



Fraud: A Problem Troubling Insurance Industry

KEYWORDS

Health Insurance, Fraud, Abuse, Types of Insurance Frauds, Causes, Reasons, Triggers, Managing Frauds.

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ABSTRACT Health insurance industry is growing and being chanted about like the new mantra, but, still India is facing a huge loss in this sector because of the everyday increasing fraud claims. There is a growing concern among the industry about the increasing incidences of abuse and frauds because they continue to be a major issue for insurers, insurance consumers and regulators. Existence of fraudulent claims, drive up the cost of insurers and inflate premium rates for policyholders due to wide range of illegal practices and acts. There has been a noticeable increase in the number of fraud cases since couple of years which stresses the need of comprehensive risk management strategies that involve fraud risk assessment and fraud prevention. The purpose of this study is to understand and analyze various types of insurance frauds, reasons behind them, triggers to identify them. The paper begins with definition of fraud and abuse, different parties involved in various types of health insurance fraud, triggers that represent possible presence and the actions that could be considered at various levels. Paper also focuses on the possible do's and don'ts for the insured and the insurers.

Introduction:

Insurance fraud is a purposeful dishonesty committed or carried out against or by an insurance company or agent for the purpose of financial gain. Frauds in insurance are becoming a major issue which impacts every insurance company and virtually every customer; as insurers increase premiums to offset fraud losses. The general consensus is that suspicious activity is increasing and the tactics used by fraudsters are becoming more and more sophisticated.

In the emerging insurance scenario in India, price of the policy and after claims service decides where an insurance company stands in the market. Leverages and frauds in the underwriting and claim settlement process have an adverse effect on the claim experience, which further affects the pricing of the policy. Because of the misdeeds of a few and lack of effective control of insurance companies, genuine customers have to pay a higher price for the products than is actually warranted; which will not only discourage new customers to come but also decline the number of existing client base in near future.

Fraud may be committed at different points or by different parties involved in the insurance transaction viz. applicants for insurance, policyholders, third-party claimants, professionals who provide services to claimants, insurance agents, company employees, etc. Common frauds include misrepresenting facts on an insurance application, inflating actual claims, submitting claims for injuries or damage that never occurred, and "staging" (performing) accidents. People who commit insurance fraud range from organized criminals, who steal large sums through fraudulent business activities and insurance claims, to professionals and technicians who inflate the cost of services or charge for services not rendered, to ordinary people who want to cover their deductible or view filing a claim as an opportunity to make a little money.

Insurance crimes also range in severity, from slightly exaggerating claims to deliberately causing accidents or dam-

age. Fraudulent activities affect the lives of innocent people, both directly through accidental or intentional injury or damage, and indirectly as these crimes cause insurance premiums to be higher. Insurance fraud poses a significant problem, and governments and other organizations make efforts to deter such activities. Among all claims received by insurers in a year, fraudulent claims account for a significant portion and cost billions of dollars annually.

Defining Fraud & Abuse:

'Insurance fraud' is not defined under the Indian Insurance Act. IRDA recently quoted the definition provided by the International Association of Insurance Supervisors (IAIS) which defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties." The Indian Penal Code (IPC) or Indian Contract Act, also do not offer specific laws regarding insurance fraud. Sections of the IPC which deal with issues of fraudulent act, forgery, cheating etc. are sometimes applied but none of them are specifically targeted at insurance fraud and are inadequate for purpose of acting as an effective restriction.

In simple parlance, insurance fraud can be defined as:

The act of making a statement known to be false and used to induce another party to issue a contract or pay a claim. This act must be wilful and deliberate, involve financial gain, done under false pretences and is illegal. Abuse can be defined as practices that are inconsistent with business ethics or medical practices and result in an unnecessary cost to claims.

A Report by India Forensic:

An exclusive research was conducted by India Forensic focusing the Insurance Sector in India. Some shocking facts were disclosed in its report which was mentored by Mayur Joshi – an Anti-Fraud Professional. According to this India forensic Research, every insurance company loses 8.5% of its revenues to the frauds, where Life insurance sector contributes more than General Insurance. 70% of the to-

tal frauds committed in the general insurance sector are of the nature of falsification of the documents like Medical Bills, Certificates, Driving License, FIR, etc. Motor Insurance is the biggest and most lucrative sector in General Insurance business followed by Health Insurance sector.

Public Alerts by IRDA of India:

The IRDA has come across certain instances of fraudulent activities and has issued alerts to the public about them.

Public Notice -1: In a public notice issued on 8th Jan 2008, by the orders of Chairman of IRDA, it states that, it has come to the notice of the Authority that, companies by the names and style M/s. Lifeline Global Limited / Lifeline EMS India Ltd. are doing health insurance business and collecting money from the general public for issuance of health insurance policies from the following addresses: 3, Coral Crest, Ground Floor, Sector 23, Nerul, Navi Mumbai & Agnelo House, S.V. Road, Khar (W), Mumbai – 400 052

This is to inform that the above companies are not holding any licenses whatsoever under Section 2C (1) and 3 (1) of the Insurance Act, 1938 from the Authority for carrying on business of insurance, which is a condition precedent under the provisions of the Act and the company's operations are in violation of the provisions of the Insurance Act, 1938 and IRDA Act, 1999. IRDA has already initiated appropriate action in the matter.

The general public are hereby cautioned not to purchase insurance policies from the said companies or through any person claiming to be their Agents / Advisers or representatives.

Public Notice -2 IRDA/CAD/PNTC/MISC/ 72/04/2013

It has come to the notice of the IRDA that a few entities under the banner of Cargo Carriers, Couriers/Logistic Providers/Freight Forwarders/Transporters or involved in similar trade are charging consideration from their clientele towards their contractual liabilities, using the terminology 'insurance', thus creating an impression that they are either insurance entities or arranging insurance on behalf of their clientele.

An entity can function as an insurer or an insurance intermediary only after obtaining a license/certificate of registration from the IRDA under the relevant provisions of the insurance Act, 1938 and the IRDA act, 1999 for carrying on such business. Only Licensed Entity/ies (by IRDA) can offer an insurance product and collect/charge insurance premium towards consideration.

The general public is also advised to check the veracity of the entity as well as the insurance arrangement promised, before making any payment towards insurance premium/consideration.

Causes:

Financial Profit: Though the causes may vary, the chief motive in most insurance crimes is financial profit which is usually centred greed and on holes in the protections against fraud.

Over Insurance: Another reason for fraud is over insurance, when the amount insured is greater than the actual value of the property insured. This allows fraudsters to make profits by destroying their property because the payment they receive from their insurers is of greater value

than the property they destroy.

Reasons behind Fraud:

- 1. Public attitude:** Socially there is no stigma (shame) to stop committing insurance fraud. Some people justify fraud because they feel the insurance premiums they pay are unjust or it is rightful to expect return on the same.
- 2. Insurer claims practices:** Insurers are reluctant to fight lengthy lawsuits and avoid efforts involved to collect sufficient evidence.
- 3. Insufficient penalties:** There is very less opposition from professional societies regulating healthcare as their disciplinary systems are not designed to penalize such fraudulent members.

Types of Health Insurance Frauds:

Deliberate and Opportunity Fraud: Deliberate fraud is purposeful act of presenting accident or loss which is covered under the policy. Whereas, opportunity fraud is created by a policyholders by over stressing a genuine claim or providing wrong information related to the pre-existing diseases etc. to get the underwriting done in their favour.

External and Internal Fraud: External fraud is claimed by either an individual or entities like policyholder, beneficiaries, medical service providers or vendors against a company. Internal fraud on the other hand is carried out against a policyholder or its company by other employees like manager, executive or agents.

Policyholder's Fraud: Nowadays, consumers have become aware of the norms, features and rules of the insurance and have started getting benefited by being involved in frauds. Policyholder frauds are divided into 3 categories, viz, eligibility fraud, application fraud and claim fraud.

Eligibility Fraud: False information is provided about the insured's employment status, pre-existing diseases or information concerning the dependent persons. Here, the beneficiary is paid benefits illegally; e.g. insured submits claim for the dependent or relative who is not covered under the policy. Another case is when a part time employee is not covered under some health plan provided by the company for fulltime employees but, by generating false records with any HR employee he is successful in receiving the benefits.

Application Fraud: The consumer knowingly enters forged information related to the pre-existing diseases, claim or important dates in its application form. For instance, a policyholder might not enter the details related to his pre-existing diseases or serious medical conditions in order to get an extensive cover and have problem free claim filing.

Claim Fraud: When a consumer enters an illegal claim for whose benefit he is not entitled for, the fraud is called claim fraud. In such intentional cases, the provider and member are seen to go for collusion and thus, benefiting the physician. These kinds of groups are also known as fraud rings. Another case, purchases several health insurance policies without letting the insurance companies know this fact and enjoy claim settlement from all. Moreover, the agents or hospitals generate higher medical bills related to hospitalization, treatment etc. to cheer their pockets.

How various parties involve in fraud:

- Concealing (hiding or covering up) Pre-Existing Disease (PED)/Chronic Ailment, manipulating pre-policy health check-up findings, fake / fabricated documents to meet policy terms conditions, duplicate and inflated bills, participating in fraud rings, purchasing multiple policies, staged accidents and fake disability claims.

- **Agents and brokers:** Providing fake policy to customer and siphoning off (draining off) premium, manipulating pre-policy health check-up records, guiding customer to hide PED/material fact to obtain cover or to file claim, participating in fraud rings and facilitating policies in fictitious names, fudging (avoiding) data in group health covers.
- **Treating doctor or hospital:** Overcharging, inflated billing, billing for services not provided, unwarranted procedures, excessive investigations, expensive medicines, over utilisation, extended length of stay, fudging records, patient history.

Trend in Health Insurance Premium:

During 2014-15, the gross health insurance premium collected by non-life insurance companies was ₹20,096 crore which registered 14.87 % growth as compared to previous year's gross health insurance premium of ₹17,495 crore. While there is a marginal increase in the share of Public Sector and Stand-alone health insurers, there is a drop in the share of Private non-life insurers from 26% in 2013-14 to 22% in 2014-15.

Classification of Health Insurance Business:

Health insurance business is classified into Group health insurance (Other than Government Sponsored), Government Sponsored health insurance and Individual health insurance. Over past five years, there is a marked increase in the share of individual health insurance premium from 35% in 2010-11 to 44% in 2014-15; whereas, the share of Government sponsored health insurance business has come down from 20% in 2010-11 to 12% in 2014-15; and of group health insurance business (other than Government business) remains static around 45% for past 5 yrs.

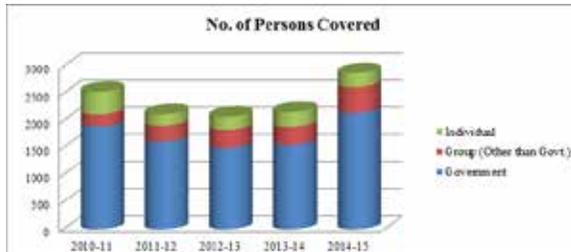
Number of policies issued & no. of persons covered under Health insurance:

During 2014-15, the non-life insurance industry has issued around 1.09 crore health insurance policies covering 28.80 crore persons; while Government Sponsored health insurance schemes covered a total population of 21.43 crore (74% of total persons covered), health insurance policies underwritten by non-life / standalone health insurers covered a total of 7.37 crore persons (26% of all persons covered). A significant increase can be seen in the number of persons covered through both Government Schemes and Group Insurance business, while the number of persons covered through individual insurance business registered a marginal decline.

Table-I Number of Persons Covered Under Health Insurance (In lakh)

Class of Business	2010-11	2011-12	2012-13	2013-14	2014-15
Government	1891	1612	1494	1553	2143
Group (Other than Govt.)	226	300	343	337	483
Individual	418	206	236	272	254
Total	2535	2118	2073	2162	2880

Source: IRDA Annual report 2014-15, pg no. 48



Trend in Incurred Claims Ratio:

One of the concerns of health insurance segment has been the persistence of high Incurred Claims Ratio (ICR), which is witnessing increasing trend over the years. While the net ICR was 94% for 11-12 and 12-13, it went up to 97% in 13-14 and it was 101% for the year 14-15. Among the various class of health insurance business, the net ICR is high particularly for Group (Other than Government) business which was more than 100% for each of the preceding four years and it is also consistently increasing over the years. During 2014-15, the net ICR of Government sponsored health insurance business has witnessed a significant rise to 108% breaching its average level of 90% witnessed during the preceding three years.

Table IV: Net Incurred Claims Ratio of Health Insurers (In Percent)

Class of Business	2011-12	2012-13	2013-14	2014-15
Government	90%	87%	93%	108%
Group (Other than Govt.)	100%	104%	110%	116%
Individual	85%	83%	83%	81%
Total	94%	94%	97%	101%

Source: IRDA Annual report 2014-15, pg no. 48

Triggers / Red Alerts:

One of the ways to control fraud is to establish triggers / red alerts through systems capabilities or manual inspection of a physical file for early detection and corresponding action. The presence or exercising a trigger is not proof of fraudulent claim; it is only an indication of possible fraud or only warrants special attention and further investigation of the claim.

Policy and claim history triggers

1. Multiple claims with repeated hospitalisation, multiple claims towards the end of policy period, close proximity of claims.
2. Claims made immediately after a policy sum insured enhancement.
3. Claims from a member with history of frequent change of insurer.
4. Claims for policy with evidence of significant over/under insurance as compared to insured's income/life style.
5. Claims from a non-traceable person or where courier/cheque have been returned from insured's documented address.
6. Second claim in the same year for an acute medical illness/surgical minor illness/ orthopaedic minor illness in the same policy period. Claims from members with regular claim history.

Hospital location or profile triggers

1. Claim or pharmacy bill from a hospital located far away from insured's residence.
2. Claims for hospitalisation at a hospital already identified on a "watch" list or black list.
3. Claims on hospital stationery which does not have landline phone number, registration number, area pin code or doctor's qualification stated on it.
4. Claims submitted that look "too perfect" in order, pharmacy bills in chronological serial number, claim documents with colour photocopies, perfect claim file with all criteria fulfilled with no deficiencies.
5. Claims with visible tempering of documents, overwriting in diagnosis / treatment papers, discharge summary bills, same handwriting and flow in all documents, X-ray plates without date, bills generated on a "word" document, etc.
6. Claims with noticeable difference in diagnosis and line of treatment. Inconsistency between specialisation of treating doctor and illness.
7. Claims with incomplete / poor medical history – complaints / presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
8. Reimbursement claim from a network hospital.
9. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.

Diagnosis or surgery-specific triggers:

1. Claims for hospitalisation due to chronic/life style diseases management.
2. Claims for medical management admission for exactly 24 hours to cover OP treatment.
3. Claims where the clinical findings do not correlate with chief complaints or diagnosis or line of treatment; exaggeration of classical clinical findings to portray severity in acute medical illness/minor surgical conditions.
4. Claims with unjustified admission in ICU, use of general anaesthesia or assistant surgeon in a minor complexity or illness.
5. Claims with surgical treatment for face, nose, ear or other exposed body parts - indication of cosmetic surgery.

Managing Frauds:

1. **Proposal verification call:** A proposal verification call made before issuance of policy will help to minimise agent-led fraud and the use of recorded calls may help substantiate evidence of fraud at claims stage.
2. **Explanation of benefits:** A detailed breakdown of what benefits are paid by the insured in claim payment can be very effective way to check if any impersonation or billing for services not provided had occurred.
3. **Whistleblower policy:** A reporting and rewards system will motivate individuals to alert an insurer about individual cases of fraud or systematic fraud. This can be a very attractive mechanism through which the general population can be engaged in the fight against fraud.
4. **"Name & shame" guidelines:** Publicly disclosing names of individuals and / or institutions involved in insurance fraud when a criminal or civil case has been filed is an effective way of raising community awareness that insurance fraud will not be tolerated.
5. **Education:** Fraud can happen accidentally, by mistake

or due to ignorance. It is in the industry's interest to educate and creates awareness about the impact of insurance fraud and its implications.

6. **Contracting:** There is no appropriate law for insurance fraud. The industry should develop model clauses for incorporation into policy contract, as of what constitutes fraud, what penalties and punitive actions would follow upon confirmation of fraud, claw back provisions for recovery of money, etc.
7. **Benchmarks:** Collaboration with IIB to aggregate and organise all industry data under one roof, in a single data warehouse can help in developing various benchmarks, on a like-for-like basis, which an insurer can compare itself with.
8. **Provider billing ID and registration portal:** The General Insurance Council or Health Forum should build a provider registration portal which will be used by providers to enter their details. After verification of the details entered by the providers by any one TPA, their details will be added to the common database and a unique provider ID will be issued to the provider. This unique ID would also act as a billing ID and would be mandatory on all claim forms. In cases of fraud, a provider will risk losing its billing ID thus incapacitating it from lodging any claims. Naturally, the industry would need to maintain a common and accessible database which can verify all billing IDs in real time.
9. **Watch list creation and maintenance:** Preparation of a list of blacklisted providers by insurers and TPAs would benefit the industry as a shared knowledge repository. Development of such repository would involve "onetime" effort of collecting existing blacklists, compiling them into user-friendly format and maintaining them as an "on-going" process. Such a watch list would resemble a website with a secure password restricted area which would contain indexed blacklists of individuals and corporate entities which have previously defrauded or abused the insurance system. This would be a centralised resource which insurers and TPA can assess and search and update.
10. **Fraud investigator training program:** Appointment of fraud investigators who meet a set minimum skill requirement would create a cadre of professional and skilled investigators. Structured training program along with mandatory examination, continuing education requirements will help in further developing and enhancing their skills. They can be issued license by the IRDA.

Potential Do's and Dont's for Consumer / Insured / Agents / Intermediaries**Do's:**

1. Always ensure that complete and accurate health history is declared on proposal form.
2. Any suggestion to alter history either by agent or customer / insured or any intermediary should be reported to the insurance company or centralised fraud hotline.
3. Any person offering to manage medical reports at pre-policy stage should be reported to the insurance company or centralised fraud hotline.
4. Any person guiding or asking you to forge or increase bills for genuine treatment should be reported to the insurance company or centralised fraud hotline.
5. Any suggestion to alter disease or dishonestly file claim of health / PTD (Permanent Total Disability) / Death / Convert OPD (Out Patient Department) treatment to IPD (In Patient Department) treatment by cus-

tomers / insured or agent or any other intermediary or service provider should be reported to the insurance company or centralised fraud hotline.

6. Always check your final bill when taking cashless treatment and sign it without fail.

Dont's:

1. Never hide or guide any insured to hide PEDs when completing proposal form.
2. Never provide false duplicate policy copy to insured.
3. Never facilitate any fraudulent claim.
4. Do not attempt to manage medical reports at pre-policy stage.
5. Never attempt to inflate bills for genuine treatment as it may lead to the entire claim being denied and result in criminal proceedings.
6. Avoid from manipulating disease/ illness in an effort to seek coverage not entitled to.
7. Never offer your insurance card to a non-beneficiary to claim treatment under your card.
8. Do not sign on blank documents, e.g. proposal form, cashless authorisation form or final bills.
9. Never accept any offer to fabricate or exaggerate claims however tempting it may be.

Conclusion:

No system can be foolproof, but a proactive and dynamic approach can make a company ready to counter fraudsters and gain an edge over its competitors. Building up a shared or centralized database of insurance industry, which shares all the information related to policyholders, their policies, claims history, premium payments frequency, etc., will help in analysing fraudulent policyholders and fraud claims and also in lowering the cost of genuine policyholders.

Continuous reassessing of processes, policies and internal checks on the employees misusing confidential information and colluding with fraudsters will help in minimizing frauds which range from a slight exaggeration to deliberately causing loss of insured assets. Fraud detection and management process and fraud investigation teams set up by the insurers should work in tandem with law enforcement agencies to weed out fraudulent claims. In spite of new regulations by government, centralized fraud bureaus, special investigative units established by insurers, computer-based tools to detect and prevent fraud the problem continues to grow, and in recent years, it has grown significantly. Lokhande M.A. (2006) Public sector has been playing a crucial role in all round development of Indian economy. In the changed business scenario, there is urgent need of restructuring public sector undertakings to make them competent and financially strong. Unviable, loss-making PSUs are burden on government exchequer and must be closed down immediately.

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