Property and casualty insurance fraud

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The best regarded, and practically the only, reference with regard to insurance fraud figures in the Spanish market is the study prepared by the ICEA using information provided by the various companies which every year take part in the National Fraud Detection Meeting organised by this institution.

The report, using the results of the 1999 meeting, concludes that in this year fraud had an impact on insurance of Pts125 billion. This is the equivalent of the total premium income for the lines of business of third-party liability and legal defence for the year 1999. Without any doubt this is a lot of money.

Of all the cases which were presented to the ICEA meeting this year by the 25 companies taking part - and which represent 25% of the sector's total premiums - 93% of the cases involve motor insurance, 6% involve other property and casualty insurance and the remaining 1% involves life and sickness insurance fraud.

These figures provoke the question of why there is such a disproportionate difference and whether there is really a greater incidence in this sector, a greater awareness at all levels and relative standardisation of fraud definitions, and ease - at least on the surface - of objectively comparing the real situation behind events, or other reasons. It may be that, in part, this great difference between the «anti-fraud» activities carried out in the motor insurance sector compared with the other sectors is explained by a greater level of maturity in fraud detection activities in the motor insurance line of business. Part of this difference however should also be attributed to differences in the definition of fraud which are used in the different lines of business.

Here we will concentrate exclusively on property and casualty insurance (including personal accident). Almost 1,700 cases were presented to the ICEA meeting between the various lines of business (general third-party liability, homeowners' multi-line, business premises, owners' associations, industrial and transport). Of these, the greatest number of cases were provided by homeowners' insurance - representing 53% of these reported cases.

With respect to MAPFRE, the companies which comprise the property and casualty unit presented 595 cases to the meeting, this is equivalent to 35% of the total number of cases presented.

It is estimated that for the year 2000 MAPFRE Seguros Generales will present 800 cases to the ICEA meeting. Without any doubt this considerable increase is due to the efforts which the regional claims departments have made in systematising the reporting process in cases of detected fraud, this allows advances to be made in achieving a better understanding of the diverse range of fraud and also to better assess the impact, in terms of economic savings, which this process has on the company's loss experience.

For two years now in the claims department of MAPFRE Seguros Generales, an annual action plan has been implemented dealing with working processes and economic incentives concerning various management variables in the claims departments, these include: speed of claim settlement, actions taken with respect to the average costs of slight losses, management of recoveries and, of course, fraud detection.

With respect to this last point, the general aims in the fraud detection process are as follows:

- To give the antifraud measures their true importance. Being aware of the amounts saved by the carrying out of efficient management, the real reach of this important process can be seen in economic terms.
- A systematic approach will help to detect common events or situations which may indicate possible fraudulent activities.

This systematisation will help to develop normalised procedures from the very first indications of fraud detected in certain claims.

- Make continual improvements in the rigour of the assessment and investigation of apparent frauds.

For this reason it is necessary to define as accurately as possible which are the conditions which may cause a reported claim to be considered as a possible fraud, with regard to the company's internal performance plan.

This is always the most complicated matter due to the large element of subjectivity which it carries. In general there are few objective limits, and many circumstances of varying natures which must be assessed in each specific case.

A committee has been set up in MAPFRE Seguros Generales in which claims handling personnel assess each of the frauds which have been reported with the aim of unifying the selection criteria for the cases which are to be presented to the meeting and in this way to favour, as far as possible, greater homogeneity in the criteria which may be applied in the claims departments to the cases which are considered to be frauds.

There are few set rules with respect to the criteria used by this committee, but if one were to be given it would be: «the case must be excluded from the meeting if its corresponding documentation raises any doubts with respect to the nature of the event».

The general definition of fraud used by the internal performance plan sets the following 5 points:

1. That there is a deception or intent to deceive on the part of the parties taking out the insurance or reporting the loss.
2. That an investigation is carried out which is more thorough than the simple confirmation which is necessary and basic in the handling of any claim (for example policy in force and premiums paid, that the real risk coincides with the policyholder, etc.)
3. That evidence is obtained which sufficiently proves the existence of fraud.
4. That the rejection is officially communicated.
5. That there is an economic saving.

The strict application of these points to great extent limits the wider range, which without any doubt exists, of fraudulent cases which are not able to be totally proved. This does not lessen the importance of the claims handling which is carried out, at times very laboriously, and which on many occasions leads to a large reduction in the final payout.

Many benefits have been obtained by the company through the skilful management by the claims handler when confronted with doubtful situations, which however have not been possible to definitely prove as fraud.

From the experience which has been obtained from the preparation for various meetings certain points have arisen which may help to bring into focus the blurred boundaries of fraud. These are some of the most significant points:

- The mere transcription of a telephone claim is not enough in order to declare fraud.

«My bag was stolen in the street with Pts100,000 in cash». Once the police report is received it is seen that this is a theft (due to carelessness) and not a robbery. How many of our policyholders know the difference between theft and robbery?

- It is not enough for there merely to be an exaggerated claim, which in the end is reduced after the claim handling process.

How many third-party liability claims like this are seen on a daily basis in the courts? Are they all attempts at fraud?

- We have to differentiate between what we consider to be fraud and the simple application of policy exclusions.

«My heater broke down after a power surge». After a loss adjuster's visit it is seen that the event occurred due to a lack of maintenance and the claim is rejected.

Is this an attempt at deceit, or in many cases is this just simple lack of knowledge?

- The fact that sufficient documentary evidence cannot be given with respect to the existence of the claimed goods is not in itself a fraud. It must be remembered that the policy makes a presumption in favour of the policyholder. It is not always easy to have available all the sales receipts for the goods which are covered by a policy.
- The skilful handling of a claim (e.g. in an apparently simulated robbery), as has already been said - even if in the end there is a great difference between what is actually paid and what was initially claimed - does not, for the effects of the meeting, count as a fraud. Under these conditions the sensible decision to close the case is in the majority of occasions the result of not being able to fully prove the fraudulent conduct of the policyholder.
- After suffering a loss the policyholder makes a claim for a sum in compensation. After

loss adjustment, the loss is correctly valued and the documentation is checked. In these situations some items may be excluded due to various reasons and in the end a sum is offered which is lower than that initially claimed.

The work needed to determine the causes of the loss and its adjustment is inherent in the loss adjustment process, and requires technical and insurance knowledge which the policyholders cannot be expected to have. There may be a lower payout but not necessarily fraudulent conduct.

If false or altered receipts are presented in order to induce an error then obviously this would be a case of fraud.

• In cases in which there is an intent to deceive and in which an investigation is carried out into the causes and the consequences and where sufficient proof is obtained to lead to a total rejection of the claim, but where there is later a payment for business reasons, these are not considered to be a fraud since there is no economic saving for the company. These cases - although it is true that they are exceptional - are the most painful to exclude from the meeting. However, and without considering other types of questions, the nature and the motivation behind these decisions fall outside the scope of the claims departments and therefore need not be commented on further.

This very restrictive scenario of what might be considered to be fraud allows the conclusion to be reached - with certain specific exceptions - that all fraudulent claims, as defined by our internal meeting, should lead to the total rejection of the claim which is made, partial payments not being acceptable.

Together with these general fraud definition criteria, it is also possible to set up automatic systems to give special warnings by the application of the claims computer systems which should include the information which has been obtained in the handling of the claim. Examples of some of the most simple warnings would include the following:

• Date of loss and date of policy inception very close (e.g. less than 30 days).

• Previous claims of the same type have been reported in less than a certain period of time.

• The existence of «rejected calls» at the call centre itself, for example due to not having the required cover at the date the claim was made. This could indicate a change of story with respect to the same loss.

• Claims made with respect to policies with previous underwriting incidences in claims.

Given the fact that an analysis of all possible cases of fraud in the various lines of property and casualty business would be too extensive to be included in this article, as a final summary we give a number of indicators or situations which may show the existence of a possible fraud. These have been obtained from the most common cases in homeowners' insurance which is the most common cause of fraud with regard to the number of policies within the area of property and casualty insurance. ■

HOMEOWNERS' INSURANCE FRAUD POSSIBILITY INDICATORS

Indicators concerning the claim

• The loss occurs shortly after the inception date of the policy/guarantee or just before its expiration.

• A strange account is given or strange loss. Cause of the loss unclear.

• Existence of various claims with the same damage on different dates or which occurred in doubtful circumstances.

• Claims which are reported late, without giving time for loss adjustment.

• The loss occurred in an unpopulated area, during the night on non-working days.

• The loss giving rise to the claim has already been repaired and repair bills are not available.

Indicators concerning receipts

• Original receipts are not provided or do not exist, only copies.

• Bills issued by various different companies are provided but written in the same typeface and with common characteristics.

• The insurance company is provided with excessive and unsolicited documentation or scarce information is provided.

Indicators concerning the policyholder

• Policyholder high loss history.

• Taking out/extending cover at a date close to the loss.

• Nervousness or contradictions when reporting the loss.

• A special interest that the claim handling is done directly with the policyholder. Provides vague and imprecise information.

• Indications of collusion: similar surnames, those involved in the loss live close to one another.