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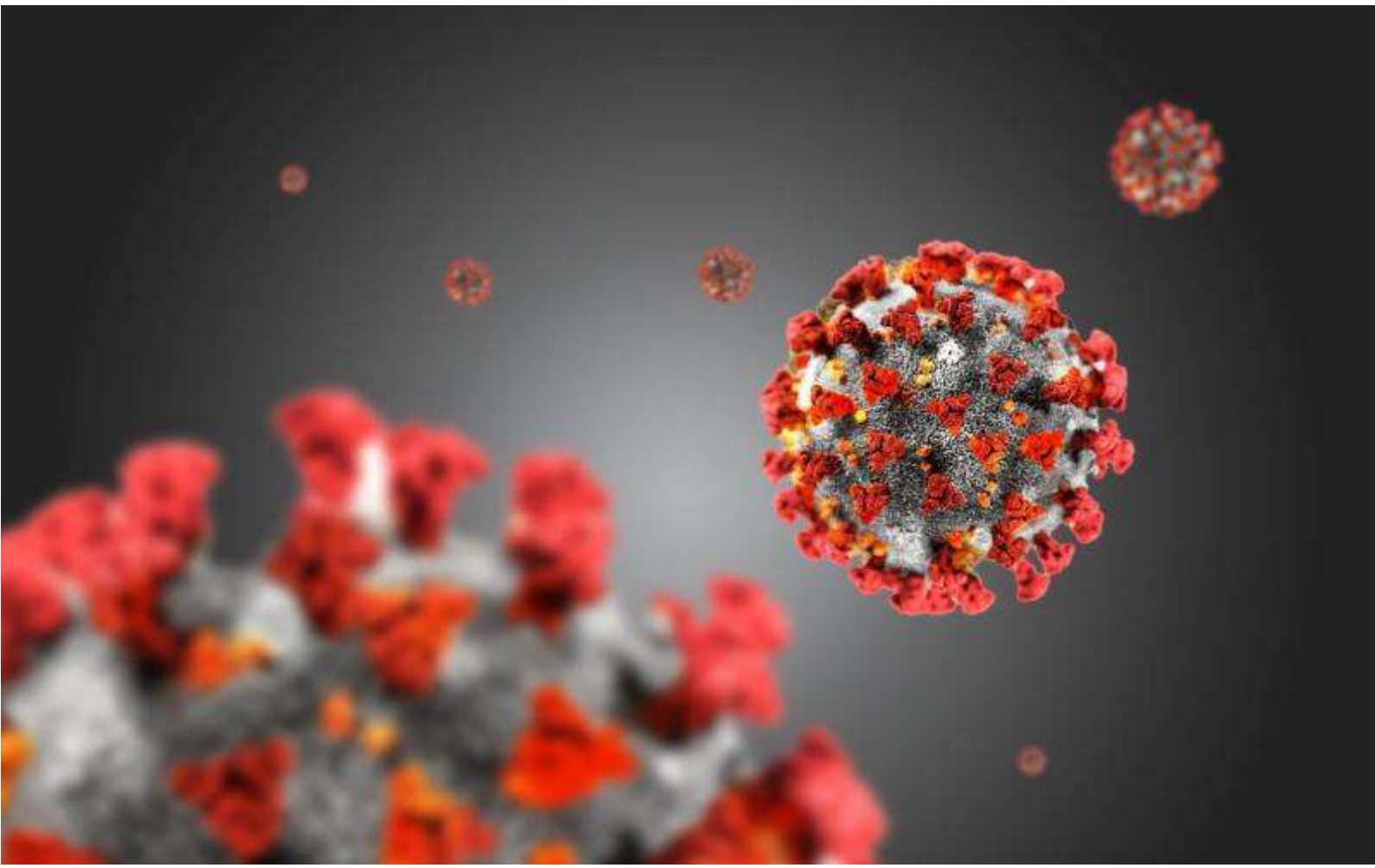
Survey Report On Impact Of Covid - 19 Pandemic On Insurance Fraud Risk Mitigation And Investigation

JULY, 2021



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APDI Association of Professional Detectives & Investigators

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FOREWORD

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Mr. Deepak Godbole

Secretary General Insurance
Institute Of India

Insurance Institute of India (III) has been active in spreading insurance awareness among the masses and in capacity building for the insurance industry participants. It conducts certification courses, training programs, examinations, undertakes research studies, organizes seminars, essay, and technical paper writing competitions.

An act committed to defraud an insurance process results in insurance fraud. False or inflated claims affect the insurance companies and, ultimately, end up in a rise in the price of insurance for the buyers. Insurance fraud investigation reveals the cases of incorrect underwriting due to wrong information or deliberately hidden facts, as also exposes false or inflated claims. While digital innovation, artificial intelligence and data analytics allows making better investigations, investigators need academic and professional support, this, being a fairly new area in insurance business operations. In collaboration with professional bodies like International Fraud Trading Group (IFTG), Association of Private Detectives and Investigators India (APDI), Lancers Network Limited and renowned fraud-fighting experts of the country, III has designed a 'Certified Private Insurance Investigator' course for training Insurance Investigators and has, by now, conducted a couple of month-long classrooms come practical training sessions for the insurance investigators. A seminar was also conducted by III to highlight the need for building academic capacity to the Insurance Fraud Investigation profession.

While the globe and the insurance industry are still battling the Covid-19 pandemic, many industries and professions are witnessing change and are heading towards the 'new normal'. In this context, to find out the changing perceptions and the ground-level realities of the Insurance Investigation profession, a survey on "the Impact of COVID-19 Pandemic on Fraud Risk Mitigation and Investigation" in the insurance sector was conducted jointly by III, APDI, IFTG and Lancers Network Limited being the knowledge partners. The survey focused on professionals in the insurance industry involved in the functions of risk mitigation, anti-fraud functions, claims investigation and seeding, pre-issuance profile checks, pay and recover services, claims management, underwriting, etc.

FOREWORD

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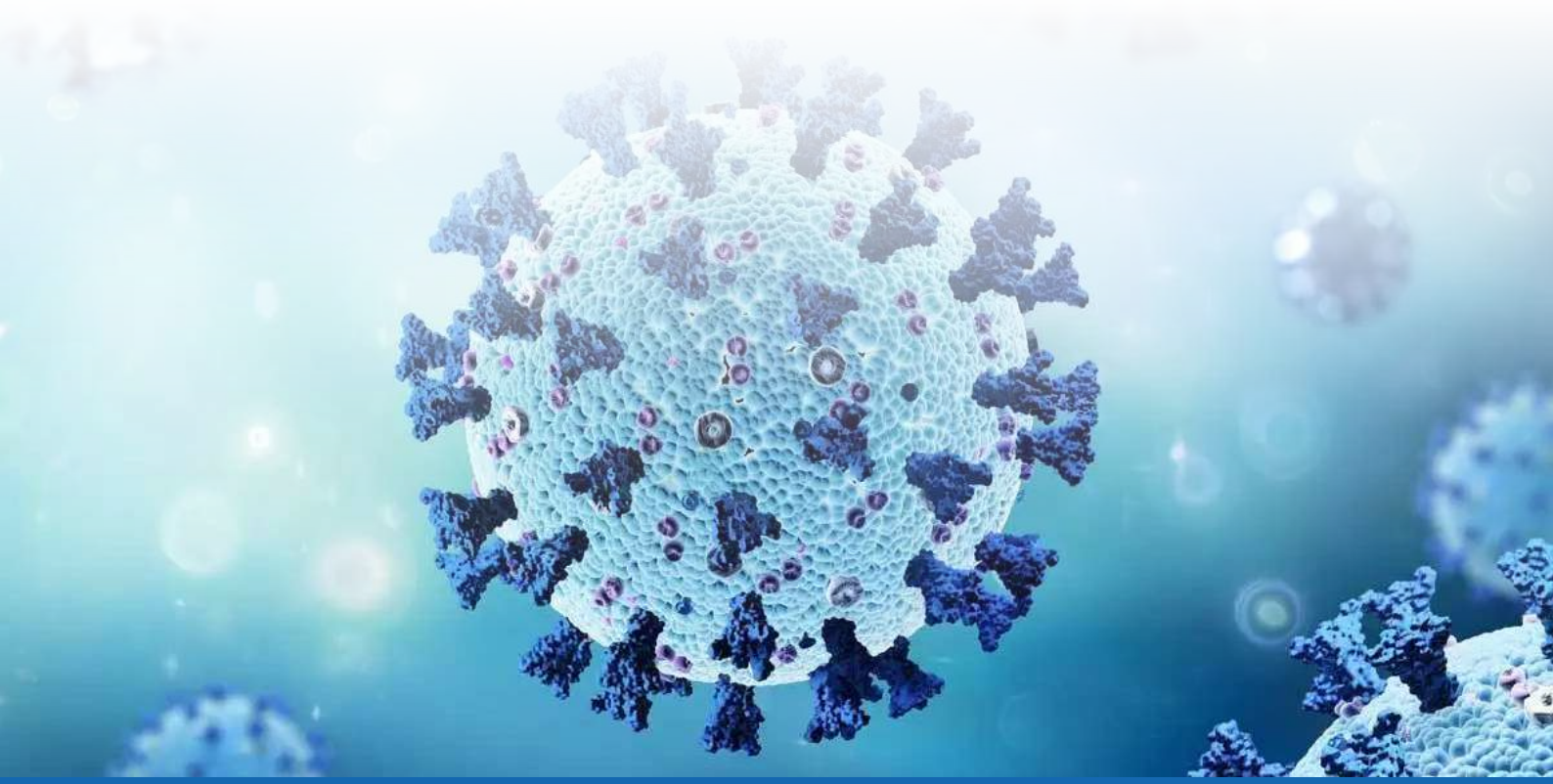
While we acknowledge the contribution of experts from APDI, IFTG and Lancers Network Limited for assisting III in designing the survey questionnaire and approaching relevant set of respondents for this survey study, we are also thankful to the respondents themselves for their timely response and for sharing candid views and opiions.

III is pleased to present the report of the research study. Some articles and messages from experts in the insurance and investigation domains complement the findings and offer additional inputs to the readers. III values feedback and suggestions. Looking forward to receiving the same at research@iii.org.in.



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Mr. Muktesh Chaturvedi,

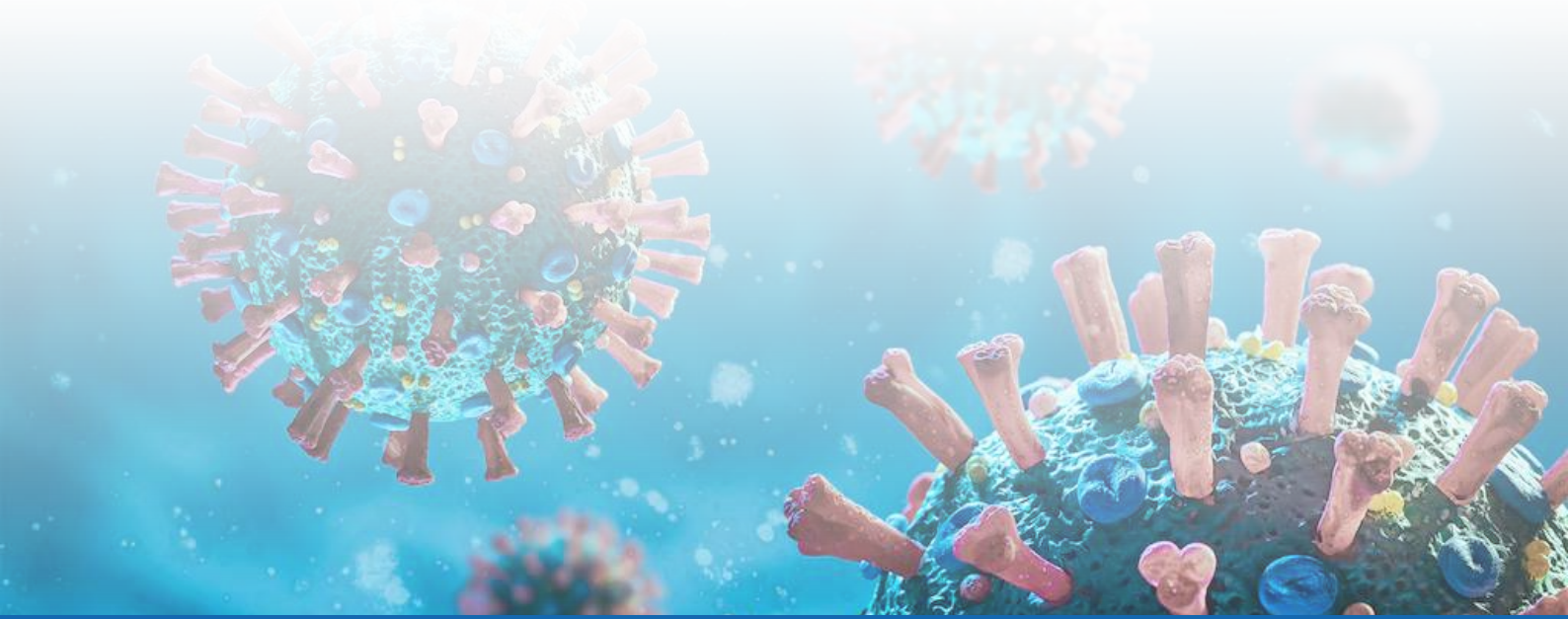
Director, College Of Insurance,
Insurance Institute Of India,
Mumbai - 400051

It is heartening to note that the insurance institute of India in collaboration with Association of Private Detectives and investigators India (APDI), International Fraud Training Group (IFTG), Lancers Network Limited has carried out a detailed survey on the impact of Covid-19 Pandemic on Fraud Risk Mitigation and investigation.

Since the beginning of last year, the world is battling with the effects of Covid-19 pandemic. The Pandemic has led to many serious physiological, economic and psychological problems. The mankind has responded to the economic part of the Crisis amazingly by adoption of hitherto untested and newly developed technology.

On the other hand, the relative lack of oversight has resulted in greater exploitation of the miseries of the situations by fraudsters. A Survey to study the impact of Covid-19 on this aspect therefore assumes great importance.

I am sure that the results of the Survey would help focus on key areas of fraud Risk Mitigation and help in preparing the insurance industry and the society from the fallout of such frauds.



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MESSAGES

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Mr. Kunwar Vikram Singh

Chairman Of Central Association Of Private Security Industry (CAPSI)

It gives me immense pleasure to note that the Insurance Institute of India collaborated with Association of Private Detectives and Investigators India (APDI) along with International Fraud Training Group (IFTG) in conducting this seminal survey aimed at gauging the impact of Covid-19 Pandemic on Fraud Risk Mitigation and Investigation.

As you are aware, India's insurance industry is one of the largest users of our services. APDI members have been at the forefront of fighting fraud in the insurance industry for over three decades. We accomplish our tasks in most hostile of environments with impeccable professionalism and integrity. APDI has also partnered with the Insurance Institute of India and International Fraud Training Group (IFTG) in developing and promoting India's first ever industry driven certification for Private Insurance Investigators – Certified Private Insurance Investigator (CPII).

These past 16 months have been extremely difficult and painful for most of us, especially for APDI members spread across the country. This survey aimed at studying the impact of Covid-19 on Fraud Risk Mitigation and Investigation is timely and insightful. I am certain that this survey and its findings will throw useful insights for all stakeholders and will work as a foundation for future studies and survey.

INTRODUCTION

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Insurance Institute of India (III) formerly known as Federation of Insurance Institutes was established in 1955, for the purpose of promoting Insurance Education & Training in the country. In its role as a leading education and training provider, III is closely associated with all the segments of the insurance industry which includes Insurance Regulatory Authority of India, public and private sector insurance companies, surveyors, third party administrators, brokers, agents and other intermediaries. The activities and programs of the Institute assist people in the insurance industry, to acquire the skills and expertise required to meet the growing needs of multiple customers, with the objective being to enhance professional insurance service to the millions in the country.

Association of Private Detectives and Investigators India (APDI) is the first and foremost national organization whose members are the leaders of their profession of investigation. APDI is headed by Kunwar Vikram Singh as National Chairman and Mr. Subhash Wadhawan, the National president. APDI has duly formulated Code of Ethics for its members. There are specially empowered committees to take care of various aspects of enrolment and discipline. APDI (Disciplinary & Appeal) Rules are in force to take action against defaulting members. APDI is officially recognized by the GOI as the representative body of Private Detectives in India.

International Fraud Trading Group (IFTG) is a recognized leader in the insurance industry. IFTG provides expert fraud solutions and corporate governance services to its clients in the insurance industry. It provides superior consulting and compliance services through technology-based solutions and a decentralized approach to management. IFTG gives great advantage to investigators and fraud-fighters by aligning international, regional and local expertise. IFTG educates and empowers professionals to ensure their confidence and expertise in evaluating and handling potential fraud instances, and provides the resources to assist in making the most appropriate claims decision. IFTG is a preferred solution provider in this area, through long-term partnerships that create intrinsic value by exceeding customer expectations.

Lancers Network Limited was established in 1980 as a specialist security and corporate investigation services provider and has been in continuous practice since then. Today it is South Asia's leading Corporate Security & Risk Consulting firm with a team of over 120 professional operating out of 5 offices and 4 field offices across India. Lancers' has been serving insurance and banking industry for over 20 years providing specialized Insurance Risk Mitigation and Investigation services such as Corporate Fraud Investigations, Due Diligence, Insurance Claims Investigations, Mystery Shopping, Profile Verifications & Training across the country. Lancers is a founding member of the Association of Private Detectives and Investigators India (APDI), Central Association of Private Security Industry (CAPSI), Certified Private Insurance Investigator (CPII). It is also an active member of American Society for Industrial Security (ASIS), Association of Certified Fraud Examiners (ACFE), Council of International Investigators (CII), World Association of Detectives (WAD), World Investigators Network (WIN).

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OVERVIEW

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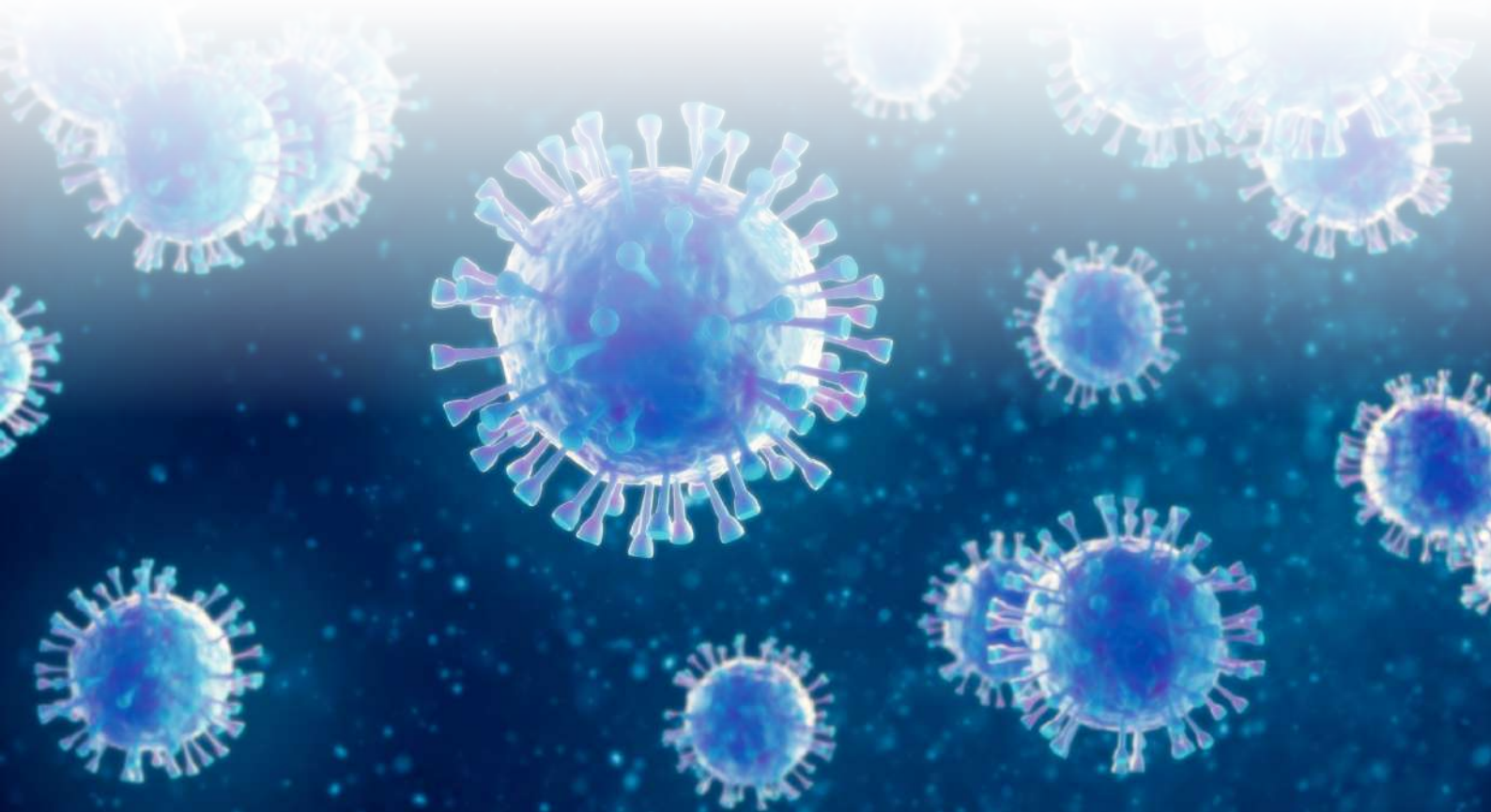
This study explores the impact of the Covid-19 pandemic on Fraud Risk Mitigation and Investigation in the insurance sector in India. In 2020, Insurance Institute of India (III) in collaboration with Association of Private Detectives and Investigators India (APDI), International Fraud Trading Group (IFTG) with Lancers Network Limited as knowledge partners, conducted a qualitative survey with respondents from the relevant stakeholder group within the Indian insurance industry. Professionals across various risk mitigation functions including claims investigation, seeding, pre-issuance profile check, pay and recover, health reimbursement and underwriting participated in the survey. Information was gathered from the perspective of insurers and service providers on how the working of anti-fraud, investigation and risk mitigation functions of the Insurance Industry had been affected by the pandemic along with evolving trends. This survey was conducted prior to the onset of the second wave of Covid-19 and is reflective of operational realities pertaining to the time period from March 2020 till February 2021.



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PROFILE OF RESPONDENTS

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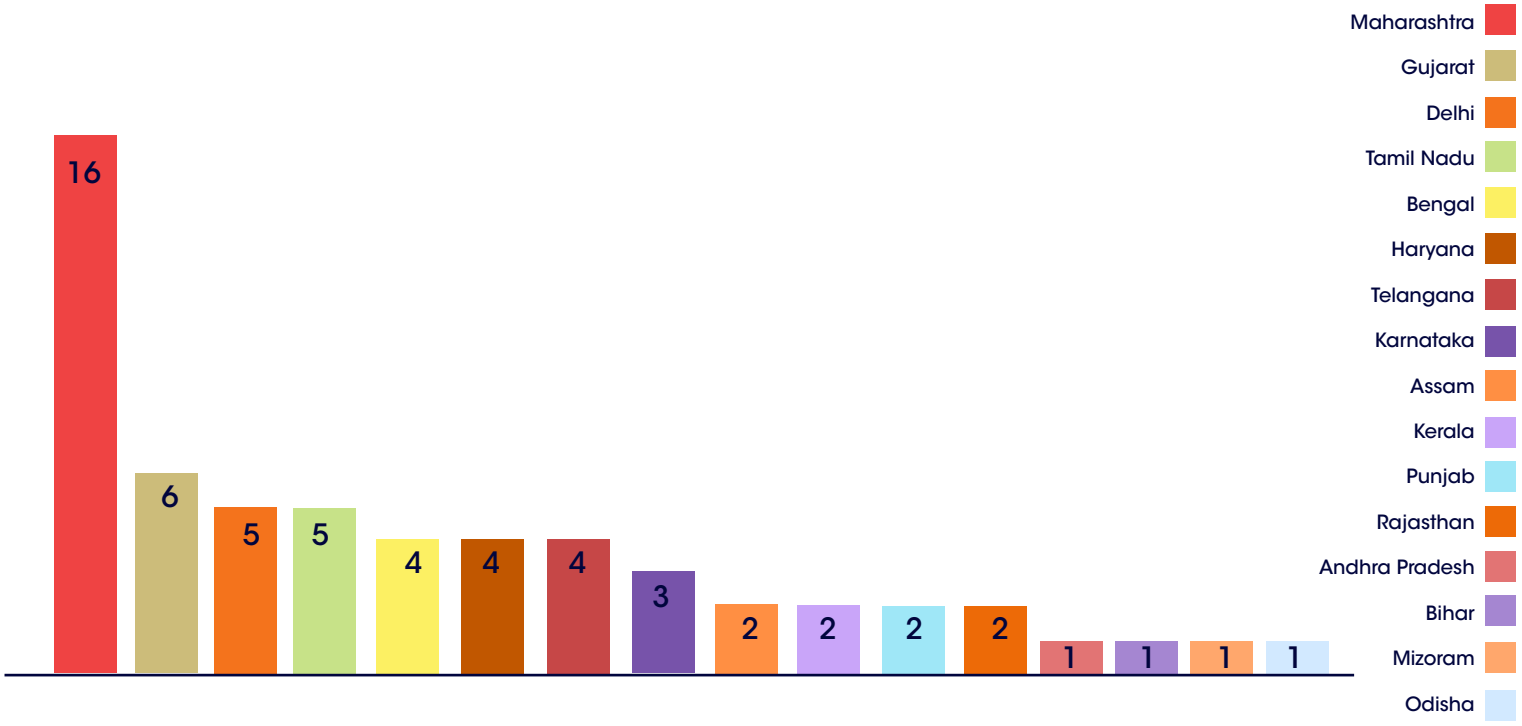
Respondents who participated in the survey are across different verticals including investigations, seeding, pre-issuance profile check, pay & recover, health reimbursement, sales, marketing and underwriting.

The survey was able to generate good interest from 59 professionals[1] from the target audience from different parts of the country. Respondents included both seasoned and young professionals from India's leading Life, Health and General Insurance companies, intermediaries and service providers. Core domains of insurance expertise and experience of the respondents were from a wide range.

4.1. Respondent Profile : State-Wise

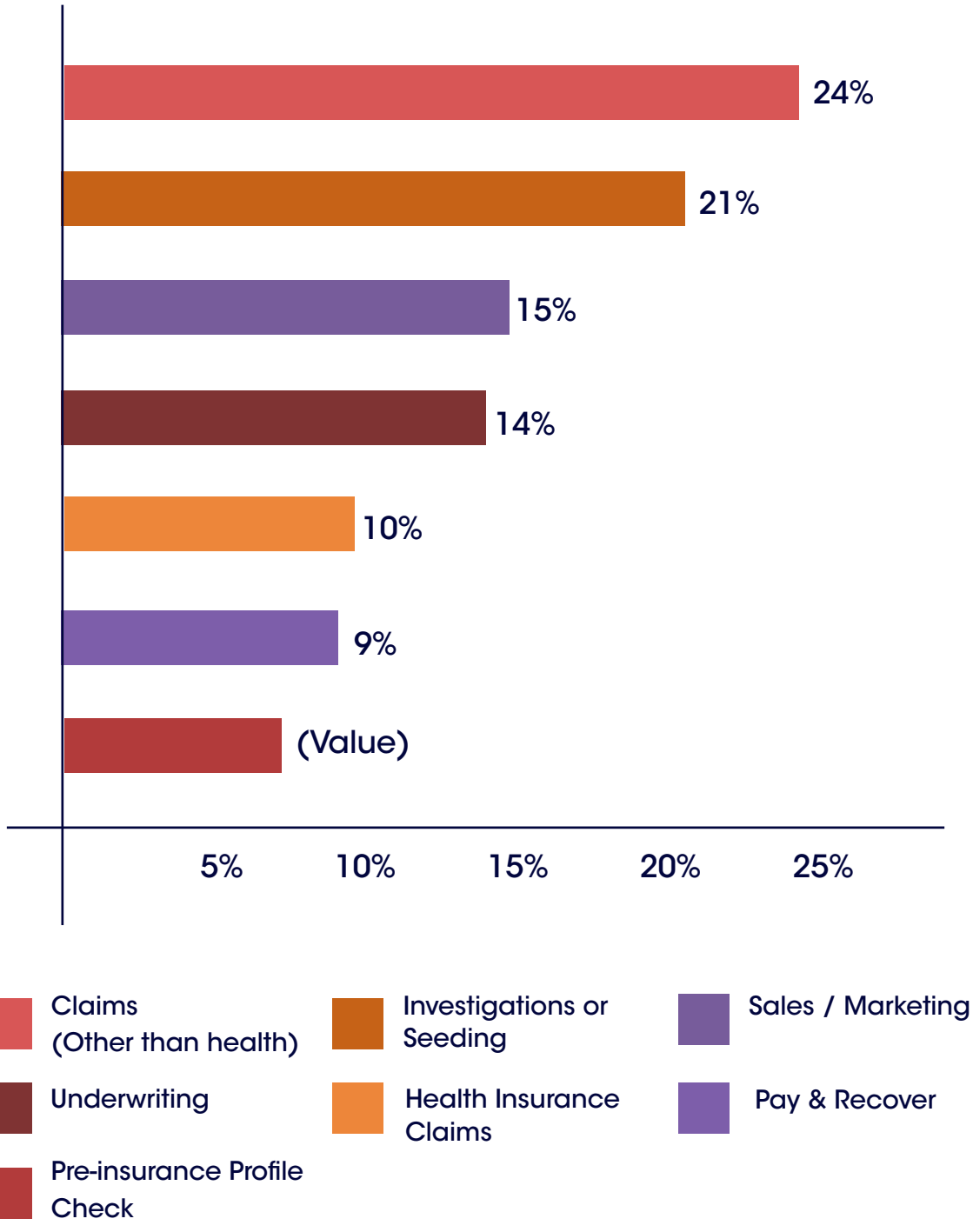
Most respondents were from Maharashtra (16), followed by Gujarat (6), Delhi and Tamil Nadu (5 each), West Bengal, Haryana, and Telangana (4 each) Karnataka (3) Assam, Kerala, Punjab and Rajasthan (2 each), and Andhra Pradesh, Bihar, Mizoram and Odisha (1 each). Most of the respondents were from insurance companies, while 10% were from MSME enterprises primarily representative of investigation service providers.



**1 As some professionals were not forthcoming in conveying their thoughts by way of filling up the survey forms, they were interviewed telephonically.Though the views of these 20 professionals from the investigation domain were used in understanding the subtleties better and for tempering and fine-tuning the research findings, the charts and tables indicate only the responses to the survey for purposes of objectivity and accuracy.*

4.2. Respondent Profile: Specialization-Wise

24% of the respondents were professionals engaged in Claims (other than health), 21% were in Investigations and Seeding functions, 15% were in Sales and Marketing, 14% in Underwriting, 10% in Health Insurance Claims, 9% in Pay and Recover Services and the remaining 7% were involved in Pre-issuance Profile Check.



IMPACT ON INVESTIGATION

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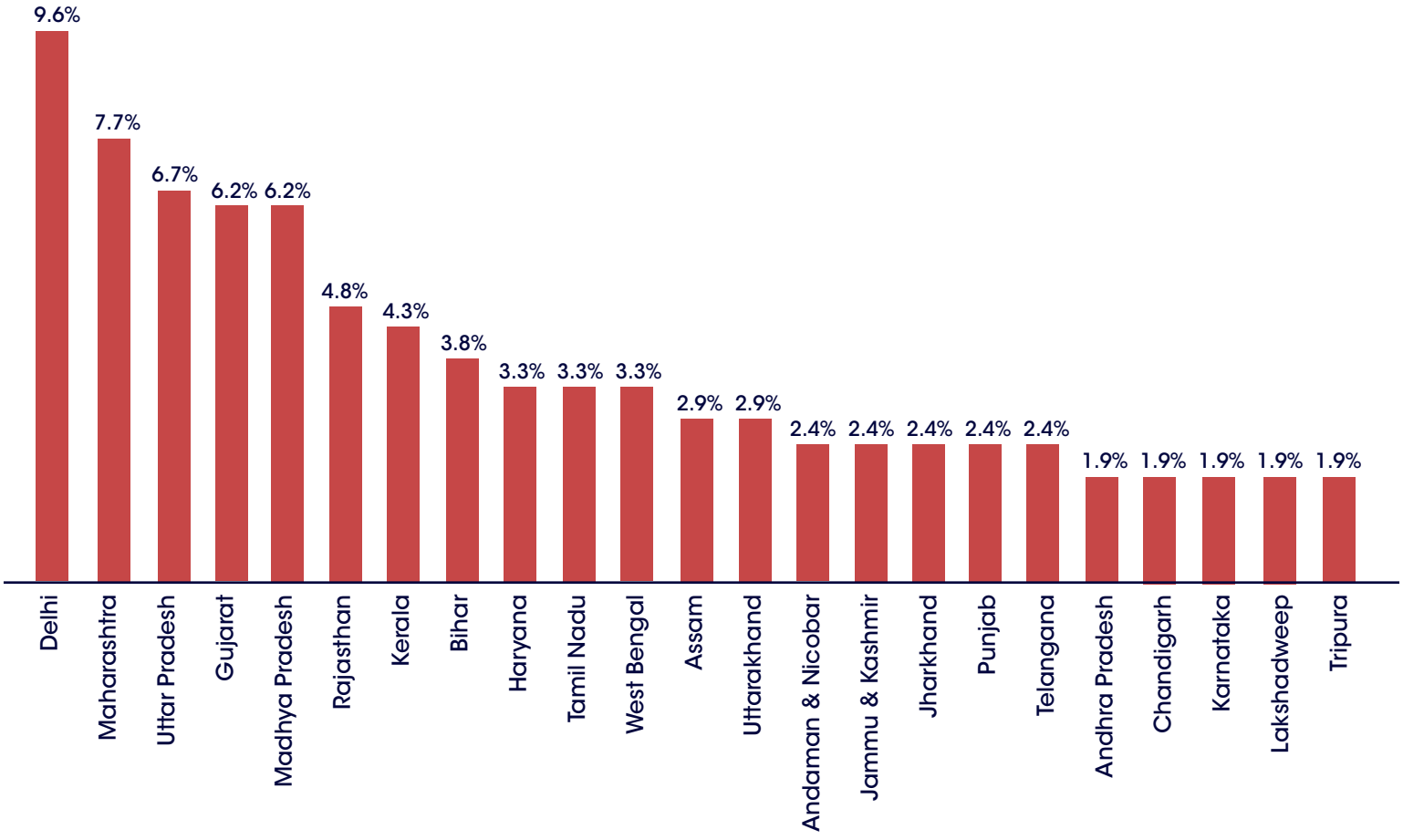
5.1 States That Saw A Surge In Cases Of Insurance Fraud:

The survey participants reported that there was significant increase in fraud cases in many cities, while some parts of the country were not affected much. The professionals who undertook the survey across the country were asked to rank the States that saw the highest number of fraudulent cases during the pandemic situation as per their information/ experience. 10% of them gave Delhi the top rank. Maharashtra was ranked topmost in incidence of fraud by 8% of the respondents, followed by Uttar Pradesh (7%), Gujarat (6%), Madhya Pradesh (6%) and Rajasthan (5%). 4% of the respondents cited Bihar as the State where most frauds occurred, while another 4% placed Kerala on the top rank, followed by Assam (3%), Haryana (3%), Tamil Nadu (3%), Uttarakhand (3%), West Bengal (3%), Andaman and Nicobar (2%), Jammu and Kashmir (2%), Jharkhand (2%), Punjab (2%), Telangana (2%), Andhra Pradesh (2%), Chandigarh (2%), Karnataka (2%), Lakshadweep (2%), Tripura (2%), followed by Arunachal Pradesh (1%), Chhattisgarh (1%), Ladakh (1%), Mizoram (1%), Puducherry (1%), Sikkim (1%), Goa (1%), Manipur (1%), Meghalaya (1%), Odisha (1%), Dadra and Nagar Haveli and Daman as and Diu (less than 1%) and Nagaland (less than 1%). No one ranked Himachal Pradesh as the topmost spot of fraud.



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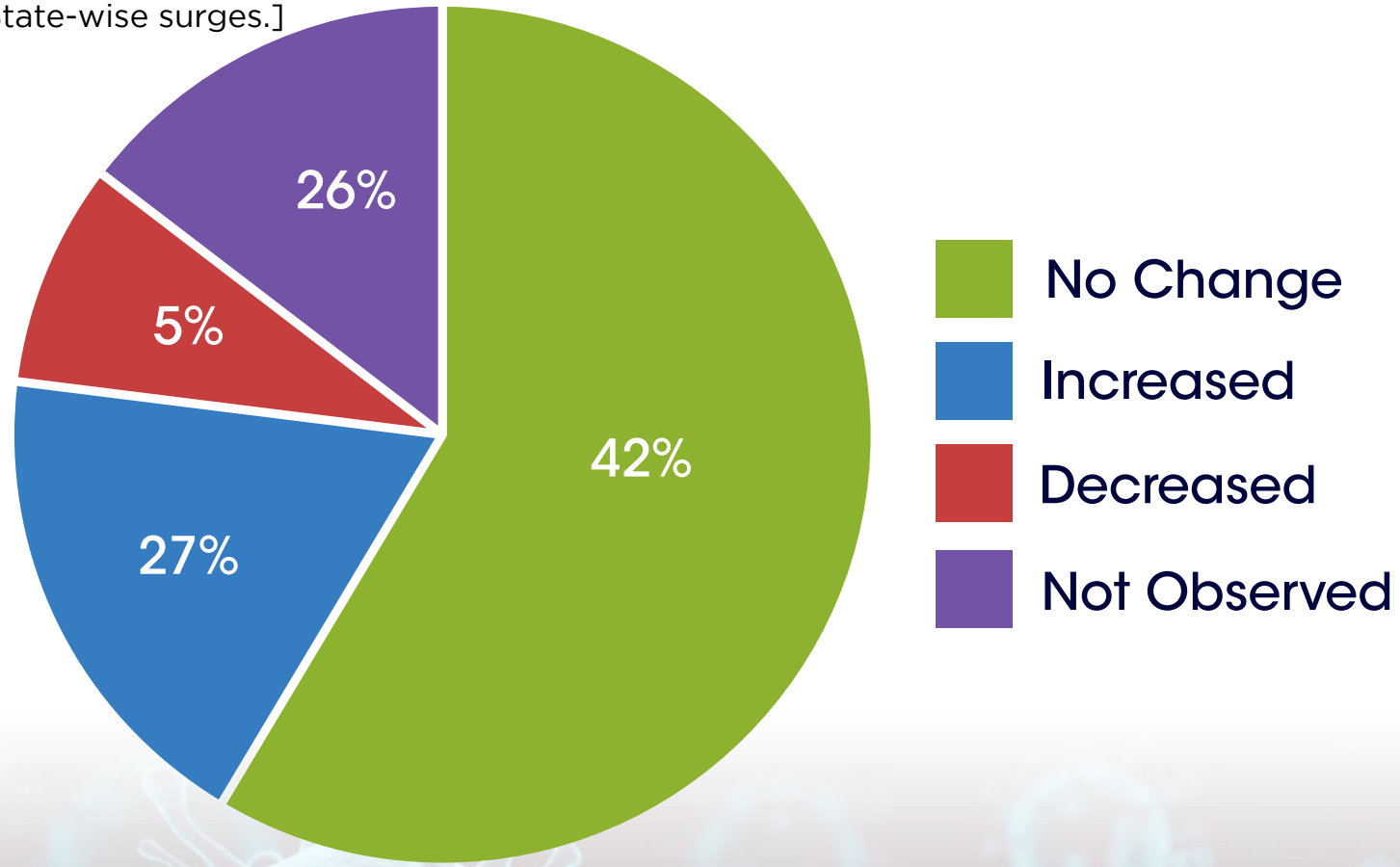
5.2. Overall Changes Observed On Instances Of Insurance Fraud :

In answer to a question about increase or decrease in fraudulent activity in the Insurance industry, 27% of respondents of the professionals stated that they witnessed an increase in fraudulent cases during the pandemic, while 42% stated that there was no significant change due to the pandemic impact, 26% said that they were not sure whether there was a change, and 5% stated that they observed a reduction in frauds.
[These changes refer to the overall position, which may not correspond with instances of State-wise surges.]



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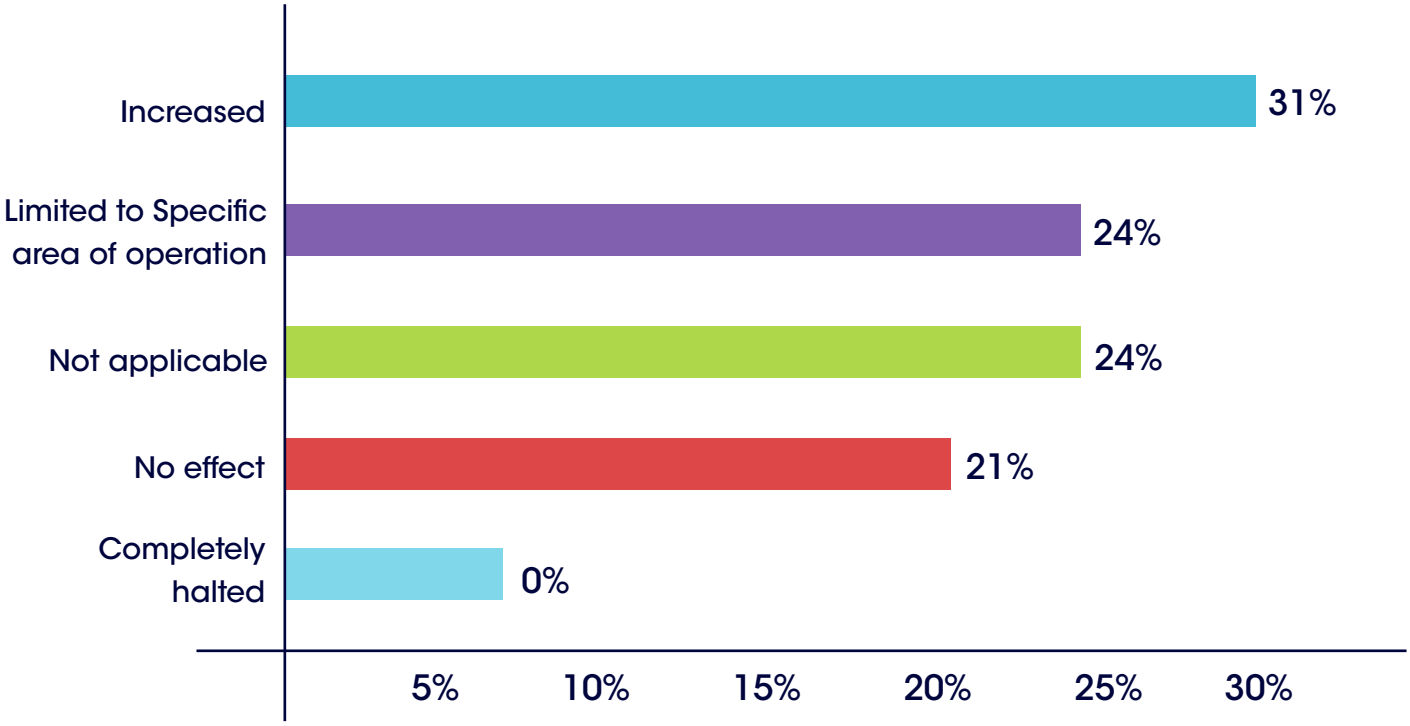
5.3. Impact Of Covid-19 On Insurance Investigation And Related Activities

45% of the respondents stated that the pandemic situation made nosignificant change to their business activities in general, indicating that it wasmore or less business as usual from the allocation point of view. A good 55%that their professional activities related to fraud investigation and fraud-fighting increased during the pandemic scenario. Among this 55%, 31% of respondents reported increased allocation of investigation activities in general. It was interesting to observe that the remaining 24% indicated that they faced business disruption, as the increasein professional activities was limited to some specific areas of their operationsonly, and consequently, they had to confine their risk mitigation operations tospecific areas, a trend more pronounced across the economy during the first wave of Covid-19. None of the professionals indicated that their investigation related activities were completely halted.



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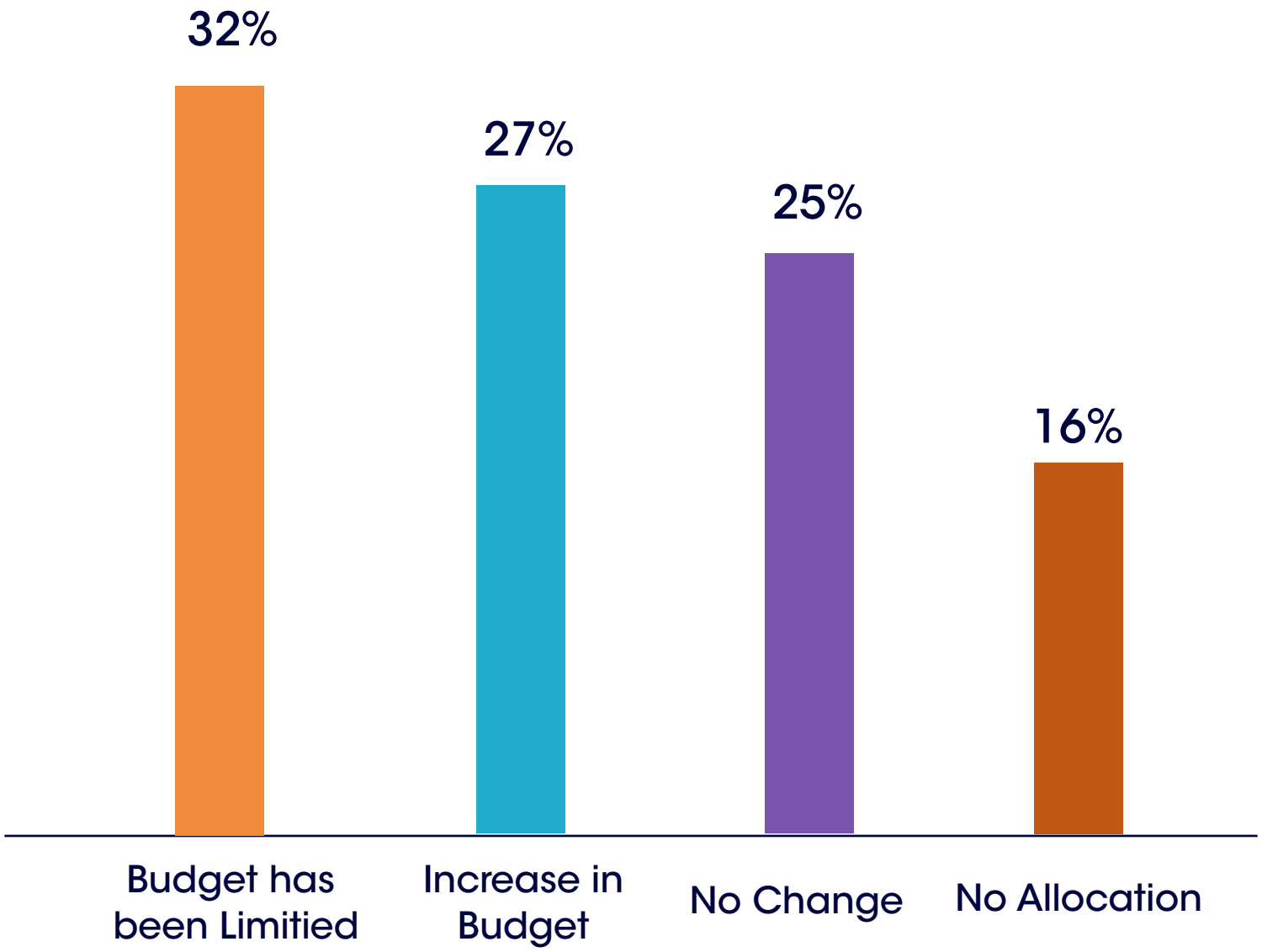
5.4. Impact on Budget Allocation for Investigations

The budget allocations made for insurance investigations indicated conflicting signals. 48% of respondents stated that their budget allocation had been limited (32%) or that there was no allocation (16%) for investigations in their budget. 27% of the respondents confirmed to an increased budgetary allocation for investigations, while 25% said that there was no change in allocation, due to the pandemic situation.



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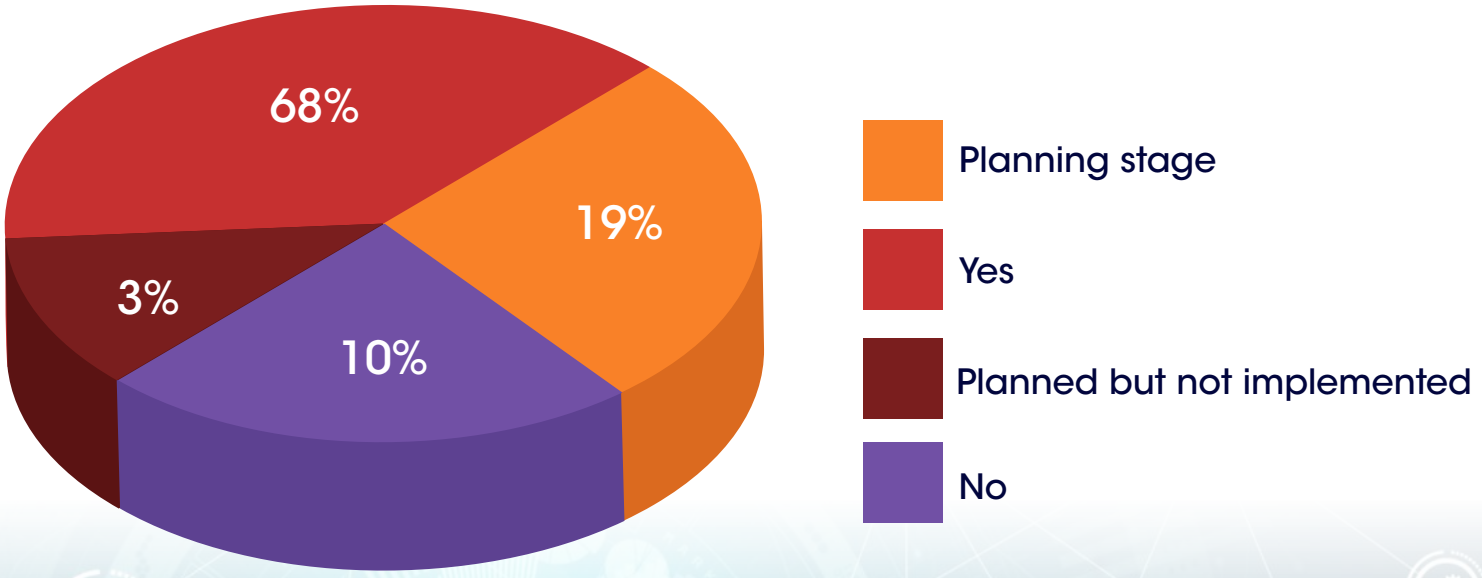
6.1. Organizational Plans On Adapting Digital Solutions For Investigations

The survey tried to find out whether the pandemic situation had caused a business disruption by way of making the industry more open towards using technology and digitization of insurance investigations. It was interesting that the idea of using digital solutions for investigations found support with an overwhelming 90% of the respondents. By way of detail, 68% of the respondents revealed that their organizations were already using digital solutions for investigations, 19% were in various stages of planning, and 3% were in the implementation stage of automated solutions, while the remaining 10% of professionals were not keen about embracing technology based solutions.

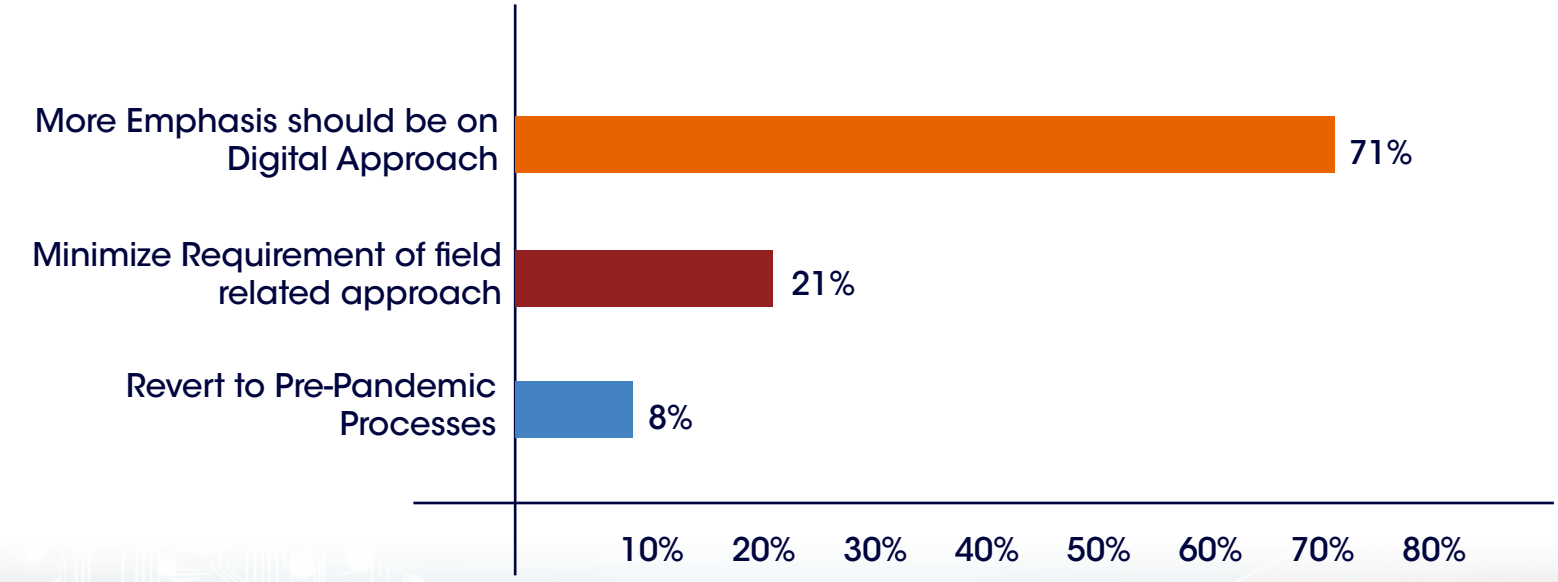
It was heartening to note that while the lockdown and the entailing uncertainties were found to be crippling many businesses, insurance investigation had opted for empowering itself by embracing technology based solutions. This was an unmistakable takeaway from by the Covid-19 pandemic.



6.2. Expectations Of Post-pandemic Changes In Investigations

A question was asked to find out the perceptions of the professionals on possible changes in field investigations after the pandemic situation, and the responses received were in line with the responses to the earlier question on adapting digital solutions for investigations.

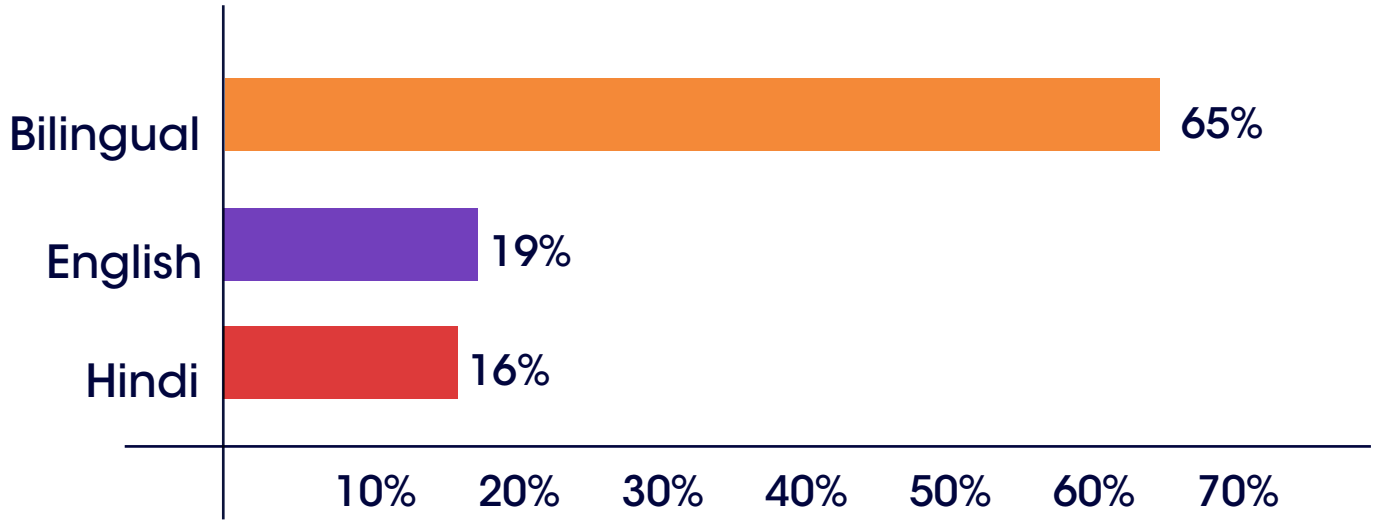
92% of the respondents emphasized that the need for increased usage of technology in investigations would continue in the Post-Pandemic times. Of these, 71% were specific that more emphasis would be on a digital approach, and 21% stated that the requirement of field-related approaches would get lowered, whereas 10% expected a return to the traditional Pre-Pandemic field approach.



The survey helped in analyzing and understanding the current trends in training and capacity development initiatives of the industry.

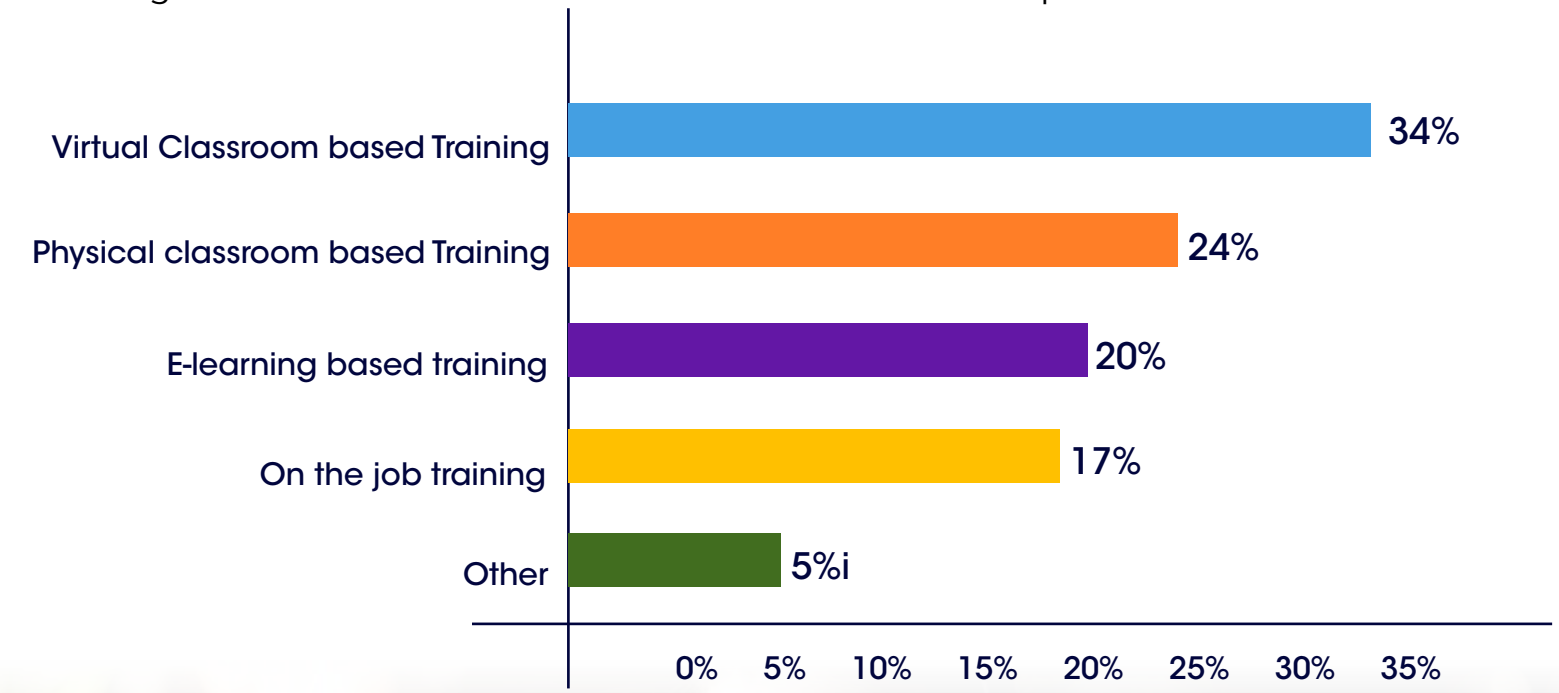
7.1. Language In Which Training Should Be Provided

19% of the professionals preferred English as the ideal language for training given that it is the unifying language, while 16% favored Hindi, the most spoken language across the country. However, one should be aware that many investigators may not be proficient in these two major languages and that in a vast part of the country, investigations are conducted in the local language along with English. Probably, due to this concern, an overwhelming 65% respondents emphasized on the need of delivering training on a bilingual mode of English plus the local language.



7.2. Mode Of Training Recommended For Investigators

The increased demand for Virtual training and E-learning models of knowledge transfer have emerged as another major take away from this survey. This seminal study reveals that the pandemic has brought about a change in the way we work, operate and learn. 54% of the respondents opined that the digital mode of training would be best way to train Investigators in future (34% preferred Virtual classrooms and 20% preferred E-learning modules), while 24% preferred the physical classroom, and 17% believed that on-the-job training was better. 5% recommended combinations of multiple modes.

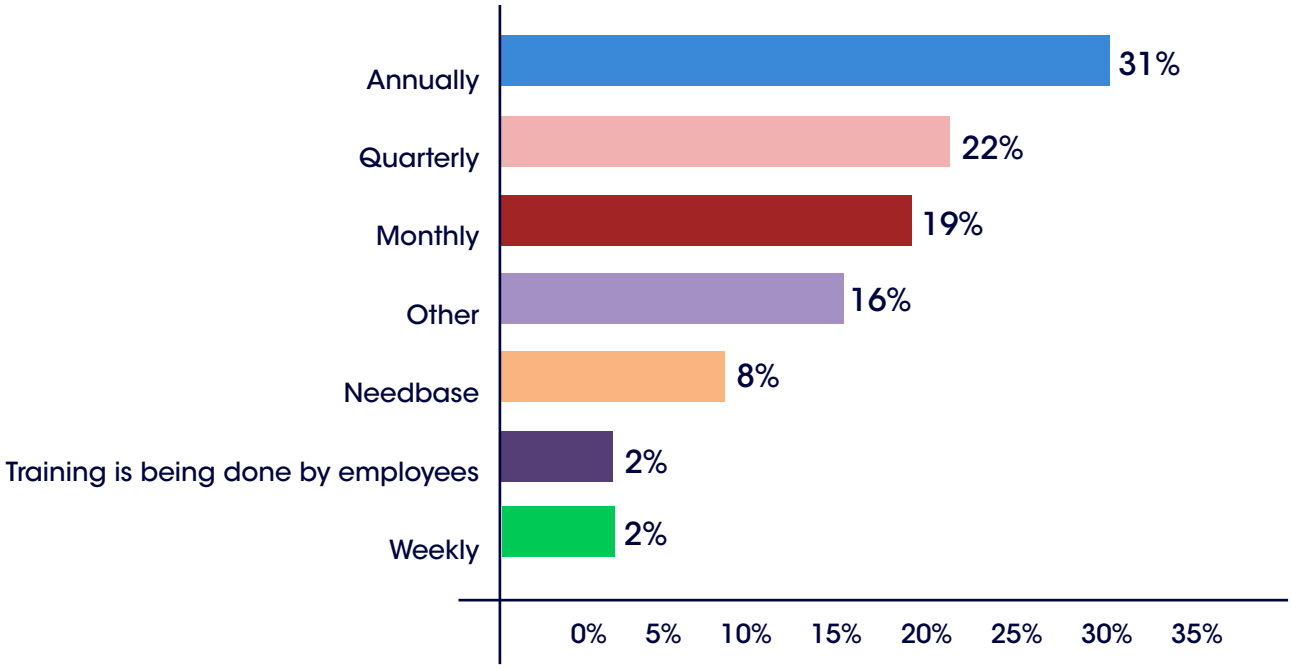


7.3. Training Plans With Internal & External (Partner) Investigators

During the Covid-19 lockdown situation which forced them to evolve quickly, Insurance Investigators have recognized the need for training and have been active in identifying means of achieving their training objectives. This industry first survey on the topic reveals that there is an increasing focus on training for internal and external investigations partners. 60% of the respondents had already conducted or at least planned training programmes for their investigators/ investigation partners as the case may be. However, 40% were yet to plan or take decisive action.

7.4. Frequency Of Training Programmes – Future Plans

The survey revealed that 31% of respondents were either conducting orintending to conduct training programmes on an annual basis, while 22% wereon quarterly mode, 19% on monthly basis and 2% on a weekly basis. 8% werehaving their training plans without any specific frequency, depending on theneed. While 16% were not conducting any training, 2% had left it to theemployees to get themselves trained as required. Given that annual trainingwas previously the norm, it was observed that there is a paradigm shifttowards holding training programmes on quarterly and monthly basis.



7.5. Need To Develop New Training Courses And Content

The survey highlights that 69% respondents believe that there was a need to develop new training courses and course content that are more aligned to the new working realities. 10% felt that there was no such need while 21% were not sure about it.

7.6. Line Of Business-wise Training To Make Insurance Investigation More Effective

As insurance investigation is growing and becoming more and more professionalized, there are many areas of insurance in which investigators need to be trained.

27% regarded Health insurance as the line of business where investigators required training amongst all. 32% flagged Motor (17% Motor OD and 15% Motor TP) insurance as the area most requiring training, followed by Life insurance (15%), Property insurance (11%), Marine Cargo insurance (11%) while 4% flagged other lines of business.

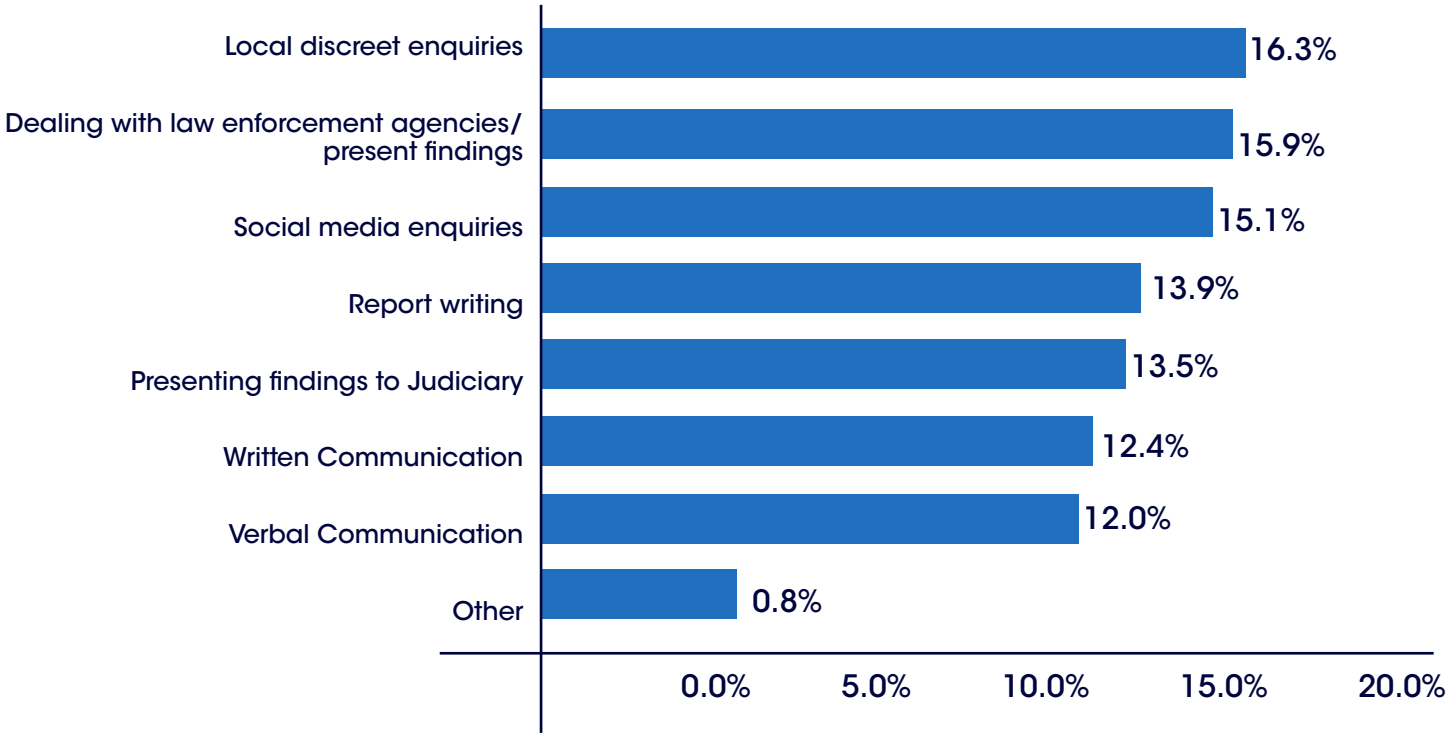
7.7. Need Of Organizations To Work With External Agencies For Investigation Training

The survey highlights a clear requirement for imparting training to investigators and for organizations that can provide such specialized training. 49% find a clear need for external specialist organizations to conduct such trainings, while 17% do not find such a need. 34% were not sure whether they need the support of external agencies for conducting trainings on investigation.

Do organizations see the need to partner with specialized agencies for investigation trainings?

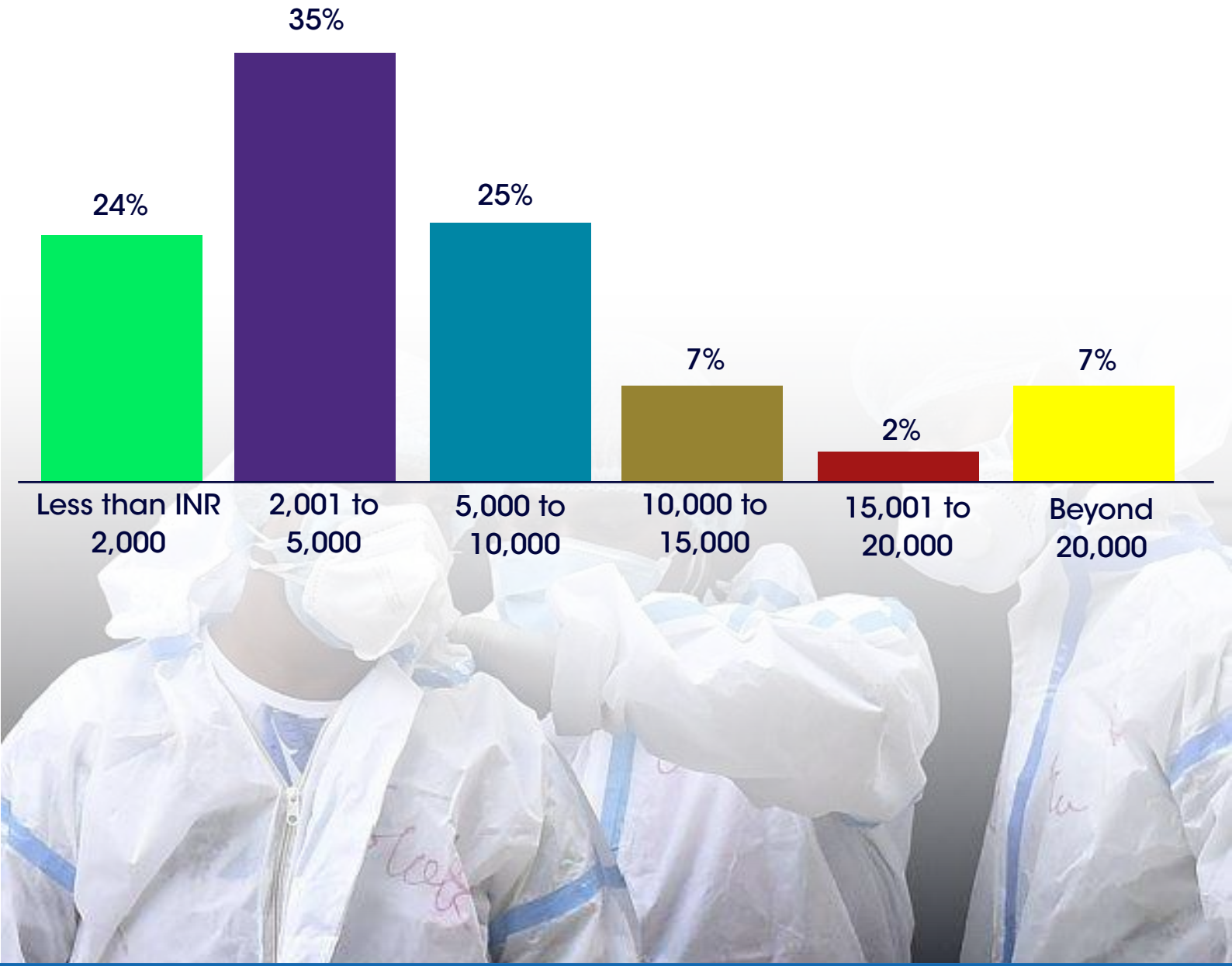
7.8. Key Skills Where Training Is Needed

As per the survey the skill flagged by most respondents for training is making Local Discreet Enquiries (16.3%), followed by Dealing with Law Enforcement Agencies and Presenting Findings (15.9%), making Social Media Enquiries (15.1%), Report Writing (13.9%), Presenting Findings to the Judiciary (13.5%), in Written Communication (12.4%) and in Verbal Communication (12%) and other skills (0.8%) The first three skills have been recognized by the industry also as most essential for insurance investigations.



7.9. Budget For E-learning And Virtual Training For 3 Days Without Accommodation

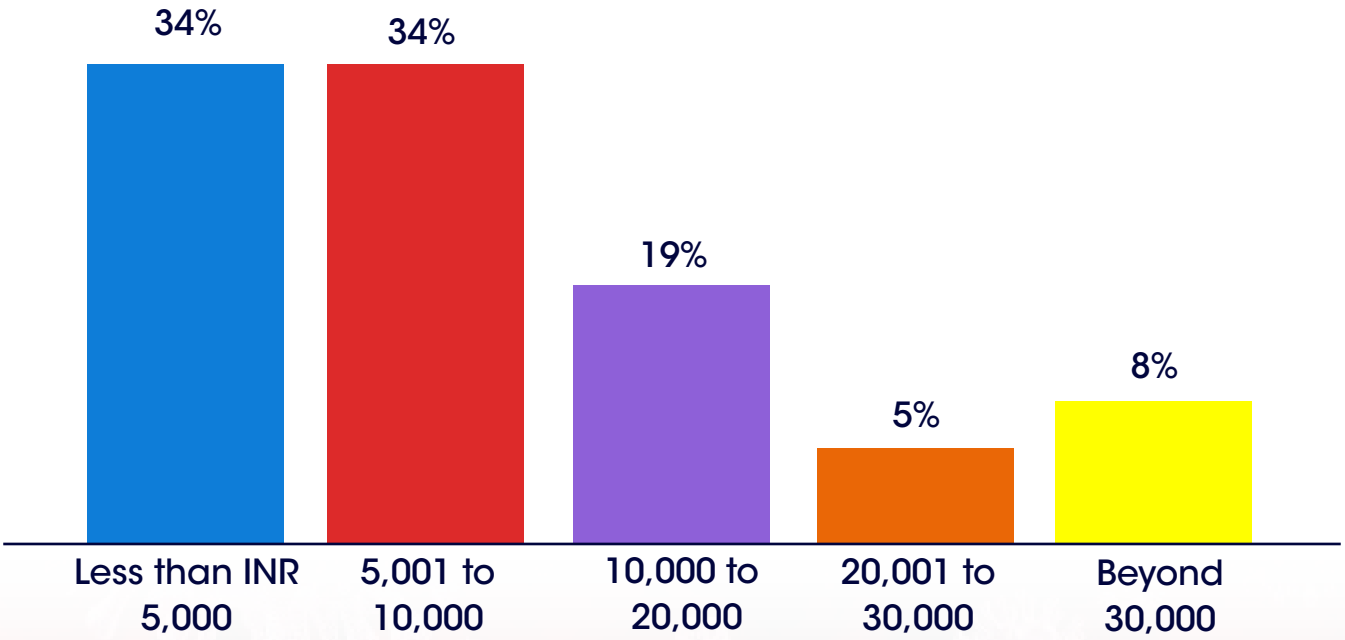
The Survey showed mixed reactions regarding the costs for skilling an employee in all aspects of insurance investigation through a combination of (i)50 hours of self-study on an E-Learning platform (on computer or smartphone) and (ii) 9 hours training on Virtual Classroom (Webinar Model) in 3days. The budget regarded most appropriate would be somewhere between Rs.2000 and Rs.5000 as per 35% of the respondents. 25% felt that Rs.5000 toRs.10,000 would be an appropriate price, while 24% felt that such a training package should cost only less than Rs.2000. For the records, 7% felt that Rs.10,000 to Rs.15,000 was the ideal pricing, and 2% found Rs.15,000 to Rs.20,000 and proper, while another 7% felt that more than Rs.20,000 was acceptable.



7.10. Budget For E-learning And Virtual Training For 3 Days With Accommodation

Responding to a question on the ideal budget for self-study (50 hours of e-learning) and physical training (with accommodation) spread over 3 days, 34% recommended a rate of less than Rs.5000 and another 34% felt that Rs.5000 to Rs.10,000 was proper. 19% felt that Rs. 10,000 to Rs.20,000 was ideal, 5%said that Rs. 20,000 to Rs.30,000 and another 8% said that such a training would cost more than Rs.30,000.

The wide variation can be understood to be due to widely different costs of accommodation in different parts of India - metro cities, big towns and small towns.



7.11. Other Key Observations

There were some key observations that came up voluntarily from the responding experts. Some of them are reproduced below:

Academic:

• Training programmes should be imparted to 'sole proprietor' firms aswell as 'professional firms' - separately in Life, Health, and General Insurance domains.

• More E-Learning Programs with modern techniques should be created.

• Fraud detection training should be updated as per current situations.

• Technology advancement happens daily. So all insurers should send their staff for training for at least 12 days per year.

• Investigators should be taught underwriting also along with investigation techniques, so that they appreciate the situation better.

• Good underwriting will definitely reduce claims that need investigation. Insurance company employees should be taught investigations techniques along with underwriting.

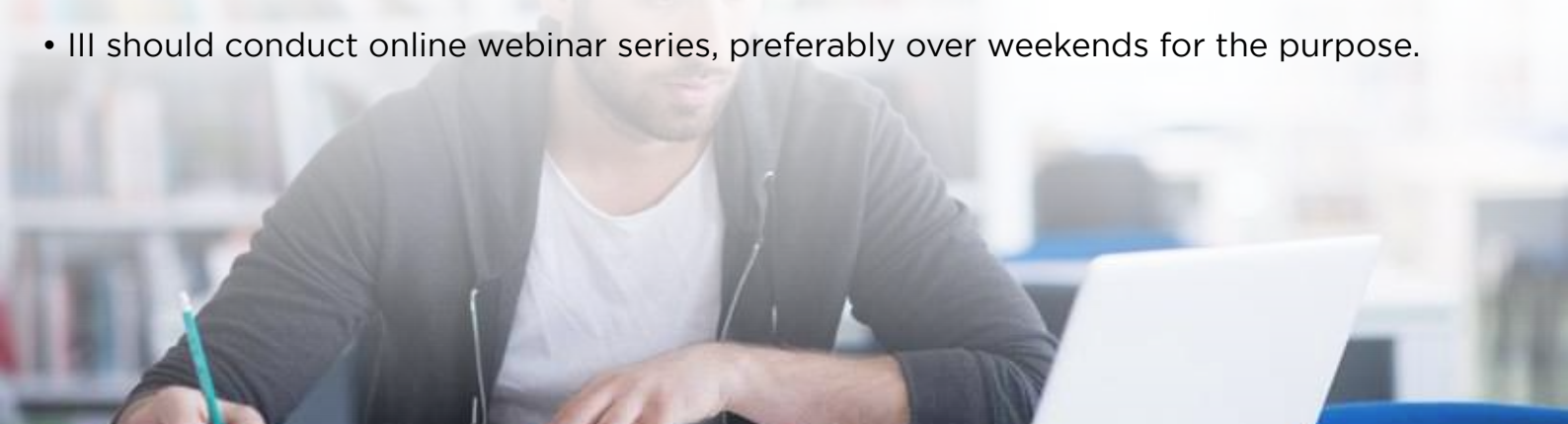
• Certification courses on Fraud investigation with nominal/ subsidized fees should be arranged. After the certification stage, they should be given advanced detailed courses regularly.

• The Regulator should mandate that Investigators should be employed as a specialized cadre and given proper training. This should be made alucrative career option to attract well qualified people and to retain interested persons in this field.

• Insurance training to investigators should be made through online modules.

• Insurance Institute of India (III) should come up with a 3 tier certification programme for educating and increasing knowledge of Investigators in the insurance industry.

• III should conduct online webinar series, preferably over weekends for the purpose.



SKILL & TRAINING

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Procedural:

• Optimal Digitization with revamp of investigations procedures is required.

• More time should be allowed for Investigation.

• Adopting new techniques and adapting to the changing scenario are of paramount importance.

• Insurers should have digital and physical verification systems to identify wrong addresses and pin-codes.

• There should be focus on Turn - Around-Time and success rates for Investigations.

• There should be common, standard and generally accepted investigation procedures.

• Government agencies are not working at their Pre-Covid-19 capability and responsibilities are getting postponed.

• Insurers need to work together to address this situation and make representations to State Governments about the claims process getting delayed due to the slow pace of government departments.

• Investigator Integrity is most important to reduce frauds. Insurers shouldhave proper mechanisms in place to ensure this.

General:

• Creating awareness, Building loyalty, and making systems perfect are some positive actions to reduce frauds.

• Create common platform for sharing experiences, open to all, with public access, to reduce fraud.

• Fraudulent people are using the Covid-19 situation to their advantage.Government should open a digital link where the Covid-19 test report ofevery individual who is tested is reflected, whether results are positive or negative.

In Parternership With:

International Fraud Training Group | CPII | APDI Association of Professional Detectives & Investigators

Knowledge Partner:

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Insurance Anti - Fraud Training

Mr. Frederick Wharton,

President and Founder
International Fraud
Training Group (IFTG)

Insurance Anti-Fraud training is a must! It cannot be a onetime introductory training program given to new employees. Every insurance company and organization need to maintain an annual anti-fraud training program to keep their entire company up to date with the schemes being perpetrated against their company and their insureds as well as the methods to investigate these frauds. The training should include underwriters, claims professionals and investigative professionals. Executive Management must also be aware and knowledgeable of the "attacks" being perpetrated against their company and their insureds by understanding how their teams are capable of identifying and combating insurance fraud. Everyone needs to be aware of fraud and the ability to investigate it. The insurance company's personnel and departments must work together. They must also work together with the investigation industry.

North American Training Group and the International Fraud Training Group were created to bring the insurance and investigation industries together through training and education. Many years back, insurance companies created the Special Investigation Units (SIU) to investigate suspected or fraudulent insurance claims as well as suspicious policy applications. The units typically hired former law enforcement officers who had experience in the investigation field but had no insurance experience. The problem that existed was the claims and underwriter professionals kept their distance from these units, as they were deemed "secretive". There was not much interaction between the departments other than making a simple case referral to that department via a computer. Many claims' professionals believed most of their referrals would end up in a "black-hole", meaning they never heard back or saw any further communication on the file from SIU. Many claims' personnel stopped referring cases because of this. SIU referrals were slowing down, and insurance executives began to believe there was no purpose for this department.

The SIU had to change. Fraud was not going away, and companies continued to lose hundreds of millions of dollars annually. SIU had to show the executive teams that the department was in fact a necessity. To make this happen, the SIU had to interact with the other departments, they had to teach and explain to those department how they investigate the cases, what is legal and illegal when investigating a "civil" case.

They had to understand that the investigators had no "law enforcement rights", so what they see in the movies and television are not always allowed. The investigators on the other hand had to understand and learn how the claims and underwriting departments worked, they had to understand the coverages, limits and perils of a policy. This in turn gave everyone the understanding of what each depart does and how they do it. SIU also had to be transparent and communicate and work together with each of the departments. The teamwork theory was set in place!

NATG & IFTG trainings were created and shared with all departments. No longer were the investigator trainings solely for investigators. We provided everyone the opportunities to obtain fraud and investigation training. The training provided an understanding of what fraud is and what it looks like, how it is being perpetrated against the insureds and insurance companies, how to investigate it and what tools are available to assist in the investigations. The more knowledge each of us has, the better we can perform our jobs. It is the same for investigations. Better information, Better Investigations, Better Results. Over the years, insurance companies began to hire private investigators to cover the excess investigations the insurance company could not handle. It was here that we developed additional trainings for the private investigator industry. Just as we provided the SIU investigators, Claims and Underwriting personnel the knowledge and training of insurance and insurance fraud, we did the same for the private investigators. This was the creation of the Certified Private Insurance Investigator (CPII) professional certification.

Today as COVID is amongst us, this pandemic has affected all organizations globally, restructuring their entire operation procedures, from having employees work remotely from their homes to having to do desk top investigations remotely. COVID has created opportunities for many professional fraudsters, but also has created opportunities for "regular" people, people who generally abide by the law. Unemployment was at all-time highs; businesses were closed whiles losing revenue and income. People became desperate. Insurance policies were seen as a means to collect some income. Create a fictious loss or claim and collect from the insurance company. Insurance companies saw a tremendous increase in claims and will continue to see these claims rise for several more years.

The insurance companies need to be proactive in reducing these crimes. Continuous training of employees is needed as insurance fraud changes daily. Training cannot be placed on the back burner or pushed off to some other time. We cannot let COVID be a distractor or excuse not to get employees trained. Remote fraud training is accessible to everyone via any internet connected device. The training is customized for each client and updated annually. Together with the Insurance Institute of India, we can have all your employees updated with the knowledge of current fraud trends and means to investigating these frauds today!

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Investigation as a tool in Insurance Fraud Risk Management

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Vice President, Internal Control
And Loss Minimization,
ICICI General Insurance Co. Ltd.

Most Insurers globally have witnessed frauds going up after the outbreak of pandemic due to Covid-19. As a double whammy, insurers faced difficulties in investigating fraud claims due to restrictions on movements, severe lockdowns making access to customers/ claimants, service providers, courts, Police stations, etc. much more difficult. Most insurers shifted to some form of non-physical investigation of claims. Whether it be voice/ video based/digital desktop investigation. One of the objective of the desktop investigation is to identify claims which can be processed straight thru, during the digital desktop investigation. All such claims, which can be processed (Paid or rejected) post desktop investigation (which may not require any elaborate examination) reduces the burden of extensive examination and sharpen the focus on real suspected claims. It also reduces turnaround time for claim processing, which is an important lever of claims management.

Interestingly, the desktop investigation is gathering momentum these days, with some insurers in various geographies of the world also deploying Artificial Intelligence (AI) to detect frauds. However, deployment of AI solutions needs to be carefully adopted. A number of AI system, source information/data/records from various sources and then use that information to detect anomalies. However, AI System are also not free from biases. And these biases can throw up inaccurate results.

The result arising from AI at this point in time, at least in the Indian context, needs to be verified using human wisdom and possibly by a combination of AI output and actual physical and field verification. The AI application will throw up suspects, which then needs to be brought to logical conclusion. Hence, at least in the near future, one does not see an all-digital AI enabled claims investigation in Indian context. We are slowly moving to a hybrid model with a combination of AI enabled digital application and robust field investigation. Ultimately, procuring evidence of fraud, in most cases will require extensive field work. Just replying on a Digital or a Physical model of fraud detection will yield limited results. Insurance investigators will continue to be relevant, as long as they understand the changing dynamics and adopt. This will help insurers, investigators and ultimately customers. Investigators will need to continue to invest in updating themselves, getting trained and getting accredited by professional accreditation institutes of repute. This alone will help them from getting redundant and fight fraud effectively.

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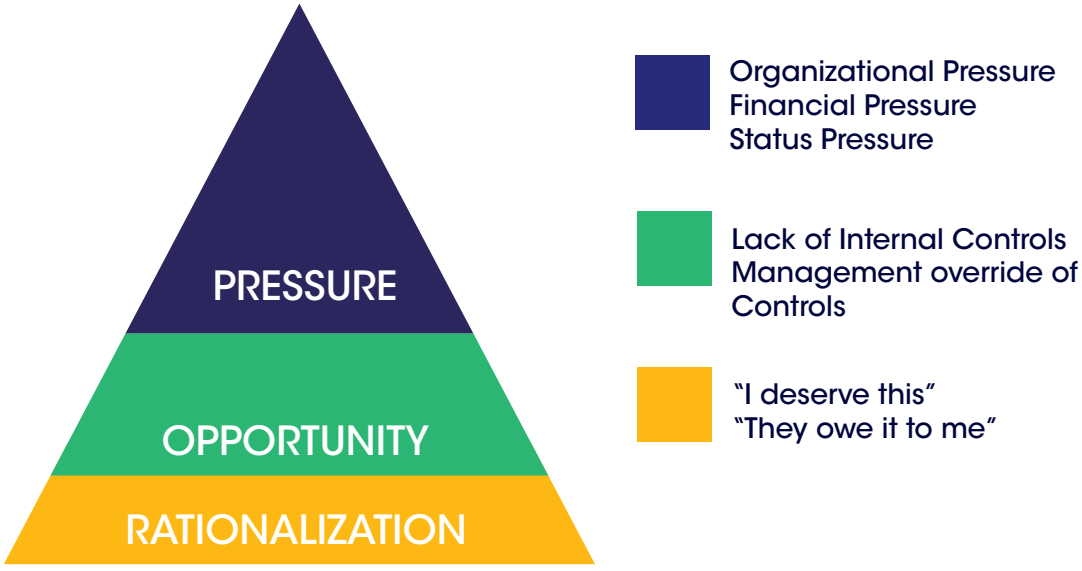
Life Insurance Frauds

Mr. Pradipto Sen

Senior Vice President
SBI Life Insurance

The insurance industry is fighting against the fraudulent activities ranging from proposal to claims and beyond. U/s 421 of the Indian Penal Code and u/s 17 of the Indian Contract Act, "fraud is an act or omission which is intended to cause wrongful gain to one person and wrongful loss to the other, either by way of concealment of facts or otherwise."
In every fraudulent activity the following are interconnected: -

- Personal justification of actions – where in the subconscious mind the actions have been rationalized and justified as correct
- Ability to execute plan without getting caught – this is the phase where the fraudster is always of the opinion that there is no chance of getting caught as he is always one step ahead.
- Financial or emotional force pushing towards fraud – in this there is always a feeling of making quick financial gains which leads to the fraud. Incidentally the "GREED" to get higher returns that what is feasible leads to fraud.



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Data Leakage And/Or Cyber Threats:

The insurance industry is continuously under threat of data leakage and cyber-attacks on its customer database. In the modern day everything is hackable and nothing is safe – not even standalone computers. It is possible to access the data without companies being aware that their database has been compromised. Because of the level of computer knowledge across the globe it has been made possible to hack even pacemakers and thereby put patients' lives in danger as impulses can be increased/decreased/stopped at the free will of the hacker. A study carried out by KPMG, Economic Times & Accenture has revealed that any company, including an insurance company, will face on a very conservative average 113 breach attempts every year. At least 1/3rd of these attacks likely to be successful.

Money Laundering And How It Ails The Insurance Industry

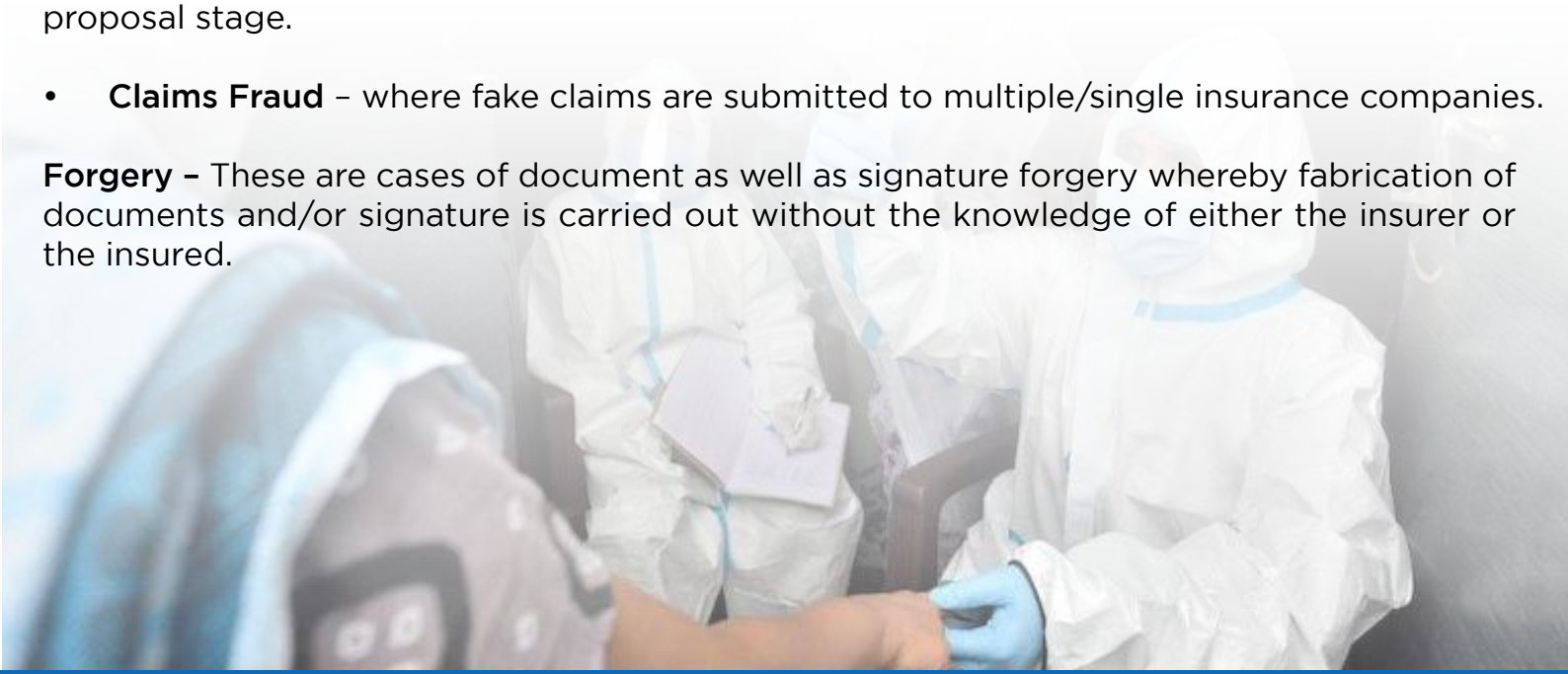
Being part of the financial industry, the insurance industry is susceptible to money laundering where illegally gained proceeds are made to appear legal. Money laundering involves three steps – placement, layering and integration. Money laundered is integrated into the financial system through additional transactions until the "unclean" money appears "clean". This money, when it enters the insurance industry is used for the purchase of bonafide policies. It is very difficult to detect this money.The Parliament has passed the Prevention of Money Laundering Act 2002 to combat instances of money laundering.

Types Of Insurance Frauds
Some Of The Types Of Frauds Seen Are As Under : -

- **Application Fraud** - where incorrect information is passed on to the insurer at the proposal stage.

- **Claims Fraud** – where fake claims are submitted to multiple/single insurance companies.

Forgery – These are cases of document as well as signature forgery whereby fabrication of documents and/or signature is carried out without the knowledge of either the insurer or the insured.



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Insurance Fraud Investigations

Mr. Sanjiv Kumar Dwivedi

Senior Vice President,
Investigation And Loss Mitigation,
Bajaj Allianz General Insurance Co. Ltd

Globally, insurance fraud is a major concern for insurers which continues to increase year by year. Insurance fraud can occur at any stage of transaction done by the individual applying for insurance, third party claimant, or by policyholders. Fraudulent activities damage the lives of innocent people both directly and indirectly as these frauds increase the cost of the premium. Approximately, 9% of revenue is lost by insurance companies due to fraudulent insurance claims every year.

TABLE 1 – GENERAL INSURANCE FRAUD IN 2019

The below figures are in INR Billion

Gross Premium	Fraud
1890.00	170.00

Source: IRDAI 2019-20 Report

TABLE 2 – COMPARISON OF FRAUD IN GENERAL INSURANCE

General Insurance Fraud	Percentage	INR Billion
Falsification Of Documents	70%	119.00
Other Frauds	30%	51.00

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Source: - India Forensic Premier Organization In Forensic Accounting Education (2012) Annual Anti-fraud Conference

In order to prevent and reduce the occurrence of fraudulent claims, insurance companies often conduct claims investigations to evaluate the legitimacy of a claim. The investigation process helps the claims adjuster make an educated decision about how to proceed with a claim. Insurance claims investigations rely on collecting and reviewing documents, taking statements, locating and interviewing witnesses, inspecting and photographing the damaged property or accident site, conducting surveillance and analysing social media accounts to conclude whether a claim is legitimate or illegitimate.

But the question is, "Is this enough to stop these fraudsters?" Traditionally, insurance companies have been relying on expert judgment of agents, adjusters and special investigation units to detect and deal with frauds. This approach worked to a certain degree in the past as the fraudsters themselves were not as evolved as they are now. Also, the number of claims were relatively small which made it humanly possible to keep a track on fraud. However, the challenge with the expert judgment is that, a huge effort and bandwidth of insurance claim experts would go into scrutinizing the claims for fraud, as these days not only the frauds are organized but also considering the current pandemic situation of the world, it has been a difficult task for the investigation teams too. Thus, it has become difficult to deal with the insurance fraud with relying just upon expert judgment and investigators.

Leveraging technology is the need of the hour. But, "how can we leverage technology to mitigate the challenge?" This is where machine learning and artificial intelligence can help to accelerate pattern recognition and optimize the productivity of claims adjusters and special investigation units. Todays advanced frauds require data mining, analytics, and customized fraudster behavioural pattern-based algorithms to be programmed for proactive, timely scam detection. Insurers need to focus on the below key elements:

- To recognize patterns for specific network groups/individuals through historical datasets and finding a balance between fraud identification and instances of false positives
- To detect possible frauds through social media analytics
- To detect fraud through text mining techniques wherein based on textual posts by individuals on social media, algorithms can be built to detect the network group

The above techniques can be utilized to build models leveraging newer technologies to prevent, detect and filter frauds. This will act as a swift enabler and thereby improve claim adjustment expenses, reduce overall claims leakage and so on, which helps to better the loss ratio finally, improving the productivity and efficiency of the insurers.

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Cyber Crime and Cyber Defense

Mr. Vishal Dubhashi

Sr. Vice President, Risk And Loss Mitigation
HDFC Ergo General Insurance Co. Ltd.

Technology has revolutionized all walks of life. Economies are becoming more dependent on technology, and thus more vulnerable to emerging variations of cyber crime and e-Fraud. Sharing and storage of all kinds of digital data across the globe has become child's play. It will be pertinent to sound a note of caution as well. It is very well a double edged sword and therefore can lead to destruction / theft of data resulting in huge financial and reputational risk. Cybercrime is both technical and an economic problem, so cannot be solved by technical means alone. This article will highlight the risk involved on a global and organizational level and risks attached to them.

DIFFERENT TYPES OF CYBER CRIMES:

Cyber crimes can be categorized in two ways :

- The crimes in which the computer is the target. Examples of such crimes are hacking, virus attacks, DOS attacks etc.

- The crimes in which the computer is used as a weapon. These types of crimes include cyber terrorism, IPR violations, credit / debit card frauds, EFT frauds, pornography etc.

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Risks For Information Technology

Cyber Risk: Risks that emanate from the use of electronic data and transmission, including technology tools such as the internet and telecom networks

Cyber Attack: Attempts to damage, disrupt, or gain unauthorized access to computer system/s or electronic network OR actions taken through the use of computer networks that result in adverse effect on an information system or the information residing therein. Cyber crime encompasses all criminal activity pursued through cyber attacks.

Cyber Security: It is the desired state of an information system in which it can resist cyber attacks / crime likely to compromise the availability, integrity or confidentiality of the data stored, processed or transmitted and of its related services.

Cyber Defense: It is a proactive computer network defense mechanism which includes response to actions and critical infrastructure protection and information assurance for an organization. Cyber defense focuses on preventing, detecting and providing timely responses to cyber attacks

Latest Cyber Attack Techniques / Risks Are As Follows:

- Hacking: Hacking means an illegal intrusion into a computer system / network. This can be done through unprotected website links (SQL injections), theft of FTP passwords using common / easily available login details and Cross-site Scripting wherein hackers corrupt a part of the real website with malicious script. Data-diddling can also occur wherein data is altered or corrupted at time of entry to cause fiscal damage

- Piggybacking: This means Accessing Confidential information after the authorized user has exchanged the authentica¬tion information or when the authorized user has logged out improperly giving access rights to unauthorized users.

- Virus Dissemination: Virus like trojans which corrupt data by modifying / deleting files or merely replicate and eat up available server memory called worms. Also, Logic Bombs wherein Viral programs which work like bombs and explode after certain amount of time or on some routine action in the network to enact destruction. Fast Flux moving of data is quick amongst computer networks making it difficult to trace source of malware or phishing websites.

- Email Bombing Or Spamming: eMail bombing refers to sending large number of eMails to the victim resulting in victims eMail account (in case of an individual) or mail servers (in case of a Company or eMail service provider) crashing. These messages propagate by bypassing the Spam Filters by using multiple source addresses called Spammers

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- **Botnet/s:** They are Network of software robots that automatically spread malware. Like in Super Zapping, system is made inaccessible to original users. In Wire-tapping, data traffic over a communication line is tapped and sourced for information which is difficult to detect as source of leak maybe far at service providers end

- **Data-Leakage:** There are many ways of such leakage including hiding of sensitive data in the normal printouts or data files sent via eMails whose expo¬sure appears to be harmless for the enterprise. More sophisticated methods include encrypting of data at time of stealing to be unknowingly decrypted later.

- **Zombie Computer / Mobile Malware:** a computer / a mobile device which has been hacked and is used to launch the attacks over a period of time. Particularly vulnerable are organizations that are into mobile platforms for selling.

- **Social Engineering Or Spear-Fishing:** Using manipulation to trick people into revealing personal / confidential information by propagating some problem with accounts and diverting them to fake websites (phishing) to reveal.

- **Distributed / Denial-of-service (D/dos) Attacks:** This means flooding a server or network of servers with useless info-traffic to make it unavailable to real users. In Scavenging, residual data is sent back before D/DOS for use by fraudster/s.

- **Web Jacking:** This is another phishing technique that can be used in social engineering engagements. Attackers that are using this method create fake websites and when victims open the link, a page appears with message that the website has moved and they need to click another link. If the victims click this link, they get re-directed to the fake page.

- **Salami Attacks:** These attacks are used for the commission of financial crimes. This is a technique wherein money or resources are stolen a bit at a time such that there is no noticeable difference in overall size. The bottom line is failure of system to detect the misappropriation. At end the funds lying are transferred in one go to intruder account before he makes off.

- **Ramson-Ware:** Ransom-ware is malware for data kidnapping, an exploit in which the attacker encrypts the victim's data and demands payment for the decryption key. Ransom-ware spreads through e-mail attachments, infected programs and compromised websites. Payment to be made is in crypto-currencies like Bitcoins which can't be traced and involves offshore storages.

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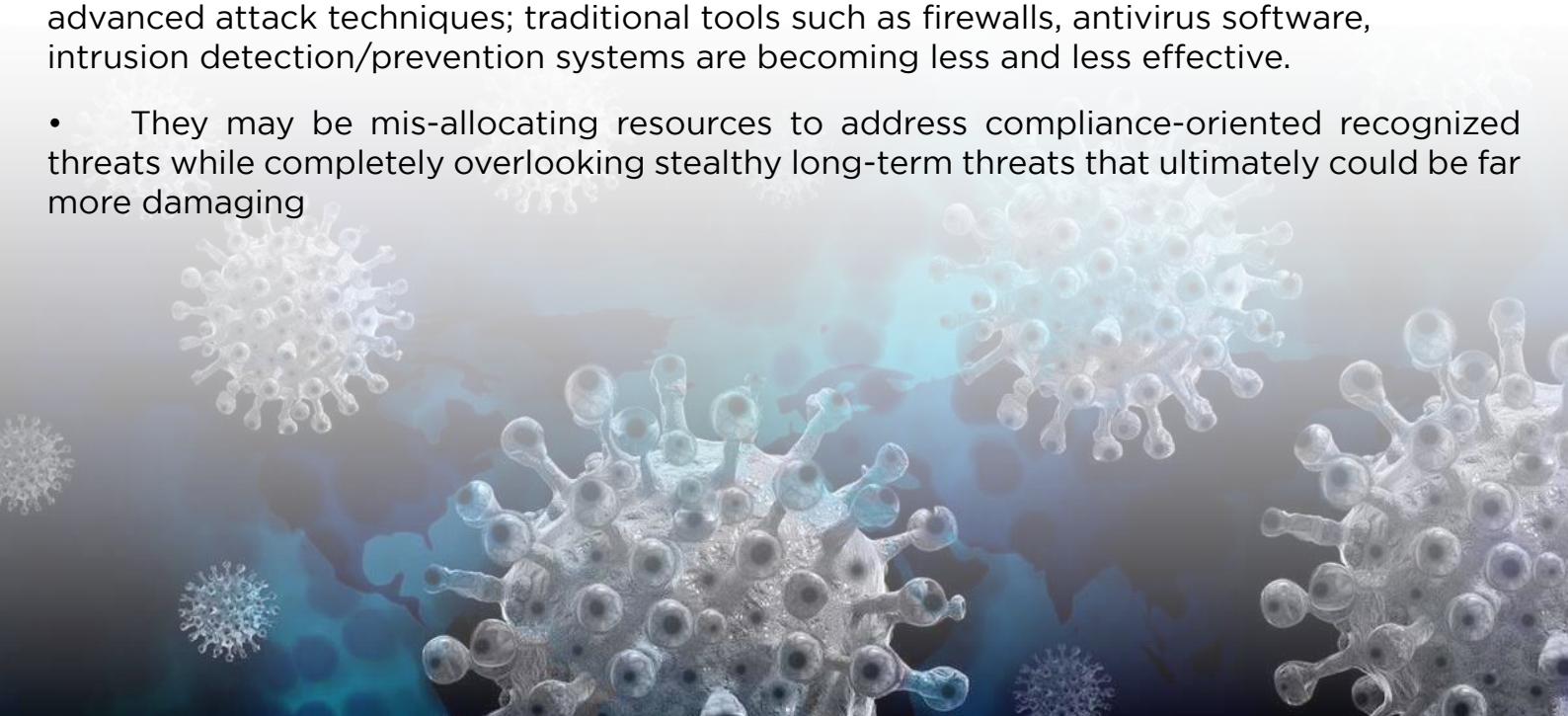
BUSINESS RISKS

By the very nature of business, Insurance Sector in general and in that General Insurers in particular are vulnerable to cyber crime incidents because :

- They collect, process and store large data including confidential customer information.
- They are connected to other financial institutions through numerous channels including but not limited to payments, investments, capital raising and debt issuance.
- During mergers and acquisitions, changes in corporate structure can affect the Cyber security
- They also outsource lot of activities which increase exposure to cyber risks.
- They are embracing Big Data and Analytics which require more ways to secure information.
- They have maximum growth in Online Channels. This shift is driving increased investment in traditional core IT systems (e.g., policy and claims systems) as well as in highly integrated enabling platforms such as agency portals, online policy applications and web- and mobile-based apps for filing claims. These introduce new cyber-risks and attack vectors.
- They have invested a lot of money in security tools and processes that may be providing a false sense of security. As attackers learn to leverage encryption and other advanced attack techniques; traditional tools such as firewalls, antivirus software, intrusion detection/prevention systems are becoming less and less effective.
- They may be mis-allocating resources to address compliance-oriented recognized threats while completely overlooking stealthy long-term threats that ultimately could be far more damaging



Few Examples Of Cyber Security Weaknesses Involving General Insurers Observed :

- Missing or Incomplete Overview of the IT-Landscape: Inventory of IT hardware and licensed software may not recognize the data flow between those IT systems, applications, and components. If data flows exist between systems with high levels of protection and systems with lower security levels, cyber criminals may be able to gain access to otherwise secure systems.

- Inadequate Control Process Regarding User Privileges: Data categorization and User rights are major issues. The failure of controls within the allocation process of user rights i.e., allowing users to have higher system privileges than warranted / the failure to recognize when an account no longer needs certain system privileges / Improper Access to Super user Accounts (accounts with privilege levels far beyond those appropriate for most users)

Such types of failures could lead to insider abuse and exposure to cyber risks.
Potential adverse consequences to insurers due to lapses in cyber security are :

1. Loss Of Confidential Data : Personally identifiable information collected and stored by insurers, including personal health information of policyholders and, in some cases, of third parties. For e.g. Private health records may be particularly valuable for competition.

2. For commercial policyholders, insurers may collect sensitive business information that could be valuable to corporate / foreign spies. In the case of certain lines such as cyber insurance products, insurers may possess information about a policyholder's network security controls and other cyber resilience information that could be in valuable and could harm intellectual property rights of either parties.

3. Disruption Of Operations : Some cyber attacks can result in disruption to normal business operations. A recent cyber security incident was reported to have destroyed the firms entire network, including emails, telephone directories, voicemails amongst business records such as contract templates. Such a malicious attack on an insurer could result in significant harm to the firm and substantial recovery costs.

4. Reputational Loss : The foundation of insurance business is policyholder trust: trust that the information collected by insurers will be protected, and trust that claims will be paid out in a timely way when appropriate. If a data breach exposes confidential information, that trust may be shaken. Similarly, if an insurer were to suffer a cyber security incident that rendered it unable to make timely claims payments that trust may also be shaken. The reputational risk could extend to the sector as a whole.

The varied challenges presented by cyber risk should be met with a broad response by insurers wherein have an effective governance structure to understand, prevent, detect, respond to and address future cyber security incidents.

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Few Best Practices For Cyber Resilience Include:

• Governance together with the engagement of Management along with a proper cyber resilience framework contributes to the mitigation of cyber risk. One Sr. official (CISO) should be responsible for developing and implementing the cyber resilience framework

• Identify critical business processes that should be protected against compromise. Information assets and related system access should be identified. Regular reviews and updates are key factors, as cyber risk is constantly evolving around "hidden risks"

• Protection - Resilience can be provided by design. Continued strong IT controls contribute to protection. When designing protection, the "human factor" should be taken into consideration via means of access to insider and outsider threats.

• Detection Comprehensive cyber security monitoring is essential, and should include third party providers, because detection goes hand in hand with continuous monitoring. Performing security analytics also helps mitigate incidents

• Response and Recovery - Incident response planning is of great importance. and Resumption of services should be within reasonable timeframe. Contingency planning, design, and business integration as well as data integrity are key enablers. Last but not least, forensic readiness is essential for deep dive investigations.

• Testing programs, vulnerability assessments, scenario-based testing, penetration tests, and red team tests are cornerstones in the testing phase. Cyber security testing should be included when systems are specified, developed, and integrated.

• Situational Awareness contributes to the identification of cyber threats. Accordingly, the establishment of a threat intelligence process helps to mitigate cyber risk. In this regard, insurers should participate in established information sharing initiatives.

• Insurers should continually re-evaluate the effectiveness of cyber security management. Lessons learned from cyber events and cyber incidents contribute to improved planning. New developments in technology should be monitored.

***Excerpts are from International Association of Insurance Surveyors**

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Fraud Investigation In Pandemic Times And Beyond – Life Insurance Policies

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Preface: Fraud is a menace, which every organization in any Industry has been impacted from. Handling the same has always been a challenge. There are various factors which expose corporates to the risk of fraud. Fraud is an ever growing threat to the economy globally and India is no exception. This not only leads to financial and legal risk for any organization but more critically damages its reputation, if not handled properly, which is very difficult to recover from.

- Fraud is defined as the deliberate abuse of procedures, systems, assets, products and or services by those who intend to deceitfully or unlawfully benefit themselves or others.

- Fraud in Insurance is defined as an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties.

Life Insurance Industry is also severely hit by Fraud. Fraud affects the lives of innocent people as well as the insurance industry. Insurance fraud has existed ever since the beginning of insurance as a commercial enterprise. It takes many forms and may occur in any areas of insurance. Financial impact due to insurance Frauds is estimated to be more than Rs. 50,000 Cr annually and significant part of this loss would be from life Insurance Industry.

In the recent times it is true that Life Insurance sector has been growing at a good rate annually and working towards more penetration in Indian Population it is also cannot be ignored that there is also an increase in fraud. This not only results in monetary loss but also loss of reputation, goodwill and customer relations to an insurance company.

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Role Of Fraud Investigators:

However, in handling such Frauds the importance of Investigators can never be ignored. As Insurance Advisors are regarded as the first underwriter for the Insurance Companies while sourcing the policies so are the Insurance Investigators who are eyes and ears for them to tackle such frauds.
There has been a rise in organized individuals and syndicates indulging in fraudulent claim filings, leading to a challenging environment for investigators. The job of investigator is to review life insurance claims that look suspicious. The investigator - an individual or a company specializing in this field - carries out a thorough investigation as well as verification of the death claims or policies. Individual investigators, compared with specialized firms operating in this area, face more difficulty while doing their job. “There have been cases where investigators looking into death claims have been physically attacked. In the past year, the number of criminals involved in filing fraudulent claims has almost doubled.

Estimates from Life Insurance Industry show there has been a 20-30 per cent increase in fraudulent claims. Insurance-sector players have woken up to this menace, which also includes claims from non-existent persons which are generated by these groups operating across the country. A senior life insurance official point out there have also been cases involving former insurance agents. The organized groups have expanded their operations in many pockets, which is spread across Pan India. While the insurance sector has come together to exchange information about these cases, such unscrupulous acts by such Fraud Nexus continue. Not only the investigators have been threatened to give reports in favour of the claims being passed but so has the Employees from Risk Containment Unit of Insurance Companies. Although cases have been filed against many such Fraudsters in recent past, such incidents continue to be reported.

Most Prevailing Modus-Operandi in Insurance Fraud, which the Investigators are required to partner the Insurance Companies are with respect to the following:

- Dead Man Insurance
- Policy Done On Terminally Ill Person
- Policy On Non-existing Person
- Death Claim On Alive Person
- Non-insurable Interest
- Concealing Correct Cause Of Death
- Fake Accidental/suicide Claim

An effective anti-fraud strategy in fact has four main components:

- Prevention
- Detection
- Deterrence
- Response

It is clear therefore, that the various elements of an effective anti-fraud strategy are all closely inter-linked and each plays a significant role in combating fraud. Fraud detection acts as a deterrent by sending a message to likely fraudsters that the organization is actively fighting fraud and that procedures are in place to identify any illegal activity that has occurred. The possibility of being caught will often dissuade a potential perpetrator not to commit a fraud. Complementary detection controls should also be in place to counter the fact that the prevention controls may be insufficient in some cases.

Newer Challenge posed by Covid-19:

While Industry was already grappling with the ever-growing frauds there came the Global Pandemic COVID 19, in the early part of last crucial quarter of Financial Year (FY) 2019-20. The advent of this new and grave challenge shook the Life Insurance Sector like any other Sectors/Industries. Covid-19 has caused severe disruption for insurance companies, and in managing risks, they have responded to some of the challenges of 2020. However, there has been huge pressure to not only sustain the business but equally posed greater challenge to handle frauds, which also had newer andinnovative methods used by Fraudsters. It posed severe challenge on Investigation of policies be it at Pre-Issuance, Existing Policies (Pre-claim) or at Claim stage. Regulator gave some breather during the initial period by increasing the timelines for completion of the Investigation. However, there had been far greater challenges faced by the Investigators, specially during the initial 5-6 months and thereafter again had come in this FY2022 with far worse 2nd wave of COVID 19. Few of these challenges are as follows:

- Restrictions in travelling due to Lockdowns/Curfews made it very difficult for the investigators to move as were being done freely Pre-Covid;
- Resistance/Refusal for Physical Meetings/Interactions by Policyholders'/Claimants in many instances due to fear of Virus spread.
- Hospitals, Municipal and Other Offices, which are crucial for verifications/ investigations were either closed or entries denied due to their pre-occupation with managing Covid 19 related issues.
- Threats to life of filed investigators from Fraudulent Nexus have also been getting more serious.
- Several of the field officers of Investigators Firms got infected with the Virus, which further depleted already limited trained/skilled Investigators/agencies.
- Offices and Staffs of Insurance Companies working remotely.
- Increase in Claims warranting investigation (including Covid claims), which increased further in last couple of months in this FY and the fear of third wave is also prevalent.

- To ease the pressure and to provide optimum levels of customer support, many insurers are facilitating the claims process by waiving certain requirements and simplifying the paperwork needed. However, it remains a challenge to deal with complex and/or high value claims, where evaluating the physical evidence and obtaining expert reports in-person is frequently a key part of the process.

- Fraudsters taking advantage of the situation and coming out with new innovative frauds like creation of fake death Certificates, Fake Covid Test Reports and now even getting news of Fake Vaccination Certificates.

Way Forward:

However, we all know that with every adversity comes opportunity too. This is no different now having once in a Century Global Pandemic situation, which may not be over so soon and also fear of third wave expected to cone in few days. It has created a need for more investigators, who are well trained for the role and aware of the changes happening around as well as innovative to counter the fraudsters. They need to be alert and being relevant by adapting to new tools and techniques to support Insurance Companies in dealing with these frauds effectively.

An insurance investigator is advised to go through their data of past claims, which they may have investigated to look for any red flags. They may also look for patterns to see whether or not specific people have more probability than others to commit fraud using data analysis. A good and successful investigator will always look out for suspicious signals to lead them to the bottom of the case and crack any frauds. This has been very evident from the cases solved by those successful investigators in the past. Few of such indicators being significant financial debt of the claimant; going through social media or lack of police reports after the supposed accident, They should be more focused on getting crucial evidences and focus more on quality report rather than on focusing on quantity/bulky report, which may not lead to any conclusion.

It is also reiterated that Insurance Institute of India (III) in partnership with APDI and IFTG, with support from Industry Experts, has launched a robust online Certified Training module for Investigators and they should take due leverage of the same, i.e., that of Certified Private Insurance Investigators (CPII). Insurance Companies too should consider them more as Partner and instill more confidence in them by addressing these challenges not only in their training and development but also having commensurate incentive/remuneration plans to motivate them to continue giving better quality outputs.

While most claims are legitimate, it's always in their best interest to take a second look at suspicious claims. There is also a need to have adequate law to prosecute a fraudster legally under the current scenario of organized insurance frauds. Taking legal action against insurance frauds is not a common occurrence and frauds of amounts not big enough are let off as opposed to the heavy investment of time and energy in pursuing the same.

Conclusion:

Fraud risk assessment aims to help an organization identify areas which make it most susceptible to fraud and take proactive measures to reduce the chance of it occurring. This helps prioritize corrective action that may need to be taken with regard to fraud prevention, detection and response initiatives.Given the prevalence of fraud and the negative consequences associated with it, there is a compelling argument that organisations should invest time and resources towards tackling fraud. There is, however, sometimes debate as to whether these resources should be committed to fraud prevention or fraud detection.

Insurers will have to continuously reassess their processes and policies to manage and mitigate the risk of frauds. While claim being a **moment of truth** when the policyholder applies for Insurance Policy and the Insurance companies are duty bound to abide by duly settling such claims in timely manner, the frauds in such claims if not dealt properly may not only lead to financial or legal risk for Companies for but also impact its reputation. At the same time the pricing of the products increases, which is passed on to policy holders in form of higher Premiums, which in these times are not viable at all and specially when the insurance penetration is so low.

At the cost of reiteration, it must be said that honest customers should not have to pay the price for fraudsters through higher premiums. Also, compared to other crimes, court sentences for insurance frauds are lenient, reducing the risk of severe or extended punishment. Today, when India's insurance industry is working towards reducing costs, one of its main focus areas to control or reduce costs is by proactively arresting frauds, which can be achieved through an effective fraud risk assessment programme and having special investigating units in each organisation.

The sharing of knowledge and data should be a common practice amongst all insurers and more so with the victims of fraudulent insurance claims, which has started but needs more to be done to counter and outsmart the fraudsters. The data should include fraud patterns and case studies, fraud customer list and intermediaries, fraudulent providers and investigators.

It is very crucial that awareness should be brought about the due legal process to be followed before reporting a case. The Authority shall also have to seriously think about having specific laws to counter the insurance frauds and setting up Insurance Fraud Bureaus.

Also, not to forget that to regulate and license the Insurance Investigators is very important as they are key partner to the Insurance Companies and have to play a bigger role in fighting out these frauds more effectively. It can aptly be concluded by sharing one famous quote **“It is better to prepare and prevent rather than repair and repent.”**

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Countering Social Inertia to Fight Frauds

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Pierre Bourdieu , the French sociologist propounds the idea that every person occupies a social space, comprising a social class, social relationships and social networks, which he calls 'habitus'. According to Bourdieu, based on one's engagement in the social space, one feels encouraged to "accept the social world as it is, to take it for granted, rather than to rebel against it," entailing a set of behaviors, lifestyle and habits which often serve to maintain Social Inertia or the status quo and the continuity of the social order through time.

Morals are standards of behavior considered right and acceptable by societies and people need to abide by to live as part of societies. Morality often implies that people have to keep the benefit of the society prime, and be willing to sacrifice personal short-term interests for the larger cause of the society. The society considers people or entities who do evil acts, as immoral; and such people often get ostracized by the society. Some moral principles do transcend time and culture, and morality condemns murder, adultery, lying and stealing in practically all cultures. The society usually does not tolerate fraudulent behavior; and people tend to act morally and follow societal guidelines. However, morality is often relative and describes the particular values of specific groups at a specific point in time. Social morality considers whether an action threatens the society's well-being.

Insurance fraud is understood at best by the society as an unfairness to an insurer. Instead of recognizing it as a criminal act of stealing from a common pool which succors its unfortunate members, sadly, the society tends to see it as a retribution of sorts, when one of its members is able to claw back what he has lost by way of premiums in an unfair and unequal deal. In essence, many do not regard defrauding insurers as a crime. Reasons for this situation could be various:

- Lack of Insurance Awareness: Insurance is not understood as the noble business that it is, which provides relief to the unfortunate from a common pool, if and when misfortune strikes. The society does not realize that the frauds are committed by certain individuals at the expense of the common pool.

- Perception that the Insurance mechanism is unfair: Insured often get irked that premiums are paid every year for health and motor insurance policies, and nothing is received unless misfortune strikes. They look at it in contrast with long-term life insurances, where accumulated savings are returned at maturity or big amounts are paid in case of death. They feel that the situation being patently unfair to them by design, committing fraud is justified. Life insurance sees another type of frauds.

- Reaction to wrong perceptions: Insurers often do not communicate reasons for rejecting claims (or paying less) though they may have compelling reasons to do so. This can cause insured to pad up claims intentionally to compensate for the perceived unfair deductions that insurers might make on a claim.

- Societal sympathy towards the underdog: Despite having committed fraud, the insured are seen by the society as hapless creatures, who, even after duly paying the premium are unfairly pitted against behemoth insurers, their corporate lawyers and money power. The entailing sympathy makes the society turn a Nelson's eye to the fraud, or even tacitly support the fraudster.

- Society identifying itself with the fraudster: Usually, people tend to identify themselves with the victim of an injustice, unfairness or fraud and take up the cause of the sufferer. In the case of insurance fraud, the victim is an intangible group of too many nameless and faceless insured, with whom the society is unable to identify itself with. The society sees insurance companies as mammoth soulless corporates, again, with scarcely anything in common. So, the society involuntarily identifies itself with the only victim it can find, the one who suffered the loss and is trying to make a fraudulent claim.

The society has been behaving in this particular pattern, which has been detrimental for the insurance industry for long. Influencing the society to change its attitude towards the insurance industry, mustering its support for the insurance cause and making it recognize insurance fraud as a crime against the society meriting zero tolerance, is a mammoth task.

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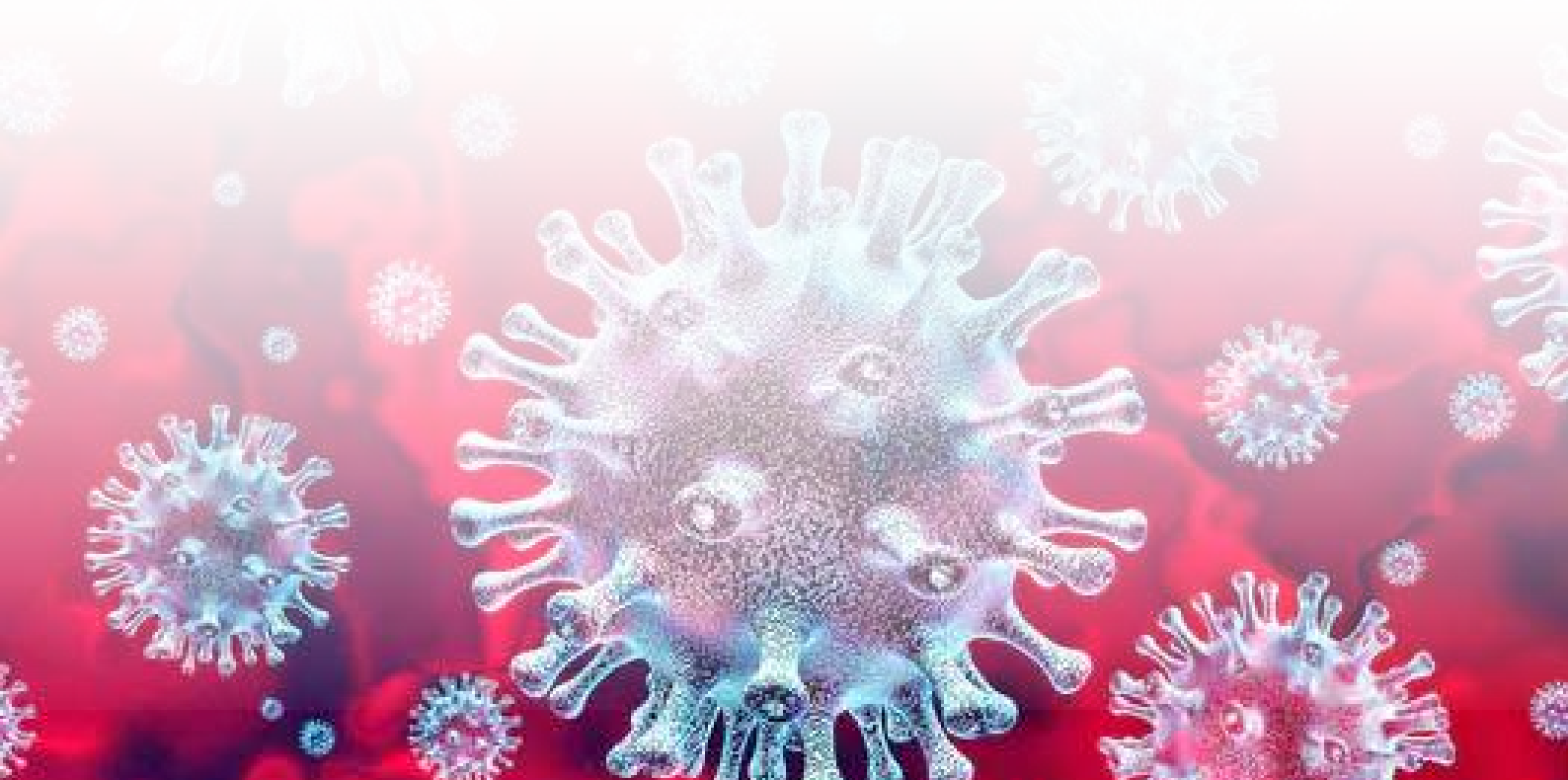
Influencing social behavior and countering social inertia is imperative for fighting insurance fraud. Social Inertia can be countered by a concerted process of Social Change, which involves alteration of the social order of a society. A step further, Positive Social Change is driven by ideas and actions with real-world implications and can occur at multiple levels, including individuals, families, communities, organizations, and governments, improving human, social and societal conditions. The basic explanations of social change, have gone way beyond the traditional ideas of decline or degeneration, cyclic change and continuous progress, to the more tangible ones the natural environment, demographic processes, technological innovations, economic processes, social movements, and political processes.

Conceptually, this includes altering social institutions, social behaviors and social relations. Influencing the behavior of the society at large would require multi-pronged approaches, intense planning and coordinated efforts by diverse players, including the entire insurance industry and larger stakeholders like the government. Reducing fraud would make insurance more sustainable, rates more viable, and the benefits of insurance accessible to many more people. The work involved is humungous, but worth undertaking, and the takeaways would be beneficial for the entire humanity in the long term.

[Note: The views and opinions expressed in this article are those of the author and do not necessarily reflect those of any organization(s) the author is associated with.]



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Use Of Technology To Fight Frauds

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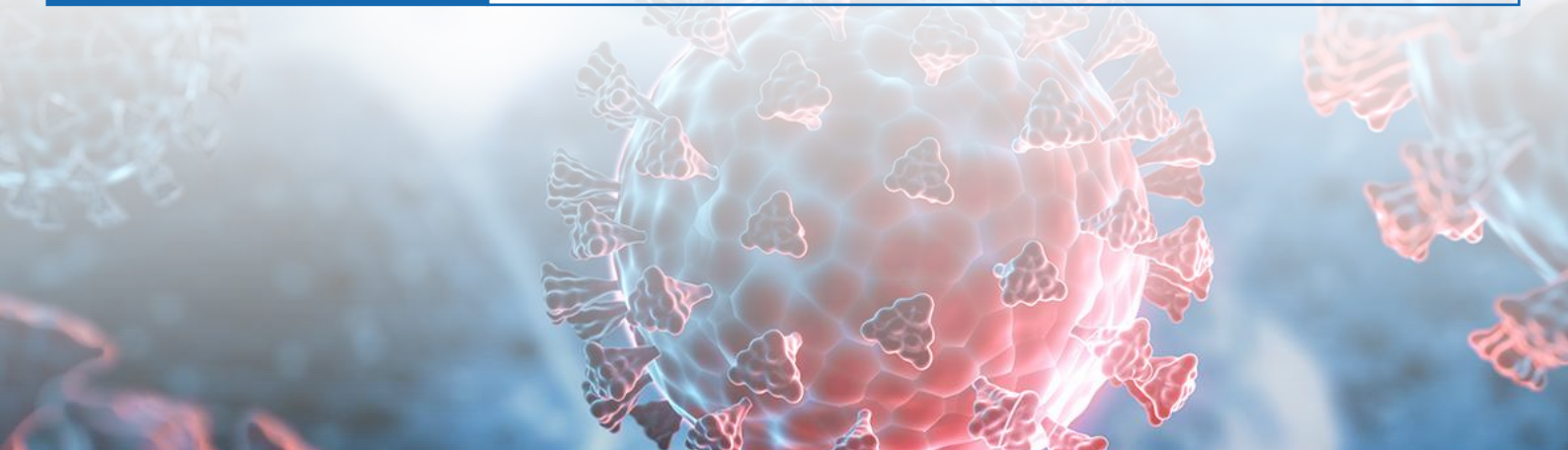
India has more than 560 Million internet users and with the cost of data going down, more and more people would be accessing the internet from their smart phones. In the post pandemic world, we believe this trend is going to see further upward growth. With the growth of technology, increased utilization and people becoming comfortable and complacent about using smart gadgets, technology is increasingly being used to commit frauds. Hence, understanding technology has become all the more important in fighting fraud. If one tries to analyze the various frauds which get committed using technology, they can be broadly classified into following two categories.

Considering the above trend, fraud fighters and investigators need to update themselves with various fraud fighting tools available in the technology space, which can help them in adding value to their roles. Some of the popular tools are discussed below.

Technology Dependent Crime	**Crime Committed Mainly By Using Technology - Computers/ Gadgets (E.G. Identity Fraud/ Card Fraud/ Cyber Frauds)**
Technology Enabled Crime	**Using Technology For Better Sophistication Or For Scaling Up Traditional Areas Of Crime (E.G. Motor Frauds, Health Insurance Frauds)**



At Insurance Company level

Automated Social Media Investigation: Social media investigation tools can help to flag inconsistencies in the data provided while buying insurance policies or during claim intimation vis-à-vis the data available on social media. It can alert the insurance company underwriters or claims managers by raising the flags which can later be investigated further. These tools sit on top of the existing technology infrastructure of the company and work as filters to weed out fraudulent practices.

Spotting Trends: Using software, existing databases can be sliced and diced to find trends or patterns in claims or establish relationships between various factors which may result into fraud later. Finding such trends from multiple data sources is difficult manually, whereas this can be done easily, using software.

Geo Fencing And Telematics: In telematics, a vehicle tracking device is installed which can send/ receive/ store data. The device collects Global Positioning System (GPS) data as well as an array of other vehicle-specific data and transmits it via General Packet Radio Service GPRS Telematics data can actually give information on the vehicle speed , fuel consumption, Vehicle faults , vehicle location, idle time, driving behavior in terms of accelerating and breaking pattern, etc. All this information can be used to issue and price motor policies appropriately and also for the fraud prevention.

One can also specify the limits within which the particular vehicle is supposed to move so that in case it is moving away from the specified path, an alert is sent on mobile. This facility is very useful for fraud prevention in marine cargo policies.

Voice Detection: Even though this technique is still a work in progress, some companies are using voice detection technology to prevent frauds. As per a report published in 2017 almost 80% to 90% of false statements could be successfully detected in motor policies using voice detection software.

Public Awareness: In many cases, insurance frauds are considered as victimless crime. Many argue that it stems from a deep-rooted belief that in an insurance contract, the customer does not get a fair deal, and hence it is alright to take back what is contractually right as per the insurance policy. To overcome such skewed perceptions, creating public awareness on how many genuine policy holders end up paying higher premium every time a fraud is committed, will go a long way to bring home the point. Technological tools can immensely help in such initiatives, by enabling better reach and enhancing effectiveness.

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At Investigator Level

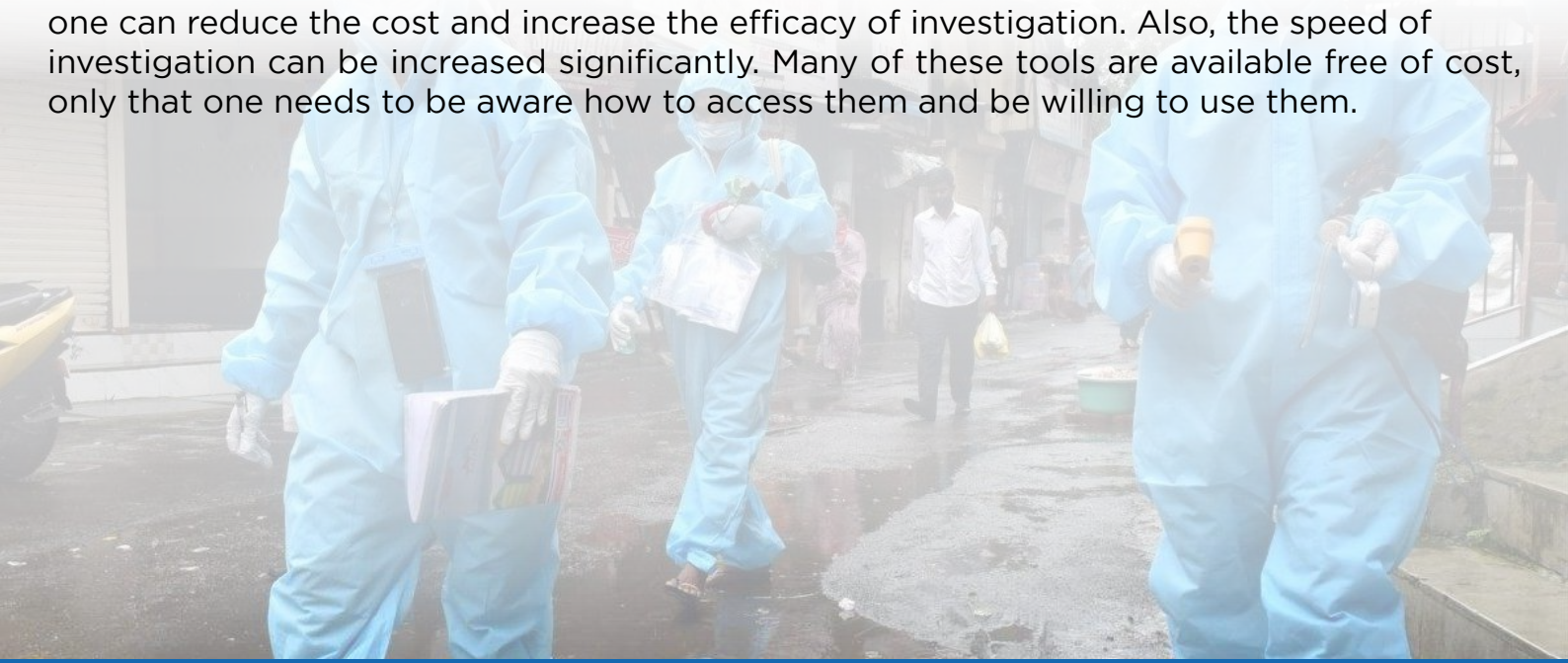
Social Media Tools: In many cases, especially for life insurance policies, fraud investigators have the responsibility to access information provided by the proposer to verify if it is correct or not. In such cases, simple technology tools and information available in public domain on various social media such as Facebook, Linked in, Twitter, Instagram and many others can be used for locating inconsistencies in information provided and cross verifying information.

Third Party public records: Third-party public records and other public domain information can be obtained by paying small fees or by way of using facility such as Right to Information (RTI) to get more information on particular data.

Location application: Satellite data, google maps and street view kind of applications can be used to look at the real time images captured for the place where incidents have happened. In some cases, the security camera footage from the surrounding area can also help to substantiate a case.

Image Analysis: In many cases, the documents submitted are supported by various images. One can look at the image metadata to obtain information whether the image was taken from internet, when it was taken, who created the image, who holds the copy write, the location of the instrument used, etc. There are many websites where one can upload a picture and get all such metadata of the image. Some of the administrative information of the image can simply be obtained by looking at the properties of the particular image even offline.

We can conclude that using technology at company level as well as at investigator level, one can reduce the cost and increase the efficacy of investigation. Also, the speed of investigation can be increased significantly. Many of these tools are available free of cost, only that one needs to be aware how to access them and be willing to use them.



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Covid 19 Disruption – A Strategic Timeout

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Insurance as an important element of financial planning, more so as a risk management tool, has been consistently gaining traction in the Indian market over the past 30 years. Economic reforms of 1991 laid the foundation for foreign insurance players to venture into the Indian market. Economic growth of the subsequent decades enabled both public and private insurance providers to spread their reach across the country. Proliferation of mobile telephony in the 2000s and of digital mobility in the last decade has ensured that an Indian has access to insurance as swiftly as she does to her contact list. Today an Indian in Leh, Kanyakumari, Bhuj or Aizwal has access to as many insurance options as her fellow citizen in Bandra Kurla Complex in Mumbai or Cyber Hub in Gurgaon. Awareness, affordability, and technology driven ease of access have indeed acted as key enablers for the insurance industry in India.

These enablers have also contributed by ushering in key disruptions to the insurance eco system. Technology and e-commerce driven access has brought about a tectonic change in customer experience. Many a times buying insurance is as easy as a click of a button. Whilst it is rare for a millennial to walk into a local branch of an insurance company anymore, her parents most probably have a trusted family insurance agent who they have operated through since their first policy. In many cases these agents have evolved and embraced modern technology as well. It is possible to insure nearly anything that one feels the need to - a cab ride, a holiday, your favorite piece of art, expensive mobile phone, critical ailments or against cyber risks. Similarly, advent of Aadhar and video KYC has further simplified customer onboarding and verification. Who can forget the importance of a MTNL/BSNL telephone bill?! Things have come a long way.

All this has been achieved just in the past two decades. Interesting bit is that this is just the tip of the iceberg. Market penetration still stands at only 3.8% of the total population. Just imagine what will the insurance industry look like once it is at 30% or 60% penetration levels? Precisely the reason why India is considered a growth market for the global insurance industry. Story of India is one of the strongest and dependable stories of potential economic growth anywhere in the world.

ARTICLES

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Since time immemorial insurance industry has been a favorite hunting ground of fraudsters. There is a good amount of literature documenting the extent of fraud being suffered by insurance companies across the world. Fraud costs USD$ 100 billion in the US, USD$ 4 billion in Australia, USD$ 3billion in the UK, USD$ 2-3 billion in other EU countries and around Rs. 45,000 crores in India per year. It is estimated that on an average an insurer loses close to 10% to frauds.

Like most criminals, fraudsters have also evolved in the past two decades. What used to be a petty crime conceptualized by an individual facing existential crisis in early 2000s has evolved into a well-oiled machine being run by nexus of individuals from varied backgrounds including finance, medicine, legal and many a times serving government officials with impunity as a multi-million dollar industry with an assured return on capital. Equipped with subject matter expertise, technology, insight, connections, and money these fraudsters are running mini organized crime empires across the country. With help from insiders, they have mapped the insurers to understand their SOPs, priorities, approach and risk appetite.

Indian insurance companies have also learned and devised effective fraud risk mitigation techniques aimed at controlling these leakages. Insurers have invested in technology and embraced analytics in their fight against fraud. Some have introduced apps for case management and reporting and are actively engaging with the law enforcement to curb this menace. When it comes to high-risk matters insurers still rely on Private Insurance Investigators (PII) for on ground execution.

PIIs are put to good use for various fraud risk mitigation activities including pre-issuance profile verification, mystery shopping, claims investigations, etc. Nature of the job is such that PIIs are exposed to the elements and thrown in to the rough of things. As insurance permeates into India's heartlands PIIs are expected to follow the trail and increasingly find themself in a hostile environment where many a times the societal intent is to recover/ extort claim money from the insurer. Increasingly PIIs are crossing paths with organized criminals. This has led to a spike in cases of hostilities towards PIIs manifesting into anything from the PII being lured by money all the way to physical violence and kidnapping. PIIs also find themselves at the receiving end of stage-managed fraudulent corruption allegations by claimants, their families and their agents. At times fraudsters trail PIIs and then confront them with open threats to their life and family.

While the insurance eco system, from insurers to fraudsters, has evolved and progressed in the last two decades, PIIs have not. In spite of exposure to possibly the highest occupational hazard in the insurance eco system, their remuneration is still at the levels of early 2000s.

Many of them are untrained, unorganized, and covering only local geographies. In case they are faced with hostilities, they are expected to fend for themselves and find a resolution on their own. Insurers need to confront this reality and work towards uplifting PIIs as part of a concerted strategy aimed at fighting fraud. A hands-off approach towards a crucial extended fighting arm might result in short term cost management but surely is a recipe for disaster in the medium and long term. PIIs are the unsung heroes who are relentlessly fighting against odds with an intent of protecting insurers and their bottom lines.

This pandemic is most certainly the biggest disruptor that our nation has experienced since independence. Its scale and ability to touch every Indian has resulted in disruption that not many could have predicted. Loss of life & livelihood, erosion of wealth at all levels of the society, coupled with the dynamic nature of the virus and its multiple variants has infused unprecedented levels of uncertainty into our lives. As with any natural calamity, this time as well insurance has been a great help. As per the latest IRDAI information, over 19.11 lakh covid health claims and over 55,000 life claims have been reported. Out of these health claims exceeding Rs. 15,000 crores and life claims of over Rs 3,600 crores have been settled.

Unfortunate as it is Covid 19 driven disruption might act as an agent provocateur in ushering in the next set of changes that will define our 'new normal'. It can have a similar impact as what 9/11 and 26/11 had on security posture of air travel, hospitality, and public buildings. Indian insurance industry is already witnessing positive change in the form of rapid adoption of Insurtech as a business continuity measure aimed at ensuring seamless delivery of service to customers. Fraud & Risk Management function can also use this disruption as a strategic time out and use this opportunity to address some seminal aspects of its functioning, which will prepare it for the oncoming growth of insurance penetration in India. Key pertinent issues that may be considered are as follows:

- Criminalisation of insurance fraud – it is imperative for an economy of India's size to have strict laws addressing insurance fraud. Western economies have adopted aggressive posture towards insurance fraud with an aim of creating an effective deterrent. In India we are witnessing a rapid evolution of insurance fraud from an individual's effort to organized crime. What are we waiting for? The sooner this elephant in the room is acknowledged, the better it is for all stakeholders including the biggest stakeholder - Government of India.

- Acknowledgement of Private Insurance Investigation as a crucial and legitimate function within the insurance landscape by the IRDAI. It is important that the ground rules, including training, remuneration and code of conduct, for PIIs is prescribed by the regulator.

- An overwhelming majority of PIIs serving the insurance industry in India are firms that fall under the definition of small and/or micro enterprises as per the Ministry of Micro, Small and Medium Enterprises. This is an opportune moment for an industry wide review of financial remuneration being paid to PIIs. It is imperative for the insurers to incentivise and support PIIs by offering them professional fees that are more reflective of realities in 2021 and not 2001.

- Certified Private Insurance Investigator (CPII) - Insurance Institute of India in partnership with International Fraud Training Group and Association of Private Detectives and Investigators (APDI) have developed India's first industry led certification – Certified Private Insurance Investigator (CPII), which should be adopted as the mandatory certification for PIIs across insurance industry.

India's story is possibly the strongest and most robust story out there. Over the centuries India has outlived most civilisations, pandemics and invasions. It has been our ability to learn and adapt to the 'new normal' that has ensured our longevity and evolution. It is in our DNA to deal, embrace and thrive with 'new normals'. This is an ideal moment for the Fraud & Risk Mitigation fraternity of Indian Insurance Industry to utilize this disruption as a 'Strategic Timeout' and prepare for the upcoming years of unprecedented growth by developing and embracing a more inclusive 'new normal'.