

TCRP

SYNTHESIS 36

TRANSIT
COOPERATIVE
RESEARCH
PROGRAM

Identifying and Reducing Fraudulent Third Party Tort Claims Against Public Transit Agencies

A Synthesis of Transit Practice

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TCRP SYNTHESIS 36

Identifying and Reducing Fraudulent Third Party Tort Claims Against Public Transit Agencies

A Synthesis of Transit Practice

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TRANSIT COOPERATIVE RESEARCH PROGRAM

The nation's growth and the need to meet mobility, environmental, and energy objectives place demands on public transit systems. Current systems, some of which are old and in need of upgrading, must expand service area, increase service frequency, and improve efficiency to serve these demands. Research is necessary to solve operating problems, to adapt appropriate new technologies from other industries, and to introduce innovations into the transit industry. The Transit Cooperative Research Program (TCRP) serves as one of the principal means by which the transit industry can develop innovative near-term solutions to meet demands placed on it.

The need for TCRP was originally identified in *TRB Special Report 213—Research for Public Transit: New Directions*, published in 1987 and based on a study sponsored by the Federal Transit Administration (FTA). A report by the American Public Transit Association (APTA), *Transportation 2000*, also recognized the need for local, problem-solving research. TCRP, modeled after the longstanding and successful National Cooperative Highway Research Program, undertakes research and other technical activities in response to the needs of transit service providers. The scope of vice configuration, equipment, facilities, operations, human resources, maintenance, policy, and administrative practices.

TCRP was established under FTA sponsorship in July 1992. Proposed by the U.S. Department of Transportation, TCRP was authorized as part of the Intermodal Surface Transportation Efficiency Act of 1991 (ISTEA). On May 13, 1992, a memorandum agreement outlining TCRP operating procedures was executed by the three cooperating organizations: FTA, the National Academy of Sciences, acting through the Transportation Research Board (TRB), and the Transit Development Corporation, Inc. (TDC), a nonprofit educational and research organization established by APTA. TDC is responsible for forming the independent governing board, designated as the TCRP Oversight and Project Selection (TOPS) Committee.

Research problem statements for TCRP are solicited periodically but may be submitted to TRB by anyone at anytime. It is the responsibility of the TOPS Committee to formulate the research program by identifying the highest priority projects. As part of the evaluation, the TOPS Committee defines funding levels and expected products.

Once selected, each project is assigned to an expert panel, appointed by the Transportation Research Board. The panels prepare project statements (requests for proposals), select contractors, and provide technical guidance and counsel throughout the life of the project. The process for developing research problem statements and selecting research agencies has been used by TRB in managing cooperative research programs since 1962. As in other TRB activities, TCRP project panels serve voluntarily without compensation.

Because research cannot have the desired impact if products fail to reach the intended audience, special emphasis is placed on disseminating TCRP results to the intended end-users of the research: transit agencies, service providers, and suppliers. TRB provides a series of research reports, syntheses of transit practice, and other supporting material developed by TCRP research. APTA will arrange for workshops, training aids, field visits, and other activities to ensure that results are implemented by urban and rural transit industry practitioners.

The TCRP provides a forum where transit agencies can cooperatively address common operational problems. TCRP results support and complement other ongoing transit research and training programs.

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The members of the technical advisory panel selected to monitor this project and to review this report were chosen for recognized scholarly competence and with due consideration for the balance of disciplines appropriate to the project. The opinions and conclusions expressed or implied are those of the research agency that performed the research, and while they have been accepted as appropriate by the technical panel, they are not necessarily those of the Transportation Research Board, the Transit Development Corporation, the National Research Council, or the Federal Transit Administration of the U.S. Department of Transportation.

Each report is reviewed and accepted for publication by the technical panel according to procedures established and monitored by the Transportation Research Board Executive Committee and the Governing Board of the National Research Council.

Special Notice

The Transportation Research Board, the Transit Development Corporation, the National Research Council, and the Federal Transit Administration (sponsor of the Transit Cooperative Research Program) do not endorse products or manufacturers. Trade or manufacturers' names appear herein solely because they are considered essential to the clarity and completeness of the project report.

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PREFACE

A vast storehouse of information exists on many subjects of concern to the transit industry. This information has resulted from research and from the successful application of solutions to problems by individuals or organizations. There is a continuing need to provide a systematic means for compiling this information and making it available to the entire transit community in a usable format. The Transit Cooperative Research Program includes a synthesis series designed to search for and synthesize useful knowledge from all available sources and to prepare documented reports on current practices in subject areas of concern to the transit industry.

This synthesis series reports on various practices, making specific recommendations where appropriate but without the detailed directions usually found in handbooks or design manuals. Nonetheless, these documents can serve similar purposes, for each is a compendium of the best knowledge available on those measures found to be successful in resolving specific problems. The extent to which these reports are useful will be tempered by the user's knowledge and experience in the particular problem area.

FOREWORD

*By Staff
Transportation
Research Board*

This synthesis will be of interest to transit agency general managers, supervisors, and staff dealing with legal services and risk management issues, as well as to consultants that work with them. It describes those practices in place at public transit agencies to prevent and respond to third party fraudulent claims, including a review of salient aspects of the public transit claims process in the context of managing current and partial tort liability. It examines the level of claims, presents a structured methodology for approaching the fraudulent claims issue, and describes practices that have been implemented to reduce claims abuse. The emphasis is on strategies that organizations have adopted to counter insurance fraud.

Administrators, practitioners, and researchers are continually faced with issues or problems on which there is much information, either in the form of reports or in terms of undocumented experience and practice. Unfortunately, this information often is scattered or not readily available in the literature, and, as a consequence, in seeking solutions, full information on what has been learned about an issue or problem is not assembled. Costly research findings may go unused, valuable experience may be overlooked, and full consideration may not be given to the available methods of solving or alleviating the issue or problem. In an effort to correct this situation, the Transit Cooperative Research Program (TCRP) Synthesis Project, carried out by the Transportation Research Board as the research agency, has the objective of reporting on common transit issues and problems and synthesizing available information. The synthesis reports from this endeavor constitute a TCRP publication series in which various forms of relevant information are assembled into single, concise documents pertaining to a specific problem or closely related issues.

This document from the Transportation Research Board integrates information from a literature review and a detailed survey of 22 risk management, safety, and legal personnel within the transit and insurance agencies. Telephone interviews were also held with subject matter experts.

To develop this synthesis in a comprehensive manner and to ensure inclusion of significant knowledge, available information was assembled from numerous sources,

including a number of public transportation agencies. A topic panel of experts in the subject area was established to guide the researchers in organizing and evaluating the collected data, and to review the final synthesis report.

This synthesis is an immediately useful document that records practices that were acceptable within the limitations of the knowledge available at the time of its preparation. As the processes of advancement continue, new knowledge can be expected to be added to that now at hand.

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Gwen Chisholm, Senior Program Officer, assisted TCRP staff in project review.

Information on current practice was provided by many transit agencies. Their cooperation and assistance was most helpful.

IDENTIFYING AND REDUCING FRAUDULENT THIRD PARTY TORT CLAIMS AGAINST PUBLIC TRANSIT AGENCIES

SUMMARY

Each year, the transit industry in the United States provides more than 8 billion transit trips to passengers who expect that their travel will be both safe and secure. Although transit is among the safest forms of transportation available, in the course of providing these services, unintended events do unfortunately and inevitably occur that injure thousands of passengers annually, often resulting in third party claims against transit agencies. Most claims are the result of situations in which the claimant has a legitimate grievance as a result of the service provider's failure to uphold the standard of care the transit agency is required to provide to its passengers. Some fraction of the claims, however, are either entirely falsified or contain exaggerations of events or their consequences. In some cases, the claimant's actual or perceived risk of apprehension for filing a false claim is comparatively small, relative to the potential for financial reward, making the public transit agency an attractive target for fraud.

This synthesis encompasses several aspects of the issue of third party fraudulent claims in the transit industry, including the detection, characterization, prediction, and mitigation of these claims. For the purpose of this synthesis, the following definition of the term "third party fraudulent claims" was developed and used in the synthesis survey to effect a common understanding of terminology among agencies participating in the study and therefore yield consistency of collected data to the extent possible. The term describes the occurrence of one or more of the following two conditions.

Third party fraudulent claims are defined as tort claims made by non-employees with the intent to defraud that include:

- Fabrication of the event or the claimant's involvement in the event
- Misstatement of the event.

"Tort claims," in the above definition, involve the demand for damages from the public transit agency and/or its insurance company based on negligence, intentional conduct, or strict liability (*Business Law: Principles and Cases*, 1970). A tort requires the presence of the following four conditions: (1) there is a required standard of conduct, (2) there is a breach of the duty to uphold that standard, (3) the breach of duty causes an injury, and (4) damage(s) is sustained (M. Condray, American Public Transit Administration, personal communication, June 22, 1995).

The level of fraudulent third party claims in the transit industry is difficult to quantify. Perhaps the most severe hindrance to determining the exact level of claims abuse is the fact that much fraud goes undetected; indeed, because claims fraud is either undetected or not verifiable by transit agencies is the usual reason why false claims are paid. Typically, if

agencies were aware of and were able to document claims fraud, the claimant would not be paid. Therefore, the question of how many fraudulent claims are paid is almost, by definition, one for which no absolutely precise answer exists.

As a result of local variations in case law and claims-related statutes, the net cost and precise nature of claims, and of fraudulent claims in particular, are distributed inconsistently across the industry. Nevertheless, whether the issue represents merely a nuisance or a serious and expensive problem to an agency, management of these claims typically requires some counterstrategy by the transit agency. This strategy may be a minimal or an extensive effort in terms of manpower, financial, and equipment demands on the public transit agency.

This report presents the results of a survey distributed to 40 large and medium-sized public transportation agencies throughout the United States. Taken together, the surveyed transit agencies supply most of the daily passenger trips provided in this country. This synthesis also presents the results of a detailed literature review and interviews with industry experts who research and manage fraudulent claims.

The 11 agencies providing information on the final disposition of claims investigations reported that a total of 522 investigations resulted in a clear finding of fraud, representing less than 1 percent of the investigations conducted by these agencies. Thirteen respondents who tracked fraudulent claims information reported that, each year, approximately 12.75 percent of their claims are denied payment based on the determination of some level of fraud. Seven respondents placed the value of denied claims at their agencies at a combined total of approximately \$1.4 million.

Survey results indicate that estimates of the size of the "fraudulent claim" problem are considerably higher than the actual numbers of these claims identified by the agencies. On average, the transit agency respondents believe that 28 percent of the money paid out in tort claims is fraudulent. This result can be contrasted with the 3.9 percent of claims actually identified by these agencies as fraudulent in 1998.

This synthesis describes those practices used by public transit agencies to prevent and respond to third party fraudulent claims. To provide a structure for the discussion of these activities, the claims management process will be subdivided into the following five stages:

1. *Identify and Analyze Loss Exposures*—Developing an awareness of the nature of the fraudulent claims issue and estimating or predicting costs of fraudulent claims.
2. *Examine Risk Treatment Alternatives*—Including elements of exposure avoidance, risk control, and risk financing within a comprehensive program.
3. *Select Appropriate Techniques*—Setting goals for the program to address third party fraudulent claims and evaluating and selecting techniques to achieve these goals.
4. *Implement Techniques*—Putting selected techniques into practice.
5. *Monitor Results*—Providing feedback to improve programs in place.

A number of agency practices are designed for the purpose of defending against fraudulent claims. Programs such as accident procedures, investigation techniques, communications with legal departments, the use of information collection technologies, and the use of accident kits comprise coordinated programs of procedures to reduce the number of claims brought against agencies and the corresponding cost of settling

suspicious or fraudulent claims. Employee manuals at transit agencies, most especially bus and rail operator procedure manuals, are effective tools for the standardization and dissemination of practices that are designed to address the issue of fraudulent claims. Rigorous training procedures that reinforce these procedures also increase the likelihood that all critical information is captured at the time of an accident. Finally, records management (including risk management information systems), special investigative units, insurance company resources, informants, surveillance, claims review and analysis processes, investigation, fraudulent claims profiles, and supplemental fact checking procedures are used in addressing fraudulent claims.

INTRODUCTION

BACKGROUND

Each year, passengers purchase more than 8 billion public transit trips in the United States, with the expectation that not only will they reach their destination in a timely and efficient manner, but that their travel will be safe and secure. Unfortunately, thousands of passenger injuries do occur annually during the provision of public transit service as a result of unintentional acts of harm (i.e., accidents) or incidents perpetrated intentionally (i.e., crimes). In 1997, the most recent year for which data are available, 33,691 personal casualties were reported to the Federal Transit Administration (FTA) (1).

Public transit agencies providing these trips, accordingly, are obligated to provide a "reasonable standard of care" for their passengers. This standard of care is derived from industry standards, such as that set forth in self-imposed general safety guidelines, maintenance requirements, and operational procedures, as well as legal standards defined by applicable state or jurisdictional case law or statutes. Although a number of circumstances can contribute to injuries sustained by public transit passengers, when the obligation to provide these levels of protection is allegedly breached by the service provider, claims against a public transit agency may result.

Furthermore, although many injuries do occur because of such circumstances as slips on icy platforms or bus stops, as the result of bus-automobile collisions, or because of trips on stairs or escalators, some fraction of those claims filed by passengers are either exaggerated or entirely falsified. The potential benefits for submitting such claims are reaped by claimants and, in some instances, medical and legal professionals. In some cases, the actual or perceived risk of claimants' apprehension is comparatively small, relative to the apparent potential for payouts, making public transit agencies attractive targets for those wishing to commit acts of fraud.

EFFECTS ON PUBLIC TRANSIT AGENCIES

The net cost and precise nature of claims, and fraudulent claims in particular, are inconsistently distributed among public transit operators industry-wide. A number of factors are thought to be responsible for this inconsistency. For example, state laws regarding the standard of care required of a transit agency could increase or decrease the likelihood

of success for those perpetrating this crime. Until October 1998, for example, transit systems operating in the state of New York were required to exercise "the utmost care, so far as human skill and foresight can go" in providing passenger service. A recent ruling by the New York State Court of Appeals, resulting from a suit against the New York City Transportation Authority, changed this negligence standard of "utmost care" to the more commonly used standard of "reasonable care." Significant differences in negligence standards still exist from state to state (2).

State laws alone, however, cannot explain differences in levels of claims against agencies, fraudulent and not, as demonstrated by intrastate differences in claims activity. For example, Philadelphia and the surrounding area consistently rank among those communities with the highest number of claims against mass transit. According to figures from the Insurance Research Council (IRC), the number of cases resulting in suits in the city of Philadelphia is far higher than other urban areas, even within the commonwealth of Pennsylvania. According to these data, in Harrisburg, 10 percent of cases reached the courtroom; in Pittsburgh, the figure was 18 percent. In Philadelphia, however, 79 percent of cases resulted in lawsuits. Recently, 14,551 claims were brought against the Southeastern Pennsylvania Transportation Authority (SEPTA) in a single year, a number far greater than the Authority's peer agency's experience (3).

It has been suggested that economic conditions in particular regions impact the number of claims brought against agencies. Regional variations also may stem from factors such as disparities in local public opinions regarding the "acceptability" of insurance fraud, which is estimated to be among the costliest crimes affecting the United States annually (4).

Nevertheless, whether the issue represents merely a nuisance or a serious and expensive problem to an agency, the management of these claims typically prompts organizations to develop strategies to counter the problem. To a greater or lesser degree, agency resources are expended on the implementation of such strategies, including the following:

- Legal experts, risk management professionals, police/security personnel, and claims investigators devoted to activities related to false claims such as the

performance of investigations and the resolution of claims.

- The cost of equipment (e.g., video surveillance systems) to document fraudulent claims.
- The cost of developing and implementing programs such as public information campaigns targeted at fraud.
- The development of agency safety standards to avoid accidents that may encourage fraud.
- The performance of the training of system personnel on agency policies, such as post-accident procedures for operators, designed to minimize claims.
- Premiums for insurance.

Furthermore, these resources are only a small fraction of the types of expenditures that some agencies face in an effort to manage the issue.

SYNTHESIS OBJECTIVES

This synthesis describes those practices in place at public transit agencies designed to prevent and respond to third party fraudulent claims, including a review of salient aspects of the public transit claims process in the context of managing current and potential tort liability. The objectives of this synthesis are as follows:

- To examine, to the extent possible, the level of fraudulent claims in the transit industry.
- To present a structured methodology for approaching the fraudulent claims issue.
- To describe practices that have been implemented to reduce claims abuses. Certain strategies are believed to have achieved notable success in reducing fraud, according to representatives of the agencies in which they have been implemented; some are innovative and not universally familiar to other industry personnel.

METHODOLOGY

This synthesis integrates information gathered from the following sources:

- A review of the literature.
- A detailed survey of 22 risk management, safety, and legal personnel within the public transit and insurance industry. (See Appendix A, Synthesis Survey Results, and Appendix B, Survey Respondents.)
- Telephone interviews with subject matter experts.

First, a review of literature and on-going research relative to fraudulent claims in public transit was conducted, as well as an extensive on-line search, drawing from industry, legal, business, university, and government

databases. The scope of the literature search included both the public transit industry itself and related fields that share fundamental similarities with the industry.

Second, a survey was developed and administered to 40 large and medium-size public transportation agencies located across all geographic areas of the United States. The survey requested information concerning each of the following topics:

- Public transit operating information,
- Defining fraudulent claims,
- Identifying fraudulent claims,
- Processing fraudulent claims,
- Preventing fraudulent claims, and
- General public transit agency insurance practices.

The questionnaire mailing list was compiled based on agency membership in the American Public Transit Association (APTA) Risk Management Committee. As such, the survey was not administered according to a random methodology, but rather focused on collecting information from those agencies with considerable experience in claims management. Most respondents are self-insured and purchase commercial insurance only as a means of covering specific categories of incidents. As a result, risk management personnel at these agencies have primary responsibility for the identification, review, processing, and denial of fraudulent claims.

Twenty-two completed questionnaires were received, 55 percent of those distributed, including 21 from public transit agencies and one response from an insurer of multiple public transit agencies in the state of Wisconsin. Several of the public transit agency respondents were municipal authorities with responsibility for more than one public transit agency. In total, 12 of the 20 largest public transit agencies in the United States participated in the survey. Twenty survey respondents directly provide bus service; 10 also provide rail service.

According to data from the FTA's National Transit Database, in 1997 the 21 public transit agency respondents:

- Provided more than 60 percent of all daily passenger transit trips,
- Operated nearly 30 percent of all transit vehicles in the United States,
- Experienced 38 percent of all collisions reported, and
- Experienced over 45 percent of all personal casualties that occurred on public transit (1).

Based on the industry response to the survey, follow-up telephone calls were made to clarify responses and to obtain more detailed information. Copies of reports, policies, and other documentation were requested from respondents

that indicated that their agencies had implemented practices that had successfully reduced claims abuse. In addition, other industry experts (beyond the survey respondents) were consulted for detailed information, including experts in the legal profession and the risk management field.

DEFINITION OF TERMS

The use of a precise definition of the term, "third party fraudulent claims," is a fundamental prerequisite in characterizing the size and nature of this problem, because the phrase's meaning and usage differ across jurisdictional lines and by transit agency terminology and practice. For the purpose of this synthesis, therefore, a single definition of the term was developed and used in the survey to effect a common understanding among participating agencies and therefore yield consistency of collected data to the extent possible:

Third party fraudulent claims are defined as tort claims made by non-employees with the intent to defraud that include:

- *Fabrication of the event or the claimant's involvement in the event*
- *Misstatement of the event.*

The data supplied by industry representatives contacted for this synthesis were based on the above definition of third party fraudulent claims. As is discussed in more detail later, however, a significant number of the experts contacted added that, in their opinion, misstatements regarding the seriousness of actual injuries were the causes of more fraudulent claims than were fabrications of events.

The term "tort claims" used in the above definition can be interpreted as follows:

Tort claims involve the demand for damages from a public transit agency and/or its insurance company based on negligence, intentional conduct, or strict liability (5). Tort liability constitutes the obligation to pay for a civil wrong. A tort is defined by the presence of four conditions:

1. There is a required standard of conduct (i.e., each member of society is required to observe a course of conduct that does not fall below a recognized standard of care),
2. There is a breach of that duty,
3. The breach of duty causes an injury (causation), and
4. Damage(s) are sustained (M. Condray, APTA, personal communication. June 22, 1995).

Technically, a claim requests a transit agency to reimburse a claimant without necessity of litigation. A lawsuit results when (typically, a lawyer is hired and) a formal summons and complaint is served and then filed with a courthouse. The terms claim and lawsuit, however, are often used interchangeably; the risk manager must handle both situations, and this synthesis addresses both as well.

IDENTIFYING AND QUANTIFYING FRAUDULENT CLAIMS

Identifying Fraudulent Claims

On the surface, it would appear that the job of the transit agency or its agent, with respect to the assessment of claims, is to distinguish those cases with merit from those without merit and to pay only the meritorious claims. Yet, for a number of reasons, other approaches are sometimes taken. Often, agencies pay all claims below a certain dollar threshold, because the cost of distinguishing the two types (and proving this in court) outweighs the cost of simply paying the claimant.

In addition, the distinction between the two is further clouded by the fact that fraudulent claims make up merely some undefined subset of the broader universe of nonmeritorious claims. Nonmeritorious claims are comprised of claims in which a transit agency has no, or limited, liability, including nonpreventable accidents, certain security incidents, and events occurring at bus stops and parking lots owned by municipalities (not the transit agency), as well as fraudulent claims.

Furthermore, in many cases fraud is difficult to prove, requiring cost-inefficient resource investment, especially when claim values are low and within pay out limits established by a transit property. When the claim includes exaggerated injuries or "padded" medical bills, efforts to identify and address fraud are further complicated. Given these realities, many transit agencies routinely accept a certain amount of fraud as a "cost of doing business." Therefore, this level of fraud is not identified and captured in agency data sets or forms because it has not been investigated.

Finally, regulations and case law regarding fraud and the required standard of care are location-specific, differing by region, or more likely by state. As a result, practices successful for identifying and addressing fraudulent claims at one public transit agency are not necessarily transferable to other agencies.

Quantifying Fraudulent Claims

Further obstacles exist to quantifying the third party fraudulent claims problem in the public transit industry as

a whole, beyond those that exist in identifying fraudulent claims at an agency level on a case-by-case basis. Unfortunately, at a national level, sources of reliable transit-specific risk cost data are not readily available to determine the total number of nonmeritorious claims or the final disposition of those claims. At the present time, there is no national repository for the collection of information on the occurrence of fraudulent claims in the public transit industry; nor has a single handbook or manual emerged that provides the authoritative voice on identifying and managing these claims in the transit environment.

More generally, however, studies have been performed yielding estimates of the levels of insurance fraud as a larger whole. The Insurance Information Institute estimates that insurance fraud cost insurers \$21 billion in 1998, or about 10 percent of claims (6). The National Insurance Crime Bureau (NICB) estimated the figure to be closer to 15 percent. A recent Massachusetts study concluded that 31.8 percent of the total bodily injury claims examined had an element of fraud. In California alone, the Department of Insurance believes 15 to 20 percent of all California auto insurance claims are fraudulent. Insurance fraud is the second largest white-collar crime in the United States, second only to income tax evasion (7).

Specifically, though, pre-existing data are not available to capture the amount paid out by the public transit industry each year for those claims that are believed to be fraudulent. Furthermore, because most public transit agencies have policies in place preventing the payment of fraudulent claims, any claim that is processed and settled by the agency is classified as legitimate, even if the injury or medical treatment is exaggerated. That is, if a transit agency pays a claim that in retrospect could be considered fraudulent, it is typically because the agency is not aware that the claim is fraudulent. Hence, the prospect of establishing firm data on the cost to the industry of paying fraudulent claims is difficult. Of course, if agencies did know which claims were fraudulent and which were not (and were therefore able to supply reliable data), the problem itself would be much diminished. Databases and files at the public transit agency that capture information on fraudulent claims only cover those claims thoroughly investigated—often at great expense—and proven to be fraudulent.

To establish an estimate of the scope of the problem of claims abuse, survey respondents were asked to supply information regarding the number of personal injury claims received by their agency in 1998. The 21 transit agency respondents reported 23,940 claims during this calendar year. Fewer agencies were able to respond to more detailed questions regarding their annual claims and determination of fraud. Nineteen of the 21 synthesis respondents provided information on claims investigations, stating that, combined, 19,696 such investigations were performed in

1998. Only 11 agencies were able to provide information on the final disposition of claims investigations; these agencies reported that a total of 522 investigations (3.9 percent of the number of claims submitted to these 11 agencies) resulted in a clear finding of fraud.

Thirteen respondents who tracked fraudulent claims information reported that, each year, approximately 12.75 percent of their claims are managed more aggressively than the average claim by the agency based on their determination of some level of fraud.

Survey results indicate that estimates of the size of the "fraudulent claim" problem are considerably higher than the actual numbers of these claims identified by the agencies. On average, the transit agency respondents believe that 28 percent of the money paid out in tort claims is fraudulent. This result can be contrasted with the 3.9 percent of the number of claims actually identified as fraudulent in 1998 by the 11 agencies mentioned previously. Seven respondents placed the total value of claims proven fraudulent (based on investigation) at approximately \$1.4 million, combined.

Nearly one-half of all respondents (9 of 21, or 42 percent) estimated at less than 5 percent the number of claims that are without any basis in fact or which arise from situations where persons not actually involved in the accident fabricate reports of their presence on a transit vehicle or at an accident scene. Although some of these situations occur, the far more prevalent fraud problem, in the opinion of the respondents, involves fabricated or exaggerated symptomology by actual passengers (or others) that is supported by documentation of treatment from health care providers. For most transit agencies, it appears that the "fraudulent claims problem" represents an on-going burden to efforts to contain operating costs, rather than a new or growing problem.

Even if an overall percentage were available that indicated the portion of claims that was fraudulent, as mentioned earlier, anecdotal evidence strongly suggests that the issue of third party fraudulent claims is not uniform throughout the industry. Some agencies experience a major fraud problem; others receive relatively few fraudulent claims. Earlier studies have demonstrated that large bus and rail properties located in major metropolitan areas pay more in fraudulent claims, as a percentage of operating expenses, than smaller agencies located in suburban or rural environments (8).

SYNTHESIS ORGANIZATION

Chapter 2 describes a general methodology for managing third party fraudulent claims, recognizing both the

prevention and response aspects of the risk management approach. The processes of identifying vulnerabilities, examining approaches, selecting techniques, implementing procedures, and monitoring results are discussed.

Chapters 3 and 4 document the state of the practice in reducing fraudulent claims. Each of the elements of the state of the practice is addressed in the order in which it takes place at the public transit agency. Chapter 3 focuses on prevention features and chapter 4 details response efforts.

This report concludes with recommendations in chapter 5 for further actions to improve the state of the practice in

the area of third party fraudulent claims. The following appendixes provide additional information to support practices identified in this report:

- Appendix A: Synthesis Survey Results
- Appendix B: Survey Respondents
- Appendix C: Illinois Statute—Metropolitan Transit Authority Act
- Appendix D: State Laws on Insurance Fraud
- Appendix E: Recommended Guidelines for Detecting Fraud
- Appendix F: Recommendations in Preventing, Detecting, and Controlling Fraud
- Appendix G: Networking Organizations.

FRAUDULENT CLAIMS WITHIN THE RISK MANAGEMENT FRAMEWORK

According to the 1995 study, *Risk Management for Small and Medium Transit Agencies (Synthesis of Transit Practice 13)* (9), transit agencies, negatively affected by escalating insurance premiums in the 1980s, were prompted to explore means beyond insurance to manage potential risk. Insurance was no longer viewed as a comprehensive treatment for coping with accidental losses arising out of transit operations.

The sole, or primary, reliance on insurance as a mechanism for addressing claims, and fraudulent claims in particular, discounts the potential benefits of employing a more integrated program containing both risk prevention and response elements. Fully addressing fraudulent claims is a process that can begin long before an accident occurs, allegedly occurs, or a claim is received by the public transit agency or its insurer. Many public transit agencies have supplemented and improved these insurance-based programs using the broad discipline of risk management to avoid risks of loss, to prevent loss through improved operating practices and programs, and to develop or improve cost reduction procedures for managing claims.

Risk management is the process of formulating and implementing a program that will minimize the adverse effects of accidental and organizational losses (such as those resulting from claims abuses) on an entity. Implementing such a program involves the tools of planning, organizing, implementing, and monitoring resources. The transit agency department undertaking this process protects the organization from the consequences of risks, including financial disruptions, liability loss exposures and legal costs, and injuries to employees and third parties due to accidents and unintended occurrences such as fraudulent claims. In addition, the department endeavors to do so at a cost that is affordable and does not fluctuate significantly from year to year. Further, there are underlying objectives that include protecting assets from loss or destruction, creating a safe work environment for employees, and reducing the likelihood of injuring or damaging a customer or other third party (10).

The effective management of fraudulent claims requires the performance of specific activities that fall within the public transit agency's greater risk management framework. To provide a structure for the discussion of these activities, the claims management process will be subdivided into the five stages depicted in Figure 1.

This chapter describes this process, defining these terms; pointing out essential interfaces supporting the identification, investigation, management, and resolution of fraudulent claims; and identifying preventative and response-oriented components of this process.

IDENTIFY AND ANALYZE LOSS EXPOSURE

To address the issue of third party fraudulent claims using an optimal allocation of resources, it is logical that the issue, first, is understood to the extent feasible. The process of achieving this understanding can be divided into two stages: (1) developing an awareness of fraud (i.e., identification of "loss exposure") and (2) estimating or predicting losses (i.e., analysis of "loss exposure").

An agency's "loss exposure," in this case the result of fraudulent claims, is the aggregate of all possible negative impacts these claims may have on the cost efficiency and the operational effectiveness of the agency. These negative impacts include financial costs. As will be discussed later, however, consequences such as the encouragement of additional frivolous lawsuits or the loss of ridership due to a misperception of agency safety may also constitute "losses" to the agency.

Both of these steps, particularly the latter, are difficult to perform accurately (reasons for the difficulty of fraud quantification have been discussed). Each is necessary, though, to implement proactive measures in order to curtail claims fraud and make efficient use of agency resources. Each will be described in further detail in the sections that follow.

Identification of Loss Exposure

The survey distributed to public transit agencies in this synthesis used a definition that identified two types of fraud: (1) fabrication of an event or the claimant's involvement in the event and (2) misstatement of an event. Although a number of agencies may experience only these two types, almost one-half of the survey respondents believed that misstatements (exaggerations) regarding the medical impacts of an actual event represented the majority of fraud experienced in the transit industry (see Appendix A).

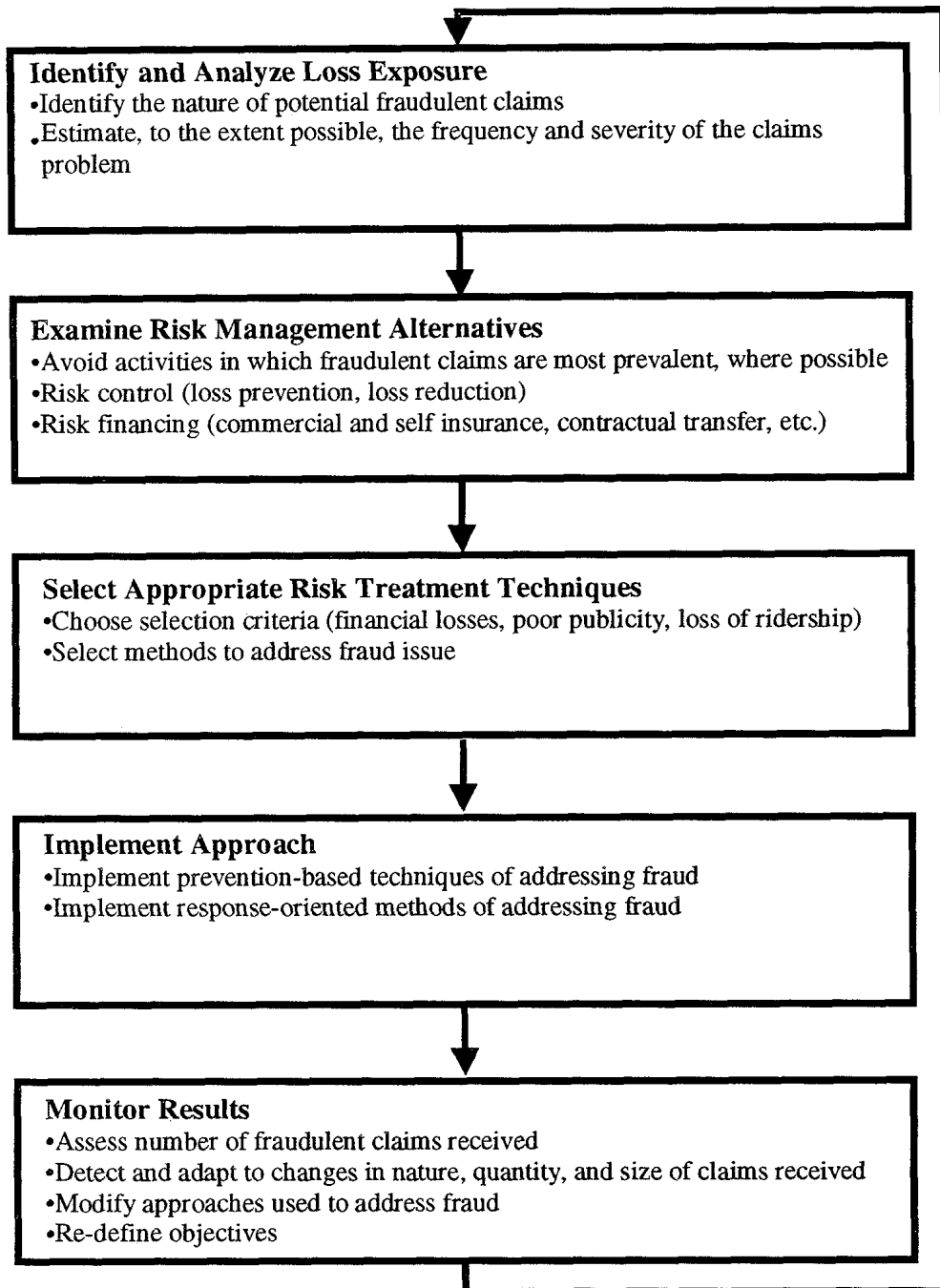


FIGURE 1 Risk management-based approach for addressing third party fraudulent claims (9).

This observation is in keeping with general trends observed in the insurance industry nationwide. An IRC study of closed claims found that one-third of auto accident injury claims appeared to involve some form of fraud, including claims "padding." According to the IRC, the vast majority of claims with the appearance of fraud involve the exaggeration of injuries, medical treatments, wage losses, or some other element of the claim as a result of an actual accident. Relatively few claims involve entirely fabricated or staged accidents (11).

Many public transit agencies, when listing perceived, relevant fraud types, would therefore likely include the following three issues:

1. Fabrication of the event or the claimant's involvement in the event,
2. Fabrication or misstatement of the injury to the claimant resulting from the event [eleven of the respondents (and all of the agencies answering the survey question regarding recommended changes to the

definition of fraudulent claims) suggested the addition of the issue of misstatement of the level of injury or damage resulting from an actual event. Several reported that such a definition currently is in use at their agency. (See survey question 2.)],

3. Misstatement of the event.

Some agencies may have additional types of potential loss exposures due to fraudulent claims; some may have fewer. As stated previously, the claims problem varies from agency to agency. In any case, each agency must develop its own assessment of the likely nature of the third party fraudulent claims based on its unique operating environment. This list is merely a starting point. As will be shown by example in the next chapter, a specific list of the types of fraudulent claims can be generated at this stage to highlight and address specific claims vulnerabilities.

Analysis of Loss Exposure

The quantification or prioritization of the estimated losses due to each type of loss identified is a more challenging prospect. Clearly, if public transit agencies had a precise (and verifiable) knowledge of which claims were fraudulent and which were valid, the issue of third party fraudulent claims would cease to be a problem, or would present a diminished issue facing the industry. Instead, estimates must be constructed based on factors such as past histories of claims abuses, inspections of records, financial records and files, and agency loss histories. Chapter 3 demonstrates, through the use of examples, specifically how this is done.

EXAMINE RISK TREATMENT ALTERNATIVES

The transit risk manager has a number of "risk treatment alternatives," those measures that can be used to address the potential losses stemming from third party fraudulent claims, from which to choose. Figure 2, excerpted from *Synthesis of Transit Practice 13 (9)*, suggests a means by which these alternatives can be divided into three categories, each of which is described in further detail in the sections that follow, for the purpose of discussion:

- *Exposure Avoidance*—achieved by abandoning or never undertaking an activity or responsibility (i.e., liability) for an asset. Avoidance of liability in this fashion is, clearly, a prevention-based measure.
- *Risk Control*—a process through which plans are developed to avoid or reduce a public transit agency's vulnerability to loss through the selection and implementation of risk treatment methods that reduce either the frequency or severity of incidents.
- *Risk Financing*—techniques used to generate funds from within and outside the transit organization to

pay for losses (settlements, judgments, and program support costs) (10).

Exposure Avoidance

Exposure avoidance eliminates entirely any possibility of loss. In many settings, however, exposure avoidance is not feasible because it would be too costly or because an agency must undertake or continue certain activities. A public transit agency, for example, cannot arbitrarily stop providing all service to areas where claims abuse is a suspected problem. In addition, it is not feasible for an agency to abandon functions for which it has been given a legalized monopoly (10).

Risk Control

Risk control includes those techniques designed to minimize the frequency or severity of losses (that is, the number of fraudulent claims or the cost of each fraudulent claim). In addition, risk control practices may be designed to make agency losses more predictable. For example, although an agency would prefer to eliminate all fraud, if this is not feasible, an operation may find it easier to manage several low-value claims rather than an infrequent, multi-million dollar suit.

Risk Financing

Risk financing techniques are those methods that generate funds to finance losses that risk control techniques do not completely prevent from happening (for example, insurance). Methods of risk financing can be divided into two categories: (1) transfer of risk (i.e., generating funds from outside the agency to pay for fraudulent claims) and (2) risk retention (i.e., generating funds from inside the agency to pay for fraudulent claims).

SELECT APPROPRIATE RISK TREATMENT TECHNIQUES

Choosing Selection Criteria

To this point, it has been assumed that the primary loss with which a transit operation is concerned is financial. Although the cost of fraudulent claims may pose the most serious problem, other issues certainly merit consideration in selecting which fraudulent claims are of greatest concern and those methods appropriate to address these claims. These loss exposures may include loss of system reputation, loss of ridership due to negative publicity (mis-perception of agency safety), and encouragement of additional frivolous claims. No two agencies, however, face the

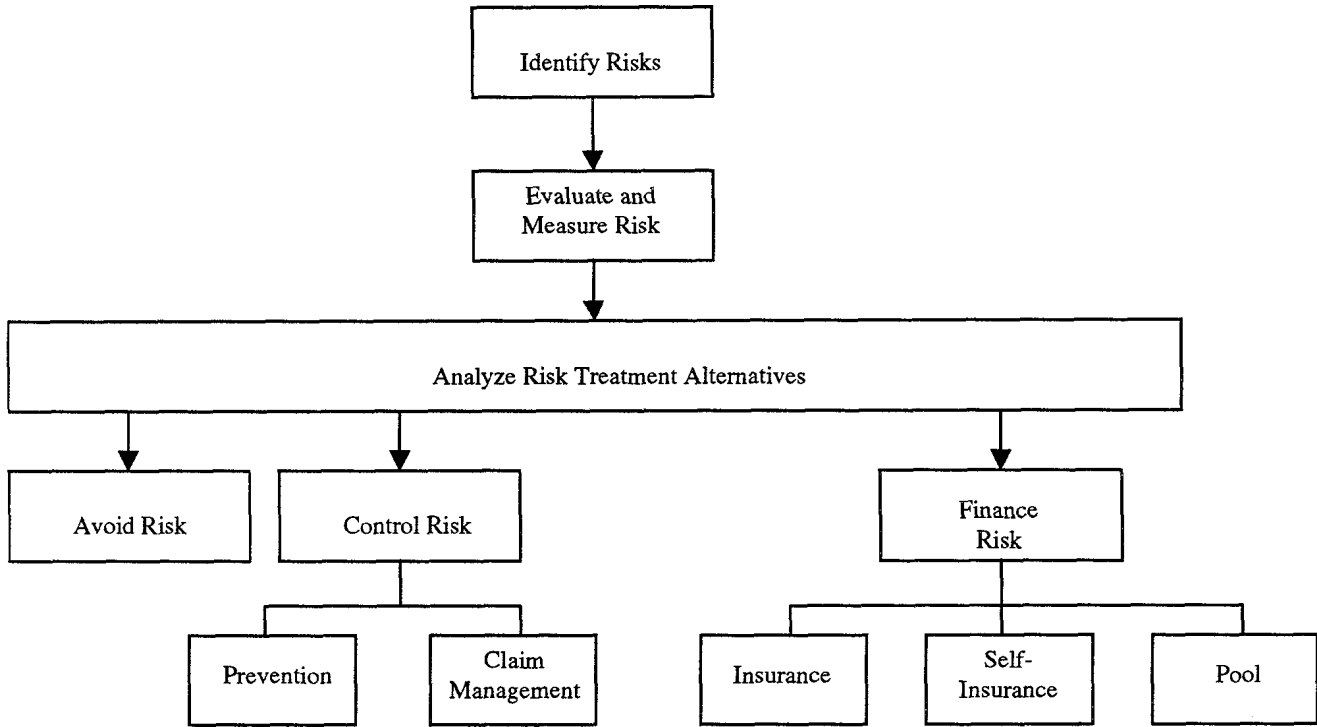


FIGURE 2 The process for risk control and risk finance (8).

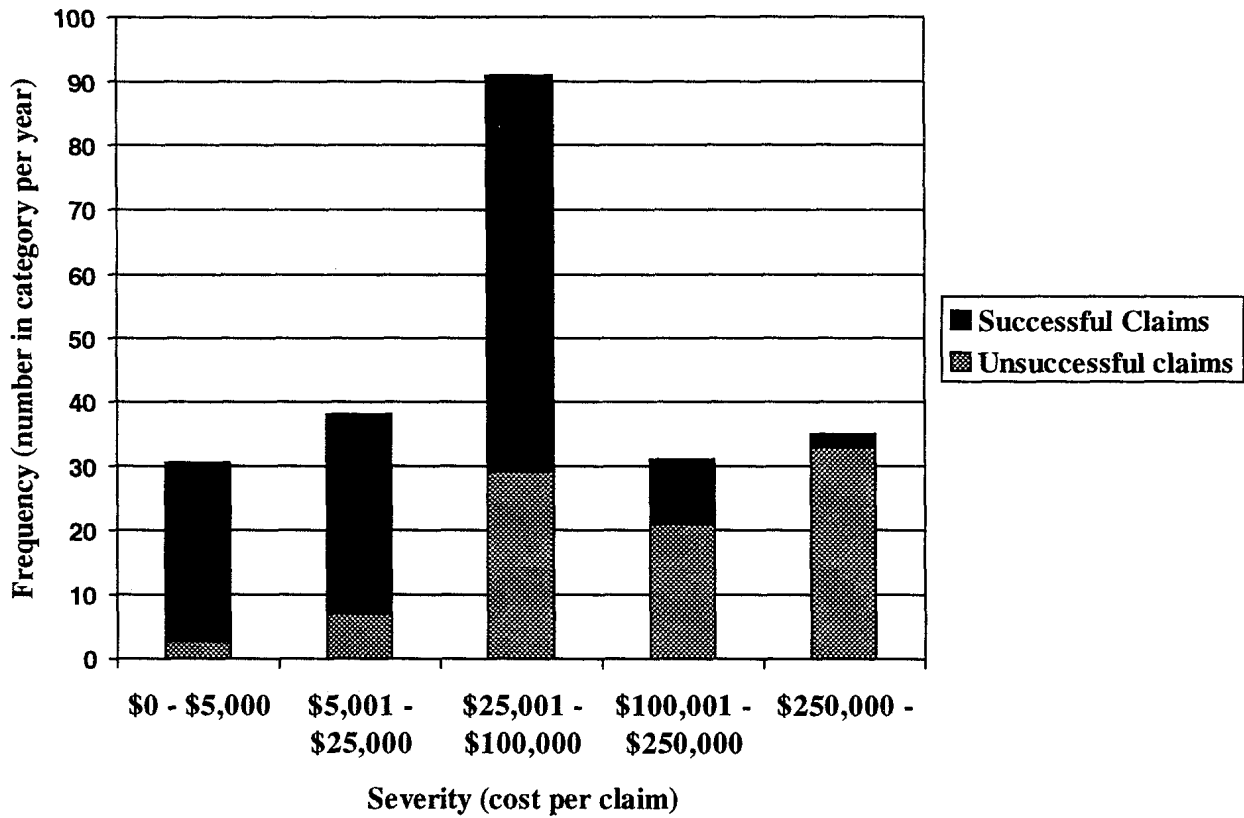


FIGURE 3 Frequency versus severity analysis.

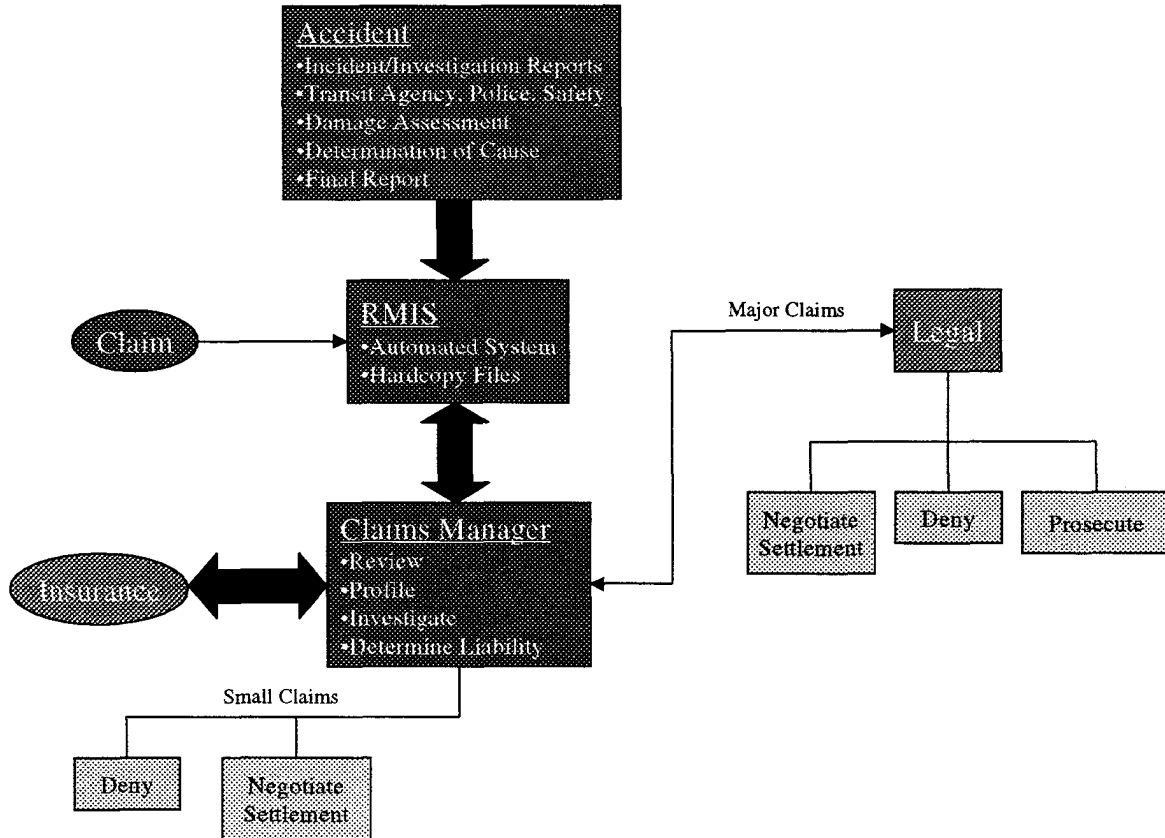


FIGURE 4 Information process for claims disposition.

same set of circumstances with regard to fraudulent claims. Based on the estimates of the size and nature of the fraudulent claim problem, as well as the operating environment of the agency, the decision (selection) criteria developed will differ.

Selecting Methods to Address Issues

A number of tools exist to assist a risk manager in determining which loss exposures (types of fraudulent claims or fraud-related issues) are of greatest concern and which methods (e.g., loss control versus loss financing) are appropriate to address these claims. For example, an agency may use the tool depicted in Figure 3 to prioritize fraud-related concerns and select appropriate responses. This figure shows the relationship between the frequency of incidents and the severity (cost in this example) per incident. This type of figure may permit a more detailed analysis, helpful to agencies in selecting alternatives. Again, one large fraudulent claim may be far more disruptive to a small agency than several lower value claims, and this information may be analyzed using this figure.

IMPLEMENT TECHNIQUES

Chapters 3 and 4 describe the implementation of efforts designed to mitigate and control fraudulent claims, presenting examples of techniques in use throughout the transit industry in order to assist agencies in developing programs that effectively anticipate, reduce, detect, and fight third party fraudulent claims. (See Figure 4 for a depiction of a typical response to a claim.)

MONITOR RESULTS

The goal of this step is to provide feedback in order to improve the program that is in place to address fraudulent claims. To the extent possible, data regarding the number and types of fraudulent claims discovered by the public transit agency are collected on an ongoing basis. These data are used to modify programs in place, if necessary.

Public transit agencies attempt to create a seamless process for the collection, analysis, and management of data concerning safety and security incidents that occur at the agency and subsequent determinations regarding the

evaluation, financial management, settlement, and legal implications of claims. Although each agency employs a different variation of this process, at its core is a system for managing information. This system may take the form of

an automated database or a paperwork trail; however, the basic purpose is the same: to catalogue pertinent facts relating to a claim in order to substantiate public transit agency actions relating to fraud.

STATE OF THE PRACTICE—PREVENTATIVE MEASURES

Each transit manager faces the problem of providing safe, efficient, customer-oriented service, vital to the local economy, to passengers who have more transportation choices than in the past, in an environment of fluctuating federal, state, and local subsidies. To address this problem and to ensure the long-term viability of local public transportation, the transit manager must achieve a balance among four separate variables: (1) fares, (2) service levels, (3) subsidies, and (4) operating costs (12).

To provide funds to support transit operations, many transit managers primarily focus efforts on maintaining or increasing subsidies from funding agencies in order to maintain fare and service levels. Of these constraints, however, subsidies are often the most unpredictable. Industrywide, often less effort is devoted to managing a fourth constraint, operating costs, which is the constraint most within the influence of many transit managers (12). Although an accurate estimate of the financial impacts of fraudulent claims does not exist, the mitigation of this issue is one target of operating cost containment. (See Table 1 for methods discussed in this chapter.)

The Bi-State Development Agency (Bi-State) serves as the public transit agency for the St. Louis area in six counties within Missouri and Illinois and subscribes to this philosophy. As with most transit systems, Bi-State faces "an almost constant budget squeeze as federal financial assistance is routinely reduced." With resources tight, an agency whose primary purpose is a customer service function like Bi-State's would prefer to devote as much of its funding as possible to providing transportation. Recently, the agency has significantly reduced insurance costs, realizing that limiting costs was the most feasible means of achieving organizational goals and that the risk management department had an opportunity to do so (13).

IDENTIFY AND ANALYZE LOSS EXPOSURES

Identification of Loss Exposure

The process of gaining an understanding of the likely losses facing a transit agency as a result of third party fraudulent claims can be thought of as being in two stages: (1) formulating a list of all types of fraudulent claims facing the transit agency and (2) describing the (alleged) causes of these claims and the associated consequences. This process might be performed informally or may

involve an explicit, written list. However, most agencies facing a known fraud problem have at least a sense of the types of claims that cause losses even if a formal analysis has not been performed. Formulating a list of types of fraudulent claims may be done using a number of data sources. An agency's past history of claims proven to be fraudulent is a starting point (examples might include "slip and fall incidents in train stations" or "soft tissue injuries on buses"). Furthermore, a past history of all claims may suggest other areas where fraud might occur, because fraudulent claims comprise a subset of the entire universe of claims received by a transit agency. Experts from within the agency and outside the agency may be contacted to refine this list, including consultants, risk managers at peer agencies, or insurance experts.

TABLE 1
SUMMARY OF PROACTIVE TECHNIQUES DISCUSSED IN
CHAPTER 3

| Stage | Examples of Techniques |
|-------------------------------------|--|
| Identify and analyze loss exposures | <ul style="list-style-type: none"> • Formulate list of fraudulent claim types • Describe causes of fraudulent claims • Research <ul style="list-style-type: none"> – Claims data history – Agency fraud history – Estimates from claims managers – Overall casualty costs |
| Examine risk treatment alternatives | <ul style="list-style-type: none"> • Asset ownership • Outsourcing • Statutory maximums and governmental immunity • Risk control (training, maintenance, inspections) • Loss reduction (incident response management of claims investigations, technology) • Commercial insurance • Contractual transfer of assets (leasing) • Self-insurance • Risk retention pool |
| Select appropriate techniques | <ul style="list-style-type: none"> • Networking (RIMS, APTA, PRIMA, PARMA, state and local agencies) • Prioritizing of fraudulent claims issues • Transit agency special investigative units |
| Implement techniques | <ul style="list-style-type: none"> • Proactive insurance company policies • Public awareness campaigns • Dissemination of accident policies and procedures |
| Monitor results | <ul style="list-style-type: none"> • Preparation and maintenance of files • Management information systems |

RIMS = Risk and Insurance Managers Society; PRIMA = Public Risk and Insurance Managers Association; PARMA = Public Agency Risk Managers Association (California); APTA = American Public Transit Association.

TABLE 2
SAMPLE LIST OF TYPES AND CAUSES OF FRAUDULENT CLAIMS

| Types of Fraudulent Claims | Causes of Fraudulent Claims |
|--|---|
| Slip and fall accidents in train stations (exaggerated injuries) | <ul style="list-style-type: none"> • Icy platforms—lack of adequate snow removal • Lack of slip resistant materials on floor • Poor maintenance (uneven surfaces) • Bus rear end collisions • Slip and fall injuries on slippery escalators • Poorly maintained parking lots • Construction debris • Lack of warning signs surrounding construction areas |
| (Claimed) soft tissue injuries | |
| (Claimed) neck and back injuries | |
| “Ghostriders” claiming injuries though they were not actual bus passengers | <ul style="list-style-type: none"> • Minor bus collisions • Sudden stops on buses • Actual, serious bus accidents that are highly publicized • Poor training of operators in reacting to an accident • Lack of transit system method (CCTV or similar) to refute claims |

CCTV = closed-circuit television.

The causes of the above fraudulent claims may include situations such as "icy platforms due to lack of snow removal" or "rear end collision to buses" (see Table 2 for sample list). Consequences of fraudulent claims may include financial loss exposures such as payments due for settlements, verdicts, or fines, should the transit agency have to pay damages awarded by a court to a claimant. Alternatively, and more typically, out-of-court settlements comprise financial costs paid by an agency. In addition, legal expenses might include the costs of preparing a legal defense or investigating an accident, or the fees imposed by the court in which the action is pending.

Analyzing Loss Exposures

Analyzing loss exposures, as explained in chapter 2, involves estimating the number of these fraudulent claims (whereas identification, in the last step, involved listing types of claims). Previous chapters have outlined the reasons why this quantification is difficult. The following sections suggest informational sources that may assist agencies in developing estimates to describe the size of the third party fraudulent claims issue they face.

Claims Data

The 21 transit agency respondents reported 23,940 claims during the 1998 calendar year. Agencies may review their claims data over the past year to gain a general idea of

trends, overall cost of claims, and types of accidents common at the agency.

Fraud Detailed in Claims Investigations

Nearly all of the synthesis respondents were able to provide data on claims investigations undertaken by their agencies, indicating that this information is generally available to the risk manager.

Overall Casualty Costs (Trends and Levels)

Some data are available on a national level regarding the partial costs of casualties/liabilities incurred by certain public transit operators. Statistics from the FTA's National Transit Database (NTD) for the year 1997 indicate that the approximately 400 public transit agencies submitting data to NTD reported an annual expenditure of \$465.4 million in casualty costs, which include the following (1):

- Premiums for insurance,
- Pay outs for uninsured occurrences,
- Provision for uninsured (or self-insured retention), and
- Recoveries or amounts received from insurance companies and others who are held liable for damage to transit property and personnel.

This amount represents approximately 2.7 percent of the \$16.94 billion the transit industry expended on operating expenses in 1997 (1). Therefore, although fraudulent claims are estimated to comprise a small percentage of total claims expenditures, because this total amounts to nearly one-half billion dollars annually, in dollar terms, national expenditures on fraud are significant.

This amount does not include anti-fraud expenditures (including the cost of programs to reduce risk, such as safety, hiring, training, anti-drug programs, computer programs and training, and other technology) and the costs of administration and risk management (all personnel and other costs associated with the processing of injury claims that result from accidents and other risk management activities, such as reserving funds against claims and procuring insurance). Earlier studies have estimated that, when risk control expenditures and administrative costs are factored into the analysis, approximately 5 percent of the transit industry's combined operating budget is devoted to managing casualties and liabilities.

EXAMINE RISK TREATMENT ALTERNATIVES

Chapter 2 divided risk treatment alternatives into the following three categories: (1) exposure avoidance, (2) risk control, and (3) risk financing, which are explained in greater detail here.

Exposure Avoidance

Asset Ownership

Public transit agencies typically are not as free as commercial enterprises to eliminate operational areas where losses are a problem (for example, eliminating service at times of day where the most claims are received). The avoidance of exposure may be and is used effectively, however, on a smaller scale by some agencies. For example, an agency may choose not to own particular assets, such as parking lots, to avoid liability for certain types of claims (slip and fall injuries, for example) in these lots (10).

Outsourcing

Although public transit agencies are generally created to provide a certain set of services to the community at large, several options still exist for exposure avoidance. Outsourcing services of particular transit routes is a growing trend in the industry. According to APTA's *Fact Book*, the dollar value of "purchased transportation" saw a 353 percent growth (from \$549 million to \$1.9 billion) from 1985 to 1994. In 1995, a survey of 232 public transit agencies revealed a level of outsourcing of 37 percent for fixed route services and 66 percent for paratransit services. In Indianapolis, for example, contracts were awarded in 1995 to private firms to provide transit service on 10 city bus routes and 3 new suburban routes, while METRO (the public transit service entity) retained the right to operate the remaining fixed route system (14).

Services that pose exposure issues may also be outsourced to shield a transit agency from liability. For example, one of the most important benefits to contracting a security force as opposed to using system employees to perform this task is to insulate the agency from liability. Reputable contract security companies carry their own liability insurance and other protections, which, in many states, are included in state licensing laws (15).

Statutory Maximums and Governmental Immunity

Another means of avoiding exposure is by taking advantage of the existence of applicable statutory maximums and governmental immunity within the transit agency's jurisdiction. These protections either affect a transit agency's civil liability (tort liability) or provide monetary caps on economic and noncompensatory (including punitive) damages (16). If an opportunity exists for a transit agency to offer support to efforts to pass new statutes offering these protections, such efforts are, obviously, advantageous to transit agencies.

SEPTA is an example of an agency within a jurisdiction with a statutory maximum. The law limits tort cases against

the agency to \$250,000 per complaint or a total cap of \$1 million per accident (17). Similarly, state laws offer certain protection from tort cases, such as in Illinois, where Section 27 of the Metropolitan Transit Authority Act immunizes the Chicago Transit Authority (CTA) from tort liability for any failure to protect passengers from criminal acts of third parties (18). (See Appendix C for the full text of Section 27 of this Act and Appendix D for anti-fraud statutes in various states.)

A defense based on Section 27 was used, for example, to justify a trial court's dismissal of a complaint filed by a passenger who was attacked and cut with a razor after witnessing another passenger having their pocket picked and confronting the pickpocket. The CTA had been aware of similar attacks prior to this incident. The language in Section 27 provides the CTA with immunity from negligence claims that allege that a CTA employee (police, security, or nonsecurity personnel) failed to prevent the commission of a crime against a passenger (16).

Risk Control

Loss Prevention

This technique is used to reduce the frequency or likelihood of the receipt of fraudulent claims. If evidence suggests that the number of fraudulent claims received by an agency is roughly proportional to the number of accidents experienced, for example, accident reduction techniques (such as driver training, routine and proper maintenance of vehicles and property, and safety inspections) may be employed to reduce accidents and, therefore, claims (9).

Loss Reduction

The goal of this approach is to reduce the severity of a single loss. In the case of third party fraudulent claims, a successful loss reduction program will lower the dollar value of each claim actually paid. Development of proper procedures for incident response and management as well as the deployment of monitoring technology may assist in curtailing the opportunity for fraud (9).

Risk Financing

As described in chapter 2, risk financing methods can be subdivided into two categories: transfer of risk (i.e., methods of generating funds to pay for fraudulent claims from outside the agency) and retention of risk (i.e., methods of generating funds to pay for fraudulent claims from inside the agency). Each will be described in further detail here.

Transfer of Risk

The most widely known risk-financing tool in the transit industry is commercial insurance. This means of financing risk, however, was not so commonly used by those larger agencies responding to the survey. Buying insurance transfers the financial responsibility for the adverse effects of risk to another party. The insurance company accepts responsibility for paying any losses incurred by the agency in return for a premium. The insurance policy is the contract that outlines the terms and conditions of the transfer.

Often, medium and smaller agencies will choose conventional (commercial) insurance over self-insurance or pooling, and even pay higher premiums. These agencies will pay a risk premium to avoid unlikely but possible adverse cost fluctuations in self-insurance or pool results. Smaller agencies, in particular, tend to choose insurance, because they cannot afford the year-to-year cost fluctuations of self-insurance and do not have a risk retention pool available to them.

Another lesser-used means of loss financing by means of transfer of risk is contractual transfer for risk financing. Contractual transfers shift losses to others, both legally and financially—this approach involves transferring responsibility for a loss. Public transit agencies may choose to lease a facility, rather than own it, for example, thus transferring legal and financial responsibility for some types of incidents to the landlord.

Risk Retention

The most commonly used means of risk financing by those agencies responding to the synthesis survey is self-insurance. It is the conscious and intentional decision by the public transit agency to pay for its own losses and the associated costs, including legal defense, adjusting expenses, and investigations. An agency may elect to pay all of the costs associated with a particular type of loss, or it may pay only up to a particular dollar limit. Self-insurance is chosen when an agency determines that the combined cost of losses, expenses necessary to handle claims and otherwise replace the services an insurer provides, plus an allowance for contingencies, is likely to be less than the cost of conventional insurance. Because the system is accepting a significant level of, if not full, fiscal responsibility for losses, the size and number of which can only be estimated, a self-insured agency is potentially subject to severe fluctuations in annual loss costs. The impact of these fluctuations, however, can be tempered by funding the reserves on new claims annually, using recommendations from an actuary.

The use of a risk retention pool is yet another major risk financing option, and constitutes a cooperative of several

entities, usually in the same industry, that agree to jointly fund losses of a particular type. Participants make contributions to the pool, which, in turn, pays losses. The pool typically handles the administrative functions, provides claims management, and promotes loss prevention. Excess insurance is often purchased by the retention pool for losses above a determined level (10).

SELECT APPROPRIATE RISK TREATMENT ALTERNATIVES

Programs targeted at addressing insurance fraud have been proven to save money across many industries, including transit. According to the NICB, return on investments focused on fighting fraud in the private sector has been estimated at seven to one, including decreased claim pay outs, savings in litigation costs from fewer claims, and decreases in insurance premiums (8).

Networking Opportunities

In chapter 2, the process of selecting appropriate risk treatment alternatives was divided into two steps: determining decision criteria and selecting techniques based on these criteria. Further, general tools and methods were set forth to perform these steps. One additional means of performing both activities should be noted, that of using input from other agencies and risk managers, in particular. Many opportunities exist, either through established organizations or through informal means, within and outside of the transit community, to understand problems facing similar operations, the consequences of these problems, and implemented solutions (both successfully and unsuccessfully). Some examples include the Risk and Insurance Managers Society, the APTA Risk Management Committee, Public Risk and Insurance Managers Association, state and local organizations (e.g., California's Public Agency Risk Managers Association).

Identifying Problem Areas and Solutions

As discussed in chapter 2, a number of decision-making tools are available in order to decide which fraud-related problems to address and in what order. In a basic sense, however, these tools assist the risk manager in prioritizing the fraud-related problems facing the transit agency so that these problems can be dealt with accordingly. An understanding of those areas in which the agency is most vulnerable to claims aids in focusing efforts on the most serious issues facing the transit agency and therefore designing effective policies and procedures.

An example of this prioritization is apparent in the New York City Transit Authority. According to the Director of

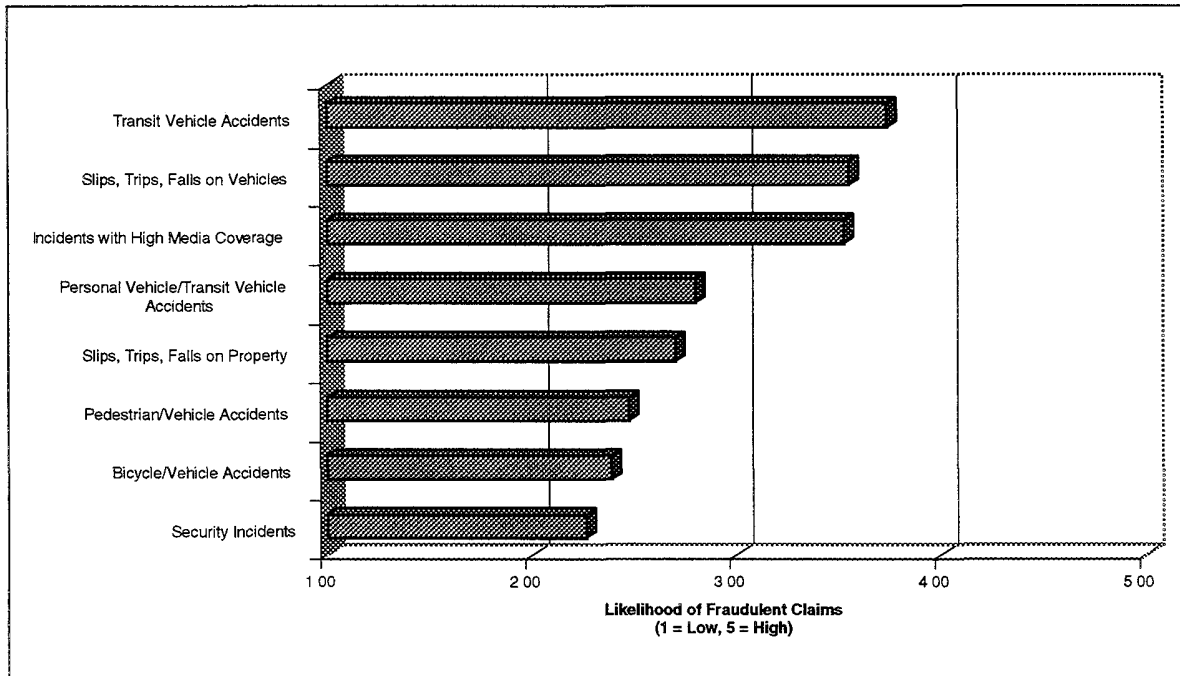


FIGURE 5 Incidents most likely to result in fraudulent claims from survey results.

Risk Management, "We have to ask ourselves: 'Where are these incidents occurring? At what stations? Are they happening on the stairways or on the platforms?' You can't spend money on safety if you don't know what you're trying to prevent." Consequently, the agency concentrates on issues such as protecting passengers from accidental injuries of which trips and falls on buses and in the subway are the highest cost item. Slip-resistant surfaces have been installed on steps to reduce the number of passengers falling on wet stairs. Bus mirrors that were out of adjustment were found to be a cause of accidents and, as a result, operators have been supplied with poles to adjust the mirrors. Signs have also been posted to warn passengers of potential hazards (19).

Survey respondents reported receiving large numbers of claims for incidents involving transit vehicle accidents and slips, trips, and falls on vehicles (Figure 5). FTA safety data, which indicate that approximately 60 percent of all accidents occur inside transit vehicles or while the transit customer is boarding or alighting transit vehicles, support this assessment, because this category of claims provides the greatest opportunity for both occurrence and misstatement (1).

IMPLEMENT TECHNIQUES

This section details programs that have been implemented throughout the transit industry and are designed to address

fraudulent claims in a proactive manner; that is, techniques applied before the accident or incident resulting in a claim allegedly occurs.

Organizing Against Fraud

Transit Agency Special Investigative Units

Several transit agencies have deliberately chosen to structure their organizations, as well as available external agency resources, in a manner that attempts to address their fraudulent claims issue most effectively (8). One such technique is the formation of a special investigative unit (SIU), a group created within the transit agency that draws on various areas of expertise in an effort to analyze claims, identify fraud, and reduce settlement costs.

Although the organization, policies, and procedures of an SIU vary from agency to agency (based, for example, on agency size, fraud concerns, levels of claims abuse, and resources available), this section describes a "typical" example of a transit organization SIU. Key elements of a successful program often include the following:

- Management personnel who are aware of and focused on the fraud issue to oversee and implement the program. Often the head of the SIU is the agency risk manager, chief of police, or director of security.
- A clear mission statement endorsed by transit agency senior management as evidence of the agency's

commitment to identify, investigate, and prevent insurance fraud.

- A needs assessment detailing, to the extent possible, the level and nature of fraudulent claims facing the transit agency.
- Awareness training of staff through dissemination of information to employees as a part of the employee handbook, internal documentation, or formal training.
- Adequate recordkeeping.
- A timely claims review process.
- A means of assessing progress.

To support the mission statement, the SIU typically has input or control over the development of fraud policies, serves as the central contact for reports of fraud, and reviews and investigates suspicious claims before they are forwarded to the insurer. An SIU includes cross-disciplinary members, incorporating representatives from, for example:

- Risk management; legal; safety, police or security; and/or human resources departments
- Claims investigators
- Specialists, such as vehicle accident reconstruction experts
- Outside experts such as claims administrators, attorneys, or investigators, as deemed necessary to supplement in-house staff skills.

The expense and extent of the SIU depends entirely on the amount of fraud suspected; some agencies choose to outsource the SIU function entirely. Note that some agencies help justify the cost of the SIU by using this unit for other types of claims, such as Workers' Compensation claims; however, the use of an SIU for multiple purposes typically does require the use of an expanded team of specialists. For example, in 1995, SEPTA established a Fraud Program to address the increasing number of fraudulent claims being received by the agency. This program was initiated with two police captains within SEPTA's legal department before being assigned a program manager and given autonomy. As the agency receives claims, they are entered into SEPTA's database. Those claims that match profiles established by the Fraud Program—for example, repeat claimants and unreported incidents—are flagged and turned over for subsequent investigation. Fraud Program investigators, in cooperation with the claims adjuster, gather information in order to perform the investigation. Fraud Program investigators routinely handle the majority of claims investigations; however, on some occasions, officers from SEPTA's Police Department are called in to assist in the investigation. Findings from investigations are then turned over to the City of Philadelphia District Attorney's Office. In addition, fraudulent claim information, when applicable, is given to the Federal Bureau of Investigation Task Force on

insurance fraud, as well as to insurance fraud units within the State Attorney General's Office and the Montgomery County District Attorney's Office. Over the course of 5 years, the number of new suits filed against the agency was halved, and more than 50 people were convicted of fraud (20).

Proactive Insurance Company Policies

This section contains details on the methods found within most insurance companies to combat insurance fraud, the elements of which have cross-applicability for transit agencies (11). Transit agencies using commercial insurance can tap into these insurance agency resources to detect claims abuse.

Based on responses from 150 insurers that service some 77 percent of the nation's property-casualty insurance market, an IRC survey estimated that companies' *direct* spending on fraud detection and prevention grew significantly, from around \$200 million in 1992 to at least \$650 million in 1996. This estimate understates total expenditures to fight fraud, because insurance companies expend funds *indirectly* on the issue and incur expenses such as the funding of state fraud bureaus and special anti-fraud task forces. Overall, it appears as if companies are spending more money to detect and deter fraud, and most insurers surveyed reported that they plan to increase spending on anti-fraud programs through 1999. More than one-fourth estimated that they would increase their spending on fighting fraud by 10 percent or more.

Nearly all insurance companies (98 percent) responding to the IRC survey had a fraud control program established within their organization and the majority reported having SIUs. Furthermore, insurers with SIUs serviced 76 percent of the property-casualty market, compared with 66 percent in 1992. These SIUs were targeted at investigating potential fraud and training company personnel in ways to detect and prevent fraud.

The survey identified training, SIU investigations, centralized claims index databases, and the support of claims management—in that order of importance—the most important factors contributing to the success of insurers in *detecting* fraud. Public awareness, criminal fraud penalties, SIU investigations, and training were cited as most critical to *preventing* fraud.

The use of a variety of resources, including underwriters, claims personnel, and corporate communications or marketing officers, to control fraud was cited as typical by IRC survey respondents. For example, fraud detection and deterrence is performed by an underwriter when assessing the degree of risk that an applicant poses. Claims personnel engage in anti-fraud efforts as part of their normal job of

determining the "fair" amount of loss to be paid on any particular claim. Corporate communications or marketing officers are involved in researching and publishing material on various insurance-related issues, including the negative impact that insurance fraud has on policy premiums, as well as educating the public on the criminal or civil penalties that apply to those filing fraudulent claims or insurance applications.

Public Awareness

A number of transit agencies have undertaken public awareness campaigns that stress fraud as a problem affecting the riding public, and one that the agency aggressively prosecutes, in an effort to reduce the submission of fraudulent claims. For example, in one year, SEPTA paid out an estimated \$40 million to settle claims. Its 1994 casualty costs and claims per Vehicles Operating at Maximum Service were the highest among its peer authorities. Among the recommendations made to SEPTA during a management review to bring these costs under control was the suggestion that the agency undertake an aggressive, extensive anti-fraud campaign to promote awareness of its willingness to prosecute those submitting false claims (12).

In the first 5 years of the campaign, the number of new suits filed against the agency was halved, and more than 50 people were convicted of fraud. SEPTA has implemented various programs, including the use of advertisement placards on vehicles and inside stations. Billboards with slogans such as, "Guess who's stealing part of your fare?" and "File a false claim and you could go to jail," were erected (20).

Dissemination of Accident and Incident Policies and Procedures

Employee manuals at transit agencies, most especially bus and rail operator procedure manuals, are the tools most commonly used for the standardization and dissemination of practices designed to address the issue of fraudulent claims. These manuals typically include a detailed description of actions to be taken by the operator in the case of an accident involving a transit vehicle and often include procedures specifically designed to limit fraudulent claims. A typical practice requires a bus or rail operator to perform the following activities when the transit vehicle is involved in an accident: (1) immediately close the vehicle's doors (preventing non-passengers from entering the bus), (2) distribute courtesy cards to all passengers (which, upon being completed, indicate who was on the bus at the time of the incident and whether injuries were sustained), (3) gather information for the accident report, and (4) limit the discussion regarding the accident to agency or police personnel (21).

Effective training of operators and other agency personnel stresses two key points regarding accident procedures:

- The costs of fraud, and claims in general, to the transit agency—explaining why accident procedures must be followed carefully in order to curtail these costs.
- The criticality of information collection activities in fighting fraudulent claims, stressing the importance of collecting all data necessary to fight fraudulent claims.

The Miami Metro-Dade Transit Agency (MDTA) addresses both of these issues by prefacing the Accident Procedure section of the agency's Bus Operator Training Manual with the following explanation:

Accidents in the transit industry cost money, for damages to other parties and property, or to our vehicle; injuries to passengers and to compensation payments; in the loss of use of the vehicle; and in poor customer relations... Often we are in a position where we must pay a claim because the operator failed to tell us exactly what happened, failed to secure the name of a passenger or observer who saw what happened, or just plain didn't report the accident to us. We expect to pay a claim when we are wrong, but we sure hate to throw the M.D.T.A's and your money away—when, by a little cooperation on the part of our operators, we might have had the other party or a third party pay for the damages and injuries (22).

This procedure plainly and succinctly explains to operators why employees must adhere to agency practices and the benefits for doing so. More complete information describing operator training on MDTA's bus accident procedures is included in Table 3.

Agencies reporting success in addressing fraud stress the importance of developing appropriate procedures for those incidents that are most likely and most costly to the agency. Table 4 shows an example of an accident procedure, excerpted from MDTA's Bus Operator Manual.

Figure 6 shows those practices in place at responding agencies to prevent fraud, and Figure 7 shows the effectiveness, according to survey respondents, of the programs in place at transit agencies to prevent fraud.

MONITOR RESULTS

A fundamental step in developing a program to reduce fraudulent claims is to maintain records adequate for the detection, analysis, tracking, and legal defense against such claims. The design of appropriate forms, which include all necessary data such as the claimant's name, address, date of birth, social security number, job description, witness names and statements, and other appropriate information crucial to case investigation, should be designed by the

TABLE 3
 SAMPLE TRAINING MATERIAL FOR BUS ACCIDENT PROCEDURES (23)

**Miami Metro-Dade Transit Operating Procedures
 Training Material for Bus Accidents**

1. Immediately note the license tag number and the make and model of any vehicle involved in any way. Stop the bus and put this information in writing, and have any other persons and passengers do the same to verify your identification.
 2. **Aid the injured if possible.**
 3. Do not move the bus. Ask the other person not to move his vehicle until directed to do so by a dispatcher, supervisor, police, or transit agency official. If bus is to be moved before pictures are taken by the supervisor, mark the position of all four wheels on the pavement with chalk.
 4. Call the transit agency and give the following: your name; badge number; route; bus number; location of accident; nature of accident; injuries and extent thereof; whether ambulance or transportation is necessary and all information which will aid the dispatcher in the performance of his duties.
 5. Pass out passenger information cards to all passengers—advising them in a courteous manner that the law requires you to call the police and Transit Agency to make an investigation, which will be completed promptly, and that you must obtain names and addresses of all passengers aboard the bus.
 6. Advise the driver of the other vehicle of the accident and apparent injuries. Get his driver's license number and insurance coverage, by whom employed, ownership of vehicle, and all other pertinent information. This is in the event the other driver is not aware he has caused an accident or injuries.
 7. If it is necessary to transfer passengers to another bus be sure you have their names and addresses. Ask the following operator to secure all names you were unable to get.
 8. Where an accident involves the steps or any functional part or piece of equipment on or near the bus—such as a window, step, or a bus stop—it is very important that the operator get persons who were near the accident at the time it occurred and had a chance to view it, to enter a comment on their card as to whether or not any foreign substance was on the steps; whether the door was broken; whether the window latch was inoperative; or whether there was a hole in the pavement or some other object caused the person to fall.
 9. When an accident involves someone alighting, and they contend that the bus was improperly parked or not close enough to the curb, the person should be asked to indicate the distance the bus parked from the curb, and this noted on their complaint—and you should note or verify any difference.
 10. Never enter into any discussion or argument with any passenger, person, bystander, or anyone else concerning the liability for the accident, whether or not the M.D.T.A. will make settlement on a claim; whether or not the M.D.T.A. has any insurance; or, any and all matters relating to this general subject. Refer the person to the M.D.T.A. representative on the scene. By all means, cooperate with the police in their investigation.
 11. Make a prompt written report of any information you may hear concerning any accident the M.D.T.A. may have been involved in regardless of when or where the accident may have occurred.
 12. Never discuss an accident you or anyone in the M.D.T.A. may have had no matter when it occurred or who was involved, except to the proper authority. Be careful of persons asking unusual questions about M.D.T.A. operations. We have on several occasions had attorneys or their investigators secure information from our personnel, which has been used against the M.D.T.A. and the operator.
 13. Never discuss or give any information on any accident or incident concerning the M.D.T.A. to anyone other than the known supervisor, the police investigator, or a duly identified investigator for the M.D.T.A. All investigators from the M.D.T.A. carry identification cards with their picture attached. Ask to see identification before giving any information and if the person is unable to produce such, politely inform him that you cannot discuss the matter, that he will have to take it up with M.D.T.A.
 14. When involved in an accident with another vehicle, or when another vehicle cuts in front of you and makes a sudden stop—immediately get the tag number of the other vehicle that has cut you off or caused the accident. As you well know, the person driving the vehicle might be responsible for the accident—but if we fail to get his license number and positive identification, we are faced with possible injury claims, which we are not liable for through our carelessness, but which we may be forced to defend in court by our failure to tie in the adverse car by positive identification.
 15. Injured persons refusing to give their names—A report must be made whether or not injured passengers will give his or her name, said it is his fault, or says he or she is not injured. You cannot force medical aid on anyone, but you must make a report.
-

TABLE 4
MDTA BUS ACCIDENT PROCEDURE (22)

| | |
|----|--|
| A. | Secure the bus in a safe manner. |
| B. | Check the level of injuries to passengers and occupants to any other vehicle, and notify the dispatcher by radio or public telephone (638-6119 or 638-6120). Aid the injured if possible. |
| C. | Set out emergency triangles as prescribed by state law. |
| D. | Obtain the names of all passengers and any other witness who may have seen the accident. Gather all information necessary for a detailed report. The accident information envelope contains courtesy packets for this purpose. |
| E. | Cooperate with police; do not leave until released. |
| F. | Do not make any statements to anyone, except police, MDTA street supervisors, or other MDTA personnel assigned to investigate the accident, describing the accident, how the accident occurred or your opinion of fault. If other persons ask for information, simply state that a complete written report will be made. |
| G. | Do not move the bus until instructed to do so by a police officer or MDTA supervisory personnel. When cleared to leave the scene, notify the dispatcher for instructions. |
| H. | If a student operator was driving the bus, both the student and the instructor must make out separate reports. |
| I. | The Accident Report is an official MDTA document. It must be completed accurately by you no later than 24 hours after the accident. Your signature confirms agreement with the entire contents. Failure to disclose all information is a major infraction and may result in termination. |

department whose responsibility it is to investigate fraud. Most states have an insurance department with a fraud unit. These agencies typically offer assistance to organizations, such as transit agencies, in drafting claims forms and forms for use by those who wish to report fraud.

To ensure the consistency of records useful in defending against fraudulent claims, systematic procedures should be

developed, disseminated, and followed for the logging of records, the assignment of claims to investigators, and the monitoring and management of claims. One additional record-keeping step, often omitted by transit agencies, is the tracking of data (8).

Management Information Systems (MIS) is one such tool for tracking records, referring to a class of software

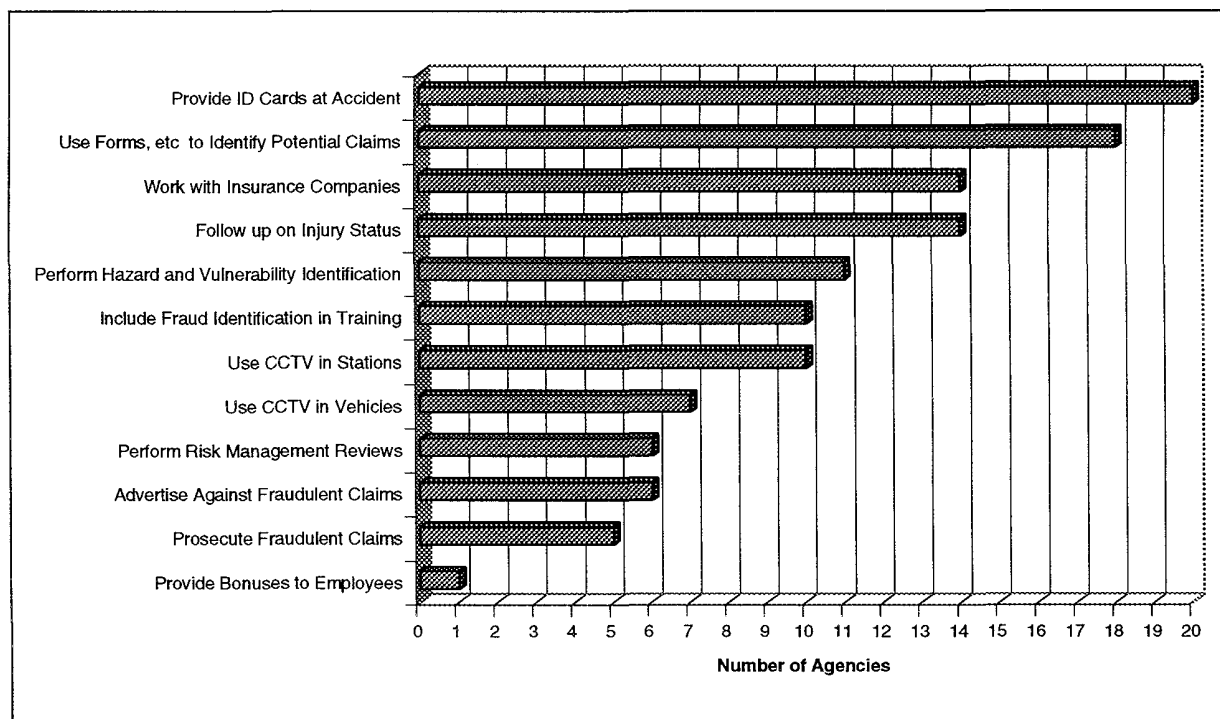


FIGURE 6 Practices used by agencies to prevent fraudulent claims from survey results.

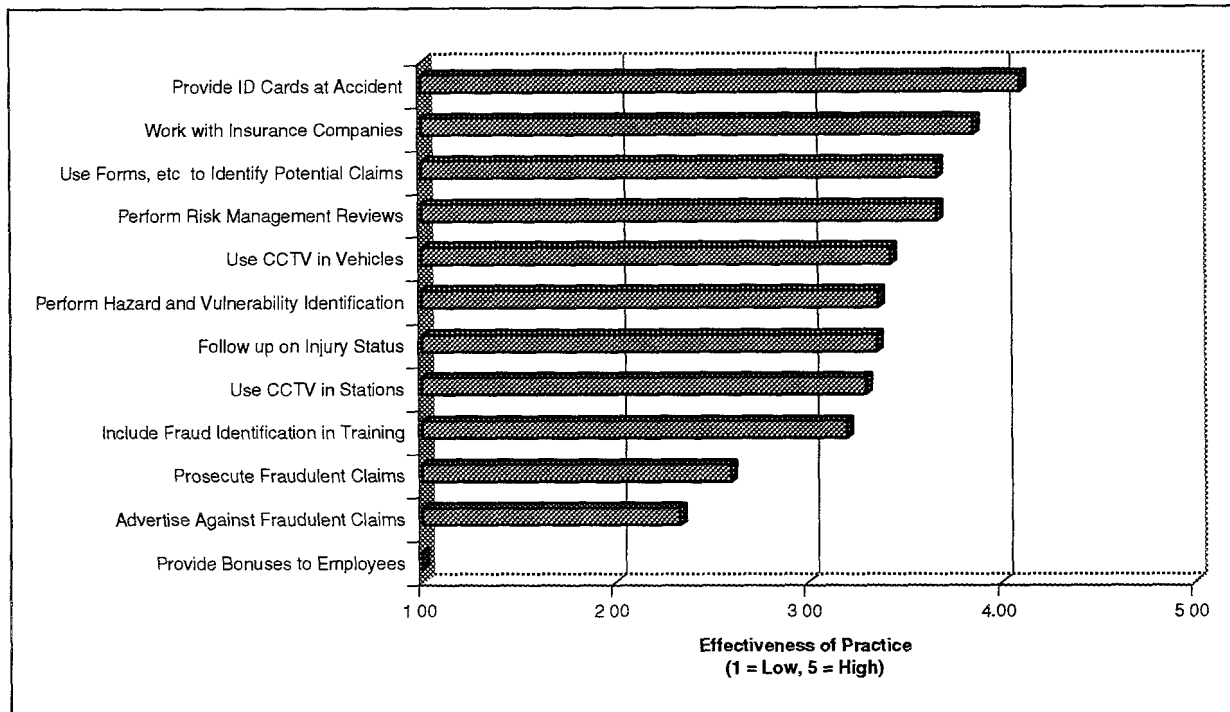


FIGURE 7 Effectiveness of practices used to prevent fraudulent claims from survey results.

that provides management with tools for integrating, organizing, and evaluating information from a particular department(s) within the agency. The advantage of a risk management information system (RMIS), a specific type of MIS designed to address risk management needs, is that claims managers are able to input and quickly retrieve information that is vital to the claims process such as the following:

- How many claims are open.
- How many lawsuits are open or pending.

- How much money has been paid out for all claims or specific claims.
- How much money has been paid for lawsuit settlements and judgments (24).

A 1994 TCRP synthesis (25) reported that resources allocated to MIS vary dramatically among the nation's transit agencies and are typically based on agency size. In addition, many agencies use unique manual risk-related record-keeping systems that present a barrier to the automation of information collection into a standardized system (25).

STATE OF THE PRACTICE: RESPONSE-ORIENTED MEASURES

This chapter explains the ways in which fraudulent claims are identified and resolved within the overall risk management process outlined in chapter 2, representing the industry "state of the practice." Where relevant, industry successful practices are highlighted to serve as examples for other agencies to use when designing or improving upon risk management approaches. Again, these practices are described using the five-step approach highlighted in earlier chapters (see Table 5 for a summary of the approaches described in this chapter). Specifically, this chapter details response-oriented activities; that is, those activities occurring after an accident or alleged accident that results in a claim or a lawsuit.

IDENTIFY AND ANALYZE LOSS EXPOSURES

As outlined in chapter 1, the job of the risk manager is to distinguish between meritorious claims/suits and those without merit, including fraudulent claims. Although the tasks of identification and analysis of loss exposures (the risks posed by fraudulent claims) are primarily proactive in nature, data resulting from claim information, after an accident, offers an opportunity to refine these assessments of risk analyses.

EXAMINE RISK TREATMENT ALTERNATIVES

The examination of alternatives is largely a proactive, rather than a reactive, process. An ongoing revision of

estimates of the size and nature of an agency's third party fraudulent claim problem, however, as data are available, allows for more effective design of programs intended as countermeasures to the problem. The honing of fraud information is a reflection of the reality that the problem itself changes over time and is critical to continuous improvement of programs designed to mitigate fraud.

SELECT RISK MANAGEMENT TECHNIQUES

The decision to undertake a particular strategy to address fraudulent claims issues at an agency depends on a number of factors, including the legal environment in which the agency operates as well as cost-benefit considerations.

Legal Protections

Agencies within jurisdictions having some governmental immunity appeared to be, overall, less aggressive in settlement strategy than those agencies that have no statutory provision for immunity. Therefore, it has been suggested that, perhaps counter to expectations, statutory limits do not save overall tort liability. This result is because agencies without legislated caps on liability tend to be more vigorous about fighting all claims, thus reducing their ratio of tort liability relative to farebox revenue to levels below that of agencies with legislated caps or favorable immunity laws. On the other hand, agencies with these legal protections

TABLE 5
SUMMARY OF REACTIVE TECHNIQUES DISCUSSED IN CHAPTER 4

| Stage | Examples of Techniques |
|---|---|
| Identify and analyze loss exposures Examine risk treatment alternatives Select appropriate techniques | <ul style="list-style-type: none"> • Revision of estimates based on investigations • Revision of alternatives based on loss data • Legal protections • Cost-benefit analysis |
| Implement techniques | <ul style="list-style-type: none"> • Accident notification • Information collection at the accident scene • Interviews • Supplementary information collection • Fraudulent claims profiling • Closed-circuit television monitoring • Use of "smart recorders" • Legal involvement in the claims process • Working with insurers • Prosecution of those perpetrating fraud |
| Monitor results | <ul style="list-style-type: none"> • Use of informants and tip lines • Management information systems |

are more likely to adopt a strategy of paying off minor claims on the theory that the cost savings after an accident occurs are related to the expediency of case settlement (22).

Cost-Benefit Analysis of Cases

Agencies typically evaluate two factors with respect to an individual claim: the strength of the case and the likely risks of fighting the case. Methods for evaluating the facts of a case are discussed in detail in the following sections. To calculate the risk in terms of individual cases requires an ability to judge the likely amount of the verdict, and the various probability factors affecting the likelihood and the amount that the agency may ultimately be required to pay. Elements to be considered and evaluated, where applicable, include the facts of the case, likely jury tendencies, outcome of a trial, contributory negligence, comparative negligence, joint and several liability, and equitable indemnity. Added to this amount is the expense incurred in defending the case.

The basic formula for calculating risk is the product of the following amounts and probability factors, all of which must be estimated:

- The likely amount of the payment if the claimant wins;
- The probability of a verdict for the plaintiff;
- The proportion remaining after considering comparative negligence of the plaintiff or the probability that contributory negligence will not bar any recovery;
- The proportion for which the agency will be held responsible, where other defendants share the burden;
- The likelihood that other defendants will not be able to pay their share, depending on the insurance coverage and financial resources of the other defendants; and
- The probability and portion of the burden that may be shifted to others (equitable indemnity or expressed contractual indemnity).

The ability to calculate the probable size of a jury verdict requires experience in trying injury cases combined with a thorough examination of medical records and consultation with medical and economic experts (16).

IMPLEMENT TECHNIQUES

Information Collection

The process of accident information collection can be divided into four general stages, each of which is further described in the sections that follow:

- Accident notification
- Information collection at the scene
- Interviews
- Supplemental information collection.

Accident Notification

The records trail accompanying an incident begins with notification that an accident has occurred. This stage ensures that each agency or department that needs to oversee or contribute to the collection and analysis of data is informed of an incident occurrence. This stage is also critical in that, if the correct departments are left unaware of the accident for too long a period of time, adequate information collection cannot be performed to defend the agency against fraudulent suits.

A number of internal and external notifications typically can be made in the event of an accident. Internal notifications may include the following: operators/station managers, dispatchers, emergency responders (fire/police/ambulance, etc.), executive management, operations, human resources, claims/legal, passenger relations, and/or public relations departments. External notifications may include the agency's state oversight agency, the National Transportation Safety Board (NTSB), and/or the state occupational safety and health administration. Each level of notification typically depends on the severity of the accident, those personnel involved (i.e., passengers vs. employees), and the nature of the accident.

Information Collection at the Scene

Identifying and resolving fraudulent claims begins with the collection of information on the sources of those claims: accidents and incidents. Survey results indicate that to identify accidents and incidents that may possibly result in the filing of claims, transit agencies rely primarily on the official reports prepared to document the accident or incident: operations reports, field reports, police reports, and final accident investigation reports (see Figure 8 for further information).

Accidents, hopefully, are rare occasions for most vehicle operators and, even with proper training, system personnel may not precisely recall all procedures that must be followed during what is typically a stressful situation. Accordingly, to facilitate the immediate and accurate collection of all necessary information at the accident scene, accident kits are used by many transit agencies. These kits often contain the following: instructions for the operator regarding accident procedures; courtesy cards to be distributed to passengers; and any other documentation that should be completed at the scene as per agency guidelines, ensuring accurate, complete, and consistent data collection.

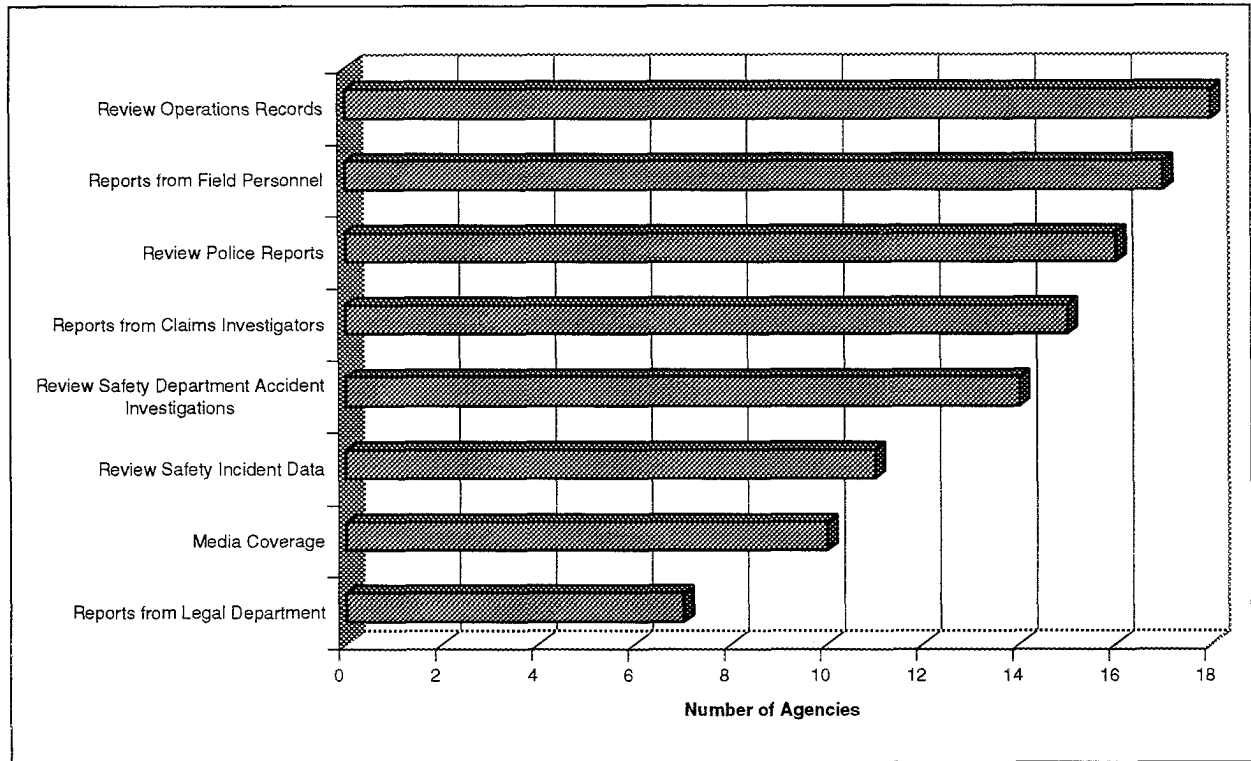


FIGURE 8 How incidents that may result in claims are identified.

Information collected at the scene is nearly always guided by forms designed specifically to ensure consistency and completeness. Information regarding the scene is noted, including the operator's or supervisor's preliminary statement, drug and alcohol testing performed, preliminary statements from passengers involved, preliminary statements from witnesses, impounded equipment, injuries, fatalities, and property damage estimates. (See Table 6 for the Massachusetts Bay Transportation Authority's Basic Focus Elements of Safety Department Accident/Incident Investigations.)

Internal departments performing investigations may include the system safety department, the police or security department, operating departments, internal auditing, and/or quality assurance, again depending on the nature of the accident. External agencies performing investigations may include the following: the NTSB, FTA, the Federal Railroad Administration, state oversight agency, local agencies, organizations hired to perform investigations, outside insurers, or peer investigation boards. Whatever organization is performing the investigation, the main goal of this process is to collect information. The more complete this information is, the more useful the investigation is in combating fraudulent claims against the transit agency.

Interviews

Interviews may be performed with system operators and witnesses. Many agencies maintain detailed policy manuals to ensure helpful, complete information gathering in this critical stage, which may be especially useful if a passenger files a claim. Investigators interview the subject and witnesses, obtaining written statements to limit the potential for variations on these stories later on. When speaking to witnesses, interviewers ascertain what happened, when it happened, who was there, who was directly involved, and who was a witness. Investigators speak with as many persons involved as possible. In addition, statements are reviewed for inconsistencies (8).

Supplemental Information Collection

Finally, supplemental information, such as diagrams (vehicles involved, direction of travel, streets/crossings, measurements, points of impact) or photographs is added to the investigation. Photographs are especially useful in defending against a fraudulent claim and can be used to record damage, lighting conditions, weather conditions, witness views, individuals who may have been involved in the accident, injured persons, and mitigating factors. Other data that may be collected in this stage include the following:

TABLE 6

BASIC FOCUS ELEMENTS OF SAFETY DEPARTMENT ACCIDENT/INCIDENT INVESTIGATIONS—MBTA

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|---|
| <p><u>Information to Gather at Incident/Accident Site:</u></p> <ol style="list-style-type: none"> 1. Intra- and interdepartmental responders' oral reports of occurrence (interview Operations staff, Transit Police or the designated incident commander). 2. Names and statements/interviews of witnesses/victims, responders (directly if possible or from on-site Transit Police and/or transportation personnel), along with number and extent of any injuries. 3. Photographs of scene. 4. Field sketch (verify measurements). 5. Impound equipment/systems (e.g., vehicle, signal system, escalator) as necessary. <p>Note: Ensure that proper regulatory agencies (e.g., DPU, NTSB) have been notified, and that responders are using appropriate personal protective equipment (e.g., safety vests, flashlights). And, refer media queries to Authority press relations staff.</p> <p style="text-align: center;"><u>Post-Accident/Incident Follow-up Information Needed to Complete Investigation:</u></p> <ol style="list-style-type: none"> 1. Intra- and interdepartmental responders' written reports. 2. Operator(s)' written statement(s). 3. Extent/\$ of property damage, and supplemental service costs. 4. Finished field sketch, any dispatcher tapes, news clippings, and any photographs taken by other departments (e.g., legal, transportation officials). 5. Personnel records (i.e., work history, performance, training). 6. Maintenance records (e.g., vehicle, systems). 7. Test results (e.g., D&A, signal, braking system components). 8. Rule book/SOP/special orders (review). 9. Reconstruction results (if applicable). 10. Service impact summary (if applicable—critique). 11. Crowd control effectiveness (if applicable—critique). 12. Criminal investigation results (if applicable). 13. Fact finding or interrogatory report. 14. Incident response/command effectiveness (critique). 15. Regulatory oversight investigation coordination and reports (e.g., NTSB, DPU, DPS, OSHA, DLI, DEP, FRA). 16. Preliminary report (prepare within 8 hours after occurrence). 17. Final report (prepare within 30 days following accident/incident). <p>Reminder: When responding to any accident/incident, our priorities are to:</p> <ol style="list-style-type: none"> 1. Ensure the care of the injured, 2. Secure the site to prevent further injuries, and 3. Oversee the investigation to determine the cause(s)—not fault—by finding out what happened, why it occurred, and how we can prevent recurrences. |
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- Intra- and interdepartmental responders' written reports and operator's written statement,
- Extent of property damage and supplemental services,
- Personnel/maintenance records and test results,
- Rule book/operating procedures/special orders,
- Reconstruction results (if applicable),
- Service impact summary,
- Criminal investigation reports (if applicable),
- Preliminary field reports, and
- Healthcare provider or pharmacy personnel interviews (8).

This document review stage is an important fraud detection step. For example, in 1995, a San Diego man filed claims for more than \$1.4 million for the alleged death of his brother, supplying false documentation, including a death certificate, a police report of a San Diego

Transit bus accident, and a newspaper obituary. In reality, no such accident had occurred, nor had the alleged victim ever existed. The perpetrator of this crime was later convicted of insurance fraud after a representative from the transit agency's insurer, upon reviewing the documents submitted, contacted the state Department of Insurance regarding a possibly fraudulent claim (26).

Review of Information for Fraud

To begin the investigation process, information filed in connection with a claim is reviewed and verified by the SIU, the claims investigator(s) for the transit agency, or other personnel assigned this task. The investigator(s) must confirm all statements made, looking for inconsistencies, for example, in billing records or records of treatment received from medical service providers.

After the reviews, the SIU or transit claims investigator may decide to continue the investigation of records, adding a specialist to the case to find discrepancies. For example, an accident reconstruction may be necessary for a case involving a bus. If the case involves an alleged injury, the investigator might conduct an activity check, which could help determine whether the subject has been active in any way. If activity checks are not effective, camera surveillance of the subject might be appropriate. Legal counsel should be consulted at this point to ensure that privacy rights and other legal issues are addressed.

Investigation practices are most effective when clearly delineated in writing, providing an information trail suitable for use in litigation. The objective of developing written investigation policies and procedures is to standardize practices (information collection, the use of diagrams and photographs to capture claims-relevant data, impairment recognition, narrative complete and descriptive enough for use in court, and causal factor analysis based on defensible data); document transit system practices; and communicate with other organizations that must use these reports, including legal departments and insurance providers (8).

Fraudulent Claims Profiles

SEPTA instructs its investigators to look for specific signs of fraud, including claims resulting from a bus or train crash that makes the news or claims that include incomplete or incorrect details. In addition, experience has shown that unemployed men between 22 and 35 are most likely to file false claims. Finally, computers are used to check for repeat claimants.

Transit agencies generally consider a wide range of indicators when attempting to identify fraudulent claims. Survey results indicate that no single indicator alone is effective in detecting fraud. These results demonstrate that any strategy to identify fraudulent claims must look at a number of factors (see Figure 9, which shows the factors that survey respondents believed to be the most likely indicators of invalid claims.) In addition, Figure 8 shows how incidents that may result in fraudulent claims are identified.

Procedures at agencies are also designed with fraudulent claims in mind. At SEPTA, for example, investigators are sent out as quickly as possible to record the names of the injured and to limit the number of frivolous or baseless suits brought against the agency. Many transit agencies also review safety incident data for the location of the accident and reports or assessments from the agency's legal counsel (8).

Previous sections have described the steps taken to collect adequate information and to analyze and profile

claims. An additional resource exists for checking facts of a case. The NICB has created a computerized database with the goal of unifying the insurance industry's efforts to fight the problem of false and inflated insurance claims. Through the NICB's toll-free telephone number, the public can relay information to authorities on suspicious claims. Callers are also eligible for awards (27). (See Table 7 for claims profiling recommendations.) In addition, Appendixes E and F offer further suggestions in identifying claims abuse.

Using Technology

Closed Circuit Television (CCTV) and Video Cassette Recorders (VCRs) at Incidents

The definition used in the survey for third party fraudulent claims includes the category "fabrication of the event or the claimant's involvement in the event." One type of such claims is the so-called "ghost rider" problem facing several transit systems. A 1988 study by SEPTA showed that two to three times as many people were filing lawsuits as had actually been injured in accidents, often persons not actually on board the transit vehicle.

For example, a subway crash at SEPTA in April of 1990 that killed four attracted 278 claims from persons claiming to have been injured; this figure, according to SEPTA, is far in excess of the actual number of passengers on board the train at the time. In addition, some of the claims were filed as many as 5 months after the crash, often a signal indicating a fraudulent claim. In another example, SEPTA received 11 lawsuits from persons allegedly injured in an accident in which an agency bus was sideswiped by a car, although no passengers had, in fact, been on board when the accident occurred (20).

To address a similar problem, New Jersey set up a sting operation in which it staged and filmed more than 10 accidents around the state. Then, it monitored the claims resulting from these staged accidents. Typical of the accidents was one in East Orange, New Jersey, in 1993. A bus carrying 15 passengers, all participating in the sting, was hit from behind by a car traveling at less than 10 miles an hour. Video cameras in the bus and outside filmed 17 people, who had been bystanders when the accident occurred, scrambling onto the bus before police arrived. All later claimed to be injured in the accident. In addition, two individuals who were never on the bus, either at the time of the accident or subsequently, also filed claims. As a result, hundreds of thousands of dollars worth of claims were filed against the bus company's insurer for treatments to injuries said to stem from the accident. Transport companies in New Jersey reported that when buses had collisions in urban areas, they would often be surrounded by "runners" for doctors and lawyers who would get on the bus,

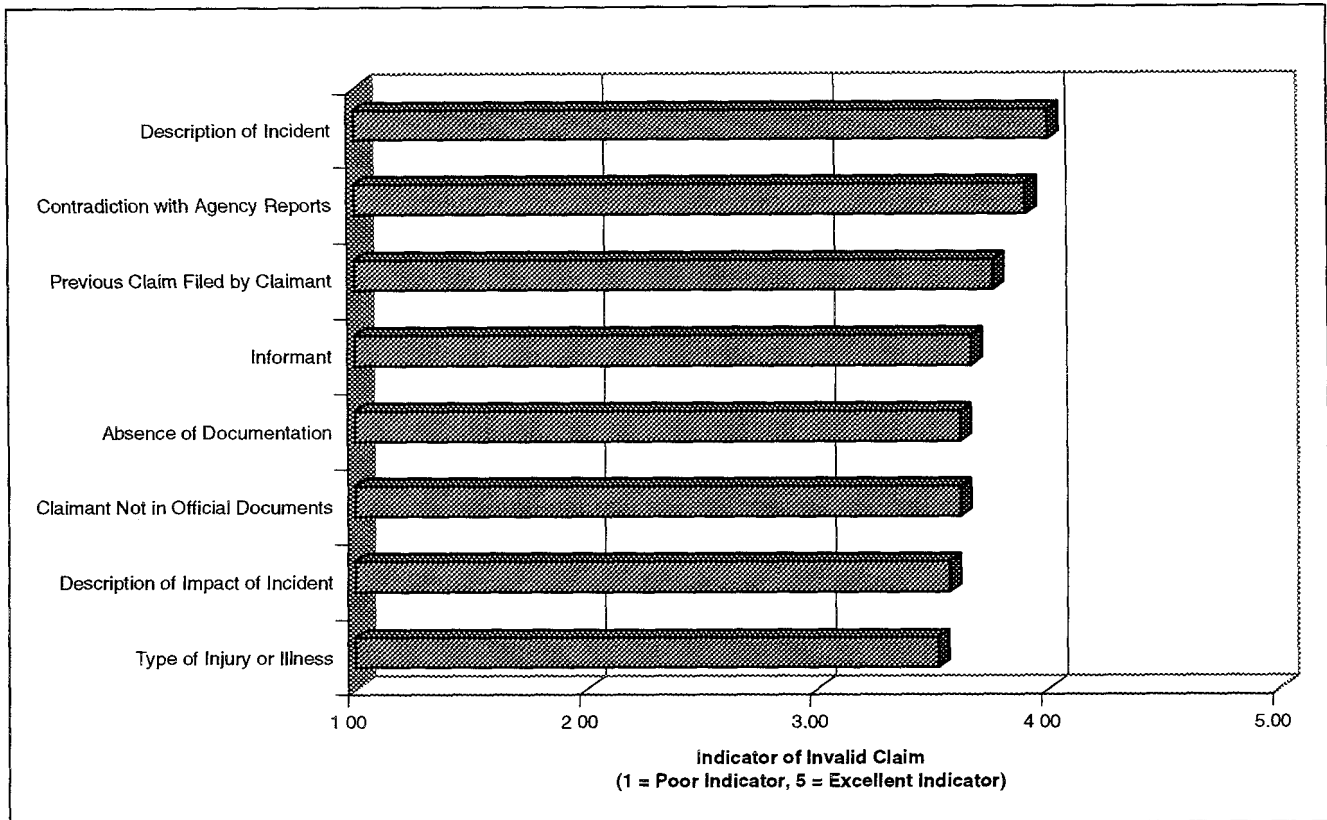


FIGURE 9 Indicators of invalid claims.

hand out leaflets with phone numbers, and encourage passengers to say they suffered from back or neck injuries, which are hard to disprove (28).

Thousands of cameras have been installed on board vehicles and on transit property across the nation that have,

according to industry experts, recorded purse snatchings, knifings, attempted rapes, drug dealing, vandalism, and assaults on drivers and passengers. Often transit systems can financially justify the use of the cameras based on the reduction in false claims generated by the cameras. In installing surveillance systems, self-protection against insurance

TABLE 7

SURVEY RESPONDENT'S GUIDELINES FOR DETECTING FRAUD

Survey respondents also included a number of additional practices used to identify fraudulent claims:

- Examination of any prior claim history by claimant (including claims against other agencies); claimants' names filed with Index Bureau to facilitate future access to this information.
- Performance of criminal checks and worker's compensation checks for information on claimant's history of submitting frivolous claims.
- Requirement of detailed statements from claimants whenever possible and a requirement of estimates/documentation of any claimed loss or damages.
- Audit of medical bills and wage loss claims.
- Cross-referencing of doctor and attorney names.
- Review of medical bills for use of chiropractor (exclusively) to treat injury.
- Use of private investigators and medical consultants to determine medical necessity of treatment and relation to injury.
- Review of claim for extreme or unlikely events (i.e., bus dragged claimant for five blocks).
- Verification that claimant completed a courtesy card.
- Review of claimant's account of situation against operator's report, supervisor's report, witness statements, video surveillance tapes, accident reconstruction report, and police report for consistency.
- Use of fraud checklist.
- If the number of bus passenger claims exceeds the number of passengers on a bus, detailed statements are obtained from every known passenger to attempt to determine which claims are fraudulent.

fraud has become as much of a purchase factor, if not a greater one, than violent crime. People can make faulty insurance claims and get \$5,000 or \$10,000 whether their claim is valid or not. In several large cities, perpetrators will "pack" the buses, intentionally causing wrecks, with 15 or 20 accomplices waiting on the side of the road to jump on to claim injuries, costing a transit agency settlements exceeding \$100,000 (29).

Modern bus surveillance systems can monitor the activities on the floor of the bus, including an operator's interactions with passengers. Some systems can be hooked up to brake lines, warning lights, turn signals, doors, accelerators, and other pieces of equipment to monitor and record their use. These tapes, which often contain the date and time as well as the speed of the bus, can be used for driver training, to review safety procedures, or in the case of an accident, to help determine what actually took place.

Most systems also have emergency call buttons that will alert transit headquarters in the event of an accident or incident. These can be either driver-activated or automatic, tripped by a sudden jolt or heavy impact. When this occurs, some digital systems automatically begin transmitting the recording to the home office over cellular phone lines. Transit agencies using digital systems can also "dial into" the bus from headquarters and monitor activities remotely.

Recently, the price of a single-camera color system has dropped dramatically, with color and digital systems now within the financial means of many more transit systems. One of the technological advances allowing better quality and more reliable video recording is what manufacturers call "multiplexing." In the past, if full-frame multiple image recordings were desired, multiple VCRs were required; an expensive, cumbersome, and laborintensive operation. If multiple images on each frame of the tape were acceptable—one from each camera—a single-VCR setup was far less expensive and cumbersome, but also made for poor quality enlargements, often unusable for identification.

Multiplexing, which has only been commercially available for mobile transit systems for several years, enhances recording capabilities, allowing the recording of the images from each camera full frame, recorded sequentially. Each image is digitized and separated by the multiplexer. Audio data from each camera are recorded separately.

The action from each camera can also be watched sequentially at a dwell time of a certain number of seconds, or it can be watched from all four cameras at once on a split playback screen. If the incident requires a blowup image, because the picture is recorded full frame, this creates much higher resolution, easier identification, and a

greater likelihood of standing up in court. Currently, test systems are being installed in hundreds of fleets across the United States. Despite the reduction in cost to outfit each bus, the overall cost is still high (29).

"Smart" Recorders on Vehicles

Digital "smart" recorders are a relatively new product. This "black box" for transit vehicles is a relatively lightweight unit connected to a network of cameras that feeds images onto a hard drive that digitally stores them. Set up near the bus driver, but only accessible to supervisors with a key, the box can be unlocked when an incident occurs so that vital bus function data can be studied (30).

A removable hard drive, about the size of a deck of cards, allows images to be downloaded into a base system for review. Depending on the system chosen, cameras can be mounted above the bus driver to scan the main aisle and rear area. Other cameras cover entrance/exit doorways and look out the rear or front windows. With most incidents coming with boarding and alighting, placement allows for optimum coverage. Almost anywhere a claim could occur can be monitored by the unit. Special software allows for storing and retrieving data. Time and dating is on each frame. Other bus functions such as brakes, speed, acceleration, turn signals, door actuation, and ignition can be retained in the system for review.

The San Francisco Municipal Railway added 10 new digital video surveillance systems in 1998 and hopes to put cameras on another 589 buses and streetcars over the next 4 years. The CTA reported that 500 digital recorders would be installed on the transit system's 1,800 buses.

Settling and Fighting Claims

Legal Involvement

Legal intervention for the transit system is normally required under either of the following two circumstances:

- The claimant files suit (thereby becoming the plaintiff) or
- The transit system believes that the claimant is asking for too much money or has had excessive medical treatment for a condition, such as a soft tissue injury.

The attorney handling a case receives assistance from the claims manager. Personnel in the claims unit investigate claims, locate witnesses, and provide coordination. The claims manager acts as a liaison between the transit department and the legal staff charged with litigating cases;

initiates investigations of factual information, claims, and potential claims; provides names of potential and recommended witnesses requested by attorneys handling cases; and receives information from legal staff in explanation of state statutes and court decisions in tort liability litigation as it affects transit operations and policy-making decisions.

Transit agencies have adopted a number of strategies for settling claims. Agencies typically attempt to settle a claim as quickly as possible if they are at fault. In other cases, where fraud is suspected, a number of factors play a part in guiding the transit agency's approach to determining the best course of action: paying a claim, negotiating a lesser settlement, fighting a suit, or prosecuting for fraud. A number of legal factors impact the decision to endorse one approach over another.

Prosecution

Several states have enacted an "insurance fraud" statute to deal with fraudulent claims as a criminal matter (see Appendix D for examples of such statutes). In many states, few are charged, and the statutes are used primarily as a deterrent. Each form sent out by an insurance company and the local transit authority, for example, may include a statement that "filing a fraudulent claim could subject a person to criminal prosecution." For example, Minnesota's statute, which appears at Minn. Statute 609.611, has not been frequently used, but has presumably been effective as a warning to those tempted to perpetrate acts of insurance fraud. Some states and localities, on the other hand, have been aggressive with criminal prosecution of fraud (31).

A New Jersey doctor was sentenced to 2 1/2 years in prison after pleading guilty to five counts of insurance fraud after admitting to filing \$120,000 in fraudulent claims with insurers. He was caught after federal and state investigators staged a bus crash and posed as injured passengers. The East Orange doctor admitted to billing insurers for accident-related services and medical supplies he never provided to patients (32).

Informants

Some agencies rely on tips (anonymous and otherwise) to address fraud. Tip lines are advertised on vehicles and in stations, sometimes offering rewards. Tip lines can be established through the transit agency on a local level or can encompass other crime-fighting goals (the nationwide Crime-Stoppers program is such an example).

A national "Lawsuit Abuse" campaign by the American Tort Reform Association has yielded similar results in New York City and Charlotte, North Carolina, and the program

is expanding to other cities. In posters, billboards, and TV and radio ads, public transportation patrons are encouraged to call a toll-free hotline if they have information about fraudulent claims (33).

In 1992, the CTA was sued, on average, 10 times a day by people claiming to have been injured on its vehicles, platforms, and properties—many with legitimate grievances, but some fraudulently. In one instance, when a CTA bus with 10 riders aboard hit a light pole, 50 persons checked into hospital emergency rooms claiming to have been injured in the accident. In another incident, after a city bus hit a passenger vehicle, 10 bystanders to the accident rolled beneath the bus and claimed back injuries. The CTA has put up thousands of placards and posters letting riders know that they are forced to pay for false injury claims and urging them to report fraudulent claims to a hotline (33).

SEPTA, like the CTA and other agencies, has implemented a tip line aimed at reducing fraud. SEPTA's program, however, is coordinated through a regional organization outside the agency: the Delaware Valley Crime Commission (DVCC). Informants call the DVCC directly, making it easier to inform authorities of information useful in investigating claims. SEPTA has rewarded informants for leads resulting in the discovery of fraudulent claims filed against the agency.

A transit agency's efforts to combat fraud are sometimes supplemented by using employee-oriented programs; requiring awareness of the problem and knowledge of what to do if action is warranted. Agencies often train staff in how to communicate with the SIU, either directly or through anonymous means, if they wish to report suspected fraud. Special phone numbers are featured in fraud prevention posters along with signs of fraud to further raise awareness and encourage reporting.

States such as Florida, New York, Massachusetts, New Jersey, and California have active anti-fraud programs. New Jersey was a pioneer in this area, with success stemming from a combination of comprehensive anti-fraud legislation and an effective fraud bureau (34).

MONITOR RESULTS

Whether an RMIS system or a paper-based system is used by a transit agency, fraudulent claims information and related fraud prevention data should be recorded to determine quantitatively which programs are working and which are lacking so that continuous improvements can be made. Table 8 includes recommendations for working with and exchanging information with insurance companies to facilitate this process.

TABLE 8

GUIDELINES FOR WORKING WITH INSURERS (35)

1. Establish a one-on-one relationship with an adjuster. While this adjuster will not always be the one to handle all of your claims, it is important for risk managers to have a contact within the claims department to help smooth out the adjustment process. If you deal with multiple insurer branch offices, know where to send various types of claims and who handles them at those offices.
 2. Supply as much information as possible in the initial claims report. Data that comes in piecemeal can be a detriment. Always provide the name and phone number of the person who the adjuster should call for additional information regarding the claim.
 3. If there is an injured third party involved in the claim, provide all the data you have on that third party (and the party's attorney, if there is one). Risk managers don't want to take calls from injured parties—let them bother the adjuster instead of the insured's employees. Also, contact with the insurer instead of the insured can prevent communication inconsistencies with the third party.
 4. One of the worst things a risk manager can do is have knowledge of a loss or potential loss and not report it. Policy notice requirements must be adhered to. Report the claim for "information purposes," even if you are unsure whether or not it will amount to anything. If you (as opposed to your broker or consultant) report claims directly to your carrier, fax the first report directly to the claims department. In addition, quarterly or semi-annually meetings with insurer claims representatives to review loss patterns and develop strategies to prevent reoccurrences are recommended.
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CONCLUSIONS

Occurrences of fraud are not distributed evenly at transit agencies around the country. Some agencies experience numerous claims with exaggerated injuries and medical bills; others receive relatively few such claims. Further, because the management of fraudulent claims is imbedded in each agency's overall risk management process, fraud is often not viewed in isolation, but is addressed as part of a larger universe of issues.

With increasing demands for cost-efficiency, reducing instances of fraud can improve returns on investments, providing money for technology, training, or improvements in customer service. Agencies surveyed are less confident in the ability of existing practices and policies to identify exaggerated claims or those claims padded by legal and medical professionals.

The reality that most instances of fraudulent claims involve exaggeration of a valid claim rather than a fictitious claim greatly complicates fraud-reduction efforts. Many agencies have accepted this situation as a "cost of doing business." Others have initiated programs that focus on the collection and analysis of data that will support the rigorous review of all medical claims, including the review of hospital records, review of other medical records, independent medical examinations, review of billing and medical services provided, and scrutiny of the professional standing of physicians and lawyers involved in these claims. Some agencies have turned responsibility for fraud over to their insurance company or risk retention pool; others staff and train special investigative units to identify fraud and support the prosecution of offenders.

For the most part, activities to address fraud in the transit industry remain largely reactive in nature; that is, agency resources are expended to review and evaluate claims after they have been filed, not to prevent or reduce claims before they occur. This reactivity stems primarily from the limited data available to direct and evaluate proactive programs.

This situation is not the result of carelessness or oversight, but simply reflects the difficulty of proving occurrences of fraud, and that, in many cases, it may be less expensive for an agency to pay a claim that may be exaggerated than to defend against it. Risk management is an exacting process. A claim is either paid or denied, based on fraud or some other reason. There is no easy way to

integrate claims fraud into existing data collection and analysis processes. There are no data fields for "believed fraud" or "estimated fraud component."

A number of techniques do exist to reduce fraud. Programs such as accident procedures, fraud investigation techniques, communications with legal departments, the use of information collection technologies, and the use of accident kits aim to reduce the number of fraudulent claims brought against agencies and the corresponding cost of settling suspicious or fraudulent claims. Employee manuals at transit agencies are effective tools for the standardization and dissemination of practices that are designed to address the issue of fraudulent claims. Training procedures that reinforce these procedures increase the likelihood that all critical information is captured at the time of an accident. In addition, records management (including risk management information systems), special investigative units, insurance company resources, informants, surveillance, claims review and analysis processes, investigation, fraudulent claims profiles, and supplemental fact checking procedures target analysis of data to defend an agency against fraud.

The FTA remains the only national clearinghouse for the collection of data on casualty and liability payments in transit in its National Transit Database. Previous studies have encouraged the FTA to revise its data collection process to capture more useful information on the risk management process. The data collected would be enhanced by the inclusion of fields to capture the following information:

- Risk finance method used by the agency
- Total number of bodily injury claims filed against the agency
- Total number of claims paid and denied by or closed without payment by the agency
- Total number of claims referred to fraud unit, if applicable
- Total number of claims denied based on fraud
- Total number of prosecutions based on fraud claim submissions
- If self-insured, claims adjustment method.

In response to the insurance crisis of the mid-1980s and the explosion in litigation in late 1980s, several agencies that have experienced fraudulent claims have implemented aggressive programs to reduce such claims.

Finally, on the basis of information gathered for this synthesis, two topics have been identified as worthy of future study: (1) standardization of reporting and (2)

computer software for risk management and research on notice of claim statutes or other protection factors for state agencies.

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GLOSSARY

- Accident**—An unforeseen, unintended event, caused by an unsafe act, an unsafe condition, or a combination of the two.
- Accident Frequency**—The rate of occurrence of accidents (e.g., the number of accidents per million miles traveled).
- Accident Severity**—A measurement of the seriousness resulting from accidents.
- Bodily Injury Liability**—A liability for damages resulting from bodily injury (including death).
- Claim**—(1) A demand for something due or believed to be due (e.g., an insurance claim) or a demand by an individual or corporation to recover a loss that may come within a policy of insurance, or (2) the demands against an insured that are referred to the insurance company for handling on behalf of the insured in accordance with the contract terms.
- Claim Reserve**—Funds to cover projected costs of a claim in, or subject to, litigation. Reserves are often accrued as liabilities and not funded until the claim is settled.
- Comparative Negligence**—A form of negligence where a plaintiff whose fault is less than the defendant's may recover a portion of his loss.
- Comprehensive General Liability**—A liability assumed, expressed, or implied under a written contract.
- Contributory Negligence**—A form of negligence where a plaintiff who is at fault to any extent is barred from recovering damages.
- Coverage**—The extent of the insurance afforded under an insurance contract; often used to mean insurance or insurance contract. A general term referring to the extent of protection against unanticipated financial claims or losses.
- Exposure**—The state of being exposed to the chance of loss; the degree or condition of what is at risk.
- Fraud**—Any act, expression, omission, or concealment calculated to deceive another to his or her disadvantage. A misrepresentation or concealment with reference to some factual material to a transaction that is made with knowledge of its falsity or in reckless disregard of its truth or falsity and with the intent to deceive another, and that is reasonably relied on by the other who is injured thereby. The affirmative defense of having acted in response to a fraud.
- Hazard**—A condition or situation that causes, increases, or influences the extent of a loss.
- Incident**—An unforeseen event or occurrence that does not necessarily result in injury or property damage.
- Insurance**—A contract whereby one party undertakes to guarantee another against loss by a contingent event.
- Legal Liability**—A liability enforceable by law.
- Liability**—(1) An obligation according to law or equity, a responsibility, the exposure to a certain adverse contingency, or (2) a financial obligation; the probable cost of meeting an obligation.
- Liability Insurance**—An insurance policy covering loss due to liability covering both damages and expenses connected with alleged or actual liability.
- Loss**—The basis for a claim for indemnity or damages under the terms of an insurance policy (e.g., any unintentional diminution of quantity or value of property); a valid claim for recovery under policies of indemnity; in its application to liability policies, the payments made on behalf of the insured.
- Loss Control**—The revision and organization of the patterns of preventative, productive, and administrative activities to minimize loss.
- Losses Incurred**—The total losses, paid or unpaid, sustained under a policy or policies.
- Losses Paid**—The amount of loss for which money has been disbursed.
- Loss Reserve**—The portion of the assets kept in a readily available form to meet probable claims for the payment of losses that have been incurred, but are not yet due.
- Personal Injury Coverage**—The coverage for libel, slander, false arrest, and invasion of privacy, usually issued as an endorsement to a standard General Liability Policy.
- Premises and Operations Liability**—A liability for accidental bodily injury or property damage resulting from either a condition on the insured's premises or the insured's operations in progress whether on or away from the insured's premises.
- Premium**—The sum of money paid for an insurance policy.
- Probable Maximum Property Loss**—The maximum amount of property loss if sprinklers worked and fire departments responded.
- Property Damage Liability Insurance**—A liability for damages resulting from injury to another's property.
- Reasonable Care**—Due care.
- Reserve**—(1) The funds of an insurance company or selfinsurance for the purpose of meeting obligations as they fall due, or (2) a liability set up for a particular purpose.
- Retention**—A form of self-insurance in which the insured assumes all losses or those losses up to a specified limit.
- Risk**—A person or thing insured; uncertainty of the outcome of an event when two or more possibilities exist.
- Risk Management**—The process of planning, organizing, directing, and controlling the resources and activities or an organization to minimize the adverse effect and cost of accidental losses.
- Safety**—A system characteristic concerning the ability to prevent or minimize occurrence of property damage and/or injuries or fatalities to personnel who interact with the system in some manner—passengers, employees, or bystanders.

Self-Insurance—The insuring of oneself by the establishment of cash reserves or high deductibles.

Self-Insured Retention (SIR)—A policy where the insured assumes a reasonable limit of losses.

Standard of Care—The degree of care or competence that one is expected to exercise in a particular circumstance or role.

Third Party Fraudulent Claims—Tort claims made by non-employees with the intent to defraud that include fabrication of the event or the claimant's involvement in the event and/or misstatement of the event.

Tort Claims—The demand for damages from a public transit agency and/or its insurance company based on negligence, intentional conduct, or strict liability.

Tort Liability—The obligation to pay for a civil wrong. A tort is defined by the presence of four conditions: (1) there is a required standard of conduct, (2) there is a breach of that duty, (3) the breach of duty causes an injury, and (4) damage(s) is sustained.

Tort Reform—Changes in laws governing civil wrongs; employed to mean changes designed to eliminate excessive awards and prevent nonmeritorious suits.

Worker's Compensation Insurance—An insurance policy or a self-insured retention, which protects an employer against an employee's job-connected injury or death. Worker's compensation is prescribed by laws in most states that stipulate the amount of settlements via a list of scheduled benefits.

APPENDIX A

Synthesis Survey Results

TRANSIT COOPERATIVE RESEARCH PROGRAM

Synthesis Topic SG-7

"Identifying and Reducing Fraudulent Third Party Tort Claims Against Public Transit Agencies"

Purpose: To obtain financial protection from litigation, transit agencies have developed an extensive array of risk management practices and policies. *Fraudulent claims* place an additional burden on risk management programs. *Controlling these claims has been identified as one of the most important, unresolved issues in transit tort liability.* The goal of this project is to estimate the magnitude of claims abuses by collecting data from transit agencies. This project will also identify what transit agencies are doing to combat the problem—what is working and what is not. All survey responses will be confidential, and survey results will be presented only in an aggregate format. Please call the number at the end of this survey if you have any questions concerning either survey questions or the confidentiality of your response. **If you respond, we will be sure to provide you with a copy of the final report. Thank you for taking the time to complete this questionnaire.**

General Information

Transit Agency Name: _____ Date: _____
 Contact Person: _____ Title: _____
 Phone Number: _____ Fax Number: _____
 Address: _____

Defining Fraudulent Claims

This synthesis uses the following definition for fraudulent claims. *In order to ensure consistency, please use this definition when completing the survey.*

Third party fraudulent claims are defined as tort claims made by **non-employees** with the intent to defraud that include:

- Fabrication of the event or the claimant’s involvement in the event
- Misstatement of the event

1. Do you agree with this definition? 11 Agencies (52.4% of responses) Yes 10 (47.6%) No
2. If you answered “no” to Question 1, how does your agency define “fraudulent claim”? (If you disagree, please use the definition above in responding to the survey). **Question 2 responses are listed separately after the questionnaire.**

3. Please Please estimate the total number of claims (legitimate and fraudulent) that your agency received in calendar year 1998. Total = 23,940, Average = 1,140, Mean = 617

4. In your experience in calendar year 1998, what percentage of claims received by your agency would you *estimate* to be fraudulent (using this questionnaire's definition of fraudulent claims)?

9 (42%) Less than 5%
6 (29%) 5%–10%
4 (19%) 10%–20%
1 (5%) 20%–30%
0 30%–40%
1 (5%) Other: _____

5. In your experience over calendar years 1994-1998, has the number of claims that you *believe* to be fraudulent: 3 (14%) Increased 5 (24%) Decreased 14 (62%) Not Changed
6. In your estimation in 1998 what percentage of those claims, that you believe to be fraudulent, resulted in some level of payment to the claimant? Average = 28%, Median = 7.5% (18 respondents)
7. In 1998, what was the approximate dollar value paid by your agency to claimants in settlement of claims which, in your *estimation*, may have been fraudulent? Average = \$13,893, Median = \$3,500 (11 Respondents)

Identifying Fraudulent Claims

8. Briefly describe the process your agency currently uses to identify fraudulent claims:

Question 8 responses are listed separately after the questionnaire.

9. How effective do you feel that this process is?

8 (40%) Very Effective
12 (60%) Somewhat Effective
0 Not at all effective
0 N/A - no process in place

10. Does your agency have a process in place to identify incidents that may result in potential claims (before claims are actually filed)? 21 (100%) Yes 0 No

If Yes, how are incidents that may result in claims identified? (Please check all that apply.)

16 (76%) Review of police reports
18 (86%) Review of operations/dispatch records (or 24 hour incident report form)
14 (67%) Review of Safety Department accident and other investigations
11 (52%) Review of safety incident data
7 (33%) Reports from Legal Department
17 (81%) Reports from field personnel
15 (71%) Reports from claims investigators
10 (48%) Media coverage
1 Other Reports on all injuries are forwarded to the Law Department

- 1 Other Passenger Complaints
1 Other Response to scenes by Claims Management, where appropriate
1 Other Bus Operator accident reports
1 Other On-site claims investigations

If Yes, how long does your agency maintain files on potential claims?

- 0 1 year
1 (5%) 2 years
1 (5%) 3 years
8 (40%) 5 years
9 (45%) Other

11. Do your policies require that investigations or “incident reviews” performed by personnel within your agency identify and collect “perishable” evidence that may be used to defend against a claim filed in the future?
17 (81%) Yes 4 (19%) No
12. Does your agency (or a department within your agency, such as Legal) actively monitor requests for and releases of information that may be used in filing a claim (engineering plans, photographs, reports, safety data, etc.)?
21 (100%) Yes 0 No
13. Is all information regarding potential claims, actual claims, and related legal actions centralized within one department in your agency?
21 (100%) Yes 0 No

If Yes, what is the name of the department?

- 13 (62%) Risk Management
3 (14%) Legal
2 (10%) Claims
1 (5%) Operations
1 (5%) Safety
1 (5%) Human Resources

14. At what point in the claims evaluation process is your agency most likely to identify a fraudulent claim?
-
-

Processing Fraudulent Claims

15. Does your agency have an automated claims management system?
14 (67%) Yes 7 (33%) No

If Yes, does your agency’s claims management system perform any automated analysis to identify potential fraudulent claims?
2 (14%) Yes 12 (86%) No

If Yes, does your agency’s claims management system track the claims made for each incident?
7 (78%) Yes
2 (22%) No

If No, does your agency perform any type of analysis to identify potential fraudulent claims?
9 (75%) Yes 3 (25%) No

If No, does your agency use a manual process to system track the claims made for each incident?
8 (89%) Yes
1 (11%) No

16. Has your agency developed fraudulent claim *profiles* to assist in their identification?
6 (30%) Yes 14 (60%) No

If Yes, please list the key elements of your profile:

17. What characteristics in a claim make you question its validity? Please rate the following characteristics for how well they indicate an invalid claim, and add any other characteristics you feel are important indicators of an invalid claim:

| Characteristic | Indicator of Invalid Claim? (1= Poor Indicator, 5 = Excellent Indicator) (Please circle one) |
|--|---|
| Absence of documentation (no cards, sheets, or other forms distributed by operators/claims personnel at scene of accident) | Average = 3.62 Standard Deviation = 1.12 |
| No mention of claimant's name in official documents (accident reports, claims reports, etc.) | Average = 3.62 Standard Deviation = .80 |
| Type of injury or illness | Average = 3.52 Standard Deviation = .82 |
| Previous claim filed by claimant | Average = 3.76 Standard Deviation = .77 |
| Description of incident | Average = 4.00 Standard Deviation = .89 |
| Description of impact of incident | Average = 3.57 Standard Deviation = .87 |
| Contradiction with reports from transit agency personnel | Average = 3.90 Standard Deviation = 1.04 |
| Informant asserts that claim is fraudulent | Average = 3.76 Standard Deviation = .77 |
| Other <u>Similar treatment profiles and bills for claimants in multiple claimant incidents</u> | 4 |
| Other <u>Chiropractic treatment for small children and infants</u> | 4 |
| Other <u>Only medical treatment if from chiropractic provider</u> | 5 |
| Other <u>Claimant is difficult to contact (no phone or long-term address)</u> | 4 |
| Other <u>Conflict in reports from other third party witnesses</u> | 5 |
| Other <u>Video documentation that event did not occur or did not occur as stated</u> | 5 |
| Other <u>Documentation that claimant had injury prior to event</u> | 4 |
| Other <u>Criminal record, particularly for misrepresentation of facts</u> | 3 |
| Other <u>Consistency of statements/testimony with known facts and procedures</u> | 3 respondents Average = 4.66 |
| Other <u>Identity of treating physician</u> | 5 |
| Other <u>Identity of attorney</u> | 3 respondents Average = 4.66 |
| Other <u>Description of accident in hospital emergency room records and records of EMS</u> | 4 |
| Other <u>Lack of credibility of claimant (same criteria used by jurors at trial)</u> | 4 |
| Other <u>Retention of attorney within days of an accident</u> | 5 |
| Other <u>Facts change over time</u> | 4 |
| Other <u>Claim injury but wait for agency approval before seeking medical attention</u> | 4 |
| Other <u>Inconsistencies in address, social security number, etc.</u> | 4 |
| Other <u>Index bureau – history of claims and litigation</u> | 3 |

18. Please identify which of the following personnel participate in claims investigations by circling how frequently they are involved.

| Personnel | Involved in: | | | | |
|--|---------------|----------------|------------------------|--|--|
| | All | Some | Not Involved | | |
| Transit agency legal personnel | All <u>2</u> | Some <u>13</u> | Not Involved <u>6</u> | | |
| Transit agency legal investigators | All <u>1</u> | Some <u>7</u> | Not Involved <u>12</u> | | |
| Personnel in Risk Management/Claims | All <u>19</u> | Some <u>1</u> | Not Involved <u>1</u> | | |
| Transit safety department personnel | All <u>4</u> | Some <u>14</u> | Not Involved <u>2</u> | | |
| Transit police | All <u>0</u> | Some <u>14</u> | Not Involved <u>5</u> | | |
| Contracted investigators | All <u>4</u> | Some <u>14</u> | Not Involved <u>3</u> | | |
| Insurance investigators | All <u>5</u> | Some <u>5</u> | Not Involved <u>11</u> | | |
| Other <u>Private Investigators</u> | All <u>0</u> | Some <u>1</u> | Not Involved <u>0</u> | | |
| Other <u>Private Vendors</u> | All <u>0</u> | Some <u>1</u> | Not Involved <u>0</u> | | |
| Other <u>Transit Field Supervisors</u> | All <u>1</u> | Some <u>0</u> | Not Involved <u>0</u> | | |

19. When conducting claims investigations, how frequently does your agency perform the following activities:

| Activity | Performed in: | | | | |
|---|---------------|----------------|-------------------------|--|--|
| | All | Some | Not Performed | | |
| Taking statements from claimants, investigating police officer(s), third parties, and witnesses | All <u>1</u> | Some <u>7</u> | Not Performed <u>12</u> | | |
| Checking hospital and medical records | All <u>12</u> | Some <u>9</u> | Not Performed <u>0</u> | | |
| Checking police records | All <u>12</u> | Some <u>9</u> | Not Performed <u>0</u> | | |
| Performing analysis of accident/incident data | All <u>9</u> | Some <u>12</u> | Not Performed <u>0</u> | | |
| Surveillance | All <u>1</u> | Some <u>17</u> | Not Performed <u>3</u> | | |
| Independent medical examinations | All <u>2</u> | Some <u>18</u> | Not Performed <u>1</u> | | |
| Other <u>Review employment records</u> | All <u>0</u> | Some <u>1</u> | Not Performed <u>0</u> | | |
| Other <u>Background checks</u> | All <u>0</u> | Some <u>1</u> | Not Performed <u>0</u> | | |

20. Approximately how many claims investigations were performed by, or on behalf of, your agency in 1998? Total = 19,696. Average = 1.036 (19 respondents)
21. Of those claims investigations, approximately how many resulted in clear findings of fraudulence in 1998? Total = 522. Average = 37 (11 respondents)
22. Approximately what percentage of total claims made by *non-employees* against your agency were denied based on your determination of fraudulence in 1998? Average = 12.75% (13 respondents)
23. What is the total estimated dollar value of these denied claims? Total = \$1,413,499. Average = \$201,928 (7 respondents)
24. Did your agency prosecute any individuals who brought false claims against your agency in 1998? 4 (20%) Yes 16 (80%) No

If Yes, what factors caused you to prosecute?

- "Video documentation that claimant was not on bus at time of event, forging on check endorsement."
- "Fraudulent statement of claim given by claimant."
- "Police noted that persons were at scene but had not been on bus."
- "Concerted effort with other defendants."

25. Based on your experience, how likely is it that the following types of incidents will result in fraudulent claims?

| Incident Type | Likelihood of Claims (1= Low, 5 = High) (Please circle one) |
|--|--|
| Incidents that receive a high level of media coverage and publicity | Average = 3.53 Standard Deviation = 1.26 |
| Transit agency vehicle accidents (bus or rail collisions, derailments, or fires) | Average = 3.74 Standard Deviation = 1.05 |
| Personal vehicle/transit agency vehicle accidents | Average = 2.80 Standard Deviation = 1.06 |
| Pedestrian/transit agency vehicle accidents | Average = 2.47 Standard Deviation = 1.12 |
| Bicycle/transit agency vehicle accidents | Average = 2.39 Standard Deviation = 1.09 |
| Slips, trips, and falls in stations/transit property | Average = 2.70 Standard Deviation = .92 |
| Slips, trips, and falls on vehicles | Average = 3.55 Standard Deviation = 1.05 |
| Security incidents | Average = 2.26 Standard Deviation = .99 |

Preventing Fraudulent Claims

26. Please identify any of the following practices that your agency currently uses to reduce fraudulent claims and rate the effectiveness of the practice in preventing claims. If you use other practices, please describe them and rate their effectiveness on the following page.

| Practice | In Use (√) | Effectiveness (1= Low, 5 = High) (please circle one) |
|---|---------------------|--|
| Provide bus/rail operators or supervisors (or other transit agency personnel) with identification cards, forms, or other documentation that must be distributed at an incident and filed with the claim to ensure that the claimant was actually at the incident. | <u>20</u> (100%) | Average = 3.53 Standard Deviation = 1.26 |
| Include fraud identification in basic training provided for transit operations and supervisory personnel | <u>10</u> (50%) | Average = 3.20 Standard Deviation = 1.23 |
| Provide bonuses or other incentives for employees who identify fraud | <u>1</u> (5%) | Average = 1.00 Standard Deviation = 0 |
| Perform independent risk management reviews to identify all the flow of information throughout the agency concerning fraudulent claims | <u>6</u> (30%) | Average = 3.67 Standard Deviation = 1.63 |
| Follow-up on the status of all injuries resulting from incidents cited in the agency's "24 Hour Unusual Occurrences report" (or similar report). | <u>14</u> (70%) | Average = 3.36 Standard Deviation = 1.15 |
| Use forms, reports, or calls to dispatch to identify and track potential incidents that may result in claims, but do not require hospitalization of the affected party at the scene (i.e., slips, trips, and falls in stations and on vehicles) | <u>18</u> (90%) | Average = 3.67 Standard Deviation = .84 |
| Perform routine hazard and vulnerability identification and resolution to quantify the likelihood that a non-employee will experience a certain safety or security incident at your agency | <u>11</u> (55%) | Average = 3.36 Standard Deviation = 1.36 |
| Use Closed Circuit Television (CCTV) to provide a record of events that occurred within a station | <u>10</u> (50%) | Average = 3.30 Standard Deviation = 1.25 |
| Use CCTV to provide a record of events that occurred within a transit vehicle | <u>7</u> (35%) | Average = 3.43 Standard Deviation = 1.51 |
| Work with insurance companies, claims adjusters, or others to review filed, settled, and pending claims to identify potentially fraudulent ones | <u>14</u> (70%) | Average = 3.86 Standard Deviation = 1.03 |
| Prosecute those who bring fraudulent claims | <u>5</u> (25%) | Average = 2.60 Standard Deviation = 1.51 |
| Advertise against the bringing of fraudulent claims | <u>6</u> (30%) | Average = 2.33 Standard Deviation = .82 |

Please fax the completed survey by **February 15, 1999** to:

Ms. Annabelle Boyd
Boyd, Maier & Associates
Fax: (804) 985-8977

or mail the completed survey to:

Ms. Annabelle Boyd
Boyd, Maier & Associates, Inc.
402 Greenwood Farms Road
Barboursville, VA 22923
Phone: (804) 985-1033

Thank you for taking the time to complete the survey!

Responses to Question 2—Definition

- Add: Event with fabrication of resulting injury.
- Our agency receives a number of bodily injury (BI) claims that are not in keeping with the minor damage to property. These BI claims are usually comprised of several months of chiropractic treatments and some time off from work (Damage to property is several hundred dollars or less.) This is the typical fraudulent claim we deal with.
- Should include misrepresentation of damages incurred as a result of the event.
- We would include fabricated injuries as well. [Agency name] does not feel it is confronted with a substantial amount of claims that are without any basis in fact, or which arise from situations where persons not actually involved in the accident fabricate their presence on an [agency] vehicle or at an accident scene. Although some of these situations surely exist, the far more prevalent fraud problem involves fabricated or exaggerated symptomology by actual passengers (or others) that is "supported" by documentation of excessive treatment by health care providers, generally chiropractors.
- By the above definition we have relatively few fraudulent claims. The majority of the fraud we encounter stems from magnification of both symptoms and damages from claims that can be traced to incidents known to have occurred.
- Our agency also includes fabricated injuries and grossly exaggerated injuries when defining fraudulent claims.
- The definition fails to include the exaggeration of actual or purported injuries that may have been suffered.
- Fabrication of the event or the claimant's involvement in the event. Misstatement of the event. Exaggeration or falsification of medical treatment by physicians or attorneys.
- Over treatment by medical providers. Use of prior injury or condition to fabricate damages for an exacerbation/reinjury claim.
- We also include misstatement of injuries, excessive treatment or wage loss, intentional misbillings by providers, gross inconsistencies in facts of event or extent of injuries.
- Besides the above, we also consider intentional misrepresentation of the actual extent and nature of damages resulting from an event as fraud.

Responses to Question 8—Process for Identifying Fraudulent Claims

- All new claims reviewed by supervisor for specific attorney involvement—claim also checked for prior claims—extreme exaggeration of events (i.e., bus dragged claimant for 5 blocks)—If yes to one or more refer the claim to an SUI investigator for an in-depth, thorough investigation, including a recorded statement from claimant.
- We identify them through the accident investigation process.
- The adjuster handling the investigation has the responsibility to evaluate the claim in light of the facts of the incident. Case-by-case basis.
- Courtesy cards signed by passengers. On-the-scene investigation.
- Operators Report, Supervisors Report, Police Report, Witness Statements, claimant's history.
- Index, background check, witness statements, medical review, vehicle information, subjective vs. objective findings, scene investigations, fraud checklist.
- Detailed statements from claimants whenever possible; examination of any prior claim history; requirement of estimates/documentation of any claimed loss or damages.
- We review all data submitted to verify accuracy. We have an internal index system that allows us to check on prior claims submitted by claimants. We look for red flags, inconsistent information and physical evidence if applicable.
- Use index system to identify other claims filed against our or other agency. Documentation for injuries, damage. Witness cards at accident scene.
- All claimants are filed with the Index Bureau; IMR's; medical management; TPA investigations; on-board cameras (but not on all coaches); surveillance.
- All initial and telephone reports are perused by the Claims Manager before assignment to the staff. At this stage the Manager looks for red flags, i.e., the alleged injured party was not listed on the accident report or police report as injured. DMV searches are conducted on most if not all claims. Bills are aggressively reduced in line with the WC fee schedule. Medical exams are requested on claimants within weeks of some reports to cut off benefits where appropriate ASAP.
- If the number of bus passenger claims exceed the number of passengers on a bus, we obtain detailed statements from every known passenger to attempt to determine the fraudulent claimant. In other alleged injury or property claims, detailed statements are also obtained from parties and witnesses. Review of police reports and other investigative agency document is also done.
- The Law Department is advised almost contemporaneously with other interested Departments, including the Police Department when a serious incident occurs on the system. Any serious incident is responded to as soon as soon as practicable. An effort is made to have claims investigators respond on a 7-day, 24-hour basis. Investigators immediately attempt to identify witnesses; begin the collection of relevant documents, including Police Reports; and photograph the scene.
- We keep an index file on all claimants. We pass our courtesy cards to passengers at each accident. We scrutinize all medical bills and reports submitted. We use private investigators on occasion.
- All claims/reports are received and reviewed by Risk Management and appropriate levels of investigation are determined based on information and experience. This is done on a case-by-case basis.
- Interview claimant. Index system. Interview witnesses.
- Independent and medical examinations and forensic engineer. Surveillance. Accident reconstruction. Index bureau check. Impact studies.
- Review CCTV data, run criminal checks and worker's compensation checks, audit medical bills and wage loss claims.
- Recorded statements, police reports, some investigations, photos, etc. If red flags pop up we may go to surveillance, background checks, IMRs, accident reconstruction.
- We manually check our claims database for prior claims filed by claimant. We use Index Bureau to determine prior claim history. We cross-reference doctor and attorney names. We use private investigators and medical consultants to determine medical necessity of treatment and relation to injury.

APPENDIX B

Survey Respondents

Bi-State — St. Louis, Mo.
 Cambria County Transit — Johnstown, Pa.
 Charlotte DOT — N.C.
 Greater Richmond Transit — Va.
 King County/Metro — Seattle, Wash.
 Long Beach Public Transit — Calif.
 Los Angeles County MTA — Calif.
 Milwaukee Transport Services — Wis.
 MTA — Houston, Tex.
 MTA Long Island Bus — N.Y.
 New York City Transit Authority — N.Y.

Port Authority of Allegheny — Pittsburgh, Pa.
 Port Authority Transit Corp. — Philadelphia, Pa.
 RTC/Citifare — Reno, Nev.
 Sacramento RTD — Calif.
 SMART — Detroit, Mich.
 SORTA/METRO — Cincinnati, Ohio
 Tri-County Met. — Portland, Oreg.
 Utah Transit Authority — Salt Lake City, Utah
 Via Metropolitan Transit — San Antonio, Tex.
 WMATA — Washington, D.C.

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APPENDIX C

Illinois Statute—Metropolitan Transit Authority Act

(70 ILCS 3605/1) Sec. 1. This Act shall be known and may be cited as the "Metropolitan Transit Authority Act."
(Source: Laws 1945, p. 1171.)

(70 ILCS 3605/27) Sec. 27 ... In the policing of its properties the Board may provide for the appointment and maintenance, from time to time, of such police force as it may find necessary and practicable to aid and supplement the police forces of any municipality in the protection of its property and the protection of the persons and property of its passengers and employees, or otherwise in furtherance of the purposes for which such Authority was organized. The members of such police force shall have and exercise like police powers to those conferred upon the police of cities. Neither the Authority, the members of its Board nor its officers or employees shall be held liable for failure to provide a security or police force or, if a security or police force is provided, for failure to provide adequate police protection or security, failure to prevent the commission of crimes by fellow passengers or other third persons or for the failure to apprehend criminals.

(Source: P.A. 84-939; 87-597.)

APPENDIX D

State Laws on Insurance Fraud

Commonwealth of Virginia

TITLE 52. POLICE (STATE)
CHAPTER 9. INSURANCE FRAUD
Va. Code Ann. § 52-37 (1998)

§ 52-37. (Effective January 1, 1999 and until January 1, 2003) Insurance Fraud Investigation Unit established; powers and duties of Department of State Police

A. There shall be established within the Department of State Police, Bureau of Criminal Investigation, the Insurance Fraud Investigation Unit. The purposes of this unit shall be to:

1. Initiate independent inquiries and conduct independent investigations when the Department has reason to believe that insurance fraud may have been or is currently being committed, and to undertake studies to determine the extent of such insurance fraud.
2. Respond to notification or complaints alleging insurance fraud generated by federal, state and local police, other law-enforcement authorities, governmental agencies or units, and any other person.
3. Review notices and reports of insurance fraud; select the incidents of suspected fraud that, in its judgment, require further detailed investigation; and conduct the investigations.

B. The Superintendent may appoint such agents as he may deem necessary to assist the Department in carrying out its powers and duties under this chapter.

TITLE 38.2. INSURANCE
CHAPTER 4. ASSESSMENT FOR ADMINISTRATION OF INSURANCE LAWS AND DECLARATIONS OF ESTIMATED ASSESSMENTS BY INSURERS
Va. Code Ann. § 38.2-415 (1998)

STATUS: CONSULT SLIP LAWS CITED BELOW FOR RECENT CHANGES TO THIS DOCUMENT

LEXSEE 1999 Va. ALS 483—See section 1.

§ 38.2-415. (Effective January 1, 1999 through January 1, 2003) Assessment to fund program to reduce losses from insurance fraud

- A. Each licensed insurer doing business in the Commonwealth by writing any type of insurance as defined in §§ 38.2-110 through 38.2-122.1 and 38.2-124 through 38.2-132 shall pay, in addition to any other assessments provided in this title, an assessment in an amount equal to 0.05 of one percent of the direct gross premium income collected during the preceding calendar year. The assessment shall be apportioned and assessed and paid as prescribed by § 38.2-403. The Commission shall be reimbursed from the fund for all necessary expenses for the administration of this section.
- B. The assessments made by the Commission under subsection A and paid into the state treasury shall be deposited to a special fund designated "Virginia State Police, Insurance Fraud," and out of such special fund and the unexpended balance thereof shall be appropriated the sums necessary for accomplishing the powers and duties assigned to the Virginia State Police under Chapter 9 (§ 52-36 et seq.) of Title 52. All interest earned from the deposit of moneys accumulated in the Fund shall be deposited in the Fund for the same use.

- C. The moneys deposited in the Fund shall not be considered general revenue of the Commonwealth but shall be used only to (i) effectuate the purposes enumerated in Chapter 9 (§ 52-36 et seq.) of Title 52 and (ii) reimburse the Commission for its necessary expenses for the administration of this section. The Fund shall be subject to audit by the Auditor of Public Accounts.
- D. In the event that the Insurance Fraud Investigation Unit is dissolved by operation of law or otherwise, any balance remaining in the Fund, after deducting administrative costs associated with the dissolution, shall be returned to insurers in proportion to their financial contributions to the Fund in the preceding calendar year.

State of Illinois

CHAPTER 720. CRIMINAL OFFENSES

CRIMINAL CODE

CRIMINAL CODE OF 1961

TITLE V. ADDED ARTICLES

ARTICLE 46. INSURANCE FRAUD, FRAUD ON THE GOVERNMENT, AND RELATED OFFENSES

720 ILCS 5/46-1 (1998)

§ 720 ILCS 5/46-1. Insurance fraud

Sec. 46-1. Insurance fraud.

- (a) A person commits the offense of insurance fraud when he or she knowingly obtains, attempts to obtain, or causes to be obtained, by deception, control over the property of an insurance company or self-insured entity by the making of a false claim on any policy of insurance issued by an insurance company or by the making of a false claim to a self-insured entity, intending to deprive an insurance company or self-insured entity permanently of the use and benefit of that property.
- (b) Sentence.
 - (1) A violation of this Section in which the value of the property obtained or attempted to be obtained is \$300 or less is a Class A misdemeanor.
 - (2) A violation of the Section in which the value of the property obtained or attempted to be obtained is more than \$300 but not more than \$10,000 is a Class 3 felony.
 - (3) A violation of this Section in which the value of the property obtained or attempted to be obtained is more than \$10,000 but not more than \$100,000 is a Class 2 felony.
 - (4) A violation of this Section in which the value of the property obtained or attempted to be obtained is more than \$100,000 is a Class 1 felony.
- (c) For the purposes of this Article, where the exact value of property obtained or attempted to be obtained is either not alleged by the accused or not specifically set by the terms of a policy of insurance, the value of the property shall be the fair market replacement value of the property claimed to be lost, the reasonable costs of reimbursing a vendor or other claimant for services to be rendered, or both.
- (d) Definitions. For the purposes of this Article:
 - (1) "Insurance company" means "company" as defined under Section 2 of the Illinois Insurance Code [215 ILCS 5/2].
 - (2) "Self-insured entity" means any person, business, partnership, corporation, or organization that sets aside funds to meet his, her, or its losses or to absorb fluctuations in the amount of loss, the losses being charged against the funds set aside or accumulated.
 - (3) "Obtain", "obtains control", "deception", "property" and "permanent deprivation" have the meanings ascribed to those terms in Article 15 of this Code.
 - (4) "Governmental entity" means each officer, board, commission, and agency created by the constitution, whether in the executive, legislative, or judicial branch of State government; each officer, department, board, commission, agency, institution, authority, university, and body politic and corporate of the State; each administrative unit or corporate outgrowth of State government that is created by or pursuant to statute, including units of local government and their officers, school districts, and boards of election commissioners; and each administrative unit or corporate outgrowth of the above and as may be created by executive order of the Governor.

HISTORY:

Source: P.A. 87-1134, § 1; 88-45, § 2-57; 90-333, § 5.

NOTES:

EFFECT OF AMENDMENTS.

The 1993 amendment by P.A. 88-45, effective July 6, 1993, renumbered this Article, which was formerly Article 45, and renumbered this section, which was formerly 720 ILCS 5/45-1 as enacted by P.A. 87-1134. The 1997 amendment by P.A. 90-333,

effective January 1, 1998, in the Article head inserted "Fraud On The Government"; in subsection (a), substituted "commits the offense of insurance fraud when he or she" for "who", inserted "or self-insured entity" in two places, inserted "or by the making of a false claim to a self-insured entity", and deleted "commits insurance fraud" from the end; in subsection (c), substituted "Article" for "Section" and substituted "the policy" for "a policy"; and added subsection (d).

State of Minnesota

Insurance

CHAPTER 60A GENERAL INSURANCE POWERS INSURANCE FRAUD

Minn. Stat. § 60A.954 (1998)

60A.954 Insurance antifraud plan

Subdivision 1. Establishment. An insurer shall institute, implement, and maintain an antifraud plan. For the purpose of this section, the term insurer does not include reinsurers, the workers' compensation reinsurance association, self-insurers, and excess insurers. Within 30 days after instituting or modifying an antifraud plan, the insurer shall notify the commissioner in writing. The notice must include the name of the person responsible for administering the plan. An antifraud plan shall establish procedures to:

- (1) prevent insurance fraud, including: internal fraud involving the insurer's officers, employees, or agents; fraud resulting from misrepresentations on applications for insurance; and claims fraud;
- (2) report insurance fraud to appropriate law enforcement authorities; and
- (3) cooperate with the prosecution of insurance fraud cases.

Subdivision 2. Review. The commissioner may review each insurer's antifraud plan to determine whether it complies with the requirements of this section. If the commissioner finds that an insurer's antifraud plan does not comply with the requirements of this section, the commissioner shall disapprove the plan and send a notice of disapproval, along with the reasons for disapproval, to the insurer. An insurer whose antifraud plan has been disapproved by the commissioner shall submit a new plan to the commissioner within 60 days after the plan was disapproved. The commissioner may examine an insurer's procedures to determine whether the insurer is complying with its antifraud plan. The commissioner shall withhold from public inspection any part of an insurer's antifraud plan for so long as the commissioner deems the withholding to be in the public interest.

APPENDIX E

Recommended Guidelines for Detecting Fraud

The following guidelines can help claims personnel identify suspicious or fraudulent claims. These guidelines, however, should not be used as the sole basis for delaying or denying a claim. It is important for claims personnel to remember that many legitimate claims fall into one or more of these categories. Education, hands-on training and experience are the keys to identifying, distinguishing and using this information to combat fraud.

- Claim filed within three months of policy inception, one month of expiration or a short time after the contestable period has expired.
- Loss occurs shortly after the coverage becomes effective or the insured contacts the agent to verify or increase coverage.
- Excessive or vague documentation.
- Medical records submitted by an agent or the claimant.
- A recent increase in benefits or an indication of multiple coverage.
- Soft-tissue injuries resulting from unwitnessed accidents.
- Repetitive claims of a similar nature for excessive periods of confinement.
- Photocopies, altered dates and the like.
- Benefits not assigned.
- Absence of the provider's medical degree, for example, "Dr. John Doe" instead of "John Doe, M.D."
- Reluctance by the provider to submit complete records.
- Photocopies of bills or claim forms showing handwritten and typed information; different kinds of typewriters, inks or handwriting.
- Several claimants using the same doctor, hospital or attorney.
- Pressure from the claimant for a quick decision, combined with threats of going to the president of the company, complaining to the insurance department or using an attorney.
- Injury occurs immediately before a strike, layoff, job termination or completion.
- Long delay in submission or notice of claim.
- Claimant has a history of frequent disabilities, prior or habitual claims.
- Unusual increase in claims from a specific geographic area.
- Provider is not in the same geographic area as the insured, particularly when a pattern develops.
- Use of post office boxes instead of regular street addresses.
- Claimant indicates extreme familiarity with and knowledge of claims process and insurance jargon.
- Claimant has a vague employment history or has worked for an insurance company, law enforcement agency or similar organization.
- Anonymous or frequent phone inquiries regarding the status of a pending claim.
- Delivery of claim material by overnight express service or in person. Claimant avoids using the U.S. Postal Service and insists on collecting the check in person.
- Claim forms completed by hand. Provider and claimant sections appear to be in the same handwriting.
- Revised information on a rejected claim that would allow the claim to be paid.
- Typed or handwritten hospital bills. (Most hospital bills are generated by computer.)
- Receipts, invoices or reports on plain stationery rather than letterhead.
- A receipt number that does not correspond to the listed date of service.
- Duplicate receipt numbers appearing with new dates of service.
- Bills from volunteer agencies.
- Claimant's hostility at having to provide documentation and an unwillingness to provide tax returns or authorization for the release of information.
- Misspelled medical or legal terminology.
- High incidence of renewal prescriptions or the excessive use of pain medication, especially controlled substances.
- Information sent by certified mail.

APPENDIX F

Recommendations in Preventing, Detecting, and Controlling Fraud

The Health Insurance Association of America recommends that insurers take the following steps to prevent, detect, and control fraud. These same steps are applicable to transit agencies in efforts to reduce fraudulent claims:

1. Adopt a clear and consistent policy on fraud. Do not overlook abusive billing statements. In the long run, it pays to examine and challenge every suspicious claim, no matter how seemingly insignificant. Insurers must prosecute fraud when it is uncovered, work closely with law-enforcement agencies, report fraud to state licensing boards, and take civil action to gain restitution. When presenting a case for prosecution, the insurer must make sure it is well documented, easily understood, and complete.
2. Centralize all fraud-detection efforts in a special unit to achieve coordination, integration, and communication. The people staffing these units must be highly trained and must work closely with other departments, especially the company's attorneys. It is important for an insurer to seek legal advice before launching a major fraud investigation and during its conduct.
3. Include strong anti-fraud messages in sales and marketing presentations. An insurer should include the addition of fraud statements in marketing materials, benefit brochures, and claim forms. Claims handlers must be trained to spot and flag suspicious claims for examination. They also must have a central place within the company to which they can refer claims and receive advice.
4. Use fraud statements on claim forms even when not required by state law. The use of the word fraud on the form can indicate the signer's knowledge and intent should that become necessary.
5. Institute strong internal controls, including computer systems that identify provider billing and practice patterns. These controls also must detect suspicious claims and monitor the claims examination process.
6. Create awareness, especially among an insurance company's top executives, about fraud and its effects on health care costs and quality.
7. Use the explanation of benefits to educate and motivate readers to spot and report suspicious claims and activities. The explanation of benefits must be explicit and easy to read, but because providers often make honest mistakes, the message should not be accusatory. The company's legal counsel should review all anti-fraud messages.
8. Become involved in fraud seminars, workshops, regional and local networks, and national associations.
9. Each of these steps can help insurers keep fraud under control, but the most important item to remember is that detection starts in the claims department. It is there that the problem is uncovered and the fight begins.
10. Education, hands-on training and experience are the keys to identifying, distinguishing, and using this information to combat fraud.

APPENDIX G

Networking Organizations

The Risk and Insurance Managers Society (RIMS)—RIMS is an international organization whose mission is "to advance the theory and practice of risk management through the following means:

- Promoting the awareness, understanding, and application of risk management.
- Developing the competency and influence of risk managers, thereby, positioning risk management as a discipline vital to the protection and utilization of human and financial resources."

RIMS has local chapters throughout the United States and Canada that meet monthly. The organization holds a regional and national annual conference and offers educational opportunities for risk management professionals (<http://www.propertyandcasualty.com/storefronts/rims.html>).

APTA Risk Management Committee—APTA is a nonprofit international association of over 1,200 member organizations including transit systems; planning, design, construction and finance firms; product and service providers; academic institutions; and state associations and departments of transportation. The overall mission of the organization is to provide safe, efficient, and economical transit services and products. According to APTA, over 90% of persons using public transportation in the United States and Canada are served by APTA members.

Specifically, APTA's Risk Management Committee brings together risk managers, safety managers, claims managers, insurance agents, and other interested parties from the membership to exchange information pertinent to those in the risk management field. Each year the Risk Management Committee sponsors a three-day seminar providing workshops on current risk management issues in the industry to the membership (<http://www.apta.com>).

Public Risk and Insurance Managers Association (PRIMA)—The mission of The Public Risk Management Association is to promote effective risk management in the public interest as an essential component of public administration. PRIMA is organized in local and national chapters and activities, with activities sponsored at both levels.

Among the goals of the organization are the following:

- To be the primary source of comprehensive, high-quality, relevant risk management information to help public servants improve the quality of life in their communities.
- To establish cooperative partnerships with other organizations to deliver services and products and to conduct activities for mutual benefit.
- To provide educational programs, publications, and information services to its membership (<http://www.primacentral.org/index.html>).

State and Local Organizations—In addition, similar organizations operate in specific states or regions, rather than at a national level. For example, risk managers in California can make use of fraud investigator's associations, as well as state organizations, such as the Public Agency Risk Managers Association (PARMA). PARMA was formed for the purpose of facilitating the exchange of ideas and innovative approaches toward risk management programs in governmental agencies. PARMA's primary goals are to provide a forum for communication among public agency risk managers and continuing professional education in the many challenges of public agency risk management.

The organization fills several roles:

- *Education and Training.* PARMA endeavors to ensure that risk management practitioners have ready access to relevant, up-to-date information needed to perform at a professional level.
- *Member Outreach.* PARMA provides a forum in which members are able to network and to receive education through participation in local, regional, and statewide programs.
- *Industry Relationships.* PARMA strives to maintain mutually beneficial relationships with associate members and other organizations.
- *Public Relations.* Finally, the association works to increase the visibility and awareness of the value of the risk management function in public agencies (<http://www.parma.com>).

THE TRANSPORTATION RESEARCH BOARD is a unit of the National Research Council, a private, nonprofit institution that provides independent advice on scientific and technical issues under a congressional charter. The Research Council is the principal operating arm of the National Academy of Sciences and the National Academy of Engineering.

The mission of the Transportation Research Board is to promote innovation and progress in transportation by stimulating and conducting research, facilitating the dissemination of information, and encouraging the implementation of research findings. The Board's varied activities annually draw on approximately 4,000 engineers, scientists, and other transportation researchers and practitioners from the public and private sectors and academia, all of whom contribute their expertise in the public interest. The program is supported by state transportation departments, federal agencies including the component administrations of the U.S. Department of Transportation, and other organizations and individuals interested in the development of transportation.

The National Academy of Sciences is a nonprofit, self-perpetuating society of distinguished scholars engaged in scientific and engineering research, dedicated to the furtherance of science and technology and to their use for the general welfare. Upon the authority of the charter granted to it by the Congress in 1863, the Academy has a mandate that requires it to advise the federal government on scientific and technical matters. Dr. Bruce Alberts is president of the National Academy of Sciences.

The National Academy of Engineering was established in 1964, under the charter of the National Academy of Sciences, as a parallel organization of outstanding engineers. It is autonomous in its administration and in the selection of its members, sharing with the National Academy of Sciences the responsibility for advising the federal government. The National Academy of Engineering also sponsors engineering programs aimed at meeting national needs, encouraging education and research, and recognizes the superior achievements of engineers. Dr. William A. Wulf is president of the National Academy of Engineering.

The Institute of Medicine was established in 1970 by the National Academy of Sciences to secure the services of eminent members of appropriate professions in the examination of policy matters pertaining to the health of the public. The Institute acts under the responsibility given to the National Academy of Sciences, by its congressional charter to be an adviser to the federal government and, upon its own initiative, to identify issues of medical care, research, and education. Dr. Kenneth I. Shine is president of the Institute of Medicine.

The National Research Council was organized by the National Academy of Sciences in 1916 to associate the broad community of science and technology with the Academy's purposes of furthering knowledge and advising the federal government. Functioning in accordance with general policies determined by the Academy, the Council has become the principal operating agency of both the National Academy of Sciences and the National Academy of Engineering in providing services to the government, the public, and the scientific and engineering communities. The Council is administered jointly by both Academies and the Institute of Medicine. Dr. Bruce Alberts and Dr. William A. Wulf are chairman and vice chairman, respectively, of the National Research Council.