Why fraud is a major threat to your SME's health costs (and how to beat it!)

Here in Kenya, insurance fraud is never far from the headlines.

Medical insurance fraud is, in particular, attracting increasing attention. Some industry experts are pointing to it as a key cause of escalating losses in the medical insurance sector. And while it's hard to quantify the full extent of the problem, it's clear that it's having a negative impact on the industry.

It also has an inevitable effect on the price of premiums, which can be a worry for cost-sensitive small and medium-sized (SME) businesses. So let's take a look at the extent of the problem and what SMEs can do to help tackle it.

The scale of Kenya's medical insurance problem

In a recent interview, chairman of the Association of Kenya Insurers (AKI) Patrick Tumbo revealed that, despite efforts to quash the problem, an estimated 20% of medical insurance claims lodged in Kenya are fraudulent.

At 75%, the claims/premiums loss ratio for Kenya's medical insurance sector is now 5% higher than any other insurance sector. This is despite a steady increase in medical insurance premium prices, which rose by 10% in 2016 and are expected to go up by 12.5% this year.

Of course this is having a knock-on effect on the profitability of insurance providers. The industry experienced a net total loss of KES 621,635,000 (USD 6m) in 2016 – more than a fivefold increase from 2015.

Real increases in the costs of healthcare, particularly hospital treatment, are of course a major contributor to the insurers' increasing outgoings. However, various forms of medical insurance fraud could be making the situation much worse.

According to the Kenyan Insurance Regulatory Authority (IRA), insurance fraud not only pushes up the costs of doing business for insurance companies, forcing them to continue increasing premiums, but is also a leading cause of insolvency.

What does medical insurance fraud involve?

Medical insurance fraud may be committed by claimants, medical providers, insurance company employees or intermediaries. Some may be acting alone but many cases will involve complex collaborative deceptions.

Suspected fraud was the reason that one insurance company recently terminated contracts with eight health facilities registered to provide care on their health insurance schemes for teachers. These included medical centres and clinics, a hospital and nursing homes. It appears that some of the fraud was initiated by the teachers themselves.

The issues picked up included claims submitted for patients who were never treated, billing for treatment already covered by the National Hospital Insurance Fund and approval of unnecessary medical procedures.

In 2013, the AKI commissioned a major survey to gauge the true prevalence of health insurance fraud. It canvassed 1,000 people, including beneficiaries, health service providers, and employees at insurance companies and related organisations. It found that 28% of respondents had come across suspicious insurance claims and 21% had spotted fraudulent claims over the past year.

According to the survey, the most preventable types of medical insurance fraud were:

- Over-servicing (medical providers offering unnecessary services to push up revenue)
- Charging for branded drugs but providing generic versions
- Other pharmacy-related fraud
- Non-disclosure of prior ailments
- Diagnosis manipulation
- Falsifying claims or altering invoices

Interestingly it identified collusion between health service providers and beneficiaries as the major cause of fraud.

Regulatory crackdown

In 2011 the IRA established the Insurance Fraud Investigation Unit (IFIU) in association with the police, to investigate instances of insurance fraud. At the time it was estimated that 35% of all medical insurance claims were fraudulent.

The IRA's 2015 quarterly report for Q4 included a special focus on insurance fraud. This highlighted that the number of confirmed cases in the medical arena had more than doubled, going from seven in 2014 up to 18 in 2015, totalling KES 1,740,000 (USD 16,910).

However it's important to note that these statistics only include cases reported to and verified by the IFIU, so they may not reflect the full volume of fraud being committed.

The AKI Medical Insurance Fraud Survey suggested that while 14.3% of insurance company workers would always report any suspicions of fraud and 63.4% would sometimes report it, 21.4% would choose to keep quiet. Reasons given for not reporting fraud included lack of faith in the relevant authorities and fear of negative publicity.

So what can your SME do?

As a company with a number of health insurance policies in place, you're in a strong position to make a difference. While you can't do much about the impact of fraud on a national level, it is within your power to do something about it on a smaller scale.

Put simply, if your staff are submitting a lot of expensive claims, it will push your health insurance premiums up. While there may be genuine reasons for a high level of claims, it's important to be aware that it could indicate fraudulent activity, either on the part of your employees, or medical providers, or both.

Simply making your employees aware of the issue will help. Even assuming all your staff are honest and would never consider making a fraudulent claim, drawing their attention to the fact that medical providers may not always be so honest will ensure they keep their eyes open for potential problems.

Here are a few suggestions to help you tackle the issue in your organisation:

Educate your employees

Consider running a talk or workshop or distributing guidance notes to educate employees on the issue. Here are some key points to include:

- Once an employee has reached their benefit limit for the year, they will have to foot any further bills themselves, so it's in their interest to keep an eye on the level of claims they are submitting.
- However they occur, high levels of claims can push up premiums. You could point out that if the premiums become unaffordable you may need to scale back the cover you provide.

- Make sure employees are clear about who their policy covers and why it's important that they don't allow anyone else to seek medical care using their coverage.
- It's vital to be open and honest when completing medical insurance application and claim forms and not to submit false, incomplete or misleading information. Any suspicion of dishonesty could lead to claims being denied and even the whole policy invalidated, which could make it difficult to get cover in future.
- If an employee is involved in medical insurance fraud, whether alone or in collusion with medical providers, they are increasingly likely to be caught out. This could put their job in jeopardy and make it harder to find employment in the future.
- Encourage employees to ask for the reason behind tests and procedures that doctors suggest, to check that they are actually necessary.
- Rather than paying bills themselves then claiming the money back, employees should ask medical providers to submit their invoices to the insurance company for direct settlement. However, they should ask for a fully itemised copy and check that it accurately reflects the care they have received, including tests, procedures and medication – then question anything unexpected.
- Warn employees not to sign anything a medical provider gives them without checking it first for any unexplained gaps, such as a missing diagnosis, or additions including tests they did not undergo.
- If they suspect they may have come across a case of medical insurance fraud, employees should report their concerns to HR, who can then investigate and refer the issue to the IFIU if appropriate.

Monitor usage

There are two key areas of monitoring for you as the employer:

- Keep an eye on the claims your employees submit. If a claim looks unusually high or a particular employee seems to be racking up a lot of claims, it's time to investigate.
- Check whether one particular medical provider is submitting excessive claims. If you suspect a provider may be over-servicing or artificially inflating their bills, consider reporting them to the IFIU and removing them from your panel of preferred providers.

Choose providers with care

Taking great care in selecting a provider will also play a major role in protecting against fraud:

- Choose an insurance provider with a good reputation and track record. A broker or insurance adviser will be able to help you.

- Check whether the insurers you're considering have a dedicated fraud investigation team – this will indicate how seriously they take the issue.
- Ask whether your top choice of insurer insists that medical providers use biometric technology to identify patients. This will help to avoid the possibility of staff letting friends or family use their medical benefits.

From local to national – making a difference

Taking steps such as these may help to reduce your company's exposure to medical insurance fraud and keep your premiums in check. And if more employers take a diligent approach and encourage staff to make a stand against insurance fraud, this could soon start to improve the national picture.

About the author:
Alniz Popat, Founder and CEO at Lifecare International

Alniz founded Lifecare 20 years ago in his native country Kenya to address the growing need for individual and corporate health insurance solutions. Soon thereafter Alniz expanded into Dubai, and in recent years he added yet another office with the establishment of Lifecare's presence in Qatar. As CEO of Lifecare Alniz is responsible for the strategic direction of the business, and it is his drive and passion to help people get the right healthcare through affordable insurance that has resulted in Lifecare's strong growth over the years. Today Alniz proudly oversees 100 caring and passionate employees who work tirelessly to deliver an excellent service to the 1,200 businesses and 25,000 members who are part of the Lifecare client portfolio. Alniz is a graduate of the University of Western Ontario, Canada in Finance and Economics, and is an active member of the Young Presidents' Organisation in Kenya, and the World Presidents' Organisation in the United Arab Emirates.