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CHAPTER6: MACHINE LEARNING

A STUDY ON FRAUDS IN INSURANCE INDUSTRY

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ABSTRACT

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. 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. This study aims to identify the frauds in insurance industry.

i. INTRODUCTION

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. 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.

As per the statement of Ernst & Young "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".

ii. 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. Insurance fraud occurs when any act is committed with the intent to fraudulently obtain some benefit or advantage to which they are not otherwise entitled or someone knowingly denies some benefit that is due and to which someone isentitled.

According to an Indian association, Out of the total outgoings in health insurance, nearly 25% are fraudulent claims. Recent surveys conducted in the US show that more than 25% of respondents think it is acceptable to inflate insurance claims, even more believe it is reasonable to do so to recover deductibles

iii. CLASSIFICATION OF FRAUD

Insurance Regulatory and Development Authority (IRDA) who regulates the insurance industry classifies fraud into these three categories

	Internal Fraud	**Intermediary Fraud**	**Policy holder/Customer Fraud**
Definition	Fraud against the insurer by its Director, Manager and/or any other officer, staff member	Fraud against the insurer or policy holders by an agent or any other third party administrator	Fraud against the insurer in the purchase or execution of an insurance product.
Examples	• Misappropriating funds • Fraudulent financial reporting • Forging signatures and stealing money from customers' accounts	Non-disclosure or misrepresentation of risk to reduce premiums • Commission fraud – Insuring nonexistent policy holders while paying premium to the insurer	**Soft Fraud**: •Exaggerating damages/loss • Deliberate or subtle lagging of claims resolution **Hard Fraud**: • Staging the occurrence of incidents • Medical claims fraud

iv.

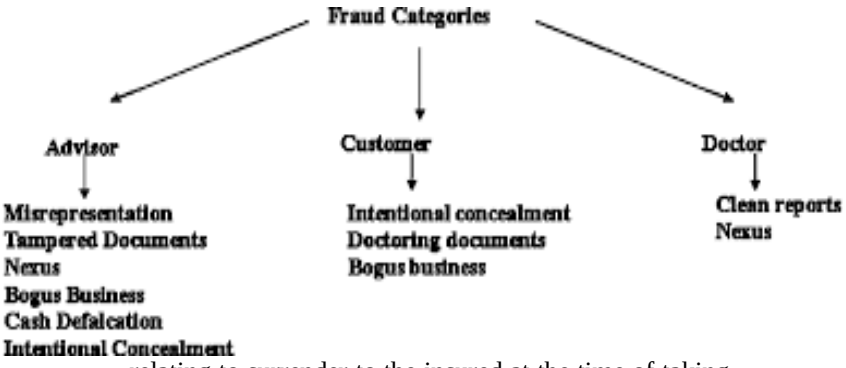
v. AREAS OF FRAUDS

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 in the insurance wherein 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. Paying

the premium in cash may be a reason for occurrence of frauds at this stage.

- **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 are forcing the insured to surrender the policy and take a new policy and 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. Fraudulent activities are 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 are helping the insured to exaggerate the level of income earned prior to the incident and making false policies

vi. TYPES OF FRAUDS IN LIFE INSURANCE:

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.

vii. TYPES OF FRAUDS IN HEALTH INSURANCE

Health insurance fraud occurs when a company or an individual defrauds an insurer or government health care program.

Policy holders are usually involved in frauds relating to:

• Concealing preexisting diseases / chronic ailments, manipulating health check ups

• Fake / fabricated documents to meet policy term conditions

• Duplicate and Inflated bills

• Staged accidents and fake disability claims

The agents and brokers are usually involved in frauds relating to:

• Providing fake policy to customer

• Manipulating pre-policy health checkup records

• Guiding customers to hide preexisting diseases

• Facilitating policies in fictitious names

• Fudging data

Provider related fraud usually pertain to:

• Overcharging, Inflated billing, Billing for services not provided.

• Unwarranted procedures, Excessive investigations and expensive medicines.

• Over utilization and extended length of stay

• Fudging records and patient

viii. MEASURES TO PREVENT FRAUD

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

ix. GUIDELINES BY IRDA

Insurance Regulatory and Development Authority (IRDA) laid down guidelines requiring insurance companies to have in place Fraud Monitoring Framework. The guidelines mandate insurance companies to have fraud detection and mitigation measures and submit periodic reports to IRDA The frame work shall at the minimum protect the insurer from the threats posed by the following broad categories: Policy Holder Fraud and Claims Fraud, Intermediate Fraud and Internal Fraud According to IRDA Insurance fraud monitoring framework all insurance companies are required to have in place as Anti-Fraud Policy duly approved by their boards. The anti-fraud policy should broadly cover the following:

• Procedures for Fraud monitoring

• Identify potential areas for fraud.

• Coordination with law enforcing agencies

• Lay down procedures for exchange of necessary information on frauds among insurers.

• Lay down procedures to carry out due diligence on the personnel –staff, agents, intermediaries, TPA before appointment.

• Generate fraud mitigation communication at periodic intervals.

• The statistics of various fraudulent cases which included outstanding cases and closed fraud cases within 30 days of the close of financial year shall be filed with IRDA .The insurer should inform both the potential clients and existing clients about their anti-fraud policies.

x. CONCLUSION:

Companies, agents and brokers only come under the purview of IRDA but hospitals, doctors and providers of health services are not covered under the net. So the insurance regulatory system needs a more integrated approach like the banking industry by sharing fraud related data among various parties and have a tighter control on frauds and increasing the gambit of monitoring and control. So as the frauds in insurance sector can be eliminated.

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