English summary

When accidents don't happen. Frauds against public and private sector insurance

Editors: Lars Emanuelsson Korsell, Helén Örnemark Hansen

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Two systems for personal insurance

This report examines frauds against personal insurance in both the private and public sectors, and against all of the social benefits administered by the Swedish Social Insurance Administration (*Försäkringskassan*).

Personal insurance policies provide compensation for amongst other things losses of income and costs incurred in association with illness and personal injury. In Sweden there is both a public sector insurance system (administered by the Social Insurance Administration), which includes both sickness benefit and illness or invalidity pensions, and private sector insurance policies, such as accident insurance and various elements of personal insurance that are included in general household and road-traffic third-party liability policies.

This two-tier system serves to facilitate insurance frauds as a result of a lack of communication between the Social Insurance Administration and private sector insurance companies, which is amongst other things due to the fact that existing confidentiality regulations prevent the exchange of information.

Eighty individuals and eight million SEK

In the context of slightly over 80 personal insurance frauds perpetrated against the Social Insurance Administration and private insurance companies that were reported to the police during the course of the year 2002, the perpetrators had illegally acquired approximately eight million SEK (approximately 870,000 Euro). A single personal insurance fraud that is not detec-

ted, and thus allowed to continue, may come to involve several million SEK since the insurance payments often continue over several years.

These amounts illustrate that frauds against personal insurance and benefits involve major economic harms. These frauds mean higher taxes and social insurance contributions, which ultimately affect all taxpayers, and higher insurance premiums, which are detrimental to all policy holders. These frauds serve also to undermine the legitimacy of the insurance system and ultimately constitute a threat to the welfare society.

Real crimes, not just "benefit cheats"

The individuals that were reported to the police during the course of the year 2000, for suspicioun of frauds against personal insurance and social benefits, were checked against the National Convictions Register. It was found that no less than 78 per cent of those who had committed personal insurance frauds had prior convictions. A large proportion of these individuals had furthermore committed large numbers of offences. This may of course be the result of a selection process, whereby the checks and controls conducted by the Social Insurance Administration and insurance companies are focused on persons with a particular type of profile; this has in turn meant that the proportion of persons with previous convictions happens to be particularly high, and much higher than that in the population as a whole; (within the population at large, approximately 40 per cent of men and ten per cent of women are usually convicted of a criminal offence at some point during their lives).

A further factor that may explain the high proportion of individuals with prior convictions is that personal insurance frauds cannot be isolated from other forms of crime. Frauds of this kind cannot be reduced to some near-innocent form of "benefit cheating", that may easily arise as the result of carelessness. Certain frauds are extremely sophisticated and involve staged road accidents in which a large number of people play different roles in the staging process, as injured parties, co-passengers, witnesses, persons who cause the injuries etc. In one such fraud-ring in Sweden, no less than 70 individuals were involved in staging 33 road accidents.

The Social Insurance Administration's controls are selective

The types of insurance that controls are focused on, the number of controls and the ways in which these controls are implemented, together determine which offences will be detected by the Social Insurance Administration and the insurance companies respectively.

No less than 70 per cent of the suspected personal insurance frauds reported to the police by the Social Insurance Administration relate to sickness benefit, and of the social benefits, the largest group relates to temporary parent's allowance (which does not formally constitute a form of personal insurance). Interviews conducted with staff at the Social Insurance Administration show that fewer controls are directed at sickness or invalidity pensions, for example, since it is more difficult to prove frauds in relation to this form of benefit than is the case with sickness benefit. Even if sus-

pected frauds relating to sickness or invalidity pensions are detected by the Social Insurance Administration, not all of them are reported to the police, since the case officers do not believe that they will result in prosecutions. It takes time and energy to produce the material needed and a written offence report, and for this reason case officers tend to concentrate on those cases where the evidence is clearest.

Controls are also selective at the insurance companies

During the year 2002, insurance companies reported only fifteen suspected cases of personal insurance fraud as compared with the 93 cases reported by the Social Insurance Administration. In the context of the interviews conducted in the study, this was explained by reference to a combination of the fact that insurance companies have only recently become aware that frauds are also directed at personal insurance policies, and of the time required to organise the necessary systems of controls.

Even if the insurance companies' claims adjusters do detect more suspected cases of fraud, only very few are subsequently reported to the police. There are a number of explanations for this selectivity. Many insurance investigators have a police background and they evaluate the evidence and only report the most "solid" cases. The insurance companies function in a market place, and reporting incidents to the police involves a risk for negative consequences in the form of adverse media publicity. The insurance companies also have good opportunities to refuse disbursement requests on the basis of civil law. Their investigators are therefore able to choose to work on the basis of the principle of least resistance, and to lean towards civil law instead of reporting a suspected criminal offence.

One quarter are convicted

Of the frauds reported, approximately half are dismissed by the police more or less immediately. At the next stage of the process, half of the remaining cases are dismissed by the prosecutor. Finally, one in four reported frauds result in a court conviction.

The most common grounds for dismissing reported offences are that there is insufficient evidence that a crime has been committed. Investigators working at the Social Insurance Administration and the insurance companies are of the opinion that these dismissals are in fact the result of other factors, such as a lack of resources and the prioritisation of other offences by the police and prosecutors.

Despite the fact that many frauds or attempted frauds involve large sums of money and are furthermore committed using forged documents, few of the cases are classified as serious by prosecutors when bringing an indictment (only 14 cases of 279 were classified as serious frauds or attempted serious frauds). One explanation for this is that police and prosecutors do not regard insurance frauds as a particularly serious form of crime.

September 11th, the Estonia disaster and the Tsunami

Major tragedies are often exploited for criminal ends. When exceptional and emotionally charged situations arise, and entire nations are mobilised in the aftermath of a catastrophe, fraudsters exploit the situation by means of personal insurance frauds. These may involve fictitious deaths, for example, leading to substantial life insurance pay-outs. This occurred in connection with the sinking of the Estonia, and there are a number of suspected cases at the present time in the wake of the Asian Tsunami.

Following the terror attack of September 11th 2001, both public and private insurance systems in the USA, as well as the support funds established for the victims of the tragedy, have experienced major problems as a result of frauds. Due to the difficulties associated with identifying individuals in the rubble of the buildings destroyed, a number of people have been alleged to have disappeared.

Collaboration prevents fraud

The conclusions drawn on the basis of this work are, among others, that frauds may be prevented

- if private and public sector insurance providers are given greater legal opportunities to exchange information on suspected cases of fraud;
- if collaborations are developed between private and public sector insurance providers in the context of the investigation of individual cases and in relation to methodological issues, such as risk assessments, for example, and methods of control.
- if both insurance systems are given greater legal opportunities to exchange information on cases of suspected fraud with other agencies.

More effective anti-crime work

Police and prosecutors must prioritise frauds perpetrated against insurance policies and the benefits system to a greater extent than is the case at present. Levels of training should be increased in relation to this form of crime. There is much to suggest that these investigations should be assigned to police and prosecutors who are specialists in this area.

By means of regular meetings and seminars, police and prosecutors could meet claims processors, claims adjusters and investigators in order to exchange experiences and improve levels of contact.

Anti-crime work could be facilitated by claims processors at insurance companies and the Social Insurance Administration documenting the information that has been provided to policy holders. If claims processors inform policy holders about the relevant regulations in the course of their contacts with clients, this information may also have a preventive effect by impressing upon policy holders the importance of providing correct information etc.