

## Areas of Frauds in Insurance Sector and ITS Impact on Financial Statements

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**Abstract:** In simple words, insurance means “a thing providing protection against a possible eventuality.” Insurance is a means of protection from financial loss. It is a form of risk management primarily used to hedge against the risk of a contingent, uncertain loss.

An entity which provides insurance is known as an insurer, insurance company, or insurance carrier. A person or entity who buys insurance is known as an insured or policyholder. The insurance transaction involves the insured assuming a guaranteed and known relatively small loss in the form of payment to the insurer in exchange for the insurer's promise to compensate the insured in the event of a covered loss. The loss may or may not be financial, but it must be reducible to financial terms, and must involve something in which the insured has an insurable interest established by ownership, possession, or preexisting relationship.

**Insurance fraud** is any act committed with the intent to obtain a fraudulent outcome from an insurance process. This may occur when a claimant attempts to obtain some benefit or advantage to which they are not otherwise entitled, or when an insurer knowingly denies some benefit that is due.

### Objectives:

- To study the various areas where frauds frequently occur
- To understand what is the impact on the financial statements.
- To list out various measures to reduce insurance frauds

This paper will be dealing with the two main components i.e. **various frauds and its impact.**

### The main areas of frauds are

- Claims
- Application
- premium

### Data Collection and Methodology

Questionnaire was given to the insurance companies to collect the data. Secondary data was also used.

- Star health insurance
- Exide Life insurance
- Reliance life insurance

**Keywords:** Claim, Application, Premium, False Claims, Surrenders, Measures, Types of Frauds, Impact.

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## I. Literature Review

In the insurance industry, fraud has always been considered a sensitive issue. The million dollar question continues to be, “**Are insurance companies quick to respond where they suspect fraudulent activities to exist?**” The onus lies on these companies to prove that fraudulent activities exist, for instance, knowing a claim is fraudulent is one thing, but proving this to be fraudulent is a different matter. Fraudulent claims and surrenders account for a significant portion of all claims and surrenders received by insurers, which also adds up to their overall costs. The main focus area of the insurance companies to reduce cost is catching the frauds proactively. This can be done through an effective fraud risk assessment program.

---- Ernst & Young

### Insurance

In simple words, insurance means “a protective coverage against a possible eventuality.”

The concept of insurance includes two parties viz. insured or a policy holder and insurer. Insured is a person who buys or takes the insurance from the insurance company. On the other hand insurer is an entity which provides protection against the loss to the insured. Insurance is a contract wherein the insurer guarantees an amount which the insured can claim at the happening of an uncertain event. The amount varies from policy to

policy and is fixed at the time of entering into the contract. The insured should have insurable interest and contract should not be entered by coercion.

### Insurance Frauds

Insurance fraud is an act of giving false information or raising false claims for which they are not eligible or denying the benefit due for which they are eligible for.

According to law, the crime of insurance fraud can be prosecuted when:

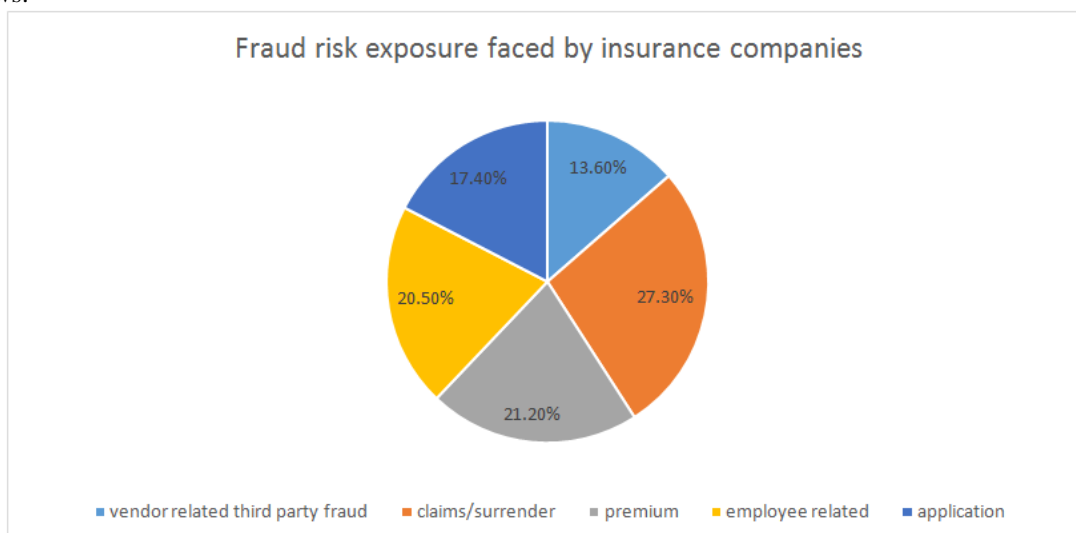
- The suspect had the intent to defraud. Insurance fraud is a "specific" intent crime. This means a prosecutor must prove that the person involved knowingly committed an act to defraud.
- An act is completed. Simply making a misrepresentation (written or oral) to an insurer with knowledge that it is untrue is sufficient.
- The act and intent must come together. One without the other is not a crime.
- Actual loss is not needed as long as the suspect has committed an act and had the intent to commit the crime. No money necessarily has to be lost by a victim.

### Areas Of Frauds

Frauds can occur in any area of insurance sector. Basically, the areas of frauds detected so far are as follows:

- **Application:** Application is the first stage on the insurance policy where in the insured applies for the insurance. In the application stage frauds occur when
  - The insured conceals certain important facts
  - Giving partial or wrong information
- **Premium:** Premium is a periodical instalment paid by the insured to the insurer for covering the risk. Frequently occurring frauds at this stage are:
  - Paying the premium in cash
- **Surrender:** Surrender is voluntarily terminating the insurance policy by the insured before the maturity or the insured event occurs. Frequently occurring frauds at this stage:
  - Forcing the insured to surrender the policy and take a new policy
  - By not disclosing the facts relating to surrender to the insured at the time of taking the insurance policy
- **Claims:** An insurance claim is a formal request to an insurance company asking for a payment based on the terms of the insurance policy. Frequently occurring frauds at this stage:
  - Fraudulent activities done by the insured to get the claim amount
- **Employee related frauds:** The frauds done by the employee through collusion with the insured or misleading the insured. Frequently occurring frauds at this stage:
  - Helping the insured to exaggerate the level of income earned prior to the incident
  - Making false policies

According to the research done by Ernst & Young, the frauds risk exposure faced by insurance companies is as follows:



**Fig 1.** Fraud risk exposure faced by insurance companies

(Courtesy E&Y)

**Life Insurance Companies related frauds and their measures**

**Life insurance:** Insurance that pays out a sum of money either on the death of the insured person or after a set period.

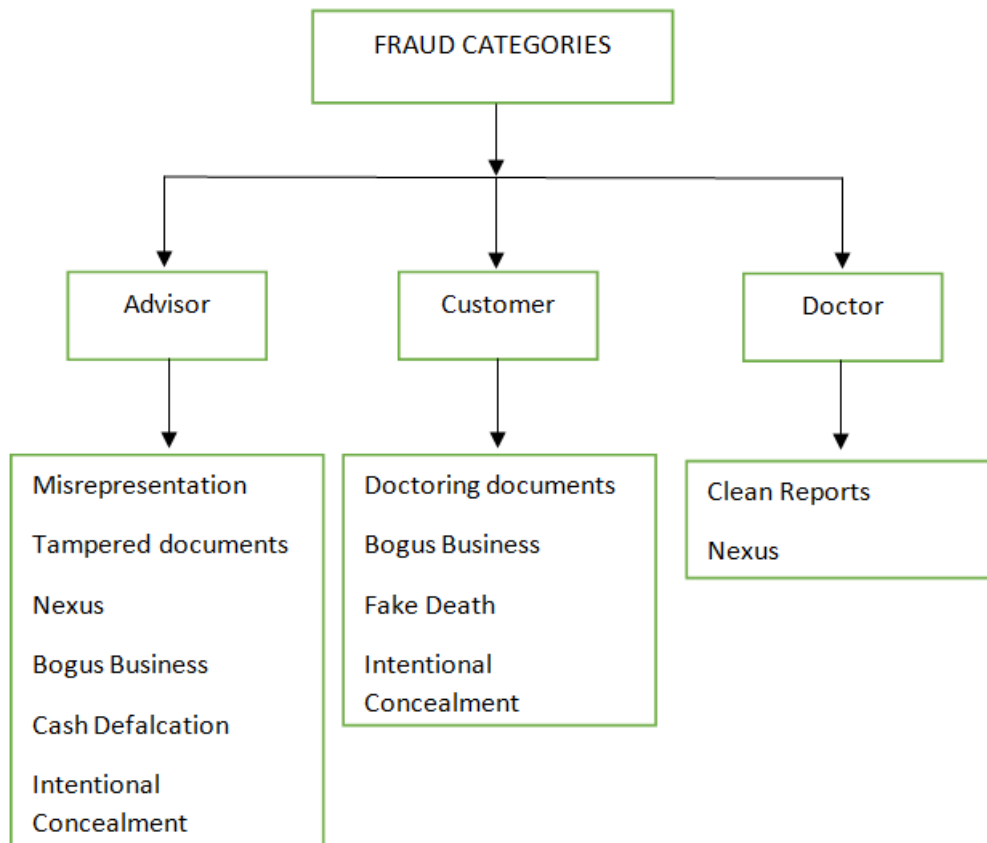
**Frauds in life insurance business:** According to the research done by us claims is the area where the maximum frauds occur.

**Types of frauds in life insurance:**

**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 a direct fraud but an indirect fraud i.e. involvement of doctors.



**Fig 2.** Categories of fraud

(As per the primary data collected by personal interview)

Some types of frauds are explained below

1. **Misrepresentation**-Misrepresentation of critical information relating to profile (includes incorrect income, educational qualification, occupation, etc. This leads to early claims.
2. **Forgery/ Tampered Documents:** Forging the customer’s signature in any document / proposal or any supporting document or submitting wrong documents.
3. **Bogus Business:** Proposal Forms submitted for nonexistent customers (bogus business)
4. **Cash Defalcation:** Delayed Deposit of Premium
5. **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
6. **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.

7. **Nexus:** Doctor's nexus means he getting involved with other perpetrators in committing life insurance fraud
8. **Fake Death:** Faking one's death to cash in on a life-insurance policy is a long, time honored practice.

Some schemes are amateurish and easily detectable. Others are quite sophisticated and involve elaborate planning in staging the fake death with accomplices, oftentimes family members. Funeral directors also have been convicted of aiding such scams.

Another way of doing fraud is to create a policy after the death of a particular person by manipulating the death certificates and claiming the benefit.

### **Claim Settlement**

Claim settlement is not a straight forward process. The basic premise is to pay all "right" claims and reject all "wrong" claims. However, deciding on what is right and what is wrong is not an easy task. A company's reputation is also based on the claim settlement ratio which is nothing but the number of claims settled for every 100 claims. In the following paragraphs, the issues the companies face in determining what fair claims are given below:

1. **Understanding of the Product:** This is probably the first problematic area. In majority of the cases, the customer doesn't know what he has purchased and what the benefits are. Very few people read the actual policy contract and understand its requirements and implications. If this applies to the literate group in the Indian Society, the problems are compounded for the poorer sections of the society, which forms a vast majority of the country.
2. **Proposal Form:** If problems in claims settlement were to be given a rating, then probably this parameter would be rated at 99%. This is the most critical problem. A large number of proposal forms are not filled in with the spirit required. Many Proposal Forms are filled in just for the sake of satisfying the insurer's needs to issue the policy – due regard and truthfulness is not given to the questions. A Life Insurance Proposal Form is filled in like a credit card application, where just the basic address etc. is given and then signed off without even pondering over the other fields in the larger proposal form. Questions are just ticked for the sake of completeness without an iota of a thought given to the facts required thereunder. At the time of claim, when the actual facts are revealed, then it is the Proposal Form which indicts the customer at a time when they don't want to accept the facts. Moreover, illiteracy causes more problems, whereby policyholders say that they were not aware of what was supposed to be given.
3. **Non-Disclosures & Misrepresentations:** This is a continuation of the previous point. It is not that the customer is always ignorant and has just committed errors unknowingly. Many times the customer does not want to disclose the facts and problems. Hence he purposely does not disclose information in the proposal form.

### **Impact of frauds on the financial statements**

Frauds have an adverse impact on the financial statements in the form of reduction in profit due to false claims.

\*As the area of frauds is a confidential area not much of information is being revealed.

### **Measures to prevent fraud:**

- Confirming from the customer that the policy has been taken without any coercion.
- To confirm that the premium is paid by the policy holder, name of the policy holder should be mentioned on the cheque given by him/her at the time of paying premium.
- Salary bill and bank statement must be scrutinized at the time of issuing the policy.
- Human life value must be calculated appropriately at the time of giving the policy.
- Not encouraging politically exposed persons for the policy.
- Creating awareness to the general public regarding the insurance.

### **Health Insurance Companies related frauds and their measures**

**Health Insurance:** Insurance taken to cover the medical expenses

#### **What is Health Care Fraud?**

Health care fraud is a type of fraud involving the use of the health care system by an individual, medical provider, or insurance company in a deceitful manner in order to profit from it. While health care fraud may not seem like a crime that can hurt others, it does have a negative impact. Health care fraud influences insurance rates every day, causing premiums individuals pay to rise to cover the insurance companies' losses. Such fraud committed by a healthcare provider can cause the loss of professional license, and may affect the healthcare of their patients.

Health care fraud and abuse is commonly thought of as the act of intentionally misrepresenting identity, symptoms, or other information, for the purpose of receiving more money or greater benefits from the insurance company.

### **Types of Health Care Fraud**

Because individuals, medical providers, and insurance companies commit fraud, there are many types of health care fraud. The primary goal of such fraud is to profit financially, or to obtain medical care without valid insurance. The types of health care fraud include:

#### **Fraud Committed by Medical Providers**

- **Billing for services and procedures that were not actually provided to the patient or fraudulent billing:** One of the more common types of health insurance fraud is something called fraudulent billing. Fraudulent billing occurs when a doctor or medical facility bills a patient for a treatment that the individual did not receive, but it can also refer to other errors that appear on a patient's itemized bill. The facility mails a copy to the patient's insurer, the insurer pays the total amount and the facility receives money for procedures not actually done. Even if the insurer negotiates the price down, the facility will still receive money from that fraudulent bill.
- Duplicate submission of a claim for the same service when it was only performed once
- In this case a provider does not submit exactly the same bill, but changes some small portion like the date in order to charge Medicare twice for the same service rendered. Rather than a single claim being filed twice, the same service is billed two times in an attempt to be paid twice
- Billing for a different, more costly, service than the one actually rendered, referred to as "upcoding"
- Upcoding is a term that is not defined in the regulations but is generally understood as billing for services at a level of complexity that is higher than the service actually provided or documented in the file.[8] For example, a supplier of durable medical equipment might bill for motorized scooters while supplying less expensive manual wheelchairs. As another example, a physician might bill simple office visits at the higher rate for complex visits. These practices are illegal. Providers should only bill for the level of services or items actually furnished.
- Billing each step of a procedure as if it was a separate procedure, referred to as "unbundling"
- Bills for a particular service are submitted in piecemeal, that appear to be staggered out over time. These services would normally cost less when bundled together, but by manipulating the claim, a higher charge is billed to Medicare resulting in a higher pay out to the party committing the fraud
- Providing a service that is not covered under a patient's insurance policy, then billing for a service that is covered
- Falsifying a patient's diagnosis to justify surgeries or other procedures that are not covered, or are not medically necessary

- **Kickbacks**

Kickbacks are rewards such as cash, jewelry, free vacations, corporate sponsored retreats, or other lavish gifts used to entice medical professionals into using specific medical services. This could be a small cash kickback for the use of an MRI when not required, or a lavish doctor/patient retreat that is funded by a pharmaceutical company to entice the prescription and use of a particular drug.

- People engaging in this type of fraud are also subject to the federal Anti-Kickback statute.

- **Erroneous Treating**

When a patient meets with a doctor, the doctor is responsible for deciding what is wrong with the patient and how to treat that person. Health insurance fraud can include something called erroneous treating, which is when the doctor treats a patient for conditions that he or she does not have. The doctor may even refer the patient to another doctor for a specialized treatment in exchange for that second doctor giving the first doctor money for that referral. Erroneous treating can also include doctors sending bills to insurance companies for treatments and procedures not actually performed.

- **Overcharging Patients**

The National Health Care Anti-Fraud Association considers overcharging patients as a type of health insurance fraud. When medical professionals complete procedures, they provide patients and their insurers with a bill for those services. Most doctors will bundle those services to bring down the total cost. Doctors who overcharge will separate the procedure into multiple steps and charge a separate amount for each step. If a patient needs an abscess lanced, the doctor might charge for the initial exam, administering a numbing agent, lancing the boil, dressing the wound and for aftercare instructions sent home with the patient. Health insurance

provides those insured with financial help for medical services. Any frauds perpetrated by doctors or patients will cause insurance costs to rise. Some examples of health insurance fraud include doctors who overcharge their patients, fraudulent bills sent to patients and insurers and claiming that procedures are medically necessary to force insurers to cover those procedures

#### **Fraud Committed by Individuals**

- Using insurance that belongs to someone else
- Adding a person to an insurance policy that is not eligible for insurance coverage, by providing false information
- Failing to remove someone no longer eligible from a policy
- Visiting different doctors to obtain multiple prescriptions
- Staging or faking an accident in order to receive care, medication, or reimbursement for expenses
- Exaggerating a claim
- Providing false information in order to receive medical coverage
- Non declaration of information at the time of taking the policy
- Submitting false documents to claim the benefit

#### **Fraud Committed by Insurance Companies**

- Collecting premiums for policies on which they do not intend to pay
- Evading state insurance regulations to sell health care insurance they are not licensed to sell
- Denying payment on services, procedures, or prescriptions that should be covered

#### **Measures to prevent fraud:**

- Proper investigation when the individual claims for the medical reimbursement
- Proper medical checkup at the time of giving policy
- Setting up a regulatory authority to check the over pricing of the bills at the hospitals

## **II. Conclusion:**

Frauds in insurance sector through false claims can be summarized into the following two broad categories

#### **Life insurance:**

- Claims is the major area where most of the frauds occur.
- Only 10% of the frauds are being detected.
- It is difficult for the insurance company to maintain the claim settlement ratio and detect frauds at the same time.
- Proper scrutinizing at the beginning and proper investigation at the time of claims can reduce the frauds.
- Impact on the financial statements in figures or % cannot be determined due to confidential area.

#### **Health Insurance:**

- Claims is the major area where most of the frauds occur.
- The insurance companies lag behind in detecting frauds because they cannot ask the hospitals regarding the treatment they provide to the patient.
- There is no regulatory authority which controls the pricing of the treatment for the doctors.

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