EFFECT OF FRAUD MANAGEMENT ON FINANCIAL PERFORMANCE OF MEDICAL INSURANCE FIRMS IN KENYA. A CASE OF AAR MEDICAL INSURANCE COMPANY.

BBM/195/17/18

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(A CONSTITUENT COLLEGE OF THE CATHOLIC UNIVERSITY OF EASTERN AFRICA)

NAIROBI-KENYA

AUGUST, 2019.

DECLARATION

DECLARATION

I hereby declare that this project is my original work and that it has not been presented for an award of a degree in any other university.

Sign…….. Date: ……..

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RECOMMENDATION

This project has been submitted for examination with my recommendation as university supervisor.

Supervisor

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This research project has been accepted by the Head of Department of Business

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DEDICATION

I dedicate this work to my family and friends. A special gratitude and love to my aunt, Monica Barrera and my uncle Bona Bol Arech. May God continue to bless you in all your endeavors.

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My sincere and heartfelt gratitude goes first to the almighty God for the gift of life and many blessings bestowed on me in the course of my studies.

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THE ABSTRACT

Incidences of fraud have continued to settle comfortably in the medical insurance companies. Poor managerial strategies and polices has been the cause of medical insurance company losses of substantial amounts of money to settling fraud claims. This necessitated a case study of the AAR medical insurance company of Kenya. The purpose of this study was to investigate the effect of fraud management on financial performance of medical insurance firms in Kenya. A case of AAR medical insurance company. The study was guided by the following objectives: To find out the effect of individual subscriber fraud on financial performance of medical insurance firms; To find out the effect of Health care provider fraud on financial performance of medical insurance firms and to suggest mitigation measures against medical frauds in medical insurance firms. The study used descriptive survey design and adopted the quantitative approach. The study enlisted 7 respondents from the fraud management department of the AAR insurance company. Questionnaires was used to collect quantitative data. Statistical Package for Social Sciences (SPSS) version 25 was used to get descriptive statistics. The study established that there have been cases of individual subscribers' fraud. However, among the group of fraud that the company experiences, is health provider fraud while non-disclosure of prior ailments is the major fraud committed by the individual subscriber. However, there is no software that can professionally detect fraudulent activities and the company does not use IT system in receiving fraudulent claims. Furthermore, the survey findings revealed that the Insurance Regulatory Authority is not doing enough to combat insurance fraud. The study recommends that computerized (IT) systems be used in handling of fraud claims. The Government of Kenya through the Insurance Regulatory Authority should do a follow up review of how medical insurance companies are managing fraud and the Insurance Fraud Investigation Unit (IFIU) should employ a proactive means of helping medical insurance company handle fraud.

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LIST OF ABBREVIATIONS

SPSS	Statistical Package for Social Sciences
IFIU	Insurance Fraud Investigation Unit
ROA	Return on Asset
ROE	Return on Equity
NHIF	National Hospital Insurance Fund
BFID	Banking Fraud Investigation Department
KPMG	Klynveld Peat Marwick Goerdeler
SIUs	State Investigation Units
IRA	Insurance Regulatory Authority
IT	Information Technology

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Medical insurance fraud is a complex and a critical challenge that is negatively affecting the operations of many health insurance providers. This research explores the effect of fraud management on the financial performance of medical insurance firms in Kenya. It focuses on fraud issues such as inflation of bills, impersonation, ordering of unnecessary tests. This chapter presents the background of the study, statement of the problem, research objectives, research questions, scope and delimitations. It also highlights the significance of the study, operational definition of key terms and ends with the organization of the study.

1.1 Background of the Study

According to Angima and Omondi (2016), health care is one of the most important elements of economic development and people's life longevity. Peoples' wellbeing contributes positively to the development of any nation. Medical insurance plays an important role in cautioning patients against such costs by paying on their behalf. Medical insurance is a facility or a policy whereby a potential patient pays some amount of money in advance in anticipation that when they need medical attention, the insurance company will cover their medical expenses that may be incurred in unforeseeable future. Nevertheless, the benefit rendered by medical insurance provider is being eroded by the rising cases of fraud.

Fraud in health insurance and healthcare is a critical problem and is responsible for losses of substantial amounts of money. According to the European Healthcare Fraud and Corruption Network (2009), an average of 5.59 percent of annual global health spending is lost to fraud. It is estimated that 20 per cent of medical claims are fraudulent. Cases of alteration of documents in order to increase the claimed amount, concealing pre-existing medical

conditions, falsified prescriptions, over-prescription of drugs and identity theft by non-members were identified as rampant cases of fraud (Olingo, 2017).

Insurance fraud is a criminal act, provable beyond reasonable doubt, that violate statutes by making the wilful act of obtaining money or value from an insurer under false pretences (Angima & Omondi, 2016). Fraud is therefore an act of deliberately deceiving the insurance company for personal gain. According to Robertson (2010), fraud consists of knowingly making material misrepresentations of fact, with the intent of inducing someone to believe the falsehood and act upon it and, thus, suffer a loss or damage. Duffield and Grabosky (2001) defined fraud as an act involving deceit (such as intentional distortion of the truth or misrepresentation or concealment of a material fact) to gain an unfair advantage over another in order to secure something of value or deprive another of a right. It occurs when a perpetrator communicates false statements with the intent of defrauding a victim out of property or something of value (Vasiu and Vasiu, 2004). The danger caused by fraud calls for an immediate fraud management.

Robertson (2010), states that Fraud management practices can be grouped into preventive, detective and responsive fraud management practices. Preventive fraud risk management practices are those techniques that are meant to reduce fraud and misconduct from occurring in the first place. Such practices include conducting a fraud risk assessment, establishment of strong internal controls, code of conduct and related standards, employee and third-party due diligence, communication and training and introduction of policies and procedures. Preventive controls aim to decrease motive, restrict opportunity for potential offenders to rationalise their action.

Fraud detection may highlight ongoing frauds that are taking place or offences that have already happened. Such schemes may not be affected by the introduction of prevention

techniques and, even if the fraudsters are hindered in the future, recovery of historical losses will only be possible through fraud detection. Potential recovery of losses is not the only objective of a detection programme though, and fraudulent behaviour should not be ignored just because there may be no recovery of losses. Fraud detection also allows for the improvement of internal systems and controls. Many frauds exploit deficiencies in control systems. Through detection of such frauds, controls can be tightened making it more difficult for potential perpetrators to act. Responsive fraud management practices aim at taking corrective action and remedying the harm caused by the fraud. In each instance where fraud is detected, Line Management should reassess the adequacy of the current internal control environment (particularly those controls directly impacting on the fraud incident) to consider the need for improvements. The responsibility for ensuring that the internal control environment is reassessed and for ensuring that the recommendations arising out of this assessment are implemented lie with Line Management of the division concerned (Trevino and Victor, 2008).

1.1.1 Financial Performance

According to Ross et al (2012) Financial performance refers to the potential of a venture to be financially successful. It is measured by how efficient the organization is in use of resources in achieving its objectives. The main goal of every organization is maximization of profit.

Return On Assets (ROA) represents the ability to make profits from its assets. It shows how efficiently the resources of the company are used to generate income. An increasing trend on ROA is an indication that the financial performance of the company is improving. Conversely, a decreasing trend means that financial performance is deteriorating (Crosson, Jr Needles, Needles, & Powers, 2008)

Return on Equity (ROE) measures the rate of return on the owners' equity employed in the firm's business. A business that has a high return on equity is more likely to be one that is capable of generating cash internally. Thus, the higher the ROE the better the company is in terms of financial performance. Khrawish (2011) explained that ROE is the ratio of Net Income after Taxes divided by Total Equity Capital. ROE reflects therefore how efficient a bank management is using shareholders' funds.

1.2 Statement of the Problem

Despite the importance role played by medical insurance firms to save lives and make health care affordable, medical frauds continues unabated which is turning to be a costly affair for Kenya's health-care system. Fraud poses significant and costly problem for both policy holders and insurance companies (Sybase, 2012). Despite sophistication and volume of fraudulent claims, the vice continues to increase with insurers not upping their game in combating it with the public and investors being the ultimate losers. It is estimated that 20 per cent of medical claims are fraudulent (Olingo, 2017) Association of Kenya Insurers (2013) notes that the number of health insurance fraudulent claims increased from 22 in 2008 to 225 in 2012. This implies that understanding the common types of frauds, causes and mitigation measures are likely to minimize these loses.

Fraud emanates from both internal and external sources thereby posing substantial cost to our economy and the world's (Jans, 2010). A lot of research has been embraced on the nature, degree and effect of misrepresentation on the execution of insurance agencies the world over. Okwachi (2009) conducted research on effectiveness of state regulation of the insurance industry in Kenya and found out that there is a lot fraudulent claim that affects the effectiveness of the insurance firms in Kenya hence proposed that the state should state insurance regulations to reduce this. Wairimu (2010) researched on challenges in management of general insurance claims and concluded that the challenge highly faced is

fraud and called for fraud management strategies to be adopted by insurance firms. Kuria & Moronge (2013) wrote on the impact of fraud control mechanisms on the growth of insurance companies in Kenya concluding that what affect the growth of insurance firm in Kenya is fraud. These researches were done on insurance firm as a whole and not on Medical Insurance firms.

Some (2012) wrote on the extent and effect of fraud on Medical insurance firm. A case of NHIF stating that there is a higher increase on fraudulent claims in medical insurance firm. It is only her who did on medical insurance firm but not on the effect of fraud management strategies on financial performance of medical insurance which this research tend to research on hence creating a gap for this study.

1.3 General Objective

The purpose of this study is to find out the effect of fraud management on financial performance of Medical insurance firms in Kenya insurance firms.

1.4 Specific Objectives

i. To find out the effect of individual subscriber fraud on financial performance of medical insurance firms
ii. To find out the effect of Health care provider fraud on financial performance of medical insurance firms
iii. To suggest mitigation measures against medical frauds in medical insurance firms.

1.5 Research Questions

i. What are the effects of individual subscriber fraud on financial performance of medical insurance firms?
ii. What are the effects of Health care provider fraud on financial performance of medical insurance firms?

iii. What mitigation measures are put in place to curb against medical frauds in medical insurance firms?

1.6 Scope and Delimitations of the Study

The scope of the study is to analyse the fraud management practices in medical insurance firms. It targets staff of AAR insurance firm, as they are believed to have first-hand information that is being sought by the researcher. The study is delimited to Nairobi County, Nairobi County. This area has numerous concentrations of medical insurance firms and therefore an ideal place to carry out a study of this nature. The study will be conducted between September 2018 to May 2019.

1.7 Significance of the Study

This study will be of significance to several stakeholders such as the medical insurance firms, hospitals, ministry of health, among others:

1.7.1 Medical Insurance Firms

The findings of this study may help medical insurance firms to understand the most common types of frauds, their causes and how to curb them. This may help them avoid losses associated with insurance frauds.

1.7.2 Hospitals

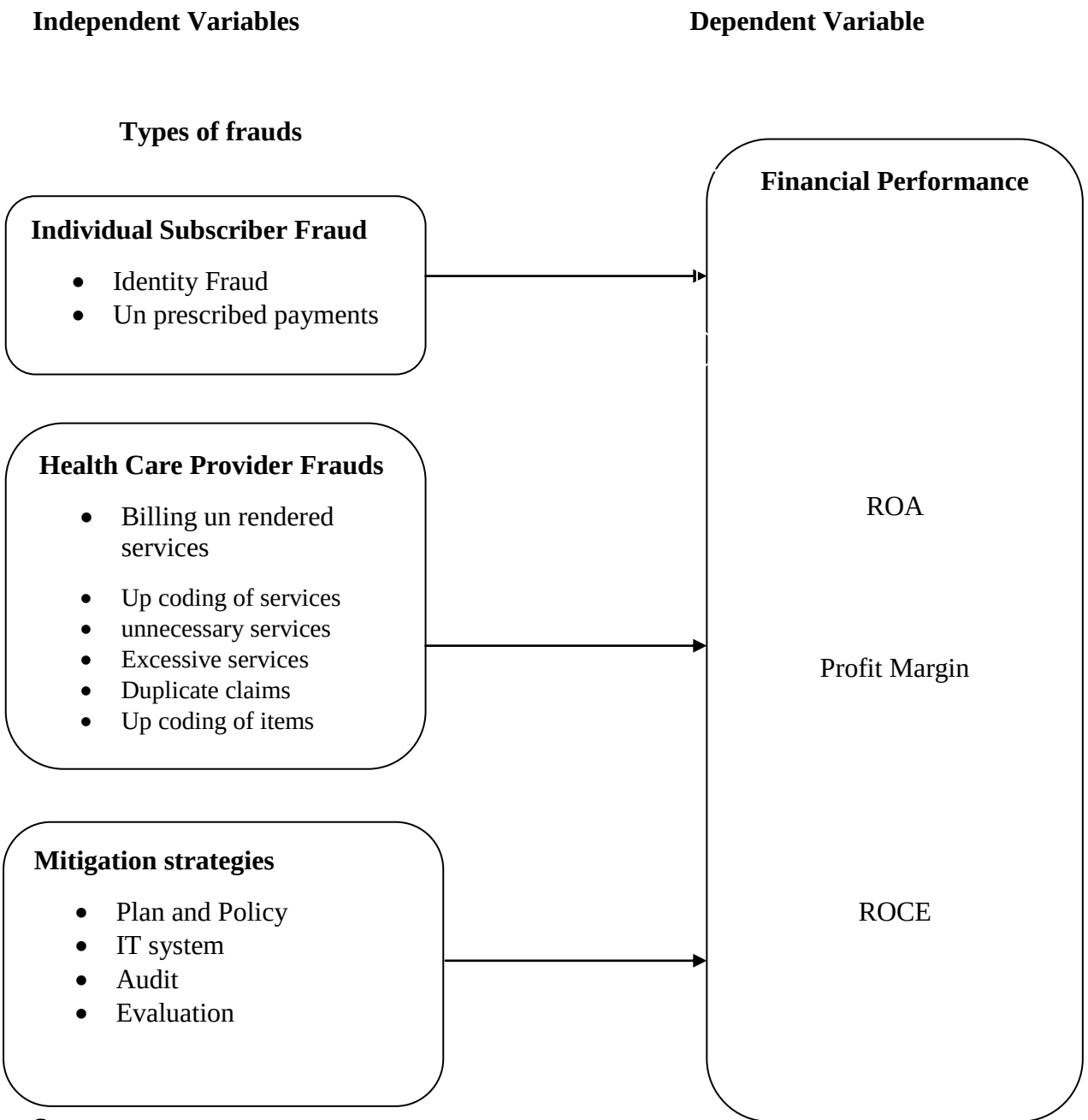
The findings of this study will help hospitals to understand issues related to insurance frauds and how to avoid them. This may create a good relationship between hospitals and medical insurance firms.

1.7.3 Ministry of Health

The Ministry of Health will benefit from the study, as it will shed more light to what ails the medical insurance sector. The findings will guide the ministry to come up with policies that streamline the health sector for the benefit of patients, hospitals and medical insurance firms.

1.8 Conceptual Framework

Conceptual Framework is the road map that a study intends to follow in the process of searching for answers to the problem at hand (Creswell, 2014). The following diagram explains the conceptual framework of the study.



Source:

Researcher (2018)

1.9 Operational Definition of Terms

The following terms have been defined as used in the study:

Fraud: Illegal acts or cheating meant to benefit the one doing it to the detriment of the medical insurance provider.

Medical Insurance Firm: This is a company that undertakes to pay for health services on behave of the person who takes an insurance cover.

Fraud Management: These are measures put in place by medical insurance firms to curb against cheating.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This chapter will explore the various phenomena of fraud in the context of financial market activities in particular the medical insurance company. It will also deal with literature of the previous studies that have been carried by different researchers related to this study on fraud management in the medical insurance sector. The chapter will be divided into four areas: concepts of fraud, fraud management strategies, insurance fraud and health care fraud.

2.1 Concept of fraud

Fraud is understood as the deception considered for benefit. An individual who is dishonesty may be called a fraud. According to Albrecht et al., (2009), there are nine things which motivates people to engage themselves in the fraud business, this include; living beyond means, craving for personal gain, high personal debt, close association with customers, perception that the payment was insufficient, too much gambling habits, and unnecessary family or peer pressure. Similarly, Some (2012) opined that Insurance fraud is deceit intentionally done by agents, employees, a broker a claimant or even the policy holder.

However, according to Rae and Subramaniam (2008), fraud perpetrators must have a perceived opportunity if not, they will not commit fraud. Opportunities include factors such as a weak board of directors, inadequate internal controls or the ability to hide the fraud behind complex transactions or related-party structures. Such opportunity gives the fraudster the power or means to exploit.

It is reasonable to argue that an individual may require assets to pay off a debt or he/she may feel impelled to present misrepresentation even without a prompt monetary need which according to Albrecht (2010), both external and internal factors play role in the commission of fraud in the insurance industry. Professionals like; health institutions, policy holders, lawyers, employees, police and among many others are frequently involved in the insurance fraud.

2.2 Insurance fraud

This is defined as the criminal demonstration which entails acquiring financial benefits from backup plan utilizing the distortion of truth (Derrig, 2002). It undermines the relationship amongst guarantors and policy holders since it exhausts the store pooled from the business chance which shows a major test to protection areas as misfortunes brought about by dishonest actions that influence the development of protected business. Ngosiah (2012), confirmed that insurance misrepresentation existed as before as the start of insurance and mature as the business itself. Fraud misfortunes are always part of financial externality, where one business takes activities or stops from acting. Therefore, the fraud is passed on from one business to the other (Ijeoma & Aronu, 2013). Increased fraud on the insurance segment has affected medical insurance profitability (IRA, 2015). This results to huge losses of revenue and increased cost of operation. The end result is increased premiums (Makove 2015)

Fraud is a trick representation of self-evident authenticity whether by words or direct, by false or deluding affirmations what should have been uncovered, that tricks and is anticipated to deceive another so that an individual will follow up on the legitimate damage (Clemency, 2002). To this regard insurance extortion has had expensive results to the Kenyan economy and in the world (Irungu, 2012).

Banking Fraud Investigations Department (BFID) gave reports concerning the taking off levels of banks in relation to the wrong done in their books which is an immediate after effect of disappointment by banks to find solutions to the issue. Due to this concern different insurance agencies and other budgetary foundations were requested to come up with an organized structure where they can share the extortion data among themselves so as to minimize the fraud cases in East Africa.

The statute regulating the industry is the insurance Act; Laws of Kenya, Chapter 487. The insurance industry in Kenya is regulated by the Insurance Regulatory Authority (IRA), a semi-autonomous regulator, set up in 2008. Insurance Regulatory Authority is expected to improve regulation and stability of the industry by formulating and enforcing insurance standards (Mumo, 2017).

In Kenya fraud occurs at different stages from application for policy up to compensation. Among the crimes that takes place is settling of claims that never occurred. In regards to this, many companies are facing the same challenges up to date (Viaene, 2004). There are three groups of insurance fraud:

2.2.1 External versus internal fraud

External is for the outsiders whereby these outsiders may be the policy holders, or applicants who usually crashes with the insiders (Viaene, 2004). It includes the case of professional provider of services such as doctors billing insurance for non-existent service or charging insurance for the same service more than ones. However, there are still other cases with good internal controls but employees still manage to circumvent the internal controls to commit fraud (Albrecht et al., 2010). Such Fraud as this; committed by insiders such as employees,

managers or a person within is internal fraud (Dedene, 2004). This internal fraud may occur by selling insurance product without proper license, misuse of insurance funds and impediment of regulatory body of investigations.

Isaac, Charlse and Eric (2016) conducted a research on Causes, effects and deterrence of insurance fraud: evidence from Ghana. The findings revealed that poor conditions of services and poor remuneration are strong causes of internal fraud.

2.2.2 Underwriting versus claim fraud

According to Viaene (2014), under Writing fraud takes place during the renewal of contract such as dissimulation of information during application. It can also be obtaining coverage at low premium. Therefore, the policy holder is required to inform the insured on the changes of insured risks, failure to do so it results to claim fraud.

2.2.3 Hard fraud versus soft fraud

It is a preplanned scheme to deceive the company. It occurs in the collusions of insiders, for example; a patient may exaggerate his/her hospital bill claiming more than what he/she has used (KPMG, 2015). On the other hand, soft fraud does not need prior planning to fraud the company. This is where people take advantage of the situation that arises at any given time. In case of accidents, the nature of injuries may be overstated by the victim so as to earn more claims. Hence the patient ends up taking the situation for granted in order to earn unwarranted benefits.

2.4 Fraud management strategies

In order for companies to survive, it is important for them to put in place appropriate fraud management strategies. The strategies have to contain high level implementation plan and policy. The fraud management policy forms the most significant part of fraud avoidance display and in this manner it should not be complicated. Associations must come up with operational management clearly arranged and techniques with a specific end goal to lessen frequencies of fraud (Hansen, 2009). It is very important for associations to make and keep up extortion strategies for controlling workers. Furthermore, company boards are responsible for the development of anti-Fraud policies. Management should focus on identifying and understanding causes of fraud and signs of clients and staff misconduct which may undermine business objectives.

Management should figure out how fraud control projects are working and convincing so as to minimize the occurrence of fraud. Organizations are supposed to come up with strategies for planning and evaluating controls with a given goal set to identify, offset and respond accordingly to fraud and the wrong done. This technique is meant to offer assistance to associations so as to attain business reliability through proper corporate administration, internal control and openness (Biestaker, Brody & and Pacini, 2006).

KPMG (2006) states that effective business-driven fraud management approaches comprise controls with three main objectives: detect, respond and prevent. KPMG also stated that an effective fraud management strategy has four phases such as: evaluating risks; designing Programs, apply the new controls and assess. In the Unites States, insurance companies regard technology as being significant to the effective management of insurance fraud. In the US there is an outburst of fraud-detecting strategies with more organizations getting gradually

advanced databases and information removal systems to facilitate with distinguish false claims and forward the same to the State Investigation Units (SIUs). These advances have assisted back up strategy to collect and explore volumes of data cases and to identify and summon doubtful cases in view of particular qualities.

Cheptumo (2014), carried out a study on response strategies to fraud-related challenges and revealed that there should be reforms thus, judiciary needs to be empowered through reforms in order to review fraud legislation and the safety documents needed. Fraud can be controlled through planned frameworks which involve board of directors, audit committees, management and staff. There should be policies that are written and fraud risk evaluation mechanisms to recognize fraud hot spots, fraud reporting procedures, fraud investigation processes, corrective action and continuous monitoring (Wilks, 2004). If these strategies are established, fraud in the insurance industry in Kenya will be minimal hence driving them away.

Additional measures to control internal fraud include effective internal control, internal audit and a deliberate fraud policy by individual insurance companies and the insurance industry as a whole. Effective internal fraud unit will deter employees or managers to shy away from fraudulent activities that will go against the insurer. The internal audit units of insurance companies should design programs, risk assessment, control activities and monitoring systems to check activities of employees and managers. Internal audit measures should be instituted by insurance companies. Insurance companies that has already audit units should be furnished with modern fraud detection measures on data gathering and practical measures through training (Isaac, Charlse and Eric, 2016).

The aforementioned strategies concerning fraud management shows that there are different approaches to fraud management. Therefore, it is not practical enough for one insurance company to apply all the strategies at the same time. This could be due to availability of resources and capacity limitations. It can be noticed that not all insurance companies experience the same impact of fraud hence a centralized claims management system needs to be executed and monitored by IRA because insurers may not be willing to share their data with fellow underwriters.

2.5 Health care frauds

Fraud is defined as an intentional deception made by the person with an intention of getting unauthorized benefits. The health care fraud occurs when a company or an individual defrauds an insurer or government health care programme which includes Medicare or the equivalent state programmes. According to Wex legal dictionary, health care fraud is a type of white-collar crime which involves the filing of dishonest health care claims so as to gain profit.According to Caren and Mbala (2016) the common forms of fraud experienced by the medical insurance firms are: overstated medical bills and concealment of patient medical history. There are various forms of health care frauds as discussed below

2.5.1 Billing for services not provided

This form explains that the state may place appropriate limits on the services such medical necessity. The providers for medical necessity are responsible for ensuring that the mandated services meet the needs of the medical necessity in the state which they are practicing. Therefore, intentional billing of unnecessary services can lead into serious consequences. This form also states that with double billing there is care for the patient but when billing for

services that are not provided, claims will be submitted for health care services that have not been provided (Stanton, 2001 & Lubao, 2008).

The solutions in countering medical bill fraud is subjecting the claims to audit to determine their validity and the use of ICT solutions to generate, verify and process expense claims (Caren & Mbala 2016).

2.5.2 Upcoding services

Upcoding is understood as billing for services at the complex level that is higher than actually provided services. It is also said that its occurrence is due to administrative error versus a malicious attempt to increase revenue. For example, a physician may bill simple office visit at the higher rate for complex visits. Thus, this kind of practice is illegal and therefore the provider should only bill for the service levels (Agrawal et al., 2013).

2.5.3 Duplicate claims

This form explains that when claims are being submitted it is not only improper coding practice that can be fraudulent, but care providers can try to submit the same claim multiple times for the same services. In this case the automatic acceptance of claims is mostly done to improve processing speed; however, Benzio (2009) rightly mentioned that efficiency matters a lot.

2.5.4 Unnecessary service

This may also happen such that more health care is provided than what was expected or needed to treat the patient. In this scenario some certificates are falsified so as to indicate the medical necessity of certain actions in order to justify the payments. According to Morris

(2009), there is need for maximizing the number of services and claims such that one is paid for the service provided. Insurance companies provide an ideal environment for fraudsters due to the firm flow near liquid funds. Insurance fraud from the dealer integrates, offering strategies from non-existent institutions, neglecting to present premiums and stirring preparations to make more commissions. Purchaser extortion incorporates exaggerated cases, distorted medicinal history, post-dated strategies, faked demise and murder.

2.6 Fraud and Financial Performance

Medical insurance firms have experienced one form of fraud or another in the recent past. Fraudulent activities affect the financial performance of the insurance company. According to Schiller (2006), a substantial amount of US$260 billion is lost globally to fraud. Nevertheless, a buoyant and well-regulated insurance industry can significantly contribute to economic growth and efficient resource allocation through transfer of risk and mobilization of savings. In addition, it can enhance financial system efficiency by reducing transaction costs, creating liquidity and facilitating economies of scale in investment (Bodla et al., 2003)

Bhattacharya (2006) states that for a business firm to be able to sustain its business operations and meet its goals and objectives it must manage its financial practices effectively and prudently.

Financial performance can be defined as a subjective measure of how well a firm can use assets from its primary mode of business and generate revenues (Nandan, 2010).

The ability of insurance companies to continue to cover financial risk in the economy market hinges on their capacity to create profit or value for their shareholders. Fraud is one of the major obstacles for the financial buoyancy required by the medical insurance companies (Viaene, 2004).

Brealey, Myers and Allen (2007) indicate that financial performance can be measured in terms of profitability, liquidity, solvency, financial efficiency and repayment capacity. Profitability is the measures of the profit generated by a firm through the use of its productive assets; liquidity measures the ability of a firm to meet its obligations when they fall due; solvency measures a firm ability to pay all its financial obligations if all of its assets are sold. Among the common accounting ratios used to measure profitability is; return on assets (ROA). Return on assets is an indicator of how profitable a company is relative to its total assets. It gives an idea as to how efficient management is at using its assets to generate earnings (Brealey, Myers & Allen 2007).

Determining the financial strength and ability of any insurance company to settle claims and stay in business can be done by calculating the Debt/Equity ratio, which is total liabilities divided by shareholders equity. This ratio is also known as risk gearing and shows the extent to which a company is financed by borrowed funds (Kumba, 2011).

In Kenya, almost all the premium income generated is through intermediaries like agents and brokers. The sales made by these professionals' impact positively on the financial performance. Meanwhile, the delay by these groups in remitting proceeds from sales made to the parent insurance company impact negatively on the financial performance (Hayes, 2010).

When medical insurance company is plunge into settling fraudulent claims such as indicated by Schiller (2006), their financial performance is affected.

2.6 Summary of Literature Review

Ernst & Young (2011) embraced a review on Insurance fraud with a specific terminal goal to choose the protection misrepresentation circumstances, potential risk it bears and its potential financial effect and in addition to industry hones intended to counter misrepresentation

possibility. The review revealed claims related extortion containing the most remarkable rate, premium redirection by certain percentage of people and representative related counterfeit. The study by Ernest & Young (2011) also revealed that Insurance fraud leads to the increase of the cost of insurance to buyers.

Insurance fraud brings serious financial allegations on insurers whereby they threaten their capability and hence compromise their profitability. This report led to the acknowledgement that though fraud has negative significant impact on insurance companies, fraud cases are rarely reported. Yet, fraud incidents have been on the increase over the years and this has led to breakdown of many companies due to the rise in fraud cases (Kumba, 2011). Medical insurance is the most affected by fraud due to exaggerations of claims or document exploitation by policy-holders and health providers. These was revealed by Okura (2013) who carried out a study on the relationship between good risk and insurance.

Several studies have been carried out on financial performance in various insurance sectors. These studies focused more on the degree, impact and the nature of extortion on the implementation of the insurance agencies that are being offered all over the world. Another research was conducted by Okwachi (2009) on effectiveness of state regulation of the insurance industry in Kenya. Wairimu (2010) carried out a study on challenges in management of general insurance claims. Similarly, Somme (2012) wrote on the extent and effect of fraud while Kuria & Moronge (2013) wrote on the impact of fraud control mechanisms on the growth of insurance companies in Kenya. Furthermore, Kosgei (2009) studied factors influencing the choice of health care financing by informal sector employees while Kubania (2011) did a study on the external environmental challenges affecting the performance of medical insurance sub sector in Kenya.

However, to the best of the researcher's knowledge, there have been little concentration on how fraud influences the financial performance in the medical insurance sector, case study of the AAR medical insurance. The case study on this sector will bring out the effect of fraud on the financial performance of the insurance company and the strategies on how to curb the fraud in the insurance companies. Therefore, this study will be handy especially to all medical insurance stakeholders.

CHAPTER THREE

RESEARH DESIGN AND METHODOLOGY

3.1. Research design

Kothari (2003) highlighted research design as the methodology and procedure employed to conduct the study and define the study type as well as the data collection that will be used.

The research used the descriptive research design aimed at determining the effect of fraud management on the financial performance of medical insurance firms in Kenya: A case study of AAR insurance Kenya. Descriptive research is a study designed to depict the participants in an accurate way (Shields et al 2013). According to Nworgu (2004), descriptive survey studies involve collecting and analysing data from a sample of the population considered to be a representation of the entire population or group.

3.2 Target Population

The target population is the entire group or entities a researcher is interested in or the group which the researcher wishes to draw conclusions (Kothari, 2003). Newing (2011) describes a population as the set of sampling units or cases that the researcher is interested in. The target population of this research was the 10 managers of the AAR insurance Kenya.

3.3 Sample and Sampling Procedure

A sample is a subset of a population to be studied (Yang, 2008). In addition, the sample is a part of the target population that has been procedurally selected to represent it. Sampling is the selection of a subset of individuals from within a population to yield some knowledge about the whole population, especially for the purposes of making predictions based on statistical inference (Black, 2004). The researcher purposively sampled 10 managers of the AAR insurance Kenya to participate in this study as the target population was small.

Purposive sampling was used because the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge and experience (Bernard 2002).

3.4 Data collection Procedure and Instrument

According to Wilkinson and Birmingham 2003, research instruments are simply devices for obtaining information relevant to your research project.

The researcher used simple structured questionnaires. Closed-ended questionnaire was used as it has the advantage of stimulating a specific response (Kasomo, 2006). Nevertheless, open-ended questions was also be provided as it allowed the participants a chance to explain what they truly felt and avoid limitations of pre-set categories of response while leading to a greater level of discovery (Gillham, 2000).

3.5 Data analysis and presentation

According to Ary 2006, data analysis is a process of finding meaning in data. It involves sorting data, editing, coding, entry, cleaning, processing and result interpretation. According to Zikmund et al. (2010), data analysis refers to the application of reasoning to understand the data that has been gathered with the aim of determining consistent patterns and summarizing the relevant details revealed in the investigation.

The data was analysed descriptively using Statistical Package for Social Sciences (SPSS). Data was presented in form of tables, charts and graphs for easy understanding.

3.6 Validity and reliability of the research

Validity refers to whether or not something actually measures what it claims to measure, it is the extent to which a text or a procedure produces a similar result under constant conditions on all occasions (Bell, 2010). Therefore, the validity of this research will be achieved through the consultation and guidance from supervisors and experts.

CHAPTER FOUR

PRESENTATION, ANALYSIS AND INTERPRETATION OF THE FINDINGS

4.0 Introduction

This chapter contains the presentation, analysis, and interpretation of results in line with the study objectives. The data that was collected from the field through questionnaires, was used to investigate the effect of fraud management on financial performance of medical insurance firms in Kenya: a case AAR medical insurance company. The findings are presented in tables, bars and frequencies.

4.1 Distribution of Questionnaires and Return Rate

The analysis of the questionnaire return rate for the number of respondents who participated in the study is presented in Table 2.

Table 4. 1: Questionnaire Distribution

Respondents	**Target Questionnaires**		**Return Questionnaires**	
	f	***%***	***F***	***%***
Fraud officers and managers	10	100	7	70

The study enlisted 10 managers and fraud officers of the AAR medical insurance company but only 7 participated, which is 70%. The small number that was unable to participate was negligible and therefore did not affect the outcome of the study in any significant way.

4.2 Demographic Information

4.2.1 Gender Distribution

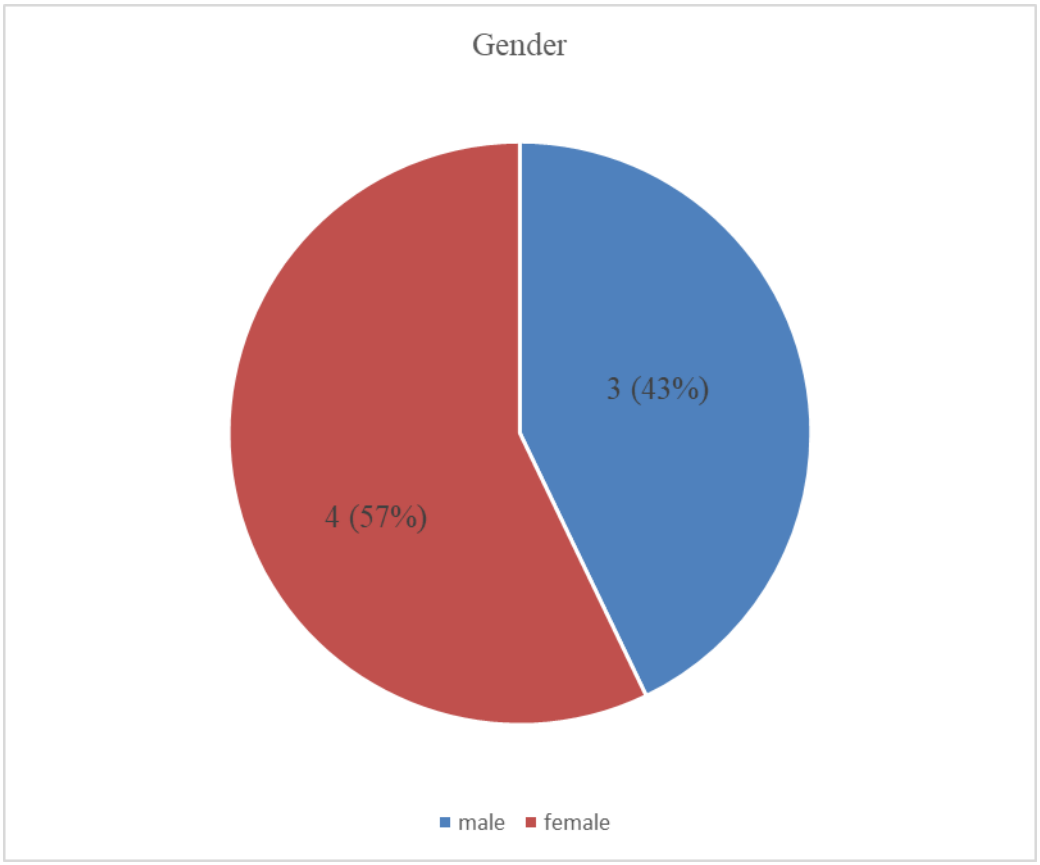


Figure 4.1: Gender

The gender analysis shows that 43% of the respondents were male while 57% were female. This implies that male respondents out numbered their female counterparts in the AAR insurance company.

4.2.2 Age of the Respondents

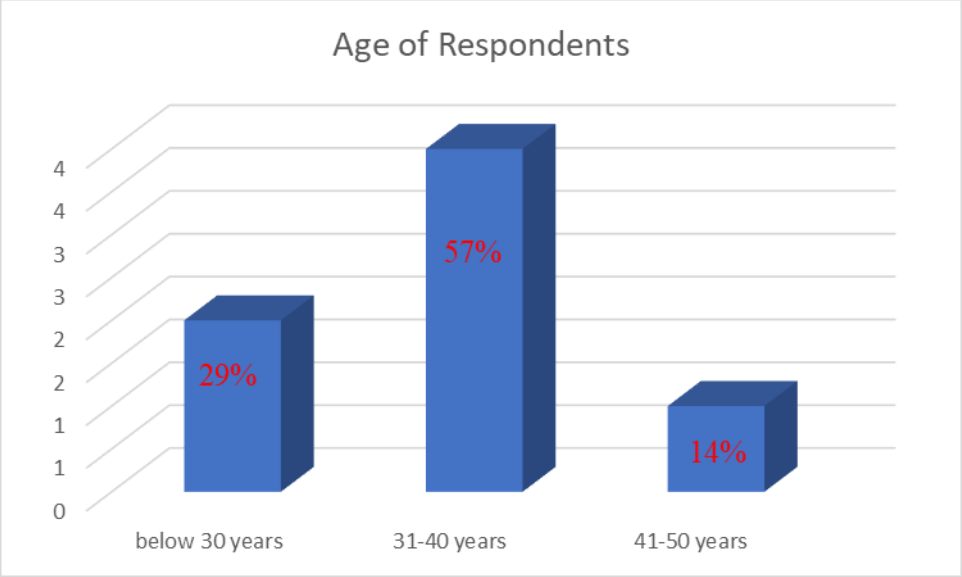


Figure 4.2: Age of the Respondents

Majority of the respondents are in the age bracket of 31-40 years with 57%. This implies that most of the respondents are in the prime of their career hence are able to respond appropriately to the items of the study. 29% of the respondents are below 30 years of age while 14% are within the age of 41-50 years.

4.2.3 Level of formal Education

Table 4.2: Level of formal Education

Level of formal Education	Frequency	Percentage
Secondary level	0	0
Tertiary level	1	14
Graduate level	6	86
Post graduate level	0	0
Total	**7**	**100**

Level of formal Education shows that majority of the officers in charge of fraud in AAR insurance had acquired a degree in that field as indicated by the 86%. Heading such a sensitive position in an insurance firm requires some kind of expertise and skills. However, 14% of the respondent had attained the tertiary level of education.

4.2.4 How long have you worked in AAR insurance company

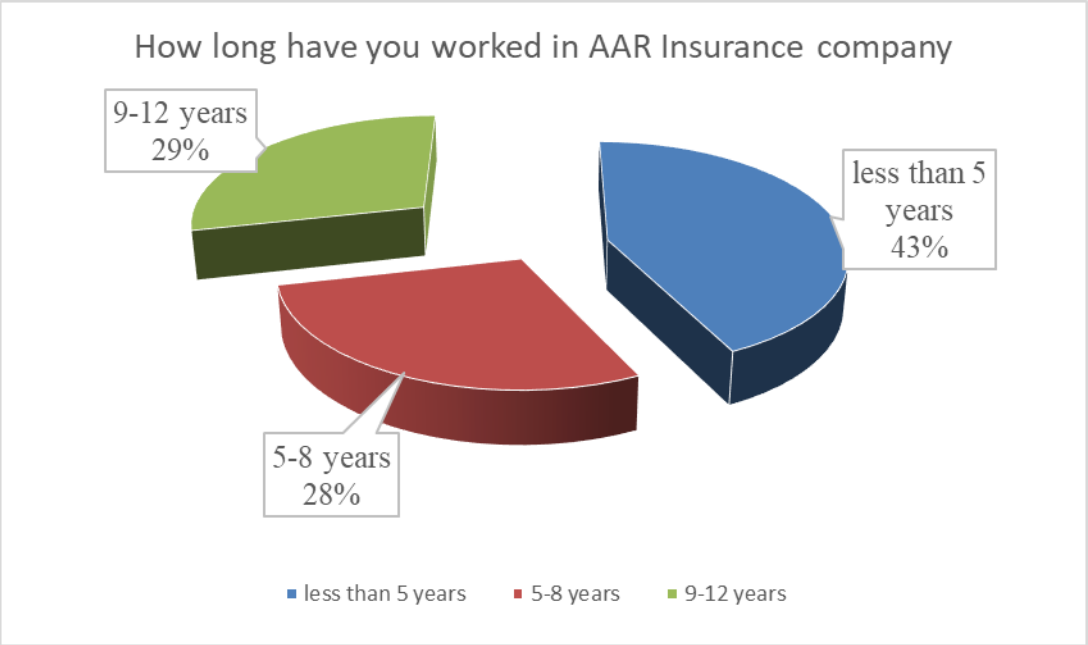


Figure 4.3: How long have you worked in AAR Insurance company

Majority of the respondents have worked in AAR Insurance company for more than 5 years as indicated by 57%. Invariably, their opinion on fraud will be of valid importance because of their relevant contribution. Nevertheless, 43% have worked for less than 5 years.

4.3 Individual Subscriber Fraud

The study embarked on trying to establish the individual subscriber fraud in AAR medical insurance. Several items were raised around this objective. The analysis of these items is as follows:

4.3.1 Experience of Fraud

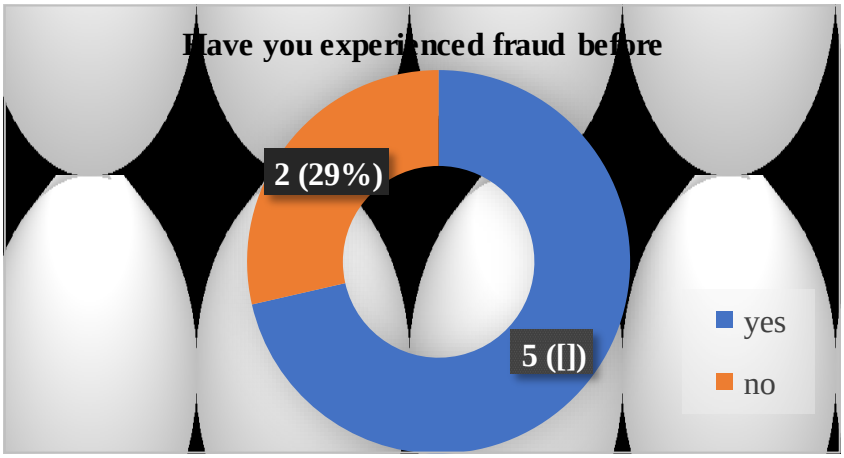


Figure 4.4: Experience of fraud before

Figure 4 shows that majority of the respondents were in agreement that they have experienced fraudulent practices before as indicated by 71%. And 29% who declined to the statement. This finding confirms the findings of Okura (2013) who carried out a similar study and reported that fraudulent related cases in medical insurance company are on the rise.

4.3.2 Group of fraud

Table 4. 3: Which group of fraud have you experienced

Which group of fraud have you experienced	f	%
Individual subscriber	2	29
Health Provider	5	71
Insurance agent	0	0
Total	7	100

Among the group of fraud that can exist in AAR medical insurance company is health provider fraud with a 71% as opposed to individual subscriber fraud with 29%.

4.3.3 Experience of fraud in the last five years

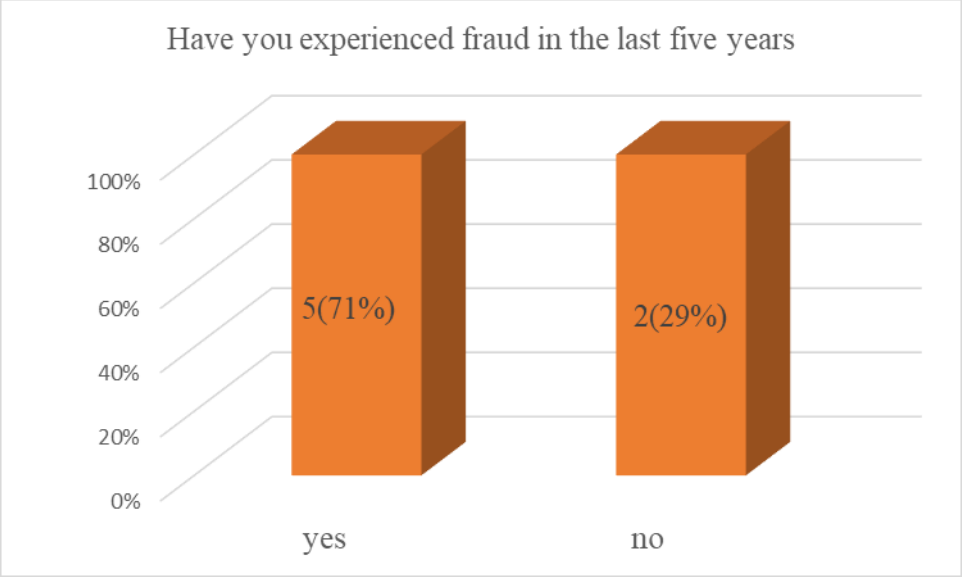


Figure 4.5: Experience of fraud in the last five years

Figure 5 shows that there been an experience of fraud in the last five years. This was attested by the 71% of the respondents and 29% who differ this opinion. We can invariably conclude

that the AAR insurance company has experienced fraud within the last five years. This confirms the findings of figure 4.

4.3.4 Level of fraud extent

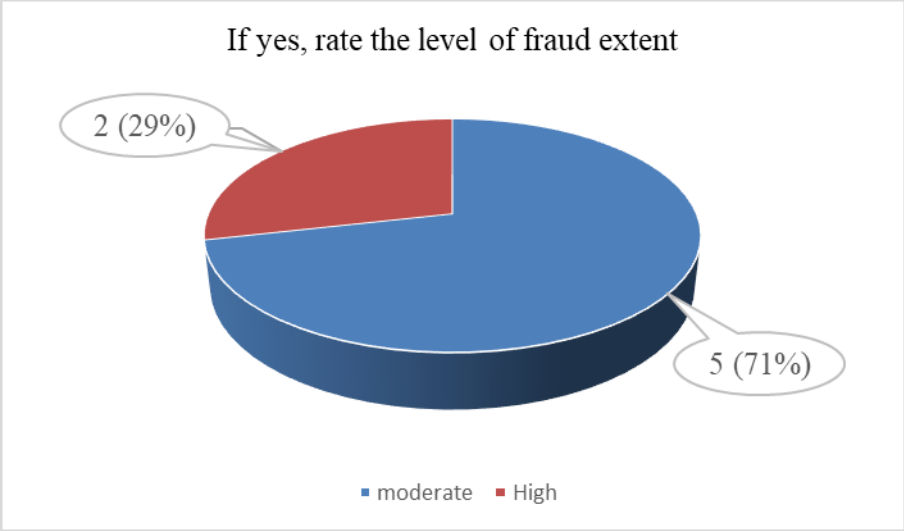


Figure 4.6: Level of fraud extent

Majority of the respondents agreed that the level of fraud extent in the last five years is moderate as indicated by 71%. 29% of the respondents differ as they agree to this level as been high.

4.3.5 Fraud committed by the individual subscriber

Majority of the respondents indicated that non- disclosure of prior ailments is the major fraud committed by the individual subscriber. A good number also did mention falsifying claims or altered invoice and diagnosis manipulation as another fraud committed by the individual. A few respondents indicated that unauthorized billing, claim for non-covered benefits and pharmacy related fraud are the ways individual commit fraud. Finally, a respondent mention over service as one of the ways the individual is involved in fraud.

4.4 Health care provider fraud

Qualitative analysis of the health care provider fraud was carried out. The following are the findings.

Majority of the respondents mentioned that pharmacy related fraud and falsifying claims or altered invoice as the major fraud committed by the health care provider. A good number said that over service, and diagnosis manipulation are the health care provider fraud. Others pointed at non-disclosure of prior ailments, claim for non-covered benefits, and fee splitting. Lastly, a few settled for generic instead of branded, membership substitution and unauthorised billing as the frauds committed by the health care provider.

4.5 Mitigation measures to curb fraud

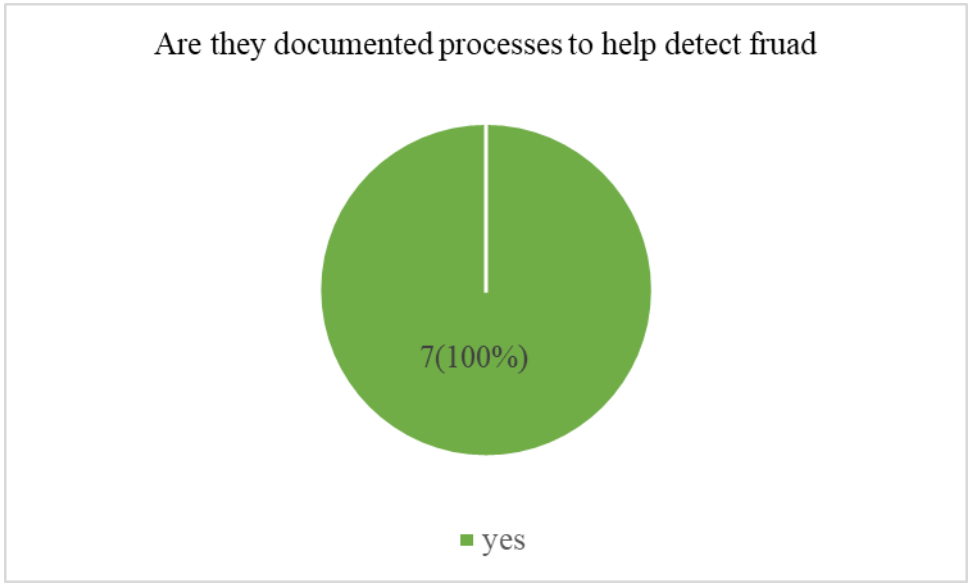


Figure 4.7: Documented processes in detecting fraud

The figure above shows that 100% of the respondents agreed that there is a documented process in the AAR insurance company which help in detecting fraudulent claims.

4.5.1 Software that can professionally detect fraudulent activities

Table 4.4: Software that can professionally detect fraud

Does your company have software that can professionally detect fraudulent activities?	f	%
Yes	2	29
No	5	71
Total	**7**	**100**

From Table 4, it can be seen that 29% of the AAR workers agree that the company have software that can professionally help in detecting fraud. This stand was opposed by the strong opinion of 71% who disagree that there is no software that can professionally detect fraud. This is a strong indication of lack of adequate measures to handle fraud in the medical insurance company.

4.5.2 IT system in receiving fraud claims

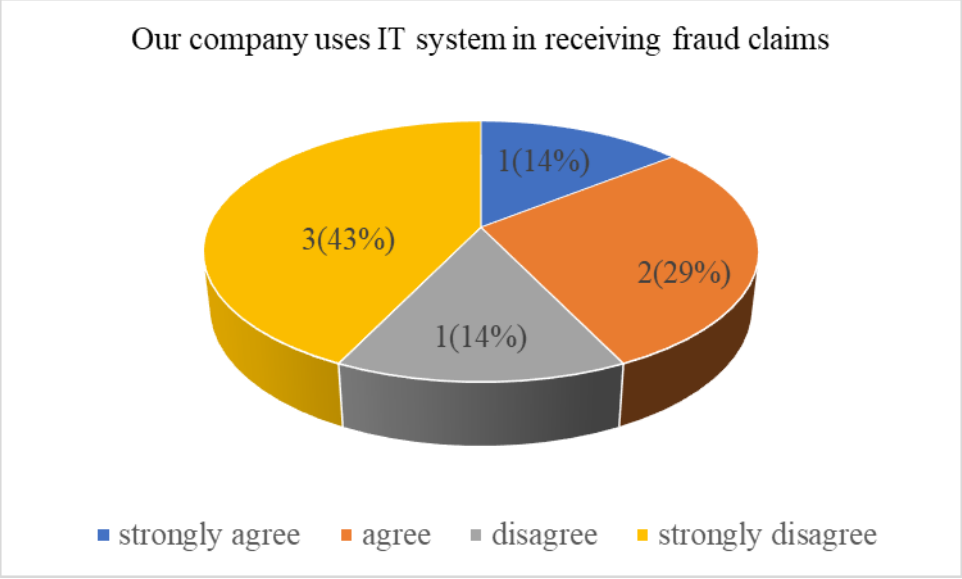


Figure 4.8: The use of IT system in receiving fraud claims

Figure 8 illustrate that 43% of the AAR insurance workers agreed that the insurance company uses IT system in receiving fraudulent claims. Majority of the respondents disagree to this statement as indicated by 57%. This is a strong indication of lack of adequate mitigation measures to curb medical insurance fraud. In the study carried out by Caren and Mbala (2016), their findings strongly suggested that the solutions in countering medical bill fraud is through subjecting the claims to audit to determine their validity and the use of ICT solutions to generate, verify and process expense claims. However, IT solutions are still prone to human manipulation and therefore not considered as the only solution to the problem.

4.5.3 General fraud management data base

Table 4.5: Availability of general fraud management database

Our company have a general fraud database management	f	%
Strongly agree	2	29
Agree	1	14
Neutral	0	0
Disagree	2	29
Strongly disagree	2	29
Total	**7**	**100**

The study shows that 43% of AAR insurance company have a general fraud database management, while 58% disagreed to this statement. This is a strong sign of lack of effective mitigation measures.

4.5.4 Reliant systems for managing fraud

Table 4.6: Our systems for managing fraud are reliant

Our systems for managing fraud are very reliant	f	%
Strongly agree	1	14
Agree	0	0
Neutral	3	43
Disagree	3	43
Strongly disagree	0	0
Total	**7**	**100**

This analysis shows that AAR insurance company has a reliant system for managing fraud as indicated by 43%. Similarly, 43% were neutral as they did not know what to say. Nevertheless, 14% had a contrary opinion as they agreed to the statement. These findings confirm the findings of Table 4.5.

4.5.5 Insurance Regulatory Authority

Table 4.7: Insurance Regulatory Authority

Insurance Regulatory Authority (IRA) is doing enough to combat insurance fraud	f	%
Strongly agree	1	14
Agree	1	14
Neutral	2	29
Disagree	2	29
Strongly disagree	1	14
Total	**7**	**100**

The findings of Table 4.7 shows that 28% of the respondents agree that the Insurance Regulatory Authority is doing enough to combat insurance fraud. On the contrary, 43% disagreed with this statement while 29% don't have anything to say. This shows that the IRA need to assist the medical insurance company in the fight against fraud. Caren and Mbala (2016), suggested establishment of government legislation against insurance fraud.

4.5.6 Guidelines from IRA helps in combating fraud

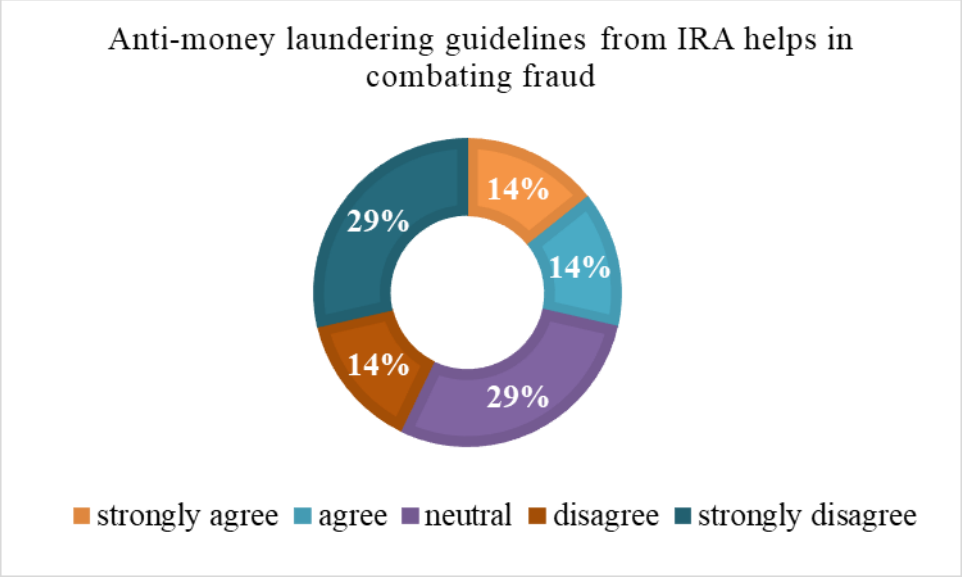


Figure 4.9: Anti-money laundering guidelines from IRA helps in combating fraud

The presentation indicates that 28% agreed that the anti-money laundering guidelines from IRA helps the medical insurance company to combat fraud. Notably, 43% disagree which confirms the findings of Table 4.7 that the Insurance Regulatory Authority is not doing enough to help medical insurance company fight fraudulent activities. However, 29% were confused on what to say as indicated by their neutrality.

4.5.7 Client providing incorrect or incomplete information

Table 4.8: Client providing incorrect of incomplete information to obtain a lower premium or higher coverage

The company is aware of the risk that the client might provide incorrect or incomplete information to obtain a lower premium or a higher coverage	f	%
Strongly agree	4	57
Agree	1	14
Neutral	2	29
Disagree	0	0
Strongly disagree	0	0
Total	**7**	**100**

The study found out that 71% were of the opinion that the company is aware of the risk of client providing incorrect information. This awareness is a prerequisite on the company's side to formulate strategies to curb such occurrences. However, 29% were neutral, this is a small population.

4.5.8 Fully-fledged claims management department

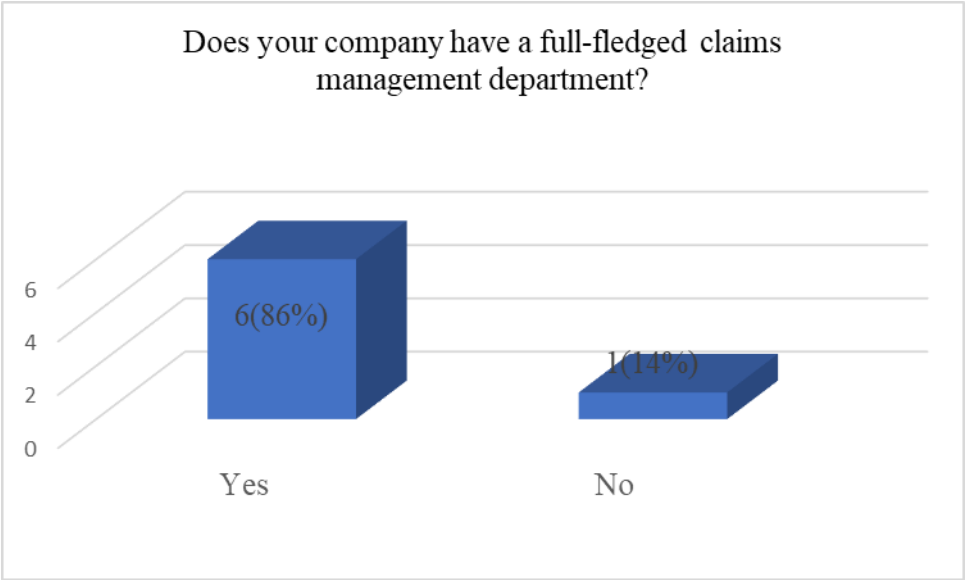


Figure 4.10: The company have a fully-fledged claims management department

Analysis of the presence of a claim's management department revealed that 86% of the respondents were in agreement that there is such department. While 14% held a contrary opinion. This finding agrees with the findings of Table 4.8. Since the company is aware of the chances of getting wrong information and claims, 86% agreeing that there is a claim department is a good that there are measures put in place to curb fraud.

4.5.9 Specific fraud management strategies

Figure 4.11: Specific fraud management strategies

Majority of the respondents concur that there are specific fraud management strategies in place as confirmed by the 86%. On the contrary, 14% disapprove. This confirms the findings of Table 10. Having a specific fraud management strategy will confirm that there is a department that handles fraud claims.

4.5.10 How often are the strategies audited and reviewed or revised

The research found out that the strategies are audited very often, however a good number responded that the strategies are audited and reviewed rarely. Furthermore, a minority of the respondents said that the strategies are audited and reviewed when need be. The inconsistency of opinion shows that there is a gap in the auditing and reviewing of the strategies for curbing medical fraud, hence the company need to do more in this arear.

4.5.11 Reliance on insurance agents, brokers, medical insurance providers and claims settling agents in claims management?

Table 4.9: Company's reliance on insurance agents, brokers, medical insurance providers and claims settling agents in claims management

Does your company rely on insurance agents, brokers, medical insurance providers and claims settling agents in claims management	f	%
Yes	3	43
No	4	57
Total	**7**	**100**

Table 4.9 revealed that 43% of the respondents agree that insurance agents, brokers, and claims settling agents are employed in claims management. Meanwhile, majority of the respondents 57% indicated that insurance agents, brokers, and claims settling agents are not involved in claims management. This is an indication of lack of adequate mitigating measures in handling fraud claims.

4.5.12 Impact of Insurance Fraud Investigation Unit (IFIU) on the prevalence of insurance fraud

Table 4.10: Impact of Insurance Fraud Investigation Unit on the prevalence of insurance fraud

Has the creation of the Insurance Fraud Investigation Unit (IFIU) had an impact on the prevalence of insurance fraud?	f	%
Yes	3	43
No	4	57
Total	**7**	**100**

It was evident from the majority of the respondents (57%) that the creation of Insurance Fraud Investigation Unit has no impact on medical insurance fraud. However, 43% hold the view that the Insurance Fraud Investigation Unit (IFIU) play an active important role in medical insurance fraud.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

The purpose of the study was to investigate the effect of fraud management on financial performance of medical insurance firms in Kenya. a case of AAR medical insurance company. The study was guided by the following objectives: To find out the effect of individual subscriber fraud on financial performance of medical insurance firms; To find out the effect of Health care provider fraud on financial performance of medical insurance firms and to suggest mitigation measures against medical frauds in medical insurance firms.

The study used descriptive research design. The study enlisted 7 managers of fraud working in the AAR medical insurance company in Kenya. Questionnaires was used to collect quantitative data. Statistical Package for Social Sciences (SPSS) version 25 was used to get descriptive statistics. The findings are discussed as follows:

5.2 Summary of the findings

5.2.1 Individual Subscribers Fraud

Generally, the study established that there have been cases of individual subscribers' fraud. However, among the group of fraud that the company experiences, health provider fraud is rated the highest with 71%. While they have been occasions of fraud in the last 5 years, it was discovered that the level of fraud extent has been moderate.

However, the study noted that non-disclosure of prior ailments is the major fraud committed by the individual subscriber. Other fraudulent activities carried out by the individual subscriber include falsifying claims or altered invoice, diagnosis manipulation, unauthorized billing, claim for non-covered benefits, pharmacy related fraud and over service.

5.2.2 Health Care Provider Fraud

The findings revealed that pharmacy related fraud and falsifying claims or altered invoice are the major fraud committed by the health care provider. Nevertheless, over service, diagnosis manipulation, non-disclosure of prior ailments, claim for non-covered benefits, membership substitution, generic instead of branded, unauthorised billing and fee splitting.

5.2.3 Mitigation measures to curb medical insurance fraud

The study revealed that there is a documented process in the AAR insurance company that helps in detecting fraudulent claims (100%). However, there is no software that can professionally detect fraudulent activities as indicated by 71%. This was further supported by the 57% who agreed that the company does not use IT system in receiving fraudulent claims. This is an indication of lack of proper fraud mitigating measures.

Remarkably, the study also revealed that 43% of the respondents agreed that the company have a general fraud database management, while 58% disagreed to this statement. In addition, majority of the respondents (43%) opined that there are no reliant systems for managing fraud. This is an indication that more has to be done in this area.

Furthermore, the survey findings revealed that the Insurance Regulatory Authority is not doing enough to combat insurance fraud. Similarly, the anti-money laundering guidelines from the Insurance Regulatory Authority is not doing enough to help medical insurance company fight fraudulent activities.

Nevertheless, the study found out that the company is aware of the risk of client providing incorrect information (71%) with the aim of obtaining a lower premium or a higher coverage. In addressing this, 86% agreed that the company have a fully-fledged claims management department hence there are specific fraud management strategies in place as confirmed by the 86%.

Meanwhile, majority of the respondents 57% indicated that insurance agents, brokers, and claims settling agents are not involved in claims management. Furthermore, the study noted that the majority of the respondents (57%) had a view that the creation of Insurance Fraud Investigation Unit has no impact on medical insurance fraud. However, 43% hold the view that the Insurance Fraud Investigation Unit (IFIU) play an active important role in medical insurance fraud.

The research found out that the strategies are audited very often, however on a contrary view a good number responded that the strategies are audited and reviewed rarely. Furthermore, a minority of the respondents said that the strategies are audited and reviewed when need be.

The inconsistency of opinion shows that there is a gap in the auditing and reviewing of the strategies for curbing medical fraud, hence the company need to do more in this area.

5.3 Conclusion

The study concludes that the AAR insurance company is generally aware of the fraudulent practices that can happen in the insurance company. Health provider fraud is the highest fraud in the health insurance company. While non-disclosure of prior ailments is the major fraud committed by the individual, pharmacy related fraud and falsifying claims or altered invoice are the major fraud committed by the health care provider.

The study also concludes that despite the AAR insurance company having a documented process for handling fraud, there is however, no use of software and IT systems in handling fraudulent claims. Similarly, the Insurance Regulatory Authority is not doing enough to combat insurance fraud.

5.4 Recommendations

In line with the findings of the study, the following recommendations were made:

5.4.1 AAR Medical Insurance Company

- The study recommends that computerized (IT) systems be used in handling of fraud claims.
- The study recommends frequently reviewed database management for fraudulent activities.
- The Government of Kenya through the Insurance Regulatory Authority should do a follow up review of how medical insurance companies are managing fraud.

- The study recommends that insurance agents, brokers, and claims settling agents should be involved in claim management.
- The study recommends that the Insurance Fraud Investigation Unit (IFIU) should employ a proactive means of helping medical insurance company handle fraud.

5.5 Suggestions for Further Research

The study only focused on the effect of fraud management on financial performance of medical insurance firms in Kenya. a case of AAR medical insurance company. This is a small area considering the many medical insurance companies in Kenya. It will therefore be important for other studies to be carried out with a bigger scope before generalizing the findings. Focus should also be on other insurance companies in Kenya such as motor insurance companies. Having said these, the following topics are therefore suggested for further research:

- Role of Insurance Fraud Investigation Unit (IFIU) in managing medical frauds.
- Effect of up-to-date information technology (IT) in the handling and management of medical fraud.
- Factors influencing health provider fraud in medical insurance.
- Relationship between insurance claims and financial position of the medical insurance companies.

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APPENDIX I: QUESTIONNAIRES

Marist International University College

Constituent College of the Catholic University of Eastern Africa

P.O. BOX 24450,00502

Karen, Nairobi.

Dear Participants,

I am a student of Marist International University College (MIUC), a constituent college of the Catholic University of Eastern Africa (CUEA). I am conducting a research on the effect of fraud management on the financial performance of medical insurance firms in Kenya: A case study of AAA insurance Kenya. Kindly assist in answering the questionnaires honestly by ticking the appropriate responses to the questions.

Your responses will be treated with confidentiality, and will be used for the purpose of research only.

Thank you very much for your cooperation.

Yours sincerely

Rebecca Arech

SECTION A: DEMOGRAPHIC INFORMATION

1. What is your gender?

1) Male [ ] 2) Female [ ]

2. To what age bracket do you belong?

1) Below 30 years [ ] 2) 31-40 years [ ]

3) 41-50 years [ ] 4) Above 50 years [ ]

3. What is your Highest Level of formal education?

1) Primary Level [ ] 2) Secondary Level [ ]

3) Tertiary Level [ ] 4) Graduate Level [ ]

4) Post Graduate Level [ ]

4. For how long have you worked in the insurance industry?

1) Less than 5 years [ ] 2) 5-8 year [ ]

3) 9-12 years [ ] 4) 13-15 years [ ]

5) Above 15 years [ ]

SECTION B: INDIVIDUAL SUBSCRIBER FRAUD

5. Have you experience fraud before Yes [ ] No [ ]

6. If yes from which group

Individual subscriber [ ]

Health provider [ ]

Insurance agent [ ]

7. Have you experienced fraud in the last five years

Yes [ ] No [ ]

8. If yes, rate the level of fraud extent

Very high [ ]

High [ ]

Moderate [ ]

Low [ ]

9. Which of the following fraud are committed by the individual subscriber? Kindly tick the one that apply to your company.

Diagnosis Manipulation	[ ]
Falsifying claims or Altered Invoice	[ ]
Merchandise substitution	[ ]
Generic instead of branded	[ ]
Over servicing	[ ]
Claim for non-covered benefits	[ ]
Script alterations	[ ]
Unauthorized billing	[ ]
Servicing non-members	[ ]
Non-disclosure of prior ailments	[ ]
Membership substitution	[ ]
Dual membership	[ ]
Up coding	[ ]
Fee splitting	[ ]
Waving Companies and Deductibles	[ ]
Pharmacy related fraud	[ ]

SECTION C: HEALTH CARE PROVIDER FRAUDS

10. Which of the following frauds are committed by health care provider? Kindly tick the one that apply to your company.

Diagnosis Manipulation	[ ]
Falsifying claims or Altered Invoice	[ ]
Merchandise substitution	[ ]
Generic instead of branded	[ ]
Over servicing	[ ]
Claim for non-covered benefits	[ ]
Script alterations	[ ]
Unauthorized billing	[ ]
Servicing non-members	[ ]
Non-disclosure of prior ailments	[ ]
Membership substitution	[ ]
Dual membership	[ ]
Up coding	[ ]
Fee splitting	[ ]
Waving Company's and Deductibles	[ ]
Pharmacy related fraud	[ ]

SECTION D: MITIGATION MEASURES PUT IN PLACE TO CURB FRAUD

11. Does your company have in place documented processes to help in detecting fraudulent claims? Yes [ ] No [ ]

12. Does your company have software that can professionally detect fraudulent activities?

Yes [ ] No [ ]

What is your level of agreement with the statements below (1-Strongly agree, 2- Agree, 3-Neutral,4- Disagree, 5 Strongly Disagree)?

STATEMENT	**1**	**2**	**3**	**4**	**5**
13. Our company uses IT system in receiving fraud claims					
14. Our company have a general fraud database management					
15. Our systems for managing fraud is very reliant					
16. Insurance Regulatory Authority (IRA) is doing enough to combat insurance fraud?					
17. Anti-money laundering guidelines from IRA helps combating fraud?					
18. The company is aware of the risk that the client might provide incorrect or incomplete information to obtain a lower premium or a higher coverage.					

19. Does your company have a fully-fledged claims management department?

Yes [ ] No [ ]

21. Does your company have specific fraud management strategies?

Yes [ ] No [ ]

22. How often are the strategies audited?

……..

..

23. How often are the strategies reviewed and revised?

……

….

24. Does your company rely on insurance Agents, Brokers, Medical Insurance Providers and other service providers (Claims Settling Agents) in claims management?

Yes [ ] No [ ]

25. Has the creation of the Insurance Fraud Investigation Unit (IFIU) had an impact on the prevalence of insurance fraud?

Yes [ ] No [ ]

LETTER OF RESEARCH AUTHORIZATION

MARIST INTERNATIONAL UNIVERSITY COLLEGE (MIUC)
CONSTITUENT COLLEGE OF THE CATHOLIC UNIVERSITY OF EASTERN AFRICA
P. O. BOX 24450 KAREN, 00502 NAIROBI
TEL: 254-02-2012787 / 2012797; FAX: 254-20-2389939

23rd January, 2019

TO WHOM IT MAY CONCERN

RE: REBECCA ARECH (BBM/195/17/18)

Assistance for Research Exercise.

The above named is a student of Marist International University College taking a Bachelor's Degree in Business Management (Finance). As part of the course she is expected to conduct a research in line of her specialization.

The research topic to be carried out is: Effect of Fraud Management on Financial Performance of Medical Insurance Firms in Kenya. A case Study of AAR Insurance, Kenya.

I hereby request for your kind assistance by allowing her to collect the data from your institution. The data is purely for an academic research and information collected will be handled with high level of confidentiality.

I look forward for your kind assistance.

Thanks in advance.

Yours sincerely,

MARIST INTERNATIONAL UNIVERSITY COLLEGE
OFFICE OF THE REGISTRAR
24 JAN 2019
P.O. BOX 24450 - 00502, KAREN, NAIROBI

REGISTRAR

SR. DR. JACKLYNE OKELLO ALARI