Legislative Oversight
Ad Hoc Committee to Study Insurance Fraud
Wednesday, October 25, 2023

Contents

AGENDA

South Carolina
House of Representatives
Legislative Oversight Committee

Ad Hoc Committee to Study Insurance Fraud

Chairman Jeffrey E. "Jeff" Johnson

The Honorable William H. Bailey
The Honorable William M. "Bill" Hixon
The Honorable April Cromer
The Honorable Russell L. Ott
The Honorable Roger K. Kirby
The Honorable Marvin "Mark" Smith

AGENDA

Wednesday, October 25, 2023

10:30 a.m.
Room 110 - Blatt Building

Pursuant to Committee Rule 4.7, S.C. ETV shall be allowed access for internet streaming whenever technologically feasible.

AGENDA

I. Discussion of insurance fraud:
- South Carolina Department of Insurance
- Office of the Attorney General
- South Carolina State Law Enforcement Division

II. Adjournment

FRAUD SNAPSHOT

South Carolina Insurance Fraud Information

What is Insurance Fraud?

- Insurance fraud occurs when an insurance company, agent, adjuster, or consumer commits a deliberate deception to obtain an illegitimate gain. It can occur during the process of buying, using, selling, or underwriting insurance.
- Insurance fraud drains SC's systems, wastes resources, and raises premiums for all SC citizens

SC Agencies involved in investigating Insurance Fraud

- Department of Insurance
- State Law Enforcement Division (SLED)
- Attorney General's Office
- Workers' Compensation Commission
- State Accident Fund
- Department of Consumer Affairs
- Department of Disabilities and Special Needs
- Department of Health and Human Services
- Department of Employment and Workforce

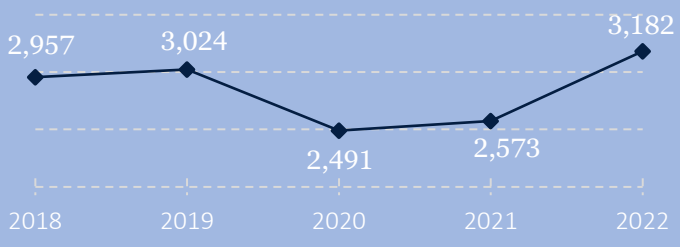
Number of Convictions from 2018 – 2022: 129

Amount of Restitution ordered from 2018 – 2022:

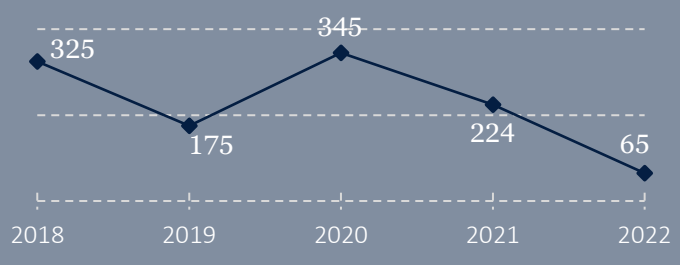
$817,197.68

Data taken from the Annual Insurance Fraud reports from 2018 – 2022.

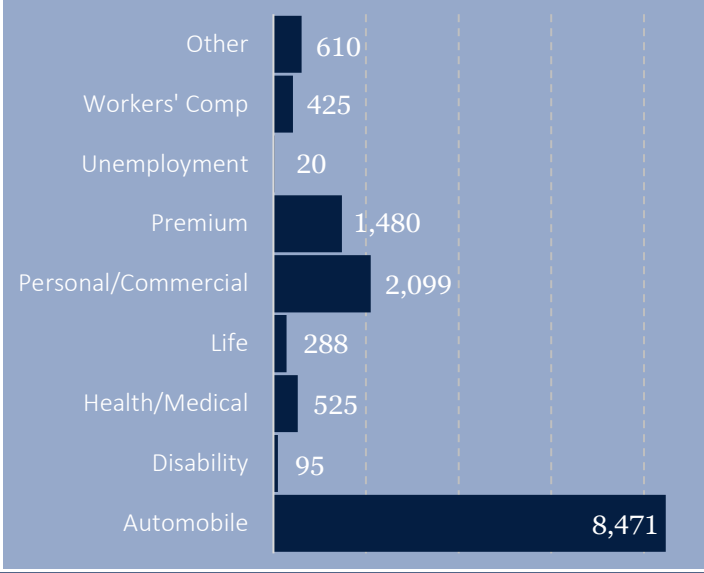
Complaints of Suspected Insurance Fraud received from 2018 - 2022



Complaints under Investigation by SLED from 2018 - 2022



Total Complaints per type of Insurance Fraud received from 2018 - 2022



House Legislative Oversight Committee

AGENCY PRESENTATIONS

DEPARTMENT OF INSURANCE

INSURANCE FRAUD: THEN, NOW, & WHAT'S TO COME

Director Michael Wise – Department of Insurance

&

Joshua Underwood – Director of the Insurance Fraud Division

[SC House of Representatives Legislative Oversight Committee:

Ad Hoc Committee to Study Insurance Fraud]

October 25, 2023

THE COST OF INSURANCE FRAUD

- A 2022 study conducted by the Colorado State University Global White Collar Task Force, in partnership with the Coalition Against Insurance Fraud estimates that the annual cost of insurance fraud in the U.S. is **$308 BILLION**.

- Total cost of insurance fraud in America: $308,000,000.000.00 ($308 billion)
  Total U.S. population: 333,287,557
  South Carolina population: 5,300,000
  Percentage of U.S. population living in SC: 1.6%
  1.6% of $308 billion equals: $4,928,000,000.00 ($4.928 billion)

- The cost of insurance fraud each year for every living South Carolina resident (regardless of their age) equates to approximately $930 per year.

- For SC adults over the age of 18 (according to the U.S. Census that number would be 4,162,716 people) the cost per adult resident for insurance fraud is approximately $1,184 every year, or $2,368 for each couple.

HIGHLIGHTS FROM THE INSURANCE FRAUD DIVISION'S ANNUAL REPORT FOR 2022

2022 Annual Report Summary

- In 2022, the Insurance Fraud Division received a record-breaking 3,182 complaints.

- 1,653 complaints were declined without SLED investigation

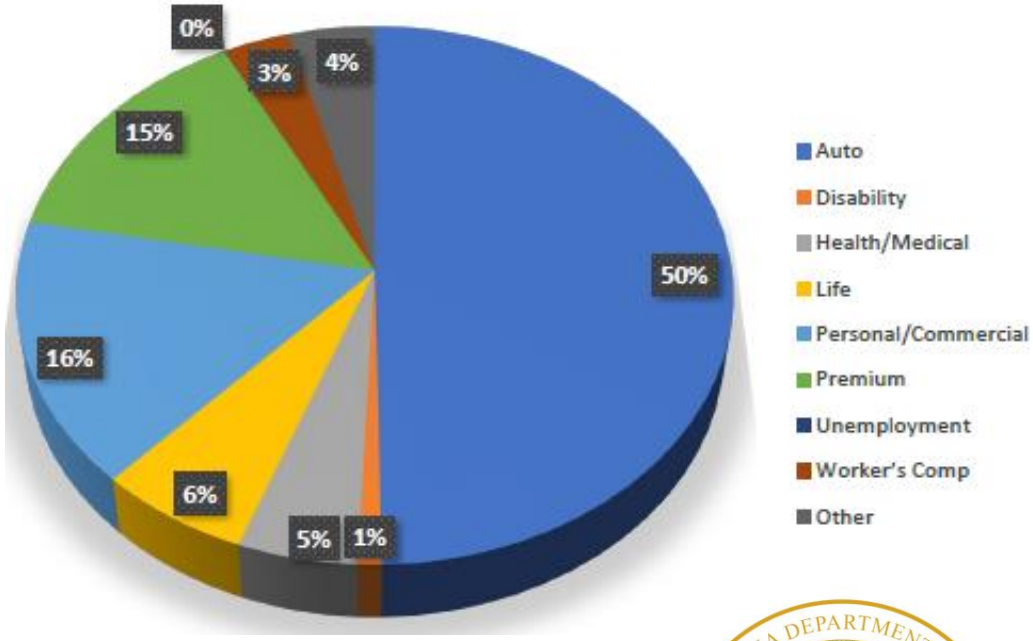
- 1,914 matters pending review, investigation, or prosecution were rolled over into 2023.

2022 Annual Report Summary Disposition of Cases

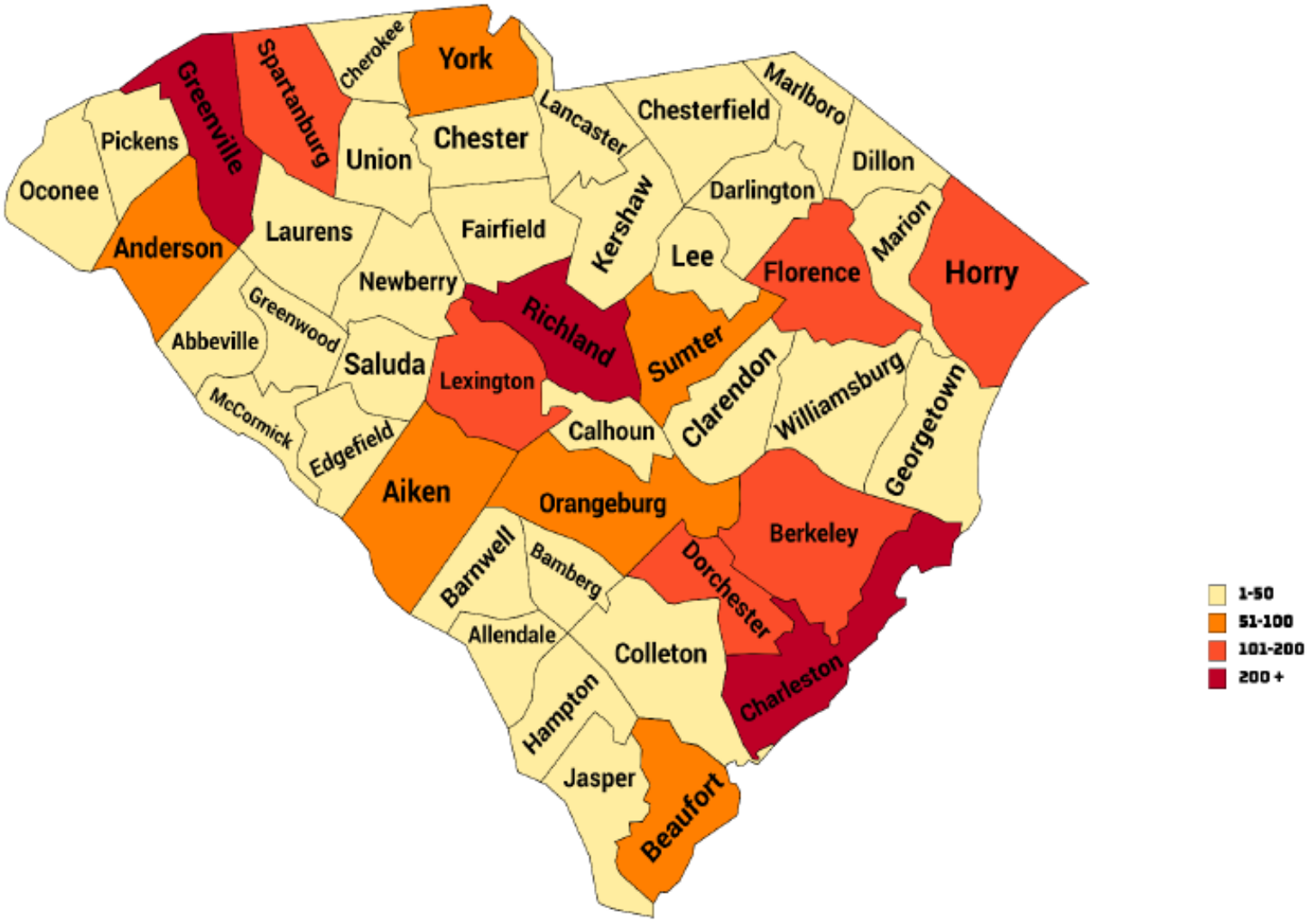
- One case was resolved with a civil fine
- 12 cases were resolved by guilty pleas across 9 counties
- Restitution was ordered in 5 of those cases for a total of $22,234.66

Complaints by Type of Fraud in 2022

TYPE OF FRAUD	NUMBER OF COMPLAINTS	PERCENTAGE OF TOTAL
Auto	1589	50%
Disability	33	1%
Health/Medical	143	5%
Life	202	6%
Personal/Commercial	511	16%
Premium	463	15%
Unemployment	1	.03%
Worker's Comp	104	3%
Other	136	4%
TOTAL	**3182**	



Complaints by County in 2022



Establishment of the Insurance Fraud Division Per the Statute

- Section 38-55-560

  (A) There is established in the Office of the Attorney General a division to be known as the Insurance Fraud Division, which must prosecute violations of Sections 38-55-170 and 38-55-540 and related criminal insurance activity. Upon receipt of any claims or allegations of violations of Section 38-55-170 and 38-55-540 and related criminal insurance activity, the Attorney General shall forward the information to the State Law Enforcement Division for investigation.

  (C) The State Law Enforcement Division shall investigate thoroughly all claims or allegations of violations of Sections 38-55-170 and 38-55-540 and related criminal insurance activity received from the Attorney General pursuant to this section.

Establishment of the Insurance Fraud Division Per Agreement

- In June 2021, the Attorney General, the Department of Insurance, and SLED entered a Memorandum of Understanding to physically relocate the Insurance Fraud Division to the Department of Insurance.

- The agreement continues indefinitely. The intent has been for statutory changes to eventually replace the MOU.

- Fines collected pursuant to the Omnibus Insurance Fraud and Reporting Immunity Act are to be collected and retained by the Department of Insurance.

Responsibilities of the Attorney General's Office per the MOU

- The Attorney General's Office delegates its authority granted by Section 38-55-560 to the Department of Insurance.
- The MOU does not prevent the Attorney General's Office from investigating and prosecuting criminal insurance activity or fraud.
- The Attorney General's Office shall review and approve cases presented by the DOI for indictment.
- The Attorney General's Office shall designate attorneys hired by DOI as Special Assistant Attorneys General to prosecute insurance fraud related cases.
- The Attorney General's Office shall assist with prosecution of insurance fraud cases as it deems necessary and appropriate.

General Responsibilities of the Department of Insurance – Insurance Fraud Division

- Investigate and prosecute suspected cases of insurance fraud
- Secure funding and FTEs to employ and designate personnel pursuant to Section 38-55-560
- Provide secure office space and equipment for the Insurance Fraud Division and SLED personnel for the investigation of insurance fraud
- Review insurance fraud complaints and refer to SLED for investigation as appropriate
- Present indictments to the Attorney General for approval and signature
- Annually track, analyze, and report progress of the identification, prosecution, and prevention of insurance fraud
- DOI will reimburse SLED for services rendered in investigating insurance fraud

Responsibilities of SLED

- Review all referrals, claims, or allegations of insurance fraud activity referred by the Attorney General's Office or the Department of Insurance
- Subject to resources, assign a minimum of 5 investigators to investigate insurance fraud related cases
- Coordinate with and assist any prosecutorial authority, as needed, to investigate any case referred pursuant to the MOU

THE INVESTIGATION & PROSECUTION OF INSURANCE FRAUD:

HOW WE OPERATE ON A DAY TO DAY BASIS

COMPLAINT PROCESSING

- Insurance Fraud Coordinator receives daily complaints from the industry, consumers, and other agencies and enters them into case management system
- Assigned prosecutor reviews the complaints and decides to decline further action, send to SLED for investigation, request claim file or other information before final decision, pursue other remedies, etc.
- IF Coordinator then sends a Decline Letter, Request for Information, or opens a case to SLED as appropriate

INSURANCE FRAUD INVESTIGATION

- When a prosecutor decides to refer a case to SLED, the IF Coordinator will send a request to the appropriate SLED supervisor and deliver all of the case materials.
- The case is then assigned to an agent, usually based on region.
- The agents are provided with office space within the Insurance Fraud Division suite to facilitate collaboration between the agents and assigned prosecutors, ultimately resulting in better cases.
- At the conclusion of an investigation, the agent and prosecutor confer to reach a charging decision.

INSURANCE FRAUD PROSECUTION

- Following an arrest, the Attorney General's Office, Clerk of Court, Solicitor, and Public Defender are notified which prosecutor is handling the case.
- An indictment is prepared and submitted to the Attorney General's Office for review and approval with a signature from the AG.
- The Insurance Fraud Division then prosecutes the case in the same manner as other general prosecution cases handled by the Attorney General's Office.

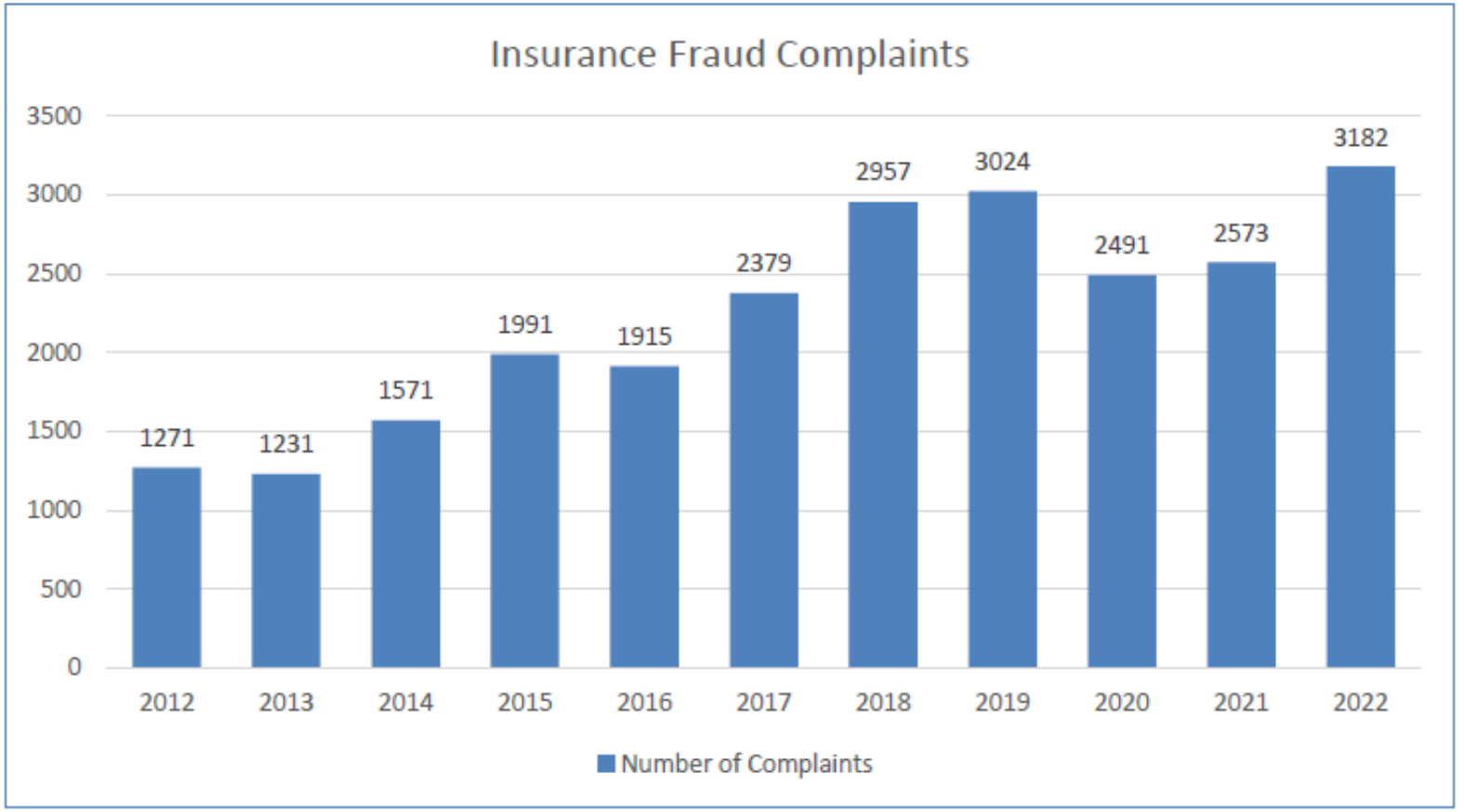
INTERAGENCY COOPERATION

- AG, SLED, DOI
- National Insurance Crime Bureau (NICB)
- Insurance Industry Organizations
- Other State Agencies
- Local Law Enforcement
- Solicitors' Offices

MATTERS OF CONCERN

(AND SOME POTENTIAL SOLUTIONS)

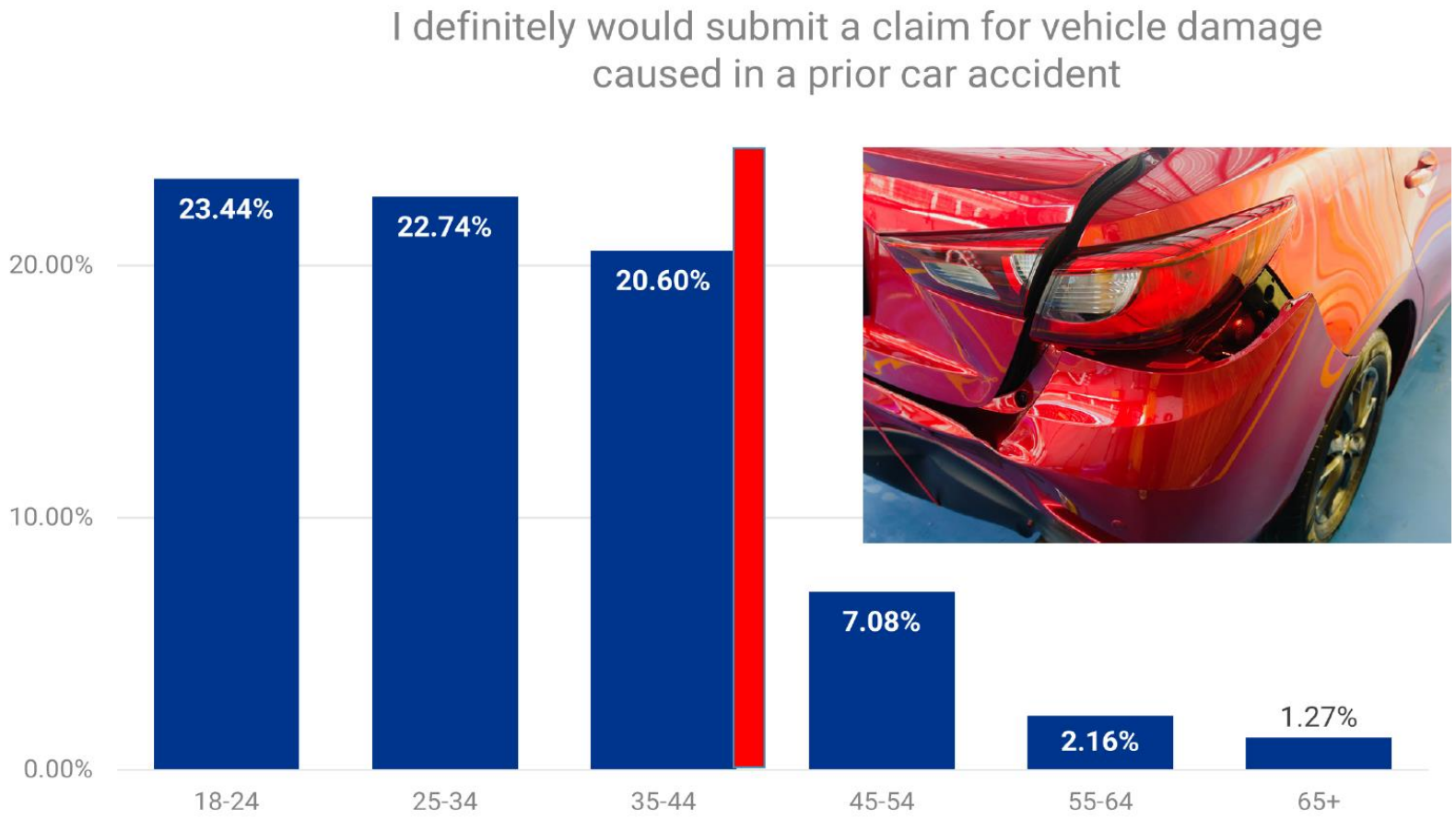
INSURANCE FRAUD IS ON THE RISE



INSURANCE FRAUD IS ON THE RISE

- The 3,182 complaints received in 2022 set a record high
- This year we have received **3,061** complaints as of October 17, 2023
- The survey/study entitled “Who Me?”: Who Commits Insurance Fraud and Why indicates trouble ahead
  - Study conducted by the Coalition Against Insurance Fraud and Verisk
  - Surveyed more than 1,500 consumers matching 2020 Census demographics

THE AMOUNT OF FRAUD IS LIKELY TO INCREASE SIGNIFICANTLY



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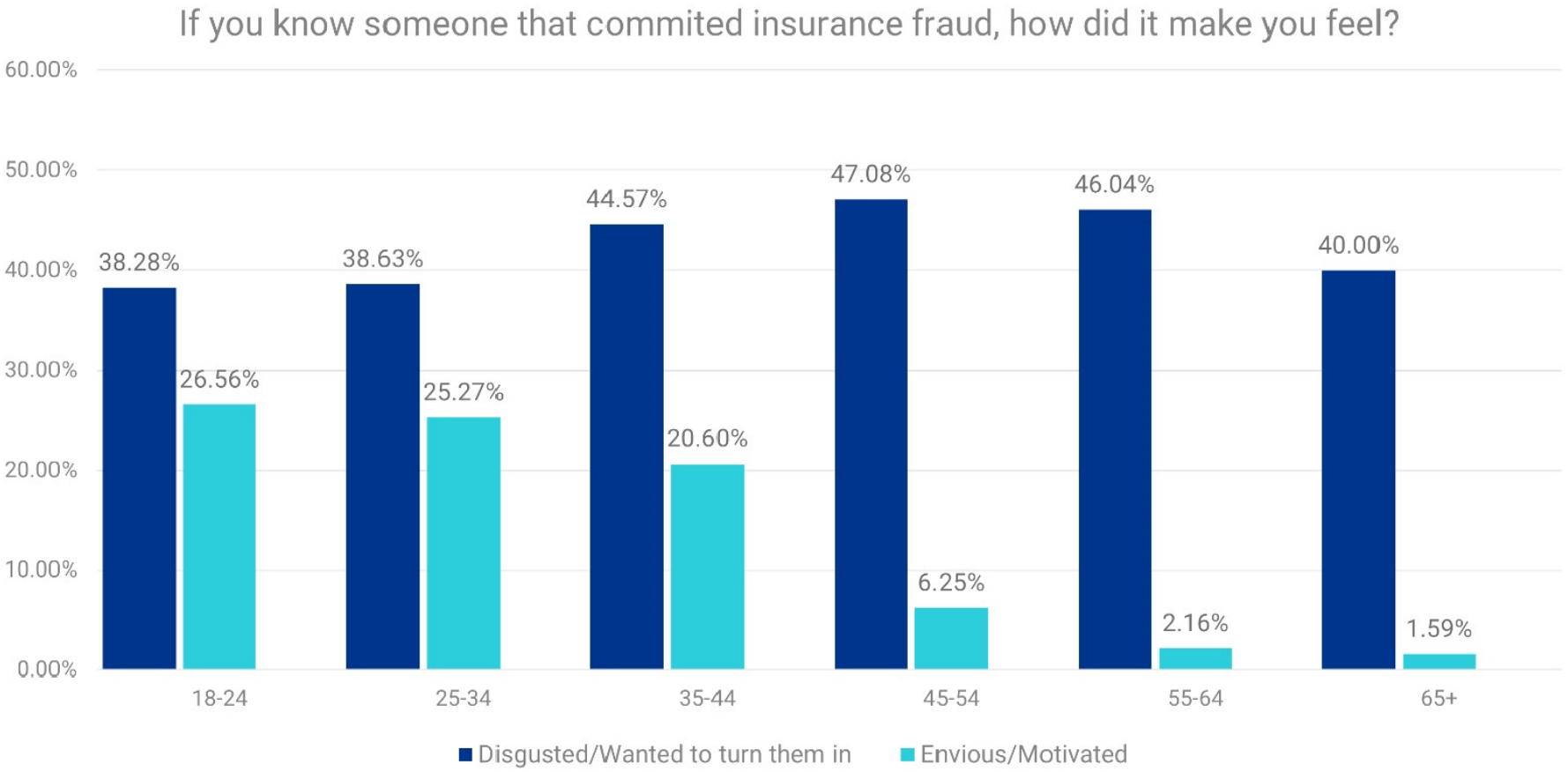

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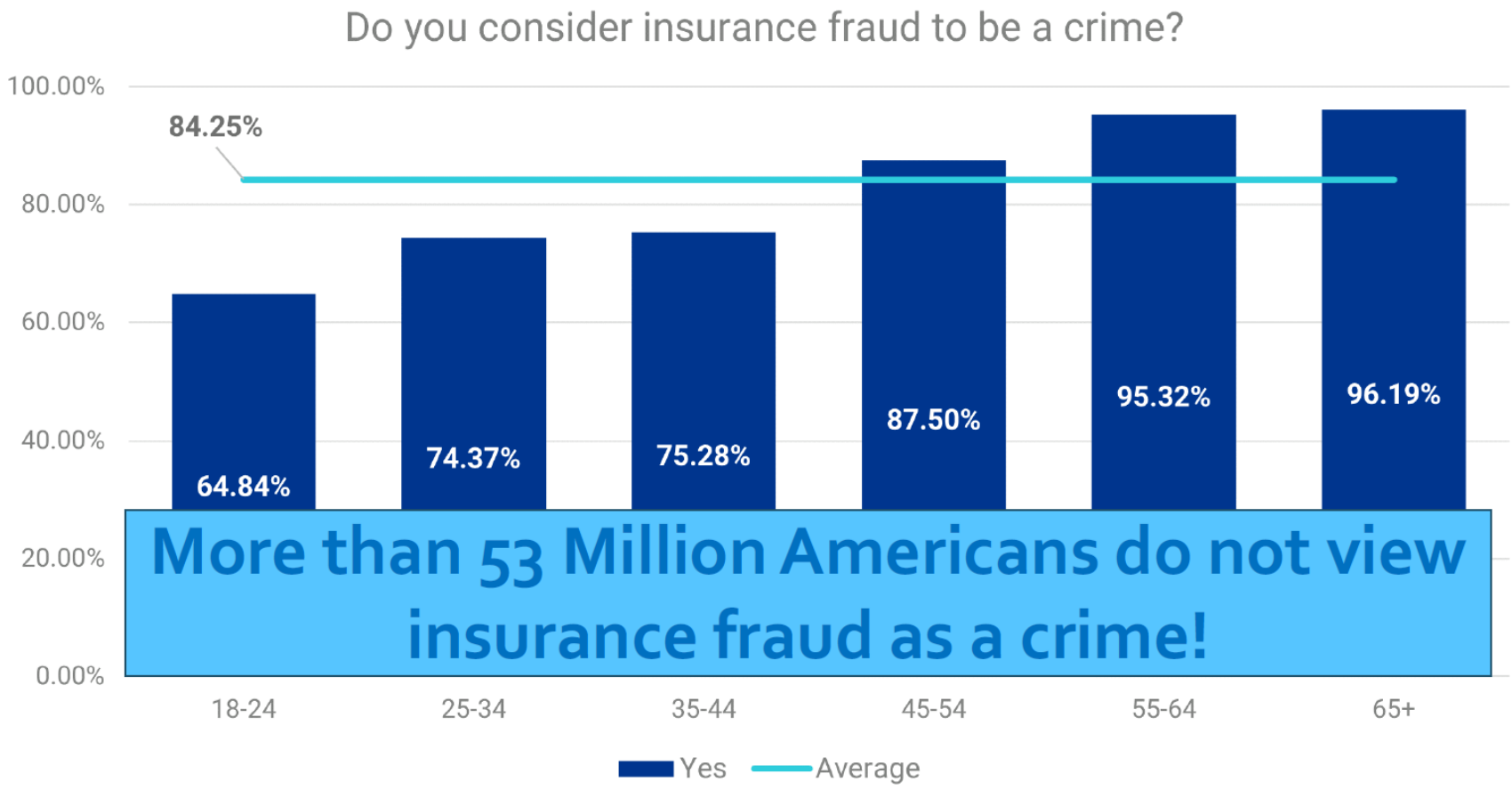

PERSONNEL NUMBERS HAVE FALLEN BEHIND

Insurance Fraud Division in 2009

- 1 Director
- 4 Attorneys
- 3 AG Support Staff
- 1 SLED Lt.
- 4 SLED Agents
- 1 Assistant Assigned for SLED Lt.
- **834 Complaints**

Insurance Fraud Division in 2022

- 1 Director
- 4 Attorneys
- 3 DOI Support Staff
- 1 SLED Lt.
- 5 SLED Agents
- No Admin Assistant for SLED Lt.
- **3,182 Complaints**

METRICS & STATISTICS

- Lack of consistency and clarity in metrics and statistics
  - Changes to the way we track types of fraud vs schemes (2023 & 2024)
  - What is the exact dollar amount of fraud in SC? No one really knows.
    - Claims are often not flagged for fraud, so the suspect gets away with it and we never know about it.
    - Many complaints do not contain enough information to determine a dollar amount.
  - Tracking complaints, investigations, cases, etc. across multiple agencies causes some confusion.
    - Hopefully new case management systems at DOI and SLED will reduce some of the statistical and managerial confusion.
    - Continuous collaboration between agencies is essential.

ACCESS TO IMPORTANT DATABASE TOOLS: "Originating Agency Identifier" (ORI Number)

- Insurance Fraud Division does NOT have an ORI Number
- This number is needed for direct access to important information
  - Criminal Histories
  - Insurance Claim Histories & Related Information

NATIONAL CRIME INFORMATION CENTER

ISO ClaimSearch

THE MOU IS A TEMPORARY SOLUTION

- 90 DAYS
- ORI Number approval???
- Future funding concerns
- Collection of Fines & Court Administration

FUTURE NEEDS & GOALS

- Statutory solutions
- Additional staff for SLED and DOI
- Increase capacity for proactive vs. reactive investigations
- Increase public awareness about insurance fraud
- Increase efforts for deterrence

QUESTIONS ????

SOUTH CAROLINA ATTORNEY GENERAL'S OFFICE

Medicaid Fraud Control Unit

House Legislative Oversight Committee

Ad Hoc Committee to Study Insurance Fraud

South Carolina Attorney General's Office
Stephanie G. Opet, Director, MFCU
Brandon Steen, AAG, MFCU

MFCU Role

Mission

1. The Unit conducts a statewide program for the investigation and prosecution of health care **providers who defraud the Medicaid program**.
2. The Unit reviews complaints of **abuse and neglect** involving patients in health care facilities receiving Medicaid funding; in non-Medicaid board and care facilities; and of Medicaid beneficiaries in a residential setting. This includes investigating and prosecuting drug diversion complaints.
3. The Unit is also charged with investigating **fraud in the administration** of the Medicaid program.

MFCU Role

The Beginning

- In mid-1970s, New York Governor and Attorney General appointed Special Prosecutor to investigate nursing home industry
- Funds intended for patient care diverted by owners/operators for personal goods and benefit
- Resulted in horrendous cases of patient abuse and neglect

MFCU Role

The Beginning

- Special Prosecutor used multidisciplinary or "strike force" approach
  - Attorneys
  - Investigators
  - Auditors
- Team of auditors conducted initial audit that generated leads for investigators
- Investigators followed leads under direction of experienced attorney

MFCU Role

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Creation of MFCUs

- Local and federal prosecutors overworked, understaffed, under financed lacked experience with these complex, sophisticated white-collar crimes
- Investigations long and tedious process
- Highly trained professionals working full-time are required
- Joe Hynes, first NY Special Prosecutor, testified before Congress that federal enforcement structure and incentive funding be provided

MFCU Role

Federal Statute and Regulations

- MFCUs defined by federal statute – 42 USC 1396b(q) federal regulations
- Federal regulations – 42 CFR Part 1007 recently revised, effective May 31, 2019, clarifies the definition of a MFCU

MFCU Role

What is a Medicaid Fraud Control Unit?

- Federal law requires each state to have a MFCU. 42 C.F.R. Part 1007
- Single identifiable entity of state government, annually certified by the U.S. Department of Health and Human Services
- Authority to conduct a statewide investigation and prosecution of health care providers who defraud the Medicaid program
- South Carolina's MFCU is housed in the Office of the Attorney General

MFCU Role

Unit Organization

A full-time "task force" concept made up of:

- Investigators
- Auditors
- Attorneys

- S.C.'s MFCU began Operation in 1995
  - Current Staff
    - Director
    - Four Prosecutors
    - Eleven Investigators, inc
      - Pharmacist Investigator
      - Nurse Investigator
    - Two Auditors
    - Two Support Staff

MFCU Role

Provider Fraud

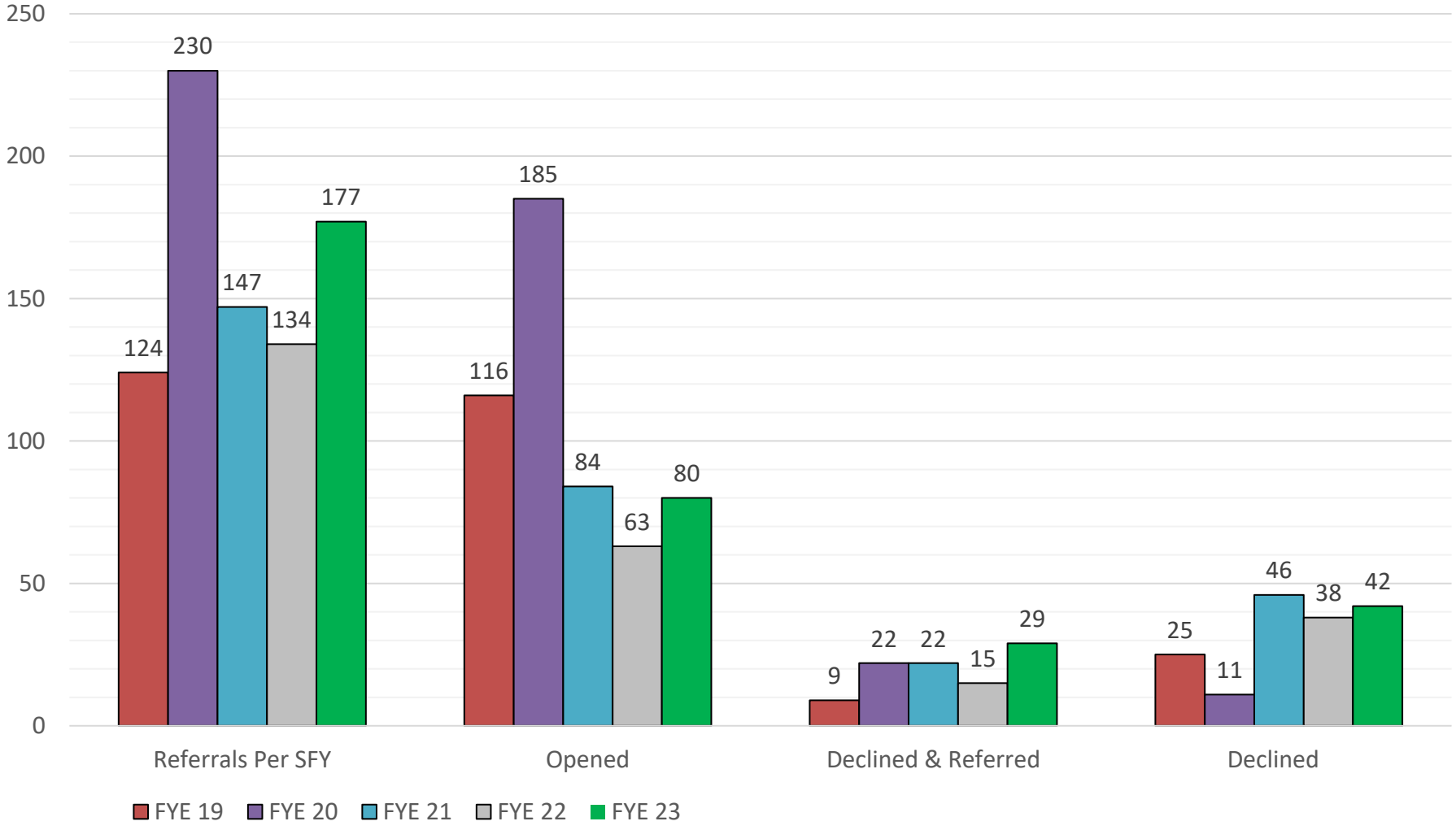
- A "Provider" is any person who provides goods, services or assistance and who is entitled or claims to be entitled to receive reimbursement, payment or benefits under the state's Medicaid program. Provider also includes a person acting as an employee, representative or agent of the provider. S.C. Code Ann. Section 43-7-60
- "Provider Fraud" is lying, cheating and stealing by a Provider involving the Medicaid Program.

MFCU Role

Patient Abuse

- Abuse, neglect, and exploitation of vulnerable adults
- All residents of a LTC facility are Vulnerable Adults under SC law
- Medicaid beneficiaries in a residential setting are also included in MFCU jurisdiction

SFY Referrals Received *Medicaid Provider Fraud*



FFY 2023 Referrals

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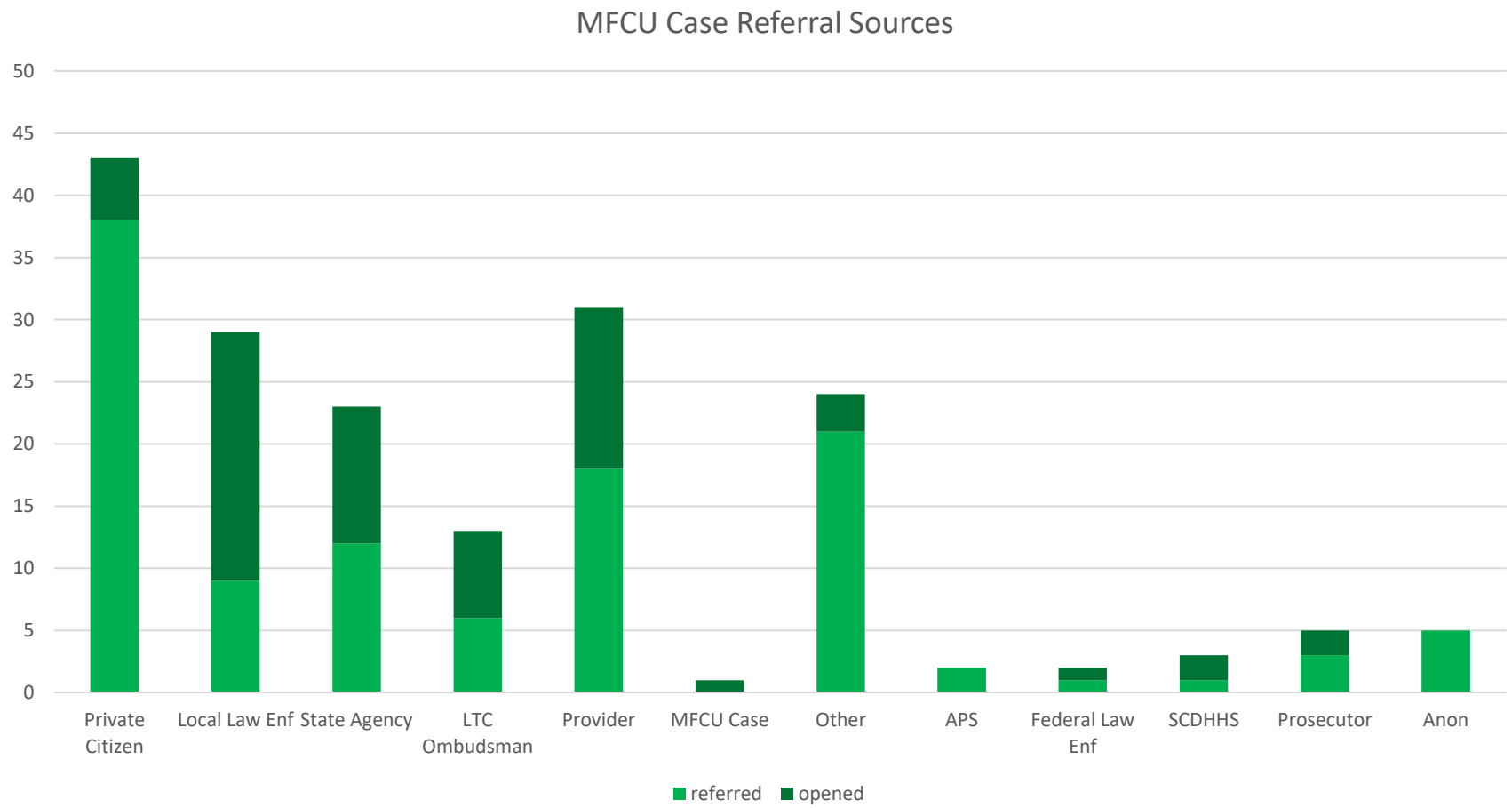
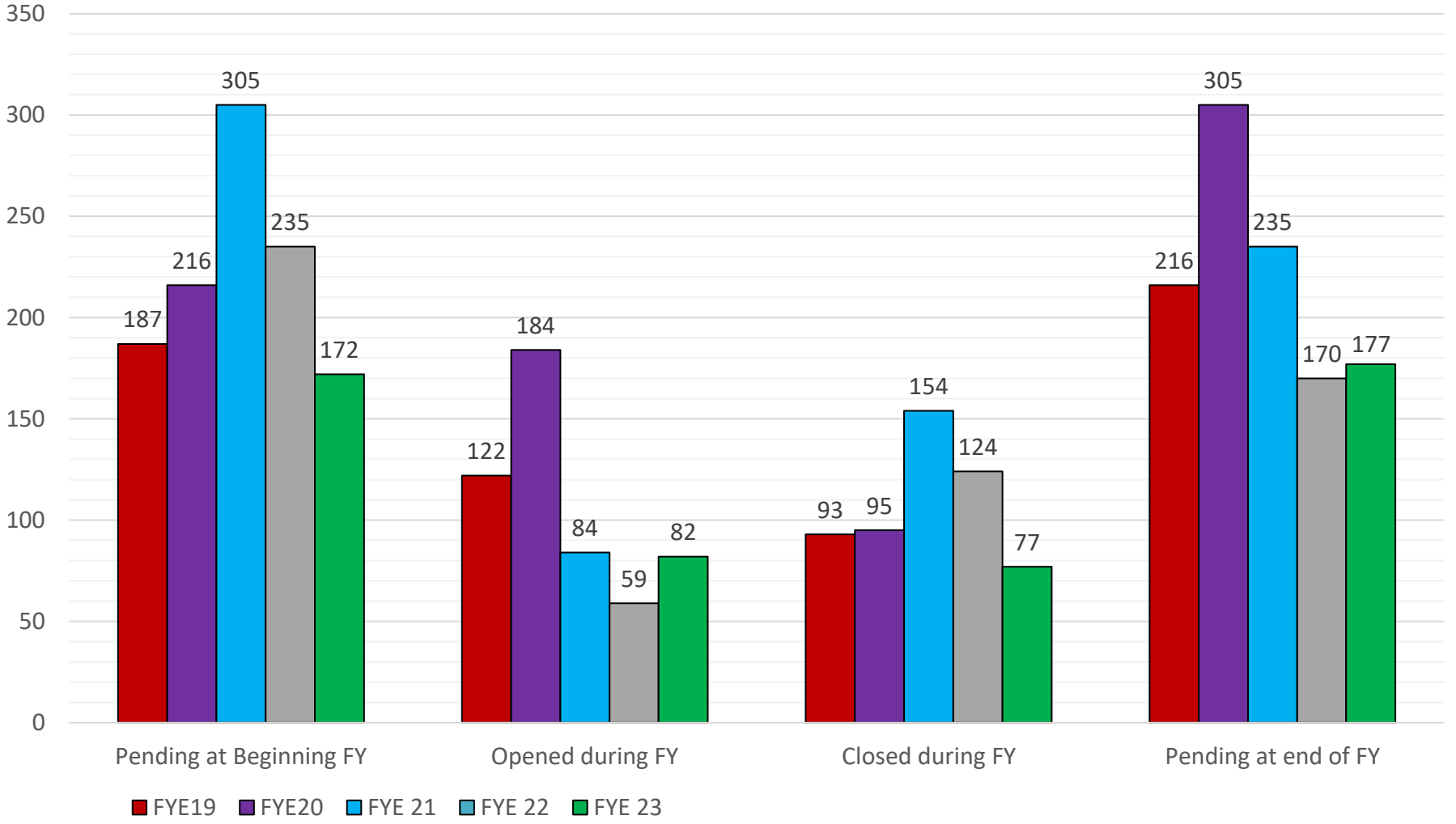


SFY 5 Year Trajectory – *Medicaid Provider Fraud*



FFY 2023 Case Breakdown

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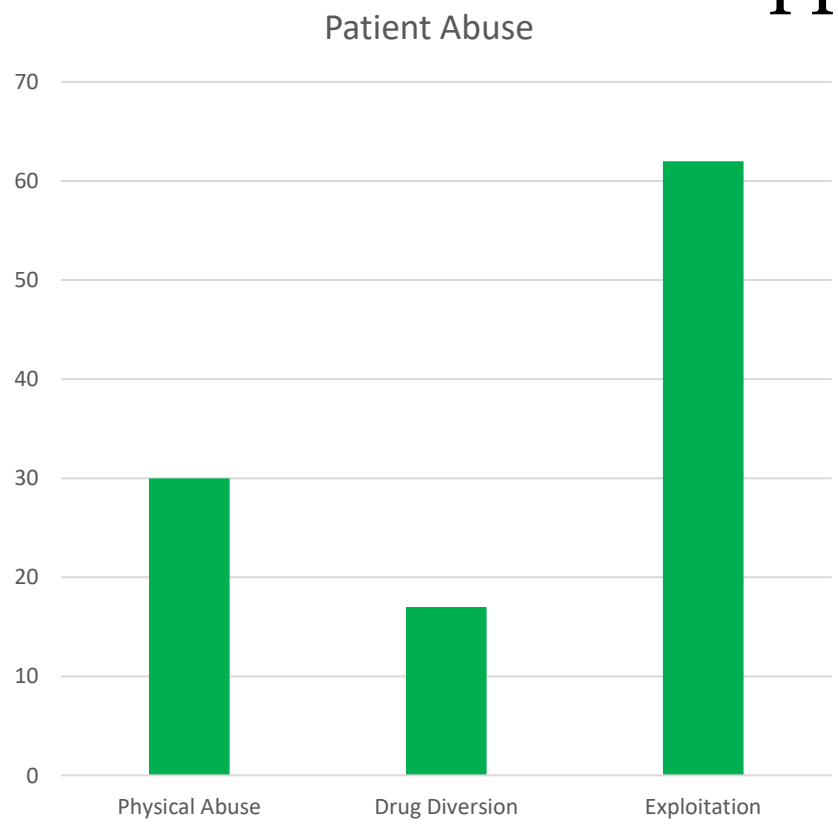
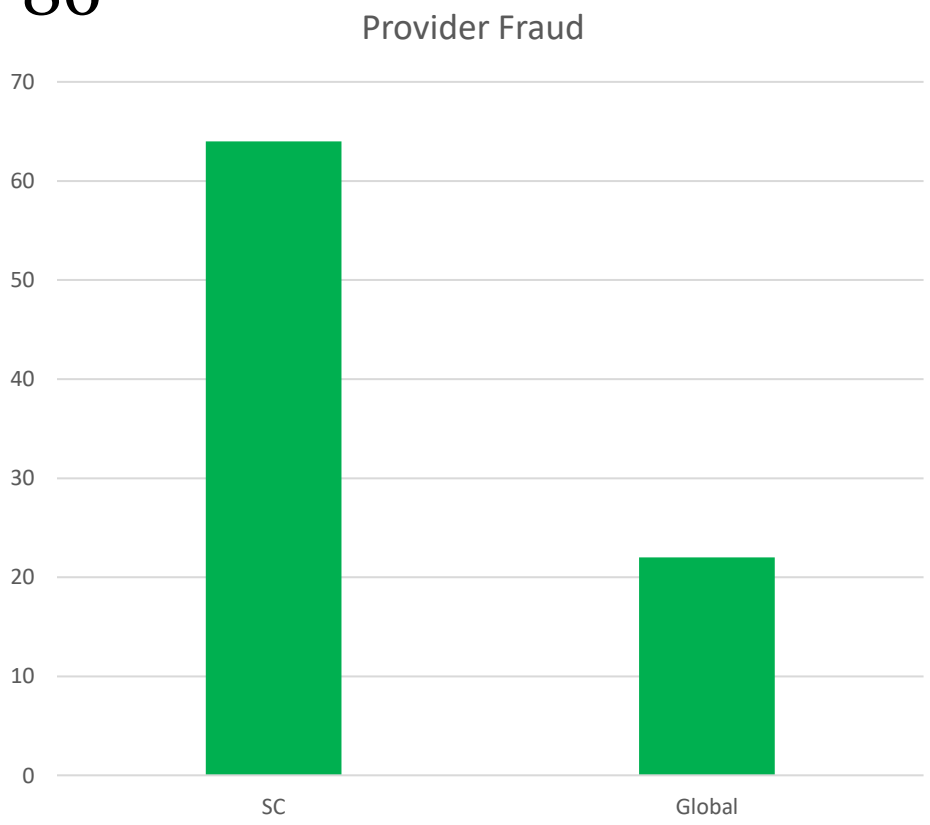
Total Number of open cases: 195

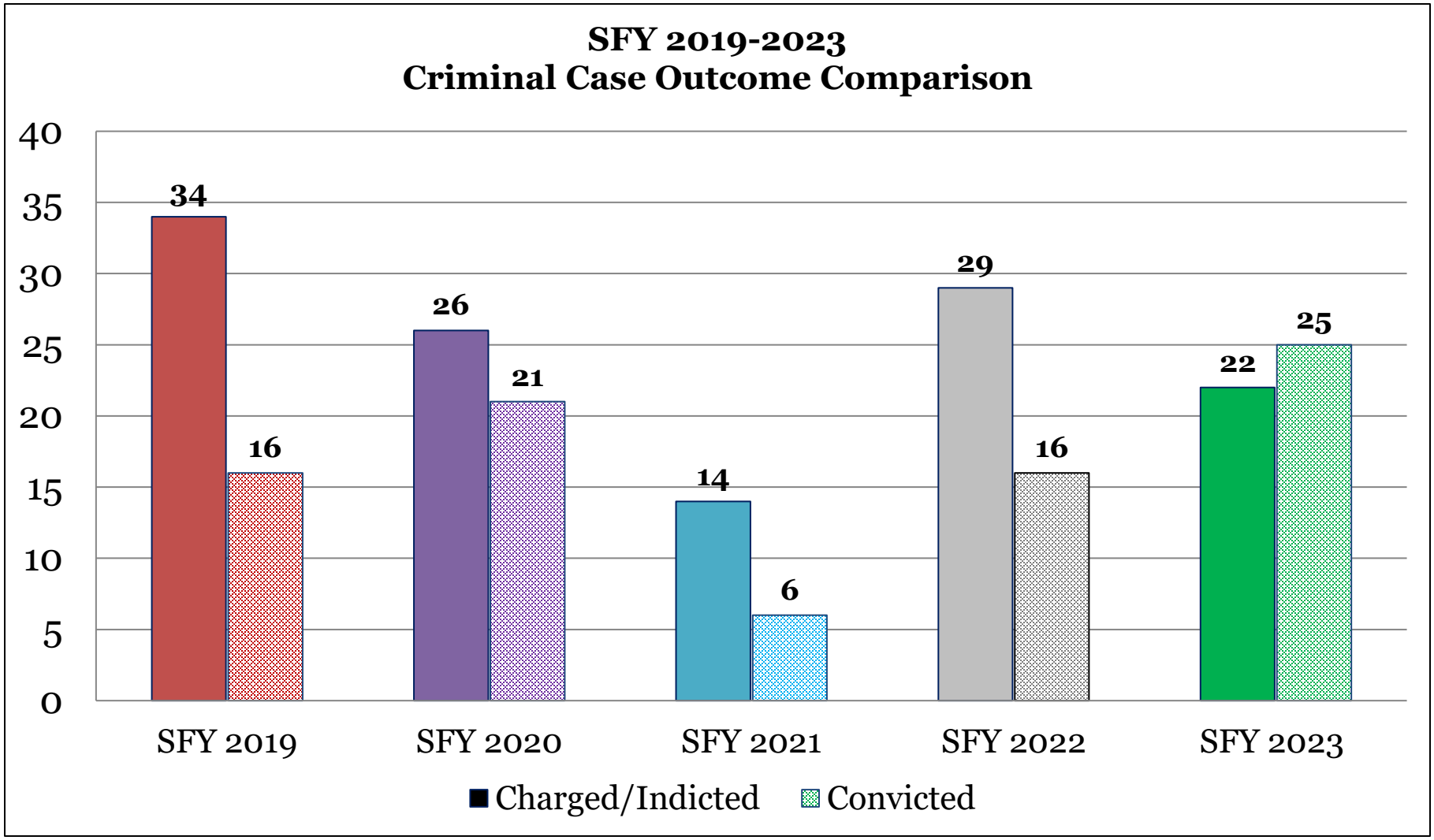
PA: 109

PF: 86





Five Year Trajectory

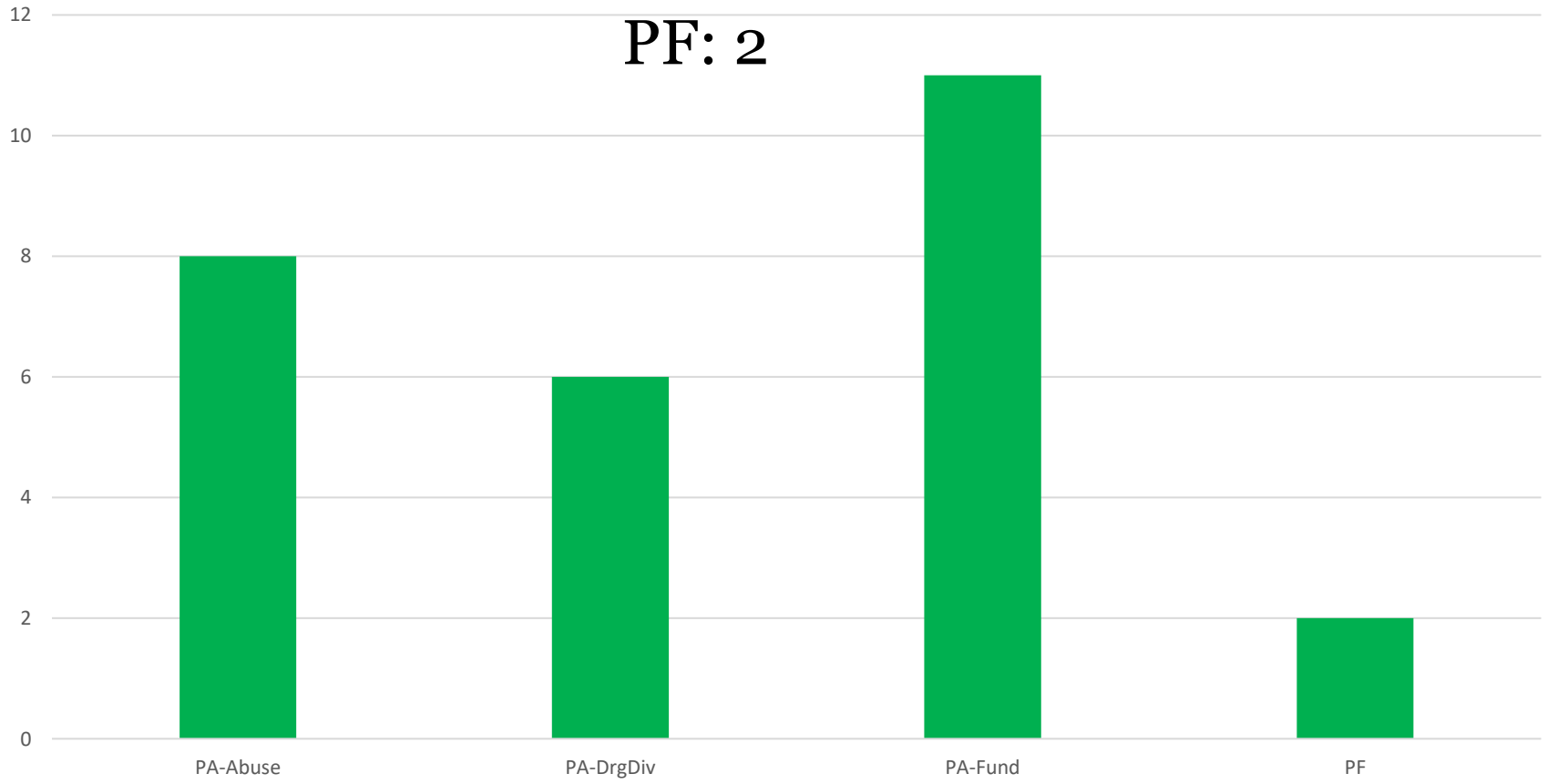


FFY 2023 Arrests

Total Number of Arrests: 27

PA: 25

PF: 2



FFY 2023 Convictions

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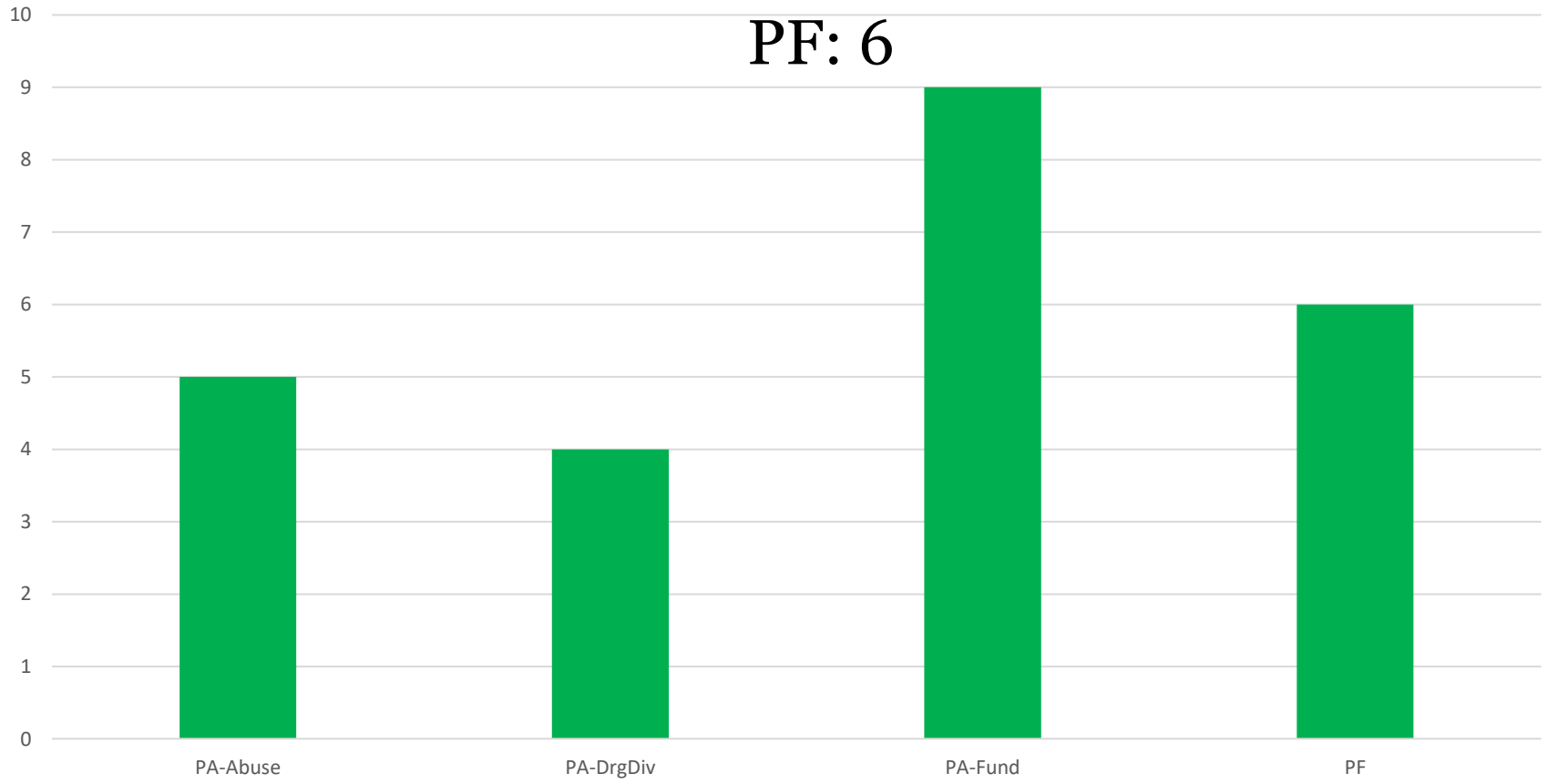
Total Number of Convictions: 24

PA: 18

PF: 6



Five Year Trajectory

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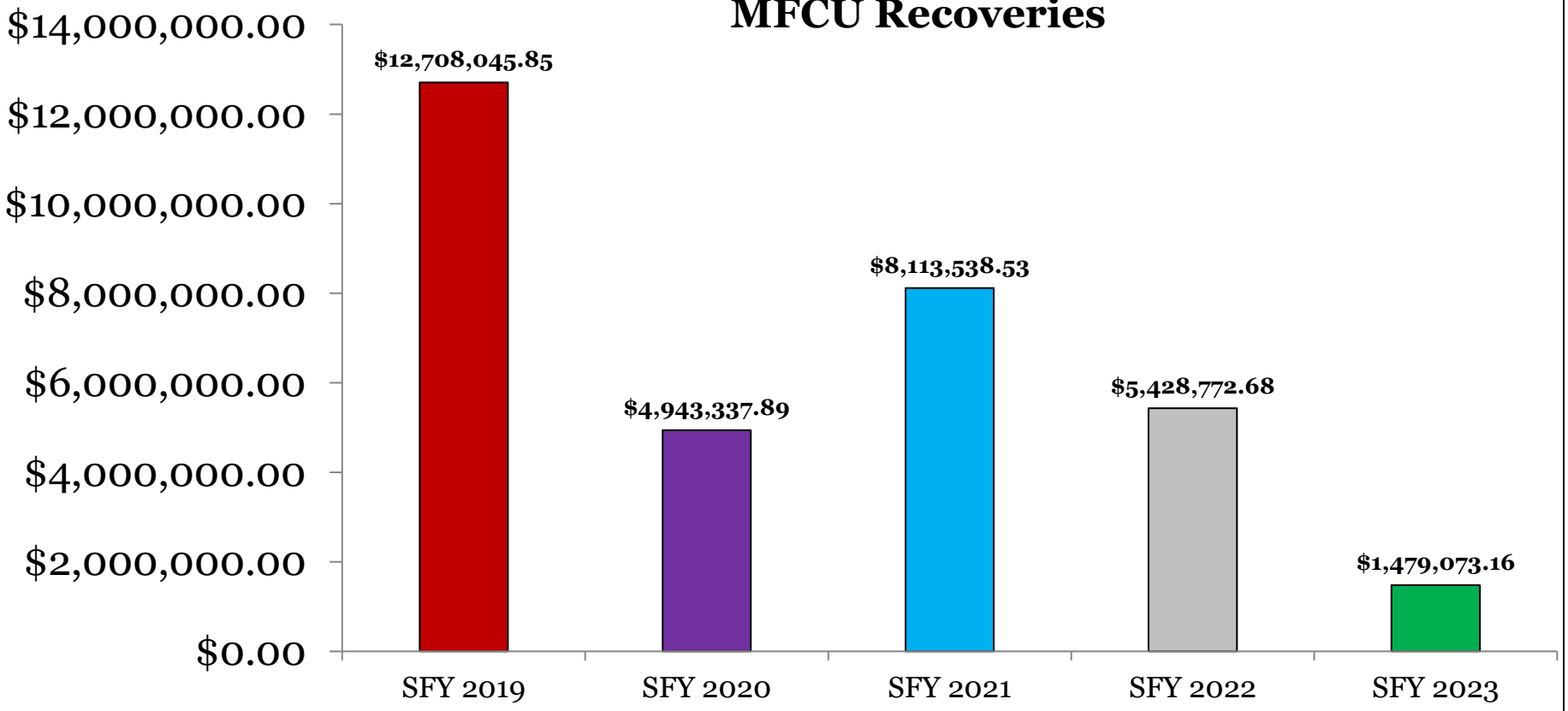

Return on Investment

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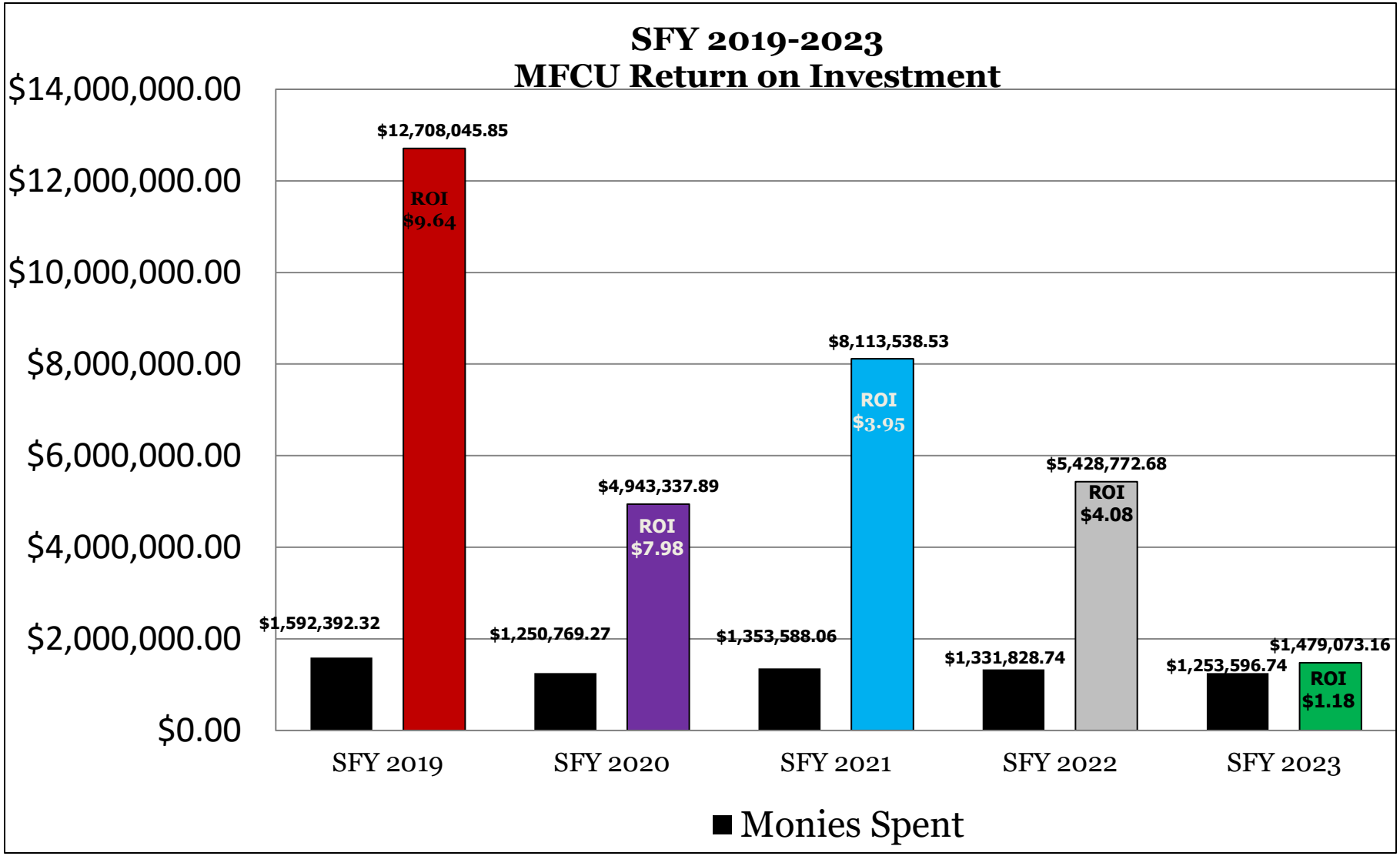

State Agency Cooperation

- **Memorandum of Understanding with SCDHHS**
  - **Must be reviewed every 5 years**
  - **Establishes procedures for coordination**
  - **Establishes regular meetings or communication**
  - **Procedure for referrals of potential fraud from Managed Care Organizations (MCOs)**
  - **Must include process for credible allegations of fraud and payment suspension**
  - **Must include written notification by Unit to Medicaid agency about referral**

State Agency Cooperation

- **Working on Memorandum of Understandings**
  - State Law Enforcement Division
  - Department of Health & Environment Control
    - Residential Care & Nursing Facilities
    - Drug Diversion
- **Improving Cooperation**
  - Department on Aging (Long Term Care Ombudsman)
  - Department of Social Services (Adult Protective Services)
  - Department of Labor, Licensing & Regulation (Provider Boards)

State Agency Cooperation

- **Example: Oakridge**
  - SCDHEC – licensing
  - SCDSS – placement
  - LTC Ombudsman – continuity of care
  - SCDHHS – payor
  - Spartanburg County Sheriff's Dept – local law enforcement responder
  - Fire Marshall

Legislative Requests – Provider Fraud

LOC Page 60

- **§43-7-60 Medical Assistance Provider Fraud**
- **Needs Tiered Penalties**
  - Current Criminal Penalty is only a 3 Year Misdemeanor **No Matter the Amount of Fraud** on the Medicaid Program & Taxpayers
  - Penalties Should be Tiered Similar to Other Property Crime Statues
  - Similar to South Carolina's Insurance Fraud Statute - §38-55-170
    - Both are centered on the Filing of False Claims. Should be similar Criminal Penalties.

Legislative Requests – Provider Fraud

LOC Page 61

- **§43-7-60 Medical Assistance Provider Fraud**
  - **Needs Expanded Definition of Provider**
    - Should include "Managing Employees and Operators" who supervise or authorize claims of employees
    - "Failed to exercise supervision or authority and, as a direct or indirect result, the false claim was made"
    - Lead to increased supervision and decreased fraud, whether intentional or unintentional

Legislative Requests – Provider Fraud

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- **State False Claims Act with Whistleblower Provision**
  - Increased need to generate our own cases
  - No way of knowing when FCA cases filed in our own state
  - Current statutes don't allow prosecution of most culpable actors; considering transition to greater civil practice with lower burden of proof

Legislative Requests – Provider Fraud

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- **§43-7-60 Medical Assistance Provider Fraud**
  - **Needs To Include Administrative Subpoena Power**
    - Similar to the Omnibus Adult Protection Act (OAPA)
    - Providers have signed agreements with the Medicaid Program to Maintain Records and to Provide Records When Requested
  - **Needs Criminal Penalties for Failure to Maintain Adequate Records & Intentionally Destroying Records**
    - Providers, under their provider agreements, are required to maintain records to substantiate claims for 5 Years
    - Criminal Penalty for Failure to Maintain Adequate Records
    - Increased Criminal Penalty for Intentionally Destroying Records

Legislative Requests – Patient Abuse

LOC Page 64

- **Omnibus Adult Protection Act**
  - **Modifying Definition of "Psychological Abuse"**
    - Change "causes" to "causes or could cause" – Similar to Assault & Battery Statues
    - The act should be criminal, not the actual harm caused by the act
  - **Criminal Penalties for a New Trend**
    - Unauthorized Recording of Vulnerable Adults
    - Trend of Posting These Records on Social Media
  - **Trafficking of a Vulnerable Adult / "Benefits Trafficking"**
    - Example Language - A person commits the offense of trafficking a Vulnerable Adult when such person through deception, coercion, exploitation, or isolation, knowingly recruits, harbors, transports, or obtains by any means a Vulnerable Adult for the purpose of appropriating the resources or benefits of a Vulnerable Adult for the person's or other person's benefit

State Agency Recommendations

- **Legislation that supports task forces and information sharing**

Questions

LOC Page 66

LOC Template
MFCU Division PERs (1-5)

Priority Concerns

1st

2nd

3rd

MFCU #	1	2	3	4	5
6. Deliverable	Receive and review PF and PA referrals	Refer PA and PF matters to other state agencies as appropriate	Investigate Medicaid provider fraud in accordance with grant requirements.	Prosecute Medicaid provider fraud in accordance with grant requirements.	Investigate patient abuse in residential health care facilities in accordance with grant requirements.
8. Associated Laws	42 C.F.R. § 1007.9(g); S.C. Code Ann. § 43-35-25; 77 FR 32645	42 C.F.R. 1007.11(b)(4); 44 C.F.R. § 1007.11(c); 44 C.F.R. § 1007.11(e)(4); 42 C.F.R. § 1007.9(e); 42 C.F.R. § 1007.9(f); S.C. Code Ann. § 43-35-70	42 C.F.R. 1007.11(a)(1); 42 C.F.R. § 1007.11(a)(2); 44 C.F.R. § 1007.11(d); 77 FR 32645; S.C. Code Ann § 43-7-60; S.C. Code Ann § 44-113-60	42 C.F.R. § 1007.7(a); 42 C.F.R. 1007.11(a); 44 C.F.R. § 1007.11(c); 44 C.F.R. § 1007.11(d); 77 FR 32645; S.C. Code Ann § 43-7-60; S.C. Code Ann § 44-113-60	44 C.F.R. § 1007.11(b)(1); 44 C.F.R. § 1007.11(b)(2); 44 C.F.R. § 1007.11(b)(3); 44 C.F.R. § 1007.11(d); eS.C. Code Ann § 43-35-5; S.C. Code Ann. § 43-35-45; S.C. Code Ann. § 43-35-60; 77 FR 32645
16. Performance Measure	Take steps to maintain an adequate volume and quality of referrals. Performance Standard 4.	Make referrals to proper Federal, State, or local agencies as appropriate.	Investigate allegations in fraud in the of the Medicaid program by administrators or providers in the program.	Prosecute violations of all applicable state laws pertaining to Medicaid provider fraud.	Investigate allegations of patient abuse, neglect, and/or exploitation within jsd.
Leader Concern 3 Priorities	.				

LOC Template
MFCU Division PERs (6-10)

Priority Concerns

1st

2nd

3rd

MFCU #	6	7	8	9	10
6. Deliverable	Prosecute patient abuse in residential health care facilities in accordance with grant requirements	Coordinate and share information with federal partners where cases involve the same suspects, allegations, investigations and/or prosecutions	Report to HHS OIG pertinent information for purposes of program exclusion under section 1128 of the Act.	Satisfy HHS OIG staffing requirements and training for professional employees.	Obtain annual recertification from HHS OIG
8. Associated Laws	42 C.F.R. § 1007.7(a); 44 C.F.R. § 1007.11(d); S.C. Code Ann § 43-35-85; S.C. Code Ann. § 43-35-80; 77 FR 32645	42 C.F.R. 1007.11(e); 77 FR 32645	42 C.F.R. 1007.11(g); 77 FR 32645	42 C.F.R. § 1007.5; 42 C.F.R. 1007.13; 77 FR 32645	42 C.F.R. 1007.17; 42 C.F.R. § 1007.9(a)-(b); 77 FR 32645; 44 C.F.R. § 1007.11(f)
16. Performance Measure	Prosecute violations of all applicable state laws pertaining to patient abuse, neglect, exploitation.	Make available to federal investigators and attorneys all information in the Unit's possession.	Timely submit to OIG pertinent information on all convictions for purposes of program exclusion. (charging documents, plea agreements, sentencing orders)	The Unit must be a single, identifiable entity of State government; employee sufficient staff and must conduct training that aids in the mission of the Unit.	Submit an annual recertification packet & annual statistical report to HHS OIG demonstrating its compliance.
Leader Concern 3 Priorities					1. Must hand-search all cases files one-by-one to collect relevant data, record in MCL, run report

LOC Template
MFCU Division PERs (11-14)

Priority Concerns
1st
2nd
3rd

MFCU #	11	12	13	14
6. Deliverable	Maintain written policies and procedures of operations	Exercise proper fiscal control over MFCU resources.	Coordinate with Medicaid's Single State Agency, South Carolina Dept. of Health and Human Resources and its affiliates.	Propose legislation
8. Associated Laws	42 C.F.R. § 1007.11(e)(5); 77 FR 32645	42 C.F.R. § 1007.5; 42 C.F.R. § 1007.9(c); 45 C.F.R. 75.307; 77 FR 32645	42 C.F.R. § 1007.9(d); 77 FR 32645; 42 C.F.R. § 1007.9(h);	77 FR 32645
16. Performance Measure	The Unit will establish written policy consistent with 42 C.F.R. 1007.11(e) (1) -(4). 42 C.F.R. Part 1007.	The Unit must operate a budget that is separate from that of its parent agency and comply with grant reporting requirements. 42 C.F.R. Part 1007.	The Unit will have a written agreement with the State Medicaid agency, hold regular meetings between the two agencies, coordinate efforts and share information as permitted. 42 C.F.R. Part 1007.	A Unit makes statutory or programmatic recommendations, when warranted to State government to improve the operation of the Unit.
Leader Concern 3 Priorities		2. Anticipate needing state funding next FFY.		3. Legislative requests have been pending since before 2018.

MEDICAID RECIPIENT FRAUD UNIT
FY 2023 ANNUAL REPORT (FY 22-23)

MISSION

The Medicaid Recipient Fraud Unit of the South Carolina Attorney General's Office works in tandem with the South Carolina Department of Health and Human Services to uphold state Medicaid laws and regulations. Our mission is to combat Medicaid fraud through in-depth investigations that result in deterrence, recovery of funds owed the state and criminal prosecution.

FY 23 BEGINNING SITUATION

Year Beginning July 2022

- LaRone Washington – Director
- Joe Giordano – AAG
- Sonya Carree – LA
- Jenn Hunger – Chief Inv.
- Scott Blair – Inv.
- Melissa Vail – Inv.
- Open Investigator Position – Inv.
- Danielle Warren – Inv.
- Sullivan Smith – Intern

Jan 2023 structure:

LaRone Washington – Director

Jennifer Hunger– Chief Investigator

Joe Giordano – AAG

Sonya Carree – LA

Scott Blair – Inv.

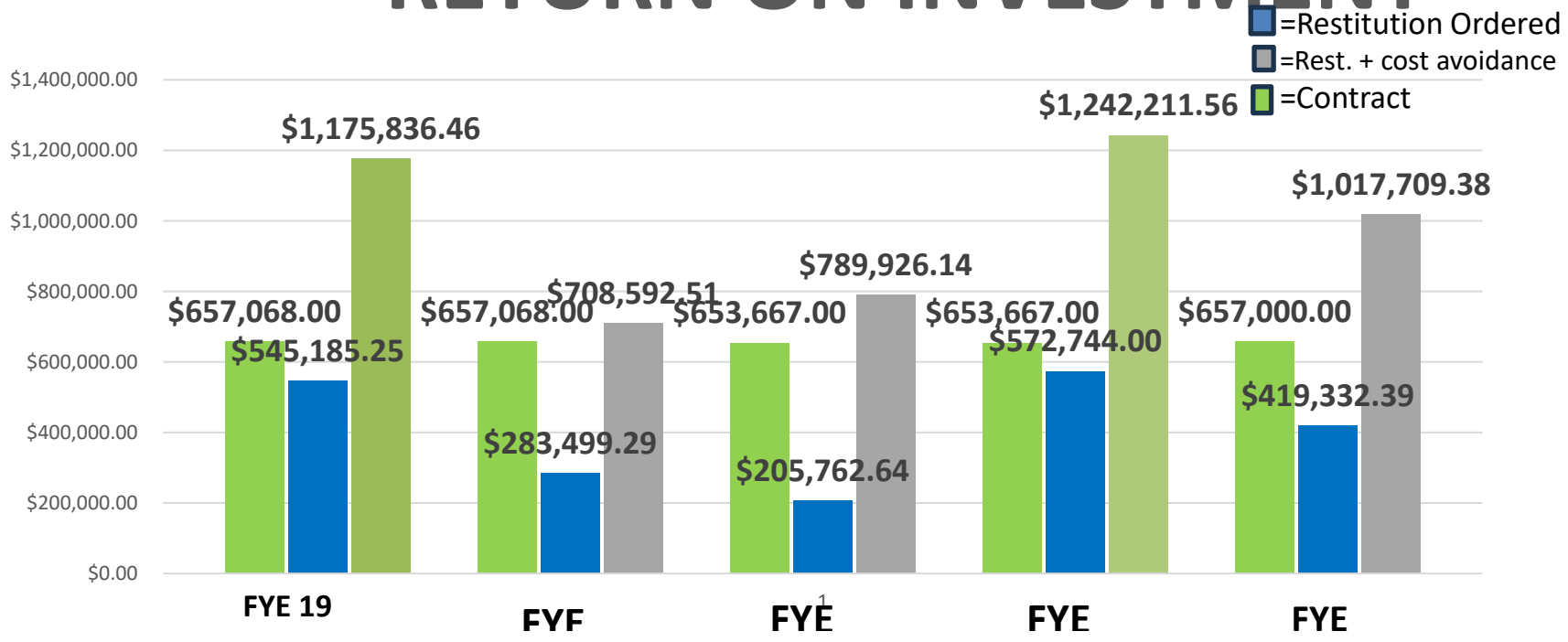
Open Investigator Position

Keenan Price – Inv.

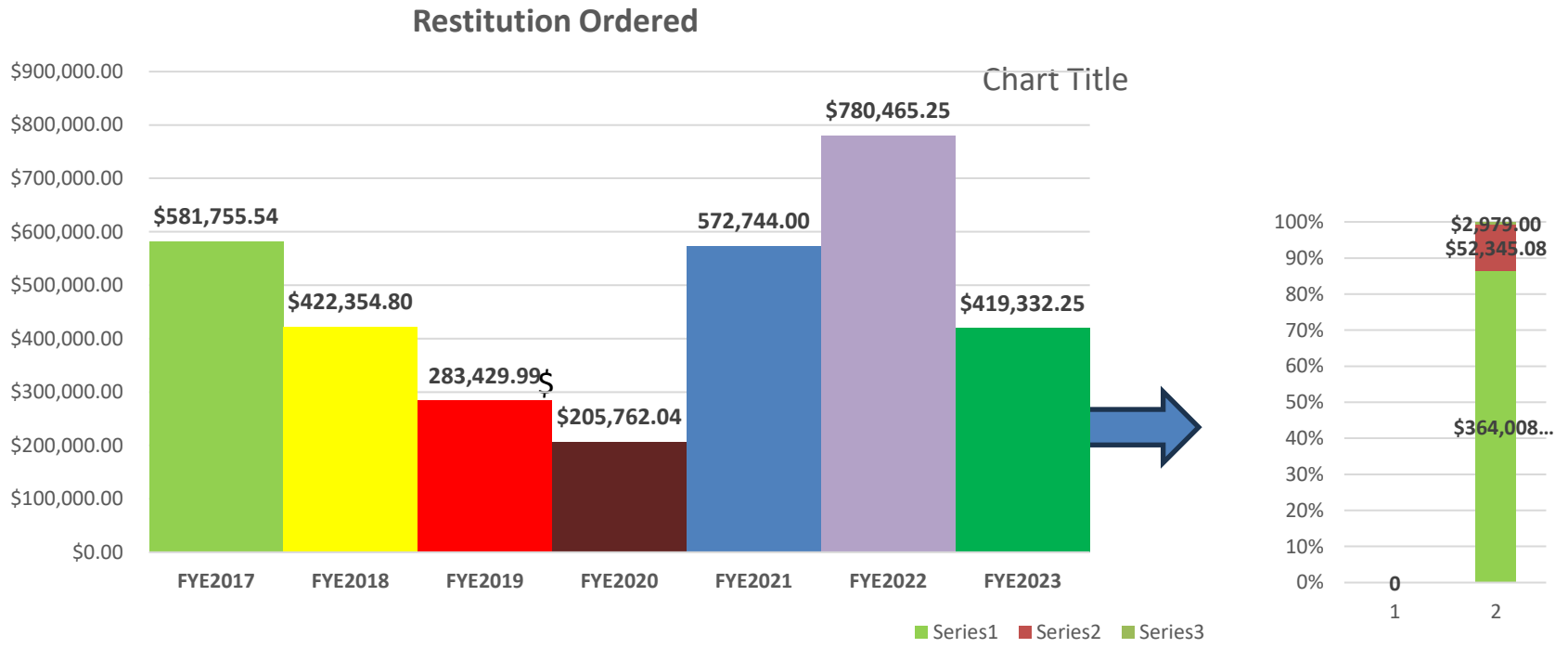
Danielle Warren – Inv.

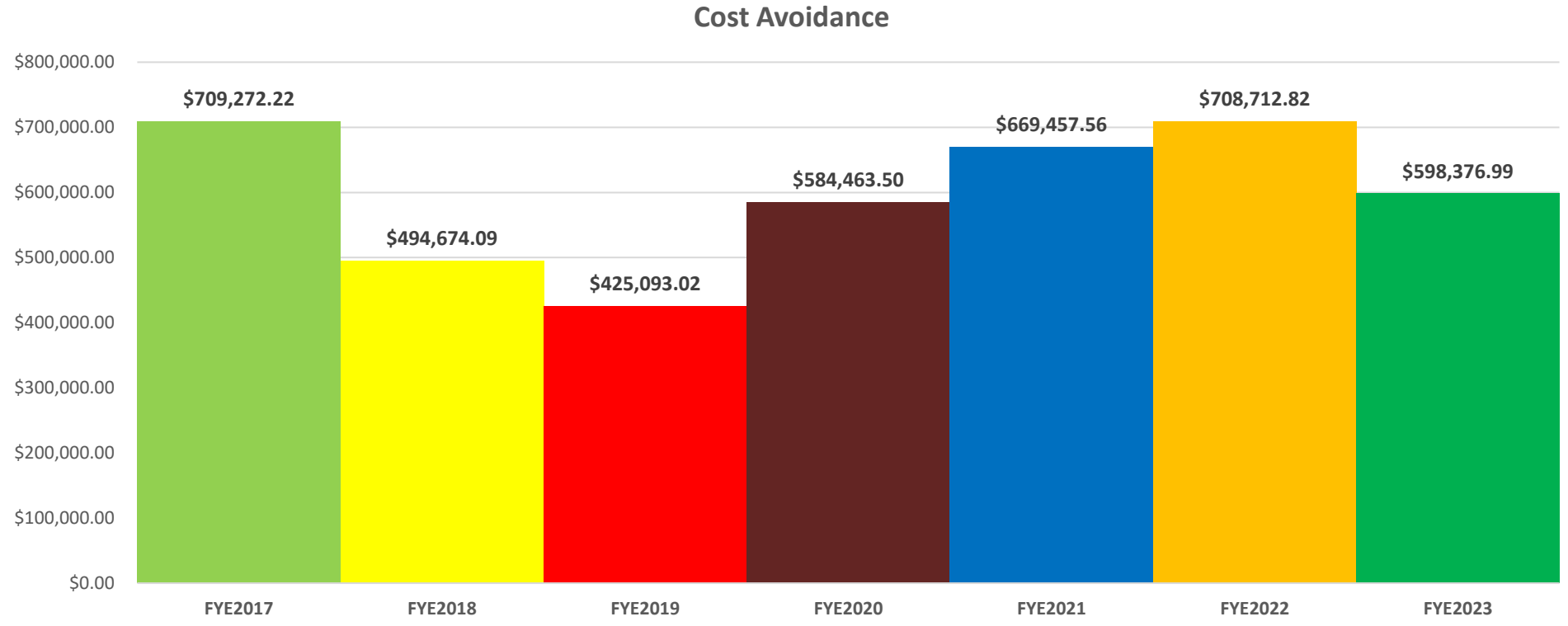
Huda Falous – Intern

FIVE YEAR TRAJECTORY
RETURN ON INVESTMENT



Medicaid Recipient Fraud – Return on Investment

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$700,000.00
$600,000.00
$500,000.00
$400,000.00
$300,000.00
$200,000.00
$100,000.00
$0.00
$709,272.22
$494,674.09
$425,093.02
$584,463.50
$669,457.56
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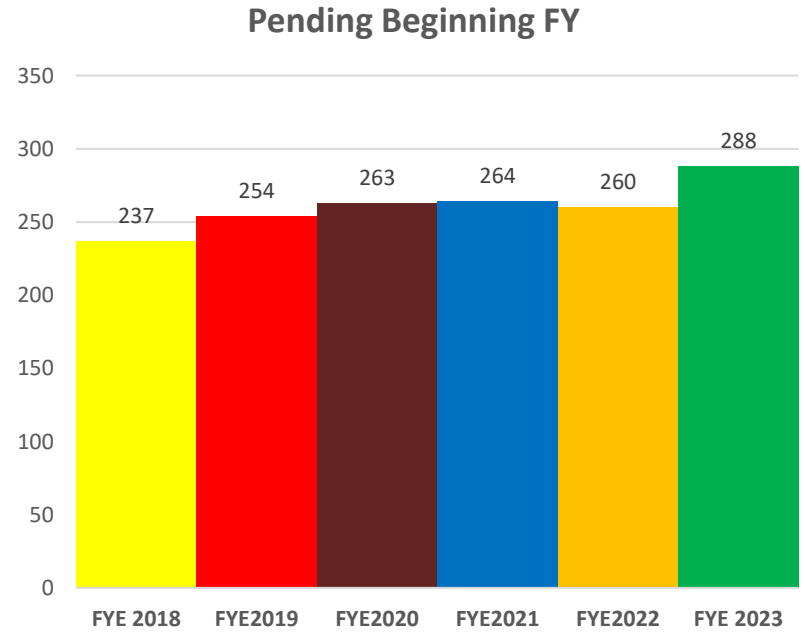
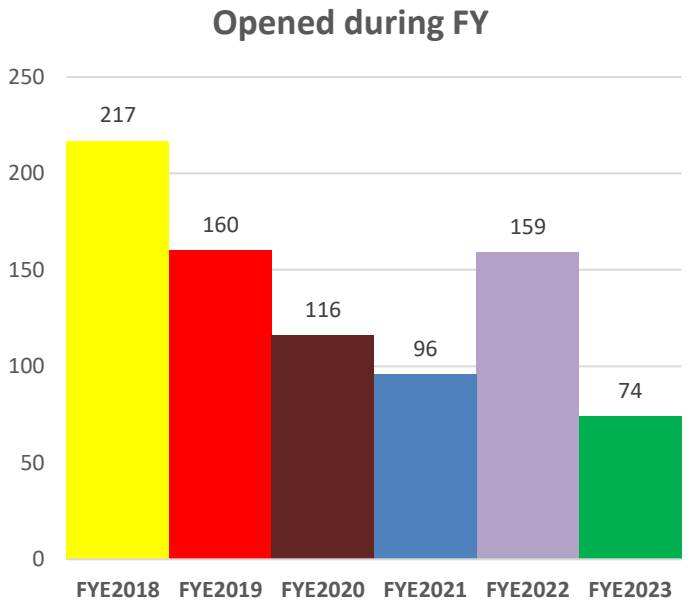
$598,376.99
FYE2017
FYE2018
FYE2019
FYE2020
FYE2021
FYE2022
FYE2023


Pending Beginning FY
350
300
250
200
150
100
50
0
237
254
263
264
260
288
FYE 2018
FYE2019
FYE2020
FYE2021
FYE2022
FYE 2023


Opened during FY
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200
150
100
50
0
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160
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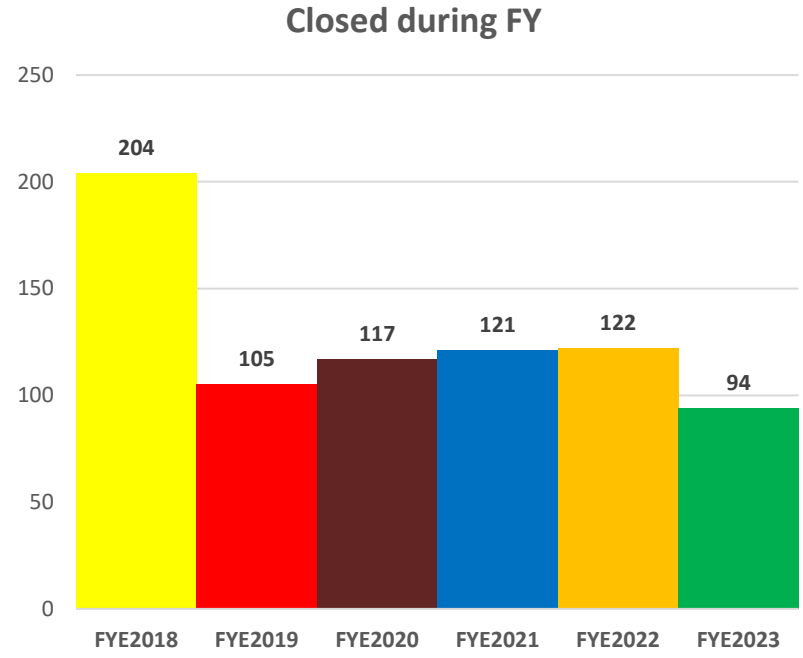
96
159
74
FYE2018
FYE2019
FYE2020
FYE2021
FYE2022
FYE2023


Closed during FY
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200
150
100
50
0
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105
117
121
122
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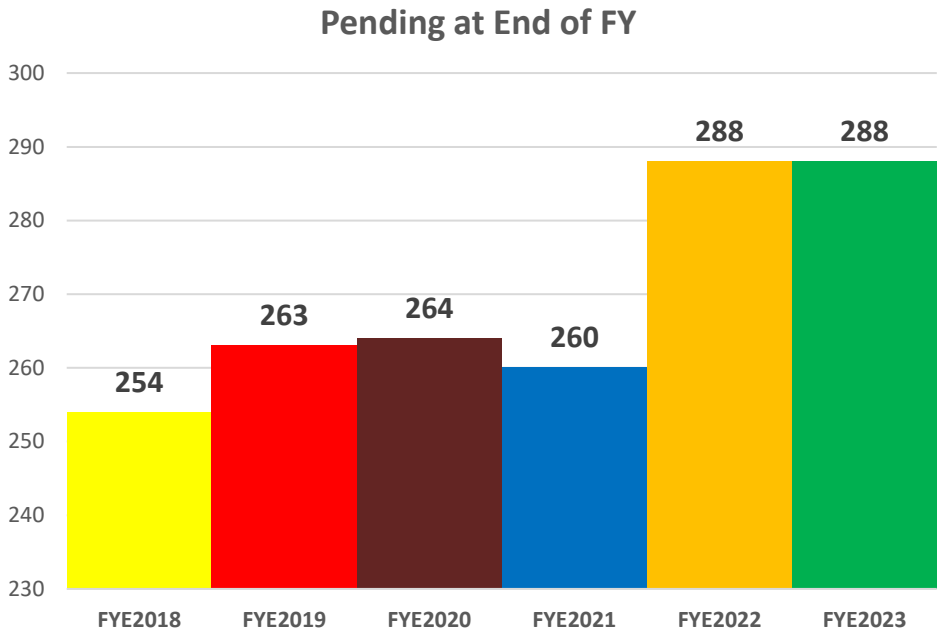
FYE2018
FYE2019
FYE2020
FYE2021
FYE2022
FYE2023


Pending at End of FY
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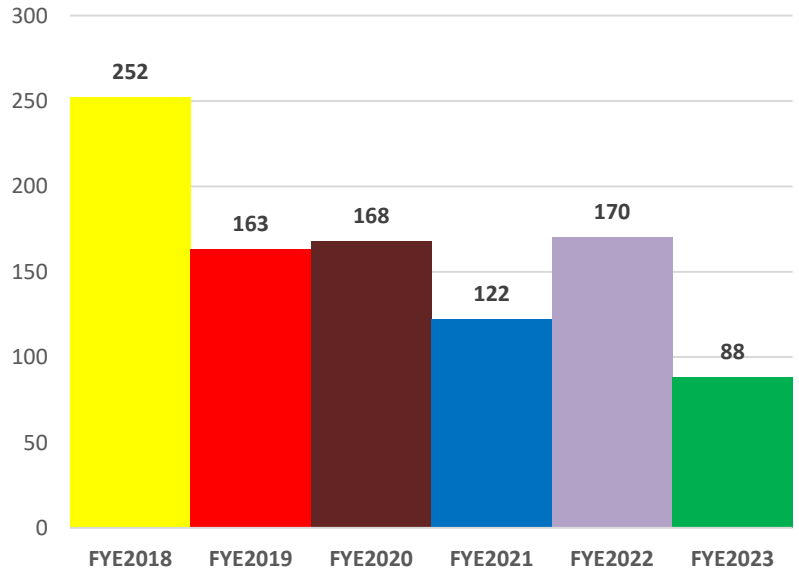
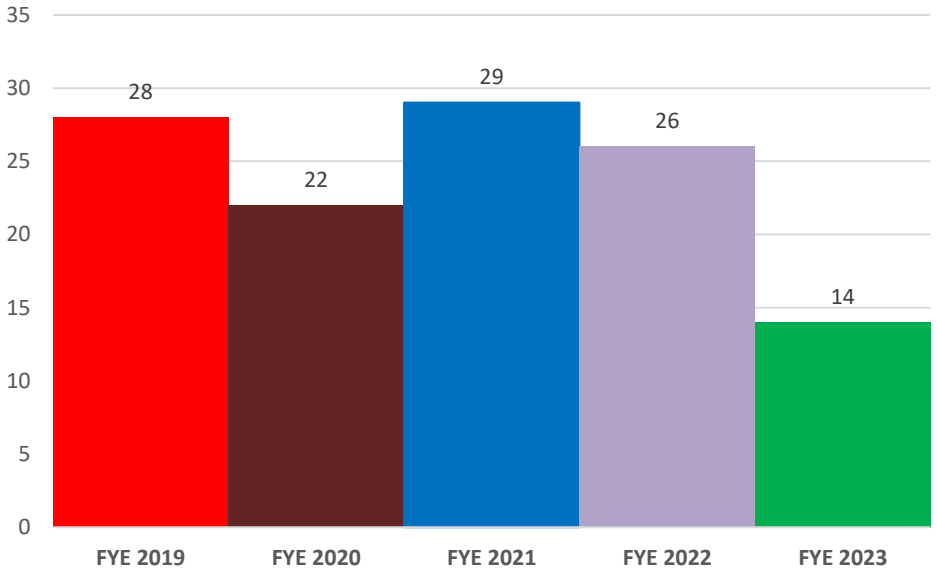
290
280
270
260
250
240
230
254
263
264
260
288
288
FYE2018
FYE2019
FYE2020
FYE2021
FYE2022
FYE2023

Referrals during FY



Declinations during FY



vements of 2022:

- On pace to close meet or exceed last year's record numbers
- Successful focus on cases 3 years or older
- Average length of time to move cases (vs. last year's time): 95.56 avg # of days vs 96.25 for last year's avg
- 2 more Special Investigators with CFE
  - Completion of white-collar trainings
- Successful start to navigation of PHE
- More narrow focus on cases likely to proceed with
  - No longer need to investigate cases with high likelihood of not prosecuting
- Added an MOU option
- "Medicaid Fraud in the Palmetto State: Insight into the AG Office's Medicaid Recipient and Provider Fraud Units"

- **<u>Asks and Goals for 2023:</u>**
- Legislation

– Amend False Statement (43-7-70) statute to make Medicaid fraud a property crime

- Bring in and orient new legal assistant
- Office space for special investigators and conference room

SOUTH CAROLINA STATE LAW ENFORCEMENT DIVISION

CHIEF MARK KEEL

LT. JEREMY SMITH

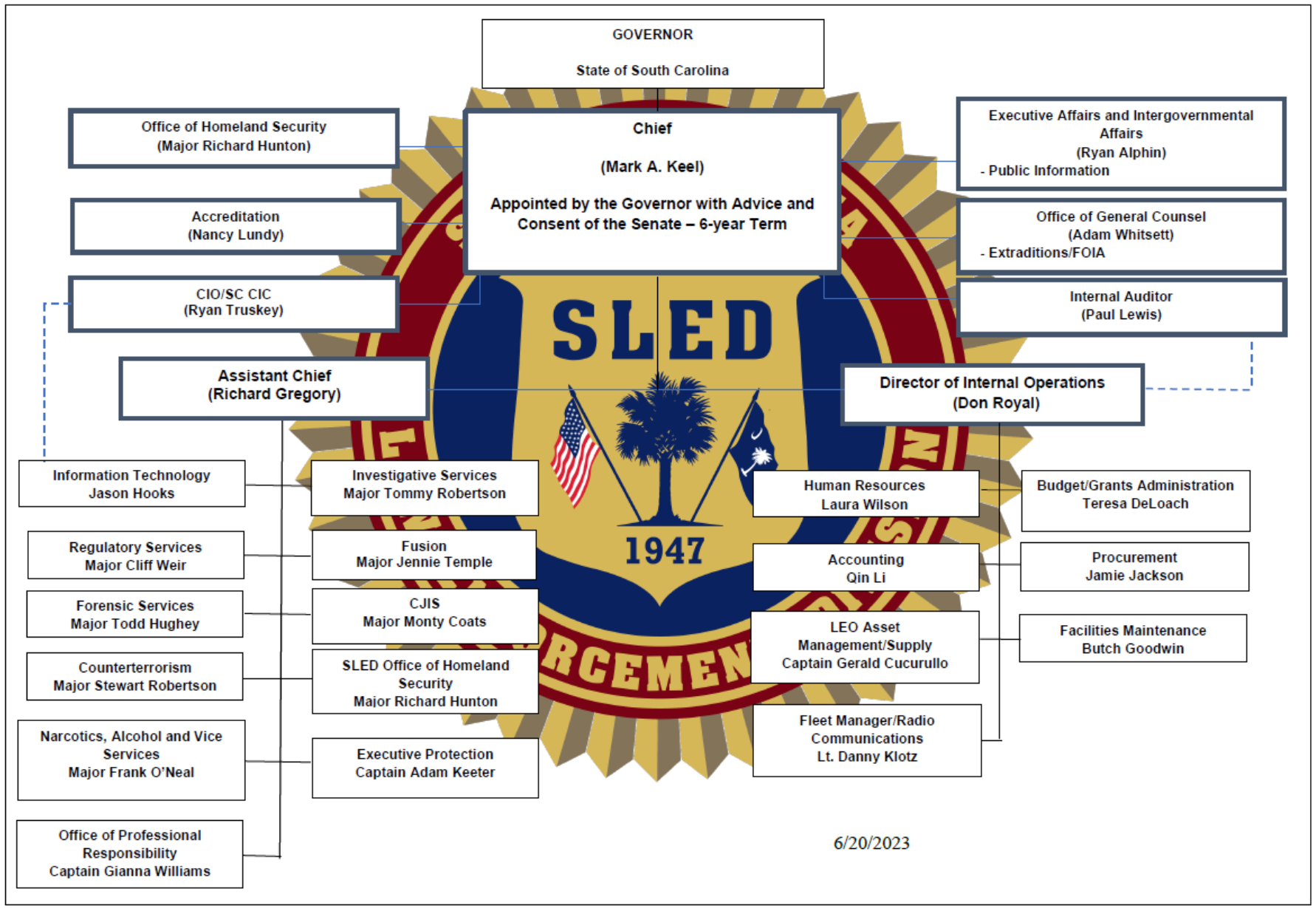
INSURANCE FRAUD IN SOUTH CAROLINA

SLED OVERVIEW

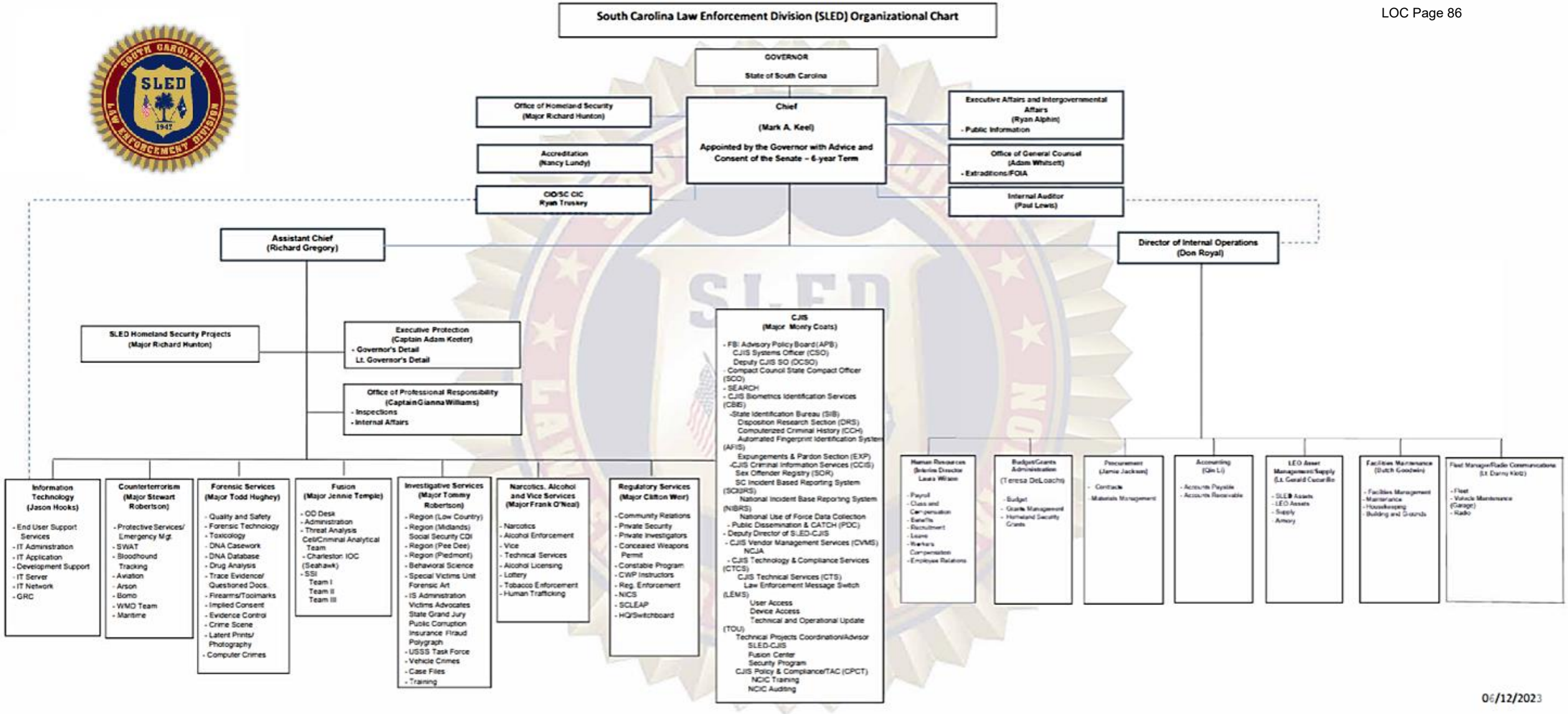
- The primary mission of the State Law Enforcement Division is to provide quality manpower and technical assistance to law enforcement agencies and to conduct investigations on behalf of the state as directed by the Governor and Attorney General.
- *"Everybody in this state deserves an equal level of law enforcement service and that's what SLED is about. No matter where you live, no matter where you're from, if crime happens in your community, we are going to be there to see that justice is served."*

- *Chief Mark Keel*

South Carolina Law Enforcement Division (SLED) Organizational Chart



South Carolina Law Enforcement Division (SLED) Organizational Chart



06/12/2023

INSURANCE FRAUD & SLED

- HISTORY OF INVESTIGATING INSURANCE FRAUD
- DATA: HOW MANY CASES & ARRESTS, WHERE ARE THEY HAPPENING
- HOW SOUTH CAROLINA COMPARES TO OTHER SOUTHERN STATES
- FUTURE NEEDS TO COMBAT INSURANCE FRAUD IN SOUTH CAROLINA

STATUTORY AUTHORITY

The Omnibus Insurance Fraud and Reporting Immunity Act was established in 1994 to aggressively confront the problem of insurance fraud in South Carolina.

SECTION 38-55-520
The purpose of this article is to confront aggressively the problem of insurance fraud in South Carolina by facilitating the detection of insurance fraud; to allow reporting of suspected insurance fraud; to grant immunity for reporting suspected insurance fraud; to prescribe penalties for insurance fraud; to require restitution for victims of insurance fraud; to establish a division within the Office of the Attorney General to prosecute insurance fraud; and to **require the investigation of alleged insurance fraud by the State Law Enforcement Division (SLED)**.

IMPACT IN SOUTH CAROLINA

- At least $308 billion in fraudulent claims are made annually in the U.S., the Coalition Against Insurance Fraud estimates.

  - Total cost of insurance fraud in America:
    $308,000,000,000.00 ($308 billion)
    Cost to South Carolina:
    $4,928,000,000.00 ($4.928 billion)

  - The cost of insurance fraud each year for every South Carolina resident is roughly $930.00 per year.

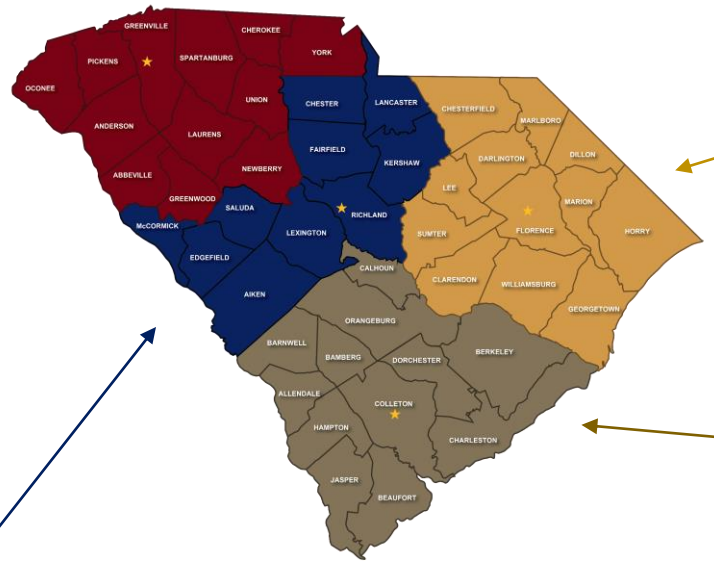
INVESTIGATING INSURANCE FRAUD

SCDOI

PIEDMONT

- CASES: 10
- ARRESTS: 0

(2 INDICTMENTS)



PEE DEE

- CASES: 30
- ARRESTS: 50

MIDLANDS

- CASES: 14
- ARRESTS: 2

LOW COUNTRY

- CASES: 8
- ARRESTS: 1

2022

62 NEW CASES ASSIGNED

72 OLD CASES CLOSED

SOUTH CAROLINA SLED LAW ENFORCEMENT DIVISION 1947

INVESTIGATING INSURANCE FRAUD

- BEFORE 2020
  - The South Carolina Attorney General's Office reviewed and assigned Insurance Fraud cases to SLED
  - Due to volume, manpower, and resources, cases could sit for long periods of time before being reviewed and assigned for investigation
  - SLED had limited resources to investigate small fraud cases and would often triage cases

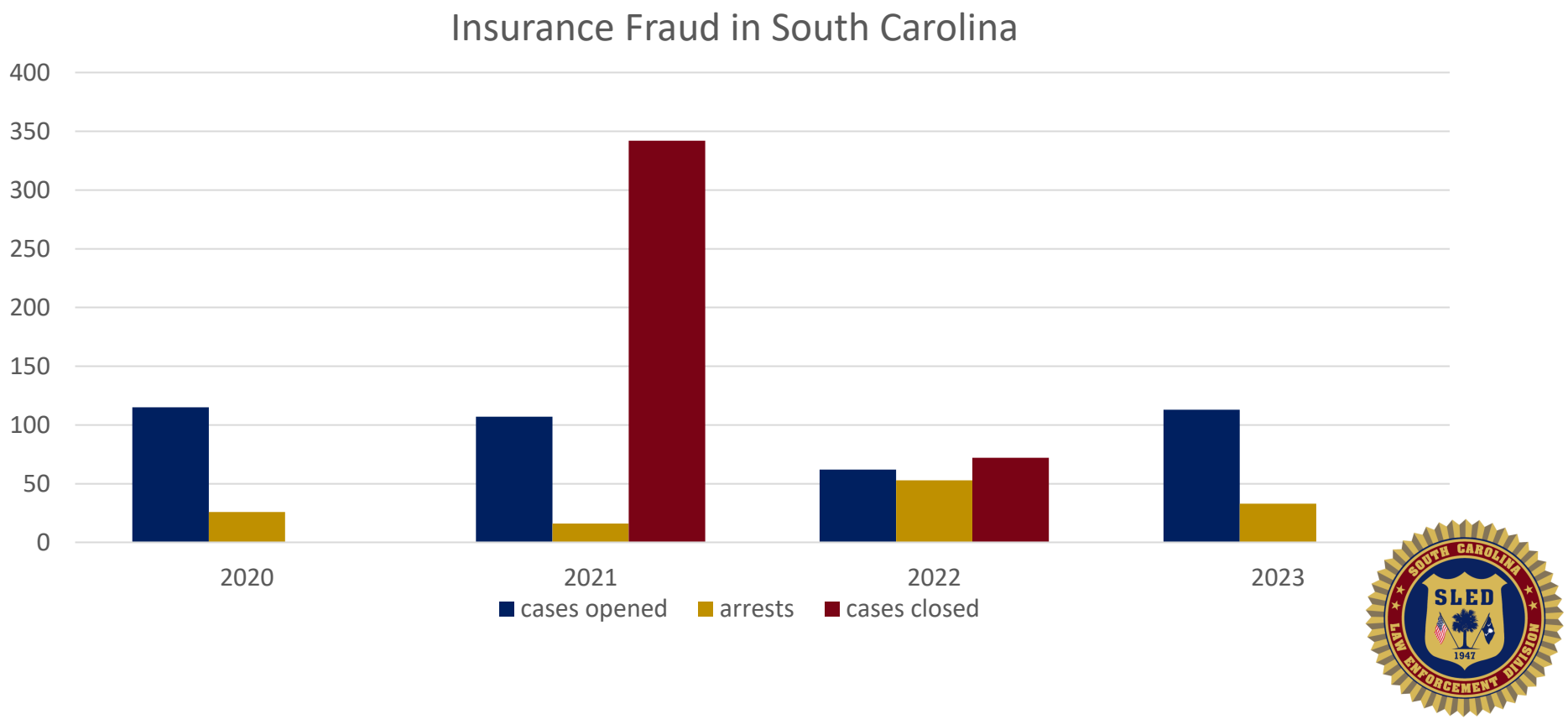
- 2020
  - 4 SLED Agents designated to investigate Insurance Fraud
  - 115 Insurance Fraud cases opened
  - 26 arrests for Insurance Fraud related offenses
  - AUGUST 2020 – SLED Lt. Jeremy C. Smith reassigned from Midland Region to State Grand Jury
  - SLED Lt. Smith creates a database to track Insurance Fraud cases for case management

- 2021
  - SC Department of Insurance (DOI) is primarily responsible for prosecuting Insurance Fraud cases
  - 107 Insurance Fraud cases opened
  - 16 arrests for Insurance Fraud related offenses
  - 342 cases closed
  - DOI provides office for SLED Lt. Jeremy Smith

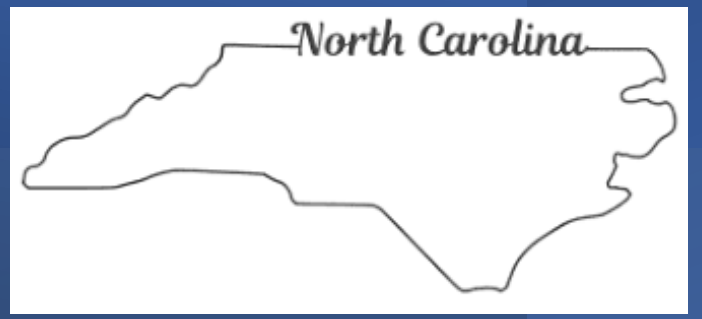
INVESTIGATING INSURANCE FRAUD

- 2022
  - 62 new Insurance Fraud cases assigned
  - 72 old Insurance Fraud cases closed
  - 53 arrests for Insurance Fraud related offenses
- 2023
  - SLED has 5 Special Agents designated to investigate Insurance Fraud (1 is a new hire)
  - There are currently 113 open cases
  - 33 arrests for Insurance Fraud related offenses
  - SLED continues to partner with the DOI on sharing data
  - SLED is building a new case management system to track modern crimes, including Insurance Fraud more efficiently
  - Currently investing multiple organized fraud cases that include over 150 claims/referrals

SC FRAUD 2020-2022 IN REVIEW



VS.



- POPULATION: 5.3 MILLION PEOPLE
- INVESTIGATING FRAUD: 5 AGENTS

- POPULATION: 10.7 MILLION PEOPLE
- INVESTIGATING FRAUD: 50 AGENTS

VS.

- POPULATION: 5.3 MILLION PEOPLE
- INVESTIGATING FRAUD: 5 AGENTS

- POPULATION: 11 MILLION PEOPLE
- INVESTIGATING FRAUD: 50 AGENTS

VS.

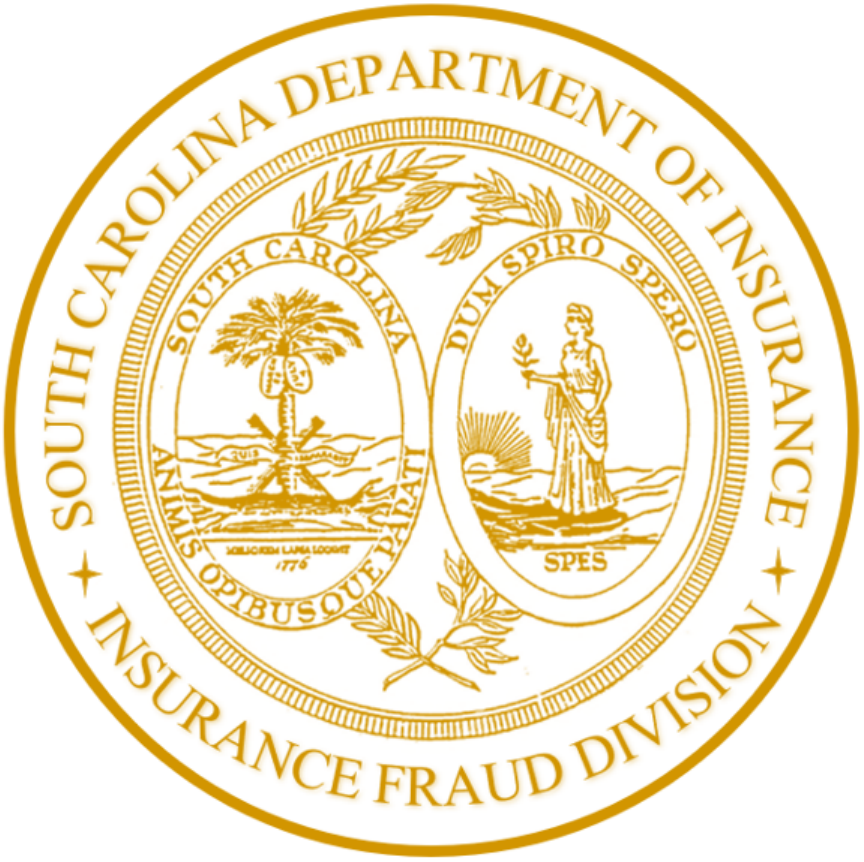
- POPULATION: 5.3 MILLION PEOPLE
- INVESTIGATING FRAUD: 5 AGENTS

- POPULATION: 8.7 MILLION PEOPLE
- INVESTIGATING FRAUD: 23 AGENTS

SUMMARY:

- To reduce insurance fraud in South Carolina, there is a need to prioritize insurance fraud cases without sacrificing agents in other areas of the agency with similar or greater need
- Add additional agents to investigate, administrative support staff, and identify technology that can assist in investigations
- Other states in the region (NC/VA/GA) have more agents per capita, as well as designated administrative support staff
- With additional staff, fewer cases would be declined and would be investigated
- Currently investigating multiple organized fraud cases that include over 150 claims/referrals
- SLED currently has 113 open cases and has made 33 arrests so far this year

2022 DEPARTMENT OF INSURANCE FRAUD REPORT



Annual Report

2022

Annual Report 2022

South Carolina Department of Insurance
Insurance Fraud Division
1201 Main Street, Suite 1000
Columbia, South Carolina 29201
Telephone: 803-737-6424
Hotline: 1-888-95-FRAUD
Fax: 803-737-0195

Current Insurance Fraud Division Staff:

Joshua R. Underwood
Special Assistant Attorney General
Director, Insurance Fraud Division

Larry G. Wedekind
Special Assistant Attorney General

Moultrie D. Roberts
Special Assistant Attorney General

Jason M. Allen
Special Assistant Attorney General

Sam J. Jones
Special Assistant Attorney General

Della Sisson
Paralegal

Ellen DuBois
Paralegal

Shayna Thompson
Program Coordinator

IN MEMORY

Stephen E. Baumgardner

April 3, 1959 to December 30, 2022

The Insurance Fraud Division lost a great friend and partner with the death of Special Agent Stephen E. Baumgardner whose long and valiant battle with cancer ended in 2022. Baumgardner began his law enforcement career with the Lexington County Sheriff's Department where he served as a patrol deputy, school resource officer, and investigator. He was proud of his work creating the Midlands Financial Crimes Working Group which was named Financial Crimes Task Force of the Year by the Carolinas Chapter of the International Association of Financial Crimes Investigators. Baumgardner served as a Special Agent with the South Carolina Law Enforcement Division investigating insurance fraud from 2015 until his death. While he will be greatly missed, we will continue to remember him for his humor, sense of style, dedication, and professionalism.

MESSAGE FROM THE ACTING DIRECTOR OF INSURANCE

I proudly present the 2022 Annual Report of the South Carolina Insurance Fraud Division to the General Assembly. This report reflects the first full year of the Insurance Fraud Division joining the South Carolina Department of Insurance.

The Insurance Fraud Division joined the Department of Insurance after the execution of a Memorandum of Understanding between the Department of Insurance, the Attorney General's Office, and the South Carolina Law Enforcement Division (SLED). This agreement, combined with funding from the General Assembly, allowed the Department of Insurance to hire its first Director of the Insurance Fraud Division in September 2021. Since that time, the Division has grown to include a total of 8 employees. The Insurance Fraud Division shall continue to operate pursuant to the MOU until legislation makes the change permanent.

This past year revealed that insurance fraud continues to persist and grow in South Carolina. In 2022, the Insurance Fraud Division received a combined total of 3,182 complaints of suspected insurance fraud, a significant increase from the previous year. This represents the largest number of insurance fraud complaints ever received in South Carolina in a single calendar year. These complaints came to the Department of Insurance by way of reports from the National Insurance Crime Bureau (NICB), the National Association of Insurance Commissioners (NAIC), individual insurance companies, and citizens utilizing online complaint forms and the Insurance Fraud Hotline. The complaints from 2022 involve a wide range of insurance products as further explained in this report.

Despite South Carolina ranking 23rd in population, NICB reports that we currently rank 19th in the country for questionable insurance claims. More importantly, South Carolina ranks 9th in questionable insurance claims involving suspected staged vehicle collisions. This type of fraud creates danger to our citizens. The people who commit this fraud stage fake car "accidents" for the purpose of making money from insurance claims. To increase the profit from these claims, the perpetrators pack the vehicles with passengers, sometimes including children, to inflate potential claims for bodily injury. In many cases, everyone involved in the "collision" is a knowing participant in the fraud. Unfortunately, in other cases the perpetrators intentionally cause collisions with innocent and unsuspecting drivers. These schemes take advantage of emergency services and divert these resources from people truly in need of help. Ultimately, this fraud affects the safety of our roads and adds to the cost of premiums paid by every South Carolina driver.

The Department of Insurance recognizes the scope of insurance fraud in South Carolina and the problems caused by these crimes. Insurance fraud diverts resources and increases costs affecting every citizen of this great state. Insurance fraud is not a victimless crime. The Department of Insurance remains dedicated to the cause of fighting insurance fraud and will continue to support the Insurance Fraud Division in the years ahead. The Department looks forward to the further development of the unit, its continued cooperation with SLED, and their successful investigations and prosecutions in the months and years ahead.

Sincerely,

Michael Wise
Acting Director of Insurance

MESSAGE FROM THE INSURANCE FRAUD DIVISION

The Insurance Fraud Division was established by the Omnibus Insurance Fraud and Reporting Immunity Act in 1994. This Act created the Division within the Office of the Attorney General to prosecute insurance fraud throughout the State. The Act further requires the South Carolina Law Enforcement Division (SLED) to investigate allegations of insurance fraud. In 2021, the Office of the Attorney General, SLED, and the Department of Insurance executed a Memorandum of Understanding to relocate the Insurance Fraud Division to the Department of Insurance.

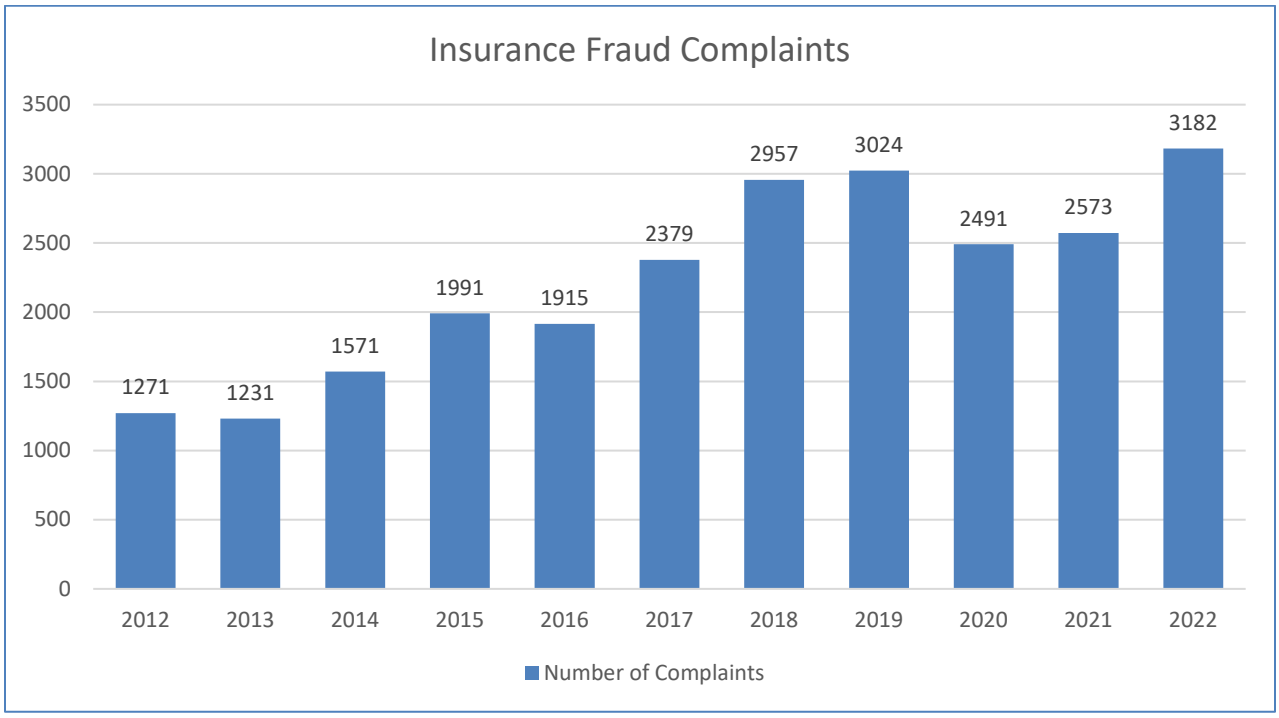
Pursuant to this agreement, the Attorney General appoints certain attorneys, hired by the Department of Insurance, as Special Assistant Attorneys General to prosecute insurance fraud related crimes under the general supervision and control of the Attorney General. SLED continues to investigate insurance fraud as a partner with the Insurance Fraud Division. The Department of Insurance employs and houses the staff of the Insurance Fraud Division. The Department of Insurance also provides office space and equipment for SLED's five insurance fraud investigators and their supervising lieutenant to facilitate the partnership between the investigators and the prosecutors.

In 2022, the Department of Insurance added three new full-time employees, a program coordinator (July) and two attorneys (December), to the Insurance Fraud Division. The eight-person staff now consists of the Director of the Insurance Fraud Division, four Special Assistant Attorneys General, two paralegals, and a program coordinator. The Director of the Insurance Fraud Division also serves as a Special Assistant Attorney General to prosecute insurance fraud cases across the state.

The backlog of cases pending review or SLED investigation has proven to be one of the most cumbersome parts of the Division's transition with copies of these files continuing to be delivered well into 2022. Our prosecutors reviewed and closed more than 300 of these cases in 2022, many of which were several years old. This focus on the older backlog of cases has resulted in a temporary backlog of newer cases and complaints. However, it was necessary to concentrate efforts to clear the older backlog to allow for better use of resources to increase the likelihood of successful investigations and prosecutions of the newer cases. The newly hired staff members are expected to catch up on the temporary backlog of newer cases while the Division continues to work through the shrinking number of older cases.

The Insurance Fraud Division has been working to build a new case management system to better track cases from initial complaint through final disposition. The first phase of the new system went into operation midway through 2022. The second phase is expected to be completed in 2023. Once fully operational, this case management system will greatly increase efficiency. It will also allow for better tracking methods which will increase analytical abilities to better identify insurance fraud trends. This new system will also improve the abilities of SLED and the Insurance Fraud Division to share case information.

In 2022, the Insurance Fraud Division received a record high 3,182 complaints. Despite receiving more insurance fraud complaints than ever before, South Carolina's situation has surprisingly improved in comparison to other states. According to the National Insurance Crime Bureau, South Carolina now ranks 19th in the nation in the number of questionable insurance claims submitted, down from 15th last year.



Unfortunately, South Carolina, at 9th, still ranks in the top ten of states with the highest number of questionable claims related to staged automobile accidents. These cases pose a serious problem for the citizens of South Carolina. Artificial property and injury claims create a higher area of risk for insurance carriers who are forced to pass the cost on to South Carolina's consumers in the form of higher premium payments. More importantly, these staged accidents often involve innocent drivers and passengers who do not know that these criminals are going to intentionally collide with their vehicles. This places both the criminals and victims at serious risk of bodily injury or death. Pursuing cases involving staged automobile accidents, particularly those involving organized ring activity, will continue to be a high priority for the Division in 2023.

Together, the Department of Insurance, SLED, and the Attorney General's Office all recognize that insurance fraud is not a victimless crime. Every citizen who must pay higher insurance premiums to recoup the money lost to fraud is a victim. Every innocent driver and passenger who gets caught up in a staged collision is a victim. Every person or business that must absorb the cost of a loss when no insurance exists because a contractor presents a false certificate of insurance is a victim. The Insurance Fraud Division remains dedicated to fighting insurance fraud throughout this state.

We would like to thank the private citizens, insurance professionals, and members of law enforcement who reported cases of suspected insurance fraud in 2022. We also thank the investigators and other insurance professionals who investigate these cases. Without their work and assistance, the fight against insurance fraud would be nearly impossible. We also thank the National Insurance Crime Bureau (NICB), the Coalition Against Insurance Fraud, the South Carolina chapter of the International Association of Special Investigative Units (IASIU), the South Carolina Insurance Association, and the Independent Insurance Agents & Brokers of South Carolina for partnering with our office and for their work in raising the awareness of insurance fraud.

Respectfully,

Joshua R. Underwood
Special Assistant Attorney General
Director, Insurance Fraud Division

SUMMARY

Status of Cases – 2022

Complaints Received

Complaints received in 2022	3182
Complaints declined for prosecution before SLED investigation	1653
Total matters pending review, investigation or prosecution as of 12/31/2022	1914

Complaints Opened to SLED For Further Investigation Before Prosecution

Investigations opened by SLED in 2022*	62
Number of arrests by SLED in 2022	53
Complaints under investigation by SLED as of 12/31/2022*	65

*These condensed numbers of investigations opened by SLED include investigations pertaining to multiple, related complaints received by the Department of Insurance and referred to SLED for investigation. Many of these complaints also relate to the investigation of multiple individuals.

Disposition of Cases

Cases disposed by Memorandum of Understanding (MOU)	1
Individuals convicted in 2022 (in General Sessions Court)	12
Number of counties in which convictions were obtained	9
Cases where restitution was ordered	**5**
Total Restitution ordered	**$22,234.66**

Monies Ordered and/or Collected Pursuant to Civil Dispositions

CIVIL – MOU's	**AMOUNT**
Fines ordered	$400.00
Fines collected	$400.00
TOTAL	**$400.00**

Monies Ordered and/or Collected Pursuant to Court Order

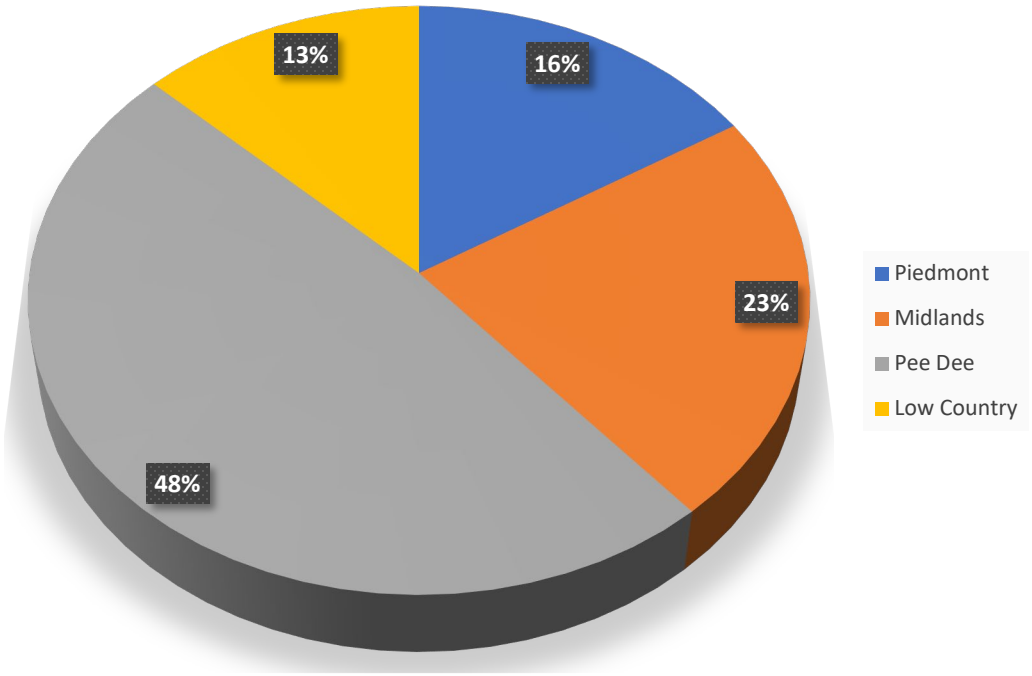
COURT ORDERED – RESTITUTION	**AMOUNT**
TOTAL	**$22,234.66**

COURT ORDERED – FINES	**AMOUNT**
TOTAL	**$0**

TOTAL COURT ORDERED MONIES	**AMOUNT**
Restitution ordered	$22,234.66
Court fines	$0
TOTAL	**$22,234.66**

2022 CASES OPENED BY SLED BY REGION

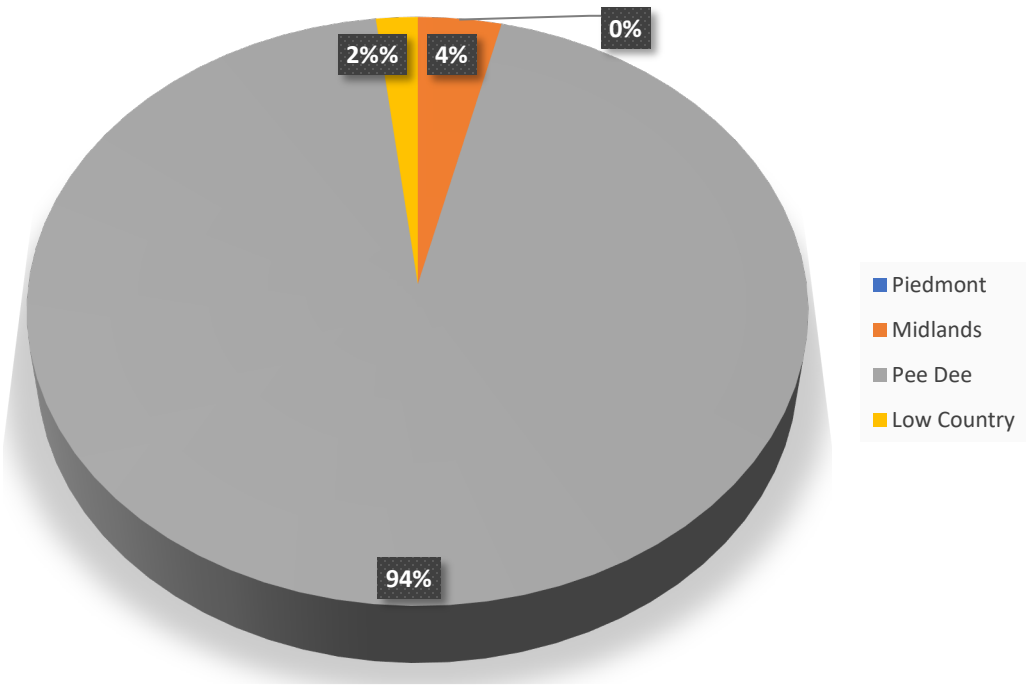
Referrals are sent to the South Carolina Law Enforcement Division (SLED) in order to decide if a complaint meets the elements of an insurance fraud crime. During 2022, SLED opened 62 cases deeming them necessary for further investigation. As the chart below indicates, these cases were received from all areas of the state:



REGION	NUMBER OF CASES	PERCENT OF TOTAL
Piedmont	10	16%
Midlands	14	23%
Pee Dee	30	48%
Low Country	8	13%
TOTAL	**62**	

2022 SLED ARRESTS BY REGION

During 2022, the South Carolina Law Enforcement Division (SLED) had 53 (2 indictments) arrests related to Insurance Fraud. As the chart below indicates, these arrests were made in two regions of the state:



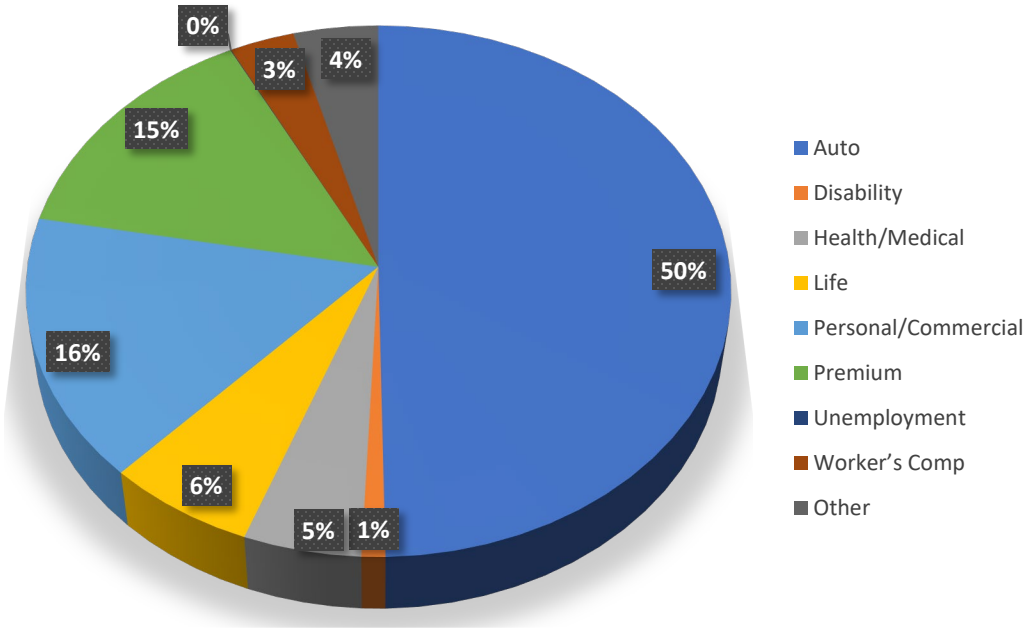
REGION	NUMBER OF ARRESTS	PERCENT OF TOTAL
Piedmont	0	0%
Midlands	2	4%
Pee Dee	50	94%
Low Country	1	2%
TOTAL	**53**	

2022 COMPLAINTS RECEIVED BY TYPE OF FRAUD

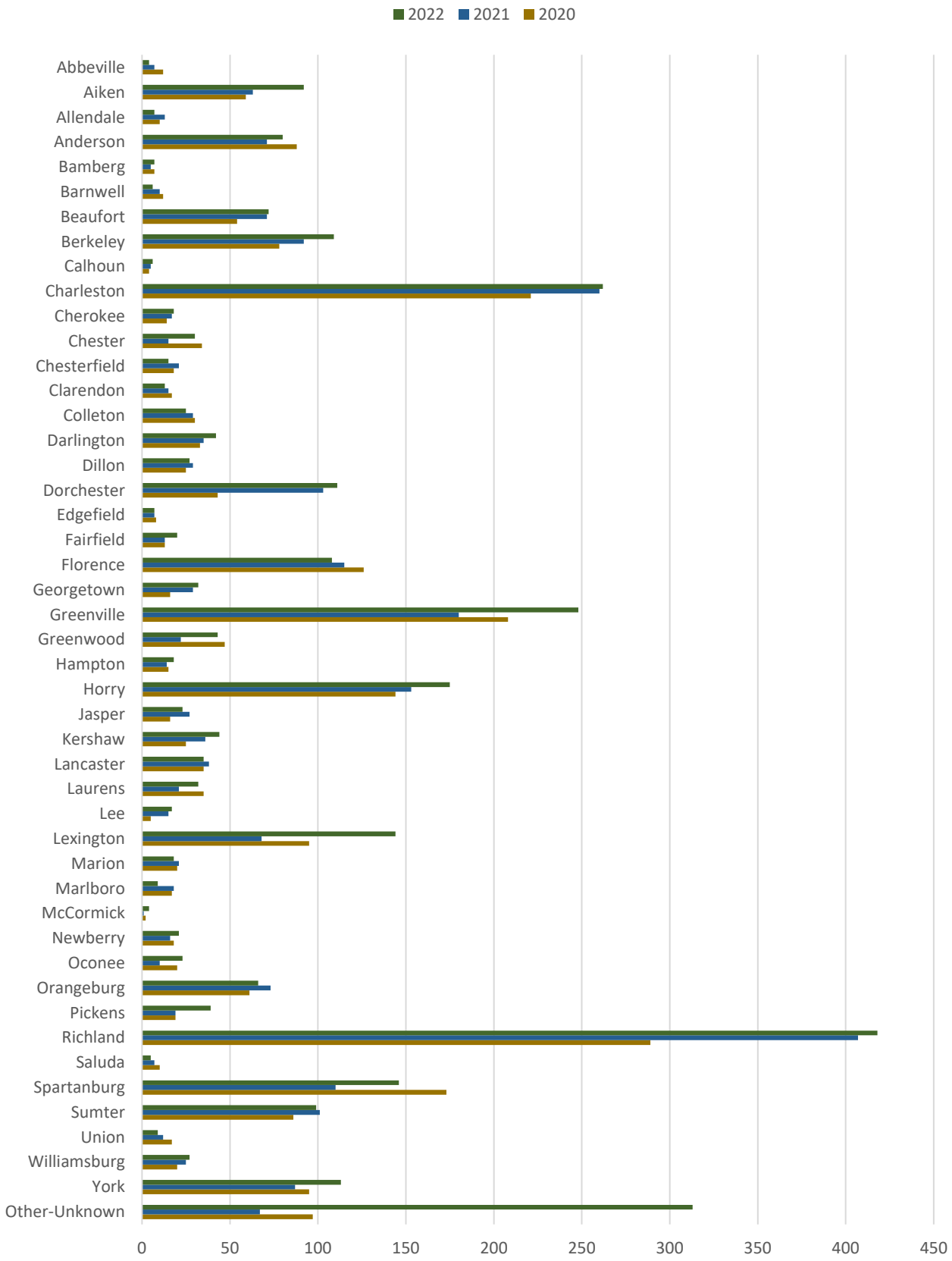
The fraud complaints received during 2022 by the Insurance Fraud Division consisted of the following types of fraud:

TYPE OF FRAUD	NUMBER OF COMPLAINTS	PERCENTAGE OF TOTAL
Auto	1589	50%
Disability	33	1%
Health/Medical	143	5%
Life	202	6%
Personal/Commercial	511	16%
Premium	463	15%
Unemployment	1	.03%
Worker's Comp	104	3%
Other	136	4%
TOTAL	**3182**	

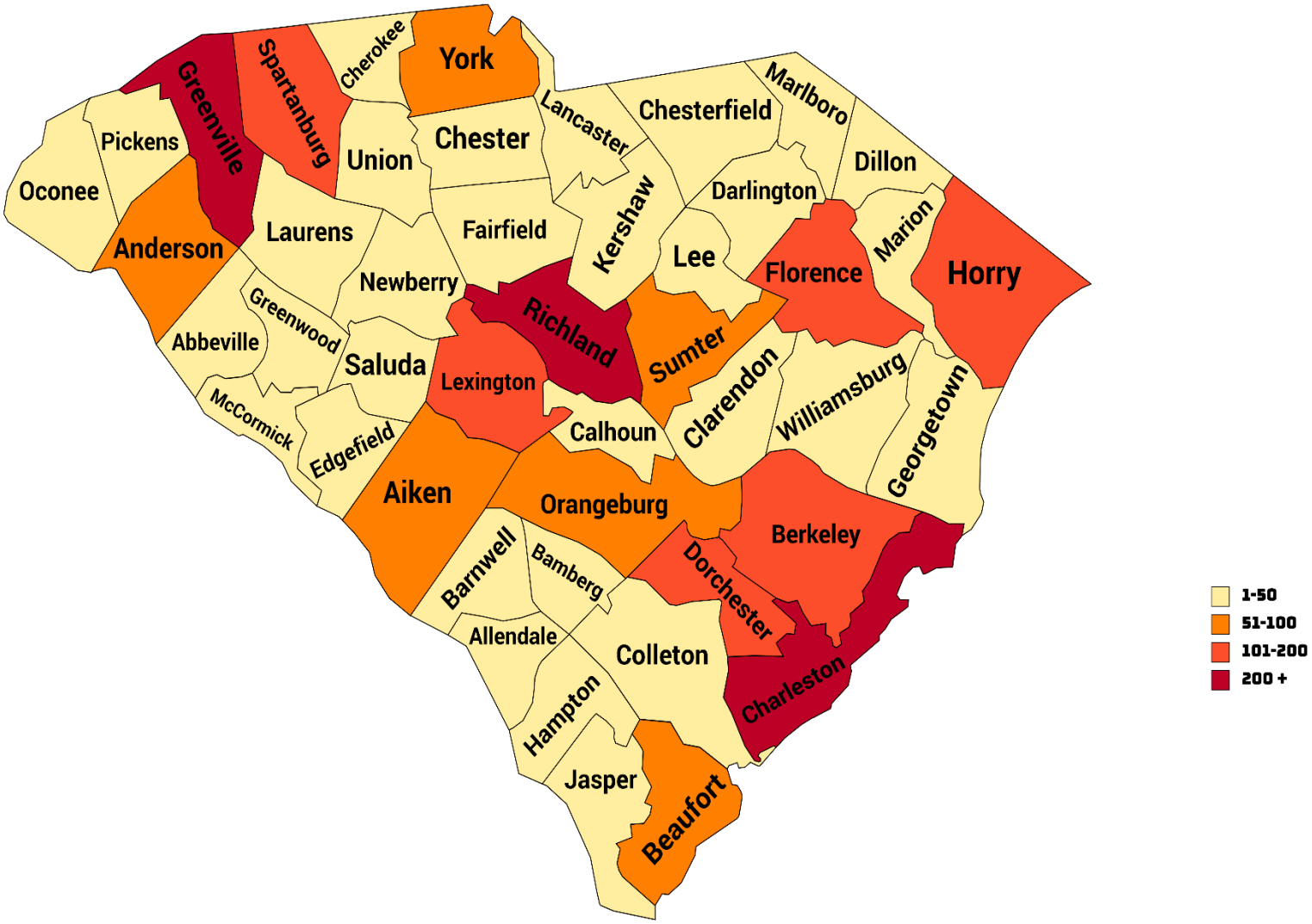
Breakdown of Complaints by Type of Fraud Chart – 2022



COUNTY COMPARISON BETWEEN 2020, 2021, AND 2022



2022 COMPLAINTS BY COUNTY MAP



2022 COMPLAINTS BY COUNTY

ABBEVILLE COUNTY

Type of Fraud	Number of Complaints
Automobile	2
Disability	0
Health/Medical	0
Life	1
Personal/Commercial	0
Premium	1
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**4**

AIKEN COUNTY

Type of Fraud	Number of Complaints
Automobile	38
Disability	1
Health/Medical	0
Life	21
Personal/Commercial	17
Premium	10
Unemployment	0
Worker's Compensation	3
Other	2
TOTAL	**92**

ALLENDALE COUNTY

Type of Fraud	Number of Complaints
Automobile	5
Disability	0
Health/Medical	1
Life	0
Personal/Commercial	0
Premium	1
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**7**

ANDERSON COUNTY

Type of Fraud	Number of Complaints
Automobile	40
Disability	0
Health/Medical	2
Life	3
Personal/Commercial	19
Premium	11
Unemployment	0
Worker's Compensation	3
Other	2
TOTAL	**80**

BAMBERG COUNTY

Type of Fraud	Number of Complaints
Automobile	3
Disability	0
Health/Medical	0
Life	1
Personal/Commercial	2
Premium	1
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**7**

BARNWELL COUNTY

Type of Fraud	Number of Complaints
Automobile	3
Disability	0
Health/Medical	0
Life	0
Personal/Commercial	1
Premium	1
Unemployment	0
Worker's Compensation	1
Other	0
TOTAL	**6**

BEAUFORT COUNTY

Type of Fraud	Number of Complaints
Automobile	32
Disability	0
Health/Medical	1
Life	6
Personal/Commercial	14
Premium	11
Unemployment	0
Worker's Compensation	0
Other	8
TOTAL	**72**

BERKELEY COUNTY

Type of Fraud	Number of Complaints
Automobile	59
Disability	1
Health/Medical	4
Life	8
Personal/Commercial	13
Premium	14
Unemployment	0
Worker's Compensation	3
Other	7
TOTAL	**109**

CALHOUN COUNTY

Type of Fraud	Number of Complaints
Automobile	4
Disability	0
Health/Medical	0
Life	2
Personal/Commercial	0
Premium	0
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**6**

CHARLESTON COUNTY

Type of Fraud	Number of Complaints
Automobile	138
Disability	2
Health/Medical	5
Life	9
Personal/Commercial	42
Premium	39
Unemployment	0
Worker's Compensation	17
Other	10
TOTAL	**262**

CHEROKEE COUNTY

Type of Fraud	Number of Complaints
Automobile	8
Disability	0
Health/Medical	1
Life	0
Personal/Commercial	4
Premium	5
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**18**

CHESTER COUNTY

Type of Fraud	Number of Complaints
Automobile	26
Disability	0
Health/Medical	0
Life	0
Personal/Commercial	2
Premium	2
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**30**

CHESTERFIELD COUNTY

Type of Fraud	Number of Complaints
Automobile	9
Disability	0
Health/Medical	1
Life	2
Personal/Commercial	2
Premium	1
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**15**

CLARENDON COUNTY

Type of Fraud	Number of Complaints
Automobile	6
Disability	0
Health/Medical	1
Life	1
Personal/Commercial	3
Premium	2
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**13**

COLLETON COUNTY

Type of Fraud	Number of Complaints
Automobile	16
Disability	0
Health/Medical	0
Life	1
Personal/Commercial	5
Premium	2
Unemployment	0
Worker's Compensation	1
Other	0
TOTAL	**25**

DARLINGTON COUNTY

Type of Fraud	Number of Complaints
Automobile	23
Disability	1
Health/Medical	1
Life	5
Personal/Commercial	6
Premium	3
Unemployment	0
Worker's Compensation	1
Other	2
TOTAL	**42**

DILLON COUNTY

Type of Fraud	Number of Complaints
Automobile	20
Disability	0
Health/Medical	1
Life	1
Personal/Commercial	2
Premium	3
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**27**

DORCHESTER COUNTY

Type of Fraud	Number of Complaints
Automobile	61
Disability	2
Health/Medical	4
Life	6
Personal/Commercial	20
Premium	10
Unemployment	0
Worker's Compensation	1
Other	7
TOTAL	**111**

EDGEFIELD COUNTY

Type of Fraud	Number of Complaints
Automobile	2
Disability	1
Health/Medical	0
Life	2
Personal/Commercial	2
Premium	0
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**7**

FAIRFIELD COUNTY

Type of Fraud	Number of Complaints
Automobile	14
Disability	0
Health/Medical	0
Life	2
Personal/Commercial	1
Premium	3
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**20**

FLORENCE COUNTY

Type of Fraud	Number of Complaints
Automobile	50
Disability	0
Health/Medical	2
Life	2
Personal/Commercial	24
Premium	20
Unemployment	0
Worker's Compensation	7
Other	3
TOTAL	**108**

GEORGETOWN COUNTY

Type of Fraud	Number of Complaints
Automobile	17
Disability	0
Health/Medical	0
Life	4
Personal/Commercial	7
Premium	3
Unemployment	0
Worker's Compensation	1
Other	0
TOTAL	**32**

GREENVILLE COUNTY

Type of Fraud	Number of Complaints
Automobile	103
Disability	4
Health/Medical	8
Life	20
Personal/Commercial	43
Premium	52
Unemployment	0
Worker's Compensation	12
Other	6
TOTAL	**248**

GREENWOOD COUNTY

Type of Fraud	Number of Complaints
Automobile	19
Disability	0
Health/Medical	0
Life	1
Personal/Commercial	5
Premium	15
Unemployment	0
Worker's Compensation	1
Other	2
TOTAL	**43**

HAMPTON COUNTY

Type of Fraud	Number of Complaints
Automobile	11
Disability	0
Health/Medical	1
Life	1
Personal/Commercial	5
Premium	0
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**18**

HORRY COUNTY

Type of Fraud	Number of Complaints
Automobile	98
Disability	2
Health/Medical	6
Life	6
Personal/Commercial	19
Premium	30
Unemployment	0
Worker's Compensation	6
Other	8
TOTAL	**175**

JASPER COUNTY

Type of Fraud	Number of Complaints
Automobile	14
Disability	0
Health/Medical	1
Life	1
Personal/Commercial	2
Premium	3
Unemployment	0
Worker's Compensation	1
Other	1
TOTAL	**23**

KERSHAW COUNTY

Type of Fraud	Number of Complaints
Automobile	20
Disability	0
Health/Medical	1
Life	4
Personal/Commercial	10
Premium	6
Unemployment	0
Worker's Compensation	1
Other	2
TOTAL	**44**

LANCASTER COUNTY

Type of Fraud	Number of Complaints
Automobile	21
Disability	2
Health/Medical	1
Life	4
Personal/Commercial	3
Premium	1
Unemployment	0
Worker's Compensation	1
Other	2
TOTAL	**35**

LAURENS COUNTY

Type of Fraud	Number of Complaints
Automobile	18
Disability	1
Health/Medical	0
Life	2
Personal/Commercial	3
Premium	8
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**32**

LEE COUNTY

Type of Fraud	Number of Complaints
Automobile	13
Disability	0
Health/Medical	0
Life	0
Personal/Commercial	1
Premium	2
Unemployment	0
Worker's Compensation	0
Other	1
TOTAL	**17**

LEXINGTON COUNTY

Type of Fraud	Number of Complaints
Automobile	65
Disability	1
Health/Medical	4
Life	5
Personal/Commercial	37
Premium	24
Unemployment	0
Worker's Compensation	3
Other	5
TOTAL	**144**

MARION COUNTY

Type of Fraud	Number of Complaints
Automobile	11
Disability	0
Health/Medical	0
Life	3
Personal/Commercial	1
Premium	2
Unemployment	0
Worker's Compensation	1
Other	0
TOTAL	**18**

MARLBORO COUNTY

Type of Fraud	Number of Complaints
Automobile	7
Disability	0
Health/Medical	0
Life	0
Personal/Commercial	1
Premium	1
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**9**

McCORMICK COUNTY

Type of Fraud	Number of Complaints
Automobile	3
Disability	0
Health/Medical	0
Life	1
Personal/Commercial	0
Premium	0
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**4**

NEWBERRY COUNTY

Type of Fraud	Number of Complaints
Automobile	13
Disability	1
Health/Medical	0
Life	1
Personal/Commercial	3
Premium	3
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**21**

OCONEE COUNTY

Type of Fraud	Number of Complaints
Automobile	12
Disability	0
Health/Medical	0
Life	2
Personal/Commercial	4
Premium	3
Unemployment	0
Worker's Compensation	2
Other	0
TOTAL	**23**

ORANGEBURG COUNTY

Type of Fraud	Number of Complaints
Automobile	36
Disability	0
Health/Medical	1
Life	5
Personal/Commercial	15
Premium	6
Unemployment	0
Worker's Compensation	1
Other	2
TOTAL	**66**

PICKENS COUNTY

Type of Fraud	Number of Complaints
Automobile	24
Disability	0
Health/Medical	1
Life	4
Personal/Commercial	2
Premium	5
Unemployment	0
Worker's Compensation	1
Other	2
TOTAL	**39**

RICHLAND COUNTY

Type of Fraud	Number of Complaints
Automobile	208
Disability	5
Health/Medical	13
Life	10
Personal/Commercial	98
Premium	49
Unemployment	1
Worker's Compensation	12
Other	22
TOTAL	**418**

SALUDA COUNTY

Type of Fraud	Number of Complaints
Automobile	3
Disability	0
Health/Medical	0
Life	0
Personal/Commercial	0
Premium	2
Unemployment	0
Worker's Compensation	0
Other	0
TOTAL	**5**

SPARTANBURG COUNTY

Type of Fraud	Number of Complaints
Automobile	78
Disability	0
Health/Medical	4
Life	12
Personal/Commercial	19
Premium	23
Unemployment	0
Worker's Compensation	6
Other	4
TOTAL	**146**

SUMTER COUNTY

Type of Fraud	Number of Complaints
Automobile	53
Disability	1
Health/Medical	0
Life	6
Personal/Commercial	6
Premium	14
Unemployment	0
Worker's Compensation	5
Other	14
TOTAL	**99**

UNION COUNTY

Type of Fraud	Number of Complaints
Automobile	5
Disability	0
Health/Medical	1
Life	0
Personal/Commercial	1
Premium	1
Unemployment	0
Worker's Compensation	0
Other	1
TOTAL	**9**

WILLIAMSBURG COUNTY

Type of Fraud	Number of Complaints
Automobile	16
Disability	0
Health/Medical	1
Life	1
Personal/Commercial	5
Premium	3
Unemployment	0
Worker's Compensation	0
Other	1
TOTAL	**27**

YORK COUNTY

Type of Fraud	Number of Complaints
Automobile	51
Disability	4
Health/Medical	3
Life	6
Personal/Commercial	21
Premium	17
Unemployment	0
Worker's Compensation	4
Other	7
TOTAL	**113**

OUT-OF-STATE / UNKNOWN

Type of Fraud	Number of Complaints
Automobile	111
Disability	4
Health/Medical	73
Life	30
Personal/Commercial	21
Premium	50
Unemployment	0
Worker's Compensation	9
Other	15
TOTAL	**313**

SELECTED STATUTES FROM THE SOUTH CAROLINA CODE OF LAWS PERTAINING TO THE OFFENSES FOR WHICH DEFENDANTS ARE PROSECUTED AND CONVICTED

§38-55-590. Annual report by Director of Insurance Fraud Division in **Office of Attorney General to General Assembly.**

The Director of the Insurance Fraud Division in the Office of the Attorney General shall annually report to the General Assembly regarding:

(A) the status of matters reported to the division, if not privileged information by law;

(B) the number of allegations or reports received.

(C) the number of matters referred to the State Law Enforcement Division for investigation;

(D) the outcome of all investigations and prosecutions under this article, if not privileged by law;

(E) the total amount of fines levied by the court and paid to or deposited by the division; and

(F) patterns and practices of fraudulent insurance transactions identified in the course of performing its duties. The director shall also periodically report this information to insurers transacting business in this State, health maintenance organizations transacting business in this State, and other persons, including the State of South Carolina, which provide benefits for health care in this State, whether these benefits are administered directly or through a third person.

§ **38-55-530. Definitions.**

As used in this article:

(A) "Authorized agency" means any duly constituted criminal investigative department or agency of the United States or of this State; the Department of lnsurance; the Department of Revenue; the Department of Public Safety; the Workers' Compensation Commission; the State Accident Fund; the Second Injury Fund; the Employment Security Commission; the Department of Consumer Affairs; the Human Affairs Commission; the Department of Health and Environmental Control; the Department of Social Services; the Department of Health and Human Services; the Department of Labor, Licensing and Regulation; all other state boards, commissions, and agencies; the Office of the Attorney General of South Carolina; or the prosecuting attorney of any judicial circuit, county, municipality, or political subdivision of this State or of the United States, and their respective employees or personnel acting in their official capacity.

(B) "Insurer" shall have the meaning set forth in Section 38-1-20(25) and includes any authorized insurer, self-insurer, reinsurer, broker, producer, or any agent thereof.

(C) "Person" means any natural person, company, corporation, unincorporated association, partnership, professional corporation, or other legal entity and includes any applicant, policyholder, claimant, medical providers, vocational rehabilitation provider, attorney, agent, insurer, fund, or advisory organization.

(D) "False statement and misrepresentation" means a statement or representation made by a person that is false, material, made with the person's knowledge of the falsity of the statement, and made with the intent of obtaining or causing another to obtain or attempting to obtain or causing another to obtain an undeserved economic advantage or benefit or made with the intent to deny or cause another to deny any benefit or payment in connection with an insurance transaction and such shall constitute fraud.

§ 38-55-540. Criminal penalties for making false statement or misrepresentation, or assisting, abetting, soliciting or conspiring to do so; restitution to victims.

(A) A person who knowingly makes a false statement or misrepresentation, and any other person knowingly, with an intent to injure, defraud, or deceive, or who assists, abets, solicits, or conspires with a person to make a false statement or misrepresentation, is guilty of a:

(1) misdemeanor, for a first offense violation, if the amount of the economic advantage or benefit received is less than one thousand dollars. Upon conviction, the person must be fined not less than one hundred nor more than five hundred dollars or imprisoned not more than thirty days;

(2) misdemeanor, for a first offense violation, if the amount of the economic advantage or benefit received is one thousand dollars or more but less than ten thousand dollars. Upon conviction, the person must be fined not less than two thousand nor more than ten thousand dollars or imprisoned not more than three years, or both;

(3) felony, for a first offense violation, if the amount of the economic advantage or benefit received is ten thousand dollars or more but less than fifty thousand dollars. Upon conviction, the person must be fined not less than ten thousand nor more than fifty thousand dollars or imprisoned not more than five years, or both;

(4) felony, for a first offense violation, if the amount of the economic advantage or benefit received is fifty thousand dollars or more. Upon conviction, the person must be fined not less than twenty thousand nor more than one hundred thousand dollars or imprisoned not more than ten years, or both;

(5) felony, for a second or subsequent violation, regardless of the amount of the economic advantage or benefit received. Upon conviction, the person must be fined not less than twenty thousand nor more than one hundred thousand dollars or imprisoned not more than ten years, or both.

(B) In addition to the criminal penalties set forth in subsection (A), a person convicted pursuant to the provisions of this section must be ordered by the court to make full restitution to a victim for any economic advantage or benefit which has been obtained by the person as a result of that violation, and to pay the difference between any taxes owed and any taxes the person paid, if applicable.

SECTION 38-55-170. Presenting false claims for payment.

A person who knowingly causes to be presented a false claim for payment to an insurer transacting business in this State, to a health maintenance organization transacting business in this State, or to any person, including the State of South Carolina, providing benefits for health care in this State, whether these benefits are administered directly or through a third person, or who knowingly assists, solicits, or conspires with another to present a false claim for payment as described above, is guilty of a:

(1) felony if the amount of the claim is ten thousand dollars or more. Upon conviction, the person must be imprisoned not more than ten years or fined not more than five thousand dollars, or both;

(2) felony if the amount of the claim is more than two thousand dollars but less than ten thousand dollars. Upon conviction, the person must be fined in the discretion of the court or imprisoned not more than five years, or both;

(3) misdemeanor triable in magistrates court or municipal court, notwithstanding the provisions of Sections 22-3-540, 22-3-545, 22-3-550, and 14-25-65, if the amount of the claim is two thousand dollars or less. Upon conviction, the person must be fined not more than one thousand dollars, or imprisoned not more than thirty days, or both.

§ **38-55-550. Civil penalties for violations of article; costs; payment; use of revenues; Attorney General to assist Insurance Fraud Division; consent agreements.**

(A) In addition to any criminal liability, any person who is found by a court of competent jurisdiction to have violated any provision of this article, including Section 38-55-170, is subject to a civil penalty for each violation as follows:

(I) for a first offense, a fine not to exceed five thousand dollars;
(2) for a second offense, a fine of not less than five thousand dollars but not to exceed ten thousand dollars;
(3) for a third and subsequent offense, a fine of not less than ten thousand dollars but not to exceed fifteen thousand dollars.
(B) The civil penalty must be paid to the director of the Insurance Fraud Division to be used in
accordance with subsection (D) of this section. The court may also award court costs and reasonable attorneys' fees to the director. When requested by the director, the Attorney General may assign one or more deputies attorneys general to assist the bureau in any civil court proceedings against the person.
(C) Nothing in subsections (A) and (B) shall be construed to prohibit the director of the Insurance Fraud Division and the person alleged to be guilty of a violation of this article from entering into a written agreement in which the person does not admit or deny the charges but consents to payment of the civil penalty. A consent agreement may not be used in a subsequent civil or criminal proceeding relating to any violation of this article.

(D) All revenues from the civil penalties imposed pursuant to this section must be used to provide funds for the costs of enforcing and administering the provisions of this article.

§ **38-43-240. Other offenses by producers.**

(A) It is unlawful for a producer, collector, or other person to:

(1) undertake or pretend to represent an insurer licensed to do business in this State, or to collect or do business for the insurer without the authority of the insurer;

(2) secure cash advances by false statements; or

(3) fail to turn over or satisfactorily account for all collections of the insurer when required.

(B) A person who violates the provisions of this section is guilty of a misdemeanor and, upon conviction, must be fined in the discretion of the court or imprisoned not more than two years.

§ **16-11-110. Arson.**

(A) A person who wilfully and maliciously causes an explosion, sets fire to, burns, or causes to be burned or aids, counsels, or procures a burning that results in damage to a building, structure, or any property specified in subsections (B) and (C), whether the property of the person or another, which results, either directly or indirectly, in death or serious bodily injury to a person is guilty of the felony of arson in the first degree and, upon conviction, must be imprisoned not less than thirty years.

(B) A person who wilfully and maliciously causes an explosion, sets fire to, burns, or causes to be burned or aids, counsels, or procures a burning that results in damage to a dwelling house, church or place of worship, public or private school facility, manufacturing plant or warehouse, building where business is conducted, institutional facility, or any structure designed for human occupancy including local and municipal buildings, whether the property of the person or another, is guilty of the felony of arson in the second degree and, upon conviction, must be imprisoned not less than three nor more than twenty-five years.

(C) A person commits a violation of the provisions of this subsection who wilfully and maliciously:

(1) causes an explosion, sets fire to, burns, or causes a burning which results in damage to a building or structure other than those specified in subsections (A) and (B}, a railway car, a ship, boat, or other watercraft, an aircraft, an automobile or other motor vehicle, or personal property; or

(2) aids, counsels, or procures a burning that results in damage to a building or structure other

than those specified in subsections (A) and (B), a railway car, a ship, boat, or other watercraft, an aircraft, an automobile or other motor vehicle, or personal property with intent to destroy or damage by explosion or fire, whether the property of the person or another.

A person who violates the provisions of this subsection is guilty of the felony of arson in the third degree and, upon conviction, must be imprisoned not more than fifteen years.

(D) For purposes of this section, "damage" means an application of fire or explosive that results in burning, charring, blistering, scorching, smoking, singeing, discoloring, or changing the fiber or composition of a building, structure, or any property specified in this section.

§ 16-13-10. Forgery.

(A) It is unlawful for a person to:

(1) falsely make, forge, or counterfeit; cause or procure to be falsely made, forged, or counterfeited; or wilfully act or assist in the false making, forging, or counterfeiting of any writing or instrument of writing;

(2) utter or publish as true any false, forged, or counterfeited writing or instrument of writing;

(3) falsely make, forge, counterfeit, alter, change, deface, or erase; or cause or procure to be falsely made, forged, counterfeited, altered, changed, defaced, or erased any record or plat of land; or

(4) willingly act or assist in any of the premises, with an intention to defraud any person.

(B) A person who violates the provisions of this section is guilty of a:

(1) felony and, upon conviction, must be fined in the discretion of the court or imprisoned not more than ten years, or both, if the amount of the forgery is ten thousand dollars or more;

(2) felony and, upon conviction, must be fined in the discretion of the court or imprisoned not more than five years, or both, if the amount of the forgery is less than ten thousand dollars.

(C) If the forgery does not involve a dollar amount, the person is guilty of a misdemeanor under the jurisdiction of the magistrates or municipal court, notwithstanding the provisions of Sections 22-3-540, 22-3-545, 22-3-550, and 14-25-65, and, upon conviction, must be fined in the discretion of the court or imprisoned not more than three years, or both.

§ **16-17-722. Filing of false police reports; knowledge; offense; penalties.**

(A) It is unlawful for a person to knowingly file a false police report.

(8) A person who violates subsection (A) by falsely reporting a felony is guilty of a felony and upon conviction must be imprisoned for not more than five years or fined not more than one thousand dollars, or both.

(C) A person who violates subsection (A) by falsely reporting a misdemeanor is guilty of a misdemeanor and must be imprisoned not more than thirty days or fined not more than five hundred dollars, or both.

(D) In imposing a sentence under this section, the judge may require the offender to pay restitution to the investigating agency to offset costs incurred in investigating the false police report.

§ **16-11-125. Making false claim or statement in support of claim to obtain insurance benefits for fire or explosion loss.**

Any person who wilfully and knowingly presents or causes to be presented a false or fraudulent claim, or any proof in support of such claim, for the payment of a fire loss or loss caused by an explosion, upon any contract of insurance or certificate of insurance which includes benefits for such a loss, or prepares, makes, or subscribes to a false or fraudulent account, certificate, affidavit, or proof of loss, or other documents or writing, with intent that such documents may be presented or used in support of such claim, is guilty of a felony and, upon conviction, must be fined not more than ten thousand dollars or imprisoned for not more than five years or both in the discretion of the court.

The provisions of this section are supplemental to and not in lieu of existing law relating to falsification of documents and penalties therefor.

§ **38-43-245. Fraudulent insurance application.**

A licensed insurance producer who, with the intent to injure, defraud, or deceive any insurance company or applicant for insurance:

(1) presents or causes to be presented to any insurance company an application for insurance, knowing that the application contains any false or misleading information or omissions concerning any fact or thing material to the underwriting of the insurance for which the application is submitted, or

(2) assists, abets, solicits, or conspires with another to prepare or make an application for insurance, knowing that the application contains any false or misleading information or omissions concerning any fact or thing material to the underwriting of the insurance for which

the applicant is submitted, is guilty of a felony and, upon conviction, must be punished by imprisonment for not more than five years or a fine not to exceed five thousand dollars, or both.

§ 38-55-580. Immunity from liability arising out of providing information concerning false statements or misrepresentations to authorized agency; malice or bad faith.

(A) A person, insurer, or authorized agency, when acting without malice or in good faith, is immune from any liability arising out of filing reports, cooperating with investigations by any authorized agency, or furnishing other information, whether written or oral, and whether in response to a request by an authorized agency or upon their own initiative, concerning any suspected, anticipated, or completed false statement or misrepresentation when such reports or information are provided to or received by any authorized agency.

(B) Nothing herein abrogates or modifies in any way common law or statutory privilege or immunity heretofore enjoyed by any person, insurer, or authorized agency.

(C) Nothing herein limits the liability of any person or insurer who, with malice or in bad faith, makes a report of suspected fraud under the provisions of this article.

(D) In addition to the immunity granted in this section, persons identified as designated employees whose responsibilities include the investigation and disposition of claims relating to suspected fraudulent insurance acts may share information relating to persons suspected of committing fraudulent insurance acts with other designated employees employed by the same or other insurers whose responsibilities include the investigation and disposition of claims relating to fraudulent insurance acts, provided the department has been given written notice of the names and job titles of these designated employees prior to any designated employee sharing information. Unless the designated employees of the insurer act in bad faith or in reckless disregard for the rights of any insured, neither the insurer nor its designated employees are civilly liable for libel, slander, or any other relevant tort, and a civil action does not arise against the insurer or its designated employees:

(1) for any information related to suspected fraudulent insurance acts provided to an insurer; or

(2) for information related to suspected fraudulent insurance acts provided to the National Insurance Crime Bureau or the National Association of Insurance Commissioners.

Provided, however, that the qualified immunity against civil liability conferred on any insurer or its designated employees shall be forfeited with respect to the exchange or publication of any defamatory information with third persons not expressly authorized by subsection (D) to share in such information.

NICB LETTER AND INSURANCE FRAUD FACT SHEET

NATIONAL INSURANCE CRIME BUREAU

October 12, 2023

The Honorable Jeffrey E. “Jeff” Johnson and Members of the Committee
Ad Hoc Committee to Study Insurance Fraud
South Carolina House of Representatives

RE: NICB Insurance Fraud Fact Sheet

Dear Chair Johnson and Members of the Committee:

The National Insurance Crime Bureau (NICB) is a national, century-old, not-for-profit organization supported by approximately 1,200 property and casualty insurance companies, including many who write business in South Carolina. Working hand-in-hand with our member companies and South Carolina state and local law enforcement, we help to detect, prevent, and deter insurance crimes. While NICB provides value to our member companies, we also serve a significant public benefit by helping to stem the estimated billions of dollars in economic harm that insurance crime causes to individual policy holders across the country every year.

NICB commends the Ad Hoc Committee for their work to study insurance fraud in South Carolina. NICB strongly supports efforts by State of South Carolina and its agencies to combat insurance fraud.

South Carolina’s insurance fraud-fighting efforts are spearheaded by the Insurance Fraud Division. Through a memorandum of understanding (MOU), the Division was transferred from the purview of the Attorney General’s Office to the Department of Insurance. The Division works with the South Carolina Law Enforcement Division (SLED) to review and investigate referred cases. According to a 2021 news release, SLED has dedicated a team of 4 law enforcement agents to investigate insurance fraud cases. These agents are responsible for investigating a yearly average of 2,650 questionable claims (QCs) filed in South Carolina. NICB provides assistance to SLED with reviewing cases for investigation.

The nearly 8,000 QCs reported since 2020 offer insight into the fraud trends impacting South Carolina, with staged vehicle accidents being the most significant and prevalent fraud issue in the state. Following a staged accident, criminals will use fraudulent information, such as inflated medical billing, to influence settlements from insurers during mediation. For example, a staged accident ring where the passengers within the struck vehicle are complicit will visit multiple health clinics and receive a myriad of treatments for alleged soft tissue injuries that cannot be verified through medical imaging in order to increase the total amount of the insurance claim. The Fact Sheet included with this letter provides information on the different tactics utilized by fraudsters and data regarding staged accidents at the local, state, and national levels. The impact on residents includes both a financial cost and a safety risk. Residents are not only faced with the costs from the damage done to their vehicles, but also risk serious injury and possible death as a result of vehicle accidents deliberately caused by fraudsters.

NICB commends previous efforts by the House of Representatives to combat these fraud trends, including passing legislation in 2021 that would have fixed state statutes to permanently move the Insurance Fraud Division under the Department of Insurance. This measure would enhance the Division's ability to combat fraud, provide access to critical resources, and assist with improving interagency communication. Although the legislation was not enacted, NICB strongly encourages the House of Representatives to revisit this issue. In addition, NICB also recommends enhancing state law to more effectively deter fraudsters, including raising minimum criminal penalties for insurance fraud. Finally, NICB also supports efforts to provide the Division with the additional resources needed to effectively carry out their fraud-fighting mission.

We thank you for your consideration and we strongly encourage you to utilize NICB as a resource and partner in the fight against insurance crimes. If you have any questions or need additional information, please contact me at edecampos@nicb.org or 847.989.7104.

Sincerely,

Eric M. De Campos
Director
Strategy, Policy and Government Affairs
National Insurance Crime Bureau

NICB Insurance Fraud Fact Sheet

South Carolina Fraud Trends

NICB's operations have identified two insurance fraud trends significantly impacting South Carolina: the use of staged vehicle accidents; and stealing identities of insureds to file fraudulent claims on their behalf.

1. Staged Vehicle Accidents

Staged vehicle accidents are used by fraudsters as a tool to defraud insurers by submitting fraudulent medical bills following a deliberate vehicle accident for soft tissue injuries or other injuries that cannot be disputed by a medical exam to an insurer. Staged vehicle accidents occur more frequently in urban areas where there is a greater volume of vehicles, as well as in wealthier communities where drivers are perceived to have more comprehensive insurance coverage. Criminals often target new, rental, or commercial vehicles due to greater insurance coverage for these vehicles. Further, women and senior citizens are frequently targeted as they are perceived by fraudsters to be less confrontational during accident schemes. Common staged vehicle accident tactics include:

- **Left, Right, or Curb Turn Drive Downs**: fraudsters attempt to hit vehicles making a left or right turn at a stop sign or traffic signal, or as a driver attempts to pull away from a curb.
- **Swoop-And-Squat**: Fraudsters use several vehicles to box in the victim and force a rear-end-accident.
- **Paper Claims**: Fraudsters file a hit-and-run claim despite the vehicle having preexisting damage. This tactic ensures no other driver can be interviewed to refute the claim.
- **Co-Conspirator Accidents**: a fraudster will recruit another individual to purposely crash into their vehicle with several co-conspirators inside in order to submit as many fraudulent medical bills as possible for each passenger. This tactic could involve the use of the fraudsters' personal vehicle or potentially stolen vehicles.
- **Rideshare Fraud**: Similar to co-conspirator accidents, a fraudster will intentionally strike a rideshare vehicle carrying co-conspirators as passengers. Rideshare companies are known to carry commercial insurance coverage with higher payouts compared to personal auto policies, which makes rideshare vehicles an attractive target for higher monetary settlements.

2. Identify Theft

Fraudsters steal or procure stolen identities in order to file fraudulent insurance claims and secure a quick settlement. Insurers believe they are interacting with the policyholder given the fraudster's ability to provide verifying information. The claims are settled and closed before the real policyholder is able to realize they have been victimized.

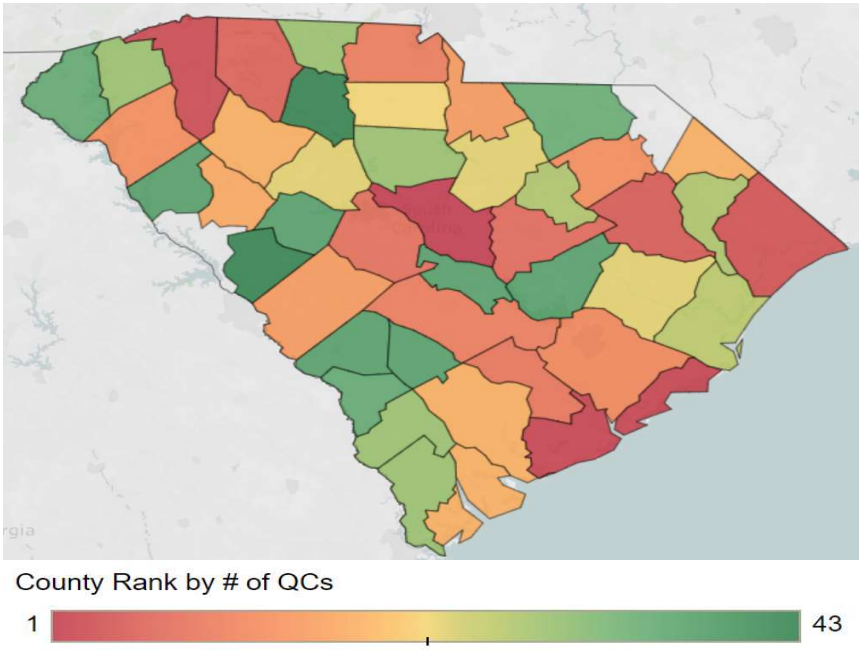
Geographic Questionable Vehicle Claims Analysis

With staged vehicle accidents a significant fraud trend in South Carolina, NICB conducted an analysis of questionable vehicle-related insurance claims by city spanning from 2020 through 2022. NICB's analysis identified the City of Columbia with the largest number of QCs in South Carolina, accounting for 118, or 13% of claims. Columbia is followed by Greenville with 48, and Florence with 35. North Charleston and the City of Sumter both recorded 28 QCs from 2020 through 2022.

South Carolina Suspicious Vehicle Accident QCs by City – Top 5				
City	2020	2021	2022	Total
Columbia	39	34	45	118
Greenville	19	13	16	48
Florence	16	10	9	35
Spartanburg	10	10	9	29
North Charleston	9	9	10	28
Sumter	15	8	5	28

An analysis of QCs by county was conducted from 2020 through 2022. Richland County ranked above all other counties in South Carolina with 131 QCs, followed by Charleston County with 65, and Greenville County with 64 claims.

South Carolina Suspicious Vehicle Accident QCs by County – Top 5				
County	2020	2021	2022	Total
Richland	43	40	48	131
Charleston	26	22	17	65
Greenville	30	16	18	64
Horry	19	19	15	53
Florence	23	14	10	47



National Questionable Vehicle Claims Analysis

NICB conducted an analysis of questionable vehicle-related insurance claims by state spanning from 2020 through 2022. NICB's analysis ranks South Carolina as 13th in the nation in terms of total Suspicious Vehicle Accident QCs from 2020 – 2022. South Carolina ranks significantly higher than states with similar population levels such as Alabama, Kentucky, and Louisiana.

State QC Rank 2020 - 2022		
QC Count Rank	**State**	**Total QCs (2020 - 2022)**
1	California	17,240
2	New York	4,289
3	Florida	3,745
4	Texas	3,479
5	Massachusetts	1,661
6	Virginia	1,524
7	Maryland	1,475
8	Georgia	1,447
9	Illinois	1,427
10	North Carolina	1,132
11	Ohio	913
12	Pennsylvania	907
13	South Carolina	889
14	Washington	746
15	Missouri	692
16	Arizona	690
17	Louisiana	678
18	Nevada	649
19	Michigan	648
20	Tennessee	577
21	Hawaii	560
22	Colorado	454
22	New Jersey	454
24	Minnesota	451
25	Connecticut	446
26	Oregon	309
27	Wisconsin	292
28	Kentucky	281
29	District of Columbia	260
30	Alabama	259
31	Indiana	246
32	New Mexico	234
33	Mississippi	205
34	Oklahoma	185
35	Rhode Island	182
36	Arkansas	180
37	Delaware	140

38	Alaska	134
39	Utah	128
40	Kansas	125
41	Iowa	107
42	West Virginia	98
43	Nebraska	82
44	Idaho	73
45	New Hampshire	52
46	Maine	40
47	North Dakota	39
48	Vermont	32
49	Montana	29
50	South Dakota	27
51	Wyoming	13

Appendix: Methodology

Data was collected from the NICB Questionable Claims database with the following criteria:

- Questionable claims with a referral reason of “Suspicious Hit While Parked”, “Paper Accident/Phantom Accident”, and/or “Staged/Caused Accident” with a referral date between January 1, 2020 and June 30, 2023.