Information Paper on

Insurance Fraud

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CONTENTS

1.0 INTRODUCTION

Insurance fraud is any act committed with the intention to fleece an insurance process. It can be perpetrated by insurance clients, insurance employees, intermediaries or service providers.

Insurance fraud is diverse and prevalent in all insurance fields. A significant proportion of insurance claims are fraudulent leading to high premiums to honest customers and contributes to damaging insurers' image and reputation.

The challenge is that insurance fraud is hard to identify and it is estimated that the number of detected fraud cases represents only a small percentage of the actual cases.

Insurance fraud is a big concern and various insurance stakeholders including insurers, regulators and insurance associations are making a concerted effort to prevent fraud.

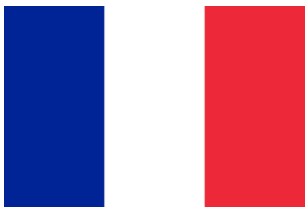
This paper investigates the impact of insurance fraud, the revolving fraud tactics and schemes, challenges in fighting fraud, the loopholes and how to seal them.

2.0 IMPACT OF INSURANCE FRAUD – GLOBAL OVERVIEW

Prevalence of insurance fraud has intensified estimation of fraud and its impact on premiums by insurers in various jurisdictions.

In the United States of America (USA), the Coalition Against Insurance Fraud (CAIF), a national alliance of consumer groups, public interest organizations, government agencies, and insurers dedicated to preventing insurance fraud estimates that insurance fraud takes at least $80 billion every year from American consumers. https://insurancefraud.org/fraud-stats/

The Association of British Insurers (ABI) in the United Kingdom (UK) established that 107,000 fraudulent insurance claims worth £1.2 billion were uncovered by insurers in 2019 – a 5% increase from 2018. Nearly 300 fraudulent claims and 2,000 dishonest applications worth £3.3 million are detected daily. Motor insurance fraud remains most common with a 6% increase in detected cases since 2018, while property fraud has seen a significant increase of 30%. The average value of a fraudulent claim was £11,400. https://www.abi.org.uk/news/news-articles/2020/09/detected-insurance-fraud/



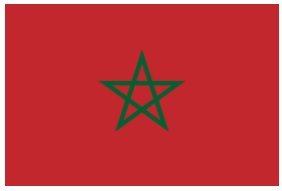
In France, the national health insurance fund (CNAM) reported that insurance fraud had reached 287 million EUR (321.4 million USD) in 2019. The fraud identified mainly came from health professionals and institutions. In 2019, 1650 investigating agents checked 13 million invoices, conducted 23,000 investigations and opened 8,800 litigation files. The investigations revealed that 48% of the fraudsters are healthcare providers such as pharmacists, doctors and ambulance drivers. Healthcare institutions come second with 31% of the fraud cases. The insured are liable for only 21% of the total loss of the CNAM. Investigators have uncovered fraud networks on the Internet which provide online falsework stoppages and invoices for medical expenses. The CNAM has also reported that the fraudulent acts are not caused by the use of the health insurance card. https://www.atlas-mag.net/en/article/health-insurance-fraud-in-france

The "2019 China Insurance Industry Intelligent Risk Control White Paper" a study published jointly by the Insurance Institute of China and FinTech "OneConnect" affirms that in China, nearly one-fifth of motor claims are fraudulent. https://www.atlas-mag.net/en/article/fraud-is-infecting-the-chinese-motor-insurance

It is estimated that the Indian insurance industry loses close to $6 billion to insurance fraud annually. This works out to about 8.5% of all the premiums collected every year. All types of insurance policies are prone to fraudulent claims. However, a fake claim on life insurance policies is six times more likely to happen when compared to other types of policies. https://www.managementstudyguide.com/abcs-of-insurance-fraud-in-india.htm

The South African Insurance Crime Bureau estimates that in 2019 up to 20% of the 2.48 billion USD paid out on short-term insurance claims could have been fraudulently paid. This cost the South African market 497.86 million USD. https://www.saicb.co.za/news/2020/insurance-crime-bureau-2020-annual-report

In Morocco, claims have been on the rise. Business professionals attribute this rising trend to an upsurge in fraud, a phenomenon that affects motor insurance in particular. To counter this, Moroccan insurance companies are currently working on the establishment of an information exchange and control system. https://www.atlas-mag.net/en/article/insurance-fraud-rising-in-morocco



In Kenya, the Insurance Fraud Investigation Unit (IFIU) detected 83 insurance fraud cases in 2019 worth Kshs386.34 Million. https://www.ira.go.ke/index.php/annual-reports-2019

Association of Kenya Insurers (AKI) rolled out an Integrated Motor Insurance Database System (IMIDS) in 2018 that saved the industry over Kshs40 million in fraudulent claims in 2019. https://akinsure.com/integrated-motor-insurance-data-system-imids

3.0 INSURANCE FRAUD TYPES

Insurance fraud can be categorized in two broad forms:

- **Soft/cultural/opportunistic Fraud:** Exaggerating a genuine claim, or providing untruthful or incomplete information in insurance application to obtain a lower premium on the insurance policy.
- **Hard/organized Fraud:** Involves planning or inventing an insured loss intentionally to receive payments for the damages, such as vehicle theft, collision, or fire. It sometimes involves an organized crime syndicate involving criminal gangs that steal vast amounts of money.

Insurance fraud can occur at any stage of the insurance cycle by various insurance players:

- **Internal Fraud:** Fraud against the insurer by its employee (underwriters, adjusters, and dishonest agents) or in collusion with internal or external parties. This might entail an insurer collecting premiums and then not paying valid claims, fraudulent financial reporting, stealing money from customers' accounts by forging signatures.
- **Intermediary Fraud:** Fraud against the insurer and or policyholders by an intermediary. According to the United States Federal Bureau of Investigation (FBI), the most common intermediary fraud is where an agent sells insurance without a license or they pocket premiums, then issue a fake policy or none at all.
- **Customer Fraud:** Fraud against the insurer by policyholders and or other parties in the purchase or execution of an insurance contract.

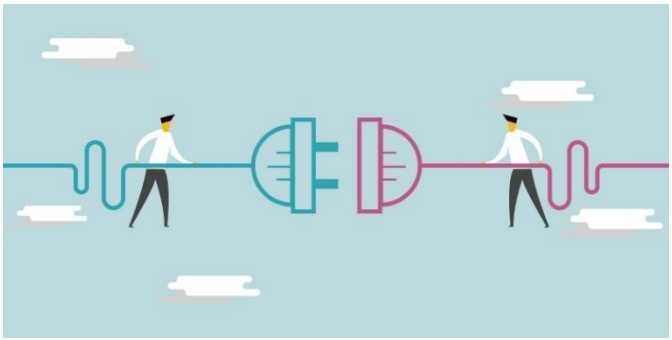
4.0 FIGHTING INSURANCE FRAUD; THE WEAK SPOTS

Insurers encounter internal and external challenges in the fight against fraud. Data was identified as the main challenge in effectively fighting fraud according to the insurance fraud report 2020 by FRISS (an international company dedicated to fighting insurance fraud) which interviewed 443 insurance professionals in 52 countries. The main issues are:

4.1 Inconsistent Internal Data Quality

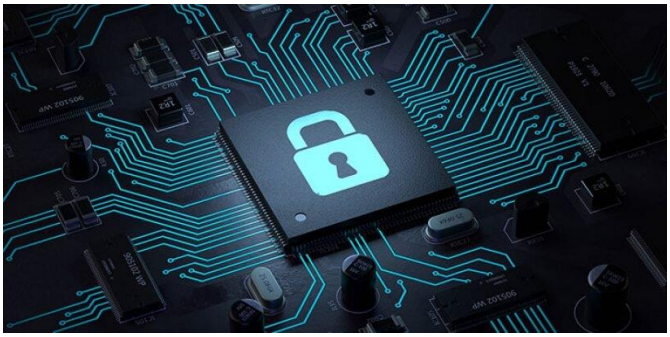
As businesses change over time due to modernization, mergers, acquisitions and introduction of new product lines, a lot of information gets lost through the process changes over the years.

In this case, data transfers and harmonization may not be completed and this results in scattered information. Getting a clear picture of a client therefore becomes a complex task.



Another challenge is the lack of uniformity in how information is recorded between departments. Insurers should break down silos and join together data sources to provide a holistic view that may expose suspicious activity and help in identification and prevention of fraud.

4.2 Data Protection and Privacy



Digitalization and growth in data means insurers have an even greater obligation to protect consumer data. The industry is founded on trust between insurers and their clients so data privacy and security by insurers is key.

While gathering data to build a case for criminal prosecutions, investigators must consider the stringent privacy implications in the data protection requirements within their jurisdiction.

4.3 Inadequate Access to External Data

Insurance intermediaries do not consistently visit customers as more and more business is handled online nevertheless, a thorough assessment of the risk has to be done. Access to external data improves the health of insurance portfolios by seeking the right balance in risk coverage. Providing clear and sound logic of whether to accept, reject or revise conditions of a policy.

Availability, cost and accessibility of external data sources vary. External data complements the completion of an applicant's profile or geographical information, thus companies have positioned themselves to be able to screen social media such as Facebook and Twitter. Other information sources include government bodies.

4.4 Poor Cooperation among Insurers

Insurers can greatly benefit from having access to more data mostly on claim history and fraud cases to improve on fraud and risk detection. To identify fraud at an early stage, it is of vital importance to share intelligence. Insurers can join forces by sharing data, working together on investigations and learning about the latest fraud schemes. This involves high-level co-operation with law enforcement agencies.

The sharing of data provides a bird's eye view of transactions and shines a spotlight on suspicious activity across multiple carriers and lines of business to help detect, prevent and investigate insurance fraud.

Indeed, some companies worry about giving out information to protect their competitive advantage but this is to their disadvantage and that of the industry in the long term. Hence the need for a neutral party to collect data and analyze for any suspicious activity. Bodies such as member associations, fraud bureaus have been useful to insurance markets in various jurisdictions.

4.5 Rapidly Changing Fraud Schemes

With the increased proliferation of technology in insurance processes and the rise in aggregator sites, insurers are struggling to keep up with emerging fraud trends, schemes and tactics. Consumers have moved to mobile, and are demanding an omni-channel experience. Fraudsters target weak spots by using fake identities obtained from insurance consumer data breaches; they are using different methods and targets to avoid being caught. They also hack into emerging innovations that are not fraud-resistant. Continuous awareness of the tactics being used to cheat the system helps in sealing the loopholes of evolving fraud schemes. The more effort a fraudster needs to put in to commit fraud, the less attractive fraud becomes.

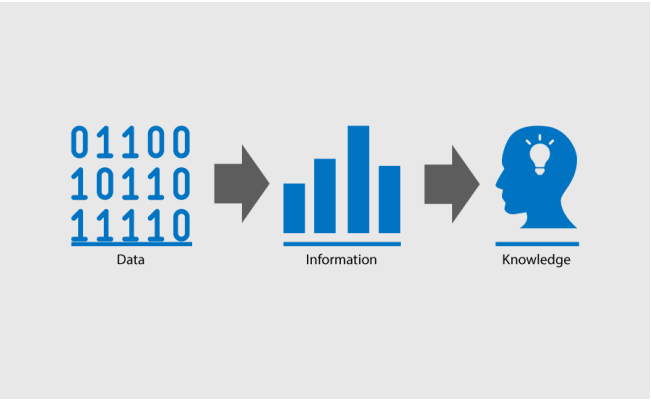
4.6 Inadequate Organizational Commitment

Insurers need to have a sound fraud detection strategy, to enable proper and timely decision making. Having a culture that emphasizes fraud detection and prevention by creating awareness in the entire organization from C-level to customer support. Insurers should empower their staff through training and have a business model that integrates the technology needed to effectively fight fraud. Organizational commitment will pay off as staff will be more aware, leading to better fraud detection and prevention thus more affordable and efficient services to customers.

5.0 INSURANCE FRAUD PREVENTION

Prevention of insurance fraud is a priority for insurers worldwide and requires greater awareness across the entire organization. Fraud prevention helps insurers reduce financial losses, maintain their reputation and customer trust. Fraud investigation has evolved, initially, it was a labour-intensive, costly and time-consuming process involving manual verifications and physical visits to examine cases.

Since it is not feasible to review every claim, insurers are taking significant strides to leverage on artificial intelligence and advanced data analytics for effective fraud detection and timely prevention.

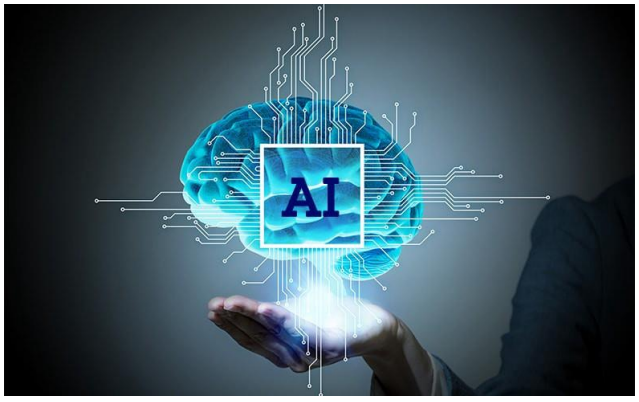


Insurance-related fraud is currently more sophisticated and would need a high degree of analytical and intelligent tactics. Insurers need to be more proactive rather than reactive by building predictive models to detect and stop fraud before it happens. Predictive

models are built on data based on historical claims, industry red flags and fraud investigation experience to identify future fraud trends. Relationships and variations of these factors are key to identifying doubtful claims. The model then gives a score to a claim and if it does not reach the set threshold, it is flagged-off for further investigations.

Link Analysis is then used to evaluate relationships (connections) between unrelated data to useful information for further investigations by competent investigators. Through various software applications, data is mined and harmonized from the company's disparate systems and many other different sources into meaningful information that reveals patterns, trends and relationships.

Advanced data analytics is a more reliable, cost-effective and accurate process than manual verifications, which also takes care of the stringent privacy implications of data protection as it uses already available data and thus controls collection and disbursement of sensitive personal information.



Some insurers are also using artificial intelligence to validate claims. An example is China Pacific Insurance Company (CPIC) that uses voice analytics technology and emotion detection solution to identify fraudulent claims by detecting and measuring uncontrolled psychophysiological changes to a person's voice during open conversations and to identify claims that require further investigations.

6.0 COLLABORATIVE INDUSTRY INITIATIVES

Fighting fraud is a universal problem and various jurisdictions have formed associations to fight this menace yielding numerous arrests and bottom-line savings. Below are some of the initiatives:

The **Insurance Fraud Bureau (IFB)** in the UK is a not-for-profit company established in 2006 to lead the insurance industry's collective fight against insurance fraud by acting as a central hub for sharing insurance fraud data and intelligence. https://insurancefraudbureau.org/about-us/

The **Insurance Fraud Enforcement Department (IFED)** is a specialist police unit dedicated to tackling insurance fraud in the UK funded by the Association of British Insurers (ABI) and Lloyds of London members. https://www.cityoflondon.police.uk/police-forces/city-of-london-police/areas/city-of-london/about-us/about-us/ifed/

The **National Insurance Crime Bureau (NICB)** in the USA is a non-profit organization that partners with insurance companies and law enforcement to help identify, detect, and prosecute insurance criminals. https://www.nicb.org/

The **Coalition Against Insurance Fraud (CAIF)** in the USA is a national alliance of consumer groups, public interest organizations, government agencies, and insurers dedicated to preventing insurance fraud. www.insurancefraud.org

FraudShare in the USA is an industry solution to help companies identify fraudulent activity so they can better understand and prevent account takeover attacks and protect customer and company assets. FraudShare is a collaborative effort by Life Insurance Marketing and Research Association (LIMRA), Life Office Management Association (LOMA) and Secure Retirement Institute (SRI) and 10 leading financial services firms.

https://www.limra.com/en/newsroom/news-releases/2019/limra-loma-and-the-secure-retirement-institute-launch-fraudshare-to-help-the-industry-combat-account-takeover-fraud/

The **Insurance Crime Bureau** in South Africa is a non-profit company dedicated to fighting organized insurance crimes and fraud by bringing together insurance companies, law enforcement agencies and other stakeholders to facilitate the detection, prevention and mitigation of insurance crimes as well as assist in the prosecution of repeat offenders and fraudsters through ongoing insurance fraud investigation through information sharing https://www.saicb.co.za/

These collaborative initiatives focus on detecting and preventing fraud, the main initiatives are:

- Exchange of relevant information in compliance with data protection and privacy requirements.
- Collaboration with law enforcement agencies and supporting police units in finding and prosecuting fraudsters.
- Collaboration with regulators in the enactment of stronger anti-fraud laws
- Empowering customers by raising awareness of insurance fraud schemes and encourage reporting of known or suspected fraud anonymously through cheat lines.
- Training and seminars for insurance staff, police, investigators, law enforcers, etc.
- Sponsoring research and surveys on insurance fraud.

7.0 CONCLUSION

We are in it together

Insurance fraud is a global problem and costs insurers lots of money. Despite the rise in fraudulent activities, insurers should strive to enhance customer experience by paying all valid claims efficiently by ensuring a high-level precision when investigating potential frauds.

Leverage on Technology

The authenticity of every claim cannot be investigated thoroughly as the process will be costly and inefficient. Data is the most valuable asset in fraud detection and investigation. Insurers are using advanced data analytics, artificial intelligence and predictive modeling with linkages to social media and other data sources in fraud detection and prevention.

Work Inward

Even with the new-age technologies and advanced data analytics, insurers should ensure internal checks and balances as organized crime can involve employees. The starting point is a breakdown of internal silos and streamline the disparate systems to have all related information in one framework, this will have a huge impact on transparency and efficiency making work easier and less prone to deliberate manipulation.

To fight fraud effectively and stay ahead of emerging fraud schemes, there is need for organizational commitment by having a fraud-fighting culture alongside a business model that integrates fraud-fighting technology. These initiatives, coupled with continuous staff training on new tactics and schemes, how to detect and prevent fraud will go a long way in reducing cases of fraud.

Collaborate:

Insurers should unite in the fight by exchanging relevant information and partnering with law enforcers. Lessons learnt from the collaborative initiatives in the more developed markets shows that some fraud tactics can cut across companies and business lines.

Fighting fraud is key for insurers and they need to adapt fast to changing market conditions and embrace new technologies to remain relevant and competitive while adhering to the data protection regulations as they effectively serve genuine customers.

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