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**Increases in Insurance Fraud During the Pandemic and Natural Disasters**

Fraud can be seen in almost every area of the legal world. The insurance industry is no exception and sees more than its fair share of fraudulent claims from both insureds and third-party claimants. The Coalition Against Insurance Fraud estimates that fraud costs American consumers $80 billion every year. In addition to that amount, fraudulent workers' compensation claims costs employers $30 billion a year. Fraudulent claims result in the average family paying $400-$700 extra in insurance premiums per year. During emergency situations and natural disasters, fraud tends to increase as there is not only opportunity, but desperation. This can be seen during the Covid-19 pandemic and the recent natural disasters including hurricanes, fires, and floods. Most if not all states have departments focused on combating fraud, but it is sometimes the laws of that state and specifically bad faith statutes, that can be the driving force for these fraudulent claims. It is then up to the claims handler to balance appropriately combating fraud while still having the manpower to be able to efficiently handle the underlying claim.

## 1. Fraud During the Pandemic

One would have anticipated that during the pandemic that insurance claims and certain fraudulent conduct would have decreased as less people were on the roads and many healthcare providers were not providing treatment. However, studies performed reveal the opposite. While there has been no study setting forth the specific reasons as to why fraud has increased during this time, theories include necessity and opportunity due to the lack of jobs and the availability of other income. Now that we are somewhat removed from the height of the pandemic, it is too easy to forget how the early days of the pandemic brought uncertainty and chaos. It had been a some time since the citizens of this country were faced with lack of resources and feelings of uneasiness, which only brought an opportunity that gave rise to fraud.

The federal government has already charged 1,500 people with defrauding pandemic-aid programs, and more than 450 people have been convicted so far. There are currently 500 people working on pandemic-fraud cases across the offices of 21 inspectors general. In addition, there are investigators from the FBI, the Secret Service, the Postal Inspection Service and the Internal Revenue Service. Agents in the inspector general's office at the

Labor Department have 39,000 investigations ongoing. About 50 agents in a Small Business Administration office are sorting through two million potentially fraudulent loan applications.

**Healthcare**

Our country had not encountered a widespread pandemic like Covid-19 for generations and our healthcare system was not prepared for what it would face with Covid-19. This was a new virus that needed new medications and preventative care, all of which led to ways to increase healthcare fraud. This can be seen by scammers offering Covid insurance, fake notices of cancellation of health insurance, fake vaccines, new age medications that could allegedly cure Covid-19, and miracle surface cleaners, etc. We even saw fraud from healthcare providers who were submitting billing for services not provided.

One of the States that was at the forefront of combating healthcare fraud was New York. In a report put out by the Department of Financial Services for the State of New York, in 2021, New York opened 60 healthcare fraud investigations that resulted in 16 arrests.[1] The Department received 25,242 reports of suspected healthcare fraud.[2] In total, 34,201 suspected insurance fraud reports were received, which was an increase of 13.6% from 2020.[3] The increase was of course not all pandemic related, or at least the studies have not been completed to make such a determination.

**Automobile**

The pandemic brought with it a shutdown of all nonessential businesses and substantially reduced the number of vehicles on the roadway. It is estimated the reduction in automobile travel was approximately 64%. Due to the reduction in the use of automobiles, insurance companies began providing reimbursement of insurance premiums. Notwithstanding the fact that vehicular traffic decreased, the number of claims did not. In fact, preliminary studies reveal that the number of claims remained consistent. The number of potential fraud related cases also did not decrease, which is more than likely attributable to opportunities created due to the decrease in the number of police and their limited investigation into minor claims. This was exacerbated by the fact that individuals did not want to interact for the proper exchange of information or investigation into claims. The number of fraudulent claims was also impacted due to the lack of response by the criminal justice system which also had decreased capacity and was strained due to closures or operating at limited capacities.

No fault automobile insurance fraud has always been an area for fraudulent insurance claims due to unscrupulous medical provides, attorneys, and other billing issues. With the pandemic, we have seen decreases in the amount of police present and the inability to adequately investigate these sometimes unwitnessed accidents, which has only lead to increases in no fault claims and staged claims.

[1] Investigating and Combating Health Insurance Fraud, Adrienne A. Harris, March 15, 2022.
[2] *Id.*
[3] *Id.*

### Arson

With the number of individuals staying home during the pandemic, it was only natural that the amount of incidents that occurred in residences increased. Studies have shown that domestic violence in the home increased in additional to home related accidents including fires. What is disturbing is the number of arsons that were occurring. The FBI's preliminary numbers for the first six months of 2020 show a 19% increase in arson nationally. In cities of more than a million people, the increase was more than 50%. Again, studies have not revealed the exact reasoning for the increase in arson but same could have been the result of other issues besides fraud including vacancies, protest, riots, and homeless camps. In 2021, the ATF reported more than 7,000 arsons across the nation, compared to around 6,000 the previous year. Los Angles reported there were approximately 400 recorded arson incidents in the first eight months of 2020, a 43% increase from the same period for the prior year.

### Workers' Compensation Claims

With the shutdown, many individuals lost their jobs as either a nonessential worker, due to business closures, or many began to work at home or in modified work environments. The work environments created by the pandemic generated additional issues for employers including workers compensation claims and specifically employees attempting to claim work related injuries when same were caused by other issues. While a large percentage of individuals were no longer employed, the number of claims in some areas of the country continued to remain consistent. This can be seen when comparing areas such as Texas and Florida to other areas that had stricter Covid-19 rules such as California and New York. The modified work environment brought new issues to the forefront including what constituted a workplace injury and whether Covid-19 was a compensable claim. While there may have been some fraud in this area early during the pandemic, many states got in front of the issue and enacted legislature to clearly defined compensable pandemic related injuries so as to avoid fraudulent conduct.

## 2. Insurance Fraud During Natural Disasters

While dealing with the pandemic, our country has also been effected by several natural disasters ranging from hurricanes, to widespread fires and floods. These natural disasters also gave rise to additional opportunity for fraudulent claims. This is especially true considering that the people in these areas had already been hit by Covid-19 and having to live with their homes and businesses being destroyed.

Natural disasters bring their own fraud issues. This is generally seen with scams for FEMA assistance and claims, identity theft, fake charitable donations, out of state contractors attempting to take advance of the unsophisticated individuals, which often has to be borne by the carrier. On the other side of that equation, fraud is committed by policyholders who seek inflated damages and misclassification of damages. According to the FBI, after Hurricane Katrina, approximately 1.6 million insurance claims were filed, totaling $34.4 billion in insured losses. The government funded approximately $80 billion for reconstruction. Of that amount, it is estimated that insurance fraud may have

accounted for as much as $6 billion. The FBI reported that in one Katrina fraud related case, more than 70 indictments were made with more than 60 guilty pleas entered.

What we are currently seeing in the wake of Hurricanes Laura, Delta, and Ida is a transformation with regard to fraud. Generally, insurance companies are being made to bear the burden of fraud from these claims including the fraud from insureds seeking amounts not related to the storm and contractors and attorneys submitting unreasonable and unrelated estimates. While these issues should work themselves out in the by anti-fraud organizations set up by the states or through court proceedings, we are seeing a toxic environment in areas of natural disaster litigation wherein insurers are being told to pay fraudulent and inflated claims or risk being found in bad faith and having to incur large penalties for the fraud being committed by others. This items should be worked out but due to the issues that were created by Covid and now the natural disasters, state officials, juries and judges are ignoring fraud in natural disaster areas resulting in insurers being unable to renew policies or resulting in defunct carriers.

## 3. Methods to Combat Insurance Fraud

Combating insurance fraud generally starts with the insured. Thus, some of the best methods to combat insurance fraud is to educate. With regard to health insurance, it is imperative to educate the insured as to how healthcare fraud occurs and ways to prevent it, including not providing confidential information to unknown sources and monitoring healthcare professions to determine whether they are billing for the services being provided. Claims adjusters should encourage insureds to report suspected insurance fraud. Creating hotlines for insureds to call to discuss insurance fraud can also help to reduce fraudulent claims.

Most insurance companies also have established anti-fraud departments who should be training claims professionals to spot suspicious activity and the resources within the company that are available to help combat fraud. Adjusters should be trained to recognize tell-tale signs of behavior that is indicative of fraud such as a policyholder being resistant to claim validation or failing to provide necessary information. Claims professionals should also be trained to take advantage of the technology a specific insurance company is investing to combat fraud. Those items could include databases such as ISO and ClaimSearch.

Insurers have also started investing in anti-fraud software. This technology can be expensive which often prohibits its use in the industry. The software can be helpful in multiple areas. For instance, in the area of property claims, photo recognition & analysis can be utilized to save costs by not performing in person inspections of property damage. This technology allegedly allows an insurer to know whether claimed property damage is real, digitally altered or previously submitted. This of course would have to be utilized in connection with real inspections to avoid bad faith situations. Other technology includes social network monitoring and predictive modeling. Due to the vast amount of social media, monitoring social media has its limits as it is virtually impossible to be able to effectively monitor the amount of data that exists. Insurers are also utilizing predictive modeling, which generally involves the creation, testing, and validation of a model to predict the probability of claims being filed. Carriers are also performing exception

reporting which identifies claims outside the range of what is considered normal and flagging those claims as potentially fraudulent.

Other technology including Google Earth and drone technology can be useful during a natural disasters to determine the extent of regional damage to later assess the claims made by various insured. For instance, whether a particular area flooded but the insured is only claiming wind damage.

Regardless of the technology utilized to combat fraud, fraudulent claims are ongoing issues that have only been exacerbated by the pandemic and the recent increase in major natural disasters in the country. In order to combat these issues, the claims handler needs to aware of the scams arising in a particular area so that they can properly adjust the claim and also avoid having an insured shifting the costs of fraud to the carrier.