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# **Liars, Cheaters and Thieves: Fraud Beyond WC**

## **Atlanta RIMS Annual Educational Conference**

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# Session Overview

- Introduction and overview
- Defining fraud: What is the opportunity?
- Types of fraud
- Common indicators of fraud: What should you look for in mitigating this scourge?
- Approaches to fraud fighting
- Culture and Ethics: A Central Tenet of Success
- Questions and answers

# Ancient History or a Ever-present Possibility?

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- **Enron**
- **Worldcom**
- **Tyco**
- **Waste Management**
- **Adelphi**
- **AIG**
- **Countrywide**

# Hubris Unrivaled

Enron's banner in lobby:

Changed from...

“The World's Leading Energy Company” to  
“THE WORLD'S LEADING COMPANY”

# So Why Did Enron Happen?

- Individual and collective greed
  - The company, its employees, analysts, auditors, bankers, rating agencies and investors didn't want to believe the company looked too good to be true
- Atmosphere of market euphoria and corporate arrogance
- High risk deals that went sour
  - When it looks too good to be true, "it probably is"
- Deceptive reporting practices
  - lack of transparency in financial reporting
- Impossibly aggressive earnings targets and extraordinary management bonuses aligned with them
- Excessive interest in maintaining unsustainable valuation

# Financial Crisis Inquiry Conclusions

## Final Report of the Nat'l Commission on the Causes of the Financial and Economic Crisis in the US:

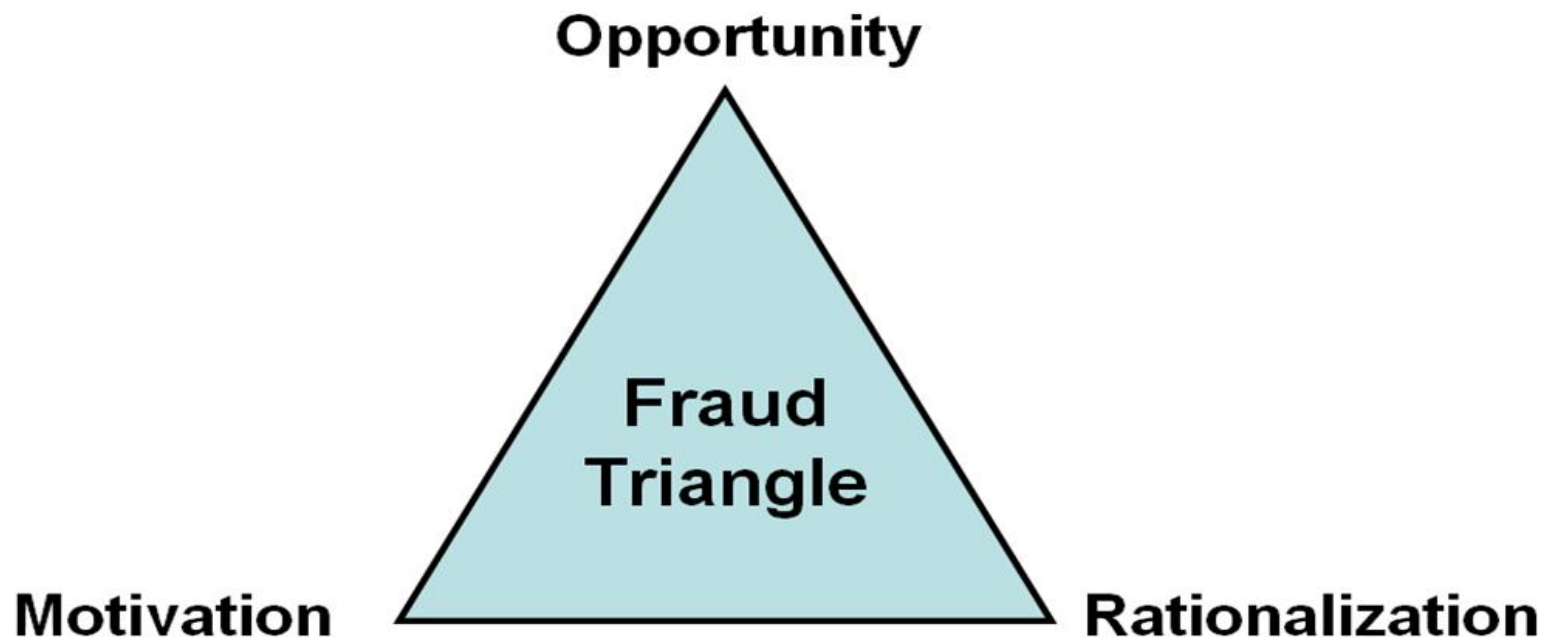
- **Financial Crisis was Avoidable**
- **Dramatic failures of corporate governance and risk management was a key cause**
- **Rating Agencies relied inappropriately on risk models & “were cogs in wheel of financial destruction”**
- **Risk management too often became risk justification**
- **Excessively risky investments and a lack of transparency were key**
- **Government ill prepared for crisis and inconsistent response exacerbated the crisis**
- **There was a systemic breakdown in accountability and ethics**

# A Month's Worth of Fraud Headlines

- Massachusetts launches new program to curb Medicaid fraud
- Feds boost health care fraud investigations
- Regulators say health insurance scams are on the rise in Indiana
- Widespread Medicare fraud alleged at Tennessee medical center
- Virginia sues top lab companies for billing fraud
- \$11M medical scam in Detroit ends with prison for mastermind
- Psychiatric CEO sentenced in Medicare fraud case
- Two held in insurance 'fraud' probe
- Using Obama care, scammers may be targeting small businesses
- Podiatrist in Conn. sentenced to prison for billing scam

# Why People Commit Fraud

Famed criminologist Donald R. Cressey



**Even the best systems of internal control cannot provide absolute safeguards against irregular activities.**

## ***Do I have a reason to steal?***

- **Biggest driver of fraud – personal financial gain**
- **Greed & work pressures**
- **External pressures**

## ***Can I get away with it?***

- **Exploitation of weak internal controls**
- **Collusion to circumvent good controls**
- **Reckless dishonesty regardless of controls**

# Can I live with myself?

- The ability to persuade oneself that something you know is wrong is really OK
- All internal restraints has been removed
- Entitlement mentality
  - *“Everyone is doing it”*
  - *“The company owes me”*
  - *“I will replace the money next month”*
  - *“No one gets hurt”*

# The Latest from NICB: First Half 2013

- Although the number of WC claims in ISO is decreasing, the number being submitted as QCs is increasing. The number of WC QCs is on course to increase again for 2013.
- WC QCs with a “Medical” Loss Type were the most common (62% of the total), and “Liability” claims were the 2nd most common (37%). The top 4 Referral Reasons were the same each year, with “Claimant Fraud” topping the lists.
- California was the state with the largest number of WC QCs in each year. When ranked by WC QCs per 100,000 residents, Delaware ranked 1st in 2011, Connecticut ranked 1st in 2012, and Maine ranked 1st in the first half of 2013.
- Chicago, IL was the city with largest number of WC QCs in 2011, however, in 2012 and the first half of 2013 Los Angeles, CA replaced it as the top ranked city.

# Cost of Fraud: How Much Is Your Company at Risk?



- The typical organization loses 5% of its revenues to fraud each year
  - Translates to a potential projected global fraud loss of more than \$3.5 T
- The median loss caused by the occupational fraud cases in a recent study was \$140,000.
  - More than 1/5 of these cases caused losses of at least \$1M
- The median detection time for fraud cases has been measured at 18 mos
- In 81% of cases, the fraudster displayed one or more behavioral red flags that are often associated with fraudulent conduct
- The most common way fraud is detected is from employee tips

# WC Fraud Statistics: Employer vs Employee Fraud



The element of employer generated WC fraud is often overshadowed by the intrigue associated with employee fraud, but.....

- A Texas Mutual study showed the average employer generated WC fraud case was worth \$1M+ vs \$2500 for employee sourced fraud
- The number of employees misclassified by employers increased 50% 2000 and 2007.
- Those schemes stole \$500 million in workers compensation premiums, taxes and other expenses
- More than 39,500 employers misclassify 704,785 workers — or 10.3 percent of the workforce
- Employers in high-risk California industries may hide up to 75 percent of their payroll — or \$100 billion — for the most-dangerous jobs
- Every \$1 invested in workers compensation anti-fraud efforts returned \$6.17, or \$260.3 million total in 2006-2007 (CA)

*Source: Coalition Against Insurance Fraud*

# Common Employer Fraud Allegations:



- **Misrepresentation of Payroll/Job Code/Job Site:** An employer can report a smaller number of workers or misrepresent those workers' job duties or job location to conceal the actual risk that any given employee takes on, thereby lowering the cost of insurance.
- **Manipulation of Experience Modifier:** Businesses create "ghost companies" to manipulate the experience modifier. In other words, a company can pose as a new business by changing the name of the company and applying for insurance through a new carrier, thus giving the "new" company a clean slate.

# Common Employee Fraud Allegations:



- **Faked/Exaggerated Injury:** An employee fabricates an injury altogether, or exaggerates a legitimate injury, in order to continue to receive benefits or more time off work.
- **Multiple Claims/Identities:** An employee may make injury claims and receive payments from both their WC administrator or healthcare provider
- **Malingering:** The claimant suffers a legitimate injury, but continues to feign symptoms after he or she has already fully recovered in order to continue to receive benefits.
- **Working While Collecting:** An employee is collecting disability benefits from one employer while working another job in which they perform tasks outside the limitations set by their doctor.
- **Prior Injury/"Monday Morning" Injury:** This is an injury which occurred outside of work, often times over the weekend, but the employee avoids reporting it or seeking medical attention

# Common Service Provider Fraud Allegations



- **Attorney/Medical Provider Relationship:** Attorneys and medical clinics may refer clients or patients to one another for financial „kickbacks“. They may also employ the work of „chasers and cappers“ who will solicit injured parties and refer them to these service providers.
- **Billing for Services Not Rendered:** A medical provider will bill an insurance company for services which were never provided. This is most common with medical bills for X-Rays, MRIs, or other expensive diagnostic tests that were never actually performed.
- **Template (Boilerplate) Billing:** Medical clinics fabricate identical injuries and prescribe identical treatment for all patients. They then use duplicated or very similar paperwork to support the treatment.

# Health Insurance Fraud



- The U.S. spends more than \$2 TRILLION on healthcare annually. At least three percent of that spending or \$68 B is lost to patient fraud
- 19 percent of the \$600 billion to \$800 billion in waste in the U.S. healthcare system annually is suspected to be fraud
- ALL Healthcare Fraud amounts to between \$125 billion and \$175 billion annually from bogus Medicare claims to kickbacks for worthless treatments
- More than \$2.4 billion in recoveries for fraud, waste and abuse in federal healthcare programs were achieved in just 6 months of 2009
- Some 1,415 individuals and organizations also were excluded from federal programs for fraud abuse; 293 criminal & 243 civil actions were brought ('09)
- 40 percent of Americans currently do not understand their medical bills or EOB statements enabling the growing problem of fraudulent billing

# Medicaid Fraud

- The 50 state Medicaid fraud control units obtained a collective 1,205 convictions, and claimed total recoveries of more than \$1.1 billion in court-ordered restitution, fines, civil settlements, and penalties in 2007
- 3,308 persons and entities were excluded from participation in Medicare, Medicaid and other federal health care programs in FY 2007
- The number of successful civil actions totaled 607 in 2007
- More than 61 percent of medical providers (4,319 total) banned from state Medicaid programs didn't show up in the federal database of state-banned providers
  - This makes it easier for banned providers to set up shop in other states and continue doing business with federal health-insurance programs

# Five Warning Signs of WC Fraud



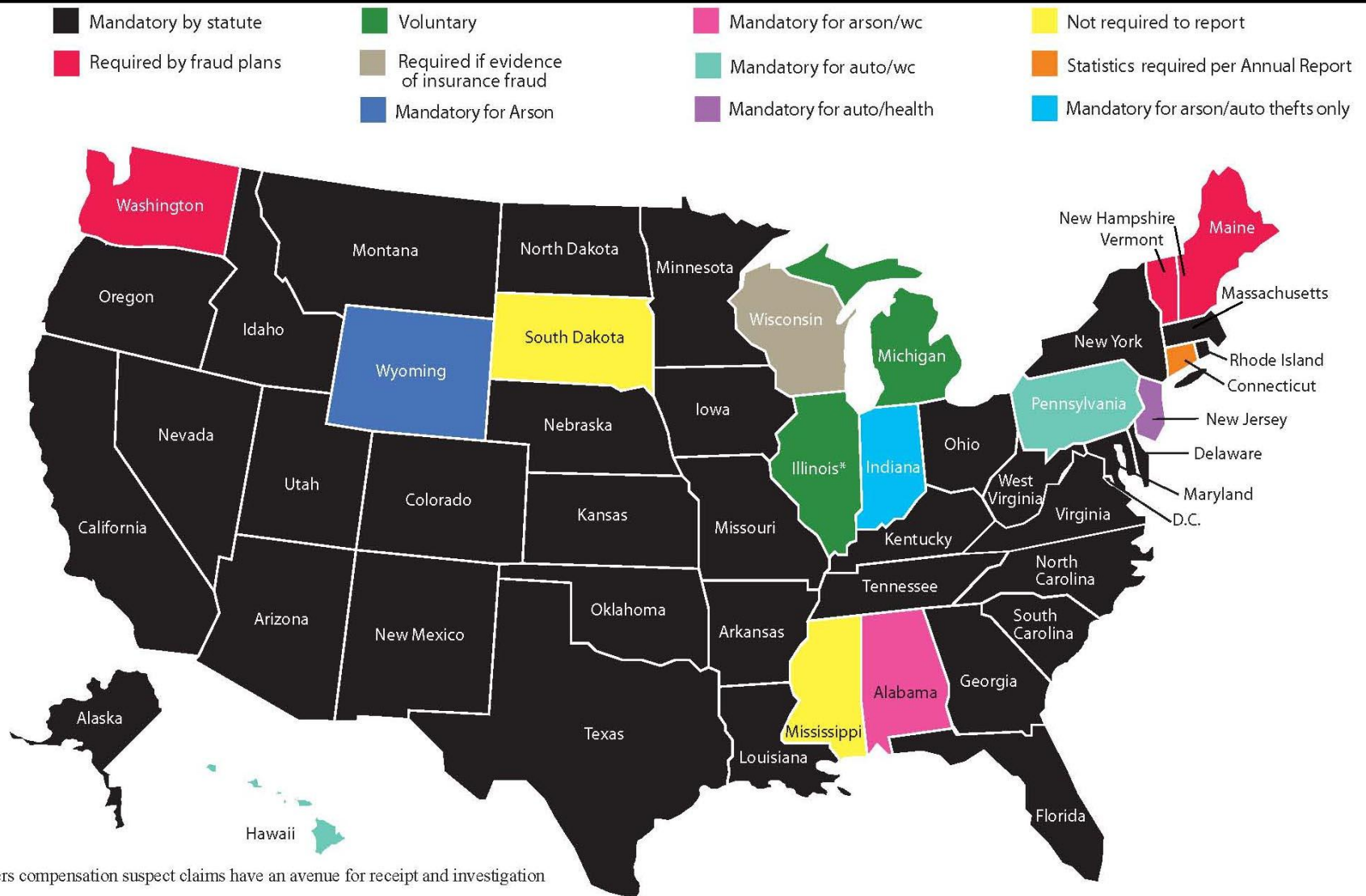
- **Lack of witnesses** — While unobserved accidents are certainly possible, an employee who commits WC fraud often chooses a moment when nobody else is around as the time of “injury.” If the worker is rarely alone on the job, this can be a red flag.
- **Time of injury** — If a suspect injury happens on a Monday, the alleged “workplace” accident actually could have occurred over the weekend. It’s especially important for employers to obtain witnesses’ accounts of how the employee was acting immediately prior to the accident.
- **Motive** — Is there a motive for the employee to falsely claim an injury? This is one of the most important questions for employers to consider. If an employee is dissatisfied or foresees an imminent dismissal, either could provide a reason to fake an injury.
- **Repeat claims** — Some 37 percent of workers who file a workers’ comp claim file a subsequent claim. Working conditions should be examined to ensure fit to the job and enable a better defense of suspected fraud.
- **Body language and inconsistency** — When someone is being dishonest, there are various telltale body language indicators to watch for, such as shifty eyes and long pauses before answering questions.

# Other Warnings Signs of WC Fraud



- Claimant is reluctant/ refuses to accept treatment
- Diagnosis would seem to warrant closer scrutiny
- Accident is not witnessed
- Accident is not promptly reported.
- An injured worker who is seasonal
- Claim occurs just before a layoff, strike or termination
- Claimant is observed in confrontation with coworkers
- Claimant has a history of short-term employment
- Claimant complains of non-work-related health problems
- Tip from a credible source
- New or disgruntled worker
- No witness to alleged injury
- Inconsistent or illogical description of incident
- Claimant difficult to contact
- Claimant acts upset when contacted

## STATES WC FRAUD REPORTING REQUIREMENTS



\* Only workers compensation suspect claims have an avenue for receipt and investigation.

# Workers Comp Fraud Prevention Tactics

- Insist on experienced, fraud knowledgeable adjusters who know what questions to ask
- Know the law firms that frequent your cases
- Develop case game plans that are agreed on by all parties
- Get involved early and be more proactive in fighting fraud
- Require employees to be engaged in their claim and recovery
- Over communicate



# General Fraud Prevention Tactics

- Institute a fraud line
- Publicize zero tolerance for fraud
- Make sure employees know that ALL claims will be investigated
- Initiate an investigation within the first 24 hours.
- Document jobs with comprehensive job descriptions including photos and videos where relevant
- Have a rapid response for spotting fraudulent claims.
- Train employees to understand fraud “policy”
  - Communicate, communicate, communicate

# What Do SIUs Provide?

- **Field Investigations**
  - Accident Scene
  - Alive and Well Checks
  - Clinic Inspections/Verifications
  - Employee Integrity Checks
  - Photo/Video Evidence Development
  - Field Interviews
  - FMLA Investigations
  - Surveillance
  - Witness procurement
  - Scene reconstruction
- **Consulting/Training/Reporting**
  - Cases specific consultations
  - Periodic results reporting
  - Fraud awareness programs
  - Fraud filings
  - State reporting
  - Training
  - ROI and leakage assessments

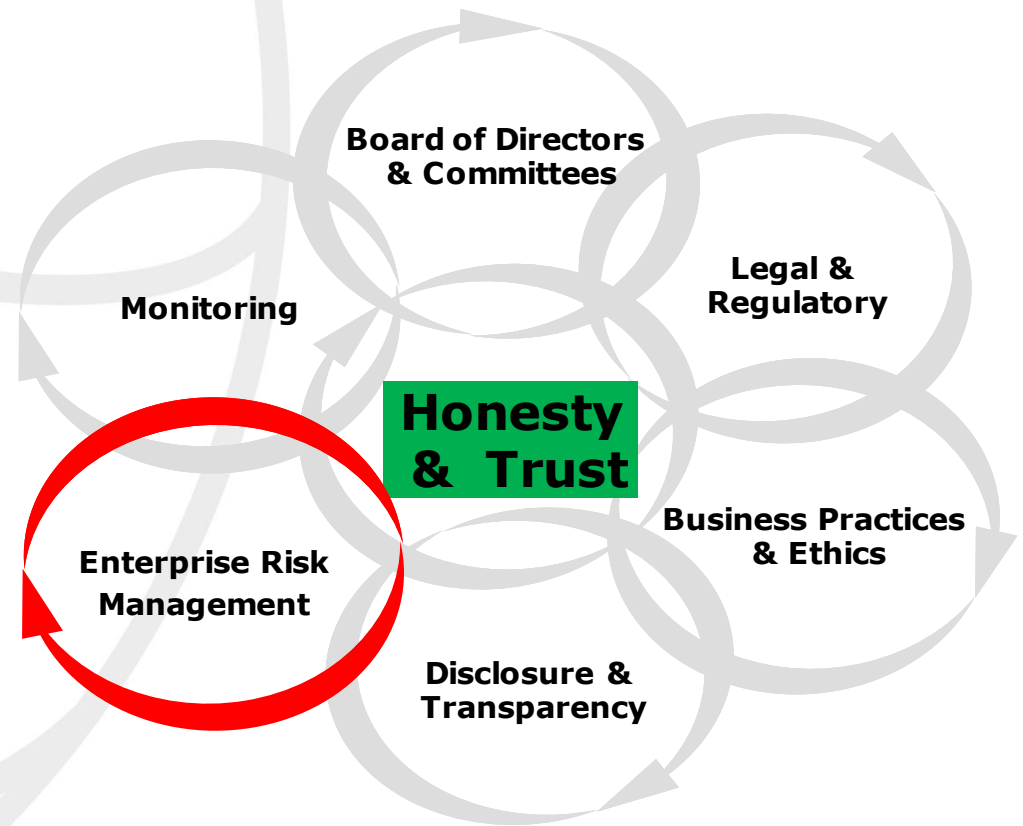
## SIU Services (cont'd)

### Desk Investigations

- **Asset searches**
- **Bankruptcy, liens and asset checks**
- **Background checks**
  - Civil
  - Criminal
- **Employment Investigations**
- **Medical investigations**
- **License investigations**
- **Social network investigations**
  - Internet profiles
- **Vehicle registration searches**
- **General public records searches**

# TRUST & HONESTY: At the Heart of Corporate Culture and Governance

Ethical behaviors are typically a part of the expected/desired corporate culture most companies aspire to or expect. Without it, it is unreasonable to expect the successful accomplishment of mission



## A Corporate Governance Framework

# What is Risk Culture ?

“When we speak of culture, we are assessing the stature of the risk function within the organization and its role and relationship with the business units.” (source: S&P)

## Risk culture:

- Is a subset of organizational culture
- **Embodies an interactive system of values and normative behaviors**
- **Is shaped by Leadership to influence desired behaviors**
- Helps the organization:
  - achieve its goals
  - **embed its values**
- **Influences risk taking behaviors** by reflecting the preferences of management and governance

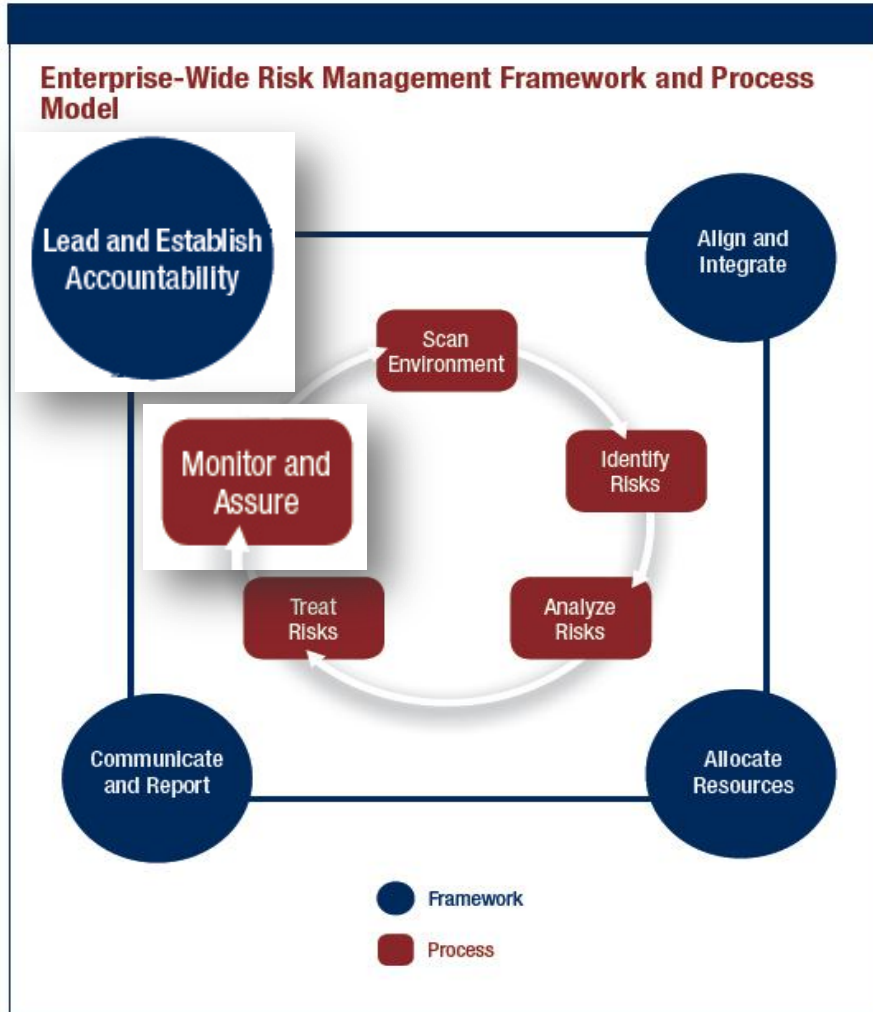
***A Well Defined & Understood Risk Culture  
is an Important Aspect of Effective FRAUD Risk Management***

# Risk Philosophy: A Sample Statement

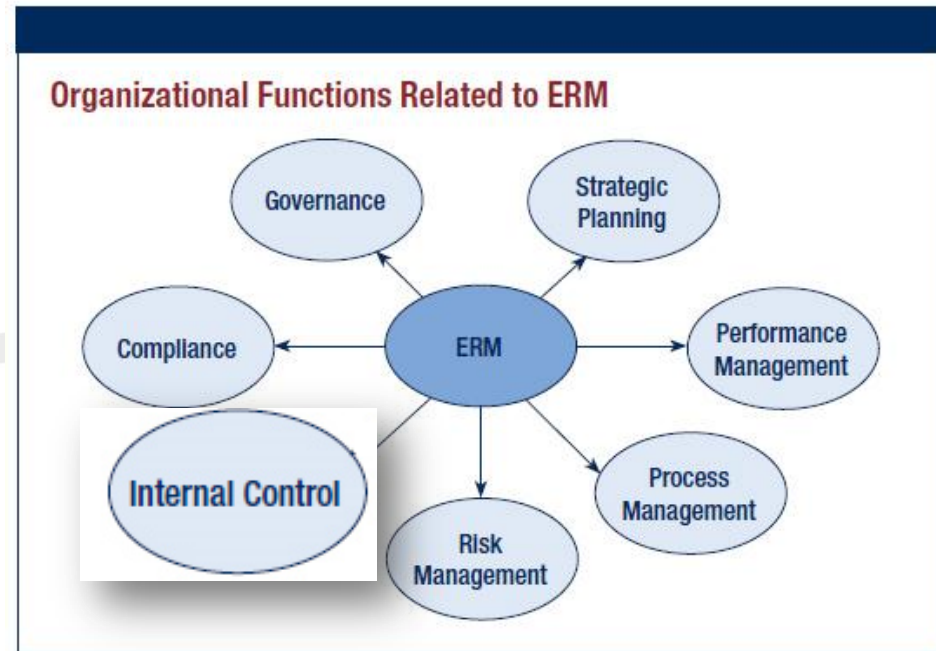
“It is Our Organization’s philosophy to align its risk management practices with our overall corporate vision, mission and strategy, and embed ethical, balanced risk taking into the business management practices of every business group leader in order to drive a culture of ethics, integrity and ultimately performance”



# Internal Control and Audit



[DA08717\_1]



[DA10216]

*Enterprise Risk Management*. Ed. Michael W. Elliott. Malvern, PA: The Institutes, 1<sup>st</sup> Edition, pp. 2.10 , 3.5

# Relationship between Internal Control and Risk Management

## Applying the Three Lines of Defense Model to Internal Control Systems



The Federation of European Risk Management Associations (FERMA) and the European Commission of Institutes of Internal Auditing (ECIIA) have established the Three Lines of Defense Model to help clarify roles in an internal control system.

### First Line of Defense

Operational management is responsible for assessing, controlling, and mitigating risks and for maintaining effective internal controls.

### Second Line of Defense

The risk management function supports and monitors operational management's implementation of risk management practices. The compliance function monitors compliance risk such as nonconformity with laws and regulations. Other second-line defense functions might include health and safety, supply chain, and quality.

### Third Line of Defense

Internal audit provides assurance to the board and senior management on organizational effectiveness of risk management and assessment efforts.

External auditors may be considered a fourth line of defense as they provide independent assurances to various stakeholders by opining on financial statements.

FERMA/ECIIA, "Monitoring the Effectiveness of Internal Control, Internal Audit and Risk Management Systems: Guidance for Boards and Audit Committees," Guidance on the 8th European Company Law Directive on Statutory Audit, September 21, 2010, pp. 9-10. [DA10330]

*Enterprise Risk Management*. Ed. Michael W. Elliott. Malvern, PA: The Institutes, 1<sup>st</sup> Edition, p. 7.8

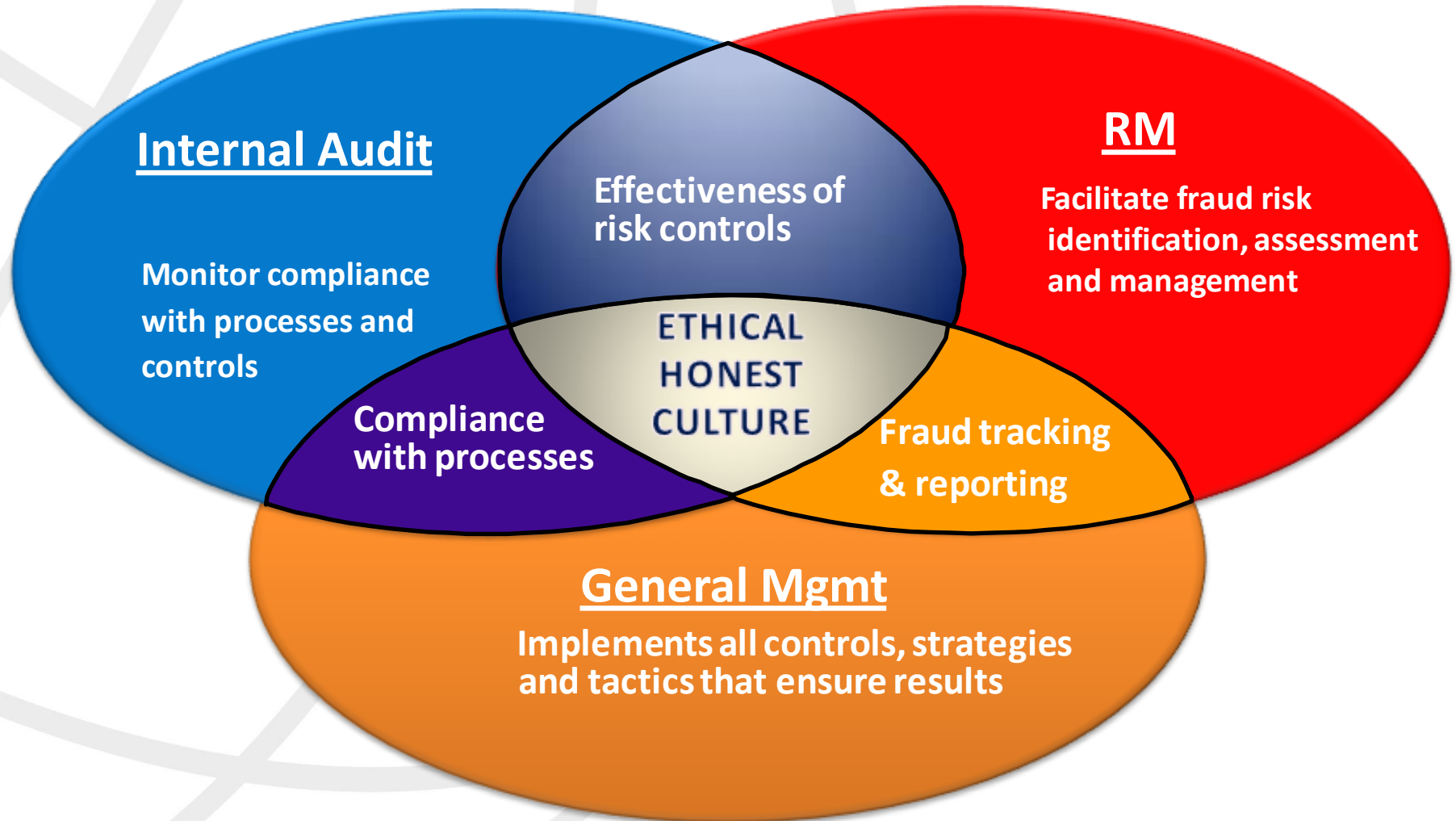
# Aligning Stakeholders

## Core Values

- What we stand for
- Define behaviors our customers, employees and other stakeholders should expect from us

- **Leadership**
- **Innovation**
- **Integrity**
- **Customer Satisfaction**
- **Zeal**
- **Diversity**
- **Social Responsibility**

# Key Stakeholder Alignment



**Audit, Risk and General Mgmt Must Partner to Control Fraud**

# Components of Strategy Alignment



# REPORT TO THE NATIONS

ON OCCUPATIONAL FRAUD AND ABUSE

— 2012 GLOBAL FRAUD STUDY —



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# Methodology



**The data in this study is based on 1,388 cases of occupational fraud that were reported by CFEs.**

# Executive Summary



**More than one-fifth of frauds in our study caused at least \$1 million in losses.**

# The Cost of Occupational Fraud



**The typical organization loses an estimated 5% of its annual revenues to occupational fraud.**

# How Occupational Fraud is Committed



**Financial statement fraud is the most costly form of occupational fraud, causing a median loss of \$1 million.**

# Detection of Fraud Schemes



**Frauds are much more likely to be detected by tips than by any other method.**

# Perpetrators



**More than three-quarters of the frauds in our study were committed by individuals in six departments: accounting, operations, sales, executive/upper management, customer service and purchasing.**

# Case Results



**Our research indicates that 40–50% of victim organizations do not recover any of their fraud losses.**

# Fraud Prevention Checklist

- 1. Is ongoing anti-fraud training provided to all employees of the organization?**
- 2. Is an effective fraud reporting mechanism in place?**
- 3. Is the management climate/tone at the top one of honesty and integrity?**
- 4. Are fraud risk assessments performed to proactively identify and mitigate the company's vulnerabilities to internal and external fraud?**
- 5. Are strong anti-fraud controls in place and operating effectively, including the following?**
- 6. Does the internal audit department, if one exists, have adequate resources and authority to operate effectively and without undue influence from senior management?**

# Key Take-a-ways

- While total frequency of WC is decreasing, the proportion of suspected fraud is rising (2013) -
- Fraud is not just about what employees do; it's about all players in the system, in and out of the company
- The “red flags” for fraud haven't changed much but fraudsters are getting more creative – new types of fraud are regularly arising (e.g. cyber)
- Partnering with the right stakeholders is key to addressing fraud in the broader context of the wide variety of fraud sources facing today's businesses
- While fraud may have hurdles to getting appropriate management attention, there are ways to better tell the story and make the case for more mitigation resources.
- Measuring and communicating fraud has grown in sophistication with more tools, better measures and a growing source of third party expertise to address the problem.
- All types of material fraud should be part of a comprehensive view into risk exposures which define the risk profile of every firm, for some firms more significantly than others



# **ADDITIONAL QUESTIONS AND DISCUSSION**



# Christopher E. Mandel, CPCU, ARM SVP, Strategic Solutions, Sedgwick, Inc.



Christopher E. Mandel is the SVP for Strategic Solutions at Sedgwick, Inc. He is engaged in helping Sedgwick chart its future through the long term planning for products, services and strategic solutions for this claims and productivity management firm. He is also co-founder and EVP, Professional Services for rPM3 Solutions, LLC as well as founder and president of Excellence in Risk Management, LLC. both independent consulting firms specializing in governance, risk and compliance, with a special emphasis on enterprise risk management. rPM3 Solutions holds a patent for a unique risk measurement process known as ARQ™. Prior to electing early retirement and for ten years from 2001-2010, Mr. Mandel was head of enterprise risk management for USAA Group, a \$165 billion diversified financial services organization. At USAA, he designed, developed and led the enterprise-wide risk management and corporate insurance centers of excellence. He also served as President and Vice Chairman, Enterprise Indemnity CIC, Inc., an Arizona based alternative risk financing facility.

Mr. Mandel has more than 25 years of experience in risk management and insurance in large, global corporates. He has pioneered the development of cross-enterprise risk management capabilities resulting in S&P rating USAA as "excellent and a leader in ERM" from 2006 through 2010. In 2007, Treasury and Risk Magazine bestowed the Alexander Hamilton Award for "Excellence in ERM" on USAA. Mr. Mandel has been a long term senior leader in the Risk and Insurance Management Society including being elected President and Chief Risk Officer and was named Risk Manager of the Year in 2004.

Mr. Mandel's deep, wide and diverse experience in all facets of risk management and insurance allows him to offer those interested in managing risk with excellence to engage him to provide everything from a comprehensive strategy and complete ERM framework to targeted guidance, tools, techniques and/or training. Mr. Mandel's innovative approach to making risk a key strategically placed and results oriented function results from solidly connecting risk management outputs to a company's key performance metrics and ultimately, mission accomplishment.

Mr. Mandel received his B.S. in Business Management from Virginia Polytechnic Institute and State University and an MBA in finance from George Mason University. He holds the RIMS Fellow (RF), CCSA, CPCU, ARM and AIC designations and is a frequent industry speaker, teacher and writer. He writes the "Risk Innovation" column for Risk and Insurance magazine and *in 2008 was elected a member of Risk Who's Who (RWW). He also wrote the Ask a Risk Manager column for Business Insurance from 1996 through 2008.*

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# References for Further Detail

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# Key Recommendations

- Providing individuals a means to report suspicious activity is a critical part of an anti-fraud program.
- Fraud reporting mechanisms, such as hotlines, should be set up to receive tips from both internal and external sources and should allow anonymity and confidentiality.
- Management should actively encourage employees to report suspicious activity, as well as enact and emphasize an anti-retaliation policy.

# Executive Summary

## Summary of Findings

- **Survey participants estimated that the typical organization loses 5% of its revenues to fraud each year.** Applied to the 2011 Gross World Product, this figure translates to a potential projected annual fraud loss of more than \$3.5 trillion.
- **The median loss caused by the occupational fraud cases in our study was \$140,000.** More than one-fifth of these cases caused losses of at least \$1 million.

# Executive Summary

- **The frauds reported to us lasted a median of 18 months before being detected.**
- **As in our previous studies, asset misappropriation schemes were by far the most common type of occupational fraud, comprising 87% of the cases reported to us;** they were also the least costly form of fraud, with a median loss of \$120,000.
- **Financial statement fraud schemes made up just 8% of the cases in our study, but caused the greatest median loss at \$1 million.** Corruption schemes fell in the middle, occurring in just over one-third of reported cases and causing a median loss of \$250,000.

# Executive Summary

- **Occupational fraud is more likely to be detected by a tip than by any other method.** The majority of tips reporting fraud come from employees of the victim organization.
- **Corruption and billing schemes pose the greatest risks to organizations throughout the world.** For all geographic regions, these two scheme types comprised more than 50% of the frauds reported to us.

# Executive Summary

- **Occupational fraud is a significant threat to small businesses.** The smallest organizations in our study suffered the largest median losses. These organizations typically employ fewer anti-fraud controls than their larger counterparts, which increases their vulnerability to fraud.
- As in our prior research, **the industries most commonly victimized in our current study were the banking and financial services, government and public administration, and manufacturing sectors.**

# Executive Summary

- **The presence of anti-fraud controls is notably correlated with significant decreases in the cost and duration of occupational fraud schemes.** Victim organizations that had implemented any of 16 common anti-fraud controls experienced considerably lower losses and time-to-detection than organizations lacking these controls.
- **Perpetrators with higher levels of authority tend to cause much larger losses.** The median loss among frauds committed by owner/executives was \$573,000, the median loss caused by managers was \$180,000 and the median loss caused by employees was \$60,000.

# Executive Summary

- **The longer a perpetrator has worked for an organization, the higher fraud losses tend to be.** Perpetrators with more than ten years of experience at the victim organization caused a median loss of \$229,000. By comparison, the median loss caused by perpetrators who committed fraud in their first year on the job was only \$25,000.
- **The vast majority (77%) of all frauds in our study were committed by individuals working in one of six departments: accounting, operations, sales, executive/upper management, customer service and purchasing.** This distribution was very similar to what we found in our 2010 study.

# Executive Summary

- **Most occupational fraudsters are first-time offenders with clean employment histories.** Approximately 87% of occupational fraudsters had never been charged or convicted of a fraud-related offense, and 84% had never been punished or terminated by an employer for fraud-related conduct.
- **In 81% of cases, the fraudster displayed one or more behavioral red flags that are often associated with fraudulent conduct.** Living beyond means (36% of cases), financial difficulties (27%), unusually close association with vendors or customers (19%) and excessive control issues (18%) were the most commonly observed behavioral warning signs.

# Executive Summary

- Most fraudsters exhibit behavioral traits that can serve as warning signs of their actions. These red flags — such as living beyond one's means or exhibiting excessive control issues — generally will not be identified by traditional internal controls.
- Managers, employees and auditors should be educated on these common behavioral patterns and encouraged to consider them — particularly when noted in tandem with other anomalies — to help identify patterns that might indicate fraudulent activity.

# Executive Summary

- Nearly half of victim organizations were unable to recover their losses due to a lack of proactive measures to prevent fraud are critical.
- Management should continually assess the organization's specific fraud risks and evaluate its fraud prevention programs in light of those risks.

# The Cost of Occupational Fraud

## **Distribution of Losses**

- Of the 1,388 individual fraud cases reported to us, 1,379 included information about the total dollar amount lost to the fraud.<sup>2</sup>
- The median loss for all of these cases was \$140,000, and more than one-fifth of the cases involved losses of at least \$1 million. The overall distribution of losses was notably similar to those observed in our 2010 and 2008 studies.