



# EXECUTIVE PERSPECTIVES

INSIGHTS ON A CHANGING INDUSTRY

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*The incidence of fraud always tends to rise in hard economic times – and economic times are harder now than they have been in more than 75 years*



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“Things will get worse before they get better.” That, unfortunately, seems to be the prognosis for the nation’s economic condition. The stock market hits new lows, losing nearly half of its value from its one-time high. Banks are reluctant to lend, automakers are flirting with bankruptcy, and every week there are stories of more firms going out of business and people losing their jobs. The stimulus package may help, but no one considers it a panacea. Everyone seems to agree that recovery will take time.

What are some of the implications for the insurance industry as the economy stumbles?

First, of course, is the fact that as many people lose their jobs or take early buyouts, they are seeking alternative forms of health insurance. The end result is that the number of people seeking individual health coverage is growing, even as the number of people covered by small group plans is steadily falling. There are numerous reasons for this:

- More people find themselves in transitional employment situations. They may have a part-time job as they seek a more permanent situation. They may have had to take a job where the health benefits are substantially less than the coverage they depended on for themselves and their families.
- More people are self-employed, often serving as consultants to the industries in which they formerly worked. As such, they have to supply their own health insurance, an expense that was once shouldered by their employer.
- Some employers give their employees money to purchase their own policy, rather than getting coverage through a group.

Although this enables people to customize their coverage, selecting those features they want while forgoing features they don’t need, their out-of-pocket costs are often more than they were under a group plan.

### *The Temptation to Be Less than Forthright*

The increase in applications for individual health care policies represents a challenge for companies. These applications usually require more underwriting than applications submitted under small group plans. Given the current economic environment, more individuals are seeking individual health care to bridge their transition to other employment. But what we risk now is the potential for applicants to be less than forthright when they fill out applications.

In the broadest sense, any application that omits pertinent information is fraudulent, whether the omission is intentional or not. Given today’s economic realities, it may well be that applications represent desperation more than anything else.

Consider a few facts:

- It is estimated that elderly couples can now expect to pay between \$250K and \$300K for medical support – the price of a new home.
- A survey of consumers in one state, Iowa, found that in order to cope with rising health care support, 86 percent said they had to cut back on how much they saved or even on what they spent on providing food to their families or heating their homes.

In short, people who might never have been tempted to withhold facts or consciously

mislead can find themselves feeling trapped into doing just that. A moderate smoker might indicate on an application that he doesn't smoke at all. A woman with diabetes might choose not to mention it, and justify the omission because her condition is controlled by diet, not by medication. Someone who had a heart attack 20 years ago but who has tested healthy since then might think the condition ancient history not worth a mention.

### ***The Industry's Answer to Fraud***

Fortunately, through the formation of MIB years ago, the industry put in place a mechanism to help ensure that applicants are forthright when applying for individually underwritten insurance products. I do not mean to sound like a spokesperson, touting the advantages of MIB. Rather, I want to remind readers of the value MIB brings to the health and life insurance industries. The industry formed MIB to help identify omission and fraud during the application process for life and health insurance products. Given the size of a typical claim, regardless of the line of business, if the adage "an ounce of prevention is worth a pound of cure" applies anywhere, it is to the underwriting process.

A search of MIB's Checking Service data base is often the sole alert to a medical or other condition that might impact an applicant's insurability - a valuable investment for any insurer looking to maximize their product line profitability.

Just consider that a policy underwritten without considering all available information can result in unexpected exposure totaling in the tens of thousands

of US dollars annually. When every industry and every segment of the economy is under siege, we cannot afford to overlook any option that helps us do our job cost-effectively. Also, even though the term "fraudulent" easily might be applied to any application that omits critical information, knowing fraud and proving it are two very different things.

One of the unique traits of MIB, given our business model, is that as usage increases, more data flows into our databases and the value of our services increase.

The database information is constantly expanding, with inputs from all lines of medically underwritten business. This contributes to a more complete, and indeed, unparalleled, picture of applicant risk. And the benefits of using this information are measurable. The most recent study shows that MIB helps save North American insurers more than \$1 billion US every year. Our Members are able to pass on the economic benefits of these fraud prevention initiatives to policyholders in the form of lower premiums.

Clearly, fraud is not a new development for the insurance industry. MIB has been helping fight applicant fraud for more than a century. We owe it to ourselves and our policyholders to do everything possible to minimize the effects of fraud. We can't wait for times to improve. The challenge is now, and we have to meet it.

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***Editor's Note:*** To comment on this issue, please email Mr. Cook at [JCook@mib.com](mailto:JCook@mib.com)



*The MIB Group is the leading provider of fraud detection data, risk management tools and actuarial analytics for the North American insurance industry.*