



No. 66

Insurance Fraud

Tony Baldock

Approximately 80-85 per cent of the insurance premiums paid in Australia each year are returned in claims paid to policyholders. Currently, this amounts to some A\$14 billion dollars annually. Of this total, approximately 10 per cent or A\$1.4 billion, are received by policyholders who, according to the Insurance Council of Australia, have fabricated or inflated a claim. The costs imposed by these frauds are borne by honest policyholders, who pay higher premiums. The burdens on law-abiding citizens and business people constitute an impediment to economic competitiveness which we as a nation can ill afford. This Trends and Issues paper provides an overview of insurance fraud in Australia, and the steps being taken by the insurance industry and by Australian police services to combat it.

Adam Graycar
Director

All insurance companies are at risk of frauds being perpetrated upon them by their customers. The nature of these frauds may vary from limited exaggeration of the value of a claim, to the entirely bogus claim, where losses never really occur.

The majority of all insurance fraud is committed by otherwise law-abiding people who are convinced that there is nothing wrong with overstating their losses “a little” or materially altering key facts. Insurance fraud is looked upon by many people as being a victimless crime.

The Insurance Council of Australia (ICA) estimates that up to 10 per cent of all insurance premiums paid by the public are lost to fraud (Insurance Fraud in Australia 1994). The total dollar amount paid out for fraudulent claims each year in this country is estimated at A\$1.4 billion.

The ICA claims that fraud adds an extra A\$70 to the cost of each and every general insurance policy issued in Australia, with the average family contributing in excess of A\$400 annually towards fraudulent claims.

In years past the insurance industry believed that fraud was perpetrated by isolated individuals either from greed or force of circumstances—for example, a fire claim to cover a failing business. Fraud was not seen as a problem worthy of a serious response. Premiums were increased accordingly to compensate for any increase in claims.

In the mid-1960s, insurance fraud became more widespread and it was accepted that fraud was a possibility among a minority of customers. It was believed that these frauds related mainly to exaggerated claims and some entirely bogus claims for relatively small amounts. Steps were taken by insurance companies to re-evaluate their internal procedures and any weaknesses that were

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identified were corrected. Any responses taken were generally limited to changes within individual organisations. The exchange of information between insurance companies was almost non-existent. At this stage it was relatively easy for fraudsters to jump from company to company with impunity even after detection.

During the 1970s, it soon became apparent that the cost of insurance fraud was increasing. Insurance companies came to accept that fraud was a possibility amongst a significant minority of their customers. Insurers were seen as fair game, and insurance fraud as not a real crime. Exaggerated claims were commonplace and the number of completely bogus claims increased. Amateur fraud became epidemic in some fields, particularly in the area of third party personal injury insurance. At this stage insurance companies began to recognise the need for cooperation between themselves. Internally, companies began to train staff in the area of fraud detection. Claims procedures were tightened and profiles developed of typical fraudsters. Professional fraud groups started to make their appearance. The need was seen for increased cooperation between the insurance industry and law enforcement agencies.

In the mid-1980s, the cost of insurance fraud increased dramatically. Not only was the number of claims increasing, but the individual amounts awarded by the courts for personal injury claims were reaching an unprecedented level. Staged motor vehicle collisions were commonplace. Organised crime soon realised that insurance fraud was a criminal enterprise that could be undertaken with minimal risk and little concern of police involvement. The 1987 stock market crash and the following recession saw a large increase in the amount of arson claims. It soon became apparent within the industry that fraud was on

the increase and that positive steps had to be taken to stem the flow of fraudulent claims.

Who Commits Insurance Fraud?

It is generally recognised by insurance fraud investigators that there are three types of insurance fraud offenders.

Average offender

This category includes a wide cross-section of our community and is not restricted to persons of a particular gender or socio-economic group. These people are generally seen as law-abiding with no prior criminal record. The average offender is viewed as a person who has either yielded to sudden temptation or is someone who is seeking to escape some form of financial hardship by engaging in fraudulent actions against an insurance company. This might entail fabricating a claim entirely, or inflating (“padding”) an otherwise legitimate claim.

Criminal offender

This is a person who will commit insurance fraud along with other street-level crimes. This person will generally have come to the notice of the police in the past and may have a criminal record. This person is usually male. Previous crimes committed by this type of offender are generally non-violent and will tend to be property or paper based in nature, such as household burglaries or cheque fraud. The criminal offender may be either a full-time criminal or, more commonly, a part-time offender who also holds down full or part-time employment. The criminal offender will usually continue to offend until he is either caught or becomes concerned about the possibility of detection—in which case he may shift to other areas of crime.

Organised crime offender

The organised crime offender is usually a career criminal who will be

part of an organised group involved in major and complex fraud against an insurance company. This group is prepared to contribute a considerable amount of time and effort, and occasionally money, to enable them to obtain large amounts of money from insurance companies by means of fraudulent claims.

Insurance fraud is generally used by both the average offender and the criminal offender as an easy source of quick money. The organised crime offender will see insurance fraud as a lucrative source of regular and substantial income. The organised crime offender may use insurance fraud as a source of funds to be used in establishing other criminal activities. In the past, insurance fraud has been used to finance the activities of persons involved in the importation and cultivation of prohibited drugs.

The “Acceptable” Crime

It is often said that the insurance industry is built on a fierce mutual distrust between insurance companies and their customers. Customers often complain that their claims have been refused because they failed to properly complete a form or did not read or understand the fine print on the insurance policy.

The insurance industry is often equally distrustful of its clients. A survey conducted for the ICA (Data Sciences Pty Ltd 1993) showed that 25 per cent of persons surveyed knew someone who had put forward a false or “padded” claim; 14 per cent of those surveyed agreed that “padding” a claim is acceptable. Insurance fraud, like tax fraud, is seen by many as a victimless crime. The cost of this “victimless crime” is passed on to the general community through higher insurance premiums.

While 94 per cent of those surveyed agreed that lodging a fraudulent insurance claim was dishonest, the general public seems loath to take an active role in combating insurance fraud. Nearly half of those surveyed said that they

would do nothing if they became aware of an instance of insurance fraud.

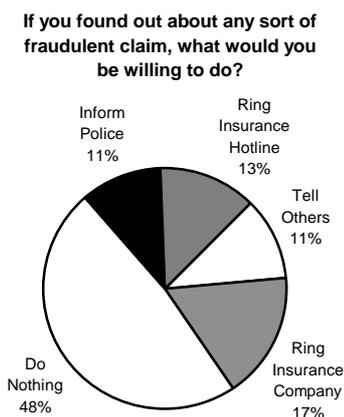
The insurance industry claims that this public antipathy towards the industry is often reflected in the lenient punishments meted out by the courts for insurance fraud.

The Cost of Insurance Fraud

Insurance fraud, like most fraud, is a "hidden crime". As much of it remains unrecognised, undetected or unproven, it is difficult to establish precise figures. Whilst most insurers will readily admit fraud is a problem, they have difficulty agreeing on the extent of that problem.

The number of claims refused by insurance companies on the basis of fraud is minimal. Insurers were reluctant to provide figures in this regard; however, several senior insurance professionals who were contacted indicated that the actual percentage of claims refused on the basis of fraud varies between 0.1 per cent and 0.75 per cent. This figure varies significantly depending on the insurance company and the business line involved. Most insurers treat the refusal of a claim as a very serious matter. Before a claim is refused it will generally have been investigated thoroughly and the decision to refuse a claim is generally vested only in senior management.

Figure 1. Community response to knowledge of fraudulent insurance claim



Insurance industry figures put the estimated range of fraudulent claims as between 3 per cent and 10 per cent of total claims. Some areas of insurance appear to be more fraud prone than others. It is estimated that up to 20 per cent of travel insurance claims are fraudulent while less than 2 per cent of professional indemnity claims involve fraud. The reasons for this variation are unclear. This may well be due to the perception that an insurance company is less likely to query a relatively small claim for lost baggage than, say, a claim for the theft of a motor boat.

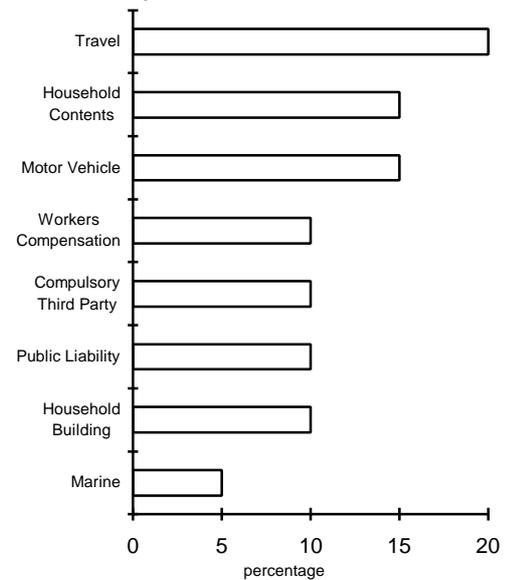
If the above figures are an accurate representation of the level of insurance fraud, it is obvious that the percentage of fraud actually detected by insurance companies is minimal.

In addition to the A\$1.4 billion estimated to be paid out each year for fraudulent insurance claims there is an additional cost to the community. It is believed that many times this amount of public monies is expended as a result of fraudulent claims. As an example, the ICA estimates that for each A\$1 paid by an insurance company in relation to an arson claim a further A\$8 of public money is expended for the maintenance of services such as the police and fire brigades, the courts, and to cover the dislocation of services where, for example, employees of a factory destroyed by arson are forced out of work and onto social security payments. If we are to rely upon the figures supplied by the ICA, the true cost of insurance fraud to the community could be as high A\$9 billion.

The Insurance Industry Responds

In the mid-1980s many of Australia's major insurance companies recognised the need for a centralised special claims unit to investigate possible fraudulent claims. These units were generally staffed by experienced senior claims staff who had been provided with additional training in

Figure 2. Percentage of insurance claims believed to be fraudulent



Source: ICA 1994

fraud detection and investigation. Many of these units also recruited former police and other experienced fraud investigators to assist in conducting their investigations. Fraud indicator profiles were developed to assist branch claims officers in identifying possible fraudulent claims. Branch staff were required to forward any suspected fraudulent claims immediately to the Special Claims Unit. Suspect claims were investigated, sometimes quite extensively, before a decision was made to either refuse or pay the claim.

At this stage it appeared that the focus on fraud control was by detection, investigation and refusal of suspect claims.

In 1991, the Insurance Reference Service (IRS) was established. This is the insurance industry database to which 39 insurance companies and approximately 400 loss adjusters subscribe. The IRS is owned by its member insurance companies and its operating objective is to assist the insurance industry in the prevention and control of insurance fraud. The IRS is routinely used to screen new insurance proposals and claims. The IRS database currently consists of more than 13 million individual insurance claims records, in addition to publicly available information relating to bankruptcy and debtor judgments. Member insurance

companies make in excess of 50 000 enquiries per month. The IRS operates under a code of conduct which establishes requisite privacy protocols and procedures.

A study of 8000 insurance proposal forms conducted by the IRS showed that 9 per cent of people did not disclose their full claims history. A further 2.5 per cent had adverse credit and public record information on file.

Since the establishment of the IRS there appears to have been a shift to fraud control by prevention. More emphasis is now placed on ensuring that a policy is not issued to a bad risk. Routine screening of the IRS database now takes place when there is any concern that information contained on a proposal may be fraudulent. A number of insurers also check the IRS database upon renewal of policies which appear to be high risk. Suspicious claims are cross checked on the IRS to help establish any relevant non-disclosures that may have occurred and to ascertain the claims history of the claimant. The establishment of a central industry database has ensured that an insurance fraudster can no longer jump from one insurance company to another with impunity.

In recent months, in order to overcome the impediments to reporting arising from the public acceptance of insurance fraud noted above, the insurance industry has introduced a fraud reward scheme. This serves the threefold purpose of deterring fraud, providing information in furtherance of investigations, assisting insurers in the denial of liability or in reducing payouts in claims where fraud is involved.

The scheme, administered by the Insurance Council of Australia in conjunction with state and territory police services, provides for rewards of up to A\$25 000 for information leading to the conviction of a person committing fraud against a participating insurer (Insurance Council of Australia 1996).

When an insurance fraud is detected by an insurer, and a claim refused, the claimant still has the option available to seek compensation for their insured loss. Most disputes, whether arising from misrepresentation or misunderstanding, are resolved before Claims Review Panels established under the General Insurance Enquiries and Complaints Scheme (Insurance Enquiries and Complaints Ltd 1996).

The majority of large insurance companies either have their own in-house legal department or use the services of external legal firms. Most insurers will vigorously defend in court any action taken against them in relation to a claim they refused because they believed that claim to be fraudulent. One major insurance company successfully defends over 80 per cent of civil actions taken out against it for the refusal of fraudulent claims.

Insurance fraud is not specifically identified in most states' criminal legislation. Persons charged with insurance fraud offences are generally dealt with under legislation relating to false pretences or obtaining a financial advantage by deception.

Statistical information relating to insurance fraud prosecutions is difficult to obtain. As there is no separate, specific offence for insurance fraud, prosecutions and convictions for this offence are not specifically identified, and appear to be included in the general "fraud" statistics. As such, it is difficult to gauge the level of police involvement in the investigation of insurance fraud.

The establishment of specialised police units, such as the New South Wales Fraud Enforcement Agency, which deal solely with sophisticated fraud, may result in the recording of more detailed statistical data which might help identify the level of insurance fraud.

Enquiries to date indicate that there is no state or federal police unit currently in existence that specifically

investigates insurance fraud. In the past, special task forces have been established to investigate particular instances of complex insurance fraud, such as the Operation Choke Task Force (Newcastle Earthquake) and the Operation Trojan Task Force (3rd party motor vehicle injury claims in Canberra and Griffith). These joint police/insurance company task forces were very successful, resulting in the prosecution, and subsequent conviction, of a number of persons who had attempted to defraud insurance companies. These specialised units were quickly disbanded after they had completed their specified investigations. Today, the investigative expertise residing with the significant number of former law enforcement officers employed in the insurance industry enables insurance companies themselves to assemble the requisite elements of a prosecution brief and present them to police for prosecution.

The American Response

The cost of insurance fraud in the United States is estimated to be US\$100 billion per annum. Bodily injury claims account for over 50 per cent of all fraudulent insurance claims in the USA. These are generally as the result of either "staged" motor vehicle collisions or "slip and fall" accidents in commercial premises. The perpetrators are generally professional criminals involved in organised crime rings. Insurance fraud is second only to tax fraud in the USA.

In 1976, Florida became one of the first American states to pass legislation that specifically targeted insurance fraud. The "False and Fraudulent Insurance Claims Act" created a specific offence for any person to present any written or oral statement in support of an insurance claim, knowing that the statement contains false and/or misleading information. The legislation specifically recognises that medical

professionals, lawyers and insurance industry employees are possible offenders.

That same year Florida created the Division of Insurance Fraud (DIF) within the Department of Insurance. The DIF is specifically charged with investigating insurance fraud cases brought to its attention which are believed to fall under the definitions of the False and Fraudulent Insurance Claims Act. DIF investigators are law enforcement officers with full police powers.

Following in the steps of Florida, 27 of the 50 American states have established insurance fraud investigation units. Thirty-five American states specifically recognise insurance fraud as an offence. The majority of those states also specifically provide for the granting of immunity from civil action to any person who furnishes information relating to suspected insurance fraud.

Most American state insurance fraud units are either fully or partly funded by a levy placed on insurance policies. In addition to their investigative responsibilities, these units maintain accurate records which help identify repeat offenders and show developing trends in insurance fraud.

National Insurance Crime Bureau (USA)

Recognising the increasing cost of insurance fraud to both the insurance industry and the general community, in 1992 the National Insurance Crime Bureau (NICB) was formed. This industry body is comprised of over 1000 member insurance companies. Upon its formation the NICB absorbed the functions previously undertaken by the Insurance Crime Prevention Institute and the National Auto-mobile Theft Bureau. The NICB is a not-for-profit organisation committed to fighting insurance fraud and vehicle theft. It is funded by a levy placed on its member companies.

To assist member companies fight insurance fraud the NICB acts as

conduit between the insurance industry and federal, state and local law enforcement agencies. It actively lobbies both state and federal legislators and urges them to introduce specific insurance fraud legislation and establish insurance fraud bureaus. The NICB has established a 24-hour toll-free telephone number for the public to report insurance fraud. Persons reporting insurance fraud may be eligible for a reward of up to US\$1000. Two hundred specially trained insurance fraud investigators are employed by the NICB to assist and advise its members companies.

The greatest achievement of the NICB is undoubtedly the establishment of its insurance fraud database—NICB EyeQ™. This database contains in excess of 350 million insurance claim and vehicle-related records provided by its member companies. Information contained on this database is available to member insurance companies and law enforcement agencies. Access to this information is available on line and a user friendly interface assists users in querying the data contained within the system. Sophisticated search options are available and records may be searched or cross-referenced using a number of search criteria which can include: name, address, phone number, social security number, drivers licence number, vehicle registration number, details of treating medical practitioner and claimants lawyers, amongst others. Since its establishment in April 1995, NICB EyeQ has already been credited with helping to identify numerous fraudulent claims. In excess of 250 000 queries are made of this database each month.

National Association of Insurance Commissioners (USA)

The National Association of Insurance Commissioners (NAIC) is the national lobby group for the state insurance

commissioners. In most American states a licence is required to sell insurance. The Insurance Commissioner is the statutory authority responsible for the issuing of licences and the regulation of the insurance industry.

The NAIC has been active in lobbying for the introduction of insurance fraud prevention laws. The NAIC has drafted the Insurance Fraud Prevention Model Act which it is actively seeking the US states to adopt. This model legislation defines fraudulent insurance acts as including fraud by both claimants and insurers, as well as fraud committed by persons in the business of insurance. A state Insurance Fraud Bureau would be established under this legislation, under the control of the state Insurance Commissioner. Fraud is defined as a felony crime. Convictions would result in fines, imprisonment, a requirement to pay restitution, and disqualification from engaging in the business of insurance.

The model requires insurance companies to have anti-fraud initiatives in place, such as an adequately staffed fraud investigation unit and an anti-fraud plan. Insurers must include a warning on claim forms and applications to the effect that presenting false information on an application or filing a fraudulent claim is a crime. Mandatory reporting of fraudulent insurance acts to the state Insurance Commissioner by persons in the business of insurance is required, with immunity provided for reporting. Confidentiality of information, gathered in investigations by regulators and law enforcement officials, is guaranteed, with some exceptions such as use in detection, investigation, and enforcement of fraudulent insurance acts. Insurance companies that do not comply with these provisions may have their licence to sell insurance in that state revoked or suspended.

Legislation similar to the above has been adopted by more than half the American states.

What more can be Done?

The police do not view insurance fraud as a major concern, and maintain that there is no need for the formation of a specialised unit to investigate insurance fraud. Should the reward programs noted above contribute to increased reporting of insurance fraud to the police, this will, at the very least, draw attention to the extent of the problem.

If legislation is enacted to create insurance fraud as a specific offence it will enhance the collection of accurate data. It would also send a clear message to the general community that insurance fraud is a criminal offence and that persons who commit insurance fraud will be treated accordingly.

The vigorous investigation and prosecution of insurance fraud offenders, coupled with adequate media coverage of successful prosecutions, will help to enhance the public perception that insurance fraud is a crime and that offenders will be detected and are prosecuted.

Insurance proposal and claim forms could be designed so that they include a visible warning to the effect that it is a criminal offence to make a false or misleading statement on those forms.

The establishment of a national toll-free hotline would enhance the reporting of suspected insurance fraud. The creation of legislation to protect from civil action, informants who, in good faith, pass on information of suspected insurance fraud, is also desirable.

The recently established Insurance Reference Service has shown that it is possible for insurance companies to work together and to effectively exchange data that will help them in the battle against insurance fraud. The use of this database needs to be encouraged and the benefits of it to non-member insurance companies emphasised. Access to this database is readily available to police

to assist in their investigation of insurance fraud.

Without the full reporting of insurance fraud and the creation of legislation to specifically define this as an offence, the true extent of this crime and the resulting cost to the community may never be known.

References

- Data Sciences Pty Ltd 1993, *Insurance & Fraud Quantitative Study*, Insurance Council of Australia, Melbourne.
- Gavin, K. 1995, *Insurance Fraud Study Tour—Report*, NRMA, Sydney
- Insurance Council of Australia 1994, *Insurance Fraud in Australia*, ICA, Sydney.
- Insurance Council of Australia 1996, *Fraud Reward Scheme Guidelines*, Insurance Council of Australia, Sydney.
- Insurance Enquiries and Complaints Ltd 1995, *The General Insurance Enquiries and Complaints Scheme, 1995 Annual Report*, Insurance Enquiries and Complaints, Ltd., Melbourne.

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