Insurance
Fraud Bureau
New Zealand

Insurance Fraud Bureau Whitepaper

3 September 2019

Insurance Fraud Bureau New Zealand

Insurance Fraud Bureau New Zealand

Whitepaper, 3 September 2019

Abstract

The following paper will give the reader an understanding of the purpose of the Insurance Fraud Bureau and how it is envisioned to work as a conduit to reduce the financial implications of fraud for the benefit of all New Zealanders.

Problem statement

Insurance fraud has been around since insurance began following the Great Fire of London in 1666. It is perceived as a "victimless" crime where nobody personally suffers a loss. The reality is that insurance fraud affects all policyholders by increasing insurers' costs, which leads to increased premiums. Insurance fraud is illegal and it impacts on communities and all policyholders.

It could be argued that fraud detection and prosecution in New Zealand is not taken particularly seriously. It is perceived as a white-collar crime that has a white-collar (i.e., soft) punishment for those found guilty.

> *"...the moral ambiguity surrounding some types of fraud is exacerbated by the characteristically short sentences meted out to offenders. In particularly high-profile cases, the leniency of punishment communicates to society that these people are somehow different from the common criminal... this tends to "decriminalise" fraud in the eyes of the public."*[1]

The Crimes Act 1961 does not recognise fraud as a crime, but that doesn't mean it is not illegal. Fraud prosecutions are brought under various other charges, including *crimes involving deceit*, *forgery and counterfeiting*, and *arson, damage, and waste*.

[1] Stotland in Australian Institute of Criminology, trends & issues in the crime and criminal justice, No. 199, March 2001

Most government agencies have an investigative team that works to detect and prevent fraud within their organisations, as it is often required by the government in order to protect public finances. Within the private insurance sector, the approach to fraud detection is more sporadic; some insurers have sophisticated approaches based on analytics and investigation, while others are less focused in their approach.

It is difficult to quantify the financial loss from fraudulent claims. This is something that is not currently being measured by the insurance sector as a whole in New Zealand, but best national and international estimates suggest that between 7 and 15% of Gross Written Premium[2] (GWP) in financial loss through fraud can be expected. This estimate will keep rising, as technology evolves and criminals get more dynamic and sophisticated unless a concerted industry effort is made to counter it.

Action is needed to highlight the damage insurance fraud does within the New Zealand economy while educating New Zealanders on the consequences and impact on people who dare to take the risk.

New Zealand needs an Insurance Fraud Bureau.

What is fraud?

Insurance fraud affects all New Zealanders. The Oxford Dictionary defines fraud as "wrongful or criminal deception intended to result in financial or personal gain".[3] Yet organisations concerned with preventing and detecting fraud are often reluctant to define it in their operational environment. One reason for this is that fraud is not a chargeable offence under the Crimes Act 1961. A person being prosecuted through the courts for fraudulent acts is often charged with *falsifying a document*, or *misuse of an official document*, *false statements or declarations*, *obtaining by deception* or *causing loss by deception*, *dishonestly taking or using a document or obtaining by deception* or *causing loss by deception*.[4]

---

[2] Gross written premiums are calculated as the actual premium less all premium refunds and rebates. Premiums are recorded gross (i.e. no deductions for commissions and brokerage incurred in writing the income). commissions.

[3] https://en.oxforddictionaries.com/definition/fraud

[4] Crimes Act 1961

> *"Insurance fraud is regarded by many as a low-risk, high-reward game for criminals, far safer than committing armed robbery, trafficking or dealing drugs. Among the elements that play to the criminals' advantage are, ... the absence of specific legislation on insurance fraud, the relatively light sentences compared to other criminal offences, and the lack of determination to root out fraud displayed by insurers, the courts and prosecution authorities."*[5]

Most insurance fraud occurs at claim time, through claims for:

- events/losses that didn't happen
- staged losses — such as arson or vehicle theft
- exaggerated claims
- non-disclosure or misrepresentation of information

Fraud can be described as either *hard* or *soft*. Hard fraud is deliberate, calculated, premeditated and sustained. It has been planned with the primary intent to deliberately deceive for a financial gain. Soft fraud is more common; it is opportunistic fraud that has only occurred through circumstance or by chance.

Hard fraud

The following are examples of hard fraud:

1. The latest iPhone has just been released and someone wants one but can't afford it. They then submit a knowingly false claim to their insurer claiming their current phone has been lost or stolen or is damaged. Their aim is to get a pay-out for their old phone that they can use to buy the new phone. This practice is then repeated every time a new iPhone is released.[6]
2. Someone cannot afford to get their car fixed. They believe they need a new one but cannot afford it. They arrange for their car to be stolen then burnt out. They report

[5] Viaene S. and Deden G., (2004) Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 pp 313-333

[6] It is interesting to note that, anecdotally, insurers report an upsurge in phone claims when a new model is released.

the theft to the police then submit a claim to their insurer. This behaviour is repeated every time a new vehicle is wanted.

Soft fraud

The following are examples of soft fraud:

1. Someone has several possessions stolen, so they submit a claim to their insurer. When filling in their claim form, they add extra items on to the list that they either do not own or that were not stolen.
2. Someone submits a claim for a piece of jewellery they have "lost" when they know that to not be the case.

In most instances, a person committing soft fraud is not aware, or is only vaguely aware, that it is illegal. Because it is such an easy thing to achieve, they rationalise it, telling themselves things like "everybody does it, it's not harming anyone else and I'm just getting my money back".

Prevalence

In an Insurance Council of New Zealand (ICNZ) fraud survey in 2005[7], 13% of respondents said that insurance companies can easily afford to pay for fraudulent claims.

In a 2001 survey of American insurance companies, an insurer's report titled, *Fighting insurance fraud: Survey of insurer anti-fraud efforts,* found that:

> "*half of all respondents rated fraud 'a serious problem;' … The major losses were said to be in soft fraud … although respondents agreed that it was difficult to make an accurate judgement as to the extent of soft or hard fraud overall[8].*"

[7] Insurance Council survey consisted of surveying Insurance Council NZ members only. ICNZ members represent 95% of the general and fire insurance market.

[8] https://www.insurance-research.org/research-publications/fighting-insurance-fraud-survey-insurer-anti-fraud-efforts

Understanding the fraud psyche

Dr Donald Cressey, a noted criminologist, developed the fraud triangle hypothesis in 1953 to describe the enablers of fraudulent behaviour.

The fraud triangle provides a framework for the psyche of people who commit fraud. Regardless of whether it is hard or soft fraud being committed, there are always three factors of the fraud triangle that can be applied: motivation, opportunity and rationalisation.

- Motivation — what drives the behaviour, such as financial stress, greed, addiction, sense of entitlement.
- Opportunity — occurs when there is perhaps a flaw in a process or a legal loophole. This is usually a temporary situation with a perceived low risk but high financial gain.
- Rationalisation — refers to the mindset of the individual and the justification of committing the act, such as, “it’s a big company, they can afford it”.

Understanding the fraud triangle allows for the development and implementation of effective anti-fraud practices and procedures that can help in deterring fraudulent behaviour.

Organisations that do not have proactive deterrent or preventative models built into their systems will always be inadvertently presenting repeated opportunities to individuals who meet the fraud triangle’s criteria.

> *"The fraud triangle provides a useful framework for organisations to analyse their vulnerability to fraud and unethical behaviour, and it provides a way to avoid being victimised. Almost universally, all three elements of the triangle must exist for an individual to act unethically. If a company can focus on preventing each factor, it can avoid creating fertile ground for bad behaviour."*[9]

When thinking about the fraud triangle, it is also prudent to have Maslow's hierarchy of needs theory[10] in the back of our minds.

When a person sees an opportunity or weakness within an organisation's systems or processes, a risk assessment is formulated very quickly, followed by rationalisation of the behaviour. This reflects back onto Maslow's hierarchy, in that successfully committing the act satisfies the person's need for financial safety and security, albeit temporarily. This, arguably, satisfies the other hierarchical needs. This pattern is likely to be repeated as long as the risk is perceived as low and the likelihood of being caught is perceived as minimal.

---

[9] https://www.brumellgroup.com/news/the-fraud-triangle-theory/

[10] Maslow's hierarchy of needs is a theory in psychology proposed by Abraham Maslow in his 1943 paper, *A Theory of Human Motivation*, that outlines what needs humans are motivated to fill and in which order.

The majority of people are law-abiding citizens, but that's not to say that many won't be looking for an opportunity for an easy win without repercussions. If people are presented with two out of the three enablers for committing fraud (i.e. motivation and rationale) they will always look for the opportunity; and likewise, if given the opportunity, people will find the rationale and motivation to commit the fraud.

> *"... the risk of fraud is a product of both personality and environmental or situational variables. This has two implications for understanding fraud risk. First, it means that individuals will vary in their propensity to commit fraud even when they are subject to similar environmental pressures. Second, it means that situations will vary in the impact on individuals according to the inherent risk factors at any given time. Just as there are likely to be high to low-risk individuals, there are also likely to be high to low-risk situations. As individuals move from one environment to another, the probability of fraud behaviour also changes. There are likely to be situational conditions that would discourage all but the most incorrigible people from committing fraud. Conversely, there are situations that encourage fraud to the point that even the average person is at risk of engaging in it."*[11]

Measuring fraud

Fraud is difficult to measure because it has so many aliases. The police in New Zealand do not collect statistics around fraud because it is usually classified into broader categories, such as theft or misuse of a document.

> *"Measuring fraud and anti-fraud requires developing clear and concise definitions of fraud for the purpose of uniform*

[11] Duffield, G and Grabosky, P. (2001) The Psychology of Fraud in Australian Institute of Criminology, trends & issues in the crime and criminal justice, No. 199, March 2001

> *measurement, and promoting their understanding and use with industry, government, academia and media."*[12]

Insurance fraud is estimated to be between 7 and 15% of GWP per annum based on international assessments and academic research.

International surveys suggest that insurance fraud in most countries is somewhere around 10% of total GWP.

> *"...there is a considerable gap between the real extent of insurance fraud and what is actually discovered."*[13]

More recent, predictive analysis conservatively estimates that losses to the general insurance industry in New Zealand are between $530 million and $614 million per annum.

Cost of fraud

Insurance fraud in New Zealand has not been formally measured, which means the individual cost of insurance fraud to domestic policyholders has not yet been quantified. Inability to quantify the cost does not mean the problem can be ignored. International estimates provide a good starting point for assessment of the impact to New Zealander policyholders.

The cost of insurance fraud has more far-reaching consequences than just a rise in premiums for policyholders. It affects all New Zealanders, because everyone pays for the costs associated with the deployment of public resources, such as police, fire and ambulance services, detection processes, and prosecution services.

An additional by-product of insurance fraud is that it can put lives at risk. An example of this is arson.

---

[12] Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333

[13] Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333].

> *"...the actual extent and cost of insurance fraud remains hard to quantify with precision. There are several obstacles to its measurement. The first, particular to the nature of fraud itself, is the fact that it is set up as a covert operation and, as such, is not self-revealing. Fraud is not a static phenomenon either. It is as dynamic as the business environment itself and swiftly capitalises on the latest opportunities."*[14]

Most people are not aware of the drastic consequences of being caught committing insurance fraud. One of the worst prices to pay for being caught is having one's policy cancelled. This can have a flow-on effect, in that some insurers share information through the Insurance Claims Register (ICR). This means that the likelihood of getting insurance cover from another company once someone has committed insurance fraud is extremely low. Inability to get insurance impacts on a person's ability to own property, as a bank will not lend to someone who is not insured. In addition, other policies held with that insurer may also be cancelled and the insurer may decline to renew them.

Current fraud detection methods

Detection of insurance fraud is often under-resourced, underfunded, difficult and often relies on astute employees making a judgement call on circumstances at claim time or suspicions arising at the time of policy inception.

The insurance industry does not tend to publicise successful fraud investigations t can have negative connotations for commercial brands. Insurers do not want to be perceived to be targeting their customers.

> *"Failure to detect fraud is bad news, and finding fraud is bad news too. The very existence of fraud is an embarrassment to insurers and their management. This helps explain why insurers*

[14] Dionne, G. (2000) The Empirical Measure of Information Problems with Emphasis on Insurance Fraud, Chapter 12 in Dionne, G (ed.), Handbook of Insurance. Boston, MA: Kluwer Academic Pubishers in Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333

still seem to prefer not to be associated with fraud in any respect, be it as victim or crusader."[15]

In a proactive effort to combat insurance fraud, ICNZ members developed the Insurance Claims Register in 1999. The ICR enables member insurers to share and view claims histories in a searchable database[16]. The ICR allows member companies to check for non-disclosure and potential double-dipping scenarios. Members can 'flag' policyholders who are deemed to be of concern for a variety of reasons, including attempts to mislead an insurer, making a suspicious claim or having previously been convicted of an offence involving dishonesty. The ICR is now recognised worldwide as a unique tool for insurers to utilise in the battle against fraud.

By using the ICR, insurers can identify claim-related fraud at the point of new business or at claim time. Whereas insurers who are not members of the ICR are exposed to the risks of taking on people who may have been identified in the ICR as potentially bad risks or being known to have committed fraud.

Individual companies who are not part of the ICR and who operate in a 'stovepipe' environment (a self-contained operation working only with their own data and resources), are more exposed to opportunistic fraud with less chance of it being detected and are thereby increasing their risk of financial loss.

While the ICR is a highly valued and effective fraud tool within the industry, it alone is not sufficient. In addition, there are some impediments to effective fraud control, including that

- fraud is not self-detecting
- proving fraud is difficult
- fraud is a dynamic, constantly evolving phenomenon
- fraud control processes are not well understood (automation of processes is often to the detriment of effective detection/prevention methods)
- not all ICNZ members are members of the ICR

[15] Sparrow, M.K. (1998) Fraud Control in the Health Care Industry: Assessing the State of the Art, Research in Brief. Washington, D.C.: National Institute of Justice, in Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333

[16] This is done in accordance with strict guidelines to ensure there is no commercial exploitation or breach of privacy.

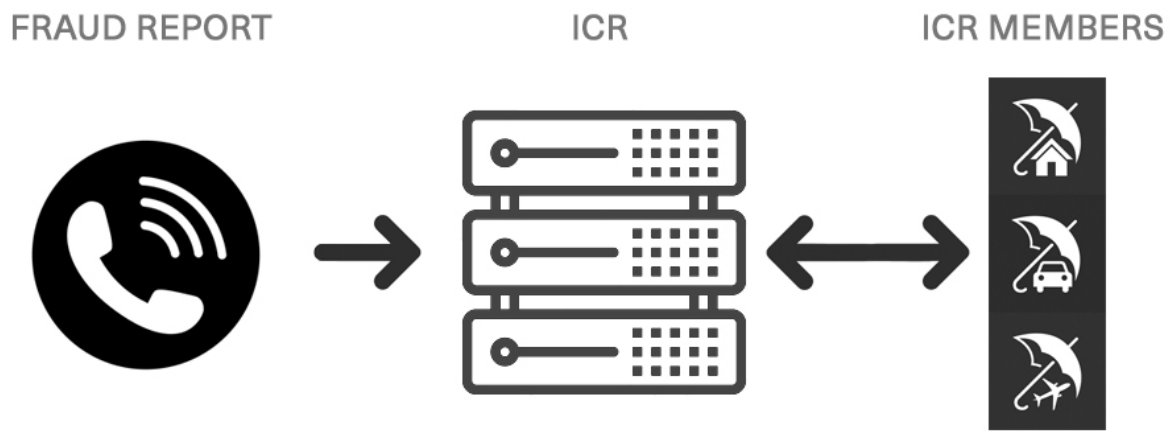
- insurers do not have any developed avenues for collaborating with law enforcement agencies
- return on investment in fraud detection is hard to quantify
- other strategic objectives prevail (including customer service delivery, processing efficiency and portfolio development).

Despite these impediments, some insurers have dedicated teams that handle discovery, investigation and prosecution (where appropriate). Other companies may have smaller teams who share fraud tasks with their main role and react to triggers such as tipoffs or proactive searching. Some companies may not have any resources to deal with fraud identification and rely on luck or proactive notifications. No matter the sophistication of their processes, all companies conduct fraud detection training for their claims teams.

Insurers also have dedicated fraud hotlines to allow members of the public to notify them of suspicious claims. Companies engage with internal or external investigators to examine and gather evidence to assess the validity of a fraudulent claim.

ICNZ also has an online and phone fraud tipoff service to receive tips on potential instances of fraud. This has the advantage that it does not rely on a member of the public knowing who the affected insurer is, so the fraud tipoff can be centrally coordinated. It also allows tipoffs to be made anonymously, which is thought to increase the likelihood of receiving a fraud report.

Reporting of insurance fraud through this avenue is limited because ICNZ is not recognised as a central point of contact for reporting insurance fraud. The IFB will be taking over administration of the fraud reporting lines from ICNZ; it is hoped this will elevate the profile of the fraud reporting functionality and lead to an increase in reports.



Once an allegation of insurance fraud is reported to the IFB, it will be checked against the ICR (where relevant) to confirm the identity of the person that has been reported. The allegation will then be passed on to the affected insurer, who will decide whether it warrants further investigation.

Fraud prevention

Prevention is costly and detrimental to insurance companies' bottom lines.

As technology improves and automation processes become the norm, the chances for data manipulation, identity fraud and insurance fraud will increase. The insurance environment will quickly become a haven for fraudsters unless fraud prevention methods and tools are given prominence within technology discussions. Simple prevention methods, such as collaboration, searching the ICR, or investing in digital applications, such as blockchain, will go some way to both prevention and detection of fraud.

On the other side of the coin, with the IoT (internet of things) becoming faster, smarter and more interconnected, the traditional method of committing fraud by dishonesty, omission or exaggeration of facts could become obsolete. This is not to say that traditional methods of detecting insurance fraud will become defunct; people who commit fraud will simply evolve with the environment.

Some of the things that insurers are doing to reduce fraud are:

- Specialist claims training — insurance claims personnel are given fraud detection training and if suspicions arise, the claim(s) are referred to specialist claims teams or investigators for closer review.
- Specialist investigators — insurers have teams of specialist claims investigators. These personnel undergo insurance training and fraud detection training. They are the front line of the fraud detection sector for the industry.
- Insurance Claims Register — the general insurance industry has a shared register of insurance claims, which is used to check whether full disclosure of claims history has been made and whether claims for the same loss are being made from more than one insurer. The ICR has been operating since 1999 and has over 7.5 million claims in the database.
- Zero tolerance of insurance fraud — insurance companies may prosecute individuals through the courts when there is clear evidence that a claim is fraudulent.
- Specialist fire investigators — arson is a major problem in insurance claims and for almost all large fires, insurers appoint specialist fire investigators to check for suspicious circumstances that might indicate fraud.
- Fraud hotline — the Insurance Council has a freephone number, 0508 FRAUDLINE (0508 372 835), which the public is encouraged to call and leave information about potential insurance fraud instances. All information given is confidential and can be made anonymously, and no details are passed to the alleged fraudster.

Solution: the Insurance Fraud Bureau

Insurance fraud continues to plague the general insurance sector despite the number of initiatives to curb it. Greater effort needs to be made to educate the public around insurance fraud issues and reduce instances of insurance fraud. ICNZ is building on the above initiatives by developing the IFB to take fraud prevention to a new level involving scale, technology, relationships and a specific brand to provide a pan-industry approach to combating insurance fraud.

The IFB is a not-for-profit branch of ICNZ. It has been developed in a similar fashion to the United Kingdom and Australian models with its sole purpose to reduce insurance fraud. It is designed to allow otherwise-competing organisations the chance to share data and collaborate with external stakeholders to benefit the whole of New Zealand.

> *"The trick... for the insurer is to convince its customers of the added value of its proprietary investment in fraud control.... Another way to break the chain of argumentation for passivity is to get insurers to co-operate and to credibly commit to concerted, uncompromising action against fraud. Co-operation would not only take away the threat for individual insurers of being commercially punished for taking a tough stance against fraud, it could also improve the cost efficiency of fraud control and upgrade its effectiveness."*[17]

It has been widely recognised that industries cannot work alone when combating fraud. There is a desire to share knowledge and training between the public and private sectors, as well as the need to build better intelligence networks to produce a far more reliable picture of the true cost of fraud.

> *"Improved communication, co-operation and co-ordination between the public and private sector are required to be able to more effectively fight insurance fraud, i.e. focus and consolidate the overall fight against insurance fraud."*[18]

Detecting fraud is hard to do and often, the cost to investigate and recover is considerably more expensive than the cost to settle the claim. Insurer reputation is also a factor which can make an insurer reticent to raise the issue publicly. However, a collaboration of resources with law enforcement, ICNZ/IFB members, and other government agencies would make detecting and prosecuting fraud more affordable, more measurable and would take away the stigma of negative publicity for the insurer, thus removing adverse branding perceptions.

Furthermore, it is expected the IFB will be able to reduce insurance fraud through

[17] Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333

[18] Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333

- educating New Zealand consumers on what constitutes insurance fraud and its consequences
- providing a central point of contact for insurance fraud issues
- developing strong multi-agency relationships
- creating a 'centre of excellence' for anti-fraud initiatives
- researching national and international patterns and trends
- providing cost-effective intelligence support to member companies enhancing their own capabilities
- reducing the cost to the sector by working with insurers and external agencies to detect and prosecute fraud
- removing negative 'brand' effects from insurers when dealing with cases of fraud
- strengthening strategic relationships with government agencies and police for data sharing and awareness of fraudulent activity
- researching and developing emerging technologies that can increase the sector's ability to develop anti-fraud measures
- providing a forum for sharing fraud information and detection processes to optimise the insurers' response.

The IFB will encourage greater media awareness and public education to remind New Zealanders of the cost of fraud and how it is shared by the population. The IFB will dispel the perception that fraud is victimless and stress that the cost is borne by everyone, not just the insurer.

Conclusion

It takes a concerted team effort to fight back against insurance fraudsters. No individual organisation or agency has the resources to single-handedly stop it. By combining resources and the expertise of insurers, law enforcement agencies, and the IFB, insurance fraud can be detected, deterred and prevented, thus helping to protect New Zealand policyholders.

Creating an IFB in New Zealand will continue the global trend of pushing the anti-insurance fraud message that it is not acceptable behaviour and that those engaging in such fraudulent acts are more likely to get caught.

The benefits to the industry are to lessen the financial impact of fraud with the additional benefits that those costs are not passed on to their policyholders.

Finally, we should all try to stamp out fraud in the insurance industry, which will never be stopped by individual insurers alone. Only a collaborative approach will have any impact on this common and significant cause of industry leakage. Having an IFB is one way of combating insurance fraud.

References

American Insurer, *Fighting insurance fraud: Survey of insurer anti-fraud efforts, Article, 2001*

Dionne, G. (2000) The Empirical Measure of Information Problems with Emphasis on Insurance Fraud, Chapter 12 in Dionne, G (ed.), *Handbook of Insurance.* Boston, MA: Kluwer Academic Publishers in Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333].

Duffield, G and Grabosky, P. (2001). The Psychology of Fraud in Australian Institute of Criminology, trends & issues in crime and criminal justice, vol 199, March 2001

Oxford English Dictionary online. https://en.oxforddictionaries.com/definition/fraud

Maslow, A.H. (1943). Theory of Human Motivation

Sparrow, M.K. (1998) Fraud Control in the Health Care Industry: Assessing the State of the Art, *Research in Brief.* Washington, D.C.: National Institute of Justice, in Viaene S and Deden G, Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 (April 2004) pp 313-333

Stotland, E. 1977. *White collar criminals,* Journal of Social Issues, vol 33, pp 179-196 in Australian Institute of Criminology, trends & issues in the crime and criminal justice, No. 199, March 2001.

Van Akkern, J. (2018). *Fraud Triangle: Cresseys' Fraud Triangle and Alternative Fraud Theories,* Brumell Group, https://www.brumellgroup.com/news/the-fraud-triangle-theory/, June 2018.

Viaene S and Deden G. (2004). Insurance Fraud: Issues and Challenges, The Geneva Papers on Risk and Insurance Vol.29 No.2 pp 313-333