

Dial-In Number: (866) 660-4683
Conference ID # 75911777

The HUB Risk Services Division Presents:

COMBATING WORKERS' COMPENSATION FRAUD



Compliance & Investigations



www.hubinternational.com

About the HUB Risk Services Division

- Board-certified and degreed safety, security, property, fleet, environmental, emergency, business continuity, and claims management professionals with an average of over 20 years experience in a variety of industries.
- Specialty areas include:
 - Safety Management Systems
 - Regulatory Compliance
 - Best Practices / World Class Safety
 - Behavior-Based Safety
 - Ergonomics
 - Fleet Safety
 - Security / WPV Mitigation
 - Process Safety Management
 - Property Protection
 - Emergency Response / Business Continuity / Crisis Management Planning
 - Industrial Hygiene and Environmental Compliance
 - Claims Management

About the Presenters

- Todd A. Macumber, MBA, CSP, CIE, ARM
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- Jason Campbell
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Senior Risk Consultant, Risk Services Division (Central)
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Agenda

- The Issue
 - Fraud, Defined
 - Scope and Impact
 - Regulatory Environment
- Key Indicators of Workers' Compensation Fraud
- What Can You Do to Minimize its Occurrence and Impact?
- Tools/Resources to Help Combat This Epidemic

The Issue

WHAT IS
INSURANCE FRAUD?
IT'S A SERIOUS
CRIME.

Fraud, Defined

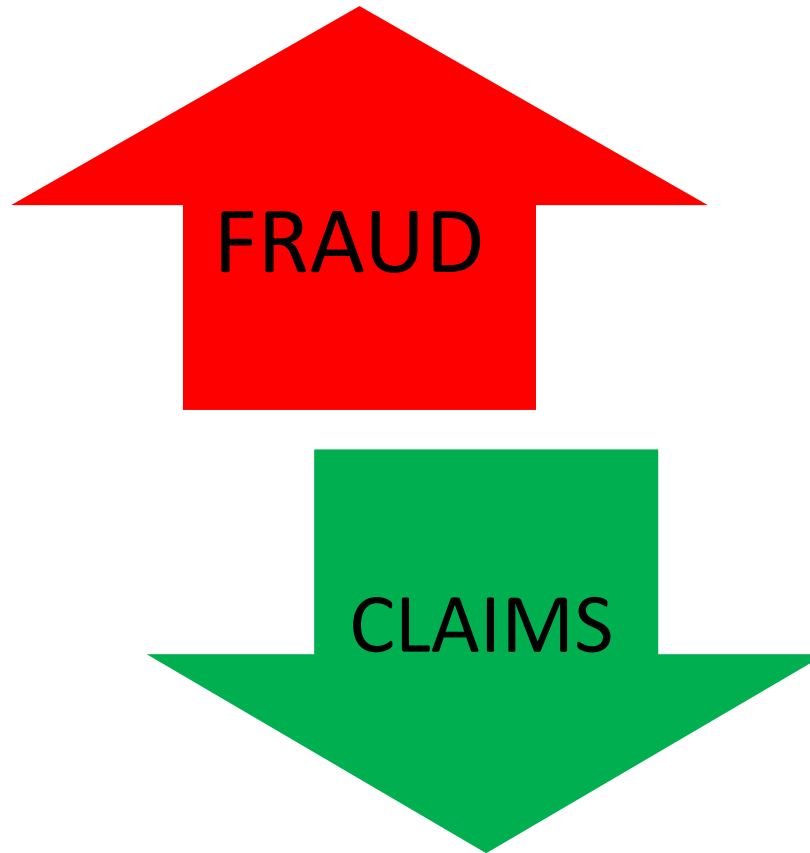
- When someone provides false information to an insurance company in order to gain something of value that he or she would not have received if the truth had been told, they've committed insurance fraud.

Fraud Defined – Got M.I.L.K.?

- Misrepresentations made must be Material to the case
- The false information must have been presented Intentionally
- A Lie must have been presented to prove, validate, affirm or deny a claim for injury or loss payment or to obtain insurance coverage
- The information must have been presented Knowingly
- The false information presented would have altered, changed or modified the manner the claim was handled, investigated, evaluated or settled

The Perfect Storm

- *Job losses* with soaring unemployment, *home foreclosures*, *falling real estate values* and unprecedented *financial crises* have formed the perfect storm of economic circumstances that tempt ordinary people to commit fraud.



During recessions in many lines, claims go down
but fraud goes up

Examples of Insurance Fraud

- **Fraudulent Claim** – Examples: staged or deliberately caused auto accidents; staged slip and fall accidents; false claim of foreign object in food or drink; faking a death to collect benefits or filing a phony death claim; murder-for-profit; phony burglary, theft or vandalism; arson; staged auto thefts; and staged homeowner accident or burglary.
- **Exaggerated Claims** - The most common perpetrators of fraud are the occasional “fibbers” or “padders” who overstate their insurance claims to make up for the deductible. Consumers pay billions of dollars annually to cover these little exaggerations. Overstating the amount of loss can include: inflating bodily injuries from an auto accident; inflating value of items taken during a burglary or theft; inflating a physical damage claim from a minor fender bender; and medical providers inflating billing or upcoding of medical procedures.

Fraud Facts

- 80 to 120 BILLION dollars a year in fraudulent Property & Casualty claims in the U.S.
 - *Coalition Against Insurance Fraud*
- 10% of all claims are fraudulent or inflated
 - *National Insurance Crime Bureau*
- 35% of all workers' compensation claims are fraudulent
 - *Insurance Research Council*

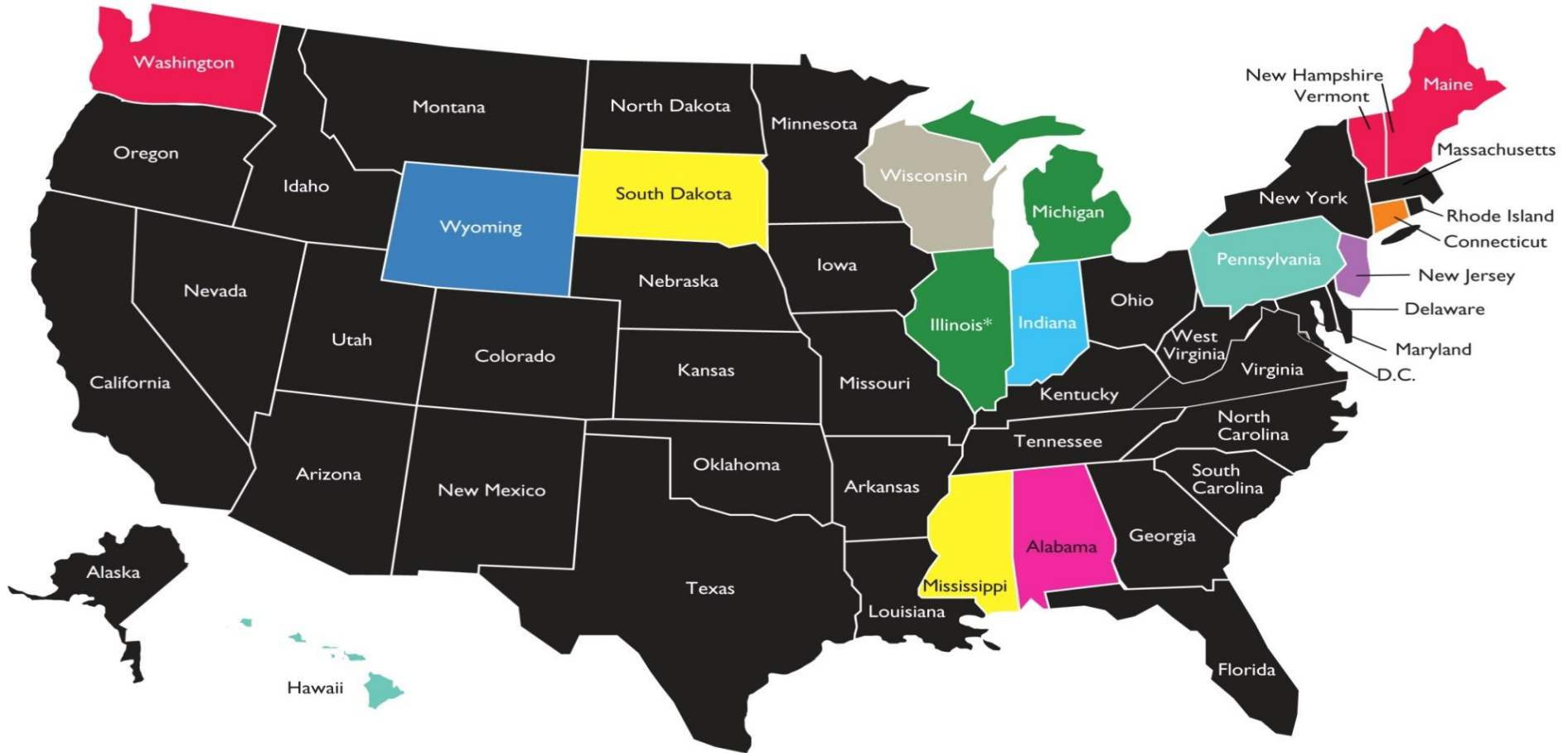
Acceptability of Insurance Fraud

The following statistics represent the public's view of acceptable insurance fraud:

- Increase claim to make up for deductible 33% agree
- Stay out of work longer than necessary 25% agree
- Increase claim to make up for premium 22% agree
- Deliberately underestimate miles driven 18% agree
- Say vehicle is garaged in area to obtain lower rates 15% agree
- Submit bills for treatment never received 13% agree
- Fail to list prior accidents, tickets or claims 8% agree
- Add old damage to new claim 5% agree

Mandatory Reporting

- Mandatory by statute
- Required by fraud plans
- Not required to report
- Voluntary
- Required if evidence of insurance fraud
- Mandatory for arson
- Mandatory for arson/wc
- Mandatory for auto/wc
- Mandatory for auto/health
- Mandatory for arson/auto thefts only
- Statistics required per Annual Report and immediate report of suspect health claim provided under health, disability, work comp, auto or self-insured health benefits



Key Indicators

Claims History & Current Working Status

- The claimant changes physicians when a release for work has been issued
- The claimant has a history of reporting subjective injuries
- Review of the rehabilitation report describes the claimant as being muscular, well tanned, having callused hands and/or grease under nails
- A surveillance or “tip” reveals the totally disabled worker is currently employed elsewhere
- After injury, the injured worker is never home or a spouse/relative who answers the phone says the injured worker “just stepped out”

Claims History & Current Working Status

- Return calls to the claimant's residence have strange or unexpected background noises, which indicate it may not be a residence
- The claimant has several other family members also receiving workers' compensation benefits or other benefits, such as unemployment
- The claimant demands quick settlement decisions of commitments or is consistently uncooperative
- The claimant is unusually familiar with workers' compensation claims handling procedures and laws
- Workers' compensation claims contain whiteout or are submitted as a photocopy

Circumstances of the Accident

- The accident occurs late Friday afternoon or shortly after the employee reports to work on Monday
- The accident is not witnessed or witnesses to the accident conflict with the applicant's version or with one another
- The claimant alleges an injury at an odd time, e.g., at lunch hour.
- Fellow workers hear rumors circulating that the accident was not legitimate
- The accident occurs in an area where the injured employee would not normally be working

Circumstances of the Accident

- The task that caused the accident isn't the type the employee should be involved in, such as an office worker lifting heavy objects onto a loading dock
- The accident occurs just prior to a strike, job termination, layoff or near the end of the employee's probationary period
- The employer's first report of injury contrasts with the description of the accident set forth in the medical history
- The accident details from the claimant are vague or contradictory, have inconsistencies or are generally not credible
- The accident is not reported promptly by the employee to a supervisor

Circumstances of the Accident

- Claimant or attorney refuses to provide complete accident or injury information
- Claimant alleges having fallen in liquid spill yet their clothes/shoes not wet from substance or there is no source of spills identified
- Claimant states the accident was not witnessed
- Witnesses or video surveillance contradict facts

What Can You Do to Minimize its Occurrence and Impact?

Methods to Minimize Fraudulent Claims

- Hire Right
- Train their managers/supervisors to recognize potentially fraudulent claims
- Manage Closings Properly
- Investigate! Investigate! INVESTIGATE!
- Get the claims team involved early, and let the claims representatives know when you believe a claim is fraudulent (and why)

Hire Right

- Background, MVR, and Reference Checks only go so far...
- Focus should also include the behavior that could drive someone to commit fraud
- Objective exposure information and performance evaluations exams will support the right person for the right position

Train Managers/Supervisors to Recognize Potentially Fraudulent Claims

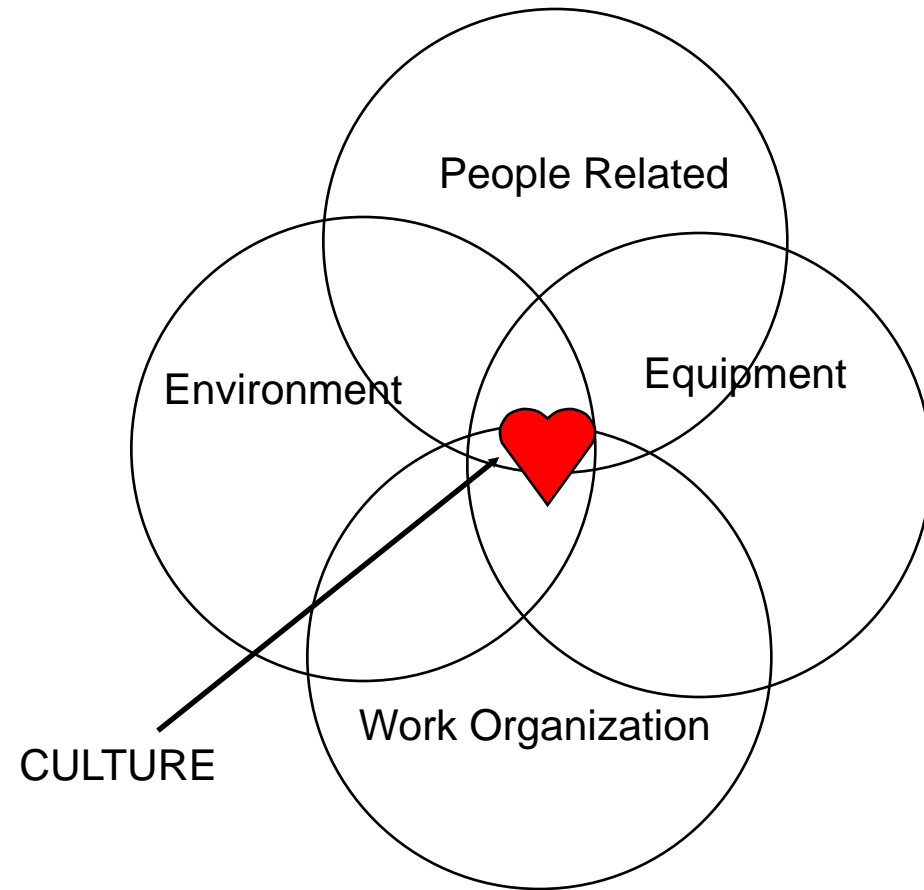
- Managers/Supervisors are not only the face of the company to the employee, but also (often) the eyes and ears
- Many “Red Flags” are easily overlooked by the untrained manager/supervisor
- Managers/Supervisors must understand the proper ways to investigate incidents, gathering the right information

Manage Closings Properly

- Claim are common with poorly managed facility/business closings
- Some of the issues that must be addressed by management include:
 - Job placement assistance and counseling
 - Potential workplace violence situations
 - Claim management contacts
 - Ongoing claim investigation and management Aggressive disability case management
 - Litigation management
 - Outplacement medical screening
 - Documentation of plant processes, conditions, and exposures
 - Critical records and documentation

Investigate! Investigate! INVESTIGATE!

- Focus on Root Causes, and Objective Factors that Caused / Contributed to the Claim
- Gather:
 - Claimant information
 - Witness statements
 - Objective operational data
 - Videos, pictures, etc.
- Bring in 3rd party firms to assist



Tools/Resources to Help Combat This Epidemic

Pre-Hire Screening

Improving Selection at Point of Hire...

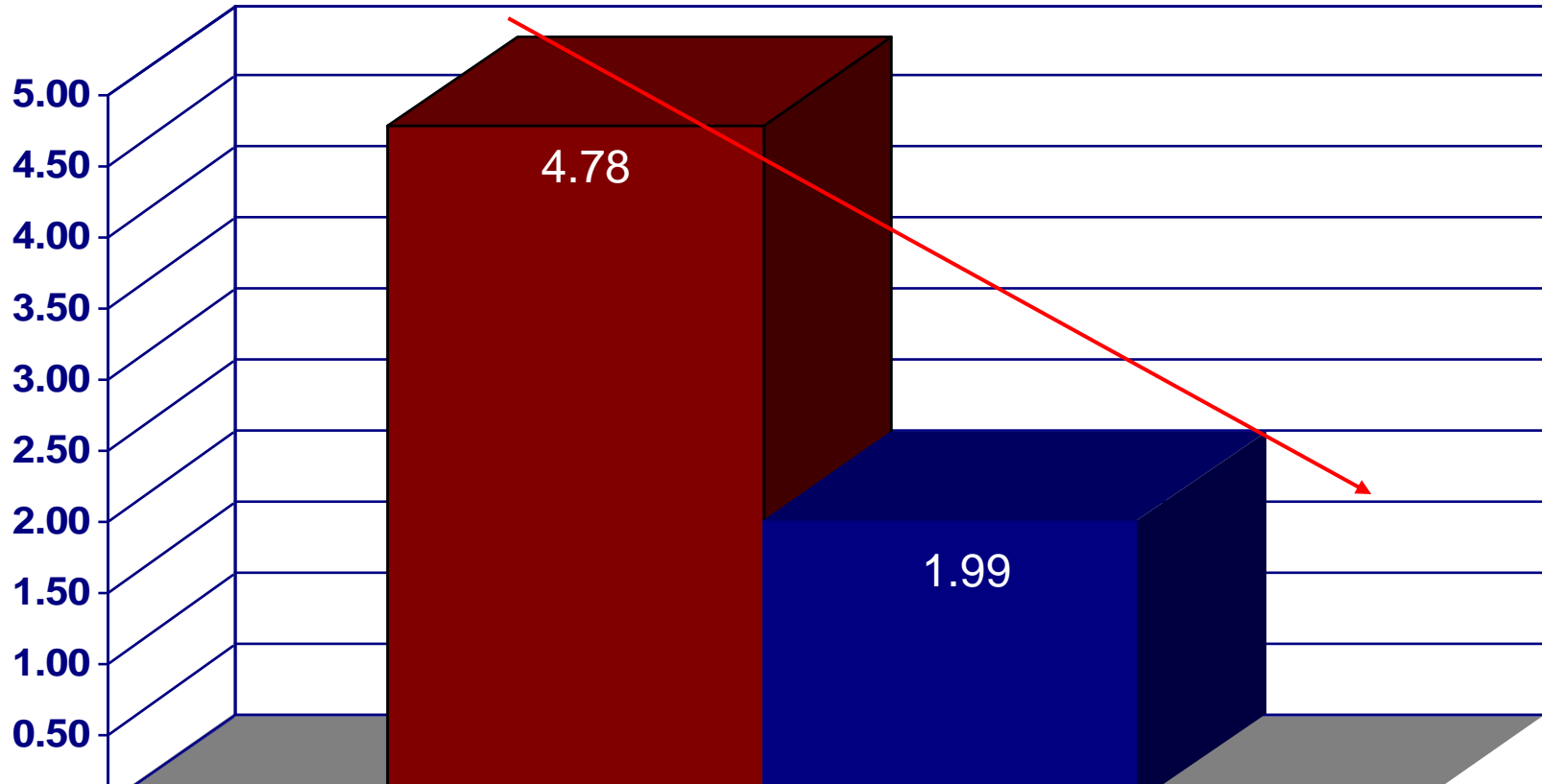
American Tesco Integrity Testing is available through
HUB

Minimize the Hiring of High-Risk Employees

- Employee Candidate Pre-Hire Screening helps identify the Psychological Risk of the Claim
 - High Risk Capture Rate is 31%
 - 6 times more effective than a Criminal Background Check
 - 3 times more effective than a Urinalysis Drug Screen
- Identifies:
 - Drug Users – 13% Failure Rate
 - Thieves – 17% Failure Rate
 - Liars / Manipulation / Entitlement – 7% Failure Rate
 - Violent Individuals – 1% Failure Rate
- Cost is only \$15 per Test
- Results are available immediately

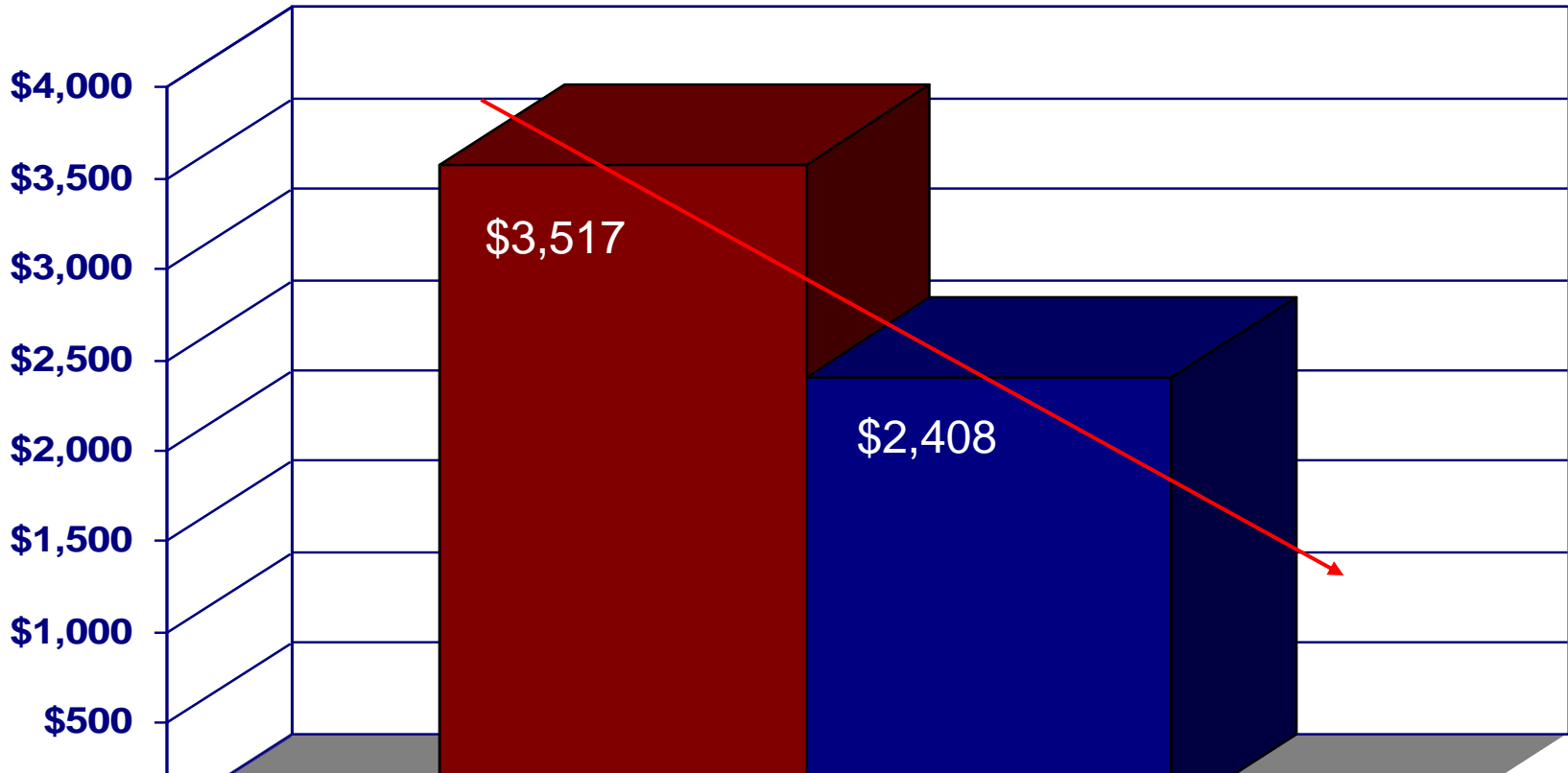
IMPACT – 58% Claim Frequency Reduction

Impact on Claim Frequency; per 100 Workers



IMPACT – 31% Claim Cost Reduction

Impact on Claim Severity; Average Cost per Claim



Why it Works

- This test is based upon value models that both guide and drive ultimate behavior in the decision making process.
- **Cognitive Dissonance** is an uncomfortable feeling caused by holding two contradictory ideas simultaneously.
- **Cognitive Dissonance** is a motivational drive to reduce dissonance by changing attitudes, beliefs and behaviors, or by justifying or rationalizing them. It is one of the most influential and extensively studied theories in social psychology.

Overview and Key Stats

- Available in 21 Languages
- 5th Grade Reading Level – 73 Questions – 15-20 minutes
- Immediate Results; Tracked by SSN
- Validated and EEOC Compliant
- Meets all State and Federal Requirements
- Litigation-Free for 31+ years
- High Return on Investment
- Documented Reduction in Workers' Compensation Costs
- Additional Benefits:
 - Reduction in FMLA, STD, LTD and sick leave
 - Reduces employee theft/pilferage
 - Reduces turnover, improves productivity and staffing
 - Streamlines the interview process

Pre-Hire Screening, cont.

Improving Selection at Point of Hire...

Job-Specific Function Testing (HPE) is available through Concentra, in partnership with HUB



Overview

- Leading provider of primary occupational health and urgent care services in the US
- 323 Primary Care Centers
- In 2009, Concentra treated over 600,000 on-the-job injuries and urgent care visits

Solutions

- Pre-Placement Services: Drug Testing, Physical Exams, Job-Specific Functional Testing
- Injury Care Services: Injury Care Treatment, Physical Therapy, Specialist Care

ADA & Pre-Employment Screening

- Job-related and consistent with business necessity
- Post-offer and pre-placement
- Objective tests correlating to the essential functions
- Consistency of employment decisions

Biomechanical Job Site Analysis

Provides written support for:

- Hiring decisions
- Internal transfers
- Pre-work screening - HPEs
- Return to work – FCEs

Entails:

- Review of client job descriptions
- Completion of the PDI by the supervisors
- Onsite measurement of each task for each job in quantifiable components
- Review of the preliminary report by the employer
- Generate the EJF report / HPE

Job-Specific Functional Testing (HPE)

- Human Performance Evaluation
- EXAMPLE: Essential Job Function Description - LIFT 1
 - Task Description: Employee must load dry stock such as flour and sugar on to conveyer. Requires vertically translating stock weighing 50 lb. From 1" to 36" up to 107/hr.
 - Functional Requirement: Lift Parameters (1" to 36") / Load (50lbs) / Frequency (107/hr)
 - HPE: Required (1" to 36") / Performed (_____) / P/F (_____)
- Many benefits, including validation on whether employee is physically capable of performing a job

Investigations

Keeping the Claimant Honest...

Special Investigations available through G4S, in partnership with HUB



Compliance & Investigations

- 325+ employee investigators located strategically throughout the United States:
 - Regardless of the type, nature or complexity of loss, G4S' qualified investigation professionals handle every facet of an investigation. Determining the facts, securing evidence and developing preventative processes are all core solutions of G4S.
 - Global coverage with operations in over 91 countries.
- 2009 Investigation Results:
 - 46,020 Surveillances conducted
 - 28,565 Claims and SIU investigations conducted
 - 1,390 State Fraud Referrals Filed
 - 167 Arrests / Convictions for Fraud and Theft
 - 65 Prosecutions pending
 - \$1,433,526.42 in restitution awarded to our clients
 - Ten's of millions of dollars saved in fraudulent claim payments



Available Investigative Options

Surveillance

International Investigations

Fraud Reviews

Clinic Inspections

Examinations Under Oath

Scene Diagrams

Alive & Wellness Checks

Fraud Awareness Training

Auditing & Consulting

Neighborhood Canvass

Hospital Searches

Driver's License Searches

Criminal Records Check

Claims / Fraud Investigations

State Fraud Referrals

Documented Fraud Packages

Statements/Recorded Interviews

Video Re-enactments of the loss

Scene Photographs

Continuance of Disability Checks

SIU Compliance & Reporting

Activity Checks

Nationwide Background Investigation

Pharmacy Searches

Skip Tracing (locates)

Civil Records Searches

And many more....

Technology to Support the Investigation

CaseTrak™

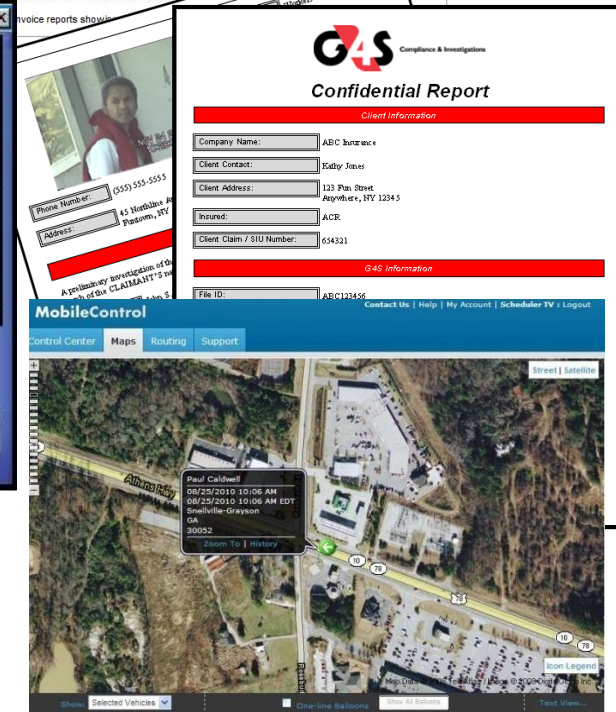
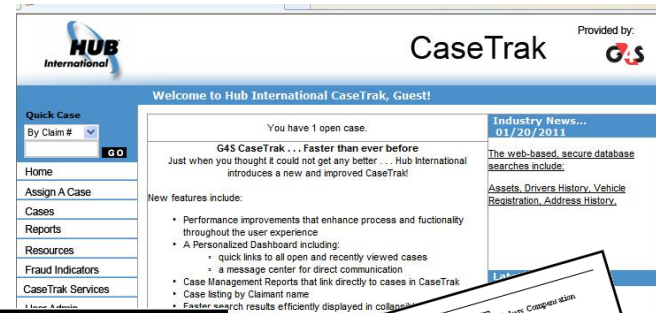
- G4S has a customized web-based interface
- 24/7 fully automated access to case status, investigative reports, and video
- Direct run Management Reports

C&I Production Systems

- View case video and reports online. They can be either supplemental or substituted for physical reports

GPS Technology

- Each G4S staff investigator is equipped with a GPS monitoring device that provides real-time knowledge of each investigator's location.



Reporting to Analyze Results

The standard monthly reporting suite can include:

- Billing Summary Report
- Case Findings Report
- Monthly Referrals by Office Report
- Assignments by Service Type Report

Report ROI on the allocated investigation costs

- The collection of claim(s) data, coupled with advanced technology that provides, consistent, reliable and detailed measurable results that quantify the outcome of investigative efforts.

REFERRAL TRENDING

TQS (TOTAL QUALITY SERVICE) SUMMARY

Communication	97.7%
Timeliness	97.2%
Quality	97.7%
Overall Score	98%

REVENUE TRENDING

Outcome Reporting

Results for: 7/14/2016 - 8/24/2016

Surveys	Total
Surveys Created:	112
Surveys Completed:	58 (52%)
Delinquent Surveys:	15 (13%)
Reminders Set:	85 (76%)
Notifications	Total
Initial Emails Sent:	114
2nd Emails Sent:	75
3rd Emails Sent:	61
Final Emails Sent:	55
Manager Emails Sent:	2

Outcomes	Yes	No
Do you believe that the investigation will impact the claim resolution OR rule out suspicious indicators?	21	37
How did the investigation impact the Claim Resolution?		
	Claim Compromised	1
	Claim Denied	4
	Claim Withdrawn/Close No Pay	3
	Rule'd out suspicious indicators allowing a better claim outcome	11
	Subrogation Opportunity Identified	2

Outcome Results *	
Claim Value:	\$5,100,769.00
Loss Paid:	\$4,665,877.00
Cost Avoidance:	\$414,891.00
Total Billing:	\$60,683.49
(Total "Life of Case" Billed Amount for Cases with Completed Surveys)	
Return Ratio:	6.84 to 1
(Cost Avoidance divided by Total Billing)	
Net Savings:	\$354,207.51
(Cost Avoidance - Total Billing)	
Files w/ Impact:	36 %
(Total Surveys with Impact divided by Total Surveys Completed)	

*Numbers represent results for the most recent Survey for a Claim File. If Multiple Surveys were completed for a Claim File, only the most recent Survey is included in these results.

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Summary

- Fraudulent Workers Compensation Claims are a big and growing issue for many businesses
- Strategies, Tools, Resources exist to minimize the occurrence and impact of fraudulent claims
- Get your claims team involved early if you have a concern
- Let us know what we can do to help!

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QUESTIONS?