LIFE INSURANCE FRAUD – RISK MANAGEMENT AND FRAUD PREVENTION

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ABSTRACT
Insurance fraud is one of the most serious problems threatening viability of insurance companies. Insurance frauds are driving up the overall costs of insurers and premiums for policyholders. It encompasses a wide range of illicit practices and illegal acts involving intentional deception or misrepresentation. The industry has witnessed an increase in the number of fraud cases since couple of years. Risk Management has been acquiring monumental importance in insurance industry. Insurance business is of dynamic nature that puts an additional onus on risk management. So insurance companies need comprehensive risk management strategies that involve fraud risk assessment and fraud prevention. The purpose of this study is to analyze various types of life insurance frauds, assess the risks associated with these frauds and finally frame an ideal risk management strategy to curtail or minimize the frauds associated with life insurance. The existing literature on life insurance fraud is used to explore the fraud risk management and internal control system of various organizations.

KEYWORDS: Insurance Fraud, Fraud Risk Management, Fraud Prevention Mechanism

Introduction
Insurance fraud is one of the most serious problems facing insurers, insurance consumers and regulators. Its existence not only increases the cost of insurance, but also threatens the financial strength of insurers and negatively affects the availability of insurance. Insurance fraud encompasses a wide range of illicit practices and illegal acts involving intentional deception or misrepresentation. The industry has witnessed an increase in the number of fraud cases in the last couple of years. Organizations are realizing that frauds are driving up the overall costs of insurers and premiums for policyholders, which may threaten their viability and also have a bearing on their profitability. Hence, companies need a more vigorous fraud management framework. Larger insurers, which spend more on the investigation and settlement of claims and on medical exam and inspection fees, are better at detecting fraud.
Risk Management in Life Insurance

Risk Management has been acquiring monumental importance, especially over the last few years, globally. Apart from the conventional areas that one has in mind with regard to risk management, there is just no end to the challenges that emerge afresh from hitherto unknown areas. It is this dynamic nature of business that puts an additional onus on risk management being thoroughly comprehensive. The corporate world has been gearing itself up for these new challenges; and their risk management strategies have been demonstrating the adoption of a wider coverage of business activity. As a natural corollary, the risk management strategies of insurers would also need to take a fresh look at how they are geared up for eventualities.

Risk Management is the process of measuring or assessing risk and then developing strategies to manage the risk (George, 2003; Harrington and Niehaus, 2004). Risk in life insurance could be associated with sales, underwriting, medical network, claims, operations and finance. Risk management is needed because of increasing instances of Fraud, to have a framework in place to battle risk and fraud issues, enhances company image, acts as a deterrent to frauds by its very existence and acts as a safety net for the Organization.

There are four directions for managing risk given in Figure 1

Figure 1

Four directions in Managing Risk

Risk can be managed by transferring the risk to another party which can be done by way of reinsurance. Reinsurance means the insurance is purchased by an insurance company (insurer) from another insurance company (reinsurer). Both the companies will enter into reinsurance agreement which contains the conditions upon which the reinsurer would pay the insurer’s losses. The reinsurer is paid a reinsurance premium by the insurer and the insurer issues insurance policies to its own policyholders. Second is avoiding the risk which means cancelling the policy if the same sounds to be suspicious. It is better to cancel the policy than to deal with high risk profiles. Third is reducing the negative effect of the risk means that a thorough investigation is done before issuing the policy. This will authenticate the information and will automatically reduce the negative effect of the risk. Fourth and last way of managing risk is accepting some or all of the consequences of a particular risk which means that sum assured should be reduced to the extent of risk.
Fraud risk assessment
Life insurance Company’s commitment to fraud control will be met by identifying opportunities for fraud, and implementing risk avoidance, prevention and minimisation procedures in day to day operations.

Principles

1. Fraud Risk is discussed openly and constructively at all levels to promote a positive risk management culture. Integrity, independence, and accountability are at all times visible and demonstrable. Management has responsibility for managing fraud risk; and the fraud risk management strategy is focused on outcomes, which assist the business to achieve their objectives. Fraud risk is assessed in the context of potential value (creation and destruction) and brand impact.

2. Procedures must be in place to monitor activities and safeguard assets, particularly in high risk areas. These must be reviewed and updated on a regular basis, the recommended period being annually.

3. Appropriate authorization policies for transactions must be established and maintained.

4. Investigation of fraudulent and corrupt activity must be followed in all cases by a review of controls to ensure that existing controls are enhanced to reduce future vulnerability. Where appropriate, changes will be made to investigation and internal audit testing, training materials and policies and procedures.

5. During system development, maintenance and enhancement, due consideration must be given to ensuring adequate fraud risk control mechanisms are incorporated within the system and associated procedures.

6. Investigation records, which are capable of identifying trends in fraudulent and corrupt activity, must be maintained.

Bali, S. et.al, (2010) revealed the findings that there have been increased incidences of fraud over the last one year. According to the survey report, there are various types of insurance frauds, which occurs in all the areas of insurance, e.g., as claims and surrenders, fake documentation, misselling, collusion between parties, etc. Today, when India’s insurance industry is working toward reducing costs, one of its main focus areas to control or reduce costs is by proactively arresting fraud, which can be achieved through an effective Fraud Risk Assessment (FRA) program i.e. Effective policy holder and vendor due diligence process, Effective claims validation, Mystery shopping, i.e., gathering market intelligence relating to tied and corporate agents, brokers, etc., Channel reviews pertaining to tied agency, banc assurance and tele calling, Contract compliance reviews including review of advertising expenses, Intellectual Property (IP) compliance, etc., Effective fraud analytics and electronic dashboards.

Baradhwaj, C. (2011) discussed various types of frauds. Customer related frauds could take place by submitting false documents at the proposal stage, misrepresentation on health, family history, occupation, etc in the proposal form, money laundering, fake claims by submitting fake claim documents. Distributor related frauds could take place by submitting false/forged documents and information, misappropriation of funds, issue of fake receipts/policies and lastly employee related frauds were discussed.
Gupta, A., & Venugopal, R. (2011) revealed the fact that in USA, the cost of insurance frauds was more than 100 billion USD in the year 2003 working out to 950 USD per family. In 2001, 73 percent of the US Property & Commercial insurers rated fraud as a serious problem - 4.6 on a scale of 5. In U.K. the fraud is in excess of four million pounds per week. The yearly figures are one billion pounds. In Canada, it is 1.3 billion Can Dollars. Survey done by India forensic revealed the fact that the insurance industry is losing close to Rs.15000 Crores every year. That is almost 9 percent of revenues of an insurance company. This clearly indicates the seriousness of the problem. According to a PwC Survey, more than a third of Indian companies do nothing about the frauds. 32 percent of the fraudsters (internal) are simply warned/transferred/reprimanded. 28 percent are dismissed. 60 percent are criminally charged/civil action taken. Mostly the fraudster is a person who has a long standing relationship with the victim company. 31 percent are Agent-hackers, 19 percent are external suppliers, 15 percent top and middle management; and 8 percent are customers.

Rose, S. (2008) discussed about many faces of insurance fraud and also highlighted the key techniques for detecting and preventing fraud. Another technique explained in the paper is predictive modelling which means to use data mining tools to build models to produce fraud prosperity scores. Tseng & Shih (2012) conducted a study and the results indicated that insurance coverage affected ethical judgment and perceived fairness, and ethical judgment and perceived fairness related to the false representation. Perceived fairness is related to ethical judgment (the more people feel it is fair to cheat, the higher propensity they have to deem the cheating as ethical). Holm, E. (2010) discussed a case study on how florida agent was charged with Insurance Fraud. Perri, F. S. (2011) conferred white collar crimes.

**Types of Fraud**

Thus from the literature review available and experience the types of fraud can be broadly divided as follows:

Internal Fraud: Internal frauds are those perpetrated against a company or its policyholders by agents, managers, executives, or other employees.

External Fraud: External frauds are directed against the company by individual or entities as diverse as medical providers, policy holders, beneficiaries, vendors and career criminals. An internal fraud often involves theft of proprietary information, improper relationships with vendors or consultants involving conflicts of interest, diversion of policyholder or company funds by employees, use of confidential information for investment purposes, intentional misrepresentation by agents to prospective customers about the characteristics or future performance of company products and any other unethical activity that might put the business interest at risk. External fraud can involve such schemes as fraudulent automobile, life, health or disability claims, the use of tax-advantaged insurance products for concealing the origins of illicit funds, or the negotiation of counterfeit checks. Internal frauds are those perpetrated against a company or its policyholders by agents, managers, executives, or other employees.
Typical fraud categories
There are three major parties involved in perpetrating life insurance fraud. One is the internal employees or the agents of the company, second is the policyholder i.e. the customers and third is not direct fraud but indirect fraud i.e. involvement of doctors. Figure 2 depicts the types of fraud committed by the perpetrators.

Some types of fraud is explained below for better understanding.
<table>
<thead>
<tr>
<th>Category</th>
<th>Case Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Misrepresentation-Misrepresentation of critical information relating to profile (includes incorrect income, educational qualification, occupation, etc)</td>
<td>Proposal form mentioned that the client had a shop in the market, investigations revealed that the client was a vegetable vendor sitting on the footpath</td>
</tr>
<tr>
<td>Forgery/ Tampered Documents: Forging the customer’s signature in any document / proposal or any supporting document</td>
<td>Client staying in Nagpur, working as a surgeon, counter signature required on the application form for some corrections, form comes back within one hour; Signature was forged by the advisor, who was client’s brother.</td>
</tr>
<tr>
<td>Bogus Business: Proposal Forms submitted for nonexistent customers (bogus business)</td>
<td>In one location the Sales Manager had logged in a proposal of a nonexistent client</td>
</tr>
<tr>
<td>Cash Defalcation: Delayed Deposit of Premium</td>
<td>Advisor had collected the premiums from the customer and had not deposited the same for almost a month, it came to the insurer’s notice when the customer was sent the lapsed letter, and was complaining. Later advisor deposited the cash. He said he used the cash as he had a financial problem.</td>
</tr>
<tr>
<td>Misselling : Product Misinformation – Selling Practice wherein the complete, detailed and factual information of products is not given to the Customer: Incomplete / Incorrect representation on: Guaranteed Returns, Rider Features, Charges, Linked Product vs. Endowment etc., Facility of Top-up vs. Regular premium, Premium Holiday</td>
<td>Customer was not told about the administrative charges, a customer was given a cover of 1lakh and premium was 5lakhs. This was a clear case of misselling as even the facility of a Top Up was not explained to the client.</td>
</tr>
<tr>
<td>Pre Signed Forms: Obtaining pre signed blank forms and filling up of the ACR/CCR without actually physically seeing the client/ satisfying oneself about the client.</td>
<td>SM had not met the customers, proposal form mentioned that customers were working in an electronic agency, however in reality they were working in a Tabela (Cow Shed)</td>
</tr>
<tr>
<td>Nexus: Doctor’s nexus means he getting involved with other perpetrators in committing life insurance fraud</td>
<td>Doctor gave clean medical reports. Influenced the Doctor to conceal information, alternatively coercing the Doctor to submit report without conducting Tests</td>
</tr>
</tbody>
</table>
According to the India forensic research, the Insurance Sector in India loses Rs 30401 Crore in the year 2011 due to frauds. In other words every insurance company loses 9 percent of its revenues to the frauds. Figures indicating such loss are listed in Table 1

Table 1 – Total Premium and Insurance fraud 2011

<table>
<thead>
<tr>
<th>Total Revenue – Premium</th>
<th>Insurance fraud</th>
</tr>
</thead>
<tbody>
<tr>
<td>INR-Billation</td>
<td>US Billion</td>
</tr>
<tr>
<td>3500</td>
<td>70</td>
</tr>
</tbody>
</table>

Insurance fraud is 9% of its total revenue

Life insurance sector contributes maximum to the frauds i.e. 86 percent which is more than 6 times of General Insurance which contributes 14 percent as given in Table 2

Table 2 - Comparison of Fraud in Life and Non-life Insurance

<table>
<thead>
<tr>
<th>Insurance Fraud</th>
<th>Percentage</th>
<th>INR-Billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Types of Life Insurance Fraud</td>
<td>86%</td>
<td>261</td>
</tr>
<tr>
<td>1</td>
<td>Misselling</td>
<td>36%</td>
</tr>
<tr>
<td>2</td>
<td>Fake Documentation</td>
<td>33%</td>
</tr>
<tr>
<td>3</td>
<td>Others</td>
<td>31%</td>
</tr>
<tr>
<td>General Insurance</td>
<td>14%</td>
<td>43</td>
</tr>
<tr>
<td>1</td>
<td>Falsification of documents</td>
<td>70%</td>
</tr>
<tr>
<td>2</td>
<td>Other fraud</td>
<td>30%</td>
</tr>
</tbody>
</table>

70 percent of the total frauds committed in the general insurance sector are of the nature of falsification of the documents. Medical Bills / Certificates top the list with 31 percent followed by Driving License (16 percent) and FIR (13 percent) which is actually a government document. It is depicted in Table 3
Table 3 – Distortion of documents in General Insurance

<table>
<thead>
<tr>
<th>Major contribution in falsification of documents for General Insurance Fraud</th>
<th>Percentage</th>
<th>INR-Billion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical bills certificate</td>
<td>31%</td>
<td>9</td>
</tr>
<tr>
<td>Driving license</td>
<td>16%</td>
<td>5</td>
</tr>
<tr>
<td>FIR</td>
<td>13%</td>
<td>4</td>
</tr>
<tr>
<td>Others</td>
<td>40%</td>
<td>12</td>
</tr>
</tbody>
</table>


**Fraud Prevention**

Holmes, S. A., et al (1999) concluded that insurance industry was more careful than other industries with regard to internal control systems in order to reduce the effect of fraud. Auditors of insurance industry could detect only customer fraud and not even a single case of insurer fraud was detected by them. Insurer fraud was detected either through suspicion or through internal or outside complaint. The schemes used by insurer fraud perpetrators were simpler, affecting fewer accounts and involving fewer violations of internal control mechanisms, than those of other industries. Insurers were also more likely to act against their employees for fraud compared to other industries. Internal whistle-blowing in other organizations compared to insurance industry was strong. Significant differences were observed in the formal fraud investigation in case of insurance industry compared to financial and other industries. Insurers rely on outside examination where as financial and other industries rely on internal investigation. Insurer and other financial institution wanted criminal prosecution of their employees compared to other industries. Anonymous (1997) in coalition against insurance fraud conducted a study which was designed on understanding the customer’s perception on unethical behavior and suggested various measures to curtail insurance fraud such as proper scrutiny of applications, proper investigation of claims and rejecting false claims or application.

Derrig, R. A. (2002) revealed that the fundamental problem for insurers coping with both fraud and systemic abuse was to devise a mechanism that efficiently sorts claims into categories that require the acquisition of additional information at a cost. Measurement, detection, and deterrence of fraud were advanced through statistical models, intelligent technologies were applied to informative databases to provide for efficient claim sorts, and strategic analysis was applied to property-liability and health insurance situations. Hunsoo Kim, W. J. (2006) conferred a multi-line insurance fraud recognition system in Korea to prevent fraud. Morley et al. (2006) and Tajudeen (2009) also discussed on control of insurance fraud on.
The Ideal Risk Management Strategy encompasses the following:

1. Validation of current Processes: Current processes and operations need a validation. This can be done with the help of a rigorous and efficient internal audit team. The objective of the audit is to assess the adequacy of controls that the company has put in place to reduce the risks and exposures, associated with the function, to an acceptable level. Specifically, the audit should assess
   - Existence and effectiveness of management controls, processes and system controls/access controls to mitigate Financial, Compliance, Market, Operational, Fraud and Misrepresentation risks involved in Risk Management Function.
   - Adequacy and existence of policies and procedures and its application
   - Compliance with applicable laws and regulations
   - Effectiveness and efficiency of the existing procedures and suggest improvements to them

2. Assessment of current People: Proper screening of new entrants if not done then the same should be done for the current employees of the organization. Appropriate reference check of the employees will help the organization that all the employees are free from integrity.

3. Identification of vulnerable areas and creating risk benchmarks: The key technique for detecting frauds are rules and red flags that means one should identify definite patterns and highlight all the activities that look doubtful, database searching i.e. share data with other database subscribers to widen claims investigations, exception reporting which means to create Key Performance Indicator (KPI) - claims benchmark and report all the events that exceed claims benchmarks.

4. Formulating a Risk policy: A dedicated risk department will help to formulate a risk policy. One of the risk policies should be to conduct periodic risk reviews. Risk reviews means inspection or assessment of branches done by the risk team. This will help to understand the weak internal control system of the organization. Risk team should build in risk triggers across all processes and then should continuously monitor risk index.

5. Set up communication channels to sensitize employees on risk, values and ethics: This can be done with the help of risk sensitization training sessions to the sales personnel. Case studies should be discussed in the training sessions and steps taken for malpractices should be discussed. This will create and spread awareness of unethical practices which will indirectly help the organization to reduce frauds.

6. Counsel the sales personnel and agents to provide complete details relating to the income and occupation and visit the customer and solicit information before giving the life advisor/employee certification report. They should maintain sanctity of the confidential report and the employee certification report. They should disclose all product features and should display high levels of integrity and ownership.
Conclusion
Increasing number of life insurance frauds not only increases the costs of the companies but also lead to inflated premium. Therefore it is very much necessary to have a proper risk management framework in order to curtail or minimize life insurance frauds. Life insurance Company’s commitment to fraud control will be met by identifying the opportunities for frauds and implementing risk avoidance, its prevention and procedures for its minimisation in the day to day system of operations. The study revealed that frauds can be prevented by formulating a risk policy; identifying vulnerable areas, creating risk benchmarks, complying with applicable laws and regulations, effectiveness and efficiency of the existing procedures and their continual improvement.

References