Texas Department of Insurance
Fraud Unit
Annual Report to the Commissioner

December 2016

Texas Department of Insurance
333 Guadalupe | Austin, Texas 78701
(800) 252-3439
www.tdi.texas.gov/fraud

Contents

EXECUTIVE SUMMARY

Texas Insurance Code, Section 701.101, requires the Fraud Unit to annually report to the commissioner of insurance the number of completed cases and recommendations for regulatory or statutory responses to the types of fraud the unit encounters.

FY 2016 STATISTICS

- Fraud reports received – 13,197
- Cases opened for investigation - 366
- Matters referred for prosecution – 106 different cases with 131 suspects
- Estimated amount of fraud identified in referred cases – $10.8 million
- Indictments or Information issued resulting from investigations - 119
- Judgments from cases referred – 116
- Fines assessed by courts on Fraud Unit cases – $84,025
- Restitution assessed by courts on Fraud Unit cases – $1.38 million
- Subpoenas issued – 343
- Public Information Act requests – 253

NOTEWORTHY ACCOMPLISHMENTS

- Implemented new records management system
- Initiated new Catastrophe Response Team (CRT) in response to severe weather events
- Hosted the 17th Annual Insurance Fraud Conference
- Completed peace officer and attorney-mandated training
- Imbedded investigator as Task Force Officer with FBI
- Created digital forensic investigator position

TOP ADJUDICATED CASES

This report summarizes 10 investigations that resulted in criminal prosecutions and convictions.

LEGISLATIVE RECOMMENDATIONS

There are no recommendations for legislative changes in this report.

Fraud Unit Overview

The Texas Department of Insurance Fraud Unit enforces laws relating to fraudulent insurance acts.[1] The unit protects the public from economic harm by investigating criminal insurance fraud allegations. Responsibilities include receiving and reviewing fraud reports, initiating inquiries, and conducting investigations when evidence shows insurance fraud might have been or is being committed. The Fraud Unit actively seeks criminal indictments, makes arrests, and helps with prosecutions to deter insurance fraud in Texas.

The Fraud Unit includes investigators, management, fraud prosecutors, and administrative support. Fraud Unit investigators are commissioned peace officers. The chief investigator supervises and directs the peace officers and coordinates and oversees the Fraud Unit's investigations.[2]

Fraud Unit Philosophy

- We practice the highest ethical standards of law enforcement.
- As peace officers, we promise to obey the oath of office and to adhere to the Law Enforcement Code of Ethics.
- All members of the unit conduct themselves according to the highest principles of their professions and in an exemplary manner.
- We protect and serve the people of Texas.
- We educate and help the public, the insurance industry, and other law enforcement agencies in efforts to identify and combat insurance fraud through enforcement of applicable statutes.

Fraud Reporting

Insurance fraud is a significant problem in Texas. In fiscal year (FY) 2016, the Fraud Unit received 13,197 reports. The unit conducts outreach and education to create awareness and emphasize the importance of reporting suspected fraudulent activity.

The Fraud Unit receives fraud reports in several different ways and from many different entities, including insurance carriers, the National Insurance Crime Bureau, National Association of Insurance Commissioners, consumers, and businesses.

The Fraud Unit encourages everyone to report suspected insurance fraud. Anyone may report fraud by email or phone, or by completing an online form at www.tdi.texas.gov/fraud/report.html. The unit maintains the Fraud Report Hotline, which allows people to report fraud to a Fraud Unit investigator.

[1] Texas Insurance Code, Section 701.101(a)
[2] Texas Insurance Code, Section 701.104(b)

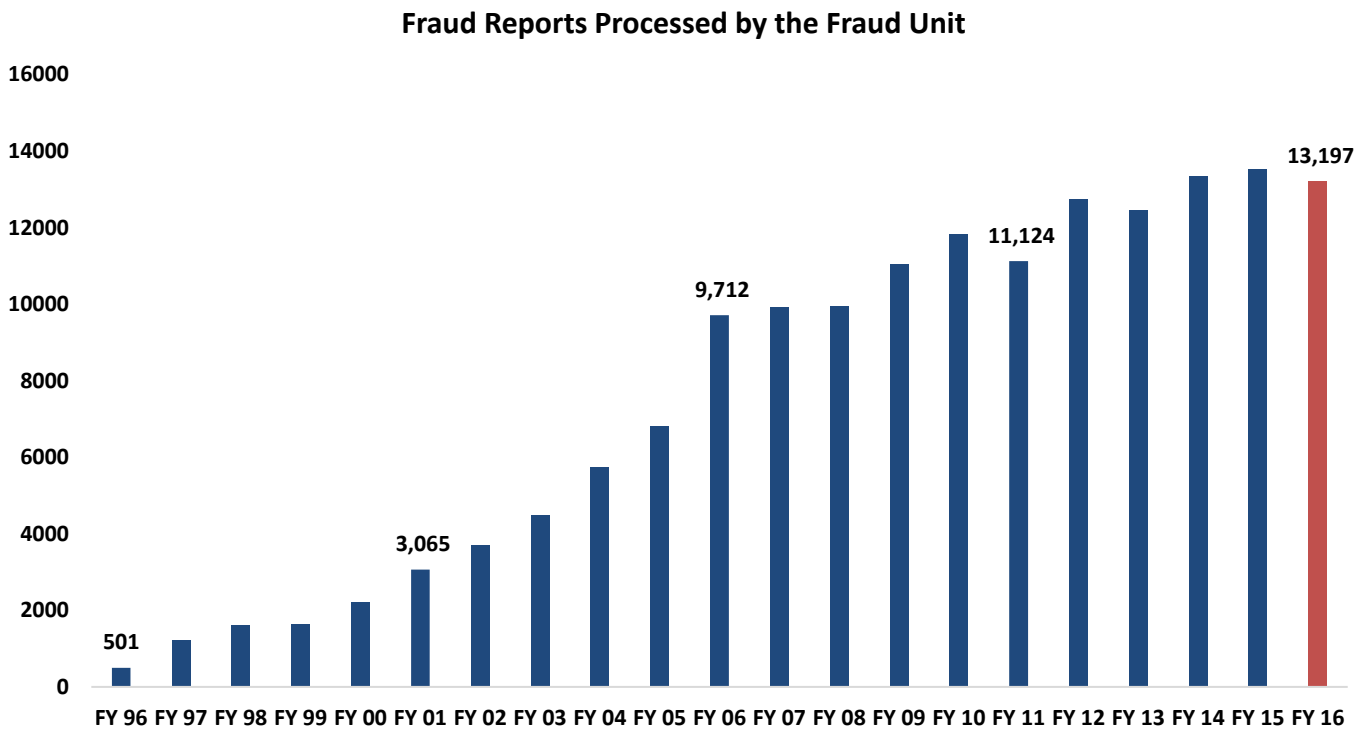


Figure 1: Fraud Reports Received since Inception of Fraud Unit

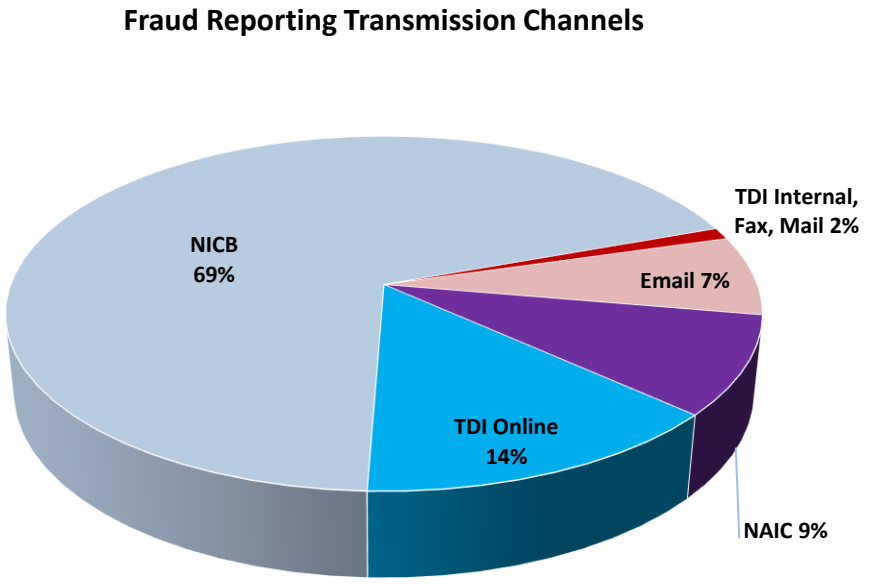


Figure 2: FY 2016 Fraud Reporting Transmission Channels

Types of Fraud Schemes Reported

Fraud Schemes	2014 (13,341 reports)	2015 (13,513 reports)	2016 (13,197 reports)
Adjuster Fraud	0.26%	0.80%	1.16%
Agent Conversion	0.81%	0.56%	.59%
Agent Fraud	1.72%	2.52%	2.60%
Arson for Profit	1.59%	1.25%	1.32%
Auto Body Shop Fraud	0.79%	0.81%	1.36%
Auto Burglary	0.50%	0.41%	.41%
Auto Theft	7.32%	6.50%	5.97%
Cargo Theft	0.01%	0.15%	.03%
Company Employee Fraud	0.07%	0.04%	.04%
Company Officer Fraud	0.08%	0.12%	.04%
Disaster Adjuster Fraud	0.00%	0.01%	.00%
Disaster Claim Fraud	0.02%	0.25%	.05%
Escrow/Fee Attorney	0.00%	0.01%	.01%
Extensive Loss History	0.92%	0.61%	.63%
Faked Death	0.02%	0.04%	.04%
Faked Injury	7.81%	7.68%	7.33%
False Billing	0.51%	1.43%	1.22%
False Claim Documents/Statements(s)	35.89%	38.96%	32.06
Fictitious Insurance Card	0.19%	0.17%	.15%
Fictitious Insurance Certificate	0.23%	0.19%	.24%
Hail Damage	3.55%	3.34%	5.88%
Identity Theft	0.37%	0.53%	.40%
Inflated Claim	3.64%	2.05%	2.23%
Jump In	1.09%	0.90%	1.12%
Life Settlement Fraud	0.00%	0.00%	.01%
Man Made Roof Damage	0.52%	0.39%	.37%
Medicaid Fraud	0.01%	0.01%	.01%
Medicare Fraud	0.01%	0.02%	.01%
Mortgage Fraud	0.04%	0.04%	.02%
Organized Crime	0.54%	0.48%	.47%
Owner Give Up	0.31%	0.16%	.45%
Paper Accident	3.73%	2.75%	3.35%
Policy Application Fraud	7.14%	6.76%	10%
Premium Fraud	0.79%	1.07%	.84%
Provider Billing Fraud	4.98%	4.91%	6.06%
Runner/Capper	0.46%	0.42%	.41%
Slip & Fall	1.33%	1.54%	.02%
Soft Tissue Injury	0.03%	0.00%	.02%
Staged Accident	1.49%	1.23%	1.44%
Theft	6.99%	6.80%	5.75%
Theft from Elderly	0.05%	0.04%	.07%
TPA Fraud	0.02%	0.01%	0.00%
Undetermined	1.22%	0.78%	.47%
Unlicensed Agent	0.23%	0.44%	.41%
Unlicensed Company	0.13%	0.10%	.12%
Vendor Fraud	1.27%	1.46%	1.76%
Water Damage - HO	0.56%	0.54%	.76%
Working & Drawing	0.73%	0.70%	1.03%

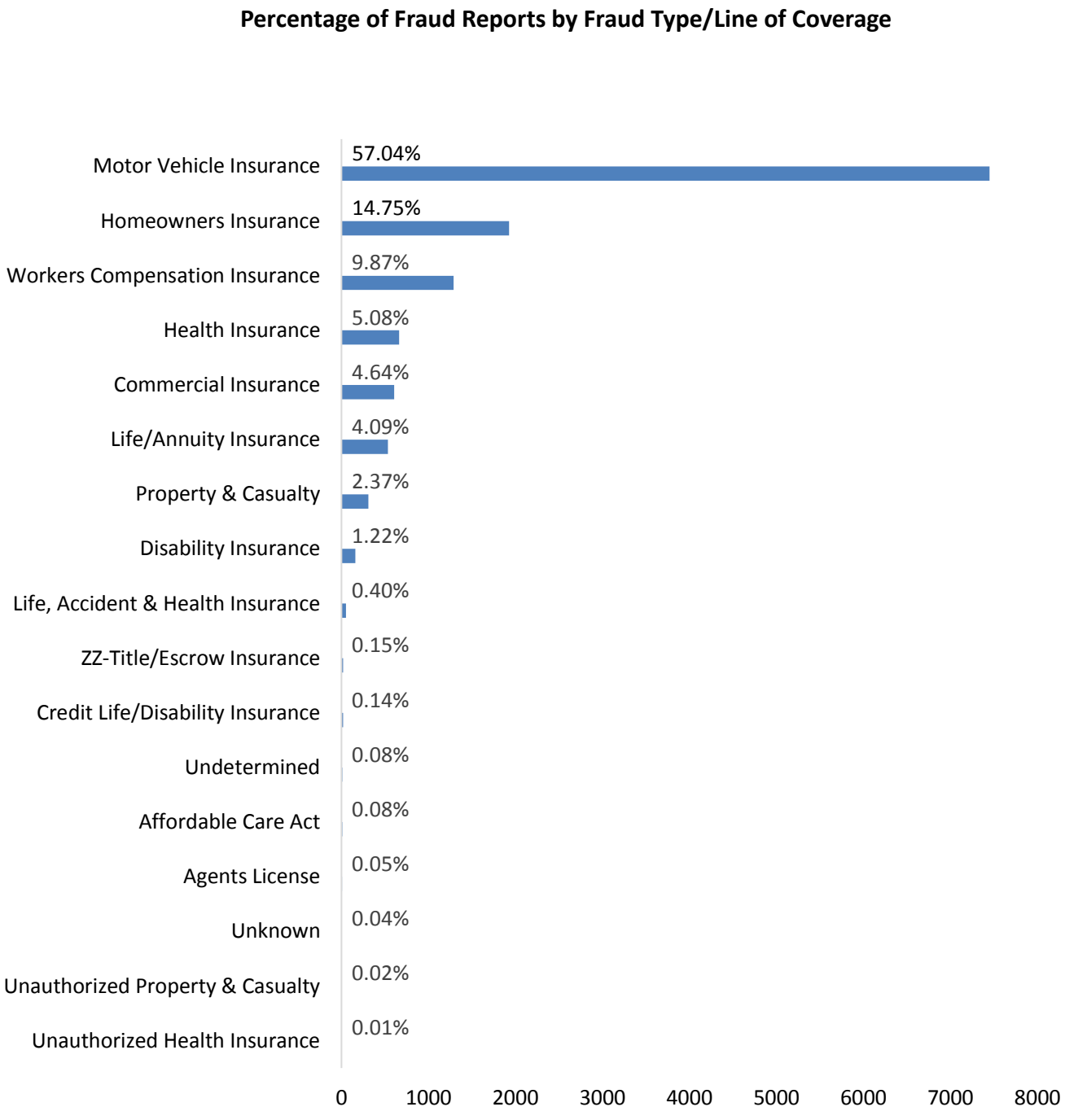


Figure 3: FY 2016 Fraud Reports by Type/Line of Coverage

In FY 2016, the Fraud Unit opened 366 investigations from fraud reports. The following table shows the number of reports received and the corresponding cases opened by type of fraud and line of coverage.

Fraud Type/Line of Coverage	No. of reports received	No. of cases opened	Percentage opened as compared to number received
Affordable Care Act	10	1	10%
Agents License	6	1	17%
Commercial Insurance	606	34	6%
Disability Insurance	160	18	11%
Health Insurance	663	29	4%
Homeowners Insurance	1927	67	3%
Life, Accident & Health Insurance	52	4	8%
Life/Annuity Insurance	534	39	7%
Motor Vehicle Insurance	7451	91	1%
Property & Casualty	310	41	13%
Title/Escrow Insurance	19	8	42%
Unauthorized Property & Casualty Ins.	2	1	50%
Workers' Compensation Insurance	1289	32	2%

In FY 2016, the unit referred 106 cases to prosecutors. The following table shows the number of referrals by fraud type and line of coverage for fiscal years 2014 through 2016.

Referral Fraud Type/Line of Coverage	FY 2014	FY 2015	FY 2016
Agents License	0	2	1
Credit Life/Disability Insurance	1	0	0
Commercial Insurance	9	10	7
Disability Insurance	16	8	11
Health Insurance	7	8	9
Homeowners Insurance	21	33	18
Life, Accident & Health Insurance	3	1	1
Life/Annuity Insurance	6	23	5
Motor Vehicle Insurance	98	67	26
Property & Casualty	9	10	9
Title/Escrow Insurance	4	0	3
Unauthorized Property & Casualty Insurance	1	0	0
Workers' Compensation Insurance	13	7	16

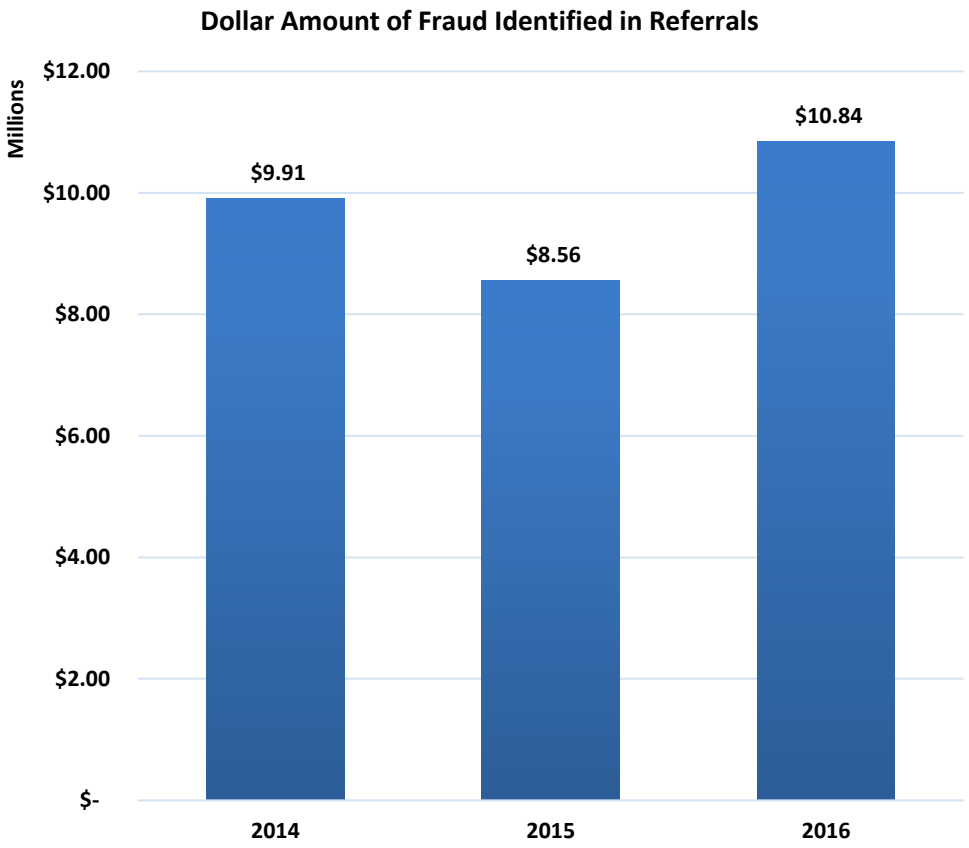


Figure 4: FY 2016 Dollar Amount Identified in Referrals

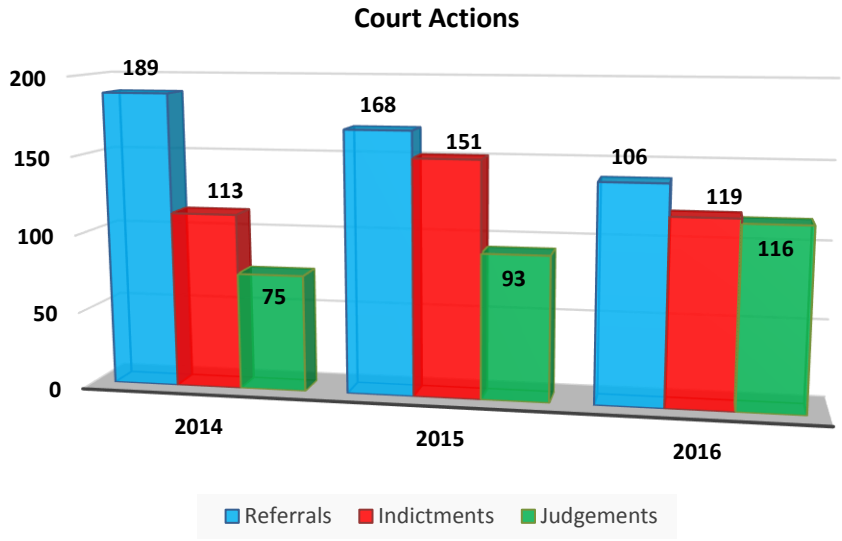


Figure 5: FY 2014-2016 Court Actions

Regionalized Fraud Unit

Although insurance fraud is traditionally associated with densely populated urban areas, the unit receives reports from rural areas as well. During FY 2016, the unit worked on a total of 977 fraud investigations. At the end of the fiscal year, there were 347 active investigations pending in 123 cities and 60 counties across the state. The unit has investigators in Austin, Dallas, Fort Worth, Houston, McAllen, and San Antonio.

In addition to reducing travel-related costs, the regionalization concept helps foster more relationships with fraud victims, as well as with local law enforcement agencies that might not be as familiar with the intricacies of this type of financial crime. Local authorities have shown a great interest in developing working relationships with the unit.

Administrative Operations

The dedication of the Fraud Unit's Administrative Operations staff drives much of the Fraud Unit's success. The investigative process begins with intake staff reviewing every incoming fraud report. They compile information from the reports and provide them to management to decide whether to proceed with formal investigations.

Criminal analysts research investigative databases and files for any clues relevant to the cases, and then provide findings to investigators. The analysts review financial data and provide graphics that prosecutors use to illustrate the flow of money associated with various insurance fraud schemes. The criminal analysts also develop link charts to show the relationships between everyone involved in the fraud scheme.

The remaining staff in Administrative Operations oversee open records requests, archived files, equipment and supplies inventory; process travel requests and reimbursements; and handle personnel matters, the unit's budget, subpoenas, evidence, and progress of referred cases.

Special Projects

The Special Projects Team consists of an investigator certified as a project management professional (PMP) and a digital forensic investigator. With the coordination and oversight provided by the unit's PMP, the Fraud Unit in FY 2016 implemented a new records management system ("X-Fire") that has expanded its ability to provide fraud report data in a more efficient manner. The intake section's fraud report processing time improved by 49 percent.

Also in FY 2016, the unit created a new position for a trained and certified digital forensic investigator. Many of the unit's criminal investigations included execution of search warrants for computers and other digital storage devices. The unit now has the ability to conduct onsite digital forensic examination of computers, cell phones, and other digital devices, including USB drives and SD cards. The Fraud Unit also has the ability to recover deleted files, search email for keywords, and examine locked or damaged cell phones.

Fraud Investigations

An investigator's primary goal is to resolve allegations of insurance fraud. While some investigations focus on an isolated offense, others involve many suspects engaged in elaborate schemes to defraud numerous victims. The unit's investigators concentrate their efforts on three major categories of insurance fraud:

Insurer Fraud schemes involve insurance companies, agents, TDI licensees (including third-party administrators, escrow and title insurance companies, and agents), eligible surplus lines insurers, and unlicensed insurance operations. These investigations may involve Penal Code offenses such as securing the execution of documents by deception, misapplication of fiduciary property, and forgery.

Claimant and Provider Fraud includes schemes such as inflated claims, false claims for property loss, staged accident rings, fake burglary claims, staged slip-and-fall cases, and other suspicious liability insurance claims. Investigators also examine reports of fraudulent billing by health care providers and reports of unlicensed providers and fraud rings involving health insurance claimants, providers, and attorneys. Fraudulent billing includes over-billing, double billing, and billing for procedures not performed.

Workers' Compensation Fraud schemes include claimants receiving benefits while working at other full-time jobs, malingering, or providers over-billing for services or billing for treatments never rendered. It may also include an employer who misrepresents payroll or employee classifications in the procurement of workers' compensation insurance.

While all investigations follow similar steps to prove or disprove allegations, the means and methods to resolve those allegations vary by the type of offense. TDI maintains close contacts with local, state, and federal law enforcement agencies, industry partners, and other TDI divisions. Investigators conduct interviews with victims, witnesses, and suspects and use the unit's subpoena authority to gather documentary evidence. Investigators also occasionally conduct surveillance and execute search warrants to seize evidence.

Beginning in May 2016, the Division of Workers' Compensation (DWC) commissioner formed an investigation unit to assume responsibility for all workers' compensation fraud investigations. Six members of the Fraud Unit, including five investigators and one intake staff member were reallocated to the DWC investigation unit. Beginning on September 1, 2016 the DWC investigation unit assumed control of all workers' compensation fraud investigations and performance measures reporting.

Fraud Prosecution

The Fraud Unit has six prosecutors that work for TDI and are deputized as assistant district attorneys in Bexar, Dallas, Harris, and Tarrant county district attorneys' offices. This initiative began in 2005 through a memorandum of understanding with the Dallas County District Attorney's Office. The program expanded to include Bexar and Harris counties in 2012 and Tarrant County in 2015.

The prosecutors work with the Fraud Unit's peace officers, local, state, and federal law enforcement, and the insurance industry to prosecute insurance crimes.

Catastrophe Response Team

The Fraud Unit created a new Catastrophe Response Team (CRT) in FY 2016 to help Texans after severe weather events. CRT members received specialized training in adjusting claims and roof inspections. Following severe weather events, the CRT is deployed to serve as a deterrent to criminal activity and meet with local authorities to discuss best practices to avoid contractor fraud. The CRT deployed after tornados struck north Dallas County in December 2015, hail storms struck Dimmit, Erath, Hood, and Tarrant counties in March 2016, and after hail storms struck Dallas, Tarrant, and Bexar counties in April 2016.

17th Annual Fraud Conference

The Fraud Unit hosted the 17th Annual Fraud Conference in Austin, October 28-30, 2015. Presenters discussed forensic accounting, cyber security trends, elderly financial abuse, cultural challenges in fraud investigations, and ethical leadership. The conference concluded with the Fraud Unit's prosecutors conducting a mock trial. The 263 registered attendees including SIU investigators, attorneys, peace officers, and TDI licensees were all eligible to receive up to 12.75 hours of continuing education credits for attending the conference.

TOP 10 ADJUDICATED CASES

1) In Harris County, Celia Castillo pleaded guilty to a first-degree felony of misapplication of fiduciary property and was sentenced to 20 years in prison. Between 1999 and 2013, Castillo, who was a licensed insurance agent, defrauded several elderly clients out of $3.2 million, by accepting money that was given to her as a fiduciary on behalf of FTS Life Gibraltar. Castillo deposited the money into her personal accounts.

2) In Tarrant County, Eddie Ette was convicted by a jury of first-degree felony of misapplication of fiduciary property and was sentenced to 10 years of probation. Ette received a fine of $10,000 and was ordered to pay $350,000 in restitution. Ette was a licensed insurance agent and owner of an insurance agency in Arlington. He received $350,000 for payment on a performance bond required by a group of lenders for a construction project. The funds were never applied to the bond. Ette claimed the money was his fee to acquire the bond.

3) In Dallas County, Katherine Andrews pleaded guilty to a first-degree felony of engaging in organized criminal activity and was sentenced to five years in prison. From June 2011 to June 2013, Andrews and 29 others misappropriated $277,319 from Union Standard Insurance Group. Andrew's scheme involved entering false claim information into the records of actual claims. Claim checks were then issued to Andrew's family members and friends who cashed the checks and gave the money back to Andrews.

4) In Dallas County, Juanita Arradondo pleaded guilty to a first-degree felony of engaging in organized criminal activity and was sentenced to five years of deferred adjudication probation and ordered to pay $42,415 in restitution. Arradondo provided her personal information and AFLAC policy number to someone who fabricated medical bills and submitted claims to AFLAC for injuries alleged to have been sustained by Arradondo. Between June 2009 and July 2010, Arradondo attempted to obtain a total of $74,515. She received $42,415 in benefits she wasn't entitled to and an additional $32,100 was denied.

5) In Dallas County, Cheryl Allen pleaded guilty to a second-degree felony of engaging in organized criminal activity and was sentenced to 30 months in prison. Allen and four other people deceived four lenders into executing wire transfers of $916,000 in loans for six properties.

6) In Nueces County, Kenneth Graves pleaded guilty to a second-degree felony of misapplication of fiduciary property and was sentenced to 84 months in prison and ordered to pay $128,918 in restitution. Graves was an administrator and broker for clients with investment accounts. He debited his clients' accounts for fees based on future time periods, even though such payments were not authorized in the clients' investment agreements.

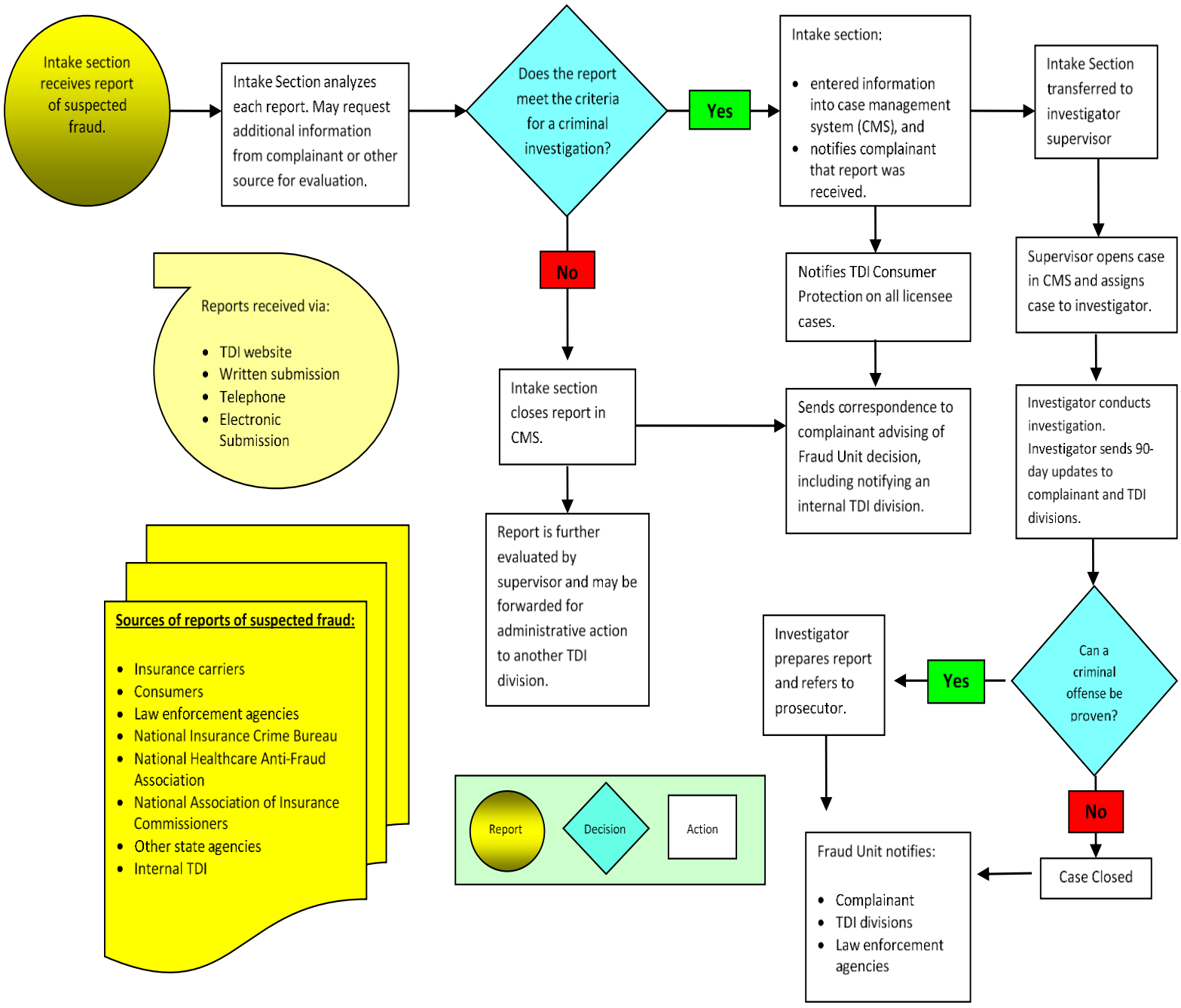
7) In Harris County, Lambert Odeh pleaded guilty to a second-degree felony of insurance fraud and was sentenced to two years in prison. Odeh was the owner and operator of Westside Medical in Houston. He staged several collisions in Harris County involving rental trucks. Odeh was indicted and he fled the county. He was apprehended in Germany and returned to Harris County.

8) In Harris County, John Reyes pleaded guilty to a second-degree felony of insurance fraud and was sentenced to 10 years' probation and ordered to pay $22,066 in restitution. Reyes was a licensed adjuster who intentionally entered fictitious claimant information into a carrier's claim system and falsely represented 13 people as claimants in multiple existing auto claims. He distributed 28 Progressive indemnity drafts totaling $55,653 among 13 people he knew weren't entitled to the funds. Ten of the 13 people who received payments admitted to participating in the scheme.

9) In Wichita County, David Wong pleaded guilty to a third-degree felony of insurance fraud and was sentenced to two years deferred adjudication probation and ordered to pay $37,893 in restitution. From January 2009 to July 2014, Wong obtained a total of $169,877 in insurance proceeds to which he wasn't entitled. He submitted billing forms for services not rendered.

10) In Tarrant County, Herman Florez was convicted by a jury for third-degree felonies of insurance fraud and fraudulent use of identifying information (identity theft). Florez was sentenced to five years of probation, 30 days in county jail, and assessed a $10,000 fine. Florez and his mother filed a fraudulent claim to receive payment of $48,000 for jewelry that was allegedly stolen. The jewelry was found to be in the possession of Florez's ex-wife, who was awarded the jewelry in the divorce.

PROCESS CHART



ORGANIZATIONAL CHART