Name Of the Student	**M S GIRIDHAR**
Name of the Faculty Guide	**IRMAI**
Roll No	
Course	**CERTIFICATE COURSE IN RISK MANAGEMENT**
E-mail id	**giridhar@glideinsurance.com**
Date of Commencement of Course	**02.06.2021**

INSURANCE FRAUDS AND RISK MANAGEMENT	
1	Introduction
2	Definition of Fraud
3	Definition as per Indian Contract Act ,1872
4	Genesis of Insurance Frauds
5	Surprising Facts noticed during the Pandemic
6	Impact on Exchequer in India & FICCI Report
7	Impact on Exchequer Worldwide
8	Categories of Fraud
9	A brief report by CAIF (Coalition Against Insurance Fraud)
10	Role of the Regulator - IRDAI
11	Case Studies – Life & General
12	Impact of Frauds
13	Doctrine of Internal Controls
14	Risk Management Techniques
15	Recommended Practices
16	Conclusion

INTRODUCTION

Insurance Industry works on a basic principle associated with underwriting an insurance risk and management of risk. Insurance is one of the fastest growing sectors in India and poised for a major growth trajectory by 2025. IT was also seen during the pandemic there was a huge surge in insurance business for health insurance related insurance policies. Insurance is a risk transfer mechanism for any business owner to survive the uncertainty and unpredictability of the risk that can or might happen. Insurance companies across offer and design tailor-made insurance plans to protect the interests and the balance sheets of Companies.

Insurance Industry and Insurance Companies face graver risks than their cross-industry counterparts. Unlike those in other sectors, Insurance Underwriters face dangers whilst dealing with claims pertaining to damage to property and equipment, diseases and illnesses of insureds, and accidents at the workplace, due to internal and external challenges regards to integrity issues within and fraudulent intentions by the external stake holders. Consequence to which the Insurers stand exposed to negative publicity and loss of reputation. The Government and the Regulators have a very stringent approach to curtail these types of drain on the exchequer as the Insurance premia collected by the Insurer is public money.

The purpose of this study is to understand, analyse different claims scenario exposures and finally frame a most suitable Internal controls risk philosophy to address frauds and suggest suitable solutions or recommendations which is beneficial to the Business owner that is the Insurance Company, in controlling frauds and bringing in a fiscal discipline which would increase the buying capacity of the proposer.

This project report has relied upon secondary data which has been collected from Articles and Websites in the public domain and on the experiences of claims managers in Insurance Companies who are engaged in controlling and mitigating insurance related frauds, by stitching a comprehensive internal controls document as a risk mitigation tool for the Insurer to arrest frauds, and finally protecting the balance sheet of Insurance Companies.

INSURANCE FRAUDS AND RISK MANAGEMENT

As defined in Webster Dictionary – Fraud is an intentional perversion of truth in order to induce another to part with something of value or to surrender a legal right

"Fraud" as defined in the Indian Contract Act, 1872

"Fraud" means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agents, with intent to deceive another party thereto or his agent, or to induce him to enter into the contract:

(1) the suggestion as a fact, of that which is not true, by one who does not believe it to be true.

(2) the active concealment of a fact by one having knowledge or belief of the fact (*misrepresentation of non-existent subject matter, property already destroyed- parenthesis is mine*)

(3) a promise made without any intention of performing it (*a policy is sold with maximum deductibles - parenthesis is mine)*

(4) any other act fitted to deceive.

(5) any such act or omission as the law specially declares to be fraudulent

GENESIS OF INSURANCE FRAUDS

Insurance fraud occurs when an insurance company, agent, adjuster, or consumer commits a deliberate deception to obtain an illegitimate gain. It can occur during the process of buying, using, selling, or underwriting insurance. Insurance fraud may fall into different categories from individuals committing fraud against consumers to individuals committing fraud against insurance companies

The reasons are myriad but not limited to the following:

It occurs primarily to make easy money.

It occurs when there are no internal control mechanism or systems in place.

It occurs when the persons monitoring the internal controls mechanism or systems are corrupt.

It occurs when there are no effective checks and balances in place.

It occurs when the Checker and Maker are one and the same.

It occurs when there is a staff crunch.

It occurs when the decision maker or the employee feels he is underpaid for all the work he is putting in.

It occurs when there is no recognition for the hard work or being overlooked at the time of promotions.

It occurs when the perpetrator wants to understand how the system responds, challenges the system, and feels a sense of accomplishment.

It occurs when there is an increased tolerance towards fraud.

It occurs when there is no effective Whistleblower Policy.

It occurs when there is a lack of will to prosecute the perpetrator of crime.

It occurs when there are no effective laws in place to control and create fear.

It occurs when the perpetrator knows how to buy his way out by bribing.

It occurs when all the stake holders jointly execute the crime.

CATEGORIES OF FRAUD:

Hard fraud and Soft fraud

Hard fraud occurs when a policyholder deliberately destroys property with the intent of collecting on the insurance policy.

Soft fraud, which is more common, occurs when a policyholder exaggerates on an otherwise legitimate claim, or intentionally omits or lies about information on an application to obtain a lower premium. Soft fraud is often considered a crime of opportunity.

Internal Fraud and External Fraud

Fraud risk in the insurance value chain can emanate from Internal (Insiders) and external factors. The risk of employees misusing confidential information and colluding with fraudsters is on the rise and insurers will need to put in place internal checks and balances to minimize such issues. Insiders know the operations and they resort to frauds for personal gains.

External (Outsiders) fraud risk can arise at various stages: registration of clients, underwriting, and the claims process. The severity of the frauds can range from a slight exaggeration to deliberately causing loss of insured assets. Outsiders resort to frauds independently or with connivance with insiders for mutual benefit.

SURPRISING FACTS NOTICED DURINGTHE PANDEMIC

Even during this black swan event, as per the collation of data and the Report of CAIF 2020 has thrown out surprising statistics even during the Pandemic when all the Offices, Industries etc were shut down.

50-69% reported that case volume remained “about the same” across Auto Category

60-65% of respondents claimed to have handled “about the same” auto claim referral volume in 2021.

11% of state respondents said their WC employer claims volume had changed to either “high” or “very high.”

29% of responding fire marshals reported an “above normal” amount of arson investigations

IMPACT ON THE EXCHEQUER IN INDIA

India does not have an effective insurance fraud law even though frauds burnt a substantial hole in the Indian insurance industry's pocket in 2019.

Key Statistics – Insurance Fraud

India’s insurance premium in 2018 for Life Insurance was US$73.74 billion and Non-Life Insurance was US$26.10 billion totaling US$99.84 billion

In FY2017-18 claims repudiated were 0.74, claims rejected were 0.43 of Life Insurance claims

According to a report, Insurance companies lose over US$6.25 billion to frauds which results in higher premiums for genuine consumers.

A media report stated that over 10% of claims in general insurance are fraudulent

FICCI REPORT

According to a FICCI report common triggers observed to detect frauds are:

Claim from a policy with only one member at minimum sum insured amount.

Multiple claims with repeated hospitalization and multiple claims towards the end of the policy period, close proximity of claims.

Any claims made immediately after a policy sum insured enhancement.

Claims from a member with the history of frequent change of insurer or gap in the previous insurance policy.

Policy claims with evidence of significant over/under insurance as compared to the insured’s income/lifestyle.

Claims from a non-traceable person or where courier/cheque have been returned from insured's documented address

The second claim in the same year for an acute medical illness/surgical minor illness/orthopedic minor illness in the same policy period for main claim. Young males between 25-35 years getting admitted for acute medical illness

Claims from members with no claim free years, i.e. regular claim history

IMPACT ON THE EXCHEQUER - WORLDWIDE

Elsewhere, the insurance frauds clocked $4 billion in Australia, $3 billion in the UK and $2billion-$3billion in other EU countries the same year.

REPORT AS PER COALITION AGAINST INSURANCE FRAUD(CAIF)

In percentage terms, most insurers lose between 10%-15% across all lines of their business, whereas health insurance fraudulent claims can even touch 35%. Further, about 90% of auto insurance frauds are the result of padding claims (which means to add damages, injuries, and fictitious passengers to insurance claims).

The other 10% of insurance frauds come from organized accident-staging. In the life insurance segment, most frauds are seen where the sum assured is between INR 2 lakh to INR 12 lakh.

Most of the advanced countries where the insurance industry has matured, have put insurance fraud laws in place. Insurance fraud is classified as a crime in all the states of the USA.

In India, there is no specific provision in the Indian Penal Code for insurance frauds. A few sections that have some relevance are-Section 205-false impersonation for the purpose of act or proceeding in suit or persecution; Section 420-cheating and dishonestly inducing delivery of property; Section 464-making a false document including signs, seals and forgery and Section 405-criminal breach of trust. However, these provisions are not adequate to prosecute a fraudster legally under the current scenario of organized insurance frauds.

Due to the mounting backlog of pending judicial cases in our courts, taking legal action against insurance frauds is not a common occurrence and frauds of amounts not big enough are let go off as opposed to the heavy investment of time and energy in pursuing the same.

Honest customers should not have to pay the price for fraudsters through higher premiums. Compared to other crimes, court sentences for insurance frauds are lenient, reducing the risk of severe or extended punishment.

Surprisingly, Indian Insurance Act does not contain a definition for insurance frauds in the Indian Penal Code, 1860 & The Indian Contract Act, 1872.

ROLE OF THE REGULATOR -IRDAI INSURANCE FRAUD POLICY

According to the Insurance Regulatory and Development Authority (IRDAI), every insurance company is required to set up a Fraud Monitoring Framework. The framework shall include measures to protect, prevent, detect and mitigate the risk of fraud from policyholders/claimants, intermediaries and employees of the insurance companies.

Anti- Fraud Policies

Insurers are expected to adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly lay down appropriate risk management policies and procedures. The Insurance company Board of Directors are mandated by the IRDAI to review their respective Anti-Fraud Policies on an annual basis, and at such other intervals as it may be considered necessary. Such policies need to provide a comprehensive guideline on fraud monitoring procedures, identification of potential avenues of fraud, guidelines to cooperate and coordinate with State and Claw enforcement agencies for identifying the act of fraud as well as the perpetrators.

These policies also guide in building a framework that will allow them to exchange information with other insurance companies with regard to sharing intelligence on the occurrence of incidents and scenarios of such frauds so that these can be red flagged within the insurance ecosystem.

Fraud Monitoring Function

Every Insurance company is mandated to have the Fraud Monitoring Function as a separate vertical that shall ensure effective implementation of the anti-fraud policies. They shall be responsible for laying down procedures for internal reporting from/and to various departments, to educate employees, intermediaries and policyholders on identification and prevention of frauds. Further, they must regularly update regulatory authorities on such incidents as well as steps taken to contain such scenarios within a stipulated time. Lastly, they must furnish periodic reports to their respective Boards for review and course correction.

Insurers are liable to inform both potential and existing clients about their anti-fraud policies. Insurers include necessary cautions in the insurance contracts and relevant documents, duly

highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of the policyholder, claimants, and their beneficiaries.

A few Insurance claims both Non-life and Life are discussed as to how fraudsters operate.

CASE STUDIES

1 THE CASE STUDY OF GHOSTS ACCOUNT HOLDERS AND INSURANCE POLICIES

The District Cooperative Bank disbursed loans to marginal farmers, SC & STs to purchase sheep for rearing purpose.

The local General Insurance Company had a tie up with the District Co-operative Central Bank to handle their Banks' complete Insurance requirement.

The Insurance Agent who was servicing their DCCB Branch collected 10,000 ear tags from the Insurance Company to tag the animals. All the animals were purportedly tagged by the local Vet Doctor and tagging charges were also disbursed by the Insurer along with the Tour bills to the Agent as well as the Development Officer concerned.

The Insurance Claims Manager was jokingly informed by the Agent that there would not be any claims and that the Policy is profitable to the Company because it was a three-year policy period.

This one statement was the trigger point of a deep diving investigation by the Insurer which led to a chilling trail of corruption, deceit and insider manipulation of records causing loss to the Bank and a possibility of claims for non-existent animals in the future.

The Insurer went to the depths of entire activity, from insurer's point of view, and it was discovered that there were no animals (no subject matter for insurance) and majority of the account holders were ghosts' beneficiaries.

The moot point was why this happened? What was the modus operandi?

People involved were in senior positions in the Bank. They were not only the decision makers but also policy makers. It was lucre of making easy money that made them to create fictious accounts, disburse the amounts, withdraw the money and for a few account holders (who bought only a few animals but claimed for the entire unit which comprise of one ram and twenty eves), money was passed by the Officers to maintain secrecy.

All the policies were cancelled by the Insurer and premium refunded to the Bank.

The reasons for cancellation of the policies were informed and there was an internal enquiry in the Bank which dragged on for years.

Verdict, no information about the outcome and Insurer also forgot.

I feel that all the concerned staff working for the Insurer should have been suspended because in a way they also became a party to this fraud by claiming tagging charges, tour bills, refreshment expenses.

Suggestion: As it was a complete breakdown of internal rules, for all such big activities involving multiple people and stake holders (Staff of Insurance Company, Banker, Govt Veterinary Surgeons), there must be a thorough audit of all such policies. There was a huge Risk to the credibility of the Insurer as well as to the Banker. Internal monitoring must be thorough, and random checking of transactions must be carried out apart from Internal Audit, External Audit, CAG, Vigilance Department surprise checks as they create a set predictable pattern and do not create shock and awe for people who are accustomed to making money on the sly.

2 GROUP PERSONAL ACCIDENT POLICY FOR CHIT FUND ACCOUNT HOLDERS

It was one of the topmost chit fund companies in that area and thousands were enrolled as chit fund members. The Insurer found a business opportunity and tailor made a GPA policy for the account holders based on their loans outstanding (which would be treated as the sum insured) and for others who had made deposits. Members who had made the deposit depending on their known sources of income, sum insured was arrived at and accordingly would be endorsed for inclusion as and when there are inclusions. It was a complicated underwriting procedure that was agreed upon since every transaction had to be vetted by the underwriter and signed off. All the guidelines were agreed to and followed by the Insurer as well as the Chit Fund Company.

As the copies of the schedules were not entered in the system since it was all manual driven, it was filed separately for easy retrievability of information.

The client made the premium deposit based on the quote and it was accounted as cash deposit transaction and the Policy was yet to be issued as the underwriting officer had to make a check.

The Policy was issued after checking the entries manually page by page running into more five hundred sheets. It took considerable amount of time. The one mistake which was committed by the underwriting officer was that every sheet was not signed and dated. This mistake proved to be costly.

One day the MD of the Chit Fund Company walked with a claim intimation for the death of a member who was killed in a road accident. The death had occurred a week earlier. The MD was apologetic saying that he was not in town and after his return, the moment the demise of the member was informed, he immediately rushed to the Insurer to give the claim intimation. The sum insured involved for the said member was INR 10,00,000.00

Claim form was issued, and it was also registered.

At the time of opening the claim docket, the claims manager wanted to check the UW docket and it was found that something was amiss. The sheet where the deceased's name was entered appeared to be fresh. The sheet in the bunch was looking fresh and the carbon which got imprinted was also fresh. When the sheet was smelled it was fresh and when the carbon was rubbed, it got stuck to his palm unlike other couple of sheets. It was evident that the sheet was inserted by someone in the office before the claim was lodged. The insurer's employee was in cohort with the chit fund company and had facilitated the insertion of the sheet.

The Chit Fund Company owner was summoned by the Insurance Claims manager and was warned that the case will be intimated to the police for an offline investigation, and that he should withdraw the claim as NO CLAIM lest things get out of hand. The claim was withdrawn within ten minutes.

Suggestion: It was a complete breakdown of internal controls and a fraudulent motive to falsify the records, manipulate and engineer a false claim. The Underwriting Manager should have signed and dated on all the documents to avoid a situation like this and moreover it became impossible to detect as to who was the insider who gave access to the client to manipulate records. But for the Claims manager presence of mind, the liability of the Insurer would have been INR 10,00,000

3 HIGH VALUED SUM INSURED LIFE INSURANCE POLICY FOR A CANCER PATIENT

A Policy was incepted with one of the private life insurers for a sum insured of INR 50,00,000 by the insurance agent who was a well-known business performer.

Proposal form, clean health declaration and medical reports as per the Company's Underwriting guidelines were also furnished. The Policy was issued based on the attached reports.

The claim intimation was given by the nominee that her husband died due to unknown disease and prayed for relief and early settlement of insurance claim.

The Insurer initiated the investigation since it was an early death counting from the policy inception date.

The investigator approached his wife, relatives and made enquiries. All the people sang the same song that he was hale and healthy prior to his death. When the villagers were spoken to it was informed that the assured was suffering and was not well for months. The investigator approached the local PHC doctor who had treated the assured and made the notes. And then the trail disappeared.

One of the villagers said that the assured was suffering from cancer for years. This one statement became a trigger point for an investigation which took the investigator to all the leading hospitals in that district and beyond. In one of the Hospitals, the investigator stumbled upon the assured's treatment details and collected all the documentary evidence. Since the hospital was reluctant, the Insurer sent a formal letter requesting for support. All the copies of line of treatment, admission date/discharge date, medical history revealed that the assured was suffering from cancer for more than two years and the life insurance policy was taken by him upon the advice of the agent who approached him. Interestingly, the agent was not from that area and was operating from an office five hundred kilometers away.

A few of the villagers gave their statements upon much persuasion by the investigator and all the findings were submitted to the Insurer who rejected the claim of the assured's nominee that the policy was obtained on misrepresentation of material facts, was fraudulent by nature and the agent's role was also taken up.

In this case, it was seen that the Insurer did not check the moral hazard involved whilst selecting the agent and there was no tab as to why the policies were being generated by the agent beyond his jurisdiction of operation? There is no bar, but the insurers must understand the big data, carry out the analytics of operations and claims that are triggered, and must be ensured it is a silent operation to not attract negative publicity for the company and all the findings must be discussed threadbare by the underwriting, claims and business teams.

4 **THE CASE OF MOTOR OD CLAIM**

The Third-Party claim for filing the affidavit and deposition before the MACT Court (Motor Accidents Claims Tribunal) came for preparation to the Claims Manager handling Third Party Insurance Claims.

The bunch of petitions came up for scrutiny.

The petitions were entered in the system and all the claim files were opened.

The advocate was also appointed to handle the claims. The appointment of the advocate was on rotation basis out of empaneled list.

The details were also entered by the claim's manager in date of loss register, vehicle wise details register and place of accident wise ledger. These ledgers were maintained to ensure that the same claim is not being filed by the same petitioners in different Courts and to have a complete control on the claims.

Since there were multiple claimants arising out of a single incident, the claims manager wanted to check whether there was any OD claim reported with the underwriting office.

The TP claim was more than a year old.

There was an OD claim, and the entire papers were pulled out along with the Underwriting papers.

The OD claim had occurred at X place within the nearest vicinity of a police station on a busy road in the morning at 0300 Hours resulting in total loss of the vehicle. None of the occupants of the car were injured in the said accident as per the claim form. The claim was settled as a total loss by the office.

The trigger point of a massive investigation by the claim's manager handling the Third-Party claims department was the nature and type of loss description made in the claim form by the owner of the vehicle.

The investigation revealed that the vehicle was involved in an accident in a different state and the TP claims were registered by the local Police Station there and the claims intimation under TP was made to the local Insurance office which was not the underwriting office but a servicing office.

Then the damaged vehicle from that state was carried on a trailer and then dumped on a road in the state where the underwriting office was located and informed that an unknown vehicle had hit their vehicle and disappeared from the scene. The local police registered the claim and did not make further enquiry as there were no occupants and no injuries to the driver of the vehicle.

Why this happened?

The driver who was involved in the accident was not having a DL but could not escape since TP claims had triggered whereas it was stage managed as an OD claim in other state by producing valid DL papers. The drivers were different.

In this case, it was clearly evident that though the claim was genuine, the way it was accommodated for the OD claim was malafide and with an intention to cause pecuniary loss to the insurer. It was a complete breakdown of internal controls.

Examples are myriad as seen in the Indian Insurance Industry Involving Surveyors, Investigators, Advocates, Police, Hospitals, Doctors, Employees of Insurers, Internal and External Auditors. There had been a complete failure in understanding the processes, how to plug the loopholes and bring an effective frauds control management program in place.

IMPACT OF FRAUDS

It is seen that the Insurance industry perse has resigned to the fact that frauds are part of their businesses and would hover in the range of 10-15%

The hit ratio for detecting the frauds and giving fool proof documents lies on Investigators and if the hit ratio is more than 10% in detecting frauds, then it is a big game changer.

It creates negative publicity for the Insurer.

It will cascade into increased premiums thereby impacting the Insurers' business and revenues.

DOCTRINE OF INTERNAL CONTROLS

So how to bring in a fool proof process in internal controls to curb this menace? A few pointers are listed below to have an overall view on an effective mechanism to bring in the discipline within the organization.

1. Checker and Maker concept must be defined clearly
2. To invest in technology by moving away from manual transactions to systems management
3. Persons with good experience must man critical departments
4. Robust Vigilance department
5. Complete control on old claims documents, storage, and retrieval policy to be written and well documented
6. Destruction of old papers under the supervision of a committee formed for the purpose
7. Forensic Audit to be carried out periodically
8. Deep diving analytics on claims emanating from a particular area, office, agent, intermediary
9. Job rotation every three years
10. Transfers every three years
11. Zero tolerance for frauds related issues to create a sense of fear
12. Right candidate for the right position- sensitive background checks at the time of selection of candidates for critical and senior positions
13. Disciplinary action initiation without a sense of fear, retribution, and persecution of the perpetrators of crime by the Vigilance Department
14. Complete Insurance fraud study by an external expert who must be authorized to suggest effective remedial measures and recommendations
15. To continuously reassess the internal controls, processes, and written policies to manage and mitigate the risk of frauds

RISK MANAGEMENT TECHNIQUES TO BE ADOPTED

1. Compulsory CAG Audit every three years
2. Fault Tree Analysis as a Risk Reduction methodology to be implemented
3. Artificial Intelligence techniques to be promulgated
4. Predictive Analytics by working on big data

5. Artificial Intelligence
6. Robust Whistle Blower Policy
7. Forensic Audit
8. Setting up of Special Investigation Units at the HO or Corporate Level though it is cost prohibitive
9. Sharing of data and findings from the top down and securing information from bottoms up
10. Constant information exchange with other Insurers in the same area.
11. Data Modelling Techniques
12. Adapting Statistical Algorithms techniques
13. Moral Hazard Reports of Intermediaries
14. A comprehensive and integrated approach to control frauds has to be well documented by taking the expert opinion from the stake holders and also making a thorough study of claims not reported with active collaboration with the law-and-order agencies

RECOMMENDED PRACTICES

- The TONE from the TOP must be clearly spelt out
- There must be complete focus on data acquisition within and data collection from different departments outside the Company
- Claims of all nature and types to be constantly churned and analyzed
- Any discernible pattern emerging out of such churning must be documented and immediately the concerned Managers / Officers to be intimated
- In high value claims involving multiple external departments there must be complete focus on possible breach of standard warranties/ conditions, imposed conditions & warranties
- The underwriter must also have a complete understanding of loss experience and claims experience - losses not reported and claims which are intimated to build a robust management of frauds
- A clear and well-defined document on Business Accommodation whilst at the time of underwriting a risk so that the processes are not diluted
- Close coordination with Govt Bodies like IRDAI, IIB, and Institutions like IRMAI, IISLA, LPAI etc; to understand the ground situations better
- Bringing in private sector also under the ambit of ACB laws
- A claims manager is the eyes and ears of the Insurer who must provide critical inputs to the underwriting team about any abnormal situations or cases that has come to his notice from any Intermediary so that the underwriter takes appropriate action if required so
- Strict rotation of deploying surveyors, investigators, and lawyers by the claim's manager
- The vigilance officer, auditor, underwriter, and the claims manager must have regular meetings to understand the ground situation by identifying potential threats from a particular area where the business is being sourced, role of the intermediary in placing business where the reputation of the Insurer would be at stake by accepting such type of business generation and suggest remedial measures for an effective management of frauds.

In conclusion, frauds are the bane of society, and the perpetrators must not be allowed to go Scot free by which all others are not embolded. The Internal Controls Document must clearly spell out the adherence to guidelines on acceptance of insurance risks, claims process, deputizing right surveyors, investigators and lawyers on rotation basis which shall in the longer run result in the Insurance Companies getting its due respect in the eyes of Indian citizens.