Claim fraud on the rise: insurance firms hard-hit

By Dr Jerry Chetty

24 Jun 2022

Despite being in the business of risk mitigation, insurance firms themselves are often subject to risk in the form of insurance crime.

Source: Supplied. Dr Jerry Chetty, manager of the Business Integrity Unit at Santam

Last year, the Association for Savings and Investment South Africa (ASISA) found that South African life insurers detected 4,287 fraudulent and dishonest claims worth R787.6m across the board.

This is a notable increase from the previous year when fewer than 3,500 cases of fraudulent and dishonest claims to a value of R587.3m were uncovered. Statistics for insurance crime in the short-term insurance industry is not readily available.

The Insurance Crime Bureau estimated that the short-term insurance industry lost about R7bn in 2019 due to insurance crime namely 20% of the R35bn worth of claims paid out. As the risk landscape changes, insurers must keep up to date with developments in fraud risk-mitigation strategies if they are to reverse this process.

Through their research, South Africa's largest short-term insurer, Santam, has pinpointed some of the areas in which insurers are facing challenges and how they can be combatted.

The reasons claimants lie

The Fraud Triangle, a model developed by criminologist Dr Donald Cressey, explains why people violate trust relationships. Much of the rise in fraudulent and dishonest claims has been driven by three factors collectively called the "fraud triangle":

- **Opportunity:** Fraud cannot happen without an opportunity to take advantage of. Unfortunately, these opportunities can be difficult to mitigate and even harder for insurers to stay on top of. Inflating claims and manipulating the claim's story are the most common ways that this may happen.

For example, the claimant may inflate a genuine claim and falsify certain details for financial gain. Claims processes, which have been implemented by insurers to speedily assist policyholders in claims settlement, are being exploited by criminal syndicates.

- **Financial pressure:** Thanks to the economic difficulties borne of Covid-19, people are feeling the financial pinch.

Some see submitting fraudulent and dishonest claims as a quick and uncomplicated way to help alleviate that pressure.

- **Rationalisation:** Rationalisation refers to the justification which is advanced to support unethical or bad behaviour. Researchers have identified six categories of rationalisation. A person's ethics plays an important role in understanding their motivation to employ rationalisation techniques.

People filing dishonest or fraudulent claims often rationalise this fraudulent behaviour by "tricking" themselves into believing that filing fraudulent claims is a victimless crime as no-one gets hurt.

While not the only driver behind why people commit insurance crime, this "fraud triangle" explains the primary motivations behind why insurance crime is trending upward.

Predicting fraud before it happens

The Theory of Planned Behaviours developed by Ajzen is another useful theory which helps in predicting people's planned behaviour by focussing on attitudes towards the behaviour, subjective norms and perceived behavioural control.

Attitude towards behaviour is related to the outcome and cost factor involved in continuing with a specific behaviour; subject norms are the views which peers or society have about the specific behaviour; and behaviour control refers to the ease or difficulty in continuing with the behaviour.

Theorical understanding is a useful component to include when developing an anti-fraud programme as it includes both transactional and behavioural aspects.

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How insurance crime is committed

The first step in combatting fraudulent and dishonest claims is understanding how and when they occur and who is responsible. What makes responding to these claims difficult is that these types of claims are often committed by a myriad of different actors.

With that said, these crimes can be split into four broad categories, each with its unique characteristics:

- **Opportunistic crime:** These are committed by one person who usually spots a chance to make some fast money. They tend to revolve around common-claim incidents with a low rand value.

One of the examples we uncovered at Santam was as follows. A policyholder claimed for items which were not stolen or which the policyholder did not own during a legitimate claim for a housebreaking incident. This was done so that the policyholder could receive a higher claims settlement amount.

Most correspondence is done by email and as soon as a field assessor is dispatched, the claim is often cancelled, and the claimant becomes unreachable.

- **Community participative crime:** This is a new and emerging trend. This occurs when individuals in a community share information about loopholes and vulnerabilities with each other. The information-sharing may not necessarily be done with malicious intent in all instances. It has been observed in some instances that information is shared about the claims experience or the claims process. Typically, what we then see is a surge in similar claims from a particular area.

- **Organised crime:** These are the incidents people think about when they think of insurance fraud. Often, they are planned and co-ordinated to deceive assessors and insurers. Some of the most common examples of this include large stores or buildings that are purposefully burnt down but claimed as accidents for financial gain. Also, where motor-vehicle accidents are staged to claim benefits from the insurance policy.

- **Cybercrime:** With cybercrime costing South African businesses more than R2.2bn per year, mitigating its effects has become a top priority. As more people work remotely, the opportunities for criminals to illegally access, and then ransom information, increases exponentially.

Business-email compromise and ransomware attacks are prevalent to industries that are data dependent or that are regularly involved in processing payments.

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Ways insurers can potentially de-rail fraudulent claims

Despite the increase in these kinds of claims, our research shows that there are several concrete steps we can take to turn these numbers around. Our observations are that fraudulent claimants are well versed in insurance processes and policy wordings; they are persistent but we as insurers are well placed to push back.

An alert management system for the collection of both complainant and intelligence-driven information is a critical early-warning system in detecting insurance crime. Complainant-driven platforms include the various whistleblowing channels available for people to anonymously report suspicions of insurance crime.

There are various technology solutions which offer good early-detection capability in identifying patterns and behaviour. We have combined technology with sophisticated intelligence and analysis machinery that can help us detect emerging risks and neutralise them before they get out of hand.

Together, these solutions are able to track a change in behaviours from fraudsters which gives us the advantage of responding quickly. We have also learnt that low-value claims matter and should also be vigorously monitored. As we see with low-value claims where we send out field assessors, fraudsters follow the path of least resistance and when confronted with a robust defence are likely to abandon their plans.

Another way to discourage fraudulent claims is through the deterrence-letter theory. Research has found that the filing of fraudulent claims decreased when insurers advised policyholders about the negative impacts of insurance crime on society and the possible repercussions a person could face for filing inflated or false claims. Such initiatives are cost-effective methods for insurers to employ as part of their antif-raud programme.

Finally, by adequately training frontline staff, sharing information with fellow stakeholders in the industry, undertaking more research and conducting extensive consumer awareness, we can reverse the trajectory of these crimes.

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