

The Rising Cost of Insurance Fraud

Clive Nicholls

Senior Vice President – Global Markets

***Monday 12th March
2012***

Insurance Fraud – The Association of British Insurers estimate that:

Insurance Fraud	Costs the industry in excess of £2 billion each year
Insurance Fraud adds	an additional £44 to every honest policyholders annual premium
UK Insurers detect	2,500 fraudulent claims each week However it is estimated that 65% of all fraudulent claims go undetected.
The Insurance Industry invests	£200 million each year to tackle Insurance Fraud
The value of savings from detected frauds represents	5% of all claims costs.

Attitudes to Fraud

A survey of 3,000 adults revealed that

16%

Would not rule out making an exaggerated claim

44%

Think it acceptable or borderline behaviour to increase the value of an item when claiming

30%

Feel the same way about overstating the extent of damage

Attitudes to Fraud

- The most common and costly is ***opportunistic*** fraud where individuals exaggerate or inflate a genuine loss.
- Only a minority of cases involve fabrication of an entire claim though these can be serious, e.g. Credit Hire Fraud via an organised crime syndicate was recently uncovered with £3.6m in fraudulent hires.
- The chief motive in all insurance fraud is ***financial gain*** and all undetected fraud increases average claims costs / premiums.
- The current economic downturn has led to an increase in both ***'desperation' and 'lifestyle'*** fraud, evidenced through the recent trend of multiple claimants.

Fraud in the Lloyd's Market?

- It is estimated that 13% to 16% of all claims have a fraudulent element but clearly varies by class of business.
- The Lloyd's Market handles circa 200,000 claims per year with a settlement value of approx. £11bn
- Potentially 32,000 claims received by the market each year have a fraudulent element.
- 65% of all fraudulent claims go undetected.
- Therefore its possible that as many as 20,800 claims are being paid or overpaid in the market each year.

Fraud in the Lloyd's Market?

- Increasing pressure to return an underwriting profit makes fraud detection more important than ever.
- The advent of CTP is placing greater pressure on Managing Agents' claims staff and increasing the likelihood of fraudulent claims being undetected.
- Lloyd's Minimum standards state that "Managing Agents should have in place an appropriate documented anti fraud strategy". But there is no one market body tasked with responsibility for fraud detection best practice (the only dedicated committee is the Motor Joint Anti Fraud committee).
- 35% of all business is written in Lloyd's via Binding Authorities. Are your audit procedures sufficiently robust to ensure that your Coverholders and TPA's have adequate fraud detection processes in place?

Insurance Fraud – The Industry Response

During 2011, two key industry initiatives have been introduced in response to Insurance Fraud:

- Creation of a ***National Insurance Fraud Register*** – an industry owned database enabling Insurers to share information on known fraudsters and identify anyone who fails to declare a previous fraudulent insurance claim
- Creation of the ***Insurance Fraud Enforcement Department*** – operated by the City of London Police and funded by the Association of British Insurers, a 34-strong team who will act on evidence of Insurance Fraud, specifically targeting organised crime

How fraud is avoidable

- *Prevention is better than cure – what fraud detection measures are there at underwriting stage?*
- *Insurers have a principal role in investigating high volume, low value opportunistic fraud.*
- *Fraud is avoidable. Claims leakage can be detected and prevented through:*

Intelligence - improved data collection, producing a systematic picture of fraud risk

A clearly **defined** fraud strategy

Improved **processes** for flagging 'suspect claims'

Appropriate **investigation / validation** of all claims with high risk indicators or fraud concerns

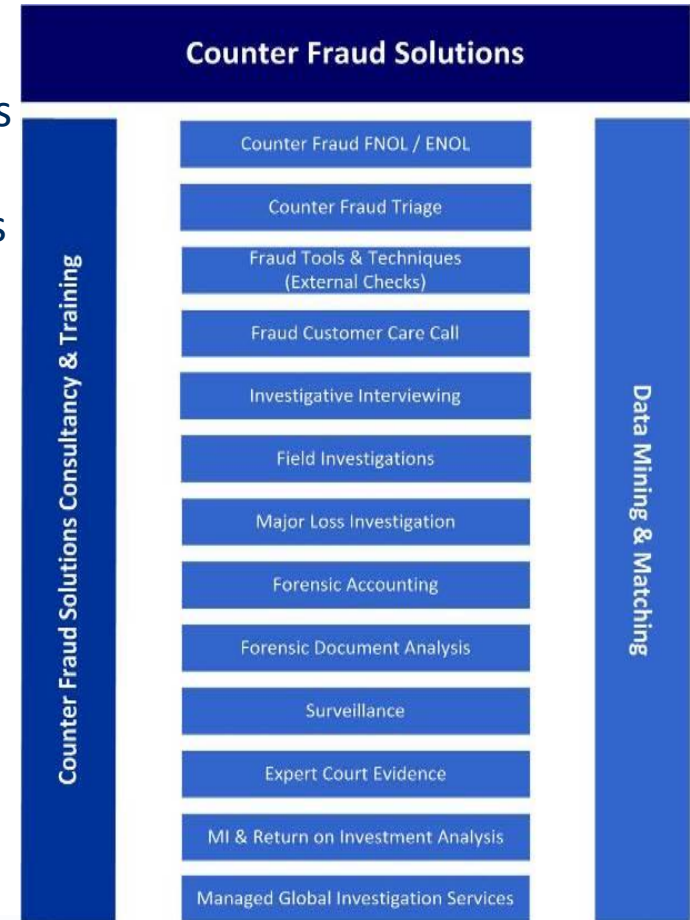
Greater industry **collaboration** / sharing of information

Crawford Experience and Approach

- Fraud can occur at any point during claim lifecycle.
- Anti-fraud culture employed throughout all our claims management departments from FNOL to settlement.
- Each claim reviewed against fraud indicators at point of referral, during site visit and when there is any material change to the claim.
- Claims with high risk indicators are referred to counter fraud solutions team and experienced fraud co-ordinators to screen claims against fraud rules and decide course of action.
- Low value claims managed through bespoke Customer Oriented Interviewing process – best of breed solution drawing from Cognitive Interview technique and Conversation Management balancing fraud detection and investigation with customer service and principles of TCF.

Crawford CFS Suite of Services

- Counter fraud triage, including open file review
- Desktop fraud investigation using applied psychology via investigative interviewing techniques
- Field Investigation including major and complex loss
- Return on investment analysis by peril and reduction in /measurement of claims spend and average claims cost
- Consultancy and specialist fraud investigative training services, technical bulletins and case surgeries
- Surveillance and forensic accountancy/document analysis
- Annual 360 strategic review



Case Study 1 – AD to Electrical Appliances

- Laptop & PSP knocked off kitchen work surface by child.
- Items inspected by supplier and damage not consistent with circumstances presented. Laptop had suffered liquid damage and was last used two years prior to alleged incident.
- Customer oriented interview undertaken – concerns discussed in detail but customer maintained damage caused as claimed.
- Following our interview, policyholder's husband called and admitted that the claim presented was not genuine and advised his wife was afraid she would lose her job and that Insurers would pursue them for committing fraud.
- Claim declined and fraud condition invoked, saving Insurers £800.

Case Study 2 – Theft of Jewellery in Cyprus

- Alleged theft of jewellery in Cyprus involving unusual circumstances.
- Budgeted action plan agreed with Insurer for site investigation to be undertaken in Cyprus.
- Premises examined which revealed no forcible or violent means utilised to enter/exit property.
- Witnesses interviewed confirming jewellery had not been seen on the individuals in question.
- Final piece of jigsaw was obtained by reviewing CCTV footage from the borders agency and their Cypriot counterparts which revealed that the Insured was not wearing the jewellery either when leaving the UK or entering Cyprus.
- Claim declined and fraud condition invoked, saving Insurers £23,000.

What does this all mean?

In 2011, we saved our clients in excess of **£25 million** claims costs through the application of our wide ranging counter fraud techniques, delivering a **51% repudiation/withdrawal rate on claims referred to CFS** and a **return on investment of £17 for every £1 of fee spend.**

Fit for the Future?

- Prevention is better than cure.
- What data sets do you have available to turn into knowledge?
- We live in a digital age. Fraudsters move with the times.
- However, old methods sometimes still work, e.g. chip and pin vs. cheques
- To meet customers needs the industry will need new products, e.g. consequences of identity theft and computer fraud.