Frauds In Health Insurance What Could Insurers Do?

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ABSTRACT

Non-life insurance contracts are based on the legal principle of the rigid standard of utmost food faith and are often regarded as contentious between the settlements. As the onus to pay the claim is on the insurer the information given by the insured in the proposal form is minutely examined for both international and unintentional lapses of utmost good faith.

INTRODUCTION TO FRAUD IN INSURANCE

Trust is one of the main high risk factors in the nonlife insurance contracts between the contracting parties. Insurers, at all times, need to have their specialized internal strategies in place to balance trust with their internal controls. Insurers should not start evaluating claims, as they do now, with a presumption that every claimant is a potential fraudster rather they should have fraud detection strategies in place that will detect a potential fraudster at the stage of their underwriting and acceptance of the risk.

But the desire to build premium incomes, among insurers, is so strong and powerful that all aspects of detection of a likely fraud are relegated to and enforced only at the claim settlement stage. Therein rests the rub to their reputations on reliability and fair mindedness. Also therein begins the woes of the insured.

Why do people commit frauds?

There are three important factors that induce many otherwise honest persons to commit frauds opportunities provided to the insured by the inadequate underwriting controls exercised by the insures and in their claim transactions as well; the personal motives of claimants that encourage them to commit frauds in the claim settlement chain mostly with the connivance of others, and their rationalization of their rationalization of their fraudulent deeds that there is nothing basically wrong in defrauding the insurers, who are hard boiled and are usually unfair in their

public dealings. They cleanse their consciences of bad feelings, believing they are only cheating a bureaucratic and an unfair institution, and not cheating an individual or a responsible body.

Health Insurance and Frauds Galore

Frauds in health insurance are intensely personal in their commitments. Insurance cover is quite often bought for the first time, when one is detected having some disease or the other and requiring costly treatment. Since it is purchased without initial medical checkups, even and adverse health condition that one is aware of is suppressed from disclosure. Health insurance involves heavy costs, and pain, suffering and anxiety both to the insured and his family members. It is so easy to buy a health cover, without stringent underwriting controls of insurers and it is available to anyone, without hassles. The only underwriting concern of an insurer is the age band to which the insured belongs and nothing else. Insurers are particularly severs on older groups above 55 years.

Adverse selection is the biggest risk factor prior to acceptance cover. The situation is made worse because health claims are paid in full without the insured having to contribute any amount to the final claim amount. The position is rendered worse due to the cashless treatments permitted, wherein the insurer has little control on the manner and costs of treatments. Claim settlement now is all a matter to be resolved among the claimant, the third party administrators and the hospital, with little intervention by insurer in the process. The behavioral pattern of these three parties is crucial to detection of frauds that might be committed. But insurers seem to prefer the option of raising premium rates to detection, preventing and discouraging frauds that in part have contributed to worsening loss ratios. The higher the rate, the more an insured feels that he is justified to get the maximum benefit, be it justified or not. Even an honest customer is induced by the operating processes of an insurer to indulge in a bit of fraud, without feeling any moral compunction.

The area in which the insurers are at their weakest is in terms of internal control mechanisms to detect the intention of fraudsters. It is the insurers that provide the initial opportunity to customers. It is the insurers that provide the initial opportunity to customers to commit frauds.

Insurers wrongly believe that they can control frauds at the time of claim lodgment. They put their reputations on the block and find that the legal redressal mechanisms are quite unsympathetic to their claim processing methods. For insurers that care for their reputations there are not many of their in the market it is a very tricky situation not to be seen as unfair and unreasonable crybabies, when real claims have to be paid.

Fraud by Hospitals

For hospitals that undertake treatment, they must ensure against the usual charges against them that unnecessary medical tests are undertaken by them just to exhaust the sum insured under the health insurance contract amount. It is and embarrassment for a hospital to be perceived, both by the insurers and the insured, as exploitative and as more commercial than patient care minded.

Insurers should check in how many cases have each of the hospitals they have recognized exhausted the full sum insured rather than charge only for the treatment really and medically required by him. Frauds of hospital authorities are no less the responsibility of the insurers. But such frauds seem to have gone on seemingly unchecked. Hospitals are the ultimate monetary beneficiaries of the entire claim settlement process and they do inherently have the greatest incentive to push up costs of treatment, once the fly is in their net.

Frauds by Insured

Quite a few insured by health insurance just they need to have treatment and forget that insurance is against unforeseen illnesses and not for known and existing illnesses. Once the cover is bought, the risk of moral hazard post ante a claim occurrence is the highest. In terms of adverse selection and moral hazard, insurers internal control mechanisms are woefully incomplete and inadequate. This is something they need to address more seriously.

Pre-Existing Health Condition

In health insurance contracts, the topic of pre-existing illnesses of an insured is a very touched issue. Insurance, after all is meant to cover the insured against an illness that he is not currently

suffering from. It is not a cover for treatment against the diseases that an insured known as he is suffering from in t the latter event, it ceases to be insurance.

Insurance by definition is a cover against future events that may not happen; and not for events that are bound and known to happen. The chance element of anything untoward happening is what he insurance takes care of viewed in this perspective, cover for pre existing illnesses of which the insured is aware is not really worthy of insurance.

While this argument is easy to understand it is the interpretation given by each interested party that is fraught with the aspect of accusation of frauds by each of them. Insures try hard to find evidence for any pre-existing condition to deny a claim. They have even gone to the extent of stating in the policy that a pre-existing condition whether declared or not in the proposal, is excluded from the cover. The why should they ask the insured for any preexisting condition in the proposal?

Again how can insured declare a pre existing condition not know to him who is the final judge and arbiter on the pre existing condition whose opinion is final? Are there other ways open to an insurer to get informational disclosures on the preexisting condition?

Detection of a Preexisting Condition

Usually, a claimant makes full disclosure of symptoms and knows health condition to the doctor, whose initial report contains all disclosures made by the patient. Should not that be the sole proof for existing condition that is known to an insured is this information available to the TPA or to an insurer? Insurers view almost all persons above 45years illness prone. They should accept such persons for insurance only after asking them to produce proofs, such as blood sugar, ECG, etc., that they normally ask for in overseas medical polices. Depending on the information disclosed, the premium rates can be fixed or the risk declined.

How Can Frauds Be Dealt With?

The fraud mitigation mechanism can function in three ways prevention detection and response. A fraud risk assessment helps insurers to understand the business risks that are unique to each

cover they must identify the gaps or weaknesses in their control systems and develop plans to fill them in and commit necessary resources to such plans. Detection of frauds through auditing and monitoring plans based on fraud risk assessment process gives high risk issues priority and facilitates detection of frauds more effectively. Response of insurers to the process of detection of frauds must lead to more analysis of the incidents to plug the loopholes in the control systems. A disciplinary system detailing enforcement and accountability protocols is the key to deterring fraud as a top priority of insurers.

Publicizing frauds committed and explaining the internal control systems for their prevention will make honest customers willingly cooperate with insurers the security checks initiated in airports is recognized as in the interests of the travelers though frisking and checking is unpleasant.

How Have Insurers Responded?

Insurers do not seem to be unduly bothered about frauds committed by the insured or the hospital. They have the alternative mechanism of either delaying claim or denying it forcing quite a few insured to go to ombudsman. The fraud detection techniques are more pronounced when claim occur. Once cannot explain why when the claim frequency is low at 5% (out of 100 persons only 5 people put in claims) they are not able to detect and devise fraud control systems at the time of the underwriting stage. That would of course put them to risking losing premiums that they would rather avoid.

The other option is to raise rates for all so that the entire insured community pays for the frauds that insurers are unable or unwilling to detect. Take for instance, an insures rating schedule in 2002 an insured aged 66years was paying a premium of Rs. 2,600 for a sum insured of Rs. 1,00,000. Now in 2007 the premium he is required to pay is Rs. 5,200 an increase of 100%. Insurers have tackled frauds committed on them by raising premiums for all and by toleration fraudsters rather than detection them in the initial stage, at the acceptance stage and at the medical treatment stage.

Role of Third Party Administrators

The TPA have been quite useful as claim intermediaries but mainly from the claimant's point of view. In fact they are regarded as the primary protectors of a claimant then the insurer himself. They have no financial risk in the claim settlements and one is not sure if they expected to be detectors of fraudulent claims. Their close liaison with the hospital authorities, on a regular basis, possibly makes them ineffective to intercede on behalf of the insures in difficult claims. TPA are expected to decide on the genuineness of the claim, with little check and even less time, before the hospitable authorities decide to admit a patient. The pressures on them are too many.

The system of reimbursement of claims though it might not be popular, deserves to be sold with much lowers rates of premiums than the cashless treatments policies. It is not the commission to the TPA that should make the difference in premiums between the two as now but the risk factors of adverse selection that need to be set off that need to be set off that need to be and the premiums to be adjusted suitably. Insurers need to have significant differential rates for theses two systems cashless and the reimbursement basis. This is another way of discouraging commission of frauds.

Conclusion

By becoming mere spectators, due to the creation of TPA, insures have no control on even data collection its analysis and the fraud detection mechanisms, and much less on claims that they are asked to pay. They need to regain control of their health business, which is the fastest growing segment in the market at over 50% per annum, by undertaking a strategic assessment of their current and future positions in the industry and by committing necessary resources not only to develop the health insurance portfolios but equally to the detection of frauds. Honest customers that buy health insurance need their insurers to be more vigilant and caring to keep premiums affordable to the needy. Detection, prevention and discouragement of a few fraudsters would show that insurer is serious enough to protect their honest customers. As yet, insurers do not seem to know what is hitting them or how they can rework their business strategies. Hopefully, competitive pressures will make them wiser.

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