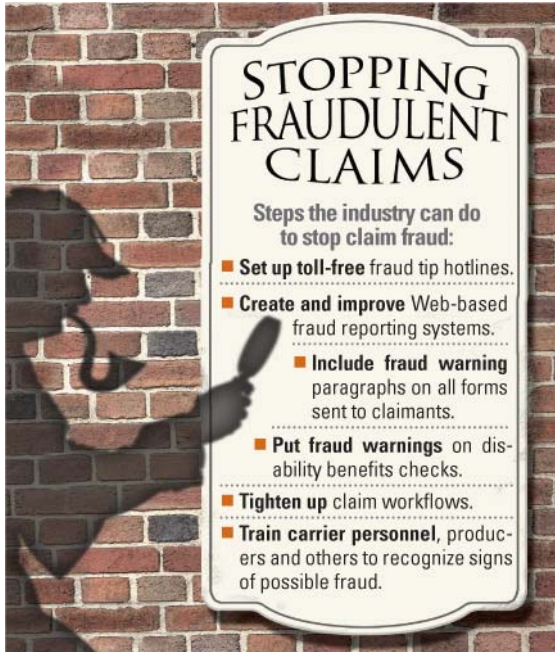


These employees may feel they have nothing to lose. So, while employers and employees in insurance special investigation units (SIUs) and fraud divisions are always vigilant, their role and importance become magnified during difficult economic periods.

The National Association of Insurance Commissioners' model anti-fraud law requires insurers to include the following statement on all applications and claim forms: "Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents materially false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison." Not all states have enacted the law, and some states have their own version of this wording, but it does provide at least a baseline for what constitutes fraud.

Those who file fraudulent claims represent a broad spectrum of people, and are not limited to one industry or occupation. We often find fraudulent claims filed by real estate agents, sales representatives, and other commissioned employees. We are seeing individuals from these sectors come up with creative ways to supplement income to make up the revenue they lost from the poor economy. (See box.)

Employees may now consider filing a disability claim for ongoing medical conditions they may have worked with for years, especially if this means that a disability benefit may supplement their sudden loss of income and saves them from foreclosure on their home.



Here's a hypothetical case of a construction worker who specializes in home additions. A few years back, this construction worker was in high demand and booked with jobs more than 2 years in advance. However, today, this same worker does not have any jobs booked and is not pulling in nearly the same amount of income. Our construction worker also has rheumatoid arthritis, but he has always found a way to work.

Now with no jobs and a reduced income, our worker decides he can't work with RA anymore. He decides to file for disability knowing that his benefits will be based on his higher income levels from previous years. It is certainly possible for medical conditions to worsen over time. However, fraud units and claims examiners need to review filed claims to ensure that the insured truly cannot work

and that insureds are not filing to make up for the lost income.

While disability benefits only pay a percentage of pre-disability earnings, under some policies this percentage may be based on past months' (even years') income and could be more than the employee makes in today's market.

No matter how difficult their financial situation may become, the majority of people would never consider filing a disability claim. However, as finances become tight, they may opt to reduce the amount of income they spend on medications, doctor visits and appropriate treatment for ongoing conditions. Over time, employees choosing this route will undoubtedly put their health at risk.

In a recent NAIC study, it was discovered that 22% of consumers surveyed had reduced their number of physician visits in order to save money. We could now begin to see an increase of legitimate disability claims filed because medical conditions have deteriorated from the lack of proper medical attention. Although these individuals are not thinking of filing a possibly "fraudulent" claim, additional reviews and investigations are initiated.

We ask the question, "What has changed in the insured's treatment and condition that has them having to stop work?" While the claims examiners assigned to the disability claims are the ones responsible for making a decision on the claim, fraud unit resources and investigative vendor support conduct treatment/pharmacy canvases, surveillance, field visits and onsite interviews.

In addition to individuals filing new fraudulent disability claims, during periods of economic decline, existing disability claims also have potential for fraud. We have seen increases of malingering, the intentional omission of information, and employees exceeding the expected recovery duration.

For example, an insurance agent is out on long-term disability as a result of a back injury, which required surgery. The expected duration is 3 to 6 months. At the 6-month recovery mark, the sales agent is clinically expected to recover. However, now the economy is bad, sales are slow, and the industry is bottoming out, our sales agent

decides that it is better to remain on claim and ‘chooses’ a co-morbid condition like depression, fatigue, or lack of conditioning to remain on claim. Our sales agent is malingering (loitering). Our crafty agent may even plan to return to work for another employer while malingering to collect both a disability benefit check and a pay check.

I recently worked on a case where a very ill claimant had been on long-term disability claim for over 8 years for progressive multiple sclerosis, and, due to her condition, we only updated her medical status yearly. During our yearly review of the claim, I requested updated medical records. The claimant’s paperwork was returned with a hand written note on it stating the claimant “had deceased.”

After investigating this further to determine if there were any survivors, I discovered the claimant died more than 10 months before. The claims examiner confirmed the deceased continued cashing the disability from the Great Beyond. My investigation concluded the claimant’s neighbor was intercepting the mail and fraudulently cashing her checks at the local check cashing corner store. The neighbor had stolen nearly \$12,000 in checks.

If they have not done so already, carriers and SIU divisions across the country can take steps to prepare for the potential increases in fraud by implementing a toll-free fraud tip hotline, include

fraud warning paragraphs on all forms they send to claimants and warnings on disability checks. These fraud warnings can serve as deterrents to potential perpetrators.

Local, state and federal authorities are taking fraud seriously and I have seen improvements in online fraud reporting, which makes it easier for people to report fraudulent actions. Tighter laws, stricter claim workflows and training around what are potential “red flags” are also helping to increase the identification of suspected fraud. It is up to all of us in the DI industry to ensure these laws and workflows are working and the offenders are being brought to the authorities for investigation and conviction.

Fraud is an issue for everyone—insurers and insureds alike—because the costs of disability fraud are eventually shared by everyone involved in obtaining and maintaining a disability policy.

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Case In Point

In early 2008, we heard about the case of a former Albany, N.Y., teacher. She was well-respected and even nominated for a national teaching award. She informed her employer and the community she was dying of cancer and collected over \$100,000 in health and disability checks. She even went to such lengths as to shave her head so that others would buy into her story that she was dying and receiving chemotherapy.

The teacher’s scheme began collapsing when her former colleagues in New York learned of the nomination and read an article describing her presumably heroic community and school contributions. She was supposed to be at death’s door, not teaching. The authorities were called in. She admitted she did not have cancer and never did. She was convicted and sentenced to prison. ■■