THE ASSOCIATION OF KENYA INSURERS

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CHIEF EXECUTIVE OFFICERS
MEMBER COMPANIES
THE ASSOCIATION OF KENYA INSURERS

Ladies & Gentlemen,

RE: INFORMATION PAPER ON INSURANCE FRAUD

Please find attached an information paper on fraud in insurance that the Association has put together for the benefit of members.

We believe it will make some good reading and assist members with information necessary to prevent/control/manage fraud.

Yours sincerely,

T. M. GICHUHI
EXECUTIVE DIRECTOR

Encl.

Information Paper on

Insurance Fraud

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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/

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

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.

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

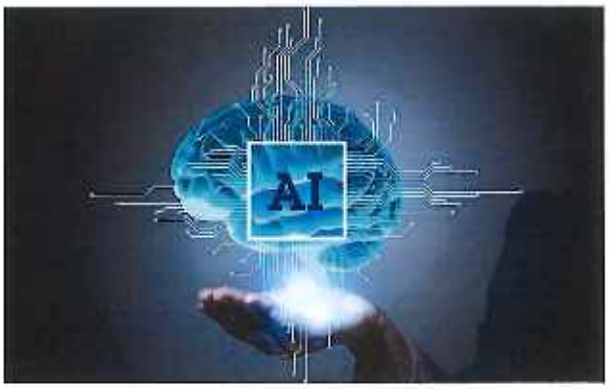
With the increased proliferation of technology in insurance processes and the rise in aggregator sites, insurers are struggling to keep up with emerging fraud trends, schemes and tactics. Consumers have moved to mobile, and are demanding an omni-channel experience. Fraudsters target weak spots by using 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.

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.



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.

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