


AKI
ASSOCIATION OF KENYA INSURERS

HEALTH INSURANCE FRAUD SURVEY REPORT

NOVEMBER 2013

EXECUTIVE SUMMARY

Fraud and abuse are widespread and very costly to Kenya's health-care system. The premium in medical business has been increasing but the business continues to make losses, a situation attributed to medical insurance fraud. According to Statistics from the Insurance Regulatory Authority[1] a total of 143 cases of medical insurance fraud were reported in 2012 and out of the Sh253.6 million lost, only Sh5.2 million recovered. In the year 2010, the loss ratio for this class of business stood at 81% with an average loss ratio of 78% over a five year period from 2006 to 2010.

It is known that fraud exists but the level of fraud is not known. This is due to inadequate information on the prevalence of medical insurance fraud particularly on the forms and financial loses in Kenya and the region. It is against this background that the Association of Kenya Insurers (AKI) contracted MaxWorth Associates to undertake a health insurance fraud survey to establish the extent of fraud in the Kenyan health industry, identify the perpetrators, and recommend strategies for minimizing the same, if not eliminating it.

Structured questionnaires, focused group discussions and in-depth interviews were carried out to obtain information from beneficiaries, health service providers, regulators, health insurers, associations, health insurance facilitators and third party administrators, investigators, the general public and industry captains. A total of 1000 out of 1500 respondents from 326 companies participated in the survey.

The survey reports on fraud awareness levels among respondents; various forms and sources of fraud in the health industry; existing health insurance detection, prevention and mitigation practices and challenges; and the estimated impact of fraud on the business operations; lessons learnt and recommendations to minimize or eliminate fraud within the health insurance industry in Kenya. The first part of this report presents the introduction, socio-demographics of the respondents and background of the survey including a brief highlight of how the survey was undertaken. The second part provides findings on the extent of fraud in the health insurance industry in Kenya. The last part contains the conclusions and recommendations from the survey by the consultants.

The study reports increasing cases of health insurance related fraud and fraudulent claims in the sector. The survey established that 28% of the respondents had come across suspicious health insurance claims while 21% had detected fraudulent claims in the last one year. From the study, nearly half (48%) of the respondents indicated that they sign claim forms before obtaining health services. This signifies limited awareness

[1] Business Daily, July 15, 2013

or appreciation of the associated risks involved and thus underscores the need for nationwide outreach programs to sensitize beneficiaries on the level and impact of fraud in the sector.

The number of health insurance fraudulent claims increased from 22 in 2008 to 225 in 2012 with slight decrease recorded in 2011. The value and total amount paid for health insurance fraudulent claims increased by an average of Kshs 46,869,450 and Kshs 497,047,607 per year from 2008 to 2012 respectively. The value of fraudulent claims as a percentage of the average total health insurance claims paid was established to be 3.7%.

Various types of health insurance fraud exists in the country but diagnosis manipulation; membership substitution, fee splitting, over servicing; provision of generic instead of branded; pharmacy related; non-disclosure of prior ailments; and falsifying claims or altered invoices were found to be the most common forms of fraud in the sector. Health Service Providers were identified as the major perpetrators of health insurance fraud at 39% and 62% by all respondents and beneficiaries respectively. Collusion between beneficiaries and health service providers; lack of sophisticated interrogation/detection software; poor internal controls; and poorly trained claims processing staff were identified as the main factors contributing to fraud in Kenya.

The results of the survey indicate that business leaders are aware of the need to address fraud and implement fraud prevention initiatives, but lack of a comprehensive and integrated approach to fraud risk management continues to pose a significant challenge. A good number of respondents (65.9%) reported that their organizations have health insurance fraud detection, handling and prevention policy. It was established that out of the 63 detected fraudulent cases, 36 (57%) have been investigated and prosecuted while 27 (43%) of the cases have been investigated but not prosecuted. However, 23% do not report fraud when detected due to lack of faith in the authority; 22.1% due to past failures by the authority; 16.8% due to fear of negative publicity and 11.1% due to company policy.

The survey reports fraud awareness creation among employees, members and industry players (31.9%) and background checks on clients using credit bureau information and address verification (15%) as the commonly used measures for preventing fraud by the industry. Use of fraud detection software, maintaining a fraud policy and a code of conduct, comprehensive ethics programme; electronic alerts to beneficiaries, reviewing and improving controls; training on fraud, quality control or claims-vetting of paper claims; screening of service providers; and forensic investigative review were considered to be effective measures for reducing

incidences of health insurance fraud in the industry.

A survey of the use of a dedicated forensic unit to detect and prevent fraud indicates that 30.2% of organizations have dedicated forensic unit with an average budgets of Kshs 937,500.75 per year. Majority, 63.1% were in agreement that the unit was successful or somehow successful. An estimated total of Kshs 101,300,016 has been recovered in the past one year. On average, Kshs 9,209,092.36 is recovered by each forensic unit in the last financial year.

In order to detect, prevent and handle health insurance fraud in the sector, the report makes the following recommendations;

- Implement a comprehensive and integrated approach to fraud risk management including well-defined whistle-blowing policy, periodic fraud risk assessment, third-party due diligence, data analytics tools to identify red flags, and automate processes to address the increasing challenge posed by fraud;
- Design and implement fraud detection, prevention and recovery capacity building programs and nationwide outreach programs;
- Establish Forensic Anti- Fraud Unit at AKI to provide specialised forensic anti-fraud regime services to AKI members including use of fraud detection software and computerized data bases (index systems that identify patterns of suspected activity including false claims and payment duplication;
- Develop and implement fraud policy, code of conduct and comprehensive ethics programme; review and improve internal controls; screen service providers; and undertake regular forensic investigative review as a measure for reducing incidences of health insurance fraud in the industry;
- Implement a multi-agency advocacy agenda to facilitate legal and governance reform and build strategic partnerships with law enforcement agencies or working relationships across multiple disciplines including public private partnerships arrangements; organize platforms for sharing information and experiences on fraud including web based platforms for sharing database of perpetrators; emerging challenges, electronic alerts to beneficiaries;
- Design comprehenssive market driven health insurance products; standardize products and procedures;
- Promote joint initiatives/synergy and encourage sharing of information and exchanges among insurers and strengthen insurer - health service provider relationship through regular meetings.

TABLE OF CONTENTS **PAGE**

LIST OF TABLES & FIGURES

List of Tables

List of Figures

1.0 INTRODUCTION

1.1 Background

The premium in medical business has been increasing but the business continues to make losses. This is attributed to high cost of healthcare and fraud. Some of the forms of fraud reported in the health insurance sector include; billing for services not rendered, billing for a non-covered service as a covered service, misrepresenting dates of service, misrepresenting locations of service, misrepresenting provider of service, waiving of deductibles and/or co-payments, incorrect reporting of diagnoses or procedures (includes unbundling), over-utilization of services, corruption (kickbacks and bribery), and false or unnecessary issuance of prescription drugs among others.

1.2 Global Outlook of Health Insurance Fraud

A review of the various reports and experiences in the regional and international insurance industry indicates that a large number of fraud in the insurance sector occur in health insurance and these pertain to overstating of claims or involve manipulation of the documents of non-existing hospitals and pharmacies or to cover up non- disclosure of facts at the proposal stage[2]. In United States, a higher number of fraudulent cases relates to hospitalization benefits and personal accident policies with Medical and Medicaid (government run) fraud arrests and convictions clearly outpacing other insurance fraud schemes by almost two to one[3]. According to an Indian Association, "Out of the total outgoings in health insurance, nearly 25% were established as fraudulent claims in India. In South Africa, the largest value of investigated fraud was in respect of Pharmacies and represented 29% of the total value. The next highest was in respect of Specialists (other than Radiology and Pathology) at 21% and then General Practitioners at 15%[4]. However, there is limited information available in East Africa region on the prevalence of medical insurance fraud particularly on the forms and financial loses.

1.3 Fraud Detection, Prevention and Mitigation

Organizations are waking up to the fact that fraud is driving up the overall costs of insurers and premiums for policy holders, which may threaten their viability and also have a bearing on their profitability. Hence, companies need a more vigorous fraud management framework. The UK experience indicates that insurers have been able to take effective and cost-efficient measures to drive down the losses through sophisticated investment in fraud screening and detection systems. There are

[2] Fraud in the Insurance on the Rise Report (2010/11) Ernst & Young.

[3] The Coalition Against Insurance Fraud Report 2010

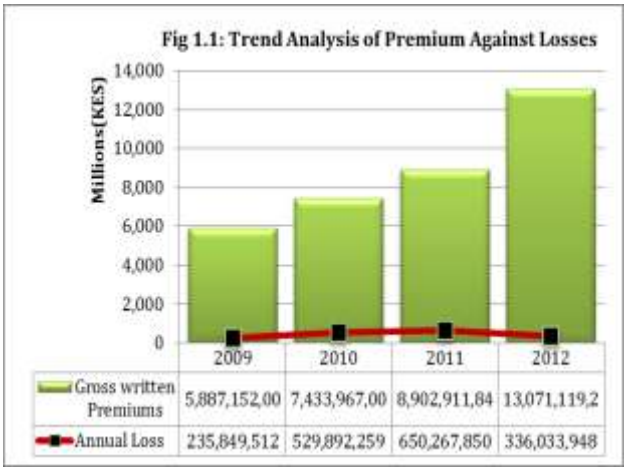
[4] KPMG South Africa Medical Schemes Anti-Fraud Survey 2012

now well-established systems that aid collaboration between insurers at a sector level, rather than simply at an individual company level.

The US in addition to legislative review, a nationwide educational outreach initiative was launched to educate, inform, and advise millions of Medicare beneficiaries about Medicare fraud and abuse through public private partnerships[5]. An estimated net savings from anti-fraud operations (savings less costs) were over $3 per enrollee, resulting in an estimated total net savings of nearly $300 million in 2008 among the large companies surveyed, an estimated net savings were about $1 per enrollee and 2008 total net savings were about $10 million for the medium-sized companies while the estimated net savings for smaller companies, stood at $2.70 per enrollee, and total net savings reported were approximately $5 million in 2008[6]. It was further reported that the knowledge that health plans have robust anti-fraud measures and controls likely prevented inappropriate billings or claims in the first place. Systems for processing electronic claims have been increasingly implemented to automatically perform audits and reviews of claims data[7]. These systems are designed for identifying areas requiring special attention such as erroneous or incomplete data input, duplicate claims, and medically no covered services. According to PWC Global Economic Crime report Survey (2009) the use of forensic technology tools were identified as the major means of detecting health insurance fraud in developed countries. The need for a more robust data analytics tools to effectively detect red flags and a dedicated "anti-fraud" department was identified as the need of the hour in medical insurance fraud mitigation in the KPMG India Fraud Survey Report, 2012.

1.4 Health Insurance Fraud in Kenya

Fraud and abuse are widespread and very costly to Kenya's health-care system. Even though the medical business premiums have more than doubled in the last 4 years, the industry registered an average loss of Kshs 33,394,812 per year (33%) over the 4 year period.



Source: AKI Annual Reports 2009-2013

[5] Beneficiaries Awareness of Medicare Fraud Report, 2001 by Department of Health & Human Services

[6] Insurers' Efforts to Prevent Health Care Fraud by Center for Policy and Research, 2011

[7] Jing Li & Kuei-Ying Huang & Jionghua Jin & Jianjun Shi, 2007. A survey on statistical methods for health care fraud detection.

A total of 143 cases of medical insurance fraud were reported in 2012 and out of the Sh253.6 million lost only Sh5.2 million was recovered[8]. In the year 2010, the loss ratio for this class of business stood at 81% with an average loss ratio of 78% over a five year period from 2006 to 2010. This is due to inadequate information on the prevalence of medical insurance fraud particularly on the forms and financial loses in Kenya and the region.

A review of existing literature reveals that most medical insurance fraud cases involve State Corporations, which have the largest membership and beneficiaries using schemes. Cases of dependents selling their cards to third parties were reported leading to rise in claims paid by the insurance schemes to hospitals per month. Fraudsters were reported to be taking advantage of the technological lapse that exists in most hospitals because very few hospitals are equipped with technology to authenticate the photo cards issued by underwriters.

The implementation of biometric based technology for authentication of insured patients has been adopted to curb rising cases of fraud in medical insurance with 60-80% coverage. A survey of Smart Applications users reveals that the system has not only contributed in reducing fraud but also in resolving potential disputes between health service providers and insurers. However, network downtimes; inaccurate reporting of balances; lack of real time updates of information and high cost of installation and maintenance remains a challenge.

It is known that fraud exists but the level and forms of fraud is not known. It is against this background that the Association of Kenya Insurers (AKI) contracted MaxWorth Associates to undertake a survey of the health industry in Kenya.

1.5 Objectives of the Survey

The primary objective of the survey was to establish the extent of fraud in the Kenyan health industry. Specifically, the survey sought to establish the various forms of fraud in the industry; identify the perpetrators and recommend strategies for minimizing the same, if not eliminating it. In addition, systems and programs employed by industry to detect, prevent and mitigate health insurance fraud and related malpractices were surveyed.

It is envisaged that the findings and recommendations of this survey will enable a complete understanding of the causes of health insurance fraud and inform the development of effective initiatives or strategies for detecting, preventing and mitigating fraud in the health sector. The Survey methodology, work plan and tools were discussed including the survey variables and sample size with AKI management and agreed upon before carrying out the survey.

[8] Statistics from the Insurance Regulatory Authority as reported by Business Daily of July 15, 2013.

2.0 DESCRIPTION OF THE SURVEY METHODOLOGY

1.6 Survey Methodology

The survey used both quantitative and qualitative techniques in collecting data. Structured questionnaires, Focused Group Discussions and in-depth interviews were carried out to obtain information from beneficiaries, Health Service Providers, regulators, Health Insurers, Associations, health insurance facilitators and third party administrators, investigators, the general public and industry captains. A total of 1000 out of 1500 respondents from 326 companies participated in the survey.

1.7 Data Collection and Analysis

Data collection was carried out from 22nd July to 9th August 2013 with the third week of data collection mainly used to revisit some companies on appointments with senior managers and a few CEOs. In order to guarantee quality survey data, 25 research assistants were selected based on their qualification, experience and knowledge of the areas of proposed deployment. Training materials were prepared and research assistants trained for two days from 18th and 19th July 2013 on the use of the survey tools. The tools were piloted within Nairobi Central Business Districts and its environs to check for reliability and consistency of the instruments. The time taken to complete each survey instruments were established and misunderstanding of certain aspects of the tools clarified. The data was cleaned and processed using STATA tools involving descriptive statistics expressed in terms of mean computation, percentages, cross tabulation and content analysis. Statistical Package for the Social Sciences (SPSS) software was used to analyze the data. The survey findings are presented in the subsequent section below.

1.8 Limitations of the Survey

A number of limitations were encountered during the survey. First, some of the respondents particularly health service providers and banks were not cooperative and highly suspicious of the survey and thus were reluctant to participate in the survey. Second, other than the underwriters most respondents had difficulty in understanding what the survey was all about despite the introductory letters from AKI. Third, CEOs of most firms accorded low priority to the survey and hence were inaccessible in view of the survey timeframe. Last, lack of effective documentation and the limitation of recalling past transactions by respondents may have had impact on the accuracy of the level and financial implications of health insurance fraud. These factors particularly suspicion and the confidentiality policies of respondent organizations may have contributed to lower fraud levels reported in this survey despite adequate time used in probing respondents in order to obtain the information as close to reality as possible.

3.0 THE SURVEY FINDINGS

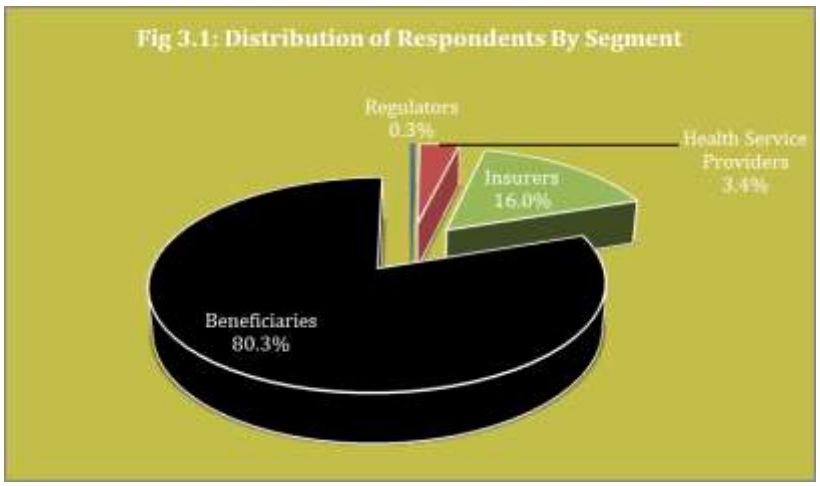
The survey reports on fraud awareness levels among respondents; various forms and sources of fraud in the health industry; existing health insurance detection, prevention and mitigation practices and challenges; and the estimated impact of fraud on the business operations; lessons learnt and recommendations to minimize or eliminate fraud within the health insurance industry in Kenya.

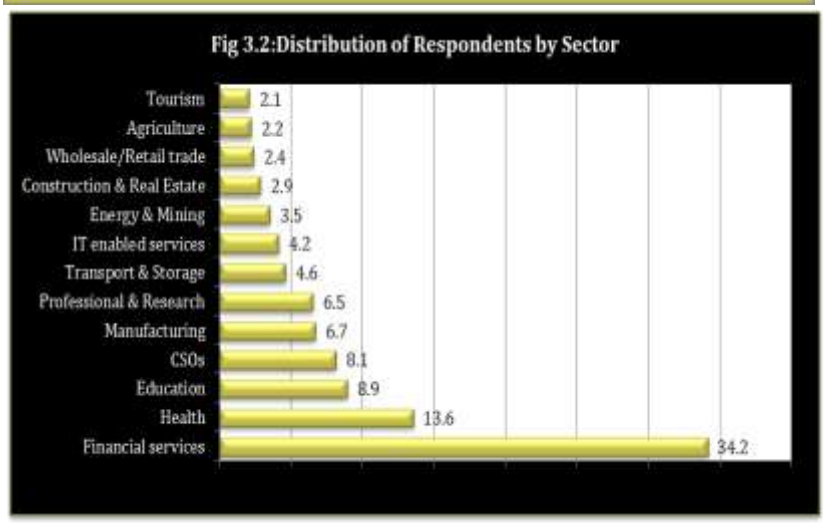
1.9 Summary Statistics

The survey targeted beneficiaries, Health Service Providers, regulators, Health Insurers, Associations, health insurance facilitators and third party administrators, investigators, and industry captains. A total of 1000 out of 1500 respondents from 326 companies participated in the survey giving a response rate of 66.7%. Additional 11 FGDs (six in Nairobi and five in other regions) were carried out. Thirty CEOs and the Insurance Fraud Investigation Unit have been interviewed to gather in-depth information. The findings of the study on key issues of the survey are presented in subsequent sections.

1.10 Demographics of the Respondents

From figure 3.1 and 3.2, beneficiaries comprised 81.7% of the total respondents surveyed with financial services sector being the majority (34.2%). The least number of beneficiaries were from Tourism, Agriculture and Wholesale and Retail trade sectors. This can be attributed to the level of health insurance coverage within these sectors. 16% and 3.4% of the respondents were Insurers and health service providers respectively. From the 34 health service providers, 59% were hospitals, 24% clinics, 12% pharmacy and 6% private practitioners. In terms of the designation of respondents, 63% were non-management, 34% were in management while 3% were executive staff.

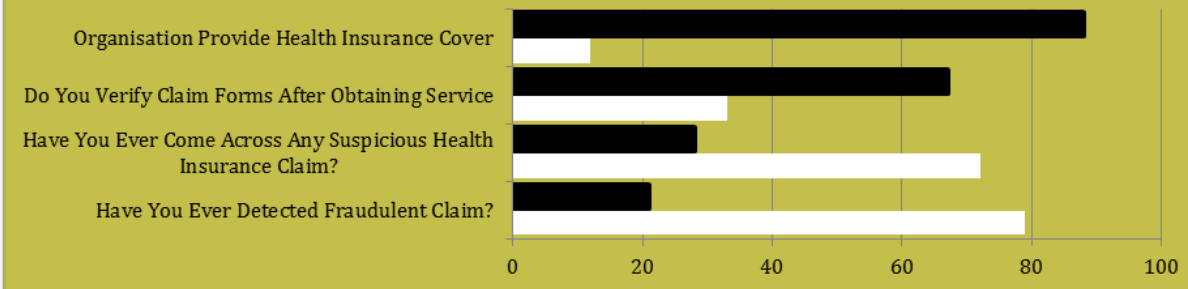




1.11 Percent Respondents with Medical Coverage and their Awareness of Health Insurance Fraud

The survey sought to establish the percentage number of respondents with health insurance cover and the premium paid in the last one year. The level of health insurance fraud in the industry was also assessed in terms of the number of respondents who had come across suspicious health insurance claims or have detected fraudulent claims. The results are shown in figures 3.3 and 3.4 below.

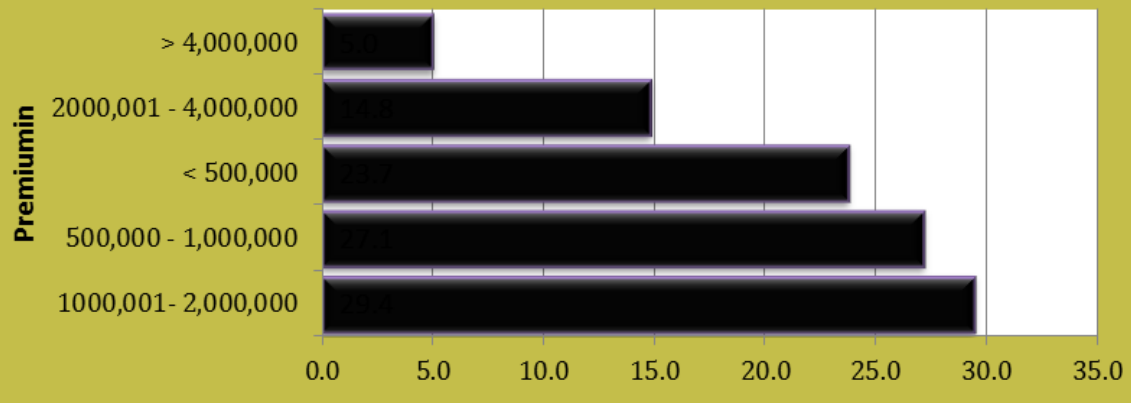
Fig 3.3: Number of Respondents with Medical Cover & Awareness Level of Health Insurance Fraud (%)



	Have You Ever Detected Fraudulent Claim?	Have You Ever Come Across Any Suspicious Health Insurance Claim?	Do You Verify Claim Forms After Obtaining Service	Organisation Provide Health Insurance Cover
YES	21	28	67	88
NO	79	72	33	12

Overall, 88% of the respondents indicated that their organizations provide health insurance cover for their employees against 12% who indicated otherwise. Majority of respondents (29.4% and 27.1%) had an annual medical cover between Kshs 500,000 and Kshs 2,000,000 with the least number of respondents having an annual cover above Kshs 4,000,000 as illustrated in figure 3.4 below.

Fig. 3.4: Value of Health Insurance Cover Per Year (KES)



	1000,001-2,000,000	500,000 - 1,000,000	< 500,000	2000,001 - 4,000,000	> 4,000,000
Respondents (%)	29.4	27.1	23.7	14.8	5.0

It was further noted that 28% and 21% of the 938 respondents had come across suspicious health insurance claims or have detected fraudulent claims respectively. Another 52% and 48% of the respondents indicated that they sign claim forms after obtaining service or before obtaining the service respectively. Most of the respondents 67% (n=767) admitted to verifying claim forms after the service with 62% always verify, 26% occasionally verify and 12% indicating that they rarely verify the claim forms after obtaining service. This indicates low awareness levels among health insurance beneficiaries and therefore a need for educational outreach initiative to educate, inform, and advise medicare beneficiaries about medicare fraud and abuse.

1.12 Trends in Health Insurance Fraud

An analysis of the number of fraudulent health insurance claims and their corresponding monetary value over five years was carried out. From table 3.1, it is evident that the number of health insurance fraudulent claims increased from 22 in 2008 to 225 in 2012 with slight decrease recorded in 2011. The value and total amount paid for health insurance fraudulent claims increased by average Kshs 46,869,450 and Kshs 497,047,607 per year from 2008 to 2012 respectively.

Table 3.1: Trends in Health Insurance Fraud Over 5 Year Period

Year	No. of Fraudulent Claims	Value of Fraudulent Claims	Health Insurance Claims Paid	Actual (%)
2008	22	KES 20,838,000	KES 1,324,565,500	1.6
2009	34	KES 25,636,000	KES 1,553,125,978	1.7
2010	36	KES 76,527,000	KES 2,298,524,167	3.3
2011	24	KES 66,050,000	KES 2,253,749,677	2.9
2012	225	KES 208,315,800	KES 3,312,755,928	6.3
Total	**340**	**KES 397,366,800**	**KES 10,742,721,250**	**3.7**

The total number of cases reported over 5 year period was 340 while the value of fraudulent claims expressed as a percentage of the total health insurance claims paid was 3.7% which is lower than reported percentage of 8-10% from industry players interviewed. This was attributed to lack of effective documentation and limitation of recalling past transactions by respondents.

1.13 Forms of Health Insurance Fraud and Perpetrators

The survey sought to establish the various forms of health insurance fraud and who the perpetrators are. Table 3.2 shows that diagnosis manipulation; fee splitting and over servicing were identified as the most common forms of health insurance fraud perpetrated by health service providers. Membership substitution, dual membership and pharmacy related fraud were commonly perpetrated by members. A cross tabulation of the percentage number of fraud cases against perpetrators identified collusion between health service providers and beneficiaries as the major cause of fraud.

Table 3.2: Forms of Health Insurance Fraud by Perpetrators

Forms of Fraud	Health Provider	Brokers/ Agents	Member	Third Party Administrator	Insurer	MIPs	n	Mean
Diagnosis Manipulation	27	5	16	1	3	0	52	**9.0**
Falsifying claims or Altered Invo	10	5	11	3	2	0	31	**5.0**
Merchandise substitution	10	1	6	2	1	0	20	**3.0**
Generic instead of branded	13	2	4	2	2	2	25	**4.0**
Over servicing	17	2	7	1	1	1	29	**5.0**
Claim for non-covered benefits	8	3	12	2	1	0	27	**5.0**
Script alterations	7	4	9	3		0	23	**5.0**
Unauthorized billing	15	5	5	3	1	1	30	**5.0**
Servicing non members	14	3	11	2	3	1	34	**6.0**
Non-disclosure of prior ailments	7	2	18	1	3	0	30	**5.0**
Membership substitution	15	1	19	4	7	3	50	**8.0**
Dual membership	9	5	20	1	8	1	44	**7.0**
Up coding	13	4	9	2	8	4	40	**7.0**
Fee splitting	15	4	13	2	9	7	49	**8.0**
Waving Copays and Deductibles	15	1	19	2	3	0	40	**7.0**
Pharmacy related fraud	15	1	19	2	3	0	40	**7.0**

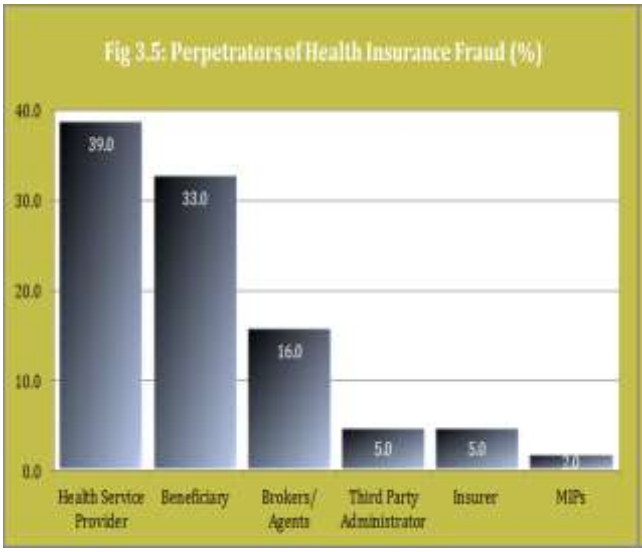
Respondents were required to rate the prevalence levels of various forms of fraud on a 5 point likert scale, where 5 is very high and 1 is very low. The result in table 3.3 below show that over servicing; provision of generic instead of branded; pharmacy related; non-disclosure of prior ailments; diagnosis manipulation and falsifying claims or altered invoices were the most prevalent forms of health insurance fraud.

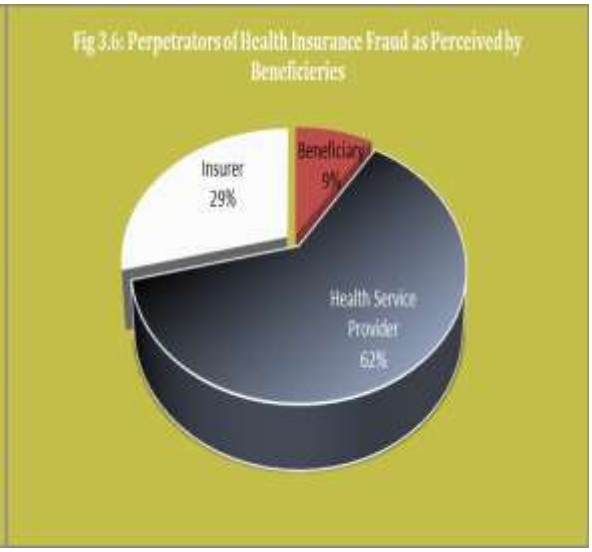
Table 3.3: Prevalence Rates of Various Forms of Health Insurance Fraud

Forms of Health Insurance Fraud	Very Low	Low	Moderate	High	Very High	Mean Rating
Over servicing	155	128	219	237	192	**3.3**
Generic instead of branded	135	162	216	244	144	**3.1**
Pharmacy Related	164	182	237	155	173	**3.0**
Non-disclosure of prior ailments	170	170	233	197	126	**2.9**
Diagnosis Manipulation	190	154	244	172	145	**2.9**
Falsifying claims or Altered Invoices	174	192	229	201	119	**2.9**
Servicing non members	214	187	232	178	89	**2.7**
Merchandise substitution	182	264	236	173	55	**2.6**
Claim for non-covered benefits	224	206	197	179	81	**2.6**
Membership substitution	222	213	213	169	71	**2.6**
Up coding	228	237	219	155	73	**2.6**
Unauthorized billing	241	241	223	143	54	**2.5**
Fee splitting	246	255	210	155	55	**2.5**
Script alterations	261	279	198	108	63	**2.4**
Waving Copays and Deductibles	264	246	191	146	55	**2.4**
Dual membership	291	245	200	127	45	**2.3**

See annex 1 for Explanations of the various forms of fraud

From figure 3.5, health service providers were identified as the major perpetrators of health insurance fraud at 39% and 62% by all respondents and beneficiaries respectively. Beneficiaries were identified as the second highest perpetrators (33%) by all respondents. However, beneficiaries identified insurers as the second highest perpetrators at 29% as illustrated in figure 3.6 below.





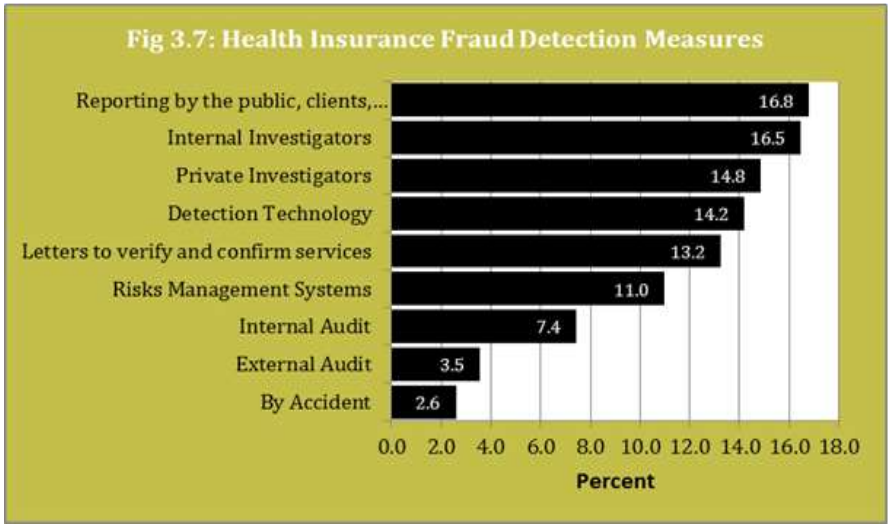
1.14 Financial Implications of Health Insurance Fraud by Perpetrators

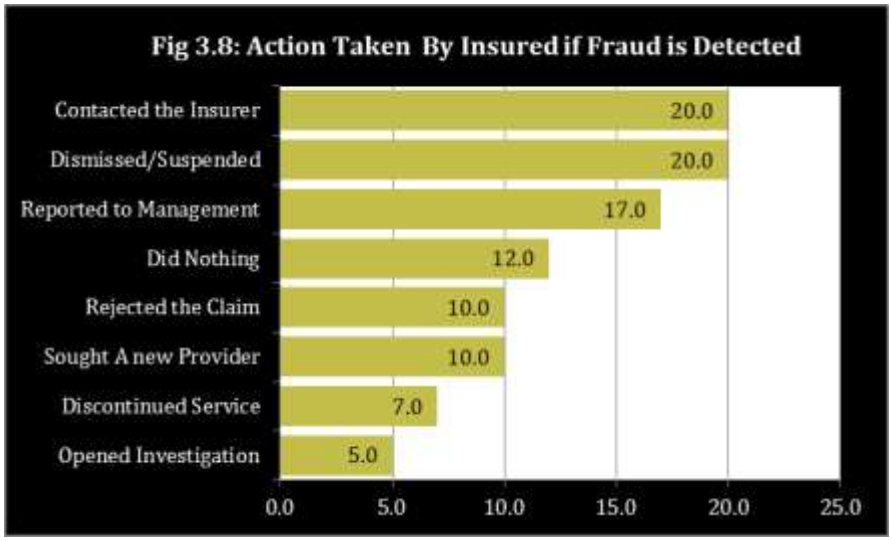
Respondents were asked to indicate the estimated total value of fraudulent claims for each category of perpetrators in the last financial year. The largest fraudulent claim incurred by respondents was related to health service providers at Kshs 15,860,000 in the last one year followed by MIPs and beneficieries at Kshs 15,600,000 and Kshs 10,840,000 respectively. The least fraudulent claims were those related to Insurer employees and others worth Kshs 3,620,000 and Kshs 590,000 respectively. on average, an estimated value of Kshs 8,457,142.86 is reported as fraudulent claims per year.

Further analysis of the costs incurred by the business as a result of incidents of health insurance fraud in the last one year was undertaken. Costs related to court proceedings (Kshs 54,600,000) were the highest followed by damages or destruction of databases and fraud detection or prevention initiatives at Kshs 9,960,000 and 9,200,000 respectively. An average, of Kshs 20,490,000 is incurred by respondents per year in dealing with health insurance fraud.

1.15 Health Insurance Fraud Detection & Handling

The results of the survey indicate that business leaders are aware of the need to address fraud and implement fraud prevention initiatives, but lack of a comprehensive and integrated approach to fraud risk management continues to pose a significant challenge. From figure 3.7, 65.9% reported that their organizations have health insurance fraud detection, handling and prevention policy. In terms of fraud detection, 16.8% of the fraud are reported by the public, clients, customers and business associates while 16.5% and are detected by internal investigators. A further 14.8% and 14.2% are





Insurer's Response to Fraud	Always	Sometimes	Never
Keep Quiet	14.3	7.1	78.6
Report to Applicable Authority	14.3	64.3	21.4
Black List Perpetrator	17.6	52.9	23.5
Negotiate Settlement	56.3	31.3	12.5
Stopped Payment	46.7	20.0	33.3

detected by private investigators and detection technology. However, 2.6% of health insurance fraud are detected accidentally. The results further show that when fraud is detected, 40% of respondents will either contact the insurer or dismiss/suspend the claims. Morover, only 5% will initiate investigations while 12% will do nothing about it.

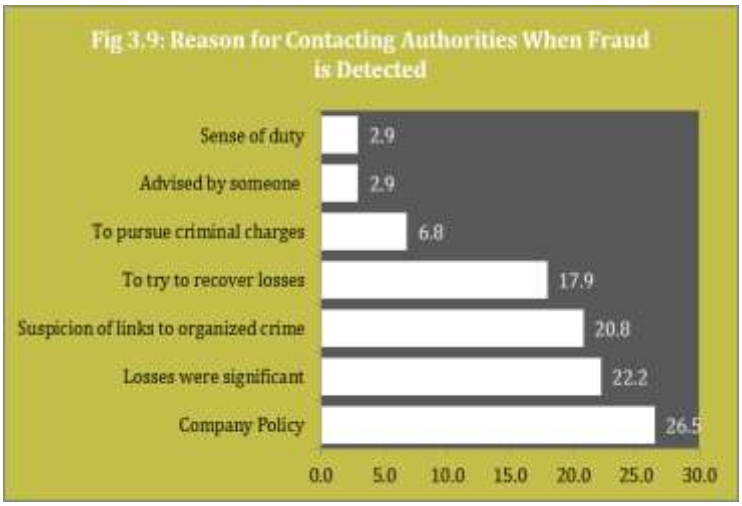
On the insurer's side, 21.4% will choose to be quiet about the fraud; 14.3% and 64.3% will always or sometimes report fraud to the authority; 70.5% will chose to negotiate settlement while 46.7% and 20% will opt to stop payments.

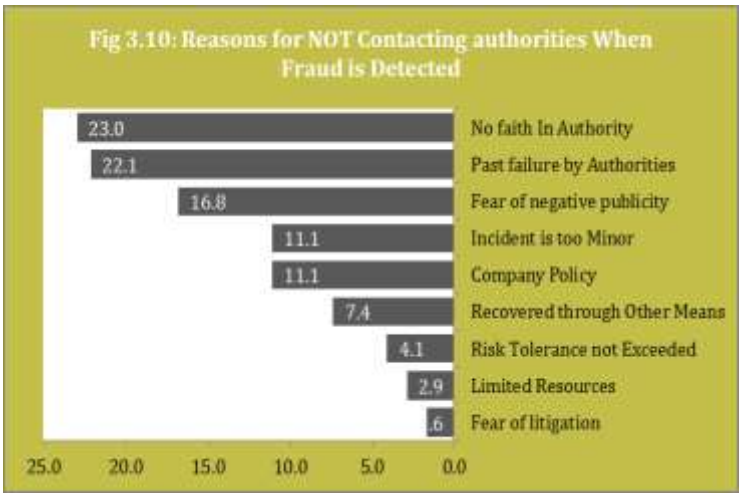
So far out of the 63 detected fraudulent cases, 36 (57%) have been Investigated and prosecuted while 27 (43%) of the cases have been investigated but not prosecuted.

Analysis of responses in figure 3.9 indicate that 26.5%, 22.2% and 20.8% report fraud when detected due to company policy, significance of the losses and suspicion of potential links to organized crime. Only 17.9% indicated their reporting to authority in order to recover losses while 6.8% do so to pursue criminal charges.

On the flip side, 23% and 22.1% do not report fraud when detected due to lack of faith in the authority and due to past failures by the authority. This was followed by fear of negative publicity at 16.8% while incident is too minor and company policy each contributed to 11.1% of the reasons why fraud is not reported to relevant authorities as illustrated in figure 3.10.

Failure of the legal system and fear of negative publicity were identified as the main factors that have resulted into cases of fraud not being reported when detected. The industry should report all cases of fraud if it is to be managed.





A survey of the factors that contributes to occurrence of fraud identifies collusion between beneficieries and health service providers; lack of sophisticated interrogation/detection software, poor internal controls and poorly trained claims processing staff as the main factors contributing to fraud. This was followed by collusion between health service providers, beneficiery ignorance and lenient approach by regulatory bodies as illustrated in table 3.4 below.

Table 3.4: Factors contributing to Health Insurance Fraud

Factors	Not Important	Somehow Not Important	Important	Somehow Important	Very Important	Mean
Collusion between beneficiery and health service provider	81	77	243	149	336	**3.7**
Lack of sophistication interrogation/ detection software	66	84	245	191	296	**3.6**
Poor internal controls	75	83	234	189	306	**3.6**
Poorly trained claims-processing staff	68	101	269	170	282	**3.6**
Beneficiery Ignorance	79	81	257	200	260	**3.5**
Collusion between service providers	82	94	251	207	258	**3.5**
Lenient approach by Regulatory bodies	61	113	271	193	242	**3.5**
Collusion between service provider and administrator staff	103	109	231	189	250	**3.4**
Benefit structure	96	107	305	174	187	**3.3**
Electronic Data Interchange (EDI)	104	148	265	167	196	**3.2**
Collusion between beneficiery and administrator staff	118	128	268	175	185	**3.2**
Collusion amongst administrator staff	114	126	256	146	175	**3.2**

1.16 Health Insurance Fraud Prevention

A survey of the practices employed in the industry to prevent and minimize fraud reveals that fraud awareness creation among employees, members and industry players (31.9%) and background checks on clients using credit bureau information and address verification (15%) are the most used measures for preventing fraud by the industry as shown in figure 3.11. Pre-employment screening of employees, strong internal controls and informant/whistle blower were rated the least used measures at 3.2%, 4.4% and 9.1% respectively.

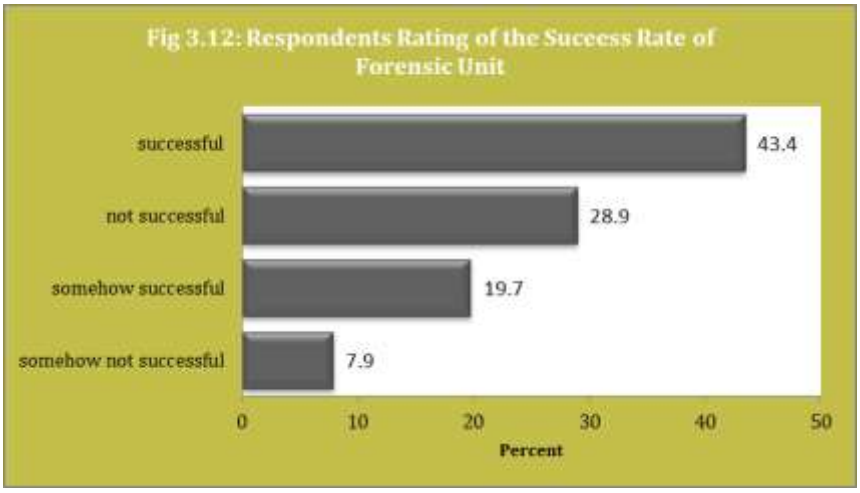
Table 3.5: Effectiveness of Health Insurance Fraud Prevention Measures

Means of reducing Fraud	Ineffective	Somehow ineffective	Effective	Somehow Effective	Very Effective	Mean
Maintaining a fraud policy	59	41	248	166	391	**3.9**
Maintaining a code of conduct	27	66	241	192	389	**3.9**
Detection software	34	44	226	187	418	**4.0**
Forensic Investigative Review	62	74	237	198	331	**3.7**
Fraud Awareness Programmes	24	49	306	213	320	**3.8**
Comprehensive ethics programme	36	99	293	204	263	**3.6**
Screening staff members	74	128	262	193	242	**3.4**
Electronic alert to members on claims	38	82	252	169	352	**3.8**
Reviewing and improving controls	27	49	275	217	323	**3.9**
Training courses on Fraud	57	71	264	187	318	**3.7**
Increasing budget of Investigative function	110	141	245	193	200	**3.3**
Quality control or claims-vetting of paper claims	45	93	241	210	319	**3.7**
Screening of service providers	47	92	249	208	316	**3.7**
Introduction of hotline	88	124	243	198	258	**3.5**
Screening of new members	74	132	278	215	211	**3.4**
Incentives for whistle-blowing	101	123	246	162	260	**3.4**

The survey further sought to establish respondents perception on the effectiveness of various measures of reducing fraud in health insurance on a five-point likert scale, where 5 is very effective and 1 being not effective. The results presented in table 3.5 show that use of fraud detection software, maintaining a fraud policy and a code of conduct, comprehensive ethics programme; electronic alerts to beneficiaries, reviewing and improving controls; training on fraud, quality control or claims-vetting of paper claims; screening of service providers; and forensic investigative review were considered to be effective measures for reducing incidences of health insurance fraud in the industry.

1.17 Application of Forensic Technology in Fraud Detection and Prevention

Forensic technology tools has been recommended as a robust anti-fraud regime that provides timely information to identify areas of risk and allow organizations to react and mitigate those risks inherent in health insurance industry. The survey sought to establish the proportion of respondents with a dedicated forensic unit to detect and prevent fraud. The results show that 30.2% of respondents indicated that their organizations have dedicated forensic unit. For respondents that indicated that their organizations have forensic unit, 87% have been existence for more than 2 years; 41% uses external investigators; 32% have their forensic unit represented in management meetings and 35% of the forensic units have an average budgets of Kshs 937,500.75 per year.



Majority, 63.1% were in agreement that the unit was successful or somehow successful. An estimated total of Kshs 101,300,016 have been recovered in the past one year. On average, Kshs 9,209,092.36 is recovered by each forensic unit in the last financial year.

Majority of respondents, 60% were of the opinion that health insurance fraud is likely to increase due to the following factors

Reasons Why fraud will increase	Frequency
New techniques of Fraud/Advanced technology	102
Corruption andCollusion Betweeen Providers and Beneficiaries	70
Lack of Proper Legislation/Rules and Regulation are not Implemented	83
Economic Hardship, poverty and unemployment	59
Lack of good will by industry Players	20
Ignorance and apathy towards fraud	18
Lack of Forensic Unit	6

4.0 CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

The number of health insurance fraudulent claims in Kenya increased from 22 in 2008 to 225 in 2012 with slight decrease recorded in 2011. The value and total amount paid for health insurance fraudulent claims increased by an average of Kshs 46,869,450 and Kshs 497,047,607 per year from 2008 to 2012 respectively. The average value of fraudulent claims as a percentage of the average total health insurance claims paid was established to be 3.7%.

The survey established that 28% of the respondents had come across suspicious health insurance claims while 21% had detected fraudulent claims in the last one year. The most type of health insurance fraud include diagnosis manipulation; membership substitution, fee splitting, over servicing; provision of generic instead of branded; pharmacy related; non-disclosure of prior ailments; diagnosis manipulation and falsifying claims or altered invoices. Collusion between beneficieries and health service providers; lack of sophisticated interrogation/detection software, poor internal controls and poorly trained claims processing staff as the main factors contributing to fraud in Kenya. Health Service Providers were identified as the major perpetrators of health insurance fraud at 39% and 62% by all respondents and beneficiaries respectively.

Business leaders were aware of the need to address fraud and implement fraud prevention initiatives with a good number of organizations (65.9%) having health insurance fraud detection, handling and prevention policy. Awareness creation among employees, members and industry players and background checks on clients using credit bureau information and address verification are the commonly used measures for preventing fraud by the industry. 30.2% of organizations have dedicated forensic unit with an average budgets of Kshs 937,500.75 per year An estimated total of Kshs 101,300,016 have been recovered in the past one year. So far out of the 63 detected fraudulent cases, 36 (57%) have been Investigated and prosecuted while 27 (43%) of the cases have been investigated but not prosecuted. However, lack of faith in the authority; past failures by the authority; fear of negative publicity and company policy were established to hinder reporting of fraud when detected.

4.2 Recommendations

1. A comprehensive and integrated approach to fraud risk management should be developed and implemented to address the increasing challenge posed by fraud. Companies must establish a well-defined whistle-blowing policy, periodic fraud risk assessment, third-party due diligence, data analytics tools to identify red flags, and automate processes to deal with fraud.

2. In view of the low appreciation of the impact of fraud amongst beneficiaries, there is a need for nationwide outreach programs to sensitize beneficiaries on the level and impact of fraud in the sector.

3. AKI should facilitate the design and implementation of Fraud detection, prevention and mitigation capacity building programs for insurers' and third party administrators' staff as well as health service providers staff to equip them with requisite capability for detecting and handling fraud.

4. Forensic Anti- Fraud Unit should be established at AKI to provide specialised forensic anti-fraud regime services to AKI members. Use of fraud detection software and computerized data bases (index systems) that identify patterns of suspected activity including false claims and payment duplication should be developed and implemented to detect and mitigate fraud.

5. Fraud policy, code of conduct; comprehensive ethics programme should be developed and imlemented including issuing of electronic alerts to beneficiaries, strengthening of internal controls; screening of service providers; and forensic investigative review as effective measures for reducing incidences of health insurance fraud in the industry.

6. Develop and implement a multi-agency advocacy agenda[9] to facilitate legal and governance reforms and build strategic partnerships with law enforcement agencies or working relationships across multiple disciplines in managing health insurance fraud. This should include public private partnerships arrangements but under a carefully crafted legal framework to safeguard the interests of each party.

7. Plan and organize platforms for sharing information and experiences on fraud including web based platforms for sharing database of perpetrators and emerging challenges with stakeholders.

8. Design comprehensive market driven health insurance products and standardize products in terms of the scope and value of health insurance coverage across insurers as well as authorization procedures.

9. Promote joint initiatives/synergy and encourage sharing of information among insurers and strengthen insurer - health service provider relationship through regular meetings, information sharing and exchanges related to health insurance fraud management.

[9] An integrated plan of action involving all stakeholders to raise awareness and manage the impact of fraud on the industry

ANNEX 1: Explanations of the Various Forms of Fraud

1. **Up coding-** intentionally use of a higher-paying code on the claim form for a patient to fraudulently reflect the use of a more expensive procedure, device or medicine than was actually used or was necessary

2. **Over-servicing** - is the result of patients who visit their Doctors more regularly than they need to, they, in a sense, see it as a free service. Doctors are also processing more patients to increase their revenue, for example, suggesting further checkups that may not be essential.

3. **Fee Splitting** -is the practice where a medical professional splits their professional fees for a referral. This is done is ensure the fees charged for any consultation or service falls below the prescribed limit set by the Insurer.

4. **Membership Substitution** – Replacing the initial beneficiary registered at the point of securing cover in order to benefit from the cover e.g. substituting a member of the family who was not under the insurance cover due to increased vulnerability of the unregistered member of the family relative to the ones on the cover.

5. **Waving Copays and Deductibles** –where wavers are offered to beneficiaries in cost sharing arrangements and higher fee is claimed from insurers or the deterrents to access service is waved.

6. **Dual membership** – membership to 2 or more schemes

7. **Merchandise substitution** – prescriptions are made for specific medicinal drugs but substitute goods e.g. Diapers are given to beneficiaries instead and claims made.