English summary of Brå report 2015:19

SUMMARY

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The Swedish National Council for Crime Prevention (Brå) – centre for knowledge about crime and crime prevention measures

The Swedish National Council for Crime Prevention (Brå) works to reduce crime and improve levels of safety in society by producing data and disseminating knowledge on crime and crime prevention work.

This report is a summary of the Swedish report Försäkringsbedrägerier, report no 2015:19.
The Swedish report can be ordered from Brottsförebyggande rådet, info@bra.se

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URN:NBN:SE:BRA-621

Summary

According to the insurance industry organisation Insurance Sweden, insureds made approximately 2 million claims in 2014. According to industry estimates, insurance companies indemnified losses in the amount of approximately SEK 50 billion and denied payment in the amount of approximately SEK 400 to 500 million. In addition, the companies conducted approximately 7,000 investigations of questionable occurrences and suspected frauds (Swedish Insurance 2014). Of these, approximately 300 were reported to the police.

It is difficult to comment on the accuracy with which the costs and reporting frequency reflect actual criminality. Moreover, the subject does not fall within the scope of the present reports. Our focus is on studying how the insurance companies and the justice system identify and investigate insurance fraud; the analysis of the work involved in discovering and investigating insurance fraud is based more precisely on a selection and organisational theory perspective.

Private insurance

The report focuses on fraud in respect of private insurance policies which have been taken out by private individuals or legal entities with their own funds. This is in opposition to the social welfare safety net of public insurance paid for by taxes and other charges; it includes essentially everyone who lives or works in Sweden and provides a safety net in the form of, for example, sickness allowance, healthcare, and pensions.

Method and material

In the study, qualitative interviews (56 in total) were conducted of individuals with different roles at a total of seven insurance companies, as well as with the police and the public prosecutor. In addition, all police reports in 2011 (262 in total) with the associated preliminary investigations and convictions (25 convictions in total) were analysed (cf. Brå 2011). We also ran Brå's suspect register and conviction register in order to track prior criminality of people suspected of insurance fraud. Finally, we also held three seminars and had two focus groups with representatives of the insurance companies and the justice system.

What affects the discovery of insurance fraud?

To summarise, the most important circumstances governing which insurance frauds are detected and not detected by the existing verification system are: 1) the insurance companies' targeting; 2) insufficient verification tools or techniques; and 3) the absence of verification and monitoring routines.

The requirements which are imposed through targeting, together with the absence of organisational routines and relevant techniques to detect insurance fraud, leave relatively great latitude for individuals in various positions at the insurance companies (e.g. claims adjusters) to have an impact on that which ultimately becomes an offence.

The insurance companies' goal: Satisfied customers

One clear result of the study is that the insurance companies have mixed feelings about verification. They argue that there is a conflict between commercial strategies and a developed verification and monitoring system. Verification, monitoring, and excessively inquisitive reviews of insureds are posited as a risk to the insurance companies, whose survival depends on their ability to keep old customers and obtain new customers. The organisational goals which claims adjusters and insurance investigators are expected to achieve thus reflect an assumption that satisfied customers lead to profit. There are no explicit goals for verification activities as such. One conclusion is that investigatory activities are to be conducted behind the scenes in respect of "bad" customers and risks, but should not be visible to insureds as a whole.

Moreover, an excessive number of police reports of insurance fraud constitutes a potential risk which might give the impression that the insurance companies are particularly exposed to fraud. According to individual insurance companies, even an excessive number of verifications and the apparent ensuing "fuss" may lead to customers voting with their feet and changing companies. In addition, many insurance investigators believe that police reporting is pointless since, in their experience, the Swedish Police nevertheless dismiss most reports. An additional reason for not building up a comprehensive verification system is the administrative costs which may reasonably be involved.

Insufficient tools for detecting fraud

The primary method of identifying persons suspected of committing fraud is informal risk assessment. According to interviews, the informal risk assessments are based primarily on gut feeling or intuition, in combination with the ability to verify the insured's claims history. Other parts of this risk assessment are the claimant's behaviour during the telephone conversation with the claims adjuster, whether the customer is a "good "or a "bad" customer, whether the damage seems reasonable, and the perceived gravity of the damage. The reason why the insurance companies and, in due course, the justice system, must resort to informal risk assessment is a lack of formal methods (such as data mining and voice analyses) to generate risk profiles. Decisions regarding investigation and verification are thus made on tenuous grounds.

The nature of the process is such that a claims adjuster can neither predict when someone will submit incorrect information nor know with certainty when he or she is speaking with an insured who is attempting to commit fraud. Focusing on claims history gives the joint claims register (GSR)[1] central importance. It assists in a situation where the claims adjuster's investigatory process is focused on individuals with an atypical number of

[1] In the joint claims register (GSR) the insurance companies aggregate information regarding occurrences. GSR is a subsidiary of Insurance Sweden and is administered by Insurance Sweden AB. Information from GSR may not, however, be used when issuing insurance or setting premiums.

occurrences, ”abnormal” behaviour (for example stubbornness and aggressiveness) and who give descriptions which appear excessively unreasonable or too good to be true. The investigatory process also tends to focus on individuals who mismanage their premium payments.

A central conclusion of the report is that the warning flags which the insurance companies use (claims history, focus on atypical behaviour, breakdown into good and bad customers) is not based on knowledge about the actual characteristics of a person who commits fraud. These criteria have instead developed because they can be communicated within the companies. They are used since the criteria enable coordination of tasks within and between the different functions in the insurance companies. There are also elements of self-fulfilling prophecies, where the criteria are used to detect similar cases, which becomes an argument for using these criteria specifically.

Lack of routines for verification and monitoring

A third circumstance which has a major impact on the selection of matters is the largely personbased nature of the insurance companies' investigation and monitoring systems. Interviews with employees at the insurance companies show that a relatively small percentage of claims adjusters send matters which are deemed relevant to the insurance investigators. Knowledge as to how to make risk assessments therefore tends to be held by in individuals rather than by the organisation as a whole.

Low risk of detection

The consequence of these circumstances is that the risk of detection of insurance fraud is low. The weight which the insurance companies attach to registered claims in the joint claims register also contributes to the creation of opportunities for criminal activity. According to the risk profile which is produced through GSR, the insured is often seen as ”normal” the first time a claim is made, which entails that a number of claims are necessary in order to increase the likelihood of in-depth verification. The reason for this is that it takes time before the insurance companies begin to increase the requirements imposed on the insured to prove that an occurrence has taken place. The risk taken by a person committing insurance fraud is also regarded as small, given the justice system's marginal interest in fraud in general. Accordingly, the likelihood that a person will be sanctioned for fraud is low.

It appears far from likely that this situation will change within the near future since the justice system and the insurance industry generally regard fraud as a low status and low priority offence. The study also revealed a circular reasoning which tends to preserve this status quo: parties within the justice system explain the low priority with the low frequency of reporting, at the same time as the insurance companies justify this frequency by maintaining that the police and public prosecutor are not interested in insurance fraud.

Universal focus on obvious cases

Another result of the study is that both the insurance companies and the justice system focus on cases with clear, easily communicated, and comprehensible evidence. The definitions of this vary, however, between the two, with the insurance companies primarily leaning to civil remedies while the

justice system focuses on criminal law. The two legal landscapes have entirely different burdens of proof. While the burden of proof in civil cases rests with the insured, who must prove that an occurrence has taken place, the police and public prosecutor are tasked with proving beyond a reasonable doubt that a person has committed fraud. This means that a person can quite conceivably be ”guilty” in a civil context at the same time as the district court dismisses the criminal prosecution for fraud. Interviews with insurance investigators indicates that few insureds are aware of this difference, which creates some confusion in the communication between the insurance companies and the insureds.

The matters which insurance companies reported to the police in 2011 were dominated by staged claims. The most common claim is a traffic accident or collision which the insurance companies determine to have been staged. The common denominator for reported staged claims is that there are clear traces of the damage which can be analysed and compared with the insured's description of the chain of events. Cases which lack such conditions are reported to the police to a lesser extent. Based on the police reports which have been studied, these involve for example, personal injury, corporate loss, fires, and so-called inflated cases, where the insured suffered a loss but makes exaggerated claims.

The study also shows that those with at least one previous conviction for fraud are overrepresented among the individuals who the public prosecutor chose to prosecute. This indicates that previous criminality in the form of fraud may be an important selection criterion.

Many are suspected of other offences

Consistent with previous studies, this study shows that persons suspected of insurance fraud are primarily engaged in criminality other than fraud. Almost 75 per cent of the individuals who were reported to the police have already been found guilty, to a significant extent, of other offences. The obvious nature of insurance fraud is that it involves a group which is relatively active in crime.

The study also shows that an overwhelming majority of those who are reported to police are men (approximate 75 per cent) and that the average age is approximately 40 years of age.

Brå's proposal

Brå's proposal can be summarised into the following two primary areas.

Build verification into claims handling

In addition to further developing the work which has already begun on automated verification, the insurance companies can increase the verification element in the claims adjustment process. Brå offers several proposals as to how this can take place. For example, spot checks can be conducted and follow-up verification can be increased for the purpose of detecting completed offences.

Another proposal which is presented in the report is to increase verification and supervision in conjunction with the first insurance claim. This type of method makes verification activities visible and can contribute to increasing the risk of detection and reduce the provocation, i.e. the impression that committing insurance fraud is simple.

Another aspect of verification activities involves management of claims adjusters and, above all, the targets of satisfied customers and prompt claims handling. It appears reasonable to attempt to take the step in order to increase, through targeting, the incentive for claims adjusters to identify persons committing fraud. This can take place by regularly training personnel about fraud and by reminding claims adjusters of the importance of verification.

An additional dimension of verification activities is the communication between the general public and insurers as a whole. Brå believes that it may be appropriate for the insurance companies to undertake enhanced informational efforts towards these target groups. This involves, for example, reducing the insurance companies' anonymity and increasing knowledge regarding the consequences of fraud and regarding the insurance companies' verification activities.

Increase knowledge about insurance fraud

Producing relevant criteria in a formal risk management plan requires increased knowledge about insurance fraud. Brå believes that one way to achieve this is to work from the principles of what is known as problem-oriented police work (POP). This is a philosophy for police work which places great weight on the formulation of problems and the evaluation of effects. For example, the insurance companies can study the effects of providing information about insurance fraud in connection with insurance claims by comparing a group which receives the information with a group which does not.

Another way to develop verification activities could be for the insurance companies to conduct a dialogue with the justice system for the purpose of increasing understanding of fraud investigations. This type of exchange of know-how has been positive with respect to benefits fraud, which is a rather similar offence (see Brå 2008:6).

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