

Texas Department of Insurance Fraud Unit 2018 Annual Report



December 2018

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Executive summary

The Texas Insurance Code requires the Fraud Unit to report annually 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 2018 statistics

- Insurance fraud reports received – 13,935.
- Cases opened for investigation – 294.
- Matters referred for prosecution – 58 cases with 74 suspects and 87 offenses.
- Estimated amount of fraud identified in referred cases – \$10 million.
- Indictments or information issued resulting from investigations – 71.
- Judgments from cases referred – 57.
- Fines assessed by courts on Fraud Unit cases – \$60,050.
- Restitution assessed by courts on Fraud Unit cases – \$13.6 million.
- Subpoenas issued – 299.

Noteworthy accomplishments

- Catastrophe Response Team responded to 43 cities in 16 different counties following Hurricane Harvey.
- Completed peace officer and attorney-mandated training.

Top adjudicated cases

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

Fraud Unit overview

The Texas Department of Insurance Fraud Unit enforces laws relating to fraudulent insurance acts. 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 seeks criminal indictments, makes arrests, and helps with prosecutions to deter insurance fraud in Texas.

The Fraud Unit staff includes investigators, fraud prosecutors, management, 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.

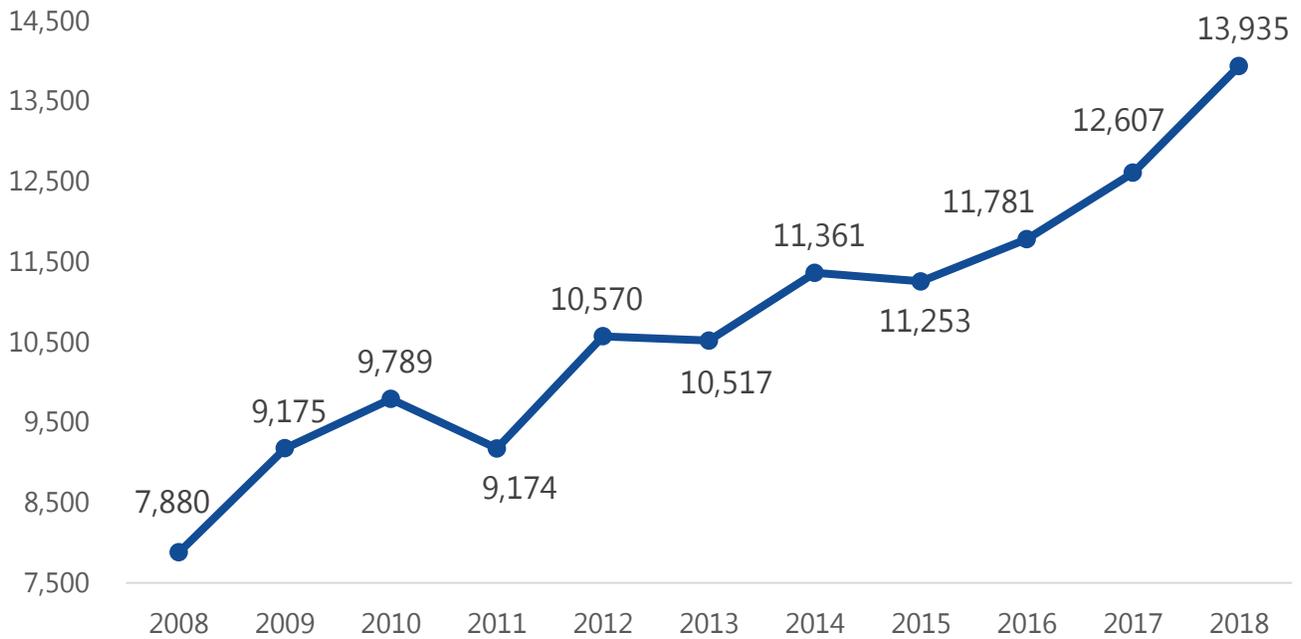
Fraud reporting

In fiscal year (FY) 2018, the Fraud Unit received 13,935 reports of suspected insurance fraud. The unit conducts outreach and education to create awareness and emphasize the importance of reporting suspected fraudulent activity.

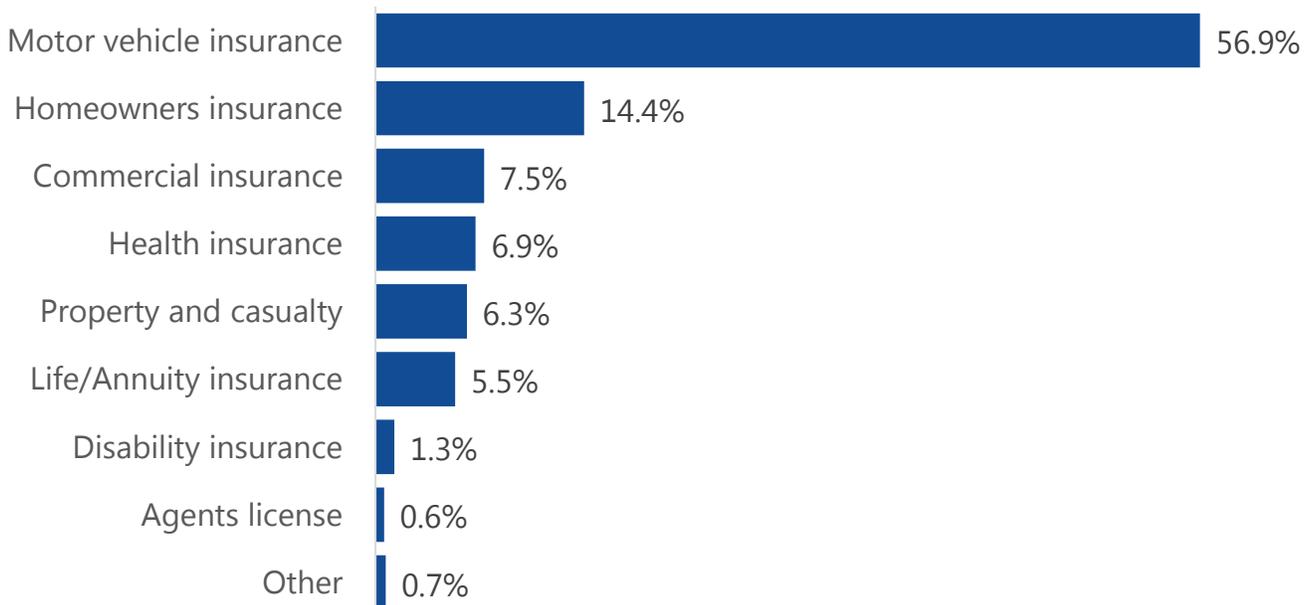
The Fraud Unit receives fraud reports in several different ways and from many entities, including insurance carriers, the National Insurance Crime Bureau, the National Association of Insurance Commissioners, consumers, and businesses.

The Fraud Unit encourages everyone to report suspected insurance fraud. Anyone may report fraud by email, phone, or by completing a form on the TDI website.

Fraud reports



FY 2018 fraud reports by type/line of coverage



In FY 2018, the Fraud Unit opened 294 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.

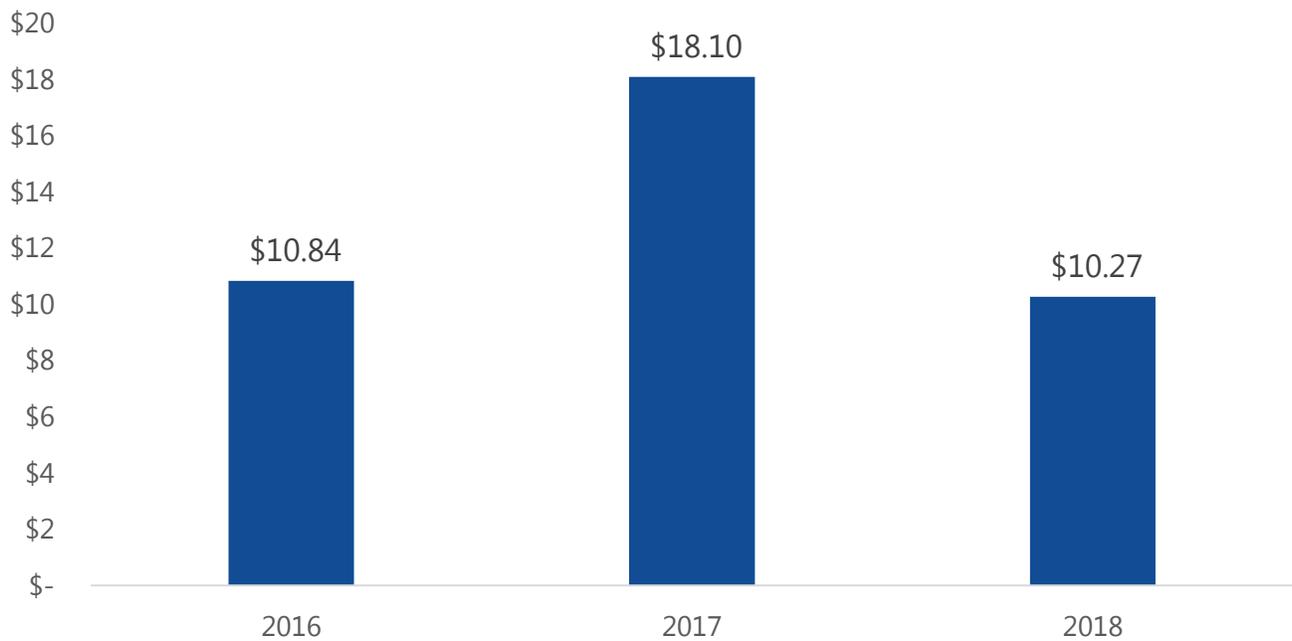
Fraud Type/Line of Coverage	Reports received	Cases opened	Percentage opened as compared to number received
Agents license	78	5	6.4%
Commercial insurance	1,041	27	2.6%
Disability insurance	184	9	4.9%
Health insurance	961	40	4.2%
Homeowners insurance	2,006	63	3.1%
Life, accident and health insurance	24	1	4.2%
Life/annuity insurance	773	36	4.7%
Motor vehicle insurance	7,928	79	1.0%
Property and casualty	872	28	3.2%
Surety bond	5	1	20%
Title insurance	4	1	25%
Title/escrow insurance	9	3	33.3%
Unauthorized property and casualty insurance	2	1	50%

During FY 2018, the unit worked on 611 fraud investigations. At the end of the fiscal year, there were 422 active investigations pending in 136 cities across the state.

The following table shows the number of referred offenses by fraud type and line of coverage for fiscal years 2016 through 2018.

Referral fraud type/line of coverage	FY 2016	FY 2017	FY 2018
Agents license	1	0	3
Commercial insurance	7	7	4
Disability insurance	11	4	3
Health insurance	9	5	13
Homeowners insurance	18	17	11
Life, accident, and health insurance	1	2	3
Life/annuity insurance	5	13	12
Motor vehicle insurance	26	29	26
Property and casualty	9	13	13
Title/escrow insurance	3	1	0

FY 2018 dollar amount identified in referrals (in millions)



Fraud Unit Organization

Although insurance fraud is traditionally associated with densely populated urban areas, the unit receives reports from rural areas as well. 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 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 charts 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.

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 two 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** schemes involve 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.

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 conduct surveillance and execute search warrants to seize evidence.

Fraud Prosecution Team

The Fraud Unit has six prosecutors who work for TDI and are deputized as assistant district attorneys in Bexar, Dallas, Harris, Tarrant, and Travis county district attorneys' offices. Fraud prosecutors in these five offices are dedicated to prosecuting insurance fraud cases referred by the Fraud Unit as well as other law enforcement agencies. The fraud prosecutors work with the unit's investigators as well as other local, state, and federal law enforcement, and the insurance industry to prosecute insurance crimes.

In FY 2018, fraud prosecutors also were deputized to prosecute specific insurance fraud cases filed by the Fraud Unit's investigators in the following counties: Collin, Johnson, Parker, and Swisher Counties.

Catastrophe Response Team

The Fraud Unit Catastrophe Response Team responds after severe weather events. Team members received specialized training in adjusting claims and roof inspections. The team is deployed after severe weather events to serve as a deterrent to criminal activity and meet with local authorities to discuss best practices to avoid contractor fraud. In FY 2018, the team deployed to 43 cities in 16 different counties after Hurricane Harvey.

Top 10 adjudicated cases

- 1) In **Swisher County**, Joseph Allen Gaines was convicted by a jury for committing a first degree felony offense of misapplication of fiduciary property of an elderly person. Gaines was sentenced to life in prison and ordered to pay \$100,000 in restitution. Gaines, a former insurance agent, persuaded senior citizens to purchase bogus annuities and then stole their investment funds.
- 2) In **Tarrant County**, Nancy Jackson Carroll, the former owner of Millennium Title, pleaded guilty to a first degree felony offense of misapplication of fiduciary property. Carroll was sentenced to 10 years in prison and ordered to pay \$8.6 million in restitution. Carroll stole millions from her clients and investors.
- 3) In **Tarrant County**, Richard Kent Livesay, a licensed Texas attorney, pleaded guilty to a first degree felony offense of insurance fraud and a third degree felony offense of barratry. Livesay was sentenced to five years in prison, had to surrender his law license, and was ordered to pay \$15,195 in restitution. Livesay filed lawsuits and claims against numerous insurance companies that he had not been authorized to pursue.
- 4) In the **U.S. District Court**, Northern District of Texas, David Roy Williams was found guilty by a jury on four counts of healthcare fraud. Williams was sentenced to more than nine years in federal prison and ordered to pay \$3.9 million in restitution. Williams, a personal trainer, submitted medical claims to insurers representing himself as a licensed medical professional.
- 5) In **Dallas County**, Letrice Anderson pleaded guilty to a second degree felony offense of insurance fraud. Anderson was sentenced to 10 years deferred adjudication, 240 hours of community service and ordered to pay \$122,550 in restitution. Anderson had submitted treatment claims by altering and manufacturing fraudulent invoices over three years and collected \$122,550 to which she was not entitled.
- 6) In **Bexar County**, Jillian Garcia, pleaded guilty to third degree felony offenses of securing execution of a document by deception and money laundering. Garcia was sentenced to 10 years on probation, 150 hours of community service and ordered to pay \$79,777 in restitution. Garcia was a licensed insurance agent who appended legitimate claims by unlawfully adding individuals who were then issued payments for which they were not entitled.
- 7) In **Dallas County**, Brian Burcham pleaded guilty to third degree felony offenses of misapplication of fiduciary property and theft. Burcham was sentenced to 10 years deferred adjudication for each offense, 160 hours community service and ordered to pay \$54,317 in restitution. Burcham was employed as an insurance agent and accepted insurance premiums for which he failed to forward to the insurance companies.

- 8) In **Somervell County**, Cody Damron pleaded guilty to a third degree felony offense of securing execution of a document by deception. Damron was sentenced to six years deferred adjudication and ordered to pay \$40,999 in restitution. Damron was a licensed insurance agent and accepted insurance premiums from a title company on behalf of a new homeowner to pay for a homeowner policy at the time of closing. Damron failed to bind the policy and failed to forward the funds to the insurance company at the time of the closing. The new homeowner sustained damage to his home and discovered he was not insured.
- 9) In **Rockwall County**, Yvonne Taylor pleaded guilty to a third degree felony offense of insurance fraud. Taylor was sentenced to 10 years deferred adjudication, 120 hours of community service and ordered to pay \$30,547 in restitution. Taylor, a licensed insurance adjuster, solicited individuals to participate in a scheme in which Taylor issued fraudulent payments and then shared in the illegal proceeds.
- 10) In **Lubbock County**, James Ray Coats pleaded guilty to a state jail felony offense of misapplication of fiduciary property. Coats was sentenced to three years deferred adjudication, 120 hours community service and ordered to pay \$10,325 in restitution. Coats was doing business as an insurance agent and accepted premiums for homeowner's insurance policies from three individuals. He failed to forward those premiums to the insurance company.

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2018 Annual Report to the Commissioner