

Workers' Compensation Fraud In America



Coalition Against
Insurance Fraud

JULY 2022



In March 2021, the Coalition Against Insurance Fraud formed its first-ever Task Force to examine the too often overlooked topic of Workers' Compensation Fraud (WC) in America. Led by Gene Donnelly, Assistant Vice President of SIU for Zenith



Insurance out of Florida, and Dominic Dugo, Coalition Outreach Coordinator and Retired Chief Deputy District Attorney of San Diego County, they joined a team of 14 insurance experts from throughout the nation with a combined more than 300 years of experience investigating, fighting and prosecuting WC fraud.

The Task Force met over a period of 15 months with the goals to 1) re-examine and determine the annual cost of comp fraud in America; 2) explain to stakeholders the types of fraud scams that occur in the area of WC; and 3) recommend 10 strategies to reduce comp fraud. With this report the Task Force seeks to raise awareness and make it easier to fight WC fraud.

For nearly 30 years the Coalition has stood as the leader in bringing together public and private interests to protect American consumers and insurers from all aspects of insurance fraud. Seeking to identify and stop fraud in America's workplace is one of the most important endeavors the Coalition can embark upon. This report represents perhaps the most comprehensive analysis yet undertaken by examining the cost of workers compensation fraud, its impact on our nation and having the leading national experts in the field identify key ways to fight against all forms of WC fraud.

We provide this report to our members and other interested parties as part of the Coalition's mission to help fight "the crime we all pay for." American workers deserve fair and full compensation for their injuries. American employers deserve to pay fair premiums and have a duty to fairly and honestly secure coverage for their employees. This report is intended to help make sure those goals are achieved. The Coalition wishes to thank and recognize those anti-fraud leaders whose efforts are set forth in this report.

TASK FORCE MEMBERS

Dominic Dugo, chair - Coalition Against Insurance Fraud • Gene Donnelly, vice chair - Zenith Insurance
Jay Bobrowsky - State Compensation Insurance Fund (CA) • Christopher Jelinek - Chubb • Steve Piper - CNA
Matthew Smith, Esq - Coalition Against Insurance Fraud • Sam King - Employers
Patrick Sidorchuk - FFVA Mutual • Chris Welch - Florida Dept. of Financial Services
Andrew Enochs & Jeffrey Cirino - FRISS • Jennifer Cunningham - Ohio Bureau of WC
Lina Valencia-Ignatius - Pinnacol • Ken Jones (retired) - Travelers

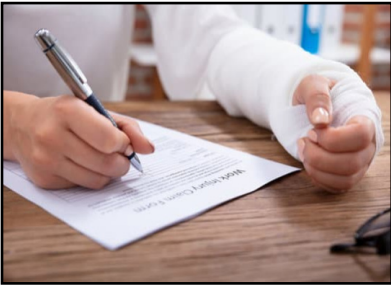
We hope you find this report beneficial and welcome your comments and suggestions at any time.

Sincerely,

Matthew J. Smith, Executive Director
Washington, D.C.

I.

\$34 BILLION OF WORKERS COMPENSATION FRAUD IN AMERICA



The Task Force set out to re-examine and update the decades old \$7 Billion estimate of comp fraud in America. Excluding self-insured, the nationwide team of experts determined there is approximately \$34 Billion of WC fraud comprising \$9 Billion in bogus employee claims and a whopping \$25 Billion in employers dodging premiums.

The committee examined a multitude of recent and past studies in the WC arena. To ascertain the value of premium fraud, it used projections of population in the USA and California; a study by Frank Neuhauser from the University of California Berkeley on the Underground Economy and Payroll Fraud; a [2020 study](#) by the Bureau of Economic Analysis that pegged the underground economy in the US at more than \$2 Trillion; and a 2017 study of California's underground economy (believed to be \$170 Billion annually). These figures were extrapolated to determine the potential premium fraud taking place in a given year is \$25 Billion.

The team also contacted experts and academics to capture the cost of employee claimant fraud. Dr. Michael Skiba, Ph.D. 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 WC claimant fraud is \$9 Billion a year.

The Task Force knows that there is also provider fraud (i.e., medical and legal professionals and cappers) within the field of WC that was not measured. Provider fraud runs throughout various types of insurance including auto, workers, healthcare and disability. In some states such as California and Florida, provider fraud steals a significant amount of resources from the WC system. When provider fraud is considered, we believe that there may be even more than \$34 Billion of comp fraud in America.

II.

SUMMARY OF THE TYPES OF WORKERS COMPENSATION FRAUD



AGENT/BROKER FRAUD

Insurance is complicated, and for this reason we have insurance agents. They help families and businesses stay protected from unforeseen catastrophes by matching insurance with risk exposures. Unfortunately, sometimes insurance agents abuse this trust for their own personal benefit.

Premium diversion is the most common scheme associated with agency fraud. Insurance agents or other office staff commit fraud when they divert money earmarked to pay premiums for an insurance policy for personal benefit. This can result in the cancellation of a client's insurance policy, or worse, the insurance policy never gets issued. Often, premium diversion is only discovered after an uninsured loss has occurred. When this happens, innocent policyholders and their employees may be left "holding the bag."

If an insurance agent knowingly does not pay the premium and pockets the premiums, the defrauding agent may produce fake policy documents in order to perpetuate the lie that an insurance policy is in force. These forged policy documents usually include fraudulent certificates of insurance, fake payment receipts, or forged policy documents. These acts of forgery are crimes in all states.

Agent fraud is also uncovered when a contractor requests a Certificate of Insurance (COI) but is denied. COI are used, for example when a construction business needs to prove their insurance status to a hiring firm. Hiring contractors require COI to help assess what liabilities they might have exposure to. Making sure a contractor that is being hired has insurance in place limits potential liabilities for the hiring contractor. In practice, a COI is generally required in order for a contractor to be paid. If a business was a victim of agency fraud and is unable to produce a valid COI, they may not be paid for work already completed.

Aside from a client losing their money, there are many possible negative consequences from agency fraud. If an insured is not able to recoup their losses, they could go bankrupt and out of business. This can also result in the delay of treatment to an injured worker as coverage for the claim is investigated.



CLAIMANT FRAUD











Claimant fraud involves making a false or fraudulent material statement for the purpose of obtaining or denying any WC benefit. Suspects are usually workers, although it could also include insurance company staff.

WC is designed to provide a worker injured on the job with medical services and

related benefits. The five major types of claimant fraud involve false statements regarding the “alleged work injury” as follows: injury was a non-work injury; injury was fake; the claim includes an exaggerated work injury; claimant denies prior injury to the same body part and claimant lies about working while out on WC.



Some red flags indicating claimant fraud are listed below:

-  Number of days worked and the amount of salary are inconsistent with occupation.
-  Cross-outs, white-outs and erasures on documents.
-  Injured workers file for benefits in a state other than principle location of the alleged industrial injury or occupational disease.
-  Injured worker-listed occupation is inconsistent with the employer’s stated business.
-  Injured worker address is different from the principle location of employers other than border states.
-  Injured worker cannot be reached because he or she is never home or is sleeping and cannot be disturbed.
-  Injured worker is seen with calluses on hands, grease under fingernails.
-  Injured workers move out of state or country shortly after filing a claim.
-  Injured workers are in line for early retirement.
-  Performs seasonal work that is about to end when they file a claim.



EMPLOYER/PREMIUM FRAUD

Premium fraud involves a deliberate attempt to lower insurance premiums by misrepresenting payroll exposures to an insurance company. The Coalition estimates premium fraud to be \$25 Billion a year in the United States.

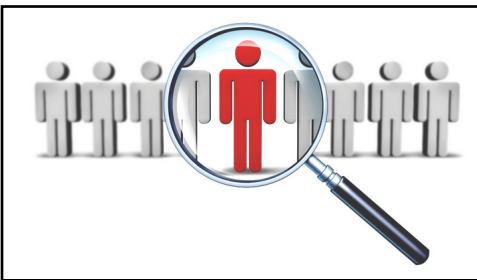
Often, the business owner commits this fraud, but suspects may include employees who have facilitated the fraud. Premium fraud results in illegally reducing costs thereby giving the cheating employer an unfair business advantage over law abiding employers. It is also a theft against the insurer.

A WC premium is determined by evaluating the company's payroll, classification codes and experience modification. The fraud typically involves suspects attempting to fraudulently represent at least one of these three variables.



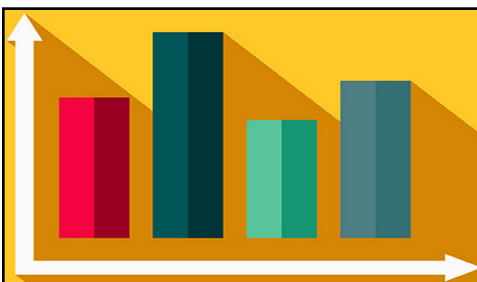
UNDERREPORTING PAYROLL

Underreporting payroll to the carrier is the most common scheme of premium fraud. Lower payrolls means lower premiums. Examples of underreporting payroll include paying employees cash off the books; claiming employees are independent contractors; hiding payroll in a shell company without insurance coverage and disguising salary to be mileage or tool reimbursements.



MISCLASSIFICATION

The classification code is based on the type of work done by a company's employees. The more risk a worker faces, the higher the rate which in turn, leads to higher premiums. An employer may cut premium costs by intentionally misrepresenting the type of work being performed such as rating employees as "Window cleaners - not greater than three stories in height" when really they should be classified as "Window cleaners - greater than three stories in height." Obviously, the risks associated with cleaning windows on sky risers are much greater than the risk associated with cleaning windows on homes. Similarly, tree trimmers could be misclassified as landscapers, or roofers misclassified as janitors.



EXPERIENCE MODIFICATION EVASION

The "X-Mod" is based on the company's history of claims compared to similar businesses. The average number is 1.0 with the number rising or falling based on the company's claim history. A company with many claims will see X-Mod rise above 1.0 resulting in higher premiums. If a business is following appropriate safety standards, ideally you would see fewer claims, and therefore a lower rate. The higher the X-Mod, the higher the company pays for WC.

The experience modification rate stays with the business even if they switch insurance companies. In an attempt to reset their X-Mod and evade higher insurance costs, a dishonest employer will change the company name and possibly ownership to purchase insurance for the newly created entity. In reality, nothing has changed other than the company's name and/or ownership. However, the "new" business is able to reap the benefits of cheaper premiums due to the lower X-Mod.

X-Mod evasion also occurs when an employer directs an injured worker to not file a claim, discounting the legitimacy of the claim or that the worker is an actual employee to artificially deflate the X-Mod. This type of evasion is not only criminal, but can also negatively impact the physical wellbeing of the injured worker.

While these are the three main areas where premium fraud occurs, the actual details of the schemes are only limited by the imagination of the criminal mind. With greater awareness of these schemes, defrauders can be identified and held accountable for their actions thus maintaining an even playing field for honest employers.



PROVIDER FRAUD – MEDICAL AND LEGAL

Provider fraud involves primarily medical and legal providers but also encompasses ancillary services such as translation and transportation companies, copy services, durable medical equipment (DME) suppliers and pharmacies. Most schemes involve knowingly billing for medical goods and medical & legal services that are unnecessary or not provided at all. It often involves a criminal enterprise (possibly a referral network) orchestrated by individuals who are not medical or legal

professionals. While claimants can be complicit in schemes, often they are unwittingly involved and potentially subject to unnecessary and potentially harmful treatment. Some common provider fraud schemes are listed below.



BILLING FOR SERVICES NOT PERFORMED

No supporting documentation for services billed in the patient's medical or legal file. If it isn't in the report, it should not be on the bill.



UNBUNDLING

Submitting multiple bills for the same service, or for multiple services that can be billed as one.



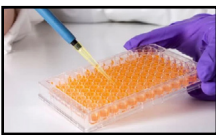
UPCODING

Billing for a more expensive service than the patient actually received.



DOUBLE BILLING

Submitting multiple bills for the same service.



BILLING FOR MEDICALLY UNNECESSARY TESTING

Testing, whose results cannot contribute to cure or relieve the injured worker from the effects of the industrial injury or cannot help to resolve a medical or legal issue.

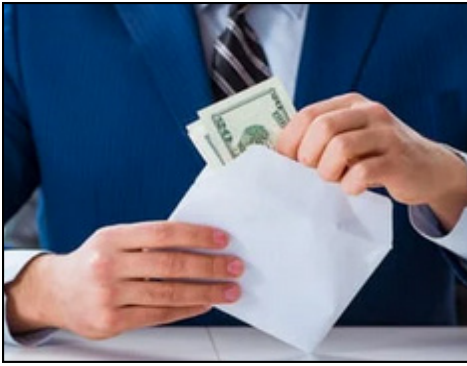


DNA TESTING

Billing for non-covered services as a covered service.

Medical services for medical conditions that do not arise out of, or occur during the course of employment, yet are billed as such. Almost always distributed from the physician's office, or by mail.

The same drugs are prescribed to all if not most of the provider's WC patients.



KICKBACKS, CAPPING AND STEERING

The unlawful referral of patients to the provider, or referrals from the physician, attorney or non-professionals to other entities with which the provider has an economic interest.

Kickbacks to the physician to prescribe or order certain services. Additionally, kickbacks can involve attorneys or other non-professionals to facilitate the criminal enterprise.

Patients recruited by marketers are often “sold” to unscrupulous attorneys, medical providers and others in the WC system with a disregard for patient care.

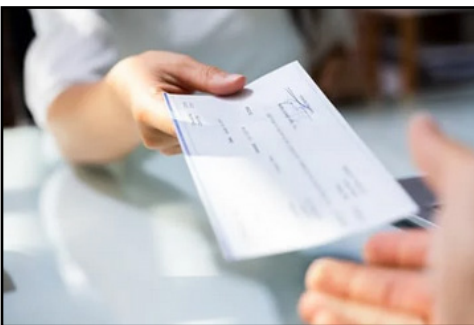
Most often discovered by studying the bill/paid data from the provider or tips from current, former employees, or patients.

OVERUTILIZATION OF SERVICES

- Services provided well beyond what would be necessary given the patient’s condition.
- Alcohol and drug testing are ripe for overutilization.
- Referring to others for services which the provider has an economic interest.
- Provider prescribes and bills for services outside of the office.
- The provider consistently refers to the same outside providers.
- Billing for interpreter services when the patient speaks English.

III.

TOP 10 IDEAS TO REDUCE WORKERS’ COMPENSATION FRAUD



1) VICTIM IMPACT

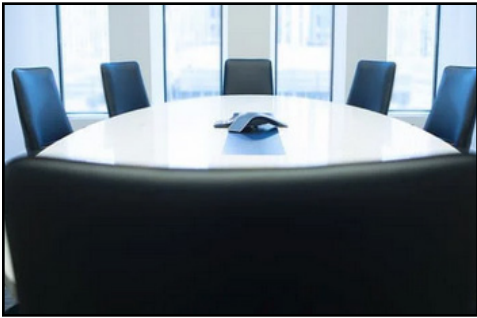
Victims of WC Insurance Fraud

While WC fraud is a cost driver to all who participate in the system (i.e. insurance carriers, self-insureds, employers), perhaps the group most impacted is the small employer. Paying benefits on any fraudulent WC claim can greatly impact their experience modification factor for years. When a company is new or has no loss history they receive a modification factor of 1.00. If that business has more claims than their peer group or are the target of fraudulent claims, they receive a higher mod and thus pay a higher premium for each of the following three years. This impact could mean the employer may be unable to increase pay, provide bonuses or grow the business. Even worse, the employer might have to reduce staff, thus creating a trickle down effect and putting a burden on state and local resources with unemployment benefits and loss of tax revenue.

It is important to ensure that the Court understands who is the true victim of WC fraud. In these cases, judges and juries are not apt to be sympathetic to a large insurance corporation likely based in another state, but would be much more likely to respond favorably when the victim is a local business in their community. Policyholders are not the only victims of insurance fraud, but at times, they commit WC fraud themselves. When this happens, innocent employees can be the victim.

Policyholders may commit insurance fraud by underestimating their payrolls in an effort to pay less in WC premiums. They may hide their payroll exposure by misclassifying employees as independent contractors or paying their workers off the books. Sometimes, to keep their insurance rates lower, policyholders will cover small claims out of pocket, which limits an employee's right to due diligence with proper claims handling. However, in the event that an employee suffers a catastrophic claim, many times these same unscrupulous policyholders will not file a claim on behalf of the injured worker. When this happens, injured workers are forced to submit claims through private attorneys or state justice departments. This not only raises the cost of claims, but can also delay a carrier accepting a claim and providing timely medical treatment.

Another victim of unscrupulous policyholders are the honest policyholders who pay their fair share. Insurance rates are developed by comparing all claims costs against insurance premiums collected. When an employer commits insurance premium fraud by underreporting payrolls or misclassifying employees, the result is higher premiums for the honest policyholders.



2) CULTURE

Anti-Fraud Culture – Critical Foundational Considerations

The development of world class anti-fraud capabilities starts and ends with an organizational culture that fully understands that fraud is contrary to the central mission of caring for injured employees and delivering on insurance carriers' promise to accurately and timely pay what is owed. Fraud illegally depletes precious limited resources intended to provide benefits and treatment to legitimately injured workers; increases premiums for honest policyholders; and it reduces profits for shareholders.

An effective anti-fraud culture requires a long term commitment of the entire organization starting with senior leadership running throughout the organization to front line claim professionals focused on anti-fraud awareness/training, investments in analytics/technology tools, and understanding that fraudulent conduct is detrimental to employees and employers. Organizations that build an anti-fraud culture as a true core commitment tend to be foundationally sound in enacting successful anti-fraud strategies and tactics.

Critical components to building this culture include: executive sponsorship – understanding the long term effect of fighting fraud has on accurate and timely claim payouts; ensuring SIU is involved throughout the totality of the insurance process inclusive of underwriting, premium audit, and claims; and exploring and implementing processes and technology that will enhance the overall investigative capability and effectiveness necessary to consistently identify and prevent fraud.



3) TRAINING

Training – The First Step of An Effective Anti-Fraud Program

In order to effectively detect, investigate and defeat WC fraud, it is essential for organizations to understand the scope and complexity of emerging fraud trends and exposures. This includes focused and timely training to address claimant, premium/employer and provider fraud.

Each type of fraud has unique challenges which require distinct investigation strategies.

This fraud training should focus on cross departmental internal training; providing new hires with in-depth instruction regarding your fraud program - not just the annual training; learning current trends and schemes with real world examples; identifying company and industry best practices; training that is fluid and flexible as fraud changes; emphasizing communication; identifying and promoting the use of subject matter experts (SME) on

current investigations and assisting others to become experts; and building relationships between field staff and policyholders.

It is critically important to work with the policyholders, from the owner/manager and leaders to the front line staff, regarding what to look for to uncover fraud and the importance fraud plays on their businesses success for customers.

Stakeholders, including SIU staff, claims, underwriting, loss prevention, employers, agents/ brokers, and law enforcement partners as well as trade associations should be educated regarding not only the Red Flags of Fraud, but also the true cost of fraud. Carriers then should promote how they can aid in recognizing and defeating fraudulent behavior.

SIU managers and staff should perform file “autopsies” to determine how and when the fraud was discovered and determine if it could have been discovered sooner. The outcomes uncovered from these ‘autopsies’ should then be shared with all appropriate staff.



4) NETWORKING

Fighting Fraud is a Team Sport

To effectively fight WC fraud, it is paramount to have a strong network of fraud fighters. Fraudsters share information both through online communications and by word of mouth. Fraud schemes are crossing state lines, at times going international, and are ever increasing in sophistication and brevity. Bad actors do not act alone, so why should

the fraud fighting community fight alone? Many times, it’s not about what you know, it’s about who you know.

Networking within the fraud fighting community has the added benefit of educational opportunities.

Organizations such as the International Association of Special Investigation Units (IASIU), host conferences and seminars year-round. IASIU is a non-profit organization whose mission is to bring the world’s fraud fighting community together through education, awareness, and networking. Another well-known organization is the National Insurance Crime Bureau (NICB), a not-for-profit organization dedicated exclusively to fighting insurance fraud and crime.

When networking is done in conjunction with an investigation, be aware of immunity laws that may apply. Before contacting another carrier or a fellow fraud fighter in another state, it is incumbent on each fraud fighter to review immunity laws that apply to your jurisdiction. Check your state statutes and regularly monitor upcoming state legislation for any changes. Additionally, the Coalition has compiled various immunity laws within each state. Other organizations that might be of assistance include professional boards such as the National Board of Chiropractic Examiners, State Medical Boards, as well as trade groups such as the The United Brotherhood of Carpenters, National Association of Home Builders and the National Roofing Contractors Association.



5) CRIME PREVENTION AND PUBLIC OUTREACH

Anti-Fraud Marketing Strategies

Deterring and reducing WC fraud requires a robust anti-fraud marketing strategy to supplement the effect of criminal investigations and prosecutions. Historically, crime was primarily deterred by the impact of criminal prosecutions. We recognize that such an approach is inadequate and outdated.

A short anti-fraud message centered on the cost of WC fraud and the impact on a person and their family can significantly reduce crime. A “catchy” easy to remember message is the best marketing strategy to implement. Your “message” can then appear in Public Service Announcements (PSAs) on Television and Radio; Bus and Trolley Ads; Anti-Fraud Posters to be displayed throughout the workplace; anti-fraud brochures distributed at community outreach events and as “Payroll Stuffers” to employees; newspaper ads in local papers, chambers of commerce and/or industry publications, and ethnic papers with ads in foreign languages; Banners flashing across email accounts and/or in word searches on the internet and any evolving social media platforms; a toll-free hotline and/or e-mail address to report insurance fraud; and any similar marketing strategies applicable to your particular community.

Often, individuals committing WC fraud are one-time offenders who are not “career criminals.” A robust anti-fraud marketing strategy designed to stop fraud before it occurs can be a tremendous benefit to employers, employees, consumers and the country.



6) Industry Outreach

Building Community Connections and Relationships

Collaboration and information sharing among stakeholders in identifying, investigating, and defeating WC fraud cannot be overemphasized. All stakeholders, including businesses and trade groups along with the general public need to practice the “See Something, Say Something” rule.

Trade groups, especially in construction, should be fully engaged. It’s important they know the importance of having written contracts with all independent contractors (ICs) properly classified; requiring ICs to carry proof of general liability, WC, and any other relevant insurance; having ICs provide certificates of insurance; and verifying any WC certificates or exemptions with appropriate authorities.

Businesses should also implement a zero-tolerance workplace policy for fraud and develop an environment that encourages employees to report their suspicions. They can introduce an official whistleblower hotline and offer rewards for tips. Employees can learn to identify the red flags of fraud and become knowledgeable about the applicable laws in their jurisdiction. However, when in doubt, report suspicions to your carrier and seek their guidance. It is also beneficial to participate in and attend any criminal proceedings to provide victim testimony regarding the impact of the fraud to the business and customers.

Furthermore, the general public can play a vital role in identifying and defeating WC fraud by verifying certificates of coverage are valid (i.e. for permits, bids, etc.) through their local or state databases. Educate yourself and be aware of any potential insurance scams including reviewing the Coalition’s website. When red flags or concerns of potential fraud exist, immediately contact your insurance carrier, the Coalition, or the NICB. Finally, private and professional associations or organizations can play a pivotal role by conducting outreach to national and regional conferences, i.e. WC Institute.



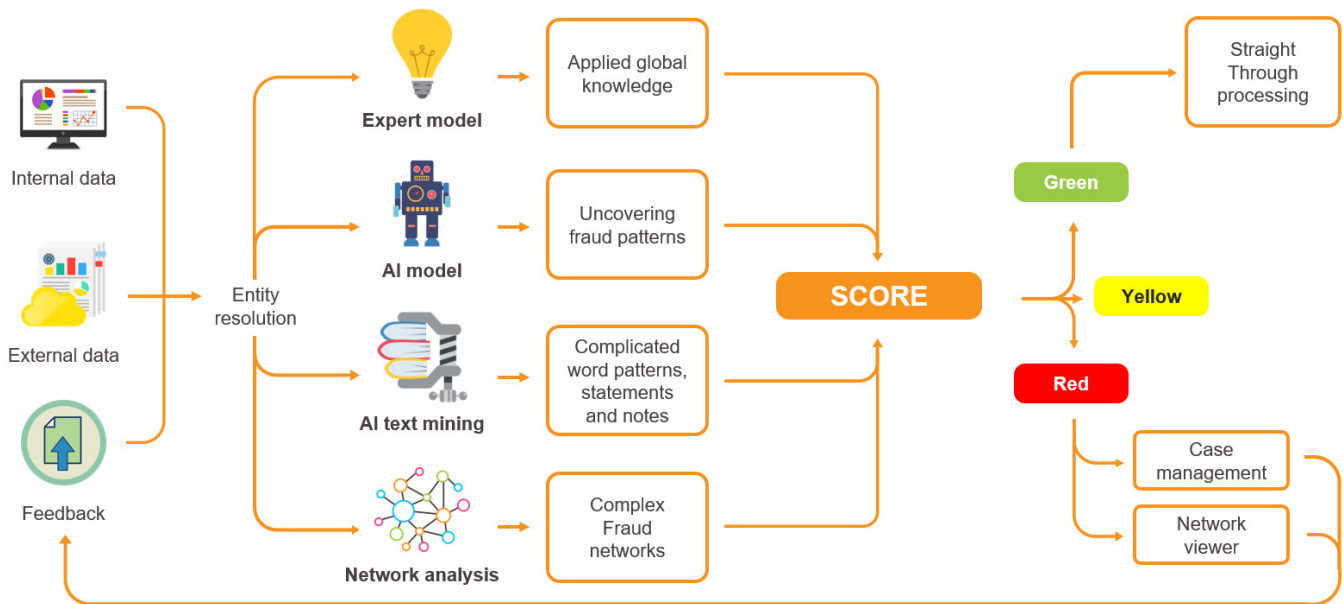
7) DATA ANALYTICS

Leveraging Technology

For decades the methods utilized to fight WC fraud have not changed. We rely on business rules, and dedicated claims adjusters to catch minute details of a claim and then form a cohesive narrative for SIU to investigate. The business rules are linear and cannot put all the pieces together.

Machine Learning has opened the door to a world of fraud fighting possibilities. For instance, an adjuster's notes can be analyzed to determine if a claim has risk factors even if the adjuster misses the risk. Network analysis can be done to connect real time links across claims that an army of analysts could not put together manually. Geo mapping can visually show uncommon movement such as a 50-mile drive to see a doctor. All these risks can be scored and shown to an adjuster or analyst for further review in real time. The question is where do you start?

Historical data is important in the use of most Machine Learning capabilities. Claims data and adjuster notes are a starting point. However, to really discover fraudulent claims, you need to have history on the ones that are fraudulent. Meaning you need a fraud feedback loop. This is as simple as reporting claim investigation outcomes that show a particular claim is fraudulent. It can be even more effective at the entity level when for instance a doctor, or hospital that is identified as fraudulent can be added to a "bad actors" list for review in future claims. The point is that for machine learning to train models on fraudulent behavior it needs data to determine the common factors that make up fraud. If you do not have the fraud feedback loop, start collecting it now. Remember, claims data and adjuster notes are a perfect place to start. While business rules work, you need the fraud feedback loop to effectively train models. Below is a diagram of how machine learning works.



The Coalition recognizes, supports and encourages the use of new technologies to identify and investigate all forms of insurance fraud, including in the fight against WC fraud. As a consumer-advocacy organization, the Coalition also urges all of our members to be ever mindful of the need for safeguards and controls to be carefully developed and put in place to insure personal data is appropriately used and protected and that all data analysis programs seek to avoid any form of discrimination or bias to the fullest extent possible.



8) LEGISLATION

Partnering to Advocate for Legislation

Unfortunately, the reality is the anti-fraud laws in many states are woefully inadequate to assist in the fight to ensure that only legitimate claims are paid; correct premiums are collected; and those who seek to circumvent the WC system are held accountable. Insurance carriers, self-insureds and all those who benefit from what is supposed to be a self-executing system must join forces to ensure a level playing field so that appropriate benefits can be paid to injured workers and proper rates can be established and premium collected to pay for those benefits.

Ensuring that [current laws](#) are enhanced or new laws are enacted is key to ensuring that we can tackle the problem. Some ways to help prevent and detect insurance fraud are included below.

Provide adequate immunity allowing carrier personnel, self-insureds, fraud fighting organizations, public entities, law enforcement personnel and prosecutors to meet when needed to discuss potential fraudulent activity.

- See [California AB 1681](#) as an example of proposed legislation.
- Enhance the penalties when fraud is committed and proven.
- Fraud in part, fraud in whole, i.e. the law in Florida.
- All fraud is charged as a felony, i.e. the law in Florida.
- Restitution to the victim is mandatory upon conviction, i.e. the law in Florida.

9) CRIMINAL AND CIVIL ACTION



Effective Civil and Criminal Remedies

Insurance crime does not differentiate between state lines, which means that there are at least fifty different sets of laws that apply to insurance fraud. As such, it is important for individual fraud fighters to “Know Their Jurisdiction.” The Coalition has an excellent resource for members available on their website.

Effective collaboration between the SIU investigators, claims representatives and legal advisors helps to ensure a cohesive strategy when gathering internal and external evidence to support a criminal or civil action. Sharing elements needed to establish a strong fraud case with your front line staff, including training on how to document claims abnormalities, can generate more productive referrals to the SIU, as well as increase the likelihood of prosecutions.

Funding is another factor that can play into a successful criminal or civil prosecution. California has dedicated grant funding which is similar to a payroll tax. This funding is earmarked for funding dedicated resources to fight WC fraud. Some states have additional tools such as *qui tam* fraud lawsuits. These lawsuits, also known as False Claims Acts, allow private citizens to sue individuals, companies, or other entities that are defrauding the government, and gives an opportunity to recover damages and penalties on the government’s behalf. The statutes provide financial rewards as well as job protection against retaliation to “whistleblowers”.

10) RECRUITMENT AND SUCCESSION



Recruitment and Succession Planning

Attracting and recruiting a diverse staff is crucial to the development of any fraud awareness program. The Coalition is committed to diversity, equity and inclusion in all aspects of the anti-fraud community.

Diversity includes life experiences and different perspectives that may not always be apparent when recruiting anti-fraud professionals. It is vital to have an open-minded and proactive approach to include different and varied candidates in the recruitment and interview process. Outreach to a diverse candidate pool requires a thoughtful and non-traditional approach.

Recruiting and developing a diverse pool of employees provides a broader team of future leaders.

A diverse team brings a unique skill set and perspective to an organization allowing assessment, analysis and solutions to problems in a varied business landscape. A diverse approach provides a significant advantage in the marketplace to the organization while being able to attract, develop and retain top diverse talent. Some benefits include: create specific diversity goals and strategies; strategic placement of job opportunities in diverse locations; and create a tiered organizational structure to allow less experienced talent to develop lasting careers.

Succession planning is the cornerstone to continued and future success of any organization. It is imperative that organizations identify and develop employees with the acumen to fill key leadership positions to ensure long range goals are achieved. Succession planning will provide visible career paths for high performing employees while ensuring these employees obtain the education and exposure to succeed. Succession planning increases the morale of future leaders while ensuring institutional knowledge and brand culture survives inevitable change. The outcome of a sound succession plan includes identifying the most qualified future leaders; creating a structure for training and development; establishing brand identity; and focusing on long term plans.



The Coalition Against Insurance Fraud Task Force report seeks to highlight how this \$34 Billion of WC fraud problem, while significant, has historically not been at the forefront in the battle to reduce insurance fraud. WC fraud has serious negative impacts upon employers, employees, providers, consumers, and our overall community. We all are negatively impacted by WC fraud.

Only by identifying the problem, designing strategies to reduce this fraud, and then taking action to implement these new anti-fraud ideas can we hope to significantly reduce WC fraud in the future.



ABOUT US

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 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 & data, services and insight as a leading voice of the anti-fraud community.

For additional information on the [Coalition Against Insurance Fraud](https://www.coalitionagainstinsurancefraud.org) contact us at 202- 393-7330 or info@insurancefraud.org



**Coalition Against
Insurance Fraud**