RGA

Global Claims Views

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Welcome to the second edition of *Global Claims Views* — a newsletter for our clients from RGA's International Claims Team.

This edition features these topical articles about important claims issues in markets around the world, written by several RGA International Claims experts.

- **India:** Fraud detection tools
- **Australia:** DSM-5
- **Asia Pacific**: Early-stage and multi-pay critical illness
- **U.K.:** The need for speed (a survey on claim end-to-end times)
- **International Health:** Questioning medical necessity
- **North America:** 2013 RGA ROSE® conference

RGA today has a global network of offices in 26 countries and clients throughout North America, Europe, Africa, Asia (including, Australia), and South America.

We hope you find *Global Claims Views* interesting, informative, and helpful! If you would like more information on any of the articles here, wish to suggest a topic for a future edition, or are interested in competitive information on any market issue, please contact your local RGA representative. We are as always available to help, and eager to share our expertise.

Kind regards,

Peter Barrett
Vice President, Head of Claims for
International & Global Mortality Markets

India: Fraud detection tools

Rahul Gupta
Chief Manager, Claims Services

Insurance fraud can present in many guises. Some are basic and unimaginative, while some are far more subtle and ingenious. The fundamental principle of commission of fraud tends to be the same – deliberate non-disclosure or misrepresentation of material information with the intention to obtain unauthorized benefits.

The extent of the problem

According to Indiaforensic Research, India's insurance sector loses INR 300 billion (US$6 billion) every year due to fraud, representing a loss of 8.5% of total industry revenue. Additionally, six times more fraud is seen within the life insurance sector (which accounts for 86% of total insurance fraud) than in the non-life / general insurance sector.

Indiaforensic also found in 2011 that mis-selling of insurance policies was responsible for 36% of fraud, and fake documentation for 33% of fraud in the life insurance sector.

RGA India recently conducted a survey with our clients which compared the incidence of fraud in 2012 with 2011. The survey, scheduled to be published in late 2013, found that 41% of the participants said mis-selling has decreased due to proactive measures taken at the proposal stage to control fraud. However, 56.5% of the participants said submission of fake documents has risen by 7.3% and incidence of non-disclosure has increased by 7%. Additionally, more than half of the survey participants believe this recent increase in fraudulent activity has contributed at least 3% to the cost of insurance, with some participants believing the cost increase may be as high as 20%.

How can we address the problem?

Managing fraud presents a great challenge for the insurance industry. Insurers are under constant pressure to cover new risks and develop original products. This pressure, combined with the fast-evolving business and technology landscapes, makes for a favorable environment for fraudsters to use to come up with innovative ways to stay one step ahead of fraud detection. Often the insurance industry is left trying to play catch-up when managing the ever-changing nature of fraud and abuse.

Fraud is unlikely to ever be eradicated completely, but there are steps we can take to control it effectively.

The first step in the process to control fraud is, of course, to detect fraud. Fraud detection tools and techniques, which can be used to identify actual as well as potential fraud, fall into two primary categories: traditional/manual and artificial intelligence.

Traditional/manual techniques

Traditional techniques of detecting fraud include:

- Manual assessments and desktop investigations of targeted claims.
- Manual data processing techniques, both to validate claims and to detect claims that are suspicious and could be fraudulent.
- Internal audits and post payment claims audits, to detect suspicious claims settled due to lack of evidence and flag them in the event any future claims are made by the same claimant. A person who has defrauded an insurer once will often attempt to do so again, and usually using the same methods. Large patterns of fraud can be unearthed using this method.

Other traditional techniques include 'Random Welcome' calls to prospective or new policyholders to confirm no mis-selling, mystery shopping to detect provider fraud, and having a dedicated risk control unit (RCU).

The traditional, manual approaches of detecting insurance fraud are costly and inconsistent for insurance companies. Close to 50% of the respondents in our recent fraud survey believe that experience analysis, having an RCU and using random welcome calling are the most effective tools for detecting fraudulent activity. However, in isolation, these are not adequate to control fraud.

Artificial Intelligence

Industry uses of artificial intelligence may include:

- Data mining and experience analysis: This is the automatic (or semi-automatic) analysis of large quantities of data or groups of data records to extract previously unknown patterns. Data mining uses information from past data to analyse the outcomes of specific problems or situation that may arise. Data mining can also be used to determine functional strategies and develop new underwriting and claims guidelines.
- Automated red flag systems: These systems use specific criteria to identify claims with suspicious trend items. Such systems need regular monitoring and periodic evaluation to verify that the cases being flagged deserve scrutiny.
- Profiling systems: These systems may also help detect trends and abnormal patterns of behaviour among an insured's claimants, advisors, providers, etc., to enable identification of the nature of the fraud being perpetrated.
- Predictive modelling: The methods listed above are often disadvantaged by the fact that instances of fraud can present similarly in content and appearance to genuine claims. However, they are not usually identical. The techniques covered so far may point to actual or potential fraud, but predictive modelling can help to unearth future fraud. This is a process whereby current facts, historical facts and abnormal patterns of behaviour are used to develop predictions about future events and behaviours. Predictive modelling is rapidly gaining attention in the insurance industry as more structured data becomes available, allowing sophisticated analytics to advance underwriting, claims and risk assessment knowledge. It can be used to identify claims that are most likely to be fraudulent in nature and also to triage claims, allowing assessors to focus on claims most likely to have the biggest impact on an insurer's bottom line.

In the RGA fraud survey, which was completed by 24 participants from 20 companies across India, only two respondents indicated they are currently using artificial intelligence in fraud detection, but 50% of the remaining respondents stated they plan to develop the capability for using artificial intelligence in the future.

Expertise gathered during manual assessments and audits will help to develop system frameworks and rules engines. Artificial intelligence tools will not only provide insights into past trends but will also help to create predictions about future events and behaviors which could improve the industry's ability to detect and manage fraud exposure. The future is likely to lie in blending the use of artificial intelligence with traditional fraud detection methods.

Australia: DSM5

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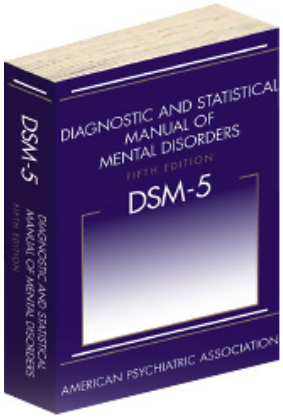


The American Psychiatric Association's long-awaited fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)* was released in May 2013. The idea of shifting from the long-established classifications provided by DSM-IV has left many in the insurance industry feeling insecure: even some senior staff in Australia, New Zealand and North America have only ever known that version. The trepidation has been encouraged by voracious debate over this edition. (Many will recall similarly animated responses to prior revisions.)

In reality, the revisions and novel inclusions in this new edition are unlikely to make a substantial difference to claims management, yet they highlight the desirability for underwriters to phrase policies with greater specificity, as previously less acknowledged adversities (e.g. binge eating and gambling) were elevated for inclusion in DSM-5.

The DSM is a prominent classificatory system for psychiatric disorders. It is used exclusively in countries such as Australia and the U.S., while professional communities in other countries have elected to work with other systems. For example, Chapter 5 of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems (ICD-10) In Occupational Health* is used in the United Kingdom and is reasonably complementary to DSM-5.

A fundamental element in the nature of the DSM, and indeed of all classificatory systems, is that these are all works in progress which are continually under assessment and review. Learned academics are appointed to steering committees, sub-committees and working parties to review current scientific literature with a view toward arriving at a consensus approach to the classification and definition of various disorders. There are always detractors who disagree with the essential opinion of a given working party, but ultimately doctors need diagnostic labels from an operational perspective as an aid to clinical communication and treatment, and to allow them to draw together people of similar clinical presentations for the sake of researching the causes and effective treatments of a given condition.

Yet this need to classify people of similar situations into one group for the purpose of research and treatment is probably at the heart of the greatest criticism of any psychiatric classification, as one's agreement with a particular diagnosis opens the door towards unhelpful labeling and stigmatization. One expects that, for example, the newly-introduced item of *Premenstrual Dysphoric Disorder* has been included to facilitate research into the extreme distress regularly experienced by 3% to 8% of women, and not so as to classify them as suffering a mental illness per se.

While the preambles to these tomes consistently warn that one should not apply such classifications outside of clinical and research contexts, the reality is that our industry requires reproducible and reliable diagnostic criteria by which we can contemplate our approaches to claimants with similarity of presentation and prognosis. While many argue that the DSM fails to provide the reliability and reproducibility we seek, it is the best the American Psychiatric Association has been able to offer after a decade of deliberation.

For the purpose of this overview, it is probably unhelpful to spend much time discussing the many valid criticisms of such classificatory systems in general, and of the DSM specifically. It is, however, important to acknowledge that psychiatry still has no objective strategies for diagnosing mental illness; reliance on the patient's self-report remaining pivotal. While it remains unclear whether or not this classificatory revision will be allowed a foothold in the marketplace, it is now timely to acquaint ourselves with some of the changes, particularly some of those of significance to our industry.

Condition	Key changes to DSM-5
Depression	The big change here is the focus on distinguishing profound grief reactions (such as those generated from bereavement, serious medical morbidity or even financial ruination). With careful assessment, some people with a presentation which formerly satisfied the diagnostic criteria for Major Depressive Episode will now be categorised as suffering from a form of Adjustment Disorder.
Substance Use	No longer are patients to be divided into those who are addicted versus abusers, the division having been found to be arbitrary and unhelpful. New categories include Gambling Disorder and Tobacco-Use Disorder.
Trauma- and Stressor-Related Disorders	This is the name of a newly created category. It includes Adjustment Disorders, Acute Stress Disorder and Post-Traumatic Stress Disorder. In the case of PTSD, an intense emotional reaction to the traumatic exposure is no longer a requisite criterion.
Psychosomatic Disorders	These have been reclassified. Several of the former Somatoform Disorder group are being brought together under the banner of Somatic Symptom Disorder. The diagnoses of Conversion Disorder and Factitious Disorder remain.
Eating Disorders	New inclusion of Binge-Eating Disorder.
Asperger's Disorder	Has now been subsumed into Autism Spectrum Disorder.
Conditions flagged for further study	Include Internet Gaming Disorder.

Clinicians with whom you liaise will continue to cause confusion, primarily because real patients don't often fit readily into some number of clearly defined diagnostic boxes. There will be a period of exacerbated anxiety over the labeling of a presentation while we all bring ourselves to speak the same diagnostic language, even though in most instances DSM-5's changes will have little real impact on the insurance industry. Especially over the next year or so, if we wish to be precise, it will behoove all involved in the use of diagnostic terminology to establish with clarity which precise version of the DSM criteria is being used when applying a particular diagnostic label.

Asia Pacific: Early stage and multi-pay Critical Illness

Tina Paap
Vice President, Claims

Dr. Paul Davis
Chief Regional Medical Director

In 1967, the first successful heart transplant operation was performed at Groote Schuur Hospital in Cape Town, South Africa by Dr. Christiaan Barnard upon Louis Washkansy. Part of the team for this historic event was Dr. Marius Barnard, a cardiac surgeon and Christiaan's brother, who was the first to recognize the need to provide a living benefit to survivors of a critical medical event. In 1983 the first Critical Illness (then called 'Dread Disease') product was introduced, covering myocardial infarction (MI), coronary artery bypass grafts (CABG), cerebral vascular incidents (CVA), and Major Cancer with cover terminating on payment of a claim.

Before long, enhancements were introduced to this product, expanding the range of covered conditions to include some less critical events, extend ages eligible for coverage, and provide specialized products and coverage for females, children, etc.

In the mid-2000s, the consumer press began to feature articles addressing a growing concern that a large number of people who had experienced one CI event, e.g. cancer, were being denied other insurance despite improving survival rates. Since the average age of a CI claimant is likely to be mid-40s, this was a valid criticism. This view was endorsed by a number of medical publications and organizations, leading to the insurance industry acknowledging the need to address this imbalance.

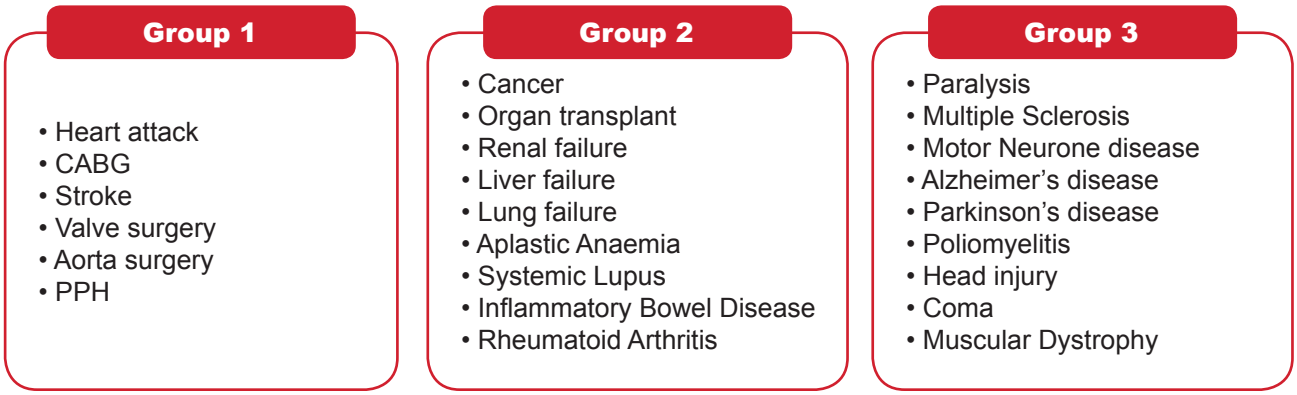
Next-generation CI products

The first step was the development of policies with the ability to reinstate or 'buy back' critical illness coverage. Multi-pay CI soon followed – policies where 100% of the sum assured could be payable multiple times for unrelated conditions. This structure relied on insurance companies grouping related impairments and excluding 'groups' after the first claim. For example: if an original claim was payable for stroke, then excluded conditions for future events could include stroke, paralysis, heart attack, CABG, dementia, activities of daily living (ADL), etc., as these would be deemed 'related to' the original event of stroke. Often, this would be illustrated by a complex matrix of excluded conditions.

Multi-pay and Early-stage CI

In recent times we have seen the increasing popularity of Early-stage Critical Illness policies (ESCI), in which covered CI events (as many as 40) are each scaled by severity, with the capacity to claim multiple times across staged levels of severity. In addition to the CI events, there may be a small number of additional 'special event' conditions that trigger a percentage of the sum assured (e.g. 20%).

The challenges when designing an Early-stage CI cover are considerable. Insurers need to consider the ability to limit exposure to multiple claims for related conditions. This requires good research and understanding of incidence rates in the relevant country population to allow accurate pricing yet enable the product to still be attractive to the target market.



Multi-pay Critical Illness — Example of a three-group construct

Design and pricing considerations

There are a number of complex factors to be taken into account when considering the design and pricing of ESCI. The nature and severity of each covered condition, the causal relationship of the claimed condition to the remaining insured conditions, and (of course) the very fact that a person experiencing one such event must have their risk profile reset to that of an impaired life for future cover.

Although the history of ESCI policies is relatively young across the Asian market, we are already seeing product variations that stratify covered events into multiple categories such as Low, Medium and Advanced severity. These categories may trigger a percentage of the sum assured, usually capped, such as 20%, 60% and 100%.

Current variations, however, may be paid at the same percentage regardless of the degree of severity, e.g. 100% for Low, Medium or Advanced severity. Some conditions, such as MI, may consist of only Low and Advanced severity levels since not all covered events can accurately be divided into a three-degree severity construct.

Where 100% benefit payment is offered for all stages, we highlight the need for capping to prevent excessive benefits being available for early stages. It is important when pricing '100% across the spectrum' products that adequate consideration be given to providing reasonable benefits for early stages.

Summary

We continue to see the popularity of CI expand, with variations appearing as the product matures across the region.

When considering severity levels, it is important to consider what medical standards, tests and facilities exist in the region for which the product is being designed. There is little point in identifying severity level criteria which are not commonly available or applicable within the region, or in defining severity levels for which there is not adequate local data to allow accurate pricing.

An additional important point for consideration is the degree to which standard screening techniques are embedded in the region (or available) across which these products are being marketed in order to determine the magnitude of any potential anti-selection.

Companies offering such products will introduce special underwriting guidelines. Due to the complexity of the product, companies will also need to establish clear claims management guidelines. Claims will need to be managed strictly to the definition severity criteria set out. A key to success is managing expectations of both sales force and customers.

For products where differing severity payments are triggered, a sophisticated claims management system will help ensure previous payments are deducted from the remaining sum assured available for subsequent claims. At the time of a second, or even a third claim, it will be essential that the insurer can effectively review all earlier claim proofs and payment information and check 'related' events and remaining sum assured.

U.K.: The need for speed

Simon Grant
UK Claims Manager

It is the responsibility of claims teams to deliver on the company's promise. When a claim is made, the customer will be interested in two key questions:

1) Will I get paid? **The answer is generally yes. In the U.K., an average of 98% of death claims and 91% of Critical Illness (CI) claims are paid.**

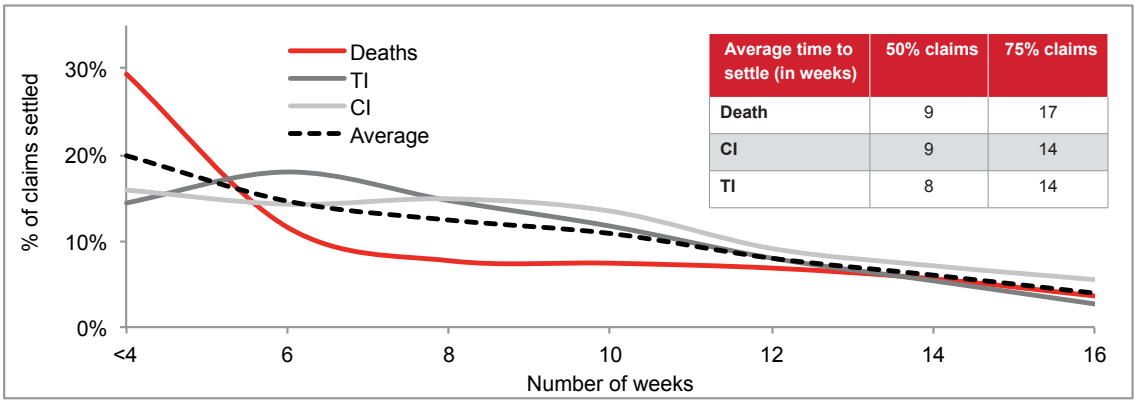
2) How long will it take? **This is an obvious question but there is little published data or statistics to provide an answer.**

RGA UK recently conducted a survey to determine the average time taken to settle claims. The survey looked at the length of time from claim notification until either a payment was made or the decline decision was communicated.

The survey was completed by a wide range of companies, and included some with large established books and some newer entrants. The results represent approximately a quarter of all death claims and a third of all CI claims within the U.K. market. Claims volumes for Terminal Illness (TI) and Total and Permanent Disability (TPD) claims were relatively low, but the results have been included for completeness.

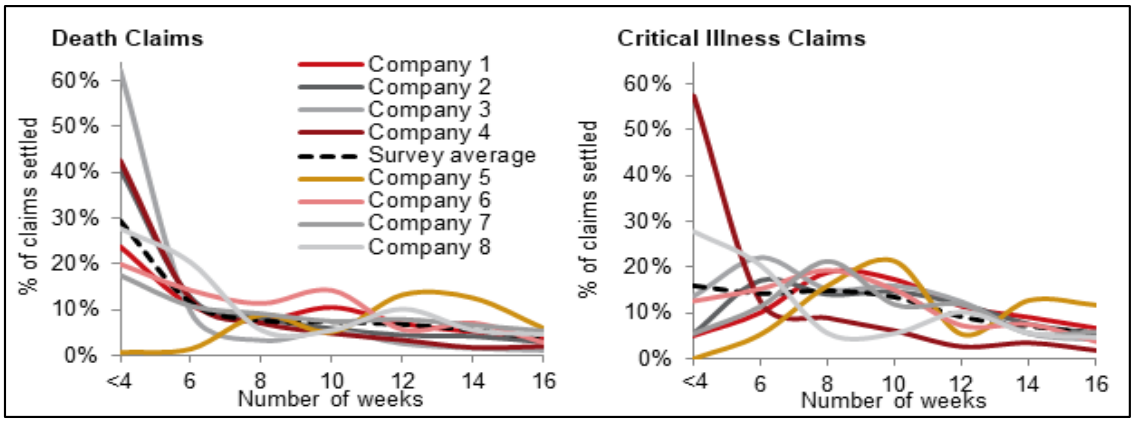
Findings

End-to-end times:	Within 1 month	Within 3 months	Within 6 months	Within 1 year
Death	29%	66%	86%	98%
CI	16%	72%	93%	98%
TI	14%	71%	91%	98
TPD	15%	23%	58%	79%

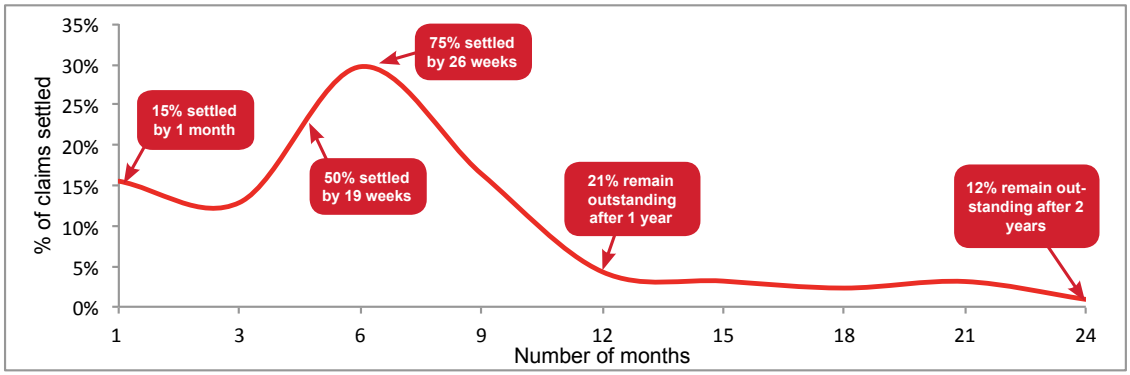


Average time to settle (in weeks)	50% claims	75% claims
Death	9	17
CI	9	14
TI	8	14

Companies show significant differences in the time taken to settle claims. The variation is particularly dramatic when comparing the number of claims settled at four weeks, when there is a difference of some 60% (as demonstrated on the following graphs). But this variation settles after six weeks, when most companies follow a similar pattern. Some variation may be attributed to the profile and maturity of the claims portfolios. We would expect newer companies to have a higher proportion of early / unexpected claims which may require closer attention and more thorough investigation. Companies 1 - 4 in the graphs below represent higher volume companies, and companies 5 - 8 are newer entrants with much smaller portfolios (<500 claims).



TPD claims are often complex and hard to assess. This is clearly reflected in the average time taken to settle these claims in comparison to death and CI claims:



Conclusions

This survey provides a comparative glimpse of claim end-to-end times within the U.K. The results show that there is a wide variation in the time taken to settle claims. It is clear that good end-to-end times can be achieved, but that this is not always the case, and the time taken to settle claims can be very lengthy. No single company led the way as best in more than one claim type, so all companies have scope for improvement.

'Risk-based' claims will always require a balance to be maintained between speed of service and prudent assessment. But long claims assessment times on events that have already taken place do not sit comfortably, especially when products are marketed and bought with the promise of financial security.

There has been a focus in recent years on improving claim payments and publishing statistics. Maybe now is the time for the industry to turn its attention to look at ways of reducing end-to-end times.

Characteristics of good performers

- Proactive claim teams looking for ways to achieve a decision
- Claims triage – Risk-based approach rather than a one-size-fits-all approach
- Interactivity with claimants – Tele-claims, deal with issues in the moment
- Good understanding of when is it all right to take a measured / understood risk
- Assessors trusted with delegated authority limits
- Use of client-supplied evidence (with robust verification checks)
- Efficient processes – minimal referrals
- Efficient gathering of evidence – understanding when enough is enough
- Efficient internal levels of control (no unnecessary rubber-stamping)

International Health: Questioning medical necessity

Colin Weston
Health Claims Manager, UK – International Health

The criteria of a well-written health insurance policy should include the requirement that all treatment is 'medically necessary'. This requirement is needed to enable insurers to combat over-utilisation – the industry term used to describe over-investigation and/or treatment of patients.

Historically, if a doctor ordered a test, prescribed a drug or performed a surgical procedure, patients and insurers generally accepted that the item was clinically appropriate and in the best interest of the patient. Now it is commonly accepted that there are often alternative treatment options available, and that some doctors are financially motivated in their treatment patterns.

The definition of what is medically necessary varies considerably, with the weakest wordings only requiring that treatment be ordered by the patient's treating physician. A good definition should require that all treatment is:

- Undertaken in accordance with accepted standards of medical practice
- Clinically appropriate in terms of
  - type, frequency, extent, site and duration
  - effectiveness for the patients injury, illness or disease
- Not performed for the convenience of the patient or healthcare provider
- Not more costly than an alternative service that is at least as likely to produce equivalent therapeutic or diagnostic results

This is a complex definition that gives an insurer the potential ability to decline a claim or question a doctor about any element of treatment that does not appear to meet the medical necessity criteria. In practice, questioning a doctor who has seen and treated the patient if one is a non-medically qualified claims technician relying on information provided by the patient and doctor is difficult, and therefore avoided by some insurers.

Many insurers rely instead on the experience and judgment of their claims staffs to assess if the claims submitted are valid (meaning that decisions are judgment-based rather than evidenced-based). To decline a claim or question a doctor effectively, it is necessary to ensure that such actions be done on the basis of fact, and that insurers have information and tools available on which to base such actions.

The U.S. has the most advanced tools available for assessing and questioning medical necessity. Commercially available evidence-based clinical guidelines can be used to identify unusual treatment and to question a doctor. These guidelines, which are continuously researched and updated, set out best practices for treating each medical condition and account for variables such as age, sex and co-morbidities. Providers (hospitals and doctors) use the guidelines as clinical pathways, and insurers use them to question treatment that deviates from them. Many markets outside of the U.S. do not have clinical guidelines, and differences in the quality and availability of medical facilities and treatments in other regions mean that U.S. guidelines are not easily transposable.

Insurers without access to appropriate guidelines need to make use of the most appropriate information and data available to them. Some countries collate and publish wide sets of clinical data and, in some cases, clinical guidance, which provide good evidence sets against which a doctor's treatment can be compared. If national statistics are not available, a useful starting point may be an industry or insurer's own historic claims data base.

Insurers should not control a patient's treatment but should be able to confirm that the treatment being provided meets policy terms and conditions, including if it is medically necessary. Often an appropriate question to be asked of a doctor is 'what is medically different about your patient that necessitates the deviation from best clinical practice (if clinical guidelines are available) or from national/industry or company historical norms'?

Questioning an attending physician's treatment of a patient is not easy, but the medical necessity of treatment is at the core of good health insurance terms and conditions. Insurers enhance their capability to ask these questions when doing so against an evidence-based set of guidelines rather than relying on experience and judgment.

North America: 2013 RGA ROSE® Conference

Sue Favilla
Consultant, Reinsurance Claims, U.S. Group Re

The 29th Annual ROSE® Conference was once again a resounding success! With approximately 200 attendees from 24 disability insurers in the U.S. and Canada filling sessions in both disability and health care tracks, our attendance was excellent. This year, we were also privileged to have a speaker from Down Under — André Dreyer, Vice President, Business Development, RGA Australia.

RGA's intent with this conference (and the reason we think we have loyal and engaged participants every year) is to provide pragmatic, insightful information attendees can use in their day-to-day work to improve case management, claim outcomes and customer service for their policyholders and claimants. Year after year, individuals tell us this is the best conference they attend due to its focus on disability claims. Attendees have the opportunity to network with others who 'do what they do, every day', and can then share what they learn with their office colleagues.

A significant challenge each year is to identify and locate speakers who are knowledgeable, can present effectively and, most important, understand the disability industry. This year, we were successful in finding both General speakers, who must address issues common to both disability and health attendees, and Disability Track presenters. We all learned from Dr. Yehude Handelsman's talk, 'Emerging Treatments and Novel Strategies in the Management of Obesity', and from an energetic presentation by Rick Kirschner, 'Dealing with Difficult People and Healthy Communication'.

Disability presentations included: Work-Ready CBT: Integrating RTW Strategies into Therapy (Maria Vandenhurk, Banyan Consulting); Return-to-Work: An Occupational Medicine Perspective (Michael Lockheart, M.D.); Disability Management of Cancer Claims (Sheryl Riley, R.N.); and Settlements, Reserves and Actuaries — Oh My! (Bill Bossi/Disability Insurance Specialists, Jeff Schuh/RGA Minneapolis, André Dreyer/RGA Australia). All of these were well received.

Always Minneapolis-based, the 2013 ROSE® Conference was held at the Hilton Minneapolis, and next year will be held September 10-12 at the new Radisson Blu in Bloomington, Minnesota — attached to the famous (or for some shoppers, infamous!) Mall of America. Over the years, professionals from China, the U.K., and Australia have attended the Conference, and we would welcome our global RGA friends and customers. With the growth of interaction and interdependence within RGA, sharing information and networking at the ROSE® Conference could be a strong consideration for 2014!

RGA Global Offices

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