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FINANCIAL UNDERWRITING CLINIC

UNDER THE RADAR

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and

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Insurance fraud and other economic crimes increase during recessionary cycles. Paradoxically, life insurers tend to become more aggressive about reducing operating expenses--especially new business acquisition expenses-during such cycles, thereby increasing their risk of exposure to insurance fraud.

Third party inspection report thresholds have risen to historically high levels for both cost-reduction and competitive reasons. Other drivers of higher IR thresholds over the past two decades have been the ultra-low cost of term and universal life products, along with the increased use of telephone interviews.

Certainly, some large direct insurers perform an in-house protective value study before raising IR thresholds. But more commonly, a direct insurer's producers provide copies of the competition's thresholds and vigorously argue that the overly conservative insurer is losing new business because of its "low" IR thresholds.

However, those who attempt insurance fraud understand that their crime has a greater chance for success if they fly an application under the radar. Occasionally, they ally with an unscrupulous or naïve producer who assists them in identifying insurers' non-IR limits, so as to apply for a death benefit amount that will not trigger an IR.

At a recent meeting, executives of a major reinsurance company presented and discussed various cases that were on the books and should have never been approved and issued. The various claims that were discussed ended up costing the company an average of $30,000 per case at the time of claim. Examples of application fraud included false identity, false Social Insurance / Security numbers, false addresses, false employment information, false occupation, false income and more - all of which would have been discovered at time of application with an **inexpensive** inspection, usually not even requiring contact with the applicant.

Based on First Financial's own file history, we are sharing actual cases that have been disguised to protect privacy and identity. These cases have remarkable similarities with the cases that were discussed at the meeting mentioned above.

Case 1

Name of Insured: Jane Doe

Face Amount: $200,000

Female: Age 28

Beneficiary: Common Law Spouse

Employer: ABC Hospital

Occupation: Registered Nurse

Income: $60,000 (Net Income)

Net Worth: $150,000

Claim: Filed one year after issue.

Cause of death: Multiple injuries to the head.

Claims Investigation Revealed:

Name: Jane Doe was the decedent's current name. The decedent had changed her name a few years ago from Jill Doe. This could have been identified through a basic spot check (via Social Insurance Number / Social Security Number Trace)

Employer: ABC Hospital - They confirmed that the decedent was never *employed* at the hospital. However, she had been a volunteer at the hospital and had sought free treatments for possible domestic violence. (Hospitals do not normally check criminal records for volunteers - if yes, they could have missed it as she had changed her name, which she did not disclose.)

Occupation: Falsified information – This could have been detected through the RN licensing body. Decedent was actually a call girl with a history of past and current criminal matters. (This could have been detected through a criminal record search at the onset of the application.)

Beneficiary: Investigation reveals that the common law spouse was the manager for the decedent and various other call girls. Note: Based on sources contacted the manager also had a long history of past and current criminal matters.

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***UNDERWRITER e-ALERT* does not recommend any specific action or risk appraisal in any individual life or health insurance application. All information and opinion published should undergo formal scrutiny by underwriting officers, medical directors, actuaries, legal counsel, and other insurance professionals as appropriate.**

Income: Decedent had not filed tax returns for many years.

Net Worth: Nominal - Decedent had lived in a rooming house with multiple other call girls.

Case Outcome: Claim was not paid for due to fraudulent misrepresentation.

Cost of claim investigation: exceeded $25,000 (reinsurer shared in cost of claim investigation.

Cost of a First Financial spot check: ($15), employment / occupation / income verification ($65)

Case 2

Face amount: $190,000

Male: Age 34

Beneficiary: Spouse

Employer: First Choice Roofing

Occupation: Roofer

Income: $40,000

Net worth: 325,000; home valued at $250,000

Claim: filed one year after issue

Cause of death: Murder - decedent died of a single gun shot

Claims investigation revealed:

Employer falsified. No such roofing company - WOULD HAVE BEEN REVEALED IN THE MOST BASIC INSPECTION

Occupation falsified. Never worked as a roofer - WOULD HAVE BEEN REVEALED IN THE MOST BASIC INSPECTION

Income falsified. Applicant was never employed due to extensive criminal history.

Net Worth falsified. Did not own the home listed as the main asset

Lived in a low income family rental apartment unit in high crime neighborhood

Multiple associations with gangs and bikers

Worked as a volunteer at the shelter

Long criminal record

Driver's license suspended for unpaid fines

Spouse was common law and employed as a housekeeper at a motel

Case Outcome: **Settled** for $80,000

Cost of claim investigation: exceeded $30,000

Total paid: $120,000

Acquisition cost of a basic inspection or a third party report might not have exceeded $20.00.

Life insurers are increasingly incurring unnecessarily high costs during extensive claims investigations and out-of-court settlements where fraudulent misrepresentation was present at time of application. These costs are unnecessary because an **inexpensive** inspection report at time of application would have revealed the fraud.

An example of a recent *spot check* before a policy was issued is described below. This involved an identity verification check and court record searches. The following information was obtained:

Search Request Date/Time: September 22, 2011 @ 2:41 PM

Proposed insured's name: John Doe

Alias: Mathew Doe (also searched under this name and using same DOB) did not disclose any criminal matters.

Current Address: 22 Home Street

Former Address: 468 Former Avenue

2nd Former Address: 32 Old Home Road

Date of Birth: May 15, 1962

Criminal Results under: John Doe

CRIMINAL MATTERS FOUND

At the time of searching the [Jurisdiction Name] Courts, within the Criminal repository of [Jurisdiction Name], back to 1991, on September 22, 2011 at 3:21 PM, (1) PENDING Criminal matter and (8) COMPLETED Criminal matters were uncovered in the Subject's name, John Doe, date of birth, May 15, 1962.

The following results were secured on September 26, 2011 at 9:46 AM:

The Subject was charged contrary to the [Jurisdiction Name] a total of (28) times between February 19, 1996 and May 7, 2011, in [Jurisdiction Name] and [Jurisdiction Name].

The Applicant is RETURNABLE to court on the following [Jurisdiction Name] charges in [Jurisdiction Name] on October 3, 2011 at 10:00 AM, in [Jurisdiction Name] courtroom, to set date.

Theft under $5,000 - [Jurisdiction Name]

Failure to comply with condition of undertaking or recognizance - [Jurisdiction Name]

The following (26) charges were DISCHARGED, WITHDRAWN or DISMISSED in [Jurisdiction Name] between January 14, 1997 and May 27, 2011:

1 x Assault - [Jurisdiction Name]

2 x Uttering threats - to cause death or bodily harm to any person - [Jurisdiction Name]

2 x Criminal harassment - prohibited conduct - repeatedly communicating with, either directly or indirectly, the other person or anyone known to them - [Jurisdiction Name]

1 x Uttering threats - to burn, destroy or damage real or personal property - [Jurisdiction Name]

2 x Failure to comply with condition of undertaking or recognizance - [Jurisdiction Name]

16 x Sexual assault - [Jurisdiction Name]

1 x Assaulting a peace officer - assaults a public officer or peace officer engaged in the execution of his duty or person acting in aid of such an officer - [Jurisdiction Name]

1 x Assaulting a peace officer - assaults a person with intent to resist or prevent the lawful arrest or detention of himself or another person - [Jurisdiction Name]

Result: The underwriter declined the insurance application of $1,000,000. The underwriter remarked that the effectiveness of the IRs (spot check/court record searches) has saved them substantial time and facilitates their established practice to minimize the risk of future claim costs.

The issues driving insurers to raise inspection report thresholds to historically high limits - including non-inspection limits of $1 million and higher - relate primarily to new business acquisition expenses. Protective value studies, if they are even used to justify high non-inspection limits, may not take into account high claims investigation costs or the understandable insistence of reinsurers to pursue these claims investigations regardless of cost. In addition, even proven misrepresentation may not win a court's sympathy during litigation as being fraudulent if it can be demonstrated that the insurer had the opportunity to verify this information at time of application for a relatively low cost.

Conclusion

“Trust, but verify.”

Phrase popularized by U.S. President Ronald Reagan, 1980-1988

Insurers are always more cost conscious during new business acquisition than when presented with a death claim. Unscrupulous applicants and producers are quite aware of the non-inspection thresholds and usually apply for face amounts that will not trigger a report or, especially, any contact with the applicant. However, applications generally include a Fair Credit Reporting Act disclosure form that is given to applicants even for application amounts under the published non-inspection thresholds. Insurers always reserve the right to order inspections even when the face amount is under the non-inspection threshold.

Inspection pricing, especially for identity verification checks not requiring a direct applicant interview, is usually **inexpensive** depending on the vendor used. Protective value is undoubtedly greater than generally assumed in light of current fraud trends.

For additional information about an inspection service whose investigators have skills in financial analysis and can talk intelligently with CPAs, corporate treasurers and other financial advisors, contact First Financial Underwriting Services Inc. Phone: (800) 570-3477 Fax: (800) 571-3477; E-mail: ali@firstfin.com

"ALARMING RISE" IN EUROPEAN TB

In September the World Health Organisation urged Western Europe to be alert against drug-resistant tuberculosis in the wake of an "alarming rise" in the number of cases reported across the region.

The WHO hopes its September action plan will prevent 263,000 cases of multidrug-resistant tuberculosis (MDR-TB) and the more lethal extensively drug-resistant TB (XDR-TB) between 2011 and 2015.

Zsuzsanna Jakab, WHO regional director for Europe, speaking with AFP (Agence France-Presse) said "TB is an old disease that never went away. Now it is evolving with a vengeance and we have to find new weapons to fight it.."

Over 80,000 new cases are reported each year in Western Europe, and London is the hardest hit capital city with 3,500 new cases diagnosed annually.

Nearly 12% of newly diagnosed TB patients have the MDR form. Fifty percent of those are expected to die as drugs strong enough to treat the disease are unavailable, and are not expected online before 2013.

MDR-TB and XDR-TB fail to respond to standard anti-tuberculosis drugs, making them much more complex and costly to treat and increasing the threat that TB will spread much more widely, especially in poorer environments where it thrives.

Rising immigration from infected areas has contributed to the rise of TB in Europe, but the WHO warned against complacency among the native populations.

Ogtay Gozalov, of the WHO European regional office told AFP "It can affect anyone. Any one of us can be exposed to these diseases and get infected. A big proportion of these people who are infected can convert and develop the (resistant) disease."

www.who.int/tb/en/

WHO GLOBAL STATUS REPORT ON NONCOMMUNICABLE DISEASES

In response to this 2011 WHO report, the United Nations convened A Summit Meeting of The NCD (non-communicable diseases) Alliance in September.

For decades, global health leaders have focused on infectious diseases — AIDS, tuberculosis, new flu bugs. They pushed for vaccines, better treatments and other ways to control germs that were only a plane ride away from seeding outbreaks anywhere in the world.

UN Secretary-General Ban Ki-moon calls the global increase in chronic diseases "a public health emergency in slow motion." The U.N. General Assembly NCD summit on chronic diseases — cancer, diabetes and heart and lung disease — is a response to nearly two-thirds of deaths worldwide, or about 36 million. In the United States, chronic disease kills 9 out of 10 people.

www.ncdalliance.org/aboutus

Global burden of chronic diseases

Infectious diseases are no longer the threat they once were. Problems like cancer, diabetes, heart and lung disease now account for 63 percent of deaths worldwide, and 9 out of 10 in the United States. The United Nations General Assembly is holding a special session on these diseases, the second time it has ever taken up a health topic.

		PERCENT OF ALL DEATHS THAT ARE DUE TO ...		PERCENTAGE OF PREVALENCE IN POPULATION...	
	POPULATION	HEART DISEASE	CANCERS	TOBACCO USE	OVERWEIGHT
World	7 billion	31	13	20	34
Australia	22.3 million	35	29	17	64
Brazil	195 million	33	16	14	52
China	1.3 billion	38	21	26	25
Ethiopia	83 million	15	4	2	7
India	1.2 billion	24	6	14	11
Iran	74 million	44	12	10	51
Mexico	113 million	26	13	13	68
Russia	143 million	61	13	41	60
United Kingdom	62 million	34	27	17	64
United States	310 million	34	23	16	71

SOURCE: World Health Organization

AP

SOME HIGHLIGHTS FROM THE 2011 ACADEMY OF INSURANCE MEDICINE OF ASIA (AIMA) CONFERENCE IN SHANGHAI

Shanghai was the stunning location for the 8th AIMA Conference. The turnout of over 450 delegates broke previous records, with representation from over 20 insurance markets. The strong medical program was balanced by presentations on product design, claims experience , claims management and underwriting operations practice.

Welcome address

In the welcome address given by Ms. Zhang Xiaohong, General Manager of China Life Reinsurance Company, delegates were reminded of the size and potential of the Chinese insurance market:

- In 2010, the industry generated US$200 billion in premium revenue; 2.7 times that of 2005. According to the Chinese Insurance Regulatory Commission (CIRC), this figure is expected to rise to US$470 billion by 2015.
- Of the premium revenue for 2010, personal insurance accounted for US$170 billion; up 29% over 2009 – including US$152 billion for life insurance, US$4.3 billion for accident insurances and US$10.6 billion for health insurance.
- The aim of the CIRC and other government bodies is to significantly raise insurance penetration and density in the next 5 years, to the levels of "moderately developed countries."

Ms. Zhang commented that although the science of insurance medicine was still in its infancy in China, there was huge potential for growth and innovation in this area given the size of the population base, availability of data and the drive for pricing, product design and risk selection tailored to local requirements.

Two recent examples of close cooperation between the insurance industry and medicine in China include the drafting of industry guidelines for critical illness coverage, with definitions, product features and policy language tailored to the Chinese market, and revised classifications of disability.

Ms. Zhang concluded by saying that China Life Re, as a state-owned reinsurer, was committed to facilitating the goal of setting up a *formal* Chinese underwriting and claims organisation in China – as an industry forum for information-sharing, continuing education and certification.

Critical Illness claims experience

John Ferguson, Regional Chief Actuary Asia, and Janice Lu, Senior Actuary, China, presented preliminary results from GenRe's 2004-2008 Dread Disease Survey.

In the latest study, 93 companies from markets throughout the Asia Pacific region participated, including companies from China, Hong Kong, Malaysia, Singapore, Thailand, Korea, India, Australia and New Zealand; representing 65 million policies in force and 200 million years of exposure. This was the first of the GenRe critical illness (CI) surveys to include results from China.

Of the total 750,000 claims reviewed, almost 500,000 were from the Chinese market.

Key preliminary findings from the survey included:

- Actual to expected (A/E) ratios suggest high levels of non-disclosure in China with male CI claims an overall A/E of 113% in 2004 rising to 120% in 2008. This tendency of a deteriorating A/E in the first few years after introduction of the CI product to a market is fairly common, and reflects the growing realisation by by consumers and agents of the possibilities for antiselection
- First year claims in China are 4 times more likely to be refused compared to those with an in-force duration of two or more years – often for

reasons of non-disclosure or not meeting the CI definition: for male lives, overall 1st year A/E is reported as 148% dropping to 118% at duration 2 years+, reflecting antiselection by policyholders. Interestingly, GenRe reported a high level of 'ex gratia' claim payments suggesting pressure at a branch level to make business decisions on claims payments.

- It was not possible to compare claim rates by smoking status in China as every policy is sold on an aggregate smoker rates basis. However data from Hong Kong showed claim rates in smokers to be 50% higher than non-smokers.
- GenRe report a huge difference in experience between individual insurers in all markets reviewed in the study. In China the best insurers had an A/E of 40%; while the worst showed A/E exceeding 140%. These differences clearly show the impact of selection/underwriting, claims management and target market at different insurers. Wide differentials were seen in all markets surveyed with A/E doubling between the best and the worst company experience.
- The dominant cause of CI claim in China is cancer – 60% of all male claims; 80% of female.
  - In males, the three most common cancer sites for CI claims are stomach/oesophagus, lung and liver. GenRe compared this with the number 1 cause of CI cancer claims in other markets: nasopharyngeal carcinoma (NPC) in Singapore and Malaysia; prostate cancer in Australia.
  - In females, breast cancer accounts for 30% of all CI cancer claims. GenRe noted that breast cancer accounts for a higher proportion of female CI cancer claims in other markets, eg 40% in Hong Kong, 60% in Singapore and Malaysia and 70% in Australia.
  - It was mentioned that breast cancer incidence rates are rising fast in China, due, it is thought, to the rising prevalance of risk factors particularly in urban areas such as lower birth rate and westernised diet leading to hormone level changes. It is interesting to note that breast cancer incidence rates in Shanghai and other cities are moving close to Hong Kong levels emphasising the greater exposure to risk factors (and also the higher rates of diagnosis due to a more educated urban population with greater access to diagnostic centres, etc.).
  - Incidence rates for throid cancer in females are increasing rapidly in China, and are expected to be reflected in CI cancer claims in the next few years. In Shanghai for example, incidence rates are 6-fold greater than in Hong Kong. It was noted that in Korea thyroid cancer incidence increased by 25% per annum between 1999 and 2008, reflecting the widespread implementation of ultrasound screening to detect microcarcinomas of the thyroid. This change in screening practice has been reflected in policyholder antiselection and CI cancer claims. The fact that in Korea, policy conditions for CI cancer permit 100% payment even for microcarcinomas did not go unnoticed by the Korean insurance-buying population – with ultrasound examinations of the thyroid carried out just prior and just after purchasing a CI policy.
- Myocardial infarct, stroke and kidney failure are respectively the second, third and fourth most common cause of CI claim.

- Stroke incidence rates are rising in China year on year, particularly in males, related in part to poor hypertension control, smoking habit (>50% in males and not reducing, and seemingly no national programmes to encourage reduction either) and high dietary salt intake.

- The GenRe study saw some significant differences in CI incidence rates by regional areas in China, and warned about extending pricing based on data for one area throughout China:
  - The incidence of certain cancers is much higher in the north-east of China compared with the north and south-west. In females, for example, breast cancer incidence rates are much higher in the north-east reflecting the more urban demographic.
  - In southern China/Guangdong province and Hong Kong the incidence of nasopharyngeal carcinoma is high, but is very low in the rest of China. This is thought to reflect different ethnicity and genetic factors and possibly also the different diet.
  - Stroke incidence rates are relatively much higher in the north-east and southern China, than other regions.

Multiple risk factor research studies for CVD in China

Dr. Duan Yanchun (FALU, FLMI, HIA), a senior medical underwriter at China Life Reinsurance, compared CVD risk factor studies for predicting cardiovascular disease in the Chinese population to the Framingham, SCORE and Qrisk models.

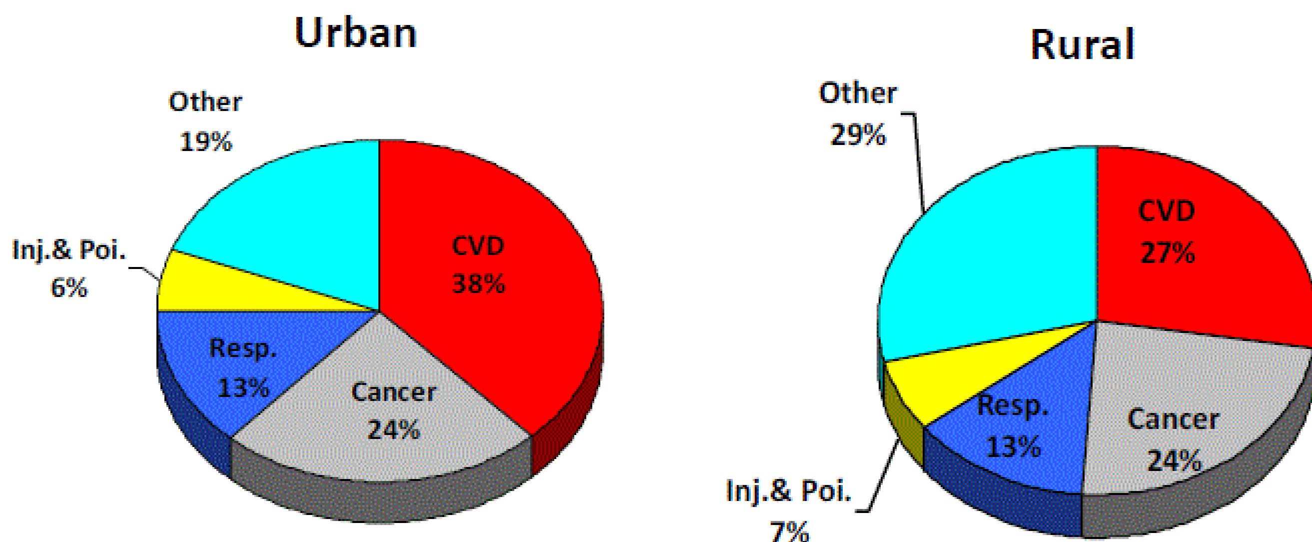
CVD is the major cause of death in urban and rural China (refer charts), with incidence rates overtaking the United States and many western countries. In the second chart, incidence rates for urban and rural China are highlighted in green. Stroke is the dominant form of CVD in China and main cause of CVD death. (see charts page 11)

Dr. Duan discussed the problems of using the Framingham predictive algorithms to determine absolute risk of coronary heart disease (CHD) in a Chinese population. She described the Chinese Multi-Provincial Cohort Study (CMCS) for cardiovascular disease and how it has been used to validate Framingham functions and recalibrate where appropriate. The CMCS cohort included 30,121 Chinese participants aged 35-64 years recruited from 11 provinces throughout China, followed up for new CHD events between 1992 – 2002. Sampling and follow-up was carried according to the criteria of the WHO MONICA project and the study approved and overseen by the Beijing Institute of Heart, Lung and Blood Vessel Diseases for the entire duration.

Dr. Duan showed how the direct use of Framingham predictive models overestimates the risk of CHD for CMCS participants and the CHD burden in the Chinese population For instance, by Framingham estimates, the proportion of Chinese people whose 10-year CHD risk exceeded 10% was 9.9%, but the CMCS model estimated that only 0.3% has that level of CHD risk. ‘Recalibration’ of the Framingham algorithms leads to far more accurate predictive capabilities. However, she went on to describe how Framingham – even when ‘recalibrated’ – underestimates the incidence of ischaemic cardiovascular disease (iCVD) – principally stroke. (see chart page 12)

Dr. Duan concluded by describing how cardiovascular risk calculators and other risk assessment tools produced by reinsurers and used in China must be adjusted to accommodate these differences.

22 Number one killer——major causes of death in 2004 in urban and rural China



Data source: Chinese Health Statistical Digest 2005, MOH, PRC

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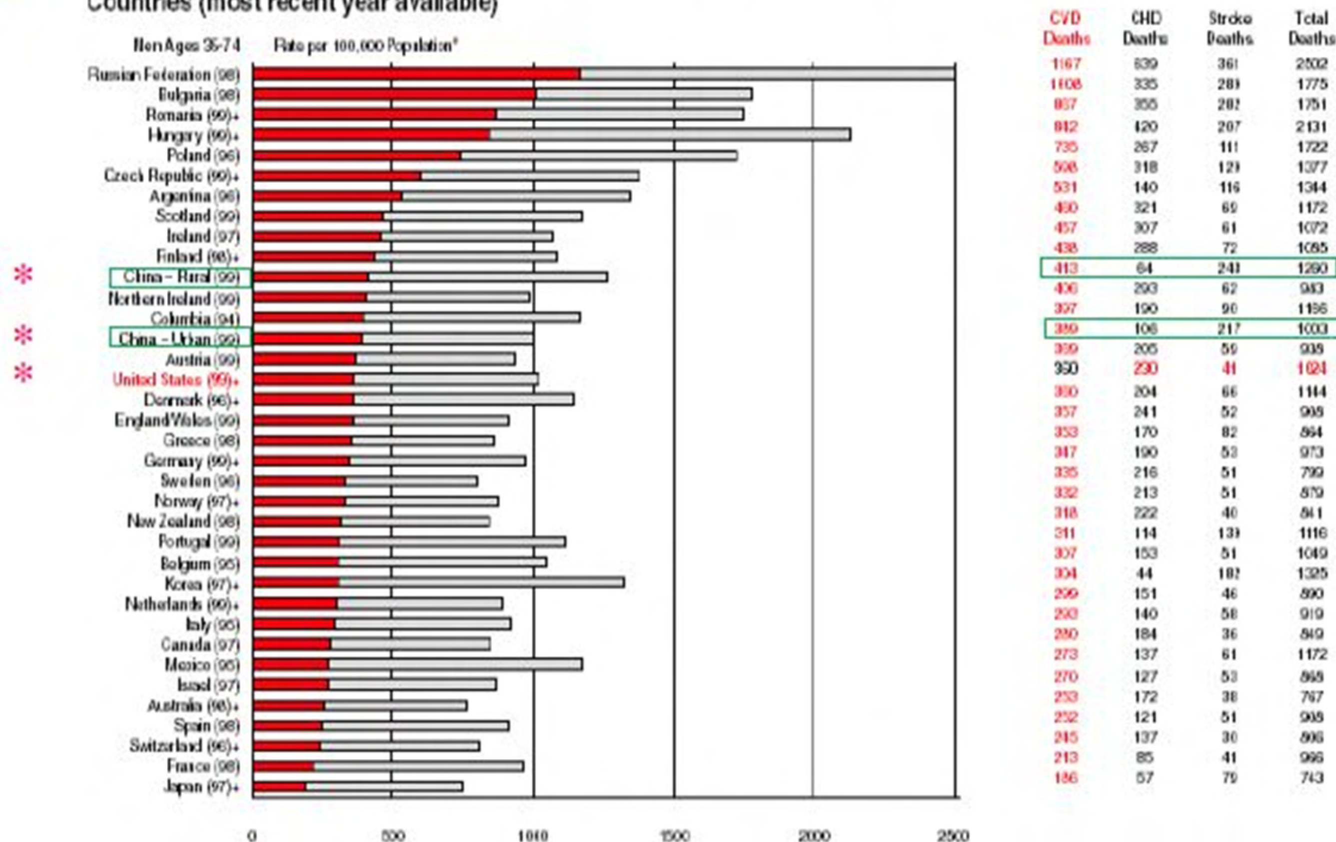
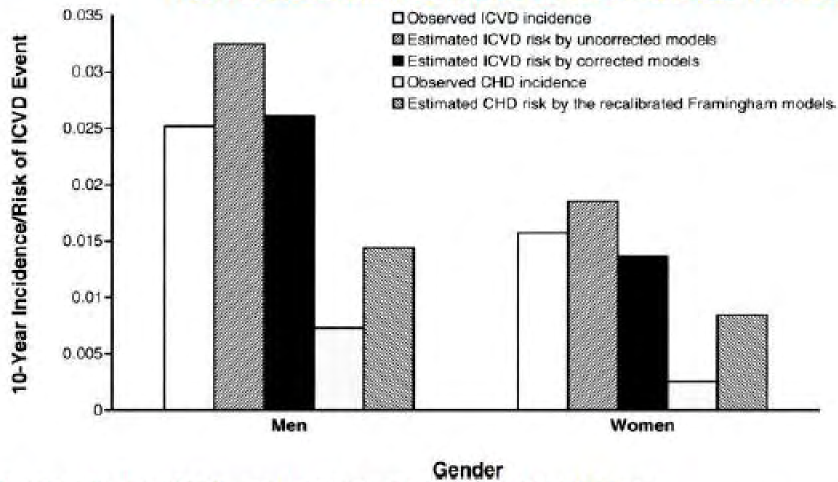


Country	CVD Deaths	CHD Deaths	Stroke Deaths	Total Deaths
Russian Federation (98)	1167	639	361	2502
Bulgaria (98)	1108	335	281	1775
Romania (99)+	867	355	282	1751
Hungary (99)+	842	420	207	2131
Poland (96)	735	267	111	1722
Czech Republic (99)+	598	318	121	1377
Argentina (96)	531	140	116	1344
Scotland (99)	460	321	69	1172
Ireland (97)	457	307	61	1072
Finland (98)+	438	288	72	1085
* China – Rural (99)	413	64	241	1290
Northern Ireland (99)	406	293	62	983
Columbia (94)	397	190	90	1196
* China – Urban (99)	389	106	217	1003
Austria (99)	359	205	59	935
* United States (99)+	350	230	41	1024
Denmark (96)+	360	204	66	1144
England/Wales (99)	357	241	52	905
Greece (98)	353	170	82	864
Germany (99)+	347	190	53	973
Sweden (96)	335	216	51	799
Norway (97)+	332	213	51	879
New Zealand (98)	318	222	40	841
Portugal (99)	311	114	131	1116
Belgium (95)	307	153	51	1049
Korea (97)+	304	44	182	1325
Netherlands (99)+	299	151	46	890
Italy (95)	293	140	58	919
Canada (97)	280	184	36	849
Mexico (95)	273	137	61	1172
Israel (97)	270	127	53	865
Australia (98)+	253	172	38	767
Spain (98)	252	121	51	905
Switzerland (96)+	245	137	30	806
France (98)	213	85	41	966
Japan (97)+	186	57	79	743

26 Estimation of 10-Year Risk of Fatal and Nonfatal Ischemic Cardiovascular Diseases in Chinese Adults



(1) the incidence of ICVD was much higher than that of CHD in Chinese;

(2) the recalibrated Framingham model significantly overestimated the risk of CHD in both men (by 97%) and women (by 228%) and underestimated risk of ICVD in both men and women; and

(3) the corrected ICVD model fit the observed ICVD incidence very well and better than the uncorrected model.

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