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Nikolaienko Serhii

PhD, Senior Lecturer

Department of Economics, Management and Marketing

Zhytomyr Ivan Franko State University

Ukraine

FRAUD IN HEALTH INSURANCE AND WAYS TO AVOIDANCE

This article substantiates the importance of investigating such an insurance market problem as fraud in the insurance market. The reasons that encourage fraud in the insurance market are analyzed. The research works of many domestic and foreign scientists are actively investigating the issues of fraud in the field of insurance. Different approaches to the term "insurance fraud" in domestic and foreign practice are defined. The classification of fraudulent actions in the insurance sphere is considered on different grounds: depending on the subjects and stages of preparation and validity of the insurance contract (at the stages of concluding the insurance contract, during the insurance contract and which are carried out by concluding the insurance contract, after the occurrence of the insured event). The motives of insurance fraud are investigated. The probable fraudulent actions in health insurance on the part of the participants of the insurance market are analyzed: insurers, insurance intermediaries. The fraudulent actions of health care workers were examined separately. Modern ways to avoidance insurance companies with insurance fraud are disclosed, such as explanatory work with assisting companies and clinics, application of additional warnings and conditions in insurance contracts, checking of compliance with the billed prices, careful checking of medical documents before the insurance policy and after the insurance event. The fraudulent actions in health insurance travelling abroad are considered. Overseas experience in combating insurance fraud has been explored, such as Canada, the USA and Germany. Recommendations on mechanisms for ensuring counteraction to insurance fraud in the domestic insurance market have been developed. The results of the study can be used to further explore the health insurance market and other risky types of insurance.

Keywords: fraud, health insurance, insurance fraud, insurance contract, insurer, insured person.

**ШАХРАЙСТВО В МЕДИЧНОМУ СТРАХУВАННІ ТА МЕТОДИ
БОРОТЬБИ З НИМ**

У даній статті обґрунтовано важливість дослідження такої проблеми страхового ринку як шахрайство на ринку страхових послуг. Проаналізовані причини, що спонукають до шахрайських дій на ринку страхування. Досліджено наукові роботи багатьох вітчизняних і зарубіжних учених, що активно досліджують питання шахрайства у сфері страхування. Визначено різні підходи до терміну «страхове шахрайство» у вітчизняній та зарубіжній практиці. Розглянуто класифікацію шахрайських дій в страховій сфері за різними ознаками: залежно від суб'єктів та етапів підготовки і дії договору страхування (на етапах укладення договору страхування, під час дії договору страхування та які

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здійснюються шляхом укладення договору страхування, після настання страхового випадку). Досліджені мотиви здійснення страхового шахрайства. Проаналізовані ймовірні шахрайські дії у медичному страхуванні зі сторони учасників страхового ринку: страховиків, страхувальників, страхових посередників. Окремо розглянуто шахрайські дії працівників медичних установ. Розкрито сучасні методи боротьби страхових компаній зі страховим шахрайством, такі як роз'яснювальна робота з асистуючими компаніями та клініками, застосування додаткових застережень та умов в договорах страхування, перевірка відповідності цін у виставленому рахунку, ретельна перевірка медичних документів до оформлення страхового полісу та після страхового випадку. Розглянуто шахрайські дії у медичному страхуванні виїжджаючих за кордон. Досліджено закордонний досвід боротьби зі страховим шахрайством на прикладі Канади, США та Німеччини. Розроблено рекомендації щодо механізмів забезпечення протидії страховому шахрайству на вітчизняному страховому ринку. Результати дослідження можуть бути використані як у подальшому вивченні ринку медичного страхування, так і інших ризикових видів страхування.

Ключові слова: шахрайство, медичне страхування, страхове шахрайство, договір страхування, страховик, застрахована особа.

Problem formulation. Insurance offenses are one of the most serious problems of insurance companies around the world. In the world market, losses resulting from undetected scams account for an average of 15-20% of the total amount of the collected insurance premiums. However, one should not forget that insurance offenses adversely affect not only the insurance companies' activities, but also bona fide insurance market participants, in particular, insurers.

The vast majority of insurance companies deal with such a criminal phenomenon as fraud. The losses to insurance companies as a result of fraudulent actions of dishonest clients (insurers) are very significant and vary from 1 to 2% of the amount of contributions received. However, among insurers it is accepted that from 10 to 20% of all insurance payments are accounted for by insurance cases prepared and staged by fraudsters.

Fraud in the insurance sector is large-scale and is gaining momentum every year. The interest in carrying out illegal actions by economic entities on the insurance market is conditioned by the tendency of the insurance sector dynamic development, state regulation imperfect system and insurance activity specificity. By the number of insurance crimes in the domestic market, the top leaders are health insurance and insurance traveling abroad.

Analysis of recent research and publications. Fraud issues in the insurance field, are actively investigated by Algazin A. I., Andrushchenko L. V., Antonov I. O., Balina S. N., Baranovsky O. I., Galaguzha N. F., Glukhov A., Gutorova N. O., Yermoshenko A. M., Zhabinets A. Y., Zhylykina M. S., Kalyuzhnyi R. A., Korystin A. E., Kogutych I. I., Larychev V. D., Litvinenko V. I., Plastun V. L., Radionova T., Suschenko V. D., Chernyavskyy S. S. and many other domestic and foreign scientists. The most discursive issues remain the means of avoidance insurance fraud and, in particular, their prevention.

Formulating the goals of the article. The purpose of the article is to identify the fraud sources, the motives for its implementation, to analyze the foreign experience of avoidance crime in the insurance market as well as to develop theoretical and practical recommendations on mechanisms to counteract insurance fraud in the domestic insurance market.

Presenting main material. For a long time insurance fraud has not been a problem in the Ukrainian insurance market. This was due to the fact that it was only developing and potential fraudsters did not yet understand how to make money. With the insurance market development the increasing demand for insurance services and the growing number of clients, the insurance business has become more attractive to all kinds of adventurers and scammers.

The most common criminal offense in the insurance industry is a fraud. There are different approaches to define this phenomenon. Extensive interpretation of the “insurance fraud” concept prevails in the national literature. Insurance fraud refers to the “unlawful behavior of the insurance contract subjects aimed at obtaining an insurance indemnity by the policyholder by fraud or misuse of trust or making less than is necessary in a normal risk analysis, insurance premium, and ordering important information during the conclusion or during the period of the insurance contract validity as well as the insurer’s refusal to pay insurance indemnity without the grounds or guarantees specified in the law and insurance rules owing to which the contract’s subjects have an opportunity to get his grant in

its favor illegally and without any reasons”. In other words, insurance fraud refers to all kinds of unlawful acts in the insurance industry, regardless of their subjects, criminal presence, etc. [9].

Plastun V. L. states that insurance fraud is the unlawful behavior of the insurance contract subjects, as a result of which the insurance contract subjects are able to illegally and free of charge to raise capital in their favor [5].

Baranovsky O. I. approaches the definition of insurance fraud otherwise: insurance fraud is the acquisition of insurance compensation by the policyholder by deception or abuse of trust, or making less than necessary, with a normal risk assessment, insurance premium, and withholding important information at the conclusion or during the insurance contract’s validity period [1, p. 401].

A different approach to the fraud concept in the insurance field has been adopted abroad. There, insurance fraud is considered as a deliberate crime aimed at deceiving an insurance company and committed by the insured (beneficiary) for the purpose of unjust enrichment at the expense of the insured by distorting information about the object of insurance, taking actions aimed at the occurrence of an insured event or increasing the amount of insurance indemnity [9].

Fraudulent actions can be carried out at different stages of preparation and the period of validity of the Insurance Contract:

- fraudulent actions at the time of the insurance contract conclusion;
- fraudulent actions during the insurance contract period of validity;
- fraudulent actions carried out by concluding an insurance contract after the occurrence of an insured event [2].

At the stage of contracting, illegal actions by potential fraudsters can be directed to:

- concealment of material circumstances that are relevant for determining the risk degree of an insured event and determining the insurance tariff’s size, the notification of the deliberately false information;

- conclusion of the contract after the actual occurrence of the insured event;

– conspiracy with the insurer's representative, which concludes the contract, for the joint execution of all the above actions; inclining the insurer's representative to breach his / her duties.

During the period of validity of the contract, fraudulent actions (inactivity) are:

– requesting for services not covered by this type of insurance coverage and their unlawful receiving (for example, in consultation with a health insurance doctor);

– failure to notify the insurer about material circumstances that is affecting the risk increasing for the insured person;

– violations of the rules of insurance, safety, etc.

When applying for insurance coverage, fraudulent actions may include:

– deliberate actions aimed at the occurrence of an insured event or an increase in its negative consequences;

– distortion of information about the occurrence circumstances of an event, which is defined as an insured event, its causes and consequences, the amount and nature of the caused losses;

– concealment of circumstances indicating that the insurer (the beneficiary) could have prevented the insured event or reduced its consequences;

– deliberately false message about the insured event;

– staging and imitation of an insured event;

– inclusion in the loss amount of treatment costs that are not necessary as a result of the insured event,

– submission of invalid or forged documents, including insurance policies, to confirm the insured event;

– making corrections in the documents (including the insurance policy): the insured event dates or the validity period of the contract, amounts, conditions of insurance, etc.;

– conspiracy with the insurer’s experts, carrying out the examination and assessment of damage, involved in the insurance act drafting, making payment decisions, etc.;

– conspiracy with third parties to sign documents that are submitted to confirm insurance case [10].

The average citizens’ attitude to insurance fraud is noteworthy. A number of sociological surveys in Ukraine indicate that the vast majority of those interviewed have quite “normal” attitude to a phenomenon such as fraud against the insurance company. They believe that insurance companies deserve it because they are partly deceiving their own clients. Many are tired of waiting for compensation, which is sometimes accompanied by legal red tape. Others, justifying insurance fraud, call the large sums paid for insurance. Unfortunately, many citizens have a persistent stereotype that the fact of submitting false information to an insurance company is not a fraud [4].

The potential opportunities’ analysis of the participants’ fraudulent actions of the Ukrainian insurance market is:

1) insurers who carry out the insurance process:

– carrying out insurance activities by organizations that have not undergone the registration and / or licensing procedure;

– issuance of fictitious insurance policies and damage to insurers in the form of the possibility deprivation of receiving insurance payment;

– development by the insurer of insurance rules and conditions, which makes it possible not to make insurance payments and to transfer responsibility to the insurer [5];

2) insurance intermediaries who take part in insurance:

– full or partial assignment of policyholders’ insurance premiums;

– theft of insurance premiums by insurers without registering insurance contracts;

– drawing up bogus insurance policies;

- agreement with the policyholder about the insured event;
- the insurance object's revaluation;
- submission of false information about the insured event to the insurance company;

3) insurers as buyers of insurance services:

- failure to notify all circumstances that are relevant to determining the insurance risk;

- falsification of the insurance event's occurrence fact;

- deliberate actions contributing to the insured event's occurrence;

4) professional risk and loss assessors:

- revaluation or underestimation of losses due to an insured event;

5) bodies that control the insurance activity.

All named market entities interact with each other and potentially engage in fraudulent activity, depending on the intentions, authority and conspiracy.

Among the most popular motives for the insurance fraud implementation are the following:

- desire to take advantage of the case to obtain maximum compensation;

- desire to repay the money spent on insurance premiums;

- benefit when obtaining compensation is the sole source of income;

- the possibility of not making insurance payments and shifting responsibility to the insured;

- full or partial appropriation of the insurers' insurance premiums for the additional income purpose (from the side of the insurance company's employees) [3].

The main drawback of health insurance is the refusal of insurers for any reason to pay the policyholder's treatment. The most common reason is that the client has not been warned about their chronic illnesses (they are not generally covered by health insurance).

Financial offenses by the insurance companies' employees and their intermediaries are also quite common today. This is primarily due to the activities of unregistered or non-existent insurance agents who sell counterfeit insurance policies and do not list the collected insurance premiums by the insurer on whose behalf they act [8]. This problem is due to the lack of a proper licensing and accreditation system for domestic insurance intermediaries. Today, virtually any person can become an agent of an insurance company.

Fraud on the part of medical institutions, unlike the abuse of the insured, is spreading quite actively. It facilitates scams and access to cash, because about 95-98% of insurance payments, according to insurers, goes directly to the accounts of health and wellness institutions. Clinics that are serving health insurance holders may receive 10-20% of the entire amount of voluntary health insurance coverage as a result of fraudulent activity. Ordinary insurers, according to experts, as a result of fraudulent operations receive less than 1% of insurance payments from health insurance.

In health insurance, the most common occurrence is an accident's staging, and often it is not without the doctors' "help". For the examination, to the insurance company someone else's x-rays and bills for services rendered are sent, fictitious diagnosis is prescribed, expensive drugs that are not needed for the patient, etc. are prescribed. There are cases when the insurance policies are used by relatives of insurers, purchase of medicines for friends and acquaintances. There are often cases when healthy people are misdiagnosed, remove non-existing neoplasms, and almost healthy teeth are depopulated. Many fraud schemes, according to experts, doctors themselves, without objective reasons, increase the bills for examinations and treatments. Doctors often prescribe expensive medicines on their own initiative, as many of them informally cooperate with pharmaceutical companies. When it comes to thousands of insureds, it is impossible to check every insurance event, and a thorough examination is too expensive. While selective control of the desired effect does not give [6].

As practice shows, in most cases, insurance crimes are committed by the insurers together with the insurance company's employees. Such an employee, who knows the information about the activities of the company "from the inside", knows how to help the policyholder to forge the relevant documents, what information to hide and how to present it all. As a result of this agreement, the employee receives a certain percentage of the fraud with the amount paid by the insurance company. Often there are cases when fraudsters are not assisted by ordinary employees, but even by the insurance company's management.

At the same time, the abuse of insured people in health insurance is most often associated with imitation of diseases, treatment of people who are not insured under this contract, obtaining services that are not provided by this policy. An insurance program, for example, covers emergency dental care, and a person complains of acute toothache to an insurance company to replace or restore an old dental filling. Interested in the flow of clients and obtaining income, the dentist confirms the critical condition of the patient and, accordingly, the need for his treatment, thereby going on a "collusion" with the client.

According to insurers, the fraudulent actions of Ukrainians are often pushed by a pathological desire to cure all diseases through a medical policy. The tendency to accumulate medicines is also pronounced. Very often, insurers cannot refuse to deliver new medicines free of charge, even if they already have the same medications left over from their past doctor's appointments.

It happens that people turn to an insurance company for compensation for an injury that they received twenty years ago. And they succeed, of course to turn this scam over because it is seldom possible to determine the age of injuries that affect your future health. Moreover, to compensate for this type of insurance as "hearing loss", you need nothing but a doctor's certificate. It is also easy to simulate fractures, dislocations and neuralgic diseases. And they are, in addition, very expensive to examine.

Quite often, and without much effort, insurers enter into an agreement after the insured event. There is a false certificate of normal health. An insurance policy is issued, and a week later, the insured seizes pneumonia with complications (which he/she had before the registration of the policy).

In order to receive monetary compensation from an insurance company, fraudsters go even to cause themselves real injury or become a “living corpse”. Fraudsters are bribing a local doctor who signs a citizen’s death certificate. They can even play the funeral themselves and then present to the insurance company a video with this action as evidence.

Recently, experts estimate that the number of fraudulent actions in health insurance has increased. Many Ukrainians simply do not have enough money to get medical care, and more experienced are physicians and policyholders who know what to say when contacting an insurance company to get a service not covered by the insurance program. However, as an abuse of health insurance is the most difficult to prove, insurers rarely go into public conflict with a client or health care institution.

Insurance companies try to reduce the percentage of fraudulent transactions through explanatory work with assisting companies and clinics. The insurance companies employ curatorial physicians who evaluate the appropriateness of a particular treatment scheme, prescribed medication, and their relevance to the diagnosis. Minor medical malpractice abuses warnings and additional terms in insurance contracts. With respect to the insured person who has transferred the policy to a third party, the insurance contract terminates. Insurers try to check carefully that the prices on the invoice and the clinic’s invoice match. However, the conspiracy of patients and doctors is rarely revealed.

To prevent insurance crimes, first of all, it is necessary for insurance companies to establish an effective system of insurance crimes investigation. So in every insurance company there is a corresponding department, which deals with

the investigation of crimes, but the cases of fraud in this area for some reason does not decrease.

Therefore, it is necessary to check carefully the documents which the person comes to get insurance with, health status, documents issued by medical institutions, conduct an independent medical examination of the insurers. It is necessary to study in detail the documents that the insurer brings to pay the insurance indemnity: check the presence and confirmation of the diagnosis, the presence of the relevant doctors' signatures and the medical institutions' signets, etc.

The state, with the help of insurers, needs to create a single database of insurers, which will display information about crimes committed by insurers, in each insurance company to create units that will monitor the sale of insurance policies, check (from the database of insurers) of potential fraudsters. Unfortunately, we do not even have official statistics on crimes committed in the insurance industry. Such statistics are kept only in the inside the insurance companies, maybe not all, and they are not officially released.

Insurance companies need to carefully select the appropriate staff to be assigned to the work, not to conclude insurance contracts solely to obtain a percentage of their contract or to obtain a percentage of the insurance compensation received by the fraudster.

In Canada, the Insurance Bureau of Canada was set up to avoid the insurance fraud. This service has deployed an agency network throughout the country: 75 agents work with 200 insurance companies to help them to investigate doubtful claims. In the USA, a special unit – the Fraud Office – has been set up under the State Insurance Supervision Service. The German Association of German Insurance Companies was established in Germany [7].

Having analyzed the world experience, Ukrainian insurers have come to the conclusion that it is already time for them to counteract the increasing number of clients' frauds, for this purpose, it is necessary to unite insurance companies in

order to protect the Ukrainian insurance market from substandard clients. By decision of the Ukrainian Insurance Organizations League board, in order to coordinate the insurance market in avoidance commercial crime, a committee of the UIOL on questions of legal protection and counteraction to fraud in insurance was created. It works to develop legislation aimed at strengthening liability for insurance fraud.

Conclusions. Insurance fraud is nowadays a big problem for insurers because such crimes undermine the prestige of insurance companies for years and cause them great financial damage. Obviously, effective counteraction to insurance offenses requires a clearer legislative consolidation of the fraud notion and penalties for insurance.

Insurance companies try to protect themselves from fraudsters by conducting a thorough examination of insurance cases, ensuring the maximum involvement of their employees in the investigation of events that could cause significant harm. At this stage, the issue of creating a unified database and system for the exchange of information about suspicious clients and insurance cases is quite relevant at this stage.

Another important step will be the international experience introduction of the collective security system in insurance, that is, the joint efforts of all insurance companies in the struggle against fraud, the creation of special state bodies and central data bank on cases of fraud in the insurance field, employees' legislative empowerment of insurance companies' security services and specially established investigative bodies with powers to conduct operational investigative measures in cases of committing offenses in the field of insurance.

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