

SAFEST - Cost of Fraud

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In 1998, Terrie E. Troxel, writing in the Insurance Research Council's report, *Inaccurate Perceptions of Insurer Profits Claims Costs Held by Public* said, "36% of Americans believe that it is acceptable to inflate an insurance claim to make up for past premiums paid." Further,

1. Compare that to the report of the Public Attitude Monitor in October, 1991, which said, "Almost one third of the respondents considered it personally acceptable to misrepresent some kinds of information when completing an auto insurance application and, as many as 14% were willing to misrepresent the facts when filing an auto insurance claim."
2. The Conning Report, *Insurance Fraud, the Quiet Catastrophe*, 1996, provides alarming estimates of the cost of fraud. The Conning Insurance Research and Publications company conducted research into the total cost of insurance fraud as provided by the estimates of insurance professionals in property / casualty, health care, and life & disability. They estimated the total expense of fraud to the insurance industry at \$120 billion per year with \$95 billion to health, \$20 billion to P&C and \$5 billion to life/disability.
3. The price of fraud is not going down!

As of 2000, the cost of health insurance hit about \$1 trillion and the P/C market was about \$301.56 Billion. Even at a fraud rate of 10%, that would mean fraud costs the public about \$130.156 Billion in P/C and health alone, not to include workers comp or life and disability. If you count those two and rate it more accurately at 20%, you easily have a cost of fraud at close to \$300 Billion per year. The insurers put about \$821 million into fighting fraud. That would be about 5/100ths of 1% of premium to pay for a 20% problem. This means to the premium paying public that they do not have \$300 billion of discretionary income to spend as they would like on such things as cars and homes, TV's and operas. They do not have \$300 billion to roll into the economy and upon which they would pay taxes. It goes to the crooks who do not pay taxes on it and who put it into their banks and may be spending it off shore.

One thing we know is that it does not go to the public where it will be spent.

In the meanwhile, this author has had conversations with some of the SIU's and hears that some of them are currently downsizing. The companies say they are going to go to outsourcing their fraud investigations. Some of the companies have come to the conclusion that they can call the investigation expense an allocated claims expense and write it off against the claim if they outsource. That increases the size of the claim to some degree, but it is an expense on the severity side of the ledger, not on the expense side and the companies are always trying to control the expenses. It is more difficult in some states to be granted a rate increase if it is the company's expenses that are going up whereas the rate increases are easier if they are the result of the company's own loss experience. So then, are the insurance companies outsourcing their fraud investigation needs? As a member of the Private Investigation community and in speaking with a number of my P/I counterparts, I think it is safe to say that the outsourcing is maybe a plan in the mind of some company claims divisions, but it is not a current reality.

So why are the insurance companies not doing more to suppress this hemorrhage of red ink? It may be one of several reasons:

1. They don't believe it is happening to them. (Not educated on the cost of fraud)
2. They don't think it is their problem. (Not concerned)
3. They know and they think if they fight it, the cost will be more than the benefit. (Not experienced in anti-fraud work.)
4. They are making a great profit and if they fight it, the profits will go down. (Not the kind of company the public wants to support.)

We have all experienced to some degree or another the first three categories. After all, the entire SIU community has been working on training issues for going on 20 years. These first three points have been major topics for the SIU's for that entire time. Let's take a look primarily at

the last one of these. Why would any company not want to fight fraud?

If we look at the way insurance companies make money, there are basically two ways: underwriting and investments. To make an underwriting profit, an insurer must pay out less than they take in. We see that they take in premium and they split it into two piles. One pile is used to pay claims. The other pile is used to pay for expenses. Together they make up what is known as the combined ratio. Julian Levy, writing in *The U.S. Non-life Insurance Market* says, " (The) combined ratio is the sum of the loss ratio and the total underwriting expense ratio." (4) Levy reports that "The combined ratios for the top 15 groups (of companies in the U.S.) were 110.8% and 109.1% for the industry for the period 1991 to 1993 (5) Obviously, not a lot of money was made on the underwriting side. That kind of ratio is no stranger to the insurance industry. How else can an insurer make money? Investments!

While they are still in possession of the premium cash, the insurer makes investments, hoping to make more in interest or dividends than they will eventually have to pay out in the combined ratio. If they make enough, it goes into surplus from which they can buy buildings, pay for equipment, pay for things voted on by the Board. Insurers have been known to possess vast real estate holdings from which they can derive cash. So the question remains, why not resist fraudulent claims? For one thing, to resist fraud reduces premium income in two ways.

1. It drives fraudulent claimants and others who are on the bubble of whether or not they would commit fraud (about 36% of the population) away from their door. According to Terrie E. Troxel, writing in the Insurance Research Council's report, *Inaccurate Perceptions of Insurer Profits Claims Costs Held by Public*, "36% of Americans believe that it is acceptable to inflate an insurance claim to make up for past premiums paid. (6)
2. If the company does not pay for fraudulent claims, they have a much harder time increasing rates based on losses.

It actually does not hurt the industry as a whole to pay for fraud. It is exactly the same as the case of arson in the late 1970's when the government had to intervene and force companies to do

something about a crime whose costs were being passed along to the insured in the form of premium increases. Insurers simply did not see it as their problem and they passed the cost of arson on to their premium paying public, most of whom thought it was the insurance company's money and they themselves were not being hurt. The fact was that then as now, insurers do not print their own money. The entire amount that went to pay for arson or that now pays for all frauds comes directly from the pockets of the insured, not from the bank account of the industry. It really makes no difference to the industry if fraud were to cost 50% of premiums, as long as it costs all companies the same in terms of the ratio of fraud to legitimate claims. All boats rise in a rising sea and if the price of fraud goes up for all companies, then all companies get that amount of money to invest before it goes back out to pay for claims, legitimate or not.

In fact, if we take a look at the industry as a whole, we see that they took in about \$247.5 Billion in P/C premium alone in 1997 (7). Eliminate, drive off or spook the fraud artists and the people on the bubble and you eliminate a good deal of the premium income. Conning Insurance Research and Publications in 1996 published their study called, *Insurance Fraud, the Quiet Catastrophe*. In it they said, that the industry as a whole spent about \$675 Million in support of fraud fighting which was the estimate for fraud fighting expenses by both the P/C and Life/Health insurers for the period immediately prior to 1996. Consider that the P/C industry was taking in more than \$247 Billion and the health insurance segment was believed to be taking in over twice that in premium and you can estimate the total premium for 1996 at well in excess of \$737.5 billion. Estimates by insurance professionals and the fraud fighting community hold that the amount that pays for fraud is about 20% of that. Yet, if Conning is right, and there is no study that shows they are not right, then the industry is actually paying 9/100ths of 1% to fight a 20% problem. And that is a real good reason not to fight fraud. It is not profitable!!! Fighting fraud is an expense and some insurers simply do not want to increase their expenses no matter who gets to pay for severity.

Admittedly, there are a few companies that take the matter seriously. They fight fraud as best they can. However, it is much like being killed by a million mosquito bites. They cannot swat them all and the vast majority of fraudulent claims are opportunistic. Those are the mosquitoes. The

really expensive ones are professionals who run injury mills or plan out their crimes well in advance. But they are in the minority. Many companies take the attitude that they cannot do anything and it is not in their best interest to fight too hard so they make a feeble attempt and publicize how they are standing tall. The end result is that fraud flourishes. The companies neither outsource nor develop in-house fraud fighting capabilities. What will it take to get the industry excited about fraud? Maybe one or two big companies who will bite the bullet temporarily and spook a few thousand people who are "on the bubble." Those companies will have a loss at first as they drive the frauds from their doors. They will definitely suffer fewer fraudulent losses and their underwriting gain may surprise them. As their premiums fall, they will gain a customer base and those are the customers who stay. Other companies may see the light and follow suit. That would be the better way.

The other way is government intervention. The government would like nothing better than to find a company callously passing on the costs of fraud to their insiders. Many states have passed laws requiring companies to fight fraud. The commissioners would like nothing better than to fight for their constituencies by making examples of a few companies taking advantage of the public and passing on the costs of fraud. If the companies do nothing, that will likely be the result. It will be in the better interests of the industry and each individual company to fight fraud. If they are not part of the solution, they are part of the problem!

Endnotes

1. *Insurance Research Council*, News release, www.ircweb.org, 7-5-98, p. 2.
2. *Public Attitude Monitor 1991*, Insurance Research Council, Oak Brook, IL, p.1.
3. *Insurance Fraud, the Quiet Catastrophe*. Conning Insurance Research & Publications, Conning and Company, Hartford, CT, 1996, p. 8.
4. Julian Levy, *The US Non-life Insurance Market, A strategic analysis of the world's Largest property and casualty insurance market*, A Financial Times Management Report, Pearson Professional Ltd., London, England, p. 11.
5. Julian Levy, *The US Non-life Insurance Market*, pp. 128-133.
6. Troxel, Terrie E., *Inaccurate Perceptions of Insurer Profits Claims Costs held by Public*, Insurance Research Council, News release, www.ircweb.org, 7-5-98, p.2.
7. Levy, *The US Non-life Insurance Market*, p. 2.
8. *Insurance Fraud, the Quiet Catastrophe*. Conning Insurance Research & Publications, Conning and Company, Hartford, CT, 1996, p. 81.