Countering Fraud in Insurance

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1. INTRODUCTION
1. Introduction

Insurance Core Principles 21:

• “The supervisor requires that insurers and intermediaries take effective measures to deter, prevent, detect, report and remedy fraud in insurance.”
1. Introduction

What is fraud?

• “A deceptive act or omission intended to gain advantage for a party committing the fraud (the fraudster) or other parties”

Other important questions

• Who commits it?
• Why is countering fraud important?
• Who is responsible for countering fraud?
1. Introduction

Legal framework

- offences and sanctions for committing fraud
- offences and sanctions for prejudicing an investigation
- ability to obtain documents and information
- ability to restrain assets
- ability to confiscate assets
- could be useful to have civil and criminal immunity for fraud reporting
1. Introduction

Application paper on countering fraud in insurance:

- Objectives of the paper:
  - provide information on how fraud can occur within the insurance sector (for ease the term insurers includes reinsurers and intermediaries)
  - insurers should assess their vulnerability and implement effective and efficient strategies, policies, procedures and controls
  - provide information for supervisors to assist them on applying anti-fraud measures
2. FRAUD RISK IN INSURANCE
2. Fraud risk in insurance

The Fraud Triangle:

- **Motive/Incentive**
  - financial problems
  - unrealistic business objectives
- **Opportunity**
  - more likely to act when risk of being caught is small
- **Rationalisation**
  - dissatisfied with insurer as an employer
  - compensation against premiums paid
  - everyone does it
  - copying the behaviour of others in the insurer
2. Fraud risk in insurance

Profile of insurance fraudsters:
• The “opportunity” fraudster:
  − law abiding citizen who sees an opportunity for fraud
  − a policyholder could inflate a legitimate claim to compensate for premiums paid
  − employee could falsify expenses or financial accounts for his/her benefit
2. Fraud risk in insurance

Profile of insurance fraudsters:
• The “professional” fraudster:
  – earns or complements income by fraud
  – may continue until detected and target a number of insurers
  – organised crime groups committing complex and extensive frauds
  – funds obtained through fraud could be used to finance other criminal acts
2. Fraud risk in insurance

Fraud risk management by insurers:

• directors should understand and recognise risk of fraud in their business
• policies, procedures and controls based on understanding of risk of fraud
• fraud risk management should be included in all insurers risk management framework
2. Fraud risk in insurance

Fraud risk management by insurers:

• Fraud risk should be:
  – considered when establishing mission, strategy and business objectives
  – analysed and reflected in relevant operational procedures and controls, eg:
    – product development
    – accepting clients
    – hiring and firing staff
    – outsourcing
    – handling claims
    – dealing with intermediaries
2. Fraud risk in insurance

Fraud risk management by insurers:

• Policies, procedures and controls should be based on a risk analysis, taking into account:
  − size of the insurer
  − group, responsibility and organisational structure
  − products and services offered
  − payment methods
  − types of policyholder
  − market conditions
  − distribution methods
2. Fraud risk in insurance

Fraud risk management by insurers:
• a separate fraud management function could be considered
• procedures for responding adequately to suspected cases of fraud (could include fraud investigation) is needed
• fraud investigation may require access to expertise (legal, IT, audit, medical)
3. INTERNAL FRAUD
3. Internal fraud

Risk factors for internal fraud include:
• organisational culture and tone from the top
• complexity of the insurer
• speed of innovation
• remuneration and promotion policies
• weaknesses in internal control
• economic climate and business situation
3. Internal fraud

Internal fraud can include:
• pilfering of cash or resources, eg equipment, stock or information
• falsifying expenses
• bribery – buying influence
• bribery can include kickbacks – receiving funds for awarding a contract to a certain party
3. Internal fraud

Typical warning signs of internal fraud include:

- managers and/or other staff working late
- directors, managers, and/or other staff suddenly resigning
- personality changes
- unexplained wealth and/or lifestyle changes
- key managers and/or other staff having too much control with no or little oversight
- conflicts of interest
- complaints
- missing statements and unrecognised transactions
- unexplained rising costs
3. Internal fraud

Internal fraud prevention policies, procedures and controls include:

- culture of ethical behaviour
- adequate supervision of management and staff
- screening of management and staff
- establishing clear responsibilities
- eliminating conflicts of interest
- observing the four eyes principle
- safeguards over use of assets
- internal complaints procedures
- transparent and consistent anti-fraud policy
- clear dismissal policy
3. Internal fraud

Internal fraud detection:

• internal audit is most successful
• internal audit should be:
  − risk based
  − independent, either internal or external
  − accountable to the board
  − include all business lines and processes
3. Internal fraud

Internal fraud detection:

• other possible detection methods include:
  − encouraging staff to report irregularities
  − establishing a policy on disclosure of information on potential fraud, eg whistle-blowing
  − exit interviews
4. POLICYHOLDER AND CLAIMS FRAUD
4. Policyholder and claims fraud

Policyholder fraud and claims fraud can be committed by policyholders:
• at inception of the insurance contract
• during the insurance contract
• when claiming payment or compensation

Claims fraud can also be committed by third parties, e.g. medical services, engineers
4. Policyholder and claims fraud

Policyholder fraud at inception:
• deliberately withholding, or providing, incorrect background and other information, for example, the refusal of coverage by other insurers or claims background
• may affect decision of insurer to offer cover and at what premium
4. Policyholder and claims fraud

Typical features of claims fraud that could occur during the insurance contract include:

• reporting and claiming of fictitious damage or loss
• exaggerating damage or loss
• misrepresenting a fact to create appearance of an incident covered under a policy
• misrepresentation of the damaged party by an imposter
• staging of incidents covered under a policy
4. Policyholder and claims fraud

When establishing policies, procedures, and controls, insurers need to:

- understand that quick claims settlements increase risk of fraud
- consider moral and ethical responsibility to prevent fraud
- recognise that fraud affects reputation
- identify and prevent fraud that could threaten policyholders or other third parties
4. Policyholder and claims fraud

Policyholder and claims fraud prevention
• consider risk enhancing factors for new products
• “product proofing”
• assess fraud risk of existing products
• adequate client acceptance policy
• ensure risks posed by intermediaries are managed - the insurer remains responsible for delegated actions
• make policyholders and beneficiaries aware of their duties
4. Policyholder and claims fraud

Policyholder and claims fraud detection
- advise potential policyholders of consequences of false or incomplete statements
- consider quality and reputation of third parties
- client could provide incorrect or incomplete information – mitigate with fraud profile of product-client combination
- fraud risk assessment of claims
- clear criteria for claims assessor
- automated checking against red flag lists
- operational targets should be combined with fraud detection targets
- ascertain competence of claims adjusters
- maintain incident database
5. INTERMEDIARY FRAUD
5. Intermediary fraud

Intermediary Fraud Risk
• intermediaries involved in some of the most important processes
• danger of trust being abused, for example:
  – withholding of premiums
  – insuring non-existing policyholders, paying a first premium, collecting commission, annulling the policy by non-payment of premiums
  – colluding with policyholders
5. Intermediary fraud

Typical warning signs of intermediary fraud include:
• request for commission immediately or in advance
• policyholder lives outside intermediary’s normal region of operation
• small portfolio but high insured amounts
• premiums received and commission paid above or below industry norms
• policyholder asked to make payments via intermediary
• insured and intermediary represented by the same person
• personal relationship between client and intermediary
5. Intermediary fraud

Typical warning signs of intermediary fraud (cont):
• unexpected developments or results
• intermediary often changes address and/or name
• frequent changes in control or ownership of intermediary
• frequent changes in control or ownership
• a number of complaints or regulatory inquiries
• intermediary is in financial distress
• churning
• intermediary insists on certain loss adjusters or claims contractors
5. Intermediary fraud

A warning sign can also exist where the portfolio of an intermediary includes a significant number of policies:

• where the commission is higher than first premium
• with arrears on premium payments
• with a payment shortly after inception
• with a high amount of claims fraud
• with a disproportionate amount of high risk insureds, for example elderly people
5. Intermediary fraud

Intermediary fraud prevention and detection

• fit and proper standards for intermediaries
• policy for appointment of intermediaries
• signed application forms and TOBAs
• require disclosure of relevant facts
• check financial soundness of intermediary
• effective sanctions policy in case of non-compliance by intermediary
5. Intermediary fraud

Terms of Business Agreements (TOBAs) could require the intermediary to confirm:

• agreement does not breach any legal obligation or rules of a competent authority
• intermediary will maintain relevant licences, authorisations etc
• compliance with insurer’s anti-fraud policies, procedures and controls
5. Intermediary fraud

To reduce potential for fraud, insurers should consider:
• not paying commission until first premium paid
• not paying more commission than a certain percentage of premiums paid
• keep unearned commission in a temporary deposit
• make a clear distinction between funding of intermediaries and paying of commission
5. Intermediary fraud

The insurer should monitor the performance and business of the intermediary, and consider:

- quality of business, including business conduct, integrity of directors, management, staff
- anticipated and actual levels and patterns of business
- warning signs
5. Intermediary fraud

Other procedures and controls to consider are to:
- send policies and renewal documents direct to policyholders
- instruct intermediaries not to accept payments in cash
- make premium cheques payable to the insurer
- ensure sufficient safeguards over intermediary client accounts
- audits of intermediary’s business
6. SUPPORTING ORGANISATIONAL MEASURES AND PROCEDURES
6. Supporting organisational measures and procedures

Training:
• should correspond with business process
• should reflect risks staff may encounter
• should at least explain anti-fraud policies, procedures and controls, including reporting of fraud
• more specific training for Board, Senior Managers and others to include relevant laws, fraud methods, detection methods and internal reporting
6. Supporting organisational measures and procedures

Reporting suspicions of fraud:
• report suspicions to a designated person
• those reporting should have adequate legal protection
• policies on keeping records of suspicions and cases
• policies for reporting suspicions to law enforcement
• policies and procedures to be communicated internally and externally
• notify supervisor of fraud related matters where the supervisor has an interest
6. Supporting organisational measures and procedures

Information exchange:
• fraudsters may target different insurers
• insurers should share information with each other
• this could be achieved by a database containing information about:
  − internal fraudsters
  − fraudulent policyholders, claimants, beneficiaries, fraudulent intermediaries and other third parties
• consider data protection and privacy laws
6. Supporting organisational measures and procedures

Information exchange (cont):
• fraudster may not just target insurers
• consider sharing information across the financial sector by, for example, linked databases
• consider data protection and privacy laws
• share knowledge on fraud risks, trends, policy issues, prevention and detection
7. THE SUPERVISOR’S ROLE
7. The supervisor’s role

The supervisor should:

• have a thorough and comprehensive understanding of fraud risk
• identify main vulnerabilities
• consider fraud risks alongside other risk assessments
• understand the activities undertaken, products/services offered
• understand internal, policyholder, claims and intermediary fraud
• regularly assess potential fraud risk
• require insurers and intermediaries to take effective measures to address fraud risks
7. The supervisor’s role

The supervisor should monitor and enforce compliance

• issue enforceable requirements with sanctions
• issue guidance
• resources to be sufficient
• staff to be skilled and trained
• fraud risk to be considered at each part of the supervisory process
• assessment of whether insurers/intermediaries have adequate fraud risk management
• use on-site inspection and off-site monitoring to enforce compliance
• power to take appropriate corrective and remedial action
• report suspected criminal activity to FIU or appropriate law enforcement agency
7. The supervisor’s role

Supervisor to regularly review effectiveness of measures taken, covering for example:

- risks of fraud in the insurance sector
- supervisory resources and training
- number and content of inspections
- adequacy of off-site and on-site supervision
- on-site inspection findings
- actions taken
- input from other authorities
- number and nature of requests for information by others
- adequacy of requirements/guidance
7. The supervisor’s role

The supervisor should take necessary action to improve effectiveness

- consider contributing to anti-fraud initiatives
- consider conveying warning information to insurers/intermediaries if aware of substantiated suspicion of fraud
- maintain records on supervisory inspections relating to combating fraud and on sanctions issued
7. The supervisor’s role

The supervisor should have effective mechanisms to cooperate, coordinate and exchange information

• with other competent authorities
• operational and policy cooperation, and coordination with/across anti-fraud authorities, where relevant
• provision of information to other authorities when suspected fraud identified
• obtain information on concerns by authorities and insurers/intermediaries
• consider the appointment of an anti-fraud contact
• maintain records on the number and nature of formal requests
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