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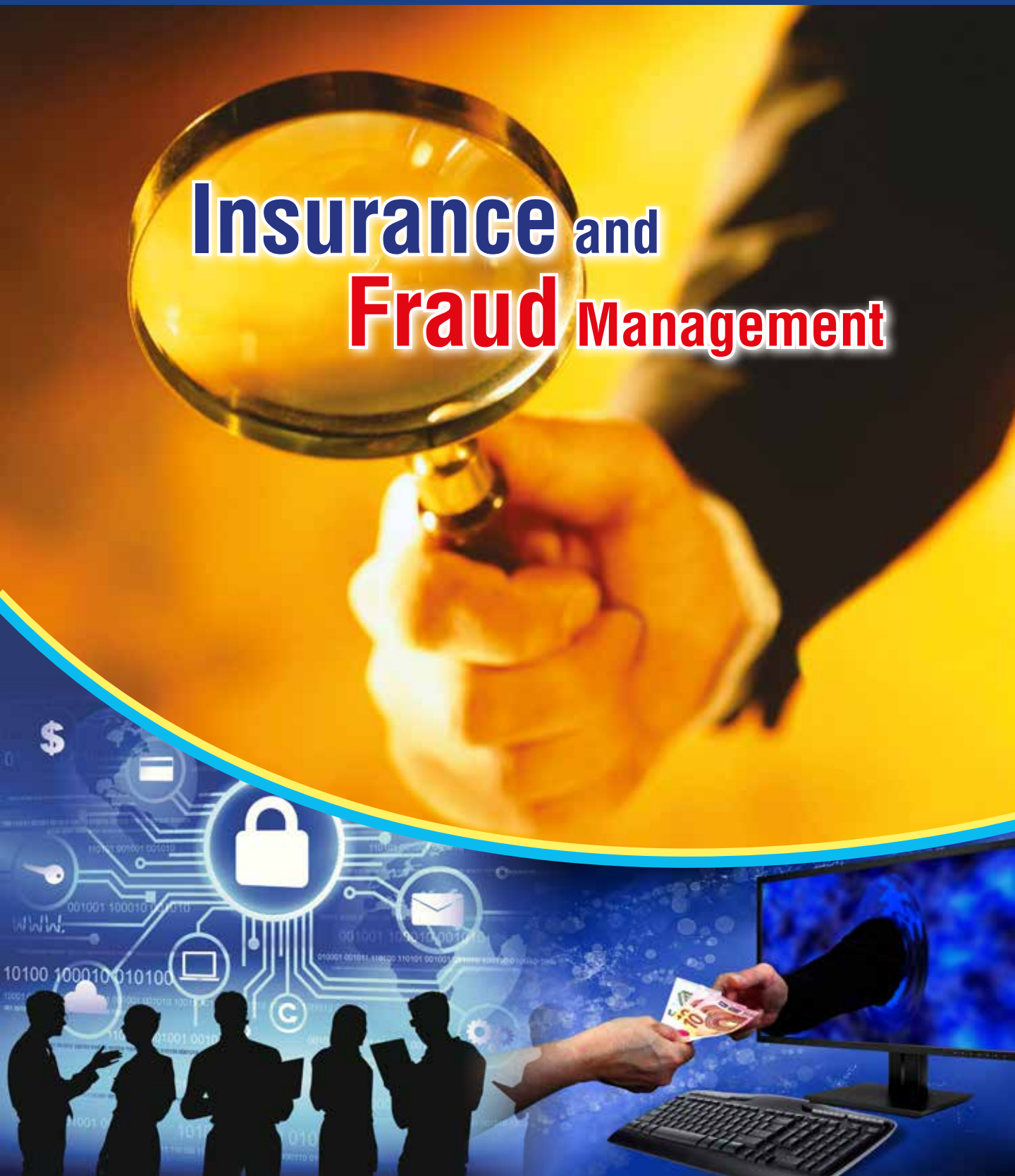
Insurance and Fraud Management



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EDITORIAL

We are happy to bring out the July – September issue of the journal, even as we pass through trying times and have to work from home. We are grateful to the contributors who have made this possible. This issue was devoted to the theme of Fraud in Insurance. The large number of interesting and informative contributions we received, is a testimony to the enormous significance that Insurance fraud has both in our practice and in our very psyche.

Fraud, as it is well known, can arise both in the form of non - disclosure of material information or mis-information, both designed with a deliberate view to deceive another party and profit from such act. The industry, it is true, suffers a great deal from this malaise. Insurance Fraud and its resultant losses for the industry has been partially responsible for high costs incurred in certain lines of insurance like health. Part of the reasons may lie in the ingenious and innovative ways by which fraudsters are able to find cracks in the systems that insurers and other institutions seek to insulate themselves from fraud. It may also stem in part from the acts of dishonest insiders who aid and abet these frauds. There may be other reasons as well.

A question arises here on which we may ponder: We, Industry practitioners cry foul with a lot of vehemence when we encounter an instance of fraud perpetrated by outsiders. Do the mass of our customers display the same vehemence, even as the consequent losses affect them indirectly as well? Have we considered that the roots of fraud may lie in the very context in which we conduct Insurance Contractual transactions! Can fraud be combatted effectively without having customers as partners in the process? Can that be achieved as long as a customer is just a statistic rather than a human being to be engaged with….

The next issue of the journal will be mainly devoted to Price Winning Articles received in our various competitions conducted by the institute. We would be happy to also publish a few other articles that are rich in content and of high interest.

We herewith announcing the theme for January – March 2021 - **'Technology and New Normal in Insurance Post Covid 19'** and for July – September 2021 - **'Insurance and ESG [Environmental, Social and Governance Risks]'.**

Insurance Fraud Management

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With the advent of advanced software development techniques, the market is flooded with many tools to detect, proactively, the probability of occurrence of wwin every type of business. They are also under considerable usage in many advanced and well developed counties - though not in India, yet.

This paper purposefully avoids discussion on these tools and plans, and seeks to look, only, into the theoretical aspects and features of *'fraud'* and its occurrence, and of the people who perpetrate (or practice?) fraud.

It is believed that it is more important - *firstly* - to know what fraud *is* than to defend it and its occurrence.

Are the nature and features of fraud and the profiles of people who perpetrate it, the same across all countries and communities?

The answer seems to be *'yes'* - as the available literature indicates.

Fraud

The simple dictionary meaning of fraud is:

"wrongful or criminal deception intended to result in financial or personal gain" (Oxford Dictionary)

Almost all the lexical definitions are similar to the above meaning.

They define a fraud with reference to the perpetrator of the fraud and not with reference to his/her victim.

However, the legal dictionary defines fraud with more reference to the victim of a fraud, rather than the perpetrator of the fraud.

It is also more elaborate with the nature of fraud:

"A false representation of a matter of fact - whether by words or by conduct, by false or misleading allegations, or by concealment of what should have been disclosed - that deceives and is intended to deceive another so that the individual will act upon it to her or his legal injury".

The Companies Act 2013 (Act 18 of 2013) also defines fraud, under Section 447 of CHAPTER XXIX (MISCELLANEOUS)

(i) "fraud" in relation to affairs of a company or any body corporate, includes any act, omission, concealment of any fact or abuse of position committed by any person or any other person with the connivance in any manner, with intent to deceive, to gain undue advantage from, or to injure the interests of, the company or its shareholders or its creditors or any other person, whether or not there is any wrongful gain or wrongful loss;

(ii) "wrongful gain" means the gain by unlawful means of property to which the person gaining is not legally entitled;

(iii) "wrongful loss" means the loss by unlawful means of property to which the person losing is legally entitled.

We can see - from all the definitions above (and from almost of all other definitions) of fraud, that there is an emphasis on *the intention part of the perpetrator* of the fraud. *Intention*, of course, is indeed a mental and *psychological inclination* of a person. And, does this mean that there is a certain *psyche - or features - in the people who intend to fraud?*

Enumerating such features is known as *'profiling'* and more often, used in *criminology* as *'criminal profiling'*. *"Criminal profiling* has also been referred to, among less common terms, as *behavioral profiling, crime scene profiling, criminal personality profiling, offender profiling, psychological profiling, criminal investigative analysis,* and, more recently, *investigative psychology." (Turvey)*

Researchers on the subject opine that *profiling* dates back to 38 c.e.

"One of the first documented uses of criminal profiling involves the demonization of Jews with a fairly crude form of profiling. Its origins are found in a report made by the anti-Semite scholar Apion to the Roman Emperor Caligula in 38 ce". (Turvey)

Though the history of profiling began on unfounded basis, it passed through centuries of development on more reasonable and scientific arguments. There are today several professionals involved in building fairly well-founded methods of *offender profiling.*

"Today's profiling community is made up of professionals and non - professionals from a variety of related and unrelated backgrounds. At the forefront is the Academy of Behavioral Profiling (ABP), 30 founded March 1999 (the author is one of five founding members and a voting member of the board of directors). The ABP is the first international, independent, multidisciplinary professional organization for those who are profiling or who are studying profiling. It has a student section; an affiliate section for the interested, nonprofiling professional; and four full member sections Behavioral, Criminology, Investigative, and Forensic." (Turvey)

"The next important historical post in profiling offenders is the book - *"The Criminal Man" (1876)* - written by the renowned Italian physician *Cesare Lombroso* (1835–1909). His research classified criminals under three types - *Born Criminals (degenrate habitual criminals) , Insane Criminals (with mental illness or sickness)* and *Criminaloids."*

Criminaloids were a large general class of offenders without specific characteristics. They were not afflicted by recognizable mental defects, but their mental and emotional makeup predisposed them to criminal behavior *under certain circumstances.*

The above classification has been compared well to the diagnosis of psychopathic personality disorder that came in the later years from the psychiatric community.

It is generally said that most of the fraudsters come under the classification of the *criminaloids* who *act under certain circumstances*, and may not possibly repeat their fraud unless and until, perhaps, such impending circumstances *recur*.

Such impending circumstances could be, in most cases, comprising of three elements - *pressing needs, ready opportunities* and a *rationale to act.*

These three elements constitute what is popularly known as the *Fraud Triangle and technically called the the Cressey Fraud Triangle.*

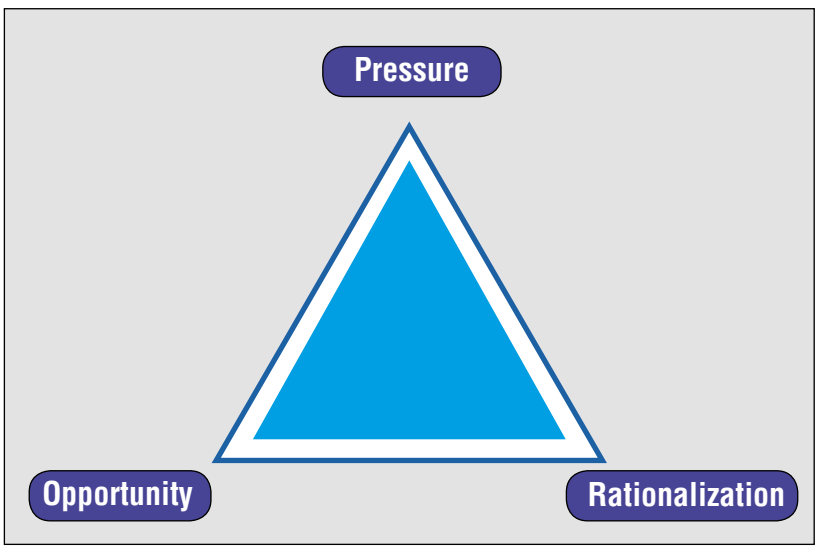
"Donald Ray Cressey, the renowned sociologist, criminologist and penologist,

revised his working hypothesis four times, until settling on a fifth iteration. This final re-formulated hypothesis was claimed to be confirmed by all 133 cases without a single exception. Similarly, in a review of roughly 200 unpublished episodes that had been collected by Sutherland, Cressey found no reason to reject his final hypothesis".

He argued that:

"Trusted persons become trust violators when they conceive of themselves as having a financial problem which is non-shareable, are aware this problem can be secretly resolved by violation of the position of financial trust, and are able to apply to their own conduct in that situation verbalizations which enable them to adjust their conceptions of themselves as trusted persons with their conceptions of themselves as users of the entrusted funds or property." (Cressey)

The following diagram depicts the *Cressey* arguments mentioned above, in a fraud triangle, with the said three essential elements - the *Pressure,* the *Opportunity* and the *Realization* - to *exist jointly* for a fraud to occur.



Michele Rílany Rodrigues Machado and Ivan Ricardo Gartner conducted an empirical study of Cressey theory to the Brazillian banking institutions and discussed in detail the three elements of the Fraud Triangle of Cressey:

""Pressure", also known as incentive or motivation, refers to something that happens in the personal life of the fraudster and that creates a stressful need, thus motivating the fraudster. This stress is non-shareable, in the sense that he - the perpetrator of the fraud - cannot discuss his problems with anyone to find a way out.

"Cressey showed that in all of the cases found in his research interviews, non-shareable problems precede the criminal violation of financial trust. These problems are related with the status required by the offender or with maintaining his/her status.

"The analysis carried out by Cressey is consistent with the literature on fraud by indicating that the problems or the pressure were related to immorality, emergencies, increased needs, reversals in the business environment, and a high standard of living etc. preceding the violations of trust.

""Opportunity" presupposes that fraudsters have the knowledge and chance to commit fraud.

"The logic is that the individual will commit fraud as soon as he/she holds a position of trust, and knows the weaknesses in the internal controls, and also obtains sufficient knowledge regarding how to successfully commit the crime.

"Thus, when pressure, which is the existence of non-shareable problems, is added to such opportunities derived from the individual's knowledge, the potential for fraud is greater.

""Rationalization" is a cognitive process of self-justification. This concept is widely discussed by sociologists, psychologists, and psychiatrists. In his hypothesis, Cressey perceived that fraudsters rationalize their trust-violating conduct as acceptable and justifiable behavior by the intention to resolve a given problem classified as non-shareable.

"So, rationalization is the process in which an employee mentally determines that fraudulent behavior is the correct attitude, considering that the company can absorb the consequences of this act or that no shareholder or stakeholder will be materially affected by the execution of the fraud. According to Cressey, the rationalization used by violators is necessary and essential for the criminal violation of financial trust, as it is by way of this that the individuals find pertinent and real reasons to act; that is, they convince themselves that carrying out the violation of financial trust is a justifiable and acceptable act.

"Thus, according to Cressey, the occurrence of fraud is conditioned by the joint existence of three

dimensions: pressure, opportunity, and rationalization. "

Cressey focused on the circumstances that led the individual to be overcome by temptation.

His hypothesis was that trusted persons become trust violators (fraudsters) when they conceived of themselves as *'having a financial problem which is non-shareable (perceived pressure)'*, are aware this problem can be *'secretly resolved by violation of the position of financial trust (perceived opportunity)'*, and are able to apply their own conduct in that situation verbalizations which enable them to *'adjust their conceptions of themselves (rationalization)'* as trusted persons with their conceptions of themselves as users of the entrusted funds or property. This hypothesis he represented as the fraud triangle.

But later, in 2004, *David T. Wolfe of Glasgow Forensic Group and Dana R. Hermanson of Kennesaw State University,* added another element - the *Capability* - to the three elements of the *Fraud Triangle* and made it the *Fraud Diamond.*

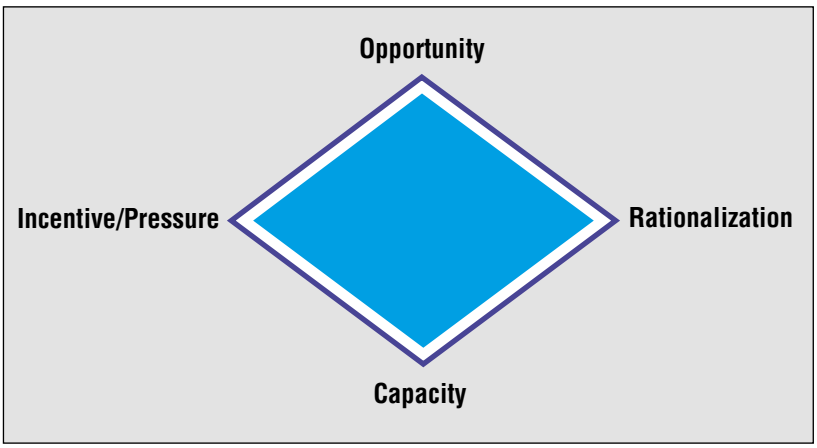
"The authors believe that the fraud triangle could be enhanced to improve both fraud prevention and detection by considering a fourth element. In addition to addressing incentive, opportunity, and rationalization, the authors' four-sided "fraud diamond" also considers an individual's capability: personal traits and abilities that play a major role in whether fraud may actually occur even with the presence of the other three elements.

"Using the four-element fraud diamond, a fraudster's thought process might proceed as follows:

1. *Incentive: I want to, or have a need to, commit fraud.*
2. *Opportunity: There is a weakness in the system that the right person could exploit. Fraud is possible.*
3. *Rationalization: I have convinced myself that this fraudulent behavior is worth the risks.*
4. *Capability: I have the necessary traits and abilities to be the right person to pull it off. I have recognized this particular fraud opportunity and can turn it into reality."*

We shall now just enlist a few common un-shareable problems which are likely to build considerable pressure on an individual to incite or prompt him/her to commitment of fraud.

- Medical problems – especially for a loved one
- Unreasonable performance goals
- Spouse loses a job
- Divorce



According to Wolfe and Hermanson, "Opportunity opens the doorway to fraud, and incentive [i.e. pressure] and rationalization can draw a person toward it. But the person must have the capability to recognize the open doorway as an opportunity and to take advantage of it by walking through, not just once, but time and time again"

Further, they have also suggested a few indicators which suppose the *capability element* in a person who is likely to perpetrate a fraud.

They are

Position/function

Brains

Confidence/ego

Coercion skills

Effective Lying

Immunity to stress

- Starting a new business or an existing business is struggling
- Criminal conviction
- Civil lawsuit
- Purchase of a new home, second home or remodel
- Need to maintain a certain lifestyle – Individual or spouse either likes expensive things or feels pressure to "one up" others regarding material possessions.
- Excessive gambling
- Drug or alcohol addiction

Insurance Frauds

Insurance frauds come under financial frauds, like bank frauds and other accounts embezzlements.

Insurance frauds, however, differ slightly because they may occur from the

internal marketing environ - consisting of all *employees* of all cadres and classes - or from the *external marketing environ* - consisting of field employees *(agents, brokers, surveyors, medical examiners etc.)* and customers *(policy holders, claimants, tenants, suppliers etc).*

It must be noted that the theories of fraud discussed in the foregoing paragraphs will not change, whichever be the quarter from where insurance fraud is committed. Frauds and fraudsters are universal in nature and the modus and their main framework is totally based on human nature, traits and psyches - *where ever they are.*

According to Whitaker of the Association of Certified Fraud Examiners (ACFE),

"Aside from tax fraud, insurance fraud is the most practiced fraud in the world. The insurance business, by its very nature, is susceptible to fraud.

"Perpetrators of insurance fraud try to create losses or damage rather than joining others who have no losses but wish to keep themselves protected in case an unknown event should occur.

"Fraud can occur at any stage of an insurance transaction by any of the following:

- Individuals applying for insurance
- Policyholders
- Third-party claimants
- Professionals who provide services to claimants

Further, Whitaker classifies insurance frauds:

(1) hard frauds and

(2) soft frauds.

"A hard fraud occurs when an accident, injury, or theft is contrived or premeditated to obtain money from insurance companies. When a legitimate loss occurs, such as theft of a cell phone, and the insured adds an item to the claim (e.g., a phone accessory) to cover the deductible, it is considered a soft fraud. Soft fraud occurs when a legitimate claim is exaggerated.

"Insurance fraud is not limited to one group, race, or gender."

Strictly speaking, there is no separate issue like insurance fraud and its management.

The theory of fraud and the profiles of fraudsters are all universal, as aforesaid, and equally relevant and applicable to all organizations - be it public or private institutions and be it financial or non-financial organizations - and in any part of the globe.

Frauds occur or recur because of human actions, traits, psyches and faces. And, all human beings across all communities and across the world carry the same traits and human characteristics and reactions to situations.

Managing Insurance Frauds

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Frauds occur or recur because of human actions, traits, psyches and faces. And, all human beings across all communities and across the world carry the same traits and human characteristics and reactions to situations.

As *Shashank Karnad of KPMG (India) says,*

"Fraud has many faces. It does not differentiate between companies, industries or even locations.

"The KPMG in India Fraud Survey-2012 found vendors and agents were among the No. 1 fraudsters, followed by management and employees at second and third place, respectively."

There are many studies that have been conducted in many countries and by many organizations to test the validity of the fraud theories of the *Fraud Triangle* and the *Fraud Diamond* in relation to the *fraud behaviour, fraud occurrence, fraud detection and fraud prevention.*

The study - *Testing of Fraud Diamond Theory Based on Local Wisdom on Fraud Behavior* - by *Edy Sujana et al of Universitas Pendidikan Ganesha Singaraja, Indonesia*, is noteworthy, in this respect and in the present context.

This research was conducted in all universities in *Buleleng Regency, Bali.*

It used a quantitative method by taking *40* finance department employees in all universities in *Buleleng Regency* as respondents. The results of this study are that all independent variables namely *pressure, opportunity, rationalization and capacity* have positive effect on fraud behavior. Then, the researchers introduced a *moderating variable* of local cultural element called the *Tri Kaya Parisudha,* which trains men to develop a way of moral and ethical living.

Tri Kaya Parisudha (TKP) is the three forms of action and human behavior that must be purified, namely in the aspects of mind, words and deeds. *TKP* is a form of Balinese local wisdom (and also Indian) and tradition that becomes a reference for behavior in daily life, which are the moral tenets for pure and virtuous living. In other words it is the essence of *ethical bearing* of an individual. Ethics induce certain righteousness and contentment of life in people and happy and contended individuals are unlikely to commit frauds.

Interestingly, when this moderating variable was introduced into the framework of the above mentioned research, results of the study showed *pressure and capacity* to have a *negative effect* while *opportunity and rationalization values are decreasing.*

Thus, the conclusion of the study was *"that whatever the pressure, opportunity, rationalization and ability a person has to commit fraud, as long as a person has good thoughts, words and behavior, fraud behavior can be minimized."*

The same thoughts are expressed by the *Price Waterhouse Coopers* study (2018):

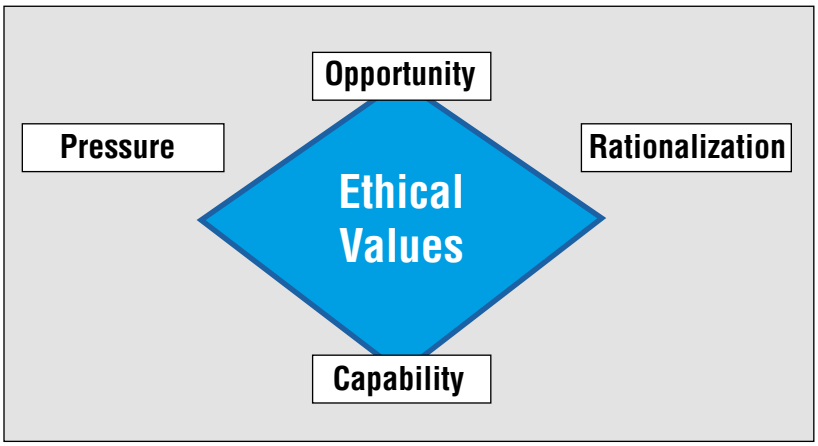
"The most critical factor in a decision to commit fraud is ultimately human behaviour – and this offers the best opportunity for combatting it."

And, human behaviour can be modified positively by ethical value systems.

There is yet another study conducted in Malaysia *("The New Fraud Triangle Theory - Integrating the Ethical values of Employees")* which says that *"high ethical values (competence, confidence, and professionalism) will reduce the likelihood of fraudulent activities by employees in performing their job."*

In the words of the researchers *Gamlath Mohottige Mudith Sujeewa et al,* of *Management & Science University, Malaysia,*

"…. the current study further validates the Cressey's fraud triangle model and Wolfe's fraud diamond model and its significance to combat the employee fraud. Moreover, the current study highlights the significance of incorporating the ethical values of the employees to those grounded theories based on the empirical evidences. As such, many researchers emphasized that the high level of ethical values of the employees reduce the likelihood of fraud in business entities. Hence, there should be a tone at the top to instil ethical culture among the employees of the business entities strategizing top down approach." (the emphasis is by the author of this paper)



We may close the discussions on the prereferential aspect of ethical importance in fraud deterrence with a small citation of another paper, *"Studying employees' pressures, rationalizations at an NGO"* by *Steve Johnson,* which reiterates the effect of moral, ethical and traditional culture of people.

It says that *"employee fraud is closely linked with how employees perceive their working conditions……..Conversely, if employees perceive that management treats them with lack of respect or the working conditions are undesirable or stressful, it's more likely that employees will commit fraud…."*

Steve Johnson also refers to the well-nigh dichotomy in the cultures of the world, in that the oriental cultures are mostly based on *collectivism* and the occidental cultures are mostly based on *individualism.*

In the East, *"the national culture includes a high degree of collectivism where close relationships are highly cherished. This carries over into the workplace where employees emphasized their desire to feel like an organizational family. When management treats them like family,*

their level of commitment and job satisfaction increases.

"In the West, where people generally value individualism over collectivism, feeling a sense of family in the workplace might be less important or even viewed as undesirable or unprofessional by some employees."

Similar views are expressed by *Yunmei Lu,* doctoral candidate at the *Pennsylvania State University* and *Hua Zhong, associate professor at the Chinese University of Hong Kong.*

"Whatever the biological, or neurobiological, factors that might contribute to criminal behaviour, culture and social structure apparently play as great, or greater role,"

For the study, the team analysed age and patterns of teenage crime in the US and Taiwan in Asia. They found significant differences, which suggest that cultural factors may also be important influences on criminal behaviour.

In the US, which tends to be more individualistic, for example, involvement in crime tends to peak in middle to late teenage and then declines.

However, in Taiwan, which has more of a collectivist culture with less separation between generations, the crime rate does not dramatically peak as it does in the US." (Quoted from an article -- *"Culture influences criminal behaviour"* -- in *Telangana Today, Thursday, February 27, 2020)*

Fraud-risk Management

Every piece of the literature on fraud dwells on a single measure against risk of fraud, namely the mitigating of the effect of the contributory ingredients of the elements *(pressure, opportunity, realization and capability)* of fraud occurrence.

This is an observable variable which can make a person induce to commit a fraud.

Proper internal checks and counter-checks and controls in the work system and their review mostly will help an organization to nullify the attempts of frauds by people. Change of personnel in the departments and transfers periodically may also reduce the degree of opportunity for employees and reduce the risk of fraud occurrence. Diligent supervision is also another deterrent.

Out of the four elements of fraud, pressure and realization are un-observable variables and opportunity and capability are observable variables.

Pressure:

It is an unobservable variant in a person. *Pressure* is mostly contributed by *non-shareable problems* of a person and it becomes difficult for any organization to assess this aspect. However, it is possible to observe any variations and mood-swings in the person by his/her immediate manager who may use the grape-wine communication channels also and try to *counsel* the person.

Such *counselling* may infuse confidence and moral strength in the person who may eventually come out of the *"pressure"*..

Such an action may serve as a measure to deter any plausible thoughts of fraud in a person in the initial stages, itself.

Opportunity:

This is an observable variable which can make a person induce to commit a fraud.

Proper *internal checks and counter-checks and controls* in the work system and their *review* mostly will help an organization to nullify the attempts of frauds by people. Change of personnel in the departments and transfers periodically may also reduce the degree of opportunity for employees and reduce the risk of fraud occurrence. Diligent supervision is also another deterrent.

Realization:

This is again an unobservable factor, as it is a mental process of the person perpetrating the fraud. It is an assertion and self-justification of the person that there is nothing "wrong" in his action of committing the fraud.

It is here that the presence or absence of ethical values in a person that come into play to either deter or activate or deters his/her thinking process to commit a fraud.

Apart from the person's natural propensity to moral and ethical ways of thinking and acting, the organization also can impart and inculcate these values and traits by periodic counselling sessions and discourses by eminent people of this field. Of late, many

organizations are conducting yoga classes also for their employees.

In fact, an *Indonesian* study by *Puspasari* and *Suwardi* (2016) was conducted *"to examine the influence of individual morality and internal controls on individuals' propensity to commit accounting fraud at the local government levels."*

"The result shows that there is an interaction between individual morality and internal controls. The absence of internal controls does not cause an individual with high moral principles to commit accounting fraud. However, individuals with low morality levels tend to commit accounting fraud when internal control s are absent."

Men matter more than checks, tools and controls.

Further, whatever be the *capability* traits in a person, a moral and ethical bearing in him/her will induce the right value system in him/her and help deter him/her from committing a fraud.

Conclusion

There is no better way to conclude this paper except by quoting the great words of *Dr. A.P.J. Abdul Kalam.*

"A nation can be corruption free only when its states are corruption free, a state can be corruption free only if its districts are corruption free, a district can be corruption free only if its Panchayats are corruption free, a Panchayat can be corruption free only if the people are corruption free, people can be corruption free only if they have imbibed the value system from their childhood."

After all, it is the *value system*, at all levels of the organization(s), that would serve as the *deterrent panacea* for all fraud presence and occurrence.

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The Evolution of Fraud in Insurance Industry

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Abstract

Insurance frauds cost businesses billions of dollars annually worldwide, making it critical for insurance companies to have foresighted approach against fraud. With companies pressured to mitigate new risks, new products are being developed with business innovation and technology to create fresh outlook. Thus, insurance industry continues to be a primary focus for fraudsters. Despite how companies divide the data, it's apparent that fraudsters possess a considerable negative influence on the insurance business.

An attempt has been made to discuss emerging fraud trends, fraud-fighting approaches and (r)evolution of fraud analytics in Insurance business. Fraud management techniques can substantially impact both the success and cost which in turn will positively affect the profitability and combined ratio. With the increasing intricacy of fraud, insurance companies need to build radical fraud detection approaches which effectively analyse unexploited data and assist to curtail fraud loss.

Keywords

Fraud Trends, Fraud-Fighting, Fraud Analytics, Technology, Business Innovation.

Introduction

As a certain volume of "grey area" endures when one considers misunderstanding and simple error, the key distinguishing element is "intent". The traditional observation of a fraudster is the one who has intention of committing fraud. The growing worldliness in marketing, operations technologies and improved data gathering allow insurance companies to trace the customer move and spot suspicious behaviour by providing remarkable fraud resistance.

The future of fraud detection, although, cannot be through a straight analytics technique. The human component in estimating risk will prevail as a crucial fragment of fraud detection. Data can advance the identification of fraudulent patterns and activity, but people will invariably be necessary to convert records into actionable intelligence. Integrating analysis of Big Data together with the present fraud detection methods will facilitate insurance companies to elevate claims processes, underwriting capacity and maintain competitive advantage.

Insurance Industry Overview

The Indian insurance industry embodies 57 insurance companies out of which 24 are life insurance and 33 are non-life insurance companies. According to IRDAI Annual Report 2018-19, "In accordance with the 'World Insurance in 2018' report issued by Swiss Re, leading reinsurance provider, insurance business in 2018 was supported with worldwide economic growth and development with Real Gross Domestic Product (GDP) at 3.2%. In 2018, Global direct premiums transcend the mark of USD 5 trillion, outreaching USD 5193 Billion (6.1% of global GDP). India's share in global insurance market was 1.92% (2018). Still, during 2018, in India total insurance premium escalated by 9.3% (inflation adjusted) though global total insurance premium escalated by 1.5% (inflation adjusted). In 2018, world-wide, the life insurance business share in total premium was 54.30% and the non-life insurance premium share was 45.70%. However, for India, the life insurance business share was over the top at 73.85% and the non-life insurance business share was at 26.15%. As published by Swiss Re, among the 88 countries, India ranked at 10 in life insurance business and its share in global life insurance market was 2.61%. In 2018, when global life insurance premium grew by 0.2% (inflation adjusted), the life insurance premium grew by 7.7% (inflation adjusted) in India. The Indian non-life insurance business observed rise of 14% (inflation adjusted) and global non-life premium grew to 3% (inflation adjusted). However, in global non-life insurance premium, Indian non-life insurance premium share was at 1.1% and India ranked at 15 in global non-life insurance markets."

Insurance businesses have detected frauds which are estimated to cost over US$6.25 billion which give rise to increase in premiums for lawful consumers. As per the Insurance Regulatory and Development Authority of India (IRDAI), it is required for every insurance company to establish a Fraud Monitoring Framework. It shall incorporate measures to detect, prevent, protect and mitigate the fraud risk from claimants/policyholders, employees and intermediaries of the insurers. It is mandated that the Fraud Monitoring Function should be a separate unit which will secure effective execution of the anti-fraud policies. It should be accountable for constituting plan for internal reporting and/from to different divisions, to upskill intermediaries, policyholders and employees in identifying and preventing frauds.

Frauds in Insurance Industry

Dark matter in the universe of insurance is the frauds taking place across the globe. The discovered events cost insurance company along with policyholders millions each year, thus its complete hidden scope can be estimated only at – the difference between the working of risk models and the actual working, with the frauds which are undiscovered get charged in premium cost. The chain of events of frauds has drawn attention of regulators, companies and whistle-blowers, like: non-disclosure of material information, inflating expenses, staged accidents, articulating false grounds for claims, producing false documents, buying policies in the name of a deceased person, embezzling of assets, altering pre-policy health check-up records and forged disability claims.

"Fraud concern is no newcomer to the insurance industry, especially in the healthcare and motor lines of business. The fact that the internet is not attributable has made the fraud situation even worse as digitisation proceeds at a pace. The emergence of the new Internet, commonly called the Blockchain, means we no longer have to trust the internet but in fact can make sure it tells the truth. In Estonia, they wrapped the internet with a Blockchain technology that has removed digital fraud from the healthcare sector in that country, and this is now being applied elsewhere. It's possible to map the Blockchain protocol over the Insurance Combined Ratio, with fraud and expense reduction on the top line and an increase in Earned Premium on the bottom line via new product and operational efficiency. This can give the c-suite an opportunity to see the effect of the new technology on their profitability before investment income." - DAVID PIESSE, Chairman of IIS Ambassadors and Ambassador Asia Pacific, International Insurance Society (IIS)

"If you stop fraudsters coming into the business in the first place then you have to spend less from the beginning, enabling you to improve the journey for other, genuine customers.

But it's difficult to get that balance in a competitive marketplace as the investment isn't so obvious. It requires a change of mind-set." - JOHN BEADLE, Head of Counter Fraud and Financial Crime, RSA

Facts about Indian and Global Economies

The total Insurance fraud amount is expected to grow from USD 2518 million in 2019 to USD 7,928 million by 2024 with a CAGR of 25.8% globally. The global direct premium transcends the mark of USD 5 Trillion and is expected to grow by 3 % in real terms which means the insurance fraud amount involved 0.048% of Global direct premium in 2019 and expected to grow by 0.15% by 2024 of global direct premium. According to the FBI, US insurance fraud costs an estimated $100 billion in FY 2019, which has increased the average premium by $400 to $700 per family annually. However, health care expenditure amounts the highest contribution in US insurance fraud. Australia has witnessed $4 billion insurance fraud whereas UK and EU countries have witnessed $3 billion & $2.5 billion respectively.

In developed economies where the insurance business has evolved have laid insurance fraud laws. However, India does not even Insurance fraud definition in Insurance Act -1938 as well as in Indian Penal code. In India, frauds brunt a $6.25 billion i.e. INR 45000 crores in the FY 2019 whereas health insurance business contributes 35% and other lines of business contribution ranges from 10-15%. Motor Insurance also plays a major role in insurance fraud and 90% of the fraud are the result of fictitious claims and remaining 10% motor insurance frauds originate from organised accident-staging. The life insurance market has also observed frauds in sum insured ranging from INR 2-12 lakh.

"Neither do we have any specific laws connected to insurance frauds which are spelled out in the Indian Penal Code, 1860. The Indian Contract Act, 1872 also does not have any specific laws pertaining to insurance frauds. Even though the sections related to forgery or fraudulent acts can be applied in the IPC, it does not succeed in deterring the commission of insurance frauds," says the Head-Fraud Control of a leading life insurance company in India.

Emerging Fraud Trends

Fraud trends in insurance business are becoming clear, the extent and scope of losses still remain grey. The following identifies some key trends in the insurance industry in present scenario:

The cost of bad debt continues- Consumers purchase insurance policies trusting the insurance company will take care of them when disaster strikes. The breach of consumers trust costs insurance industry billions of dollars each year.

Policy applications are having an identity crisis- As consumers use internet-enabled devices, it presents additional risks for businesses by creating opportunities for fraudsters to mispresent information without customer knowledge.

False filings- This substantially includes falsifying applicant's personal or business financial status by document forgery. Instances comprise the use of unaudited statements and exaggerated net worth and income figures.

Contact Centre- With the advancement in online fraud prevention, fraudsters redirect to the contact centre to circumvent detection. Implementing high-pressure strategies with technology to socially stage agents, fraudsters take over customers' accounts or request for fresh policies.

Stacking- A customer buys collective small policies to expand coverage, while minimizing underwriting check, by manipulating amount requirements and limited age.

Ghost brokers will try to haunt consumers – Often known as "street" brokers, they falsely personify themselves as an insurance company's employee who has particular access to customer discounts, and frequently advertise on reliable sites. They deliver the lowest priced policy to the customer, afterwards without customer's awareness pocket the refund by cancelling the policy.

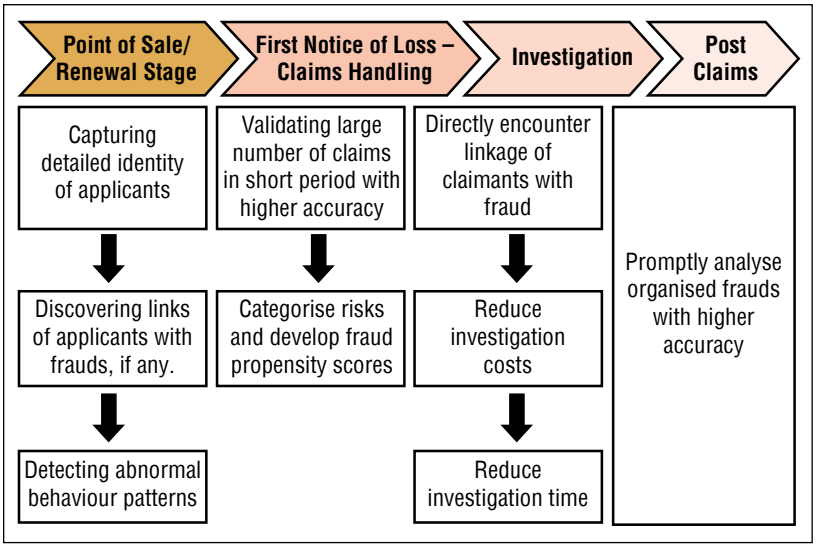
Increasing popularity of insurance aggregators – Insurance companies have low data clarity and direct engagement with the consumers. Higher level of quote manipulation can be expected to secure a better quotation. Fraudsters can access from any area, and can effortlessly modify their moves to avoid detection if no verification and proof is established.

Twisting: An agent or broker substitutes' policy which is existing with a fresh policy from the corresponding carrier to generate additional revenue through commissions. As frequently, twisting leads to an extra cost to the insurance company.

Fraud Detection

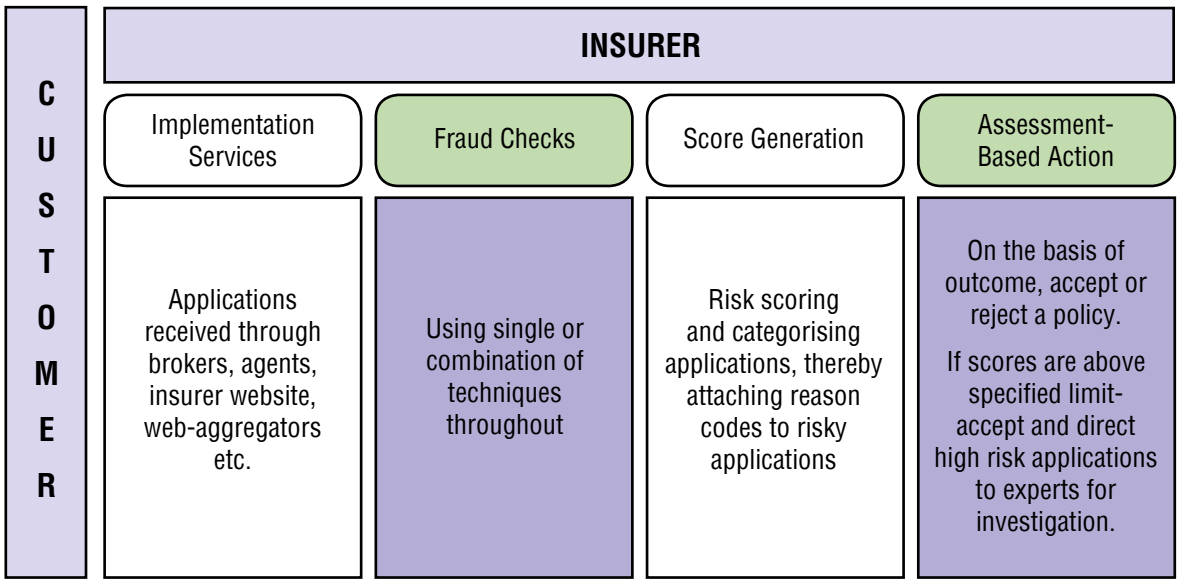
Fraud detection can take place in mainly four stages of life cycle of a policy. Fraud analytics if utilised at all stages of the lifecycle of a policy would facilitate insurance companies to have complete picture of every policyholder who flags the way to devise organized frauds.

Fraud Analytics over different stages of policy lifecycle



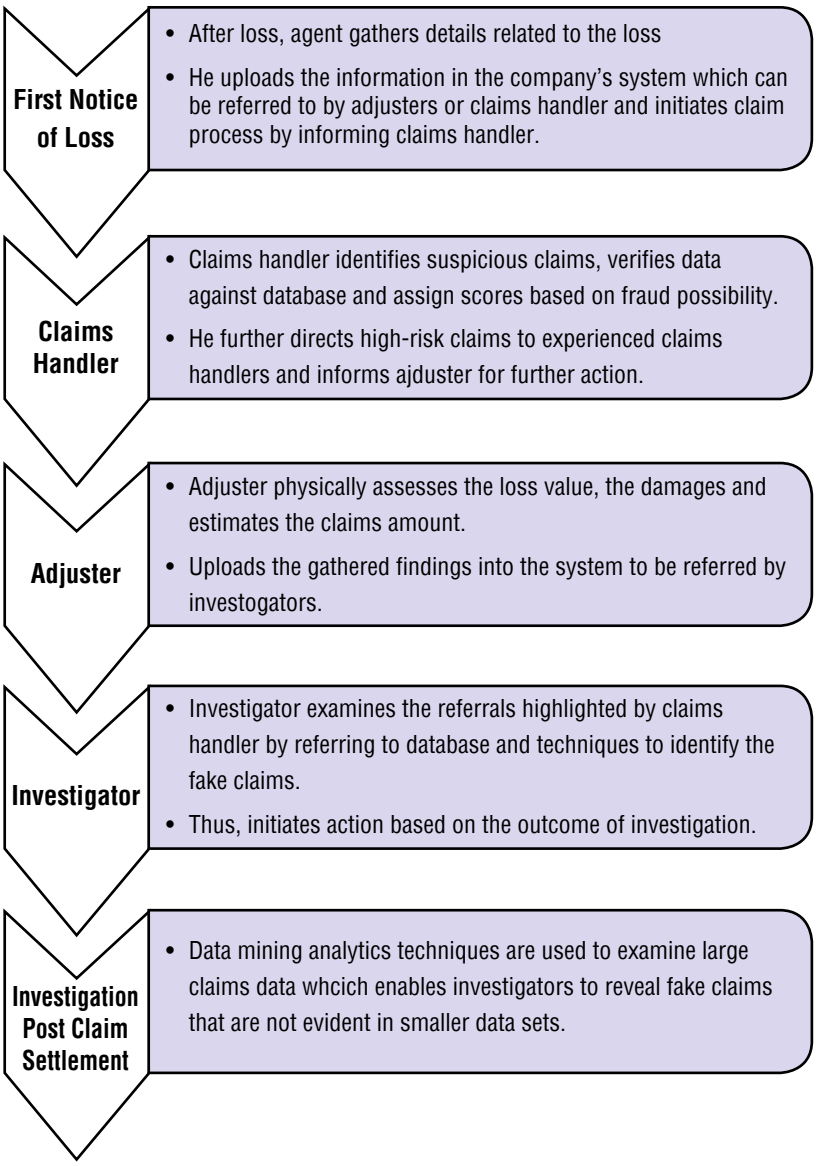
As a substantial number of claims fraud is set-up at the application/renewal stage, it is essential for insurers to scrutinize on the underwriting fraud to reduce premium leakage and mitigate risk to established frauds at the claims stage. At the second stage, the function of claims handler is of great significance because they are accountable to process and investigate insurance claims comprehending to policies. Therefore, the incapability of claims handlers to precisely detect questionable patterns brings about fake claims getting indemnified. At the investigation stage, analytics is extensively used as investigators scan every claim pointed out by the claims handlers. They examine claims' data against diverse data sources (like claim history, policy information, medical reports etc.) to validate the accuracy of the information submitted by claimant. Methods like social network analytics allow fraud investigators to speedily uncover connections of claimants with forged activities, thus, reducing the time span taken to reveal masked linkages among potential fraud and entities. At the post-claims stage, fraud analytics application is in a beginning phase. The analysts study enormous amount of claims data applying multiple tools and techniques (like automated red flags, combinations of business rules, text mining, predictive modeling etc.) to detect dark connections between claims and various entities associated in such frauds. These observations enable insurance companies to uncover organized fraud, besides constantly improving models and methods operating at the FNOL, POS and Investigation stage.

Fraud Detection Process: Underwriting Stage/ PoS



For the purpose of validating a considerable amount of claims with high accuracy in a short time, claim handlers are prescribed to apply sophisticated analytics. Consequently this gives rise to identify low-fraud events (with low-lying probability as 0.001 percent). Some analytics approaches, such as predictive modeling, facilitate insurance companies in categorizing risks and in real time obtain fraud propensity scores. This assists claims handlers in adjusting their series of questioning and directs claims which are suspicious to investigators. Visualizations of data patterns and reporting also aids insurance companies aware of the effects of fraud analysis which is ongoing on their businesses. As reported by WNS DecisionPoint™, insurance companies applying analytics outlined increased benefits in contrast to the companies which are using automated indicators or traditional methods.

Fraud Detection: Claims, Investigation and Post-Claims Stage



Fighting fraud is a task that may never end. But by making it harder for criminals to succeed, AI-based group analysis could give investigators a powerful way to fight back faster against organized insurance fraud. In implementing identity verification solutions, companies should focus on verifying the stakeholders involved in the insurance claim process, including verifying the identities of claimants, witnesses and businesses who submit information into the claims process. Finally, companies should host their fraud prevention solutions as an enterprise platform cutting across business lines to eliminate data silos and prevent duplicative fraudulent claims.

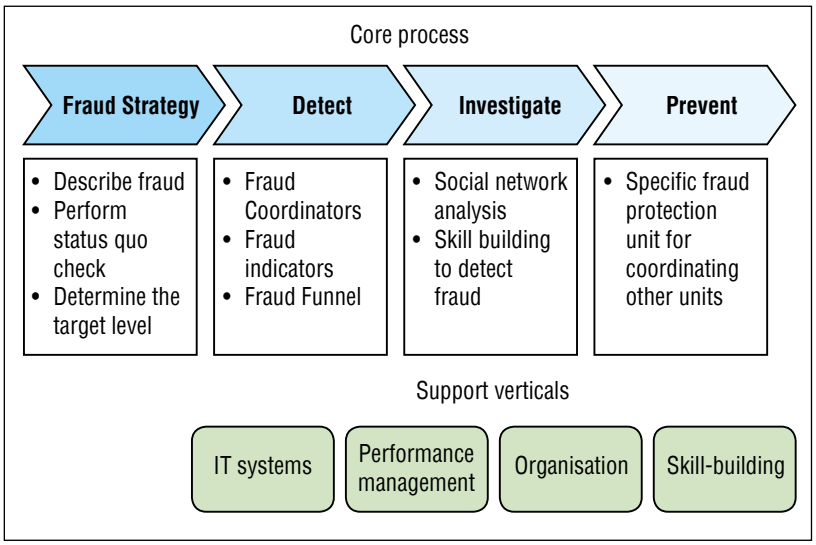
Fraud Prevention

Every insurance company must start with their own claims process in addition to allied functions, upgrading the detection and operating various fraud events. In stage II, the company must ensure fraud management comprehensively encompasses safety from organized fraud and ribbon of fraudsters, thereby making every attempt to work together with other insurance companies in fight against frauds.

Stage I: Put fraud management on increased professional ground

This structure is built on a distinctly described fraud strategy (for example, no leniency of any established fraud to safe-guard genuine customers), and uses seven forces, both for core process (detect, investigate, prevent) along with the associated support verticals (IT systems, performance management, organisation and skill building).

Framework for Fraud Benchmarking



Measures for an insurance company to improve in fraud management

1. Optimize detection
2. Introduce a triage(initial case assessment and decision on resource allocation) function
3. Use extended investigation methods

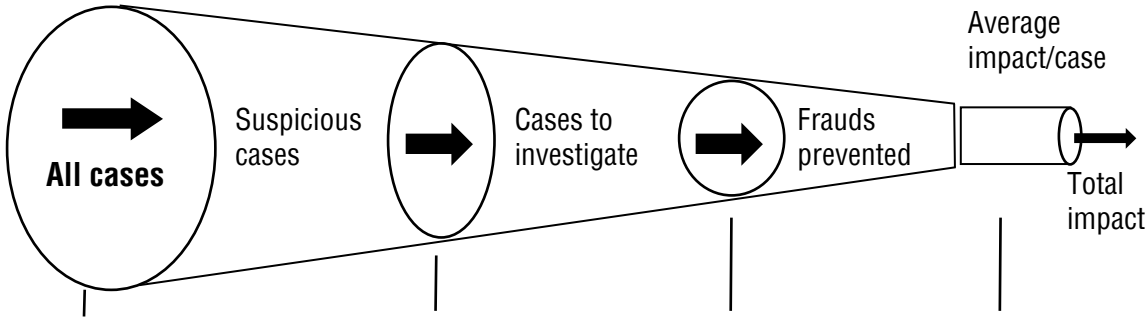
Stage II: Re-form forces to withstand organized frauds

Improving fraud management is not a one-time plan but a continuous project requiring continuous improvement and development as it is crucial to keep pace with the tricks and methods of the fraudsters. At this point, the second stage for enhancing fraud management is initiated. This includes making use of other methods such as scrutinizing addresses, bank accounts and telephone numbers to establish any suspicious cause and based on network analyses automatic IT recognition. The techniques utilised also need to be altered: a special unit is required to confront organized fraud, linked to the courts and police. Such unfolding needs due diligence and considerable investments in IT support and staff, while surviving under the influence of the individual insurance company.

- First build up procedures, roles and KPIs, instead of promptly making big IT investments.
- Pilot early in parallel to design.
- Invest in skills and the number of fraud experts.
- Pursue continuous improvement.
- Optimize beyond the claims division.

Fraud Funnel

Period when the policy was concluded



Detection Rate (x %)

Where manual/ technical recognition indicates no. of fraudulent cases, divided by total claims.

Forwarding Rate (x %)

No. of investigated frauds, divided by no. of suspected frauds.

Conversion Rate (x %)

No. of cases where via fraud protection payment is successfully avoided on claim, divided by number of cases investigated for fraud.

Average Impact (INR)

Payments avoided because of fraud investigation, divided by operational claims expenditure.

(R)evolution of Insurance Fraud Analytics - Shift in Fraud Detection Approach

Fraud costs insurance companies billions of dollars annually around the world, making it compulsory that insurance companies take a farsighted approach against frauds. Insurers should set up a technology structure, work out analytics and advanced automation, and develop measures to prevent it. While 'cross-platform', 'mobile' and 'digital' are helpful conception, these are much unrefined to apprehend the in-depths of digital strategies, that overrun into each operational part as insurance companies anticipate to modify the way they carry out business. Fraud is one of the largest costs for insurance carriers, therefore prevention is fundamental to ensuring a seamless experience. Accurate fraud scores at underwriting and continual proactive monitoring are going to be key to understanding which customers can be safely streamlined.

As insurance business rely upon forecasts about complicated events, it has consistently been a data-driven and data-hungry industry. The advancement of analytics unveils the universe of nearly limitless possibilities for insurance businesses where all companies have deep-rooted foundation of statistics and information. The insurance industry as a whole has had a slow acceptance of Big Data analytics on account of price concerns, and regulations might be the restricting force of the future.

Claims fraud detection needs to be fast while aggregating data from numerous external sources. Leveraging fraud prevention techniques in this way allows carriers to process claims in seconds, reducing overall processing costs and also satisfying the good customers companies want in their books. It thus enables insurers to minimise risks of fraud at every stage of policy lifecycle, thereby preventing losses at critical transaction areas.

Fraud function units have three principal objectives:

- Determine frauds and pull possible fake claims for detailed review.
- Bring back claims which are non-fraudulent into the claims cycle.
- Carry out the first two functions as transparently as possible in the business cycle.

The force towards analytics and Big Data for fraud is approaching with a plea of modelling and automation. But, a filtered automated operation can produce as substantial scope for fraud as previously remained in the business by generating exploitable data pattern recognition. The most advanced plans still produce a data product and not a complete piece of information, thus fraud detection requires human touch. Even though data is at the base of the modern revolution in insurance business advances and practices, it should constitutionally endure as an industry which confides on human insight and gut feelings. An appropriate combination of human review and machine can level fraud detection to another level, and an analytics foundation assists the top level of objectivity. Eventually, insurance companies encounter way out of bearing the cost to adopt the current fraud detection capacities presently and of continuing ongoing operations in belief that analytics will cheapen and standardise before increased battling squeezes margins insubstantial. "People are still required to take this analysis and produce the final intelligence product that is useful to insurers," said Fletcher.

"Causing the greatest stir out of all today's analytics tools is AI, which stands to revolutionise the whole insurance industry over the next 2-5 years, from robo-advisors and chatbots through to claims automation and mitigating fraud. While analytics teams retain the greatest degree of oversight, AI capabilities are currently being embedded across the whole insurance organisation."- HELEN RAFF Head of Content at Insurance Nexus

"There will be much more data from structured and unstructured data sources in the future – a huge challenge! 'Past developments are a good representation of future uncertainty' will not be replaced but solutions with AI-tech (big data) in combination with smart data strategies will enable insurances to make decisions based on models and evidence."- ANDREAS STAUB, Managing Partner at Fehr Advice

"The rise of InsurTech, the analytics explosion and the new face of insurance has created a birth of new roles and impact points across the industry. No longer is analytics and data relegated to just information technology and actuarial — we are now seeing it being integrated into the business culture and DNA of insurance organisations."- MARGARET MILKINT, Managing Partner, The Jacobson Group

Shift in Fraud Detection Approach

Fraud Detection Methods		
Internal Audit	**"Red Flag" Indicator**	**Scoring Models**
• Random checks on sample claims leave a room for some fraudulent claims to go undetected • Lack of experience of insurance fraud professionals results in lower detection and investigation rate	• Rule-based indicators to detect suspicious behaviour • Red flags indicate the need to further investigate a claim and does not conclude the claim to be fraudulent	• An advancement to rule-base techniques, wherein insurers provide scores to rule-based indicators (either manual or automated) • Based on fraud propensity scores, claims are classified into various segments such as high, medium and are subsequently referred to for further investigations

Fraud-Fighting at the Baseline

- Flag abnormal patterns by having process established to escalate when required.
- Monitor message boards, information sites and chat room to scrutinise suspicious claims.
- Conduct regular analyses of underwriting, sales and businesses to flag doubtful policies.
- Create an anti-fraud culture making employees accountable for fraud detection and prevention.
- Implement and continuously update fraud detection and anti-fraud training and tools.
- Use predictive modelling/ data analytics in fraud prevention/ detection.
- Design documents to avert fraud by applying behavioural science approaches (such as fraud warnings, wordings of questions etc.).
- Band together with industry watchdogs and law enforcement to increase fraud protection.
- Maintain open communication among underwriting, claims, and reinsurance companies as trends are determined; provide regular feedback.

Conclusion

In the light of the ongoing developments, insurance companies demand to act decisively and swiftly with definite counteractions to notice the silent untapped prospect from advanced fraud management and also to minimise a potential competitive trouble in comparison to other companies. This is to simply safe-guard the genuine insurance customers as well as drive off the risk of anti-selection by fraudsters. If frauds are not challenged more efficiently across the room, fraudsters will shift their concentration to insurance companies which do not protect themselves successfully. With the growth in rigorous checks and data analytics, the insurance industry eventually appears to take measures to eliminate such unethical practices. After years of target on effectiveness in the claim's unit, authorising the exchange within the claims function gives fraud management the opportunity to handle with positive implications while it automatically involves to refine claims processes before fraud management.

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Insurance Nexus Global Trend Map 2017

An Insight into Insurance Fraud and it's Prevention

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Abstract

In the paper I'm going to highlight the maturing insurance industry in our country & how it deals with the ongoing frauds by various means. With the emerging technology, fraudsters are becoming smart & new sophisticated fraud ideas are emerging. To address this, the Insurance Industry needs to be upgraded to become smart in tackling the market wide problem that happens in so many different ways & at so many different levels. Insurance Industry needs to smartly prevent, detect & thereby manage frauds from occurring. With the emerging technology the companies are adapting to newer upgraded equipment & tools to prevent & detect fraud from happening. The role of data analytics is important in the tackling of the menace through continuous & repeated reviewing & scoring of the claims. Companies are now adopting newer & layered tools to detect fraud. While there are Anti-Fraud policies being issued by companies to have internal check on the fraud, there are various other frameworks to keep a check on both external & internal fraud. Now is the time for Artificial Intelligence to be adapted by the industry. A lot of companies are now accepting that the new trend of IoT (internet of things) & chatbots needs to be applied for larger

data analysis, quick policy issuance & faster claim processing without hassle & with early detection of possibility of fraud. Things are moving faster in the industry & India needs to keep pace so also adopt technology which can help prevent, detect & manage fraud in a smarter way. Quite a few developed countries with a matured insurance industry are able to deal with insurance fraud legally not only because of the adaptation of developed technology but also because their insurance fraud laws are in place. India as a developing country with a maturing Insurance market, also needs to have a proper law in place for Insurance Fraud.

Introduction

There is a growing concern of increasing fraud in insurance industry. This causes financial loss & industry mismanagement & loss of trust on the sector by the stakeholders. As fraud can take place at any level of transaction, in any sector & by anyone involved with the transaction, here in the paper we are going to read about the definition of fraud, how it is managed by way of detection & prevention & how AI has been a boon in preventing & detecting insurance frauds at various levels. Below is a simple example of how fraud takes place in our very own vicinity with law protectors involved.

In India it is a common practice in almost every shop, office, organization to have a local priest come to do Puja every morning. This incident took place in one of the police stations in a State capital. Every morning this priest would come to offer flowers to the Gods & Goddesses kept on the shelf. To reach the shelf he would use a chair kept for the inspector. One day while offering flowers the chair broke & the priest fell off & broke his leg. The station in charge then took him to the hospital & got his leg plastered. After a few months an Insurance company received a motor TP claim for the same priest. Briefs specified as "helper in a truck". When the investigating team reached the house of the priest he wasn't home, on asking his wife about the accident she blabbered out that it wasn't a motor accident & the priest only fell off the chair in the police station. The FIR, which of course was registered with the same police station, said it was a motor accident. This is a case of Fraud committed at a police station itself. This example is only to show the severity of fraud.

What is Fraud?

As a matter of concern, 'insurance fraud' is not yet defined under the Indian Insurance Act. IRDA quotes the definition provided by the International Association of Insurance Supervisors (IAIS) which defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties."

Thus, insurance fraud is an intentional act of omission or commission of deceiving against or by an insurance company, insurer, agent, any staff, employee, manager, director or the insured for the purpose of financial gain. It is applicable when the insurer deliberately denies some benefit to the insured or the insured attempts to gain benefit which he is not entitled to. Fraud may be committed at different points in the transaction by anyone involved in the process - such as the applicants, policyholders, third-party claimants, or professionals who provide services.

The main motive or the reason behind committing such fraud is unlawful financial gain. Frauds with financial interest pose a risk to all segments of the financial sector. It affects the confidence of the consumer & the stakeholders thereby hampering the reputation of the individual insurer & Insurance sector. Insurance fraud has existed ever since insurance began as a commercial enterprise. Out of all the claims the insurance company receives some are fraudulent. This costs both the company and the insurance sector as a whole. It affects not just the industry but the larger consumer group who has to pay a higher premium.

Category of Fraud

The following are a broad category of frauds as classified by the IRDAI in their circular dated 22-Jan-2013.

I. **Policyholder Fraud and/or Claims Fraud -** Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud at the time of making a claim.

II. **Intermediary Fraud -** Fraud perpetuated by an insurance agent/ Corporate Agent/intermediary/Third Party Administrators (TPAs) against the insurer and/or policyholders.

III. **Internal Fraud –** Fraud/ misappropriation against the insurer by its Director, Manager and/or any other officer or staff member (by whatever name called).

Commonly Committed Fraud in Different Insurance Industries:-

- *Producing forged documents:* This can happen by anyone inside the company or outside the company. For example- the issuing of false certificate or submitting of a false license by the claimant.

- *Non-disclosure of critical information:* The Company's agent or the client may purposefully not disclose an important information to each other. For example- a critical illness is not disclosed by the customer, or non-disclosure of terms & conditions by the employee.
- *Buying of policies in the name of a dead person or a person with a terminal illness:* There have been many cases where the name of a dead person has been used to buy policies & later claim that the person died an accidental death.
- *Stating false reasons for claims:* Customers take advantage of medi-claim policies. Where they might not be admitted to a hospital but can provide a forged document of illness.
- *Misappropriating assets:* A lot of asset misappropriation fraud take place inside the company itself like cheque tampering, cheque forgery, theft of cash etc.
- *Inflating expenses:* In case of medical bills payment, the expenses can be shown higher than the actual incurred. Also during a vehicle repair the cost can be inflated.
- *Staged accidents and fake disability claims:* In many cases an accident is staged whereas it did not take place at all. Also there have been cases where a person is injured through some other way than a road traffic accident but claims were made under the motor accident.

Management of Fraud

As per IRDAI guidelines, "all insurance companies are required to have an Anti-Fraud Policy duly approved by their Boards. The Policy shall duly recognize the principle of proportionality and reflect the nature, scale and complexity of the business of specific insurers and risks to which they are exposed. While framing the policy, the insurance company should give due consideration to all relevant factors including but not limited to the organizational structure, insurance products offered, technology used, market conditions, etc. As fraud can be perpetrated through collusion involving more than one party, insurers should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly, lay down appropriate risk management policies and procedures across the organization. "

Prevention

Steps for Prevention of Fraud:

To avoid costs of litigation and other expensive measures, it is necessary that insurance companies move rigidly against fraud. This happens by taking a proactive step toward fraud detection. Companies should go ahead with actively detecting & preventing the action rather than waiting for fraud to happen and dealing with it afterwards; companies should implement important processes that identify potential fraud beforehand and provide the ability to move quickly when fraud is detected. There are a few steps to be taken proactively in prevention of fraud:-

1. Implementation framework:

A bedrock of foundational framework should reflect a fraud detection strategy that address questions like: How can we check all claims for deceit thereby ensuring fast claim processing? How can we detect fraud before we proceed with a claim settlement & payment? How can we enhance efficiency in fraud investigation? How can we keep trace of behavioral change in fraud? How can we detect positive false signals? What is the best possible method to automatize the fraud detection process & predict the likelihood of occurring of fraud? Implementing a strong framework enables management in better decision making & set priorities, use of resources and investments.

As per IRDAI guidelines, "all insurance companies are required to have an Anti-Fraud Policy duly approved by their Boards. The Policy shall duly recognize the principle of proportionality and reflect the nature, scale and complexity of the business of specific insurers and risks to which they are exposed. While framing the policy, the insurance company should give due consideration to all relevant factors including but not limited to the organizational structure, insurance products offered, technology used, market conditions, etc.

A strong framework can range from a unique solution that automatizes the stored institutional knowledge of the claims, analyses data thoroughly, and also the overall networking structure of the involved parties to enable workflow management. From there, the insurer can add a large number of scoring

engines, data related to third parties, criminal history if any, & many other tools. An important tool is securing the involvement of staff in detection of fraud through emphasizing on the importance of early identification of suspicious claims & properly investigating into the matter. An empowered human involvement is important for the tools to function more effectively.

2. Know the potential of fraud:

Knowing the potential of a case to be a fraud claim allows one to take proper & immediate action. This also helps in early detection & minimization of loss. Optimizing the investigation efficiency may help to detect & to avoid loss of cost & maximize savings. The investigation team should focus mainly on the areas where there can be a potential fraud occurring, successful identification of one matters in long run cost saving. Examples of common false claim schemes include deliberately destroying property and exaggerated bills on repairs.

3. Use of data & analytics to detect fraud:

They say fraud comes in all shapes and sizes. In general, insurance fraud can be divided into two categories: criminal fraud & cultural fraud. Criminal fraud is one where the fraud is carried out by habitual professional offenders trying to drain the system. Cultural fraud is one where the claimant is genuine but tries to gain by exaggerating the loss to increase the claim amount.

Data analytics plays an important role & can be applied to detect fraud. By analyzing the history of fraud, insurers can use predictive analysis to produce a suspicion index, which gives a value for the proclivity of fraud. The process works like this: Adjusters simply enter data, and claims are automatically given a Suspicion Score to indicate the likelihood that fraud has occurred. The technology behind this involves utilizing data-mining tools and applying quantitative analysis.

4. Continuous reviewing & rescoring claims:

One becomes successful in combating fraud with continuous reviewing of the claims. This comes from persistence & good timing in applying the array of tools one has, which includes data analysis & Predictive modelling. Claims should be monitored continuously to check fraud potential. As an insurance company one must target the right claims at the right time with the right tools. Through continuous reviewing & rescoring of the claims, insurers can detect a pattern that reveals fraud. The suspicion scoring index that is mentioned above may show high risk for some claims & low risk for some others. In some claims the scoring may come at a later stage. For this, the reviewing & rescoring has to be done on a repeated basis. With technology up gradation, one has to be far more upgraded with newer forms of analysis than following the traditional ones. But this does not completely remove the role of humans. Human analysts are required to initiate action after suspected fraud has been flagged. This is where training employees to identify fraud becomes an important piece of the overall fraud-detection puzzle.

5. Adopt a layered approach:

In the world of IT, a "layered approach" refers to using a variety of tools and technologies to tackle a challenge. Fraud is a complex, multifaceted problem, and no single method can detect all fraud. Each fraud-detection method needs to be crafted to address a specific area. Different rules and indicators are needed for different types of policies and claims. Fraudsters hide in multiple databases, so fraud-detection methods must search them all. Because of the complexity of fighting fraud, it is advisable to bring in outside expertise to help formulate a framework and implement the technology, tools and methods needed to deal effectively with fraud.

The modern insurance organization has a number of technology tools at its disposal to detect fraud. For example, videos, photos and even live streaming can be used to document evidence at a car crash or crime scene. It's difficult for the average person to fake a video, especially when the device's location access is turned on. A virtual gold mine lies within unstructured data, and it is imperative to collect, organize, index and mine the data to detect fraud. Always remember: "You can't claim what you can't prove".

6. Revise based on market conditions:

Criminals are ever resourceful, so always be ready to quickly adapt to changes in the ways fraud is undertaken, as well as changes in your industry. For example, professional criminals are sophisticated enough to become familiar with the analytical approaches that insurance companies use to detect fraud, and to change their tactics when committing fraud. As fighting fraud becomes more proactive, insurers must spot new fraud trends early and take steps to stay ahead of the bad guys.

Your everyday policyholders may also try to be more creative with their insurance claims when the economy is in a down cycle. Keep your claims staff aware of the type of market conditions the policyholders are facing so the staff can

be on the lookout for new and inventive fraud attempts that may be unknown to the software in place.

Detection

India is a huge market for insurance & a large amount goes into claims payment. A loss of 40000 crore is suffered every year which constitutes 8.5% of the revenue generated by the industry. Given the huge losses borne by the insurance industry as a whole & with fraud getting more & more relevant, companies have started taking action to detect the frauds at an early stage & preventing a possible loss.

The detection of fraud starts with identifying suspicion claims. Studying a definite pattern in the type of claims lead to possibility of a fraud or scam. Continuous statistical analysis with the help of statistical tools may help in earlier detection of an anticipated fraud.

Prevention & detection of fraud go hand in hand. The methods of detection of fraud more or less involves the same methods as its prevention.

Some of the most common methods of detection of fraud are as below:

I. Investigation and cross check of documents

A thorough check through the documents received from any sources is necessary. The documents need to be verified by different issuing authorities for authentication. If there is the slightest of doubts the documents need to be cross checked & rechecked. Proper investigation into the source of the document is important to remove any kind of misconception.

II. Knowing the potential of fraud

As mentioned earlier, one of the steps to prevent fraud from happening is knowing the potential of the fraud to minimize the loss. The same applies to detection. On which item the potential of fraud is more, needs to be detected. Optimizing the investigation may help in early detection of fraud & may help in reducing the loss.

India is a huge market for insurance & a large amount goes into claims payment. A loss of 40000 crore is suffered every year which constitutes 8.5% of the revenue generated by the industry. Given the huge losses borne by the insurance industry as a whole & with fraud getting more & more relevant, companies have started taking action to detect the frauds at an early stage & preventing a possible loss.

III. Use of analytics

Since analytics plays an important role in every growing sector, it is necessary that a specified team is dedicated towards it. The past history of claims, areas of fraud, potential products which are vulnerable to fraud all need to be thoroughly checked. The huge amount of data captured needs to be run & rerun through various analytical tools to help early detection of possible fraud.

IV. Running through special investigation of every doubtful claim

There is need for special investigation groups who would thoroughly go into suspected fraud matters. Not only does the investigation need to find out the loop holes due to which the fraud could occur, but these loops holes need to be filled with proper guidelines so as to prevent fraud occurrence in future.

V. Allocating private investigators

Private investigators play an important role in bringing out the best about claim cases. They are like a dedicated team investigating into each & every aspect of the claim, be it documentation, first hand report, witnesses, etc. They delve deep into a case & find out the real background to detect fraud possibility. Therefore it is important to have a special team looking into the matter.

The biggest impact of fraud is faced by insured & prospective customers. It leads to a delay in processing of the claims, delay in settlement, & the investigation goes on and on, consuming a lot of valuable time & money of the insurance company. It is hard to specify the time taken for an investigation to complete because it depends on the type of fraud & the potential & people involved in the fraud. Where a normal case may take just 30-45 days of time for investigation & settlement thereafter, a complex investigation process may take years. Fraud may drive the policy cost high & also affect the ratio of claims for insurers.

In 2013, Insurance Regulatory and Development Authority of India (IRDAI) came up with the **Insurance Fraud Monitoring Framework** to help insurance companies curb the occurrence of insurance fraud. It has been more than 7 years now & Insurance companies have their own Anti- fraud policies set as per the guidelines of IRDAI. This definitely helps in early detection of fraud cases

& has also curbed the internal frauds in companies.

The Anti-fraud policy of IRDAI specifies the following:

Anti-Fraud Policy

All insurance companies are required to have in place an Anti-Fraud Policy duly approved by their respective Boards. The Policy shall duly recognize the principle of proportionality and reflect the nature, scale and complexity of the business of specific insurers and risks to which they are exposed. While framing the policy, the insurance company should give due consideration to all relevant factors including but not limited to the organizational structure, insurance products offered, technology used, market conditions, etc. As fraud can be perpetrated through collusion involving more than one party, insurers should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly, lay down appropriate risk management policies and procedures across the organization.

The Board shall review the Anti-Fraud Policy on at least an annual basis and at such other intervals as may be considered necessary.

The anti-fraud policy shall broadly cover the following aspects:

• Procedures for Fraud Monitoring:

Well-defined procedures to identify, detect, investigate and report insurance frauds shall be laid down. The function of fraud monitoring shall be either an independent one or can be merged with existing functions like risk, audit etc., The Head of this function should be placed at a sufficiently senior management level and should be able to operate independently.

• Identify Potential Areas of Fraud:

Identify areas of business and specific departments of the organization that are potentially prone to insurance fraud and lay down detailed department-wise, anti-fraud procedures. These procedures should lay down the framework for prevention and identification of frauds and mitigation measures.

• Co-ordination with Law Enforcement Agencies:

Lay down procedures to coordinate with law enforcement agencies for reporting frauds on timely and expeditious basis and follow-up processes thereon.

• Framework for Exchange of Information:

Lay down procedures for exchange of necessary information on frauds, amongst all insurers through the Life and General respective councils. The insurance companies are well advised to establish coordination platforms through their respective Councils and/or Forum to establish such information sharing mechanisms.

• Due Diligence:

Lay down procedures to carry out the due diligence on the personnel (management and staff)/ insurance agent/ Corporate Agent/ intermediary/ TPAs before appointment/ agreement with them.

• Regular Communication Channels:

Generate fraud mitigation communication within the organization at periodic intervals and/or ad hoc basis, as may be required; and lay down an appropriate framework for a strong whistle blower policy. The insurer shall also formalize the information flow amongst the various operating departments as regards insurance frauds.

Key Statistics – Insurance Fraud, Source- Financial Express published on 13-Apr-2020

- India's insurance premium in 2018 for Life Insurance was US $ 73.74 billion and Non-Life Insurance was US $ 26.10 billion totalling US$ 99.84 billion
- In FY2017-18 claims repudiated were 0.74, claims rejected were 0.43 of Life Insurance claims
- According to a report, Insurance companies lose over US$6.25 billion to frauds which results in higher premiums for genuine consumers.
- A media report stated that over 10% of claims in general insurance are fraudulent

Control & Minimizing Impact

In India we do not yet have a fraud control law despite the fact that there is a large amount of loss borne by the insurance industry every year. Even though it is a crime & action taken under the IPC for different fraudulent activity is mentioned in section 421-424, the fact is that fraud as a crime is nowhere defined in the Indian Penal Code. A few other sections that have some relevance are-Section 205-false impersonation for the purpose of act or proceeding in suit or persecution; Section 420-cheating and dishonestly inducing delivery of property; Section 464-making a false document including signs, seals and forgery and Section 405-criminal breach of trust. However these are not adequate to prosecute a fraud committing group or an individual fraudster for the organized crime committed under the current circumstances.

Most of the developed countries, where insurance industries have matured, have come up with insurance fraud laws. For example in the US, insurance fraud is classified as a crime & they have insurance fraud laws in place. Of these, 19 states, require companies to form programmes to combat frauds and in some cases to develop investigation units to detect the frauds. 41 of the states have their own insurance fraud bureaus. In Canada, the Insurance Crime Prevention Bureau was formed in 1973 to fight insurance frauds, collect information on insurance frauds and carry out investigations. In the UK, the Fraud Act 2006, defines insurance fraud as a crime. The Insurance Fraud Bureau in the UK focuses on detecting and preventing organised and cross-industry insurance frauds. In Denmark, the Forsikring & Pension (F&P), the Danish pensions and insurance association, organises exercises at the Danish Police Academy on how to combat insurance frauds.

In India a lot of different provisions have to be made to deal with the large number of insurance fraud claims reported every years. But due to the large amount of pending claim cases in our courts taking legal action against insurance frauds is a task. It is also a matter of concern that the amount of time & energy one must invest in running around the courts may even exceed that of the fraud amount. So in a situation like this, usually the frauds are neglected because no proper action could be taken due to lack of insurance fraud laws.

India's insurance industry is maturing day by day. As it matures, the risk involved in fraud management is going to be a major concern. There is a need to continuously review the anti-fraud policies & processes to manage the risk of fraud. There needs to be a definite law enforcement in place so as to deal with the smart frauds occurring in various segments of the insurance industry.

The internal policies of different companies now need to be clearly specified to avoid internal fraud. There are cases of employees of the companies partnering with fraudulent activity groups to release confidential information of the company. There needs to be an internal check on the outflow of information so as to minimize the risk from inside. On the other hand external risk factors are always there. A market of racket is there to sell all types of upgraded fraudulent ideas to their clients. Starting from issuing of a fake policy to intimation of a claim & the process there off, fraud happens at various levels. The severity of the fraud can range from a slight exaggeration to deliberately causing loss of insured assets. The insurance industry is aware of the risk but the lack of comprehensive & integrated system to manage fraud risk continues to be a concern. Innocent customers have to face the outcomes of the loss due to fraud. The rise in premium amount is a product of the losses faced by insurance industry due to fraud every year.

Role of Artificial Intelligence Combating Fraud

The development of business is dependent on technology. And technology is upgrading rapidly. With the invention & development of artificial intelligence it is paramount that every sector of business put AI in their day to day business. Insurance industry has already involved AI in its use. While talking about the Prevention & Detection of fraud in insurance sector, it was mentioned that along with the role of

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data & analysis it is very important to have human involvement for decision making & detecting the fraud. Artificial Intelligence will do exactly that. It is a technology which, when fed the right amount of data, can interpret the data, learn from the experience, is able to perform tasks normally requiring human intelligence & deliver the specified required goal.

What AI does is via pure algorithms. It analyses a large amount of data & finds patterns. Then it can spot differences where it cannot fit into the patterns. For example, by comparing new claims to old data it can help detect claim values that are unusually high or where it finds similarity between the new & existing claims. AI can also be used in visual analytics where the AI can assess the damage done to a vehicle or property

just by going through the real time pictures or the videos.

AI can take a view through a company's claims structure, employee details & policy holders to look for patterns that could indicate a large scale fraud. The analysis might include a behavioral data, transaction histories & movement histories. With health & motor insurance claims where the company is more susceptible to fraud the AI might compare the bills of hospitals for similar illness & can spot an exceptionally higher amount of claim or a lower amount of claim which may mean that the fraud was of a minor amount so as not to get detected.

AI Detection Feature

- Scoring of Risk- AI can read through a large amount of data & score the risky claims. It can check & cross check the data, segment the risk & score them. This will help in knowing the risk factors involved in claims. Work which might normally be time consuming if studied & analyzed by a human can be done by AI in a matter of seconds. This is a great way to simplify the fraud detection system of Insurance.

- Real Time Data- Being able to collect rich, real-time data from the physical world through Internet of things, use of sensors is also leaving its mark in the insurance industry. For Example: in motor industry, insurers can use telematics to collect real time data from vehicles. Previously they used basic information about the vehicle & driver to build policies. Now they can use telematics analytics & complex algorithms to the same work within seconds.

- Behavioral Data- AI can automatically explore customers' economic & social data, not interfering with their privacy of course, to determine their way & pattern of living. A customer's financial stability & lifestyle risk factors can be determined through AI. It can help the company as well as customers with the setting of tailored premiums. The financial behavior of the customer may determine the higher or lower premium to be fixed.

- Live Monitoring- AI continuously monitors the change of pattern in claims & adapts to that. Wherever it experiences a change in pattern it triggers it. For example: in health insurance, t. he continuous monitoring through wearable such as fitness tracker like fitband etc may help track clients movements, their health & fitness without breaching their privacy.

- Automation- One of the most important factors which would be implemented through the use of AI is to improve the claim process. It will be touchless & shall remove excessive human interference. The customer may experience a hassle free claim filing & claim would be settled within a matter of a few minutes. AI not just settle quickly but efficiently, undergoing through various tools to check policy, verify it & detect any fraud possibilities. If it finds necessary it may trigger an alarm. If not, it may settle the claim.

Law is the Need of the Hour

Since Indian Insurance Act does not define insurance fraud, it is the need of the hour to frame specified definition & law for the fraud committed by or against the industry. We do not have any specific laws acknowledging insurance fraud. Whether in Indian Penal Code, 1860 or The Indian Contract Act, 1872, none of these defines the fraud or has any law pertaining to the insurance fraud. Even though we have sections mentioned above, pertaining to forgery or fraudulent acts, it does not succeed in deterring the commission of insurance fraud. The insurance industry feels that there should be a proper guideline as is present, in many of the countries with a matured insurance market. The central and state governments shall also have to seriously think about having specific laws to counter the insurance frauds and setting up of insurance fraud bureaus.

Annexure

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Insurance Frauds Across the Globe: Lessons Learnt

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Abstract

Globalisation accompanied by rapid technological developments have taken the entire globe by storm. In the eve of increasing digital acceleration, it is important to understand the critical aspects of the insurance sector; an industry that could potentially face a greater impact due to this incessant global change. This study aims to explore one important but ugly facet of the industry; insurance frauds and their impact on a global scale. Insurance frauds are but a sad reality that plague the industry. It is essential for all the stakeholders in insurance to understand the adverse impacts of fraud and explore ways to deal with this menace. Different economic conditions are prone to different kinds of malpractices and some of the important ones are outlined in this paper to gain a wholesome view in this area. A few of the regulatory measures as well as industry-specific practices across the globe are also highlighted.

Keywords

Globalisation, Frauds, Insurance, Global Practices.

Introduction

Fraud in simple terms means willful deception for some financial or personal gain. Fraud is a criminal act and is thus defined in many laws and regulations

over the globe. Insurance fraud is defined by the Federation of Indian Chambers of Commerce and Industry as, "The act of making a statement known to be false and used to induce another party to issue a contract or pay a claim. This act must be willful and deliverate, involve financial gain, done under false pretence and is illegal."

The Re-Insurance Group of America(RGA) has in its 2017 Global Claims Fraud Survey reported 3.58% incidence of global claims fraud, whereas the Americas suffer from a much lower claims fraud rate of 1.47%. However, this could be a red herring since the Federal Bureau of Investigation has estimated cost of such insurance frauds in the United States of America to be approximately more than $40 billion per year. The insurance business contributed a whopping $602.7 billion to the US GDP in 2017. Taking into consideration the above figures, cost of fraud amounts to 6.64% of the entire business worth of the industry, which is an alarming sign.

The principal revenue for insurers is the money received in the form of premiums from policyholders. When losses due to frauds are compensated from the same, the impact of such frauds fall upon the honest policyholders in the form of higher claims. The increasing number of fraudulent claims also reduce the reliability and credibility of genuine claims and lead to additional and prolonged verification of the authenticity of such claims causing unnecessary delays for both the insurers and the policyholders. These time delays and hassles reduce the customer friendliness of the insurance companies, thus lowering their brand value amongst the customers. This, then becomes a vicious cycle.

During such tumultuous times, the role of regulatory bodies becomes conspicuously more important than before. They must actively support the insurers by aiding in better, faster and more accurate prevention, detection and correction of such frauds. Regulatory bodies in different countries njeed to cooperate with each other and establish effective and faster exchange of information for the betterment of the entire industry worldwide.

This research effort traces the instances of frauds across the globe and highlights the actions needed to be taken to minimize such instances.

Insurance Frauds in USA

In USA, insurance fraud is second only to tax fraud. In 1976, Florida was the first American state to pass legislation that specifically targeted insurance fraud. Legislation recognized that medical professionals, lawyers and insurance industry employees are possible offenders. Florida also created Division of Insurance Fraud (DIF) within the Department of Insurance. DIF investigators are law enforcement officers with full police powers.

In 1992, the National Insurance Crime Bureau (NICB) was formed in the USA and 1000 insurance companies became members. This is a not-for-profit organisation committed to fighting insurance fraud and vehicle theft. It is funded by a levy placed on its member companies. NICB acts as a conduit between insurers and government. There is also a 24 hour toll free telephone number so that the public can report any insurance fraud. The information in the insurance fraud database is available to member insurance companies and law enforcement agencies.

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The positive development in US is the introduction of fraud prevention laws. Legislation defines fraud as an act that includes fraud by both claimants and insurers. In US, fraud is defined as a felony[1] crime. Convictions result in fines, imprisonment and disqualification from engaging in the business of insurance. Anti fraud initiatives, adequately staffed fraud investigation unit, anti fraud plan – these efforts

have been initiated by insurers in US. Warning on claim forms and applications ensures that awareness is created about consequences of fraud in the initial stage itself.

Fraud bureaus are state agencies charged with the investigation and prosecution of insurance fraud in their state. Some are multi line fraud bureaus that investigate frauds across all lines of insurance. Illinois is a state that does not have insurance fraud bureaus, so it relies on special investigation units to identify and deter fraudulent insurance claims. There are accident reconstruction experts who assist the special investigation units by providing clearly articulated evidence of automotive insurance fraud. Soft insurance fraud can involve exaggeration of injuries sustained as a result of traffic accident. Hard insurance fraud can be dangerous – it can involve staged automobile collisions.

One of the most infamous forms of the staged accident is the **swoop and squat**. The swoop and squat involves two offending vehicles and one unsuspecting victim. In this case, one of the offending vehicles drives in front of the victim, while the second offending vehicle swerves in front of the first. The first offending vehicle then abruptly slams on the brakes, causing the victim vehicle to rear-end it. Often, the defrauders who perpetrate this type auto insurance scam will target persons talking on cell phones, driving with children or infants in the vehicle, or the elderly.

Insurance Frauds in UK

Every hour of every day 15 fraudulent insurance claims are exposed in UK. Insurance fraud – whether inventing or exaggerating a claim or lying to get cheaper cover is a serious criminal offence that affects every honest insurance customer, adding to their premium costs.

In UK, there is a not-for-profit organisation - Insurance Fraud Bureau that is engaged in the detection and prevention of organized and cross-industry fraud. The insurance fraud enforcement department (IFED) is a specialist police unit dedicated to the identification and prosecution of insurance fraudsters.

On 13th Sept 2012, the Insurance Fraud Register (IFR) was launched to combat fraud and bring together data on known fraudsters across the country. The IFR is a conduit through which insurers share data with other industries, so an insurance fraudster might find it difficult and costly to get insurance, but also may find it more difficult and costly to access other financial services and products.

Fronting in motor insurance describes the situation in which a car that will be used principally by an inexperienced driver is insured in the name of an experienced driver to obtain a cheaper premium. During claim processing, a series of clearly worded questions are asked and answers are recorded to decide the acceptance of claim. In UK, fronting is a common method of motor insurance fraud.

The insurance industry's counter fraud strategy in UK comprises

- Routine exchange of information between insurers
- Sharing of claims history to identify potential frauds
- Compliance with data protection and privacy requirements
- Proposal, claim and renewal forms draw attention to sharing of data – remind customers to be honest in disclosing all the relevant information.

In UK, specialist law firms provide a complete range of legal services to insurance companies. These companies have developed expertise in detecting motor frauds like staged accidents, deliberate slam on, low velocity collisions etc. However, in the Indian scenario, such specialist firms may prove to be way too costly if their charges are unreasonable. But the concept is a good one that is worth emulating because such legal firms can help reduce an insurer's exposure to fraudulent claims.

Insurance Frauds in Australia

Approximately 80-85% of insurance premiums paid in Australia each year are returned in claims paid to policy holders. Of this, 10% are received by policy holders, who according to the Insurance Council of Australia, have fabricated or inflated a claim. The costs imposed by these frauds are borne by honest policyholders, who pay higher premiums. The Australian insurance industry and Australian police services have joined hands to combat frauds. All insurance companies are at risk of frauds being perpetrated upon them by their customers. Nature of these frauds may vary from limited exaggeration of the value of a claim to an entirely bogus claim where losses never really occur. Many people look upon insurance as a victimless crime.

In earlier years, the insurance industry believed that fraud was perpetrated by isolated individuals either from greed or force of circumstances. For example – a

fire claim to cover a failing business. Fraud was not considered serious enough. Premiums were increased accordingly to compensate for any increase in claims.

In Australia, travel insurance claims were more fraudulent than any other claims. The general perception is that insurers do not bother about smaller fraudulent claims, but when these small amounts add up, they can lead to a fraud of a substantial amount. The greater problem is that the percentage of fraud detected is minimal.

In the mid 1980s, many of Australia's major insurance companies recognized the need for a centralized special claims unit to investigate possible fraudulent claims. Experienced senior claims staff was provided additional training in fraud detection and investigation. Fraud indicator profiles were developed to assist branch claims officers in identifying possible fraudulent claims. Branch staff had to forward suspected fraudulent claims to the special claims unit for further investigation.

In 1991, the Insurance Reference Service (IRS) was established. This is the insurance industry database to which 39 insurance companies and 400 loss adjusters subscribed. The objective of IRS was to assist the insurance industry in the prevention and control of insurance fraud. IRS is used to screen new insurance proposals and claims.

The IRS database consists of individual insurance claim records, publicly available information relating to bankruptcy and debtor judgments. The IRS operates under a code of conduct which establishes requisite privacy protocols and procedures.

Today, the focus has shifted to fraud control by prevention rather than detection. There is emphasis on ensuring that the policy is not issued to a bad risk. IRS ensures that checks and controls are there to ensure that an insurance fraudster can no longer jump from one insurance company to another with impunity. Fraud reward scheme administered by Insurance council of Australia has a three-fold purpose of deterring fraud, providing information for further investigations and assist insurers in the denial of liability or in reducing payouts in claims where fraud is involved.

The legal department within the insurance company has to fight claim cases or insurer can use services of external legal firms. This strengthens the vigorous defense by insurance firms. Special police squad has been set up to deal with insurance frauds. Statistical information relating to insurance fraud prosecutions is difficult to obtain. The police-insurance joint task force in Australia has yielded good results. The investigative expertise with number of former law enforcement officers employed in insurance industry enables insurance companies to themselves assemble the requisite elements of a prosecution brief and present them to police for prosecution.

Insurance Frauds in UAE

In an independent survey of 700 private health care providers in the UAE, it was found that 96% of private providers did not control the identification of the insured member. 40% private pharmacies switched medications when asked to. 35% of private providers did not collect co-participation and deductibles. 30% had untruthful claim forms. 28% private providers charged insured patients more than uninsured patients. 0% private providers had ethics and compliance programs.

In UAE, penal law 390-399 penalizes fraud and provides 6 months to 3 years imprisonment in jail. What we saw 10 or 15 years ago was fraud with providers in the periphery of the profession. But today the situation has changed dramatically. Less than 5% fraud is prosecuted. Internationally, 25% of patients surveyed think it is acceptable to recover a deductible by raising a claim amount. Among the hundreds of thousands of claims filed each year, finding the irregular ones is no easy task. Auditing all claims is not feasible due to growth of insurance industry and cost of doing business. The UAE has realized that data management needs technology intervention and training is a must to reduce the incidences of fraud.

Insurance Frauds in Nigeria

Nigerian insurance sector suffered when marketing took precedence over insurance underwriting throwing caution to the winds. Employee promotions were invariably related to the volume of new business procured. Most insurers in Nigeria substitute strict risk underwriting with aggressive concern for large volume sales and profits. This stems from the belief that fraud costs can always be passed on back to the insuring public through higher premiums. Very bad risks were accepted at lower premiums.

Regulatory intervention in Nigeria is weak and fraud is not treated as a serious crime. This kind of attitude threatens the survival of the insurance institution and undermines the industry's competitive edge in the global market.

The Nigerian regulatory authority has strengthened the sector through

consolidation. Reform of the Nigerian insurance sector was meant to strengthen the capacity of the industry. A need was felt for an equally effective regulatory framework for insurance fraud control. In Nigeria, many claims are paid by insurers without verification due to the high cost of performing inspections. Good governance practices are lacking in developing economies like Nigeria. Frauds in Nigeria have dented the image of the country.

Frauds in India

Indian insurance sector has witnessed a spate of frauds that have led to massive losses. The losses are anywhere between 8-9% of the total size of insurance sector. The General Insurance Council asserted in 2017 that 10-12% claims were suspected to be fraudulent claims. According to a study conducted by EY Consultancy in 2018, insurance frauds increased by 30% as witnessed by 56% of life insurers in India. Outlook India reported in October 2019 that insurance frauds are nearly 8.5% of the revenue generated by the industry.

In the health insurance field meanwhile, medical bill forgery has fast become a rampant issue for insurers to contend with. Indiaforensic found that medical bills were now the most common target of frauds by external parties, accounting for almost a third of all falsified documentation schemes uncovered by authorities over the past year. Frequent manipulation of the necessary doctor credentials and recommendations on certain policies was also cited, with some policyholders going to extremes to subvert certain medical screening and pre-conditions tests.

India is plagued by lack of available data pertaining to insurance frauds. A preliminary estimate put fraud claims at

Indian insurance sector has witnessed a spate of frauds that have led to massive losses. The losses are anywhere between 8-9% of the total size of insurance sector. The General Insurance Council asserted in 2017 that 10-12% claims were suspected to be fraudulent claims. According to a study conducted by EY Consultancy in 2018, insurance frauds increased by 30% as witnessed by 56% of life insurers in India. Outlook India reported in October 2019 that insurance frauds are nearly 8.5% of the revenue generated by the industry.

6% of the total number in India but the actual % could be much more. A survey conducted showed that more than 50% of third party claims in India are bogus. In case of health insurance, estimated number of fake claims in the industry is estimated at around 10-15% of total claims.

Lack of clear cut strategy to combat frauds is a key challenge. For the insurers, providing evidence for the frauds is a greater challenge.

Use of Fraud Analytics to Mitigate Insurance Risks

Data analytics is a fast developing potent tool that is increasingly being used in various fields for innovation, problem-solving and so on and so forth. This use of analytics termed as fraud analytics can be successfully used in the field of insurance for detection of frauds; resulting in mitigation of insurance risks associated with underwriting, fraudulent claims, and additional costs. Fraud analytics involves the use of complex algorithms to derive patterns from large amounts of past and present data, to detect anomalies and identify potential frauds which can be further examined by experts for thorough investigation.

Various types of techniques can be used such as calculating the ratio of referrals to special investigation units to total claims received, and devise an acceptable ratio for which Artificial Neural Networks can be used. Data Mining techniques such as Clustering can be used to study the history of denied claims, and analyse the bases for rejection of such claims in terms of various risk indicators; thus providing a reasonable basis for approval of future claims. Pattern recognition algorithms can be used to identify a certain specific individuals or entities that usually appear in fraudulent claims. The presence of such persons can flag the claims as high risk ones and so on.

Conclusion

Insurance frauds have become a global phenomenon. Western world is also witnessing an increase in the number of frauds as fraudsters become adept in using technological tools to defraud insurers. There is a need for insurance industry to join hands with insur-tech

firms who buttressed by their grip on technology can support the insurance sector in dealing with frauds effectively.

Appropriate internal control and management information systems are vital to fight frauds. Regular and credible financial reporting systems give management the opportunity to identify fraudulent activities. Regulators, insurance industry and Government should work together to set up a system that can effectively detect/ prevent/ fight frauds. Data analytics should be used by the insurance sector to fight frauds.

Enforcement of stricter underwriting controls and a robust claims processing mechanism can support measures to deal with fraud. Indian insurance industry should have an active dialog with other prominent nations across the globe and try to learn from the best practices. Generally, insurance frauds occur because people feel that it is not considered a serious crime – so frauds should be classified as a criminal offence and the guilty must be brought to book. The power of social media should be exploited to cascade this message across the population. There is also an urgent need for the insurance sector to brandish a new image as an industry that is socially conscious and ethically vigilant.

Notwithstanding all this, we have to face the reality that cyber crimes are on the rise and insurance sector is as susceptible to this risk as the banking and the financial services sector. Can the insurance sector rise to the occasion and be a step ahead of the fraudsters? This is a million dollar question that needs deeper introspection and greater clarity of thought.

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Insurance and Fraud Management: Trends, Opportunities and Challenges 2020

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Abstract

The paper covers general insurance industry trends in India with a special focus on fraud management. The first half talks about insurance opportunities and industry growth trends. It can be seen that even including the sudden turmoil of 2020, India remains to be an attractive landscape for insurers. Discussion on factors defining the outlook of the industry till 2020 brings back the traditional governing principles of the business hence posing importance on the fraud detection mechanisms. Post the basics of fraud and investigations is cleared out, the paper identifies and addresses the challenges faced today and might face in the coming future by covering implementable digital solutions. Using new variables emerging from technologies like blockchain, IoT, and voice analytics to the insurer's strength is explored.

Insurance Industry: India and the World

Introduction

The insurance industry is seeing a multitude of levels of growth and maturity levels across geographies. Globally non-life insurance has seen a growth rate of 2.9% in 2019 with trend lines hardening and little deviation in its coming outlook. In India, it continues to remain one of the highest

growing sectors with CAGR (Compound Annual Growth Rate) of 13% during 2014-19 according to an EY-ASSCOM report.

The insurance industry in India is broadly divided into 2 categories:

1. Life Insurance
2. Non-life or general insurance

This paper will focus broadly on general insurance in the Indian context. The non-insurance industry in India stood globally at 15th rank with a market share of 1.9% on total premiums taken in the year 2018.

Indian markets pose a huge potential and opportunities as the need is very high and the current picture is very bleak. Though the reports of healthcare insurance penetration in India vary widely, it is in the range of 10%-44% compared to US healthcare which reported 91.5 penetration in 2017.

According to the national healthcare provider's data, India has been low on its healthcare spends which were 1.28% of its total GDP (2017-18). It ranks very poorly at 184 out of 191 as per WHO data of 2019. Despite this, the government aims at continuously improving the number with a target of 2.5% of GDP by 2025 which is still significantly lower than the developed countries. It has since bringing in new investments especially in the health insurance domain to increase the coverage of Indians and securing their out-of-pocket expenses in case of health emergencies. But since the cost of treatment is also increasing, the need for insurance coverage is becoming the need of the hour. As far as other lines of businesses are concerned the penetration numbers are lower even for motor insurance where the number stands at 40% even when third party insurance has been mandated by law.

Amid the COVID 19 crisis, there has been a dip seen in the insurance booked. The gross direct premium in non-life has declined by 10.7% to Rs 15,784.66 crore in March 2020 compared to Rs 17,672.89 Cr in March 2019. Motor insurance which accounts for around 38-40% of the total market has been the most affected due to stop to new vehicle bookings and lockdown.

Against all this, still, the conditions paint an opportunistic picture for the insurance companies, especially in the health insurance industry. We have thus seen a boom in the number of insurance companies in the past decade who are working towards improved products and larger customer choice.

Customer Experience vs. Fraud Management

As any market with healthy competition, the insurance companies have been incorporating in numerous innovations to stay ahead of the crowd while striving to be a profitable business. This has led to continuous innovations towards improving insurance journey from policy underwriting to claim settlement to make it more seamless. Insurance one of the few sectors how have been able to see the successful implementation of the blockchain technology in its claim settlement and travel insurance policies. Reduction of the wait and the effort have been seen to be a game-changer as most of the companies are working towards using data analytics tools to get policy issuance in seconds and claim settlement within minutes without any human intervention.

To see a holistic picture, we studied a report published by EY in the Global

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Insurance Outlook 2020, there has been an experiment to determine what factors revolving around insurance have the

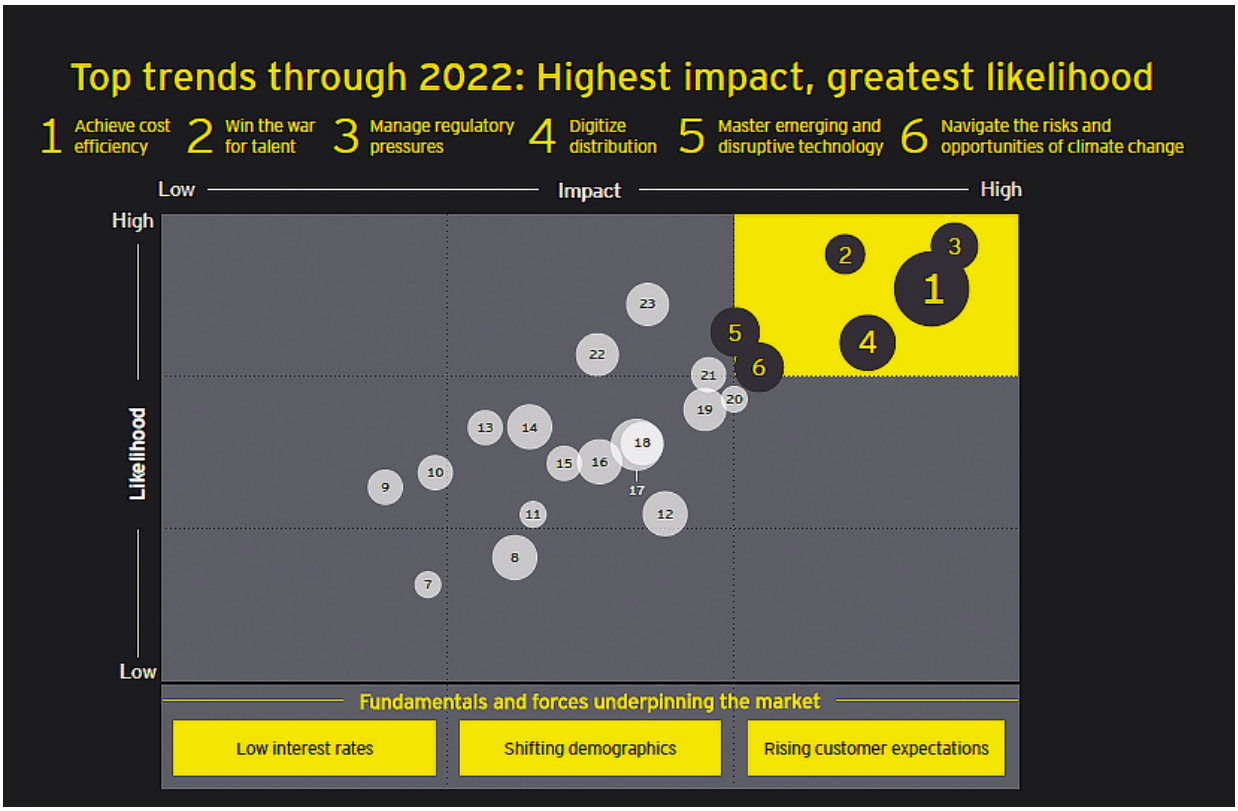

Table 1.1. Source: 2020 Global Insurance Outlook - EY

most impact on the market and company sustainability. The 23 factors under evaluation included "growing adoption of AI", "Diversification", "Emergence of new risks protocols" and "IOT & connected insurance". Surprisingly, the results of the study indicated more grounded and traditional factors as the winners.

Firstly, it is the "achievement of cost efficiency", followed by the "attracting talented people" in the organization that made most of the difference. A close winner is also to "manage regulatory pressures" and "digitization of distribution". Refer to above table 1.1 for more details.

These trends are expected to be driving the next 2-3 years in insurance. Interestingly, as you can see, it's not always about using the best technology for short customer journeys and diversification of new products before the heart of the business which is talent pool and cost efficiencies.

While analyzing the risks of losing money by the insurers, one of the major threats is to lose money to fraudulent claims. As insurers end up paying more value to more claims, the loss is transferred to the insurers as well by the increase in premiums. The frauds in insurance can vary from a simple exaggeration of the value of damage in a motor accident by 500 Rs to a loss of multimillion rupees because of an organized crime committed by staging multiple claims with the involvement of multiple entities from insured to garages to companies own employees.

The Indian Institute of forensic studies has estimated an annual loss of $6.25 billion due to fraudulent claims in India, globally it is estimated to be around $400 billion with $100billion in the US alone. The losses are very high but so is the opportunity to curb these loses reducing the money leakage and have a direct impact on the bottom line of the company.

"Achievement of cost efficiencies" as important it is more and more difficult to achieve due to its complexity and often a tradeoff between the customer experience and cost efficiencies. Thus, one of the major ways of saving money to achieve savings comes from strong fraud detection and risk mitigant leg in each insurance organization.

In 2013, IRDA (Insurance Regulatory and Development Authority) to all the CEOs of the insurance companies to have a fraud regulation framework

implement in their respective companies. Since then, it has been an integral part of every insurance company in India and has been establishing itself for the past 7 years with building its network of on-ground employees of the company and private investigators while working on automating the data to get alerts on claims. There is still a lot of ground to be covered. According to the financial express article, insurance frauds had impacted the industry by around Rs 45000 Cr which then affected the premium of the customers by 10-12% in each line of business out of which a large chunk of them still go undetected.

Fraud Management

Let's understand the fraud's major categorization of fraud currently prevailing insurance.

According to IRDA, the frauds can be classified into these three categories

a. Policy Holder Fraud and Claims Fraud: Fraud against the insurer in the purchase or execution of the insurance product including at the time of making a claim

b. Intermediate Fraud: Fraud by the insurance agent/intermediary against the insurer and policyholders

c. Internal Fraud: Fraud against the insurer by its staff member

To give an example, the insured, sometimes, in the greed of money tries to take advantage of the insurance contract through exaggeration of the claimed amount or making a false claim. These sometimes are supported or executed by the intermediaries like garages or hospitals or even the companies' own employees.

The department monitoring this thus needs to be very vigilant and should show zero tolerance toward fraud to set an example towards an ethical society.

The core operation of fraud management lies under 3 pillars:

1. Identification of potential fraud cases to be investigated

2. Investigation and collection of documents to decide on the case as fraudulent, exaggeration, or not.

3. Continuous automation and process improvements to increase efficiencies.

The success rate of the cases while complying with the regulatory mandate of settling claims within a set timeline brings out the top 2 results governing matrices in the management of the fraud.

That being said, it's way more complex to get those results while looking minutely at each detail of a single case to identify the macro across industry-level trends.

The following are the current challenges that are being faced:

1. **Regulatory pressure:** Insurance is a heavily regulated market with insurance regulatory body IRDA in place which is continuously working towards getting more people onboarded with insurance coverage. To do so sometimes leads to the relaxation of few norms in customer's benefit or to put new restrictions on the body, which is responsible to delay or reject claims, i.e., the investigations body. The department faces a pressure the get hard evidence that too in a set time to be presented before the claims team who takes the final call on the claim. This then is also heavily scrutinized by the regulators and auditors to make sure the requirements are being met. This helps in balancing the two opposite forces of experience vs fraud detection.

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2. **Information availability and data quality:** The pressure on agents to get more commissions out of more policies getting booked leads to incomplete filling of critical information. Also, sometimes as the agent doesn't want to lose his market share of customers refrains from sharing contact related information so that he/she remains the only point to contact the insured. On top of it, IRDA has still not mandated KYC in many insurance products. All these factors directly lead to the non-identification of a single customer. This posses a big challenge during the investigation as the investigator has to put in added efforts to get that information back or cannot successfully get the results on the case due to lack of information. This leads to lower success rates and higher turn-around time. This challenge can be supposedly overcome by strong operational and IT processes along-with help from the regulator.
3. **Threats from new touchpoints:** Trends have been seen where more policies are getting booked on the digital channels. As the reliance on agents is decreasing, it demands these new channels to be very secure and robust. To enhance the readiness of the ecosystem, emerging technologies like IoT and blockchain will bring in the concept of connected systems. The insurers need to be ready with their analysis of new threats emerging due to these changes before getting fully onboarded with them.

Fraud detection companies have been finding ways to address these challenges by focusing on the third pillar of their core i.e., bringing process efficiencies and automation.

Investigation success no longer remains a factor of talent or luck of the investigator to get enough proof to catch a wrong claim. The risk factors are rapidly changing mainly because of reduced risks due to evolving predictive technologies. Once, the concept of connected entities like connected cars and connected physical activity become dominant, the underwriting risk will be substantially reduced. On the flip side, the data velocity and volume will put pressure on the actuaries and product makers to focus on customizations at an individual level rather than community. If this happens then the comparatively stable premium due to sable risk line will be challenged and modified.

The following new industry trends have been shaping up in recently:

1. **Industry-wide data unifications:**

   With the initiation from GIC and IIB towards addressing wrong claims, the insurers are coming together to share their data with the industry. This data then gets consolidated by the board and gets shared back to the insurers in case any anomaly occurs. This has opened new possibilities for an industry level analytics of data and knowledge sharing. More than that it brings that same information available to each of member companies helping the leveling the field of market.

2. **Additional sources of information:**

   With the digitization of public records, government data, new fields emerging for analytics.

   The fraud management employees can refer to public records like Vahan and criminal court data to know more about the claim. Also, technology variables like app usage data, voice and video recordings, news articles as well as from new options like blockchain and IOT, insurance companies have now with them enormous and continuously evolving data. Since it's new, the understanding of the data to the right potential to create insights is a game-changing step. The key here to attract the right talent or get associated with the right vendors providing wholistic technology solutions that help the insurers see beyond what they have been seeing.

According to Mckinsey report on digitalization of insurance for process efficiencies they have mentioned these attributes to digitally integrate via a common ecosystem platform, connect to ecosystem platform and institutionalize dialogue and adapt existing technologies in claims:

- The invoice-verification service provider(s)
- Claims assessors
- Direct repair-shop network
- Roadside assistance service providers
- Rental-car companies
- Third-party and OEM repair shops
- Law firms Police and courts
- Weather-information providers
- Insurtech claims solution providers
- Internet of Things solution providers and aggregators
- Artificial-intelligence solution providers Once this integrated ecosystem is built, it is expected to build linkages and clearer picture can be formed while investigating a case.

3. **Entity network analytics:** Insurers in the markets where insurance is matured have been able to successfully link the entities with each other to build a network that henceforth is used for analytics.

   In India, it's still has a long way to go due to data discrepancies and quality but continuous improvements and efforts are being made.

4. **Speech Analytics:** From policy insurance to investigations, the customer is proving us a lot of data. With technology improvements, these sometimes take a new form in terms of voice and images. Harvesting this data to generate more insights are being tried out one of which is speech analytics. Here tools are made to overcome the multilingual challenges as well as to judge emotions that the talker is feeling from his/her voice to identify a potential fault.

5. **Robotic investigations:** As investigations are taking its natural course of action and each manual process is getting scrutinized to see if it can be replaced by a machine. This helps in eradicating any chances of discrepancies due to human error as well as is expected to speed up the turnaround time of investigations. This data will help to bring artificial intelligence faster into the ecosystem as the data being collected will be used to train the machine to think like a human investigator.

6. **Advance alert capabilities and trend analytics:** As the industry is growing and is now able to clearly see cases where the full cycle of insurance is getting completed. The talent pool is getting more knowledgeable and on the continuous lookout to find new ways to accurately detect fraud. With analytics coming in picture, more derived variables are getting created which is bringing in data consolidation and understanding. This aggregated by testing new hypotheses every day by thinking like a fraudster the adding onto the learnings and hence the repository to create advance alerts.

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New problems lead to new solutions, the mantra is to "Keep pushing digital while bringing it to scale". This Mantra gets tested in this turbulence due to global pandemic conditions where the economies are crashing globally, and many industries are in trouble. But this journey of digital transformation has shown early signs of getting catalyzed due to lockdown conditions motivating the employees to come up with digital solutions all fieldwork and manual processes. This thus is expected to trigger the oncoming of new technologies in the insurance industry faster than expected.

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Combating Insurance Frauds Through Analytics

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Abstract

The menace of insurance frauds has assumed gargantuan proportions leading to losses for the insurance industry. Fraudsters are using sophisticated tools and techniques to commit frauds. This paper highlights the increase in the number of fraudulent claims in India and their deleterious impact on sustainability of the insurance business model. The growth in the occurrence of hard frauds in rural India is a matter of concern too. Indian insurance sector has a long way to go in their attempts to fight frauds using sophisticated tools like the Western world.

Automation and digitization has only added to the vulnerabilities of the insurance sector. The conventional methods using statistical data to detect frauds are no longer enough. The insurance industry needs to deploy analytics solutions to manage frauds effectively. Analytics offers a plethora of advantages for insurers. Integration of structured as well as unstructured data is essential for taking the right decisions. The challenge here is to explore the various options and choose the right solution for the business. There is also a need to set up dedicated fraud fighting teams with the right skill-sets and competencies. Dealing with insurance frauds has to be a collective effort with the support from all stakeholders.

Keywords

Fraud, Analytics, Big data, Predictive Modeling, Social CRM.

Introduction

Fraud occurs when an individual deliberately practices deception to gain something by unlawful means. The act of fraud is classified as a civil or a criminal offence. The Association of Chartered Fraud Examiners (ACFE) defines fraud as the use of one's occupation for personal enrichment through deliberate misuse or misapplication of the organization's resources or assets.

Growing instances of frauds can dampen the prospects of the insurance sector as a whole and can also adversely impact the lives of innocent people. The way fraud is being perpetrated is changing due to sophisticated techniques and tools that can be exploited to minimize the detection of fraud. Some of the reasons attributed for growing incidents of insurance frauds are – increased dependence on branch network for selling insurance policies, presence of numerous third parties in carrying out the transactions and finding out the balance between automation and manual intervention to deal with frauds.

Every year, the general insurance industry pays Rs 70000 crores in claims in motor, health and marine insurance. About 10-13% of general insurance claims are fraudulent whereas in case of life insurance frauds occur where the sum assured is between Rs 2-12 lakhs. Industry veterans put the estimate of occurrence of frauds at 10% - on a conservative basis. 90% of life insurance frauds occur in the sum assured bracket of Rs 1 lac to Rs 10 lacs.

Insurance frauds are generally classified as hard frauds and soft frauds.
Soft frauds are those that involve exaggeration of legitimate claims by policyholders. Hard frauds are those where someone deliberately plans a loss such as a theft of a motor vehicle or setting fire to property covered by an insurance policy.

Organized nature of insurance frauds is what is surprising the insurance industry. In certain cases, officials of the insurance company were found to be colluding with the fraudsters.

Growing Incidents of Insurance Frauds – A Cause for Concern

Fraudsters are becoming more innovative.

In some retail categories, one in ten claims turns out to be a fraudulent one. Insurers face two choices – either they have to accept proposals liberally and be strict when it comes to claims processing or they have to exercise extra vigilance while accepting proposals and be liberal while settling claims. Too much scrutiny while issuing policy makes it difficult to sell policies in a market where penetration is low.
If claims are delayed then customers will lose trust in the insurer. Insurers want to simplify the claims process and wipe out the trust deficit faced by insurers.

Indian insurers have identified 80 districts across India as those that hold the dubious distinction of being leading districts in filing fraudulent claims. Surprisingly, in India, the rural areas are leading this development. For example, Maharashtra's Nandurbar, Gujarat's Mehsana, Haryana have acquired a notorious reputation. Insurers do not accept proposals from these areas or they charge a higher premium. Poor due diligence in underwriting policies have led to losses of over Rs 10000 crore for the insurance industry. These fraudsters often act as organized crime syndicates having access to sophisticated technologies for committing a fraud.

In some of the mofussil areas in India, fraudsters identify terminally ill patients, stage manage an accident and file insurance claims. The claim amount is shared with all the accomplices like family members, police, lawyers, doctors, village level administrators and hospital authorities. UP is another state that has gained notoriety for the highest number of fake accident claims.

The biggest frauds are seen in medi-claim policies where policyholder in connivance with hospital authorities created fake claims by forging documents and creating false evidences. Insurers have also faced frauds in motor insurance claims.

Insurance distribution channels affect such misbehaviors in Taiwan (Picard, Wang & Wang, 2019). Frauds occur in Taiwan by postponing of claims to the end of the policy year by filing a single claim for several events. Car dealer agencies have a role to play in this fraud. Car repairers join policyholders to defraud insurers underwriting motor insurance. There are two types of fraud – discount fraud and warranty fraud. These frauds are perpetrated by customers along with front line employees. In discount fraud, a discount announced by insurer for specific circumstances is availed of by the insured even when they do not qualify for the offer. In a warranty fraud, a car repairer replaces defective part in the car with a new spare part and triggers the product's warranty although the defective part was not original and not protected by the warranty.

An electronic database of fraudsters serves as a tool for monitoring controls. But drawing patterns for fraud occurrences are also proving to be a challenge because patterns keep varying.

Deleterious Impacts of Frauds in the Insurance Sector

As per recent estimates, insurance frauds lead to losses of around Rs 4000 crores every year and makes up for 8.5% of the revenue generated by the insurance industry. Insurers are now setting up separate departments to deal with this situation.

Statistical analysis, referrals from claim adjusters or insurance agents is being used by insurance companies. However, the real victims of insurance frauds are customers who have to deal with increased premiums and delayed claims settlements. The problems get exacerbated because of the time it takes to detect a fraud and investigate it further. A normal case of fraud takes around 15 – 45 days but some complicated cases can take longer.

Fraudulent claims can lead to reputational damage to insurers. The insurer's ability to manage claims falls under a scanner leading to a trust deficit among its customers. Many insurers are compelled to develop exhaustive underwriting methods that need greater investments (time, talent, technology) and a similar effort is required to investigate claims. All these efforts end up increasing the cost of cover.

Fraud Fighting Measures in India

In US, anti-fraud efforts in insurance are more pronounced with the fraud bureaus having powers similar to the police. Shared databases that contain insurance data and powerful fraud detection weapons contribute to mitigation of risks emanating from frauds. National Association of Insurance Commissioners (NAIC) and Coalition Against Insurance Fraud (CAIF) solicit active involvement of insurers, regulators and consumer bodies to streamline anti-fraud attempts.

The anti-fraud efforts in UK are driven by the Regulator, the Financial Services Authority along with participation by insurers. These entities have jointly formed fraud bureaus that collect claims data from insurers and use fraud detection software.

Indian insurers are lagging behind in fraud detection and investigation efforts. Lack of a dedicated team is the main stumbling block in India. The Western world believes that a dollar invested in anti-fraud efforts leads to returns of five or more dollars. The concept of shared databases is still alien to the Indian insurance sector. There is no Indian investigative agency that can support the insurance industry. Customer education efforts are also sub-optimal despite the fact that the threat of cyber crimes is growing day by day.

A joint working group of IRDAI and NHA has been formed to work on key areas of mutual interest and co-operation - fraud and abuse control is one of the areas. The idea is to detect and deter frauds through a repository and capacity building by developing a standard format for reporting frauds. Developing standards for field verification and investigation is a part of this agenda.

Some of the steps by insurers to check frauds

1. Restricting issuance of policies in certain geographies with a history of frauds
2. Use of predictive modeling in underwriting process to eliminate subjectivity when assessing a policy for potential fraud.
3. Creating a repository of fraud claims within the insurance sector

Fraud Analytics

Vulnerabilities have increased in the digital world. As more and more data gets generated, these streams of information can pose additional risks in terms of exposure to frauds. Automation and digitization have necessitated the need to use analytics for fraud detection. Fraud analytics will need three skill sets – understand fraud vulnerabilities; know the data structure and use of strong analytic techniques. But acquiring these skill sets can be a daunting task for luddites.

The insurance sector has embraced digitization in the best way possible. Social networks and communities are enabling insurers to connect with customers. This helps in branding, customer acquisition, and retention. Feedback through digital media can be used for customized products and competitive pricing.

The statistical models used by insurers to fight frauds suffers from drawbacks like

- Some frauds going undetected
- Reliance on prior frauds
- Inability to integrate information from different channels

Growth in unstructured data can lead to a situation where a fraud can go undetected. Data from various sources is combined so that a model can be created. The best value is obtained from unstructured data. Fraud analytics can play a crucial role in integrating data.

Using analytics, frauds can be stopped in real time. Analytics can process large volumes of data at high speeds. The data stored can be used for identifying unusual behavior. Fraud investigation efforts can increase operational

efficiency. Digitalization has resulted in easy availability of customer and transaction data. Technology can be used to increase the speed and efficiency of anti-fraud processes.

The benefits of fraud analytics are

1. Identification of all events including low incidence events through use of predictive modeling
2. Frauds can occur during claim or surrender, payment of premium or due to actions of an employee or a third party. Data is also getting fragmented due to the plethora of channels through which insurance is sold and distributed. Analytics can provide enterprise-wide solutions to deal with frauds.
3. Integration of internal data with third party data can enhance fraud detection capabilities. For example – if data in a medical bill is used in a model properly, anomalies in billing can be discovered easily reducing the time for investigating and detecting the fraud.
4. Analytics can also help in getting the best value from unstructured data (example – third party reports). Information available in social media is not appropriately stored by insurance companies. Text analytics can review unstructured data and provide valuable insights for fraud detection.

Social CRM is a process that can be used to fight insurance frauds. Integration of social media within multiple layers of the organization leads to greater transparency with customers. Social CRM uses a company's existing CRM and gathers data from various social media platforms. Data from social chatter acts as a reference data which is used in conjunction with existing data in the CRM.

The case management system analyzes data based on business rules and the response whether the claim is fraudulent or not is confirmed by investigators independently. It needs to be remembered that the output of social analytics is just an indicator. It needs to be substantiated further. Axa-Oyak is a Turkish insurance company that used the social CRM solution to manage risks and prevent frauds.

Learning fraud patterns from historical data can be useful for fighting fraud. Descriptive analytics, predictive analytics and social network learning tools are recommended because these can be applied across a wide variety of fraud applications. Infinity, a property and casualty company used predictive analytics and this resulted in increase in success rate for pursuing fraudulent claims from 50% to 88%. The time required for investigating fraudulent claims was reduced by as much as 95%.

Data needs to be pre-processed for fraud detection. Fraud detection models can be built using descriptive analytics tools like peer group analysis, break point analysis and hierarchical clustering. Logistic regression, decision trees, random forests and neural networks are some of the tools for building fraud detection models using predictive tools. Page Rank, homophily, bi-graphs and egonets are the tools available through social network analytics.

Recommendations

There are various customer touch points in an insurance transaction that can lead to the occurrence of a fraud. As insurers digitize processes and embrace data-driven solutions, new opportunities for fraud get introduced. There is a need for industry-wide sharing of ideas and information.

Besides technological tools, behavioral economics can aid fighting of insurance frauds. Rather than asking people to endorse their acceptance of the principle of utmost good faith, it is better to have additional checks to confirm the same. This can be done through intelligent placement of questions.

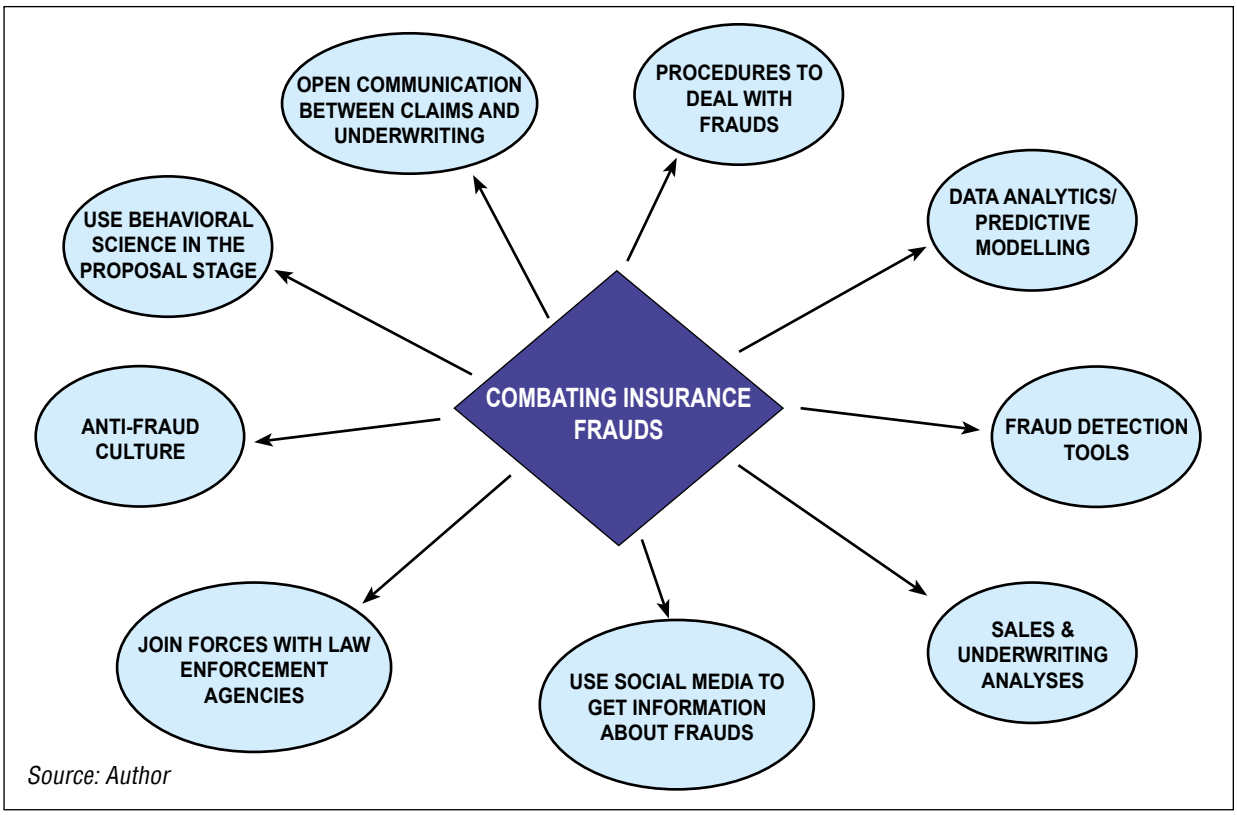
Insurers have to improve their image through better customer engagement efforts. Both insured and insurer need to have shared goals and become long term partners in health and well-being. Getting to know policyholders deeper will develop customer intimacy and breed customer loyalty.

Data holds a prominent place in the scheme of things to combat frauds. Insurers must invest time and other resources to develop processes for ethical evaluation of new data sources and conversion of this data into actionable insights.

Insurers must implement a customized fraud loss management exercise to strengthen controls. Institutionalizing a comprehensive fraud analytics solution that can generate red flags can support a monitoring framework. Periodic updating of fraud-control policies is a must.

Most insurance frauds happen at the claim stage; the occurrence of technology driven frauds is lower. Technology can, at best, be one of the tools for fighting insurance frauds because fraudsters seem to be having access to sophisticated tools to commit a fraud.

There is an urgent need for professionals specializing in forensic sciences such



Source: Author

as fire investigators, computer forensic investigators and forensic accountants.

Summing Up

Insurance industry transacts large amount of money – so it becomes a target for frauds. Additionally, insurers have to battle negative perceptions about them. Fraudsters feel that it is justified to defraud insurance companies who are perceived as impersonal organizations. If insurance frauds can be reduced through appropriate technological interventions, the claims ratio of insurers will improve and premiums will reduce.

The insurance sector – life insurance in particular- has seen a jump in the premium collected. In 2016-17, the life insurance sector collected a premium of Rs.4.18 lakh crores; in 2017-18, this amount increased to Rs 4.58 lakh crores. Even the claim settlement ratios of life insurers have vastly improved. Vigorous checks, use of data analytics and technology-enabled KYC-verification process has enabled insurers to detect frauds. However a lot more needs to be done.

Frauds need to be prevented to protect the interests of customers. Tighter underwriting controls are needed to reduce frauds. The costs of protection increase with increasing number of frauds as risks are pooled in insurance.

Insurers have a legal and moral obligation to shareholders and policyholders to combat frauds and desist paying fraudulent claims. Insurers have to interact with all the stakeholders across the customer value chain. It is the duty of all stakeholders in the insurance industry to join hands and fight the menace of insurance frauds. If insurers can share fraud data among themselves, it can prove to be a step in the right direction.

IRDA had come up with the Insurance Fraud Monitoring framework to curb the menace of insurance frauds. The insurance industry has created a data center of fraudsters and their methods. Fraud control units are being set up under a separate department called “Risk and Loss Mitigation”.

Conservative methods of dealing with fraud after it has happened will no longer hold good in an era when sustainability of an insurance company depends on its operational efficiency. Legacy approaches to fraud prevention are not enough as institutions continue to rely on siloed data and manual processes. With the growing number of frauds that occur abetted by technology, companies must invest in real-time identity verification software solutions. They

should focus on digital channels that are under greater risk.

Analytics can integrate data across silos enhancing expert knowledge. Use of the right tools to prevent, predict, detect and remediate fraud is crucial. Analytics can lead to both short term as well as strategic benefits. Well trained fraud analysts and investigators will add immense value to an insurer's attempts in fighting frauds.

Technologies such as AI and block chain can enable reduction in insurance frauds. If machine learning capabilities are deployed for fraud detection, the AI will learn to predict the occurrence of fraud much more efficiently. Larger data pools complemented by predictive analytics tools enhance fraud prevention and detection.

Fraud control needs a holistic approach but it needs support from technology as well as regulatory authority.

Fraud prevention solutions must be hosted as an enterprise platform cutting across business lines to prevent duplicate fraudulent claims. If the bad actors can be dissuaded from committing an insurance fraud, fraud losses can be reduced to a great extent. Fraud prevention technologies must be well-integrated and must match steps with the efforts of fraudsters. Fostering a zero-tolerance culture for fraud and providing anti-fraud training to employees and agents are the next vital steps.

Concerns about data privacy and identity thefts continue to pose challenges in an insurer's attempt to fight frauds. Even more worrisome is the tendency of customers to justify soft frauds. The increased instances of hard frauds in rural India continue to be a cause of concern.

Academic research on insurance frauds has revealed that there are three key principles that can increase the accuracy of data revealed by an insured. The idea is to make it easier to be accurate, easier to be truthful, and harder to tell lies. Some of the strategies are – use of simple language, prompting the insured to recall from memory (e.g., "When did you last have an accident"). This will also forewarn the applicant that his answers are being monitored (the sentinel effect).

Ironically, fraud risks can be aggravated by efforts of an insurance company to simplify application and underwriting procedure or attempt by the insurance company to enhance the customer's claim experience.

Constant vigilance is the need of the hour because fraudsters have become sophisticated and creative. Absence of strict punishment/ jail term for the offenders is proving to be a deterrent to stem the growth in insurance frauds. A proper penal code to punish fraudsters is needed to eradicate frauds. In addition to technological interventions, stringent laws and regulatory policies can play a vital role in curbing insurance frauds.

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Insurance Frauds: A Closer Look

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Abstract

There are a total of 58 Insurance Companies operating in India – 24 In Life segment, 34 in Non-Life segment. In addition to these, there is sole national re-insurer, namely, General Insurance Corporation of India (GIC Re). As on 31st March 2020, as per data available from Insurance Regulatory and Development Authority of India (IRDAI) website, the total underwritten business premium by Indian insurance companies for FY 2019-20 was whopping 4.48 lakh crores – 2.58 lakh crores from life insurers and 1.89 lakh crores by non-life insurers. Yet as per the last available data, insurance contribution as percentage of Indian GDP was less than 4% in India.

Though the scenario seems bleak, but if taken in positive stride, this represents huge growth potential for insurance companies. In 2018, the Government of India announced its ambitious program – Ayushman Bharat to provide health coverage of Rs 5 lakhs to 100 million people. Government's policy of insuring the uninsured would gradually push insurance penetration in the country and proliferation of insurance schemes. According to a report by the India Brand Equity Foundation (IBEF), the Indian insurance industry is expected to grow to Rs 19,56,920 crore (US$ 280 billion) by FY2020, owing to the solid economic growth and higher personal disposable incomes in the country. The only hiccup

in this scheme of things is nature and kind of frauds plaguing the insurance industry. Despite the enormous numbers shown above, it is estimated that Insurance companies on an average loose a minimum of 8.5% of total revenue to insurance frauds every year. This number touches 35% for health segment. In real terms, this translates to approximately 45 thousand crore of fraud claims every year. Most of the advanced countries where the insurance industry has matured have put insurance fraud laws in place. Eg: Insurance fraud is classified as a crime in all the states of the USA while In the UK, the Fraud Act 2006, defines insurance fraud as a crime. In India, we do not have any specific laws connected to insurance frauds which are spelled out in the Indian Penal Code, 1860. The Indian Contract Act, 1872 also does not have any specific laws pertaining to insurance frauds. A few sections of IPC that have some relevance are –

- Section 205 - false impersonation for the purpose of act or proceeding in suit or persecution;
- Section 420-cheating and dishonestly inducing delivery of property;
- Section 464-making a false document including signs, seals and forgery; and
- Section 405-criminal breach of trust.

However, these provisions are not adequate to prosecute a fraudster legally under the current scenario of organized insurance frauds. Due to the mounting backlog of pending judicial cases in our courts, taking legal action against insurance frauds is not a common occurrence and frauds of amounts not big enough are let go off as opposed to the heavy investment of time and energy in pursuing the same.

Keywords

Insurance Fraud, Neha, Rohini Database, Employee Dishonesty, Artificial Intelligence, Regulatory Sandboxes Etc.

Introduction

In terms of gross premiums generated by a country, India ranks 10th for Life Insurance and 15th for Non-Life insurance products. The average growth reported by Insurance Industry is around 10-12% per annum. However with strong growth in insurance industry, cases of fraud have also increased over the past few years.

What is more perplexing is that the term 'insurance fraud' is not defined under the original Indian Insurance Act, 1938. IRDAI recently quoted the definition provided by the International Association of Insurance Supervisors (IAIS) which defines fraud as

"an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties."

Insurance fraud occurs when an individual or group of individuals attempt to earn profit either through non-compliance or through finding ways and means to exploit loopholes in the terms and conditions of the insurance agreement. The perpetration of these frauds is committed by the likes of insurance agents, existing and prospective policyholders, claimants and in certain scenarios, employees.

Insurance frauds pose a significant problem, and affect the lives of innocent people, both directly through accidental or intentional injury or damage and indirectly as these crimes cause insurance premiums to rise every year. Insurance Frauds also lead to delay in claim settlements; in fact claims could also get rejected in certain cases. Sometimes it becomes very hard to specify the time frame required to investigate the fraud because it completely depends upon the type of fraud, people involved and relative potential of the fraud.

How Do Insurance Frauds Happen?

The Insurance Regulatory and Development Authority of India which is the apex body and overseeing the business of Insurance in India sets out these 3 broad categories of fraud –

- **Internal Fraud** – Fraud/ misappropriation against the company by its Director, Manager and/or any other officer or staff member (by whatever name called).
- **Intermediary Fraud** – Fraud perpetuated by an insurance agent/ Corporate Agent/intermediary/Third Party Administrators (TPAs) against the company and/or policyholders.
- **Policyholder Fraud and/or Claims Fraud** – Fraud against the company in the purchase and/or execution of an insurance product, including fraud at the time of making a claim.

An insurance fraud could either be a hard fraud or a soft fraud.

A hard fraud occurs when someone deliberately plans or invents a loss such as a theft of a motor vehicle or setting fire to property covered by an insurance policy.

Soft frauds are more common and include exaggeration of legitimate claims

	Internal Fraud	Intermediary Fraud	Customer Fraud
Definition	Fraud against the insurer by its Director, Manager and/ or any other officer, staff member	Fraud against the insurer or policy holders by an agent or any other third party administrator	Fraud against the insurer in the purchase or execution of an insurance product.
Examples	• Misappropriating funds • Fraudulent financial reporting • Forging signatures and stealing money from customers' accounts	• Non-disclosure or misrepresentation of risk to reduce premiums • Commission fraud - Insuring non existent policy holders while paying premium to the insurer	**Soft Fraud:** • Exaggerating damages/ loss • Deliberate or subtle lagging of claims resolution **Hard Fraud:** • Staging the occurrence of incidents • Medical claims fraud
Control Framework	Internal audit teams independently examine the processes and report weaknesses in control mechanisms	Having documented policy for appointment of new intermediaries, appropriate sanction policy in case of non-compliance by the intermediary	Adequate client acceptance policy, client should be identified and identity verified. Professional judgment based on experience should be used.

Source: https://actuariesindia.org/

by policyholders. They are also referred to as opportunistic frauds.

Fraud is willful and deliberate, involves financial gain, done under false pretense and is illegal. Fraudsters have become increasingly innovative. Newer ways of cheating the insurance companies are being used almost every day. Some of the most common methods are listed in this below.

- **Hiding a pre-existing condition:** The most common way to defraud a company is to have insurance policy issued to a person who has a terminal illness. This does not happen much in urban India. However, there is not much infrastructure available in rural India. The most common fraud is buying insurance in the name of an ill person. The doctor who comes to check the patient for pre-existing illnesses is either bribed or threatened. Hence, even if a person has life threatening disease, the doctor will write a report that says that they are fit to be covered under insurance. Later, when the patient dies of the disease, insurance money is fraudulently claimed.

- **Fabricated documents to meet terms and conditions of the Insurance:** Insurance companies in India provide riders wherein if a person dies of accidental death then the payout is double of the sum assured as compared to payout in natural death. This provision is also misused in order to make fraudulent claims. If a person having an insurance policy dies even of natural causes, dependents claim that the victim died because of an accident. Once again, doctors and medical professionals are threatened in order to obtain relevant documents which leads to massive losses for insurance companies.

- **Participating in fraud rings:** Health and motor insurance are more prone to such kind of fraud. In these cases, document forging is the norm. There are many hospitals in India which exist for the sole purpose of providing fake documents for insurance claims. Insurance companies have to be on the lookout for these hospitals since they create many fraudulent claims from one geographical area. By the time, the insurance companies realize what is going on these fraudsters pack their bags and move to a different location in order to start all over again. The surveyors and investigators deputed

to verify the veracity of motor claims work hand in gloves with insured's in getting inflated amounts in return for a commission.

- **Withholding information of multiple policies:** It is the responsibility of the insured to inform all the other insurers of the existing policies on same subject matter proposed for insurance whether group, individual to prevent the making of multiple claims on an issue and make a profit out of it.
- **Other forms of frauds:** Submission of forged or inflated bills is also fraud, especially when no expenses have been undertaken. An insurance policy is not supposed to be profitable. The objective of health insurance to cover the medical expenses incurred when one has diseases or requires surgery is defeated. Moreover, with such false claims, the claim incurred ratio of insurance companies increase, which in turn pass on the burden to honest policyholders by raising premiums. A person might stage an accident or distort facts so that they can call for compensation for their medical and hospital expenses.

As India's insurance industry matures, fraud risk management is going to be a major concern for insurers and business leaders. Insurers will have to continuously reassess their processes and policies to manage and mitigate the risk of frauds.

How Can Insurance Fraud Be Prevented?

The insurance regulator in India has come down hard upon insurance companies which deny claims. New laws have been formed which state that an life insurance company has three years to find out if the data furnished at the time of buying the policy was incorrect. After three years have passed, the data is assumed to be accurate, and insurance companies are forced to pay the claim. The same moratorium in case of health insurance segment is limited to 8 years. Strict timelines have been enforced for Insurance companies to process the claims and inform the claimant of his/her claim status. The Regulator has devised policy for Protection of Policyholder's Interest to minimize instances of harassment by Insurance Companies, with provisions for award of penalty for lapses. Though the provisions of these regulations are formulated keeping in best interest of policyholders, yet some dishonest elements of society out of greed exploit or take advantage of the loopholes present in the insurance sector.

With a aim to push the idea of digital India, the government has allowed creation of eIA or Electronic Insurance Account where a person can manage all his Insurance policy information viz life insurance, health insurance, pension or general etc and access it anytime from anywhere. It aims to save lot of paperwork and provides a way to protect against policy theft or policy loss.

Nevertheless, it is imperative that Insurance Companies need to continue their unrelentless fight to weed out fraud insurance claims. In this connection, some of the ways which can help Insurance Companies to identify and mitigate losses on account of fraud are explained below:

1. **Insurance Repository:** With a aim to push the idea of digital India, the government has allowed creation of eIA or Electronic Insurance Account where a person can manage all his Insurance policy information viz life insurance, health insurance, pension or general etc and access it anytime from anywhere. It aims to save lot of paperwork and provides a way to protect against policy theft or policy loss. A person is allowed to have only one e-Insurance account. After proper verification of KYC documents, unique ID and login credentials are generated. However, the purpose for which such e-Insurance Accounts was conceived has not achieved its maxim due to lack of publicity by concerned authorities. Insurance companies should take the charge here and publicize use of this facility. With gradual adoption, the same can be made as a prerequisite for availing insurance services. The aim behind such a move would be to prevent frauds where insured tries to take benefit from multiple policies on occurrence of the claim. Purpose of Insurance is to act as a buffer for financial shocks on happening of certain specified insured event. It is a risk transfer mechanism, which aims to provide peace of mind to protect against losses in exchange of premium amount. The purpose of Insurance is to minimize the losses or try to restore the status quo before happening of the insured

event which turns into a claim. As per contribution clause in most of the general insurance policies, if insured has taken multiple policies for same subject matter, the claim should be settled proportionately under the policies. In health insurance policies, the regulator has allowed insured to claim the balance amount from other policy if not payable under one policy. When all such information is available at a commonplace in e-Insurance Account, the Insurance companies can avoid lot of insurance frauds pertaining to multiple claims for same event under different policies with other insurance companies. This will also help Insurance companies to assess their liabilities in a better way and insurance repositories can act as a common platform to share information pertaining to policyholder's insurance information with each other for diligent underwriting of proposal and efficient disposal of claims.

2. **Central Insurance Information Databases:** Often companies are pressed to accept or deny a proposal at time of porting, while awaiting details from previous insurance company. Instead if data is accessible on a real-time basis, the companies can attend to prospective customers more efficiently and with convenience. Insurance companies can collaborate with the regulator and government authorities to create platform or leverage an existing one using which information sharing across Insurance companies can be easily achieved. In this context, VAHAN database can be chosen as a base model. The idea could be as simple as allowing Insurance companies to search insurance information pertaining to a particular policy in few clicks without waiting for confirmation from other insurance companies. This can be quite helpful esp in motor insurance, where incorrect declarations relating to No Claim Bonus (NCB) is a common scenario. Though insurance companies have integrated their systems with VAHAN database to weed out frauds related to mismatch of vehicle particulars, the same can be extended to access current/previous policy information using the vehicle number. This will help insurance companies to identify and access the nature of risk being proposed for insurance based on past claims history. Another benefit that can be achieved by incorporating insurance information in VAHAN is identification of those cases, where insured try to take motor policies to cover for losses after lapse of previous policy or provide incorrect declarations to evade mandatory physical inspection before policy issuance. Though such a mechanism for verifying existing insurance policies is already in place in accordance with GR 27 of The Motor Vehicles Act, 1988, but the existing mechanism is not robust and creates lot of interdependencies among insurance companies. Instead VAHAN database can be updated with latest insurance information by insurance companies on frequent intervals to act as a single point of reference. Similarly in health sector, one of the objectives of National eHealth Authority, which was setup in 2015, is to promote setting up of state health record repositories and Health Information exchanges to facilitate interoperability. However a lot of work needs to be done in this direction to achieve real ground results.

3. **Insurance Information Bureaus:** One problem with insurance companies in India is that they do not extensively share data as banks do. This is the reason why every insurance company has to rely on its own network to detect fraud. It is extremely important that all insurance companies form a common database and start sharing fraud data extensively. "The government should make provisions so that just as banks can determine the creditworthiness of an individual by querying the Credit Information Bureau of India Ltd (CIBIL), insurers in future may be able to get details of an individual's insurance history and his claims record whenever they get a new proposal," says Sandeep Malik, a reputed Insurance & Risk Management Consultant who specializes in insurance fraud. The sharing of knowledge and data should be a common practice amongst all insurers and the regulator. This data should include fraud patterns and case studies, fraud customer list and intermediaries, fraudulent providers and investigators. IRDAI few years back came up with the Insurance Fraud Monitoring Framework to help curb insurance frauds. Though it's still early days in the area of data sharing between the insurers, it's certainly a step which will help companies to prepare better for spotting fraud. "Anti-fraud policies at insurance companies have improved knowledge dissemination and hence help early detection of fraud cases. Internal resource training has also

helped reduce frauds involving internal," says Anik Jain, CEO and co-founder of Symbol Insurance. By sharing this information across the industry, companies can plug the gaps and informed while taking related decisions. ROHINI database, which is a registry of hospitals and medical day-care centres, in the health insurers and Third Party Administrators (TPAs) network can be used as a reference point while empanelling of network hospitals or TPA's or guiding insured to undergo treatment at all available nearby hospital in most cost-effective way.

4. **Artificial Intelligence:** Technology has revolutionized each and every sector it has touched. Insurance industry too experienced changes when it moved from manual system to machine driven enterprises. With proper checks and precautions in place in the system, many of malpractices plaguing the insurance industry could be controlled. Now is the time to adopt to third wave of change with emphasis to be laid on use of Artificial intelligence systems. Auto Claim Adjudication could be one of the way forward. It uses advanced AI software to scan for errors, and then match key details to make the decision of approval, denial or change to the claim automatically. Business rules can be implemented inside the software to expedite claim processing which are genuine and within the boundaries of the customer's insurance policy. Based on experience, it can be slowly evolved to identify and flag those claims which seem suspicious or need review. A number of upfront validations such as member matching, provider matching and business rules and edits can help

Technology has revolutionized each and every sector it has touched. Insurance industry too experienced changes when it moved from manual system to machine driven enterprises. With proper checks and precautions in place in the system, many of malpractices plaguing the insurance industry could be controlled. Now is the time to adopt to third wave of change with emphasis to be laid on use of Artificial intelligence systems.

and improve auto adjudication process. Example: system can be designed to flag series of claim from a particular service provider where there is a mismatch in diagnosis and claimed benefit. Another business rule implemented in the software could flag claims for review from set of service provider who are unreliable or suspicious of committing insurance frauds. Access to such information on real-time basis could also prevent frauds where fraud perpetrator exploit the system by making a fraudulent claim at a branch/area which is different than home policy servicing branch. According to a FICCI (Federation of Indian Chambers of Commerce & Industry) report, existing systems can be overhauled to respond to common triggers that can help to detect frauds such as:

- Claim from a policy with only one member at minimum sum insured amount.
- Multiple claims with repeated hospitalization and multiple claims towards the end of the policy period or close proximity of claims.
- Any claims made immediately after a policy sum insured enhancement.
- Claims from a member with the history of frequent change of insurer or gap in the previous insurance policy.
- Policy claims with evidence of significant over/under insurance as compared to the insured's income/lifestyle.
- Claims from a non-traceable person or where courier/ cheque have been returned from insured's documented address
- The second claim in the same year for an acute medical illness/ surgical minor illness/orthopedic minor illness in the same policy period for main claim. Young males between 25-35 years getting admitted for acute medical illness
- Claims from members with no claim free years, i.e. regular claim history

5. **Regulatory Sandbox:** Insurance is inherently based on the principle of Uberrima fides or Utmost good faith. Insurance companies underwrite insurance contracts on basis of the information received by it in the proposal form. And the source of this information is the

insured himself. Thus insurance companies have no choice except to go by the words of the customer before underwriting a new business. And once a contract is issued, the hands of insurance companies are tied if they fail to prove that declarations made by insured were false. The resources to prove such wrong declaration with an intention to commit insurance fraud are limited, esp in health insurance segment. To address this issue, regulator has now come up with certain relaxations under Regulatory Sandbox Regulations, 2019, to allow insurance companies to leverage latest technologies and create and offer such innovative products which help insurance companies to track, record or monitor vital health parameters on real time basis. Seizing the opportunity Insurance companies have come up with proposals that would allow them to offer products with mobile application monitored wellness programs or use of wearable fitness trackers or engagement through specialized platforms on a routine basis. The idea is to assess potential future liabilities with continuous self-monitoring by insured person and mitigate frauds where medical evidence to prove or establish insurance fraud is hard to come by. In one of the product approval, insurance company has requested benefits to be restricted to a defined set of hospitals (also known as PPN Network hospitals), which are trusted brands and known to maintain high ethical standards.

6. **Employee Sensitization:** Many a times, employees of the insurance companies are hand in gloves to insurance claim frauds. Even when claim is untenable, the facts are represented in such a way so that claim can be paid. Though the modus operandi is quite old, but still insurance companies suffer a lot from such a phenomenon. While insurance companies have laid out elaborative code of conduct for employees and enforced strict measures and guidelines to discourage employees from working against the best interests of organization, yet those seasoned with the loopholes in the system know how to get through. Enforcing disciplinary policies did deter the employees, still not everything is perfect. Insurance companies need to sensitize employees in regards of losses happening on account of internal frauds. Proper training and audit mechanism with strict enforcement and compliance should be in place to minimize such incidents. Publicity should be given to Whistle Blower policy among the employees with provision of identify protection and/or suitable rewards for reporting internal frauds. Another area that need to be focused is to keep employees updated with knowledge of newer kinds of frauds happening in industry. Subject Experts should be posted in those geographical areas which are known to be notorious in reporting fraudulent claims. Employee rotation policy should be followed strictly to ensure that employee do not end being part of insurance fraud nexus.

According to IRDAI, every insurance company is required to set up a Fraud Monitoring Framework. The framework shall include measures to protect, prevent, detect and mitigate the risk of fraud from policyholders/ claimants, intermediaries and employees of the insurance companies. Insurers are expected to adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly lay down appropriate risk management policies and procedures.

7. **Anti Fraud Policies:** According to IRDAI, every insurance company is required to set up a Fraud Monitoring Framework. The framework shall include measures to protect, prevent, detect and mitigate the risk of fraud from policyholders/claimants, intermediaries and employees of the insurance companies. Insurers are expected to adopt a holistic approach to adequately identify, measure, control and monitor fraud risk and accordingly lay down appropriate risk management policies and procedures. The Board of Directors of Insurance Companies are mandated by the IRDA to review their respective Anti-Fraud Policies on an annual basis, and at such other intervals as it may be considered necessary. Such policies need to provide

a comprehensive guideline on fraud monitoring procedures, identification of potential avenues of fraud, guidelines to cooperate and coordinate with State and Claw enforcement agencies for identifying the act of fraud as well as the perpetrators. These policies should also guide in building a framework that will allow them to exchange information with other insurance companies with regard to sharing intelligence on the occurrence of incidents and scenarios of such frauds so that these can be red-flagged within the insurance ecosystem. Insurers are also liable to inform both potential and existing clients about their anti-fraud policies. Insurers are liable to include necessary cautions in the insurance contracts and relevant documents, duly highlighting the consequences of submitting a false statement and/or incomplete statement, for the benefit of the policyholder, claimants and their beneficiaries. Insurance entities continue to curtail fraud, yet a lot needs to be done to make the existing framework more robust and comprehensive. Perpetrators have the creativity to identify ways of subverting the system, so staying ahead needs constant software upgradation and monitoring by seasoned professionals!

Conclusion

The future looks promising for the insurance industry with several changes in regulatory framework which will lead to further change in the way the industry conducts its business and engages with its customers. Business leaders are aware of the need to address insurance frauds, but the lack of a comprehensive and integrated approach to fraud risk management continues to be a concern. While insurance companies are 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.

At the present moment, most insurers only share a negative list i.e. a list of customer, distributors and medical professionals who have earlier committed fraud. Hence, the system is reactive and not predictive. A start has been made as a repository has been formed in 2016. About 43 insurance companies have come together and have appointed credit rating agency Experian in order to use Experian's big data and analytics capabilities. However, in order for Experian's system to work, insurance companies have to regularly share data with Experian's systems. To many insurance companies, this is unacceptable given the fact that it entails a lot of costs and also compromises the security of the data. However, it is likely that over time, data sharing becomes the norm and fraudulent policies are discovered more easily.

Another focus area is that the law punishes insurance companies but does not provide any recourse to them. It is the need of the hour to have laws that can provide swift recourse against insurance frauds. Even if an insurance company proves that a person has actually tried to commit fraud, they get away with very light punishment. In order to stop the fraud in the insurance sector, it is important that strict laws are created as well as implemented. These laws will act as a deterrent to professional frauds that are making a career out of cheating insurance companies and also act as a deterrent for others looking to exploit this industry. References can be drawn up from laws that are passed in USA, UK and Canada and suitable provisions be incorporated to make a coherent law policy for dealing with insurance frauds in India.

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Life Insurance Frauds

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The insurance industry is today fighting against the fraudulent activities right from proposal to claims and beyond. In order to understand "fraud" let us start at the beginning.

What is Fraud?

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."

Types of Insurance Frauds

As the insurance industry matures over the year, the frauds are also ingeniously carried out by the fraudsters. Some of the types of frauds seen are as under: -

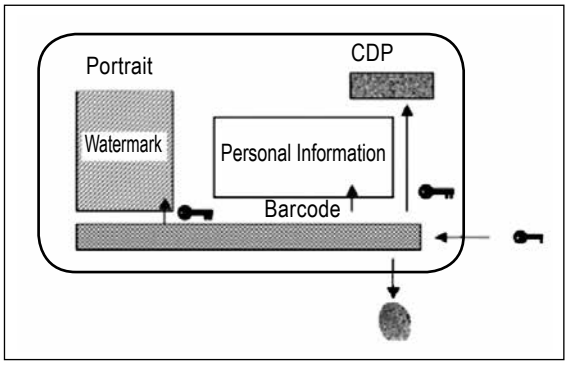
1. **Application fraud** - where incorrect information is passed on to the insurer at the proposal stage through the front line sales intermediaries. In rare cases these frauds are orchestrated by the customers to get themselves insured.
2. **Claims fraud** – where fake death claims are submitted to multiple/ single insurance companies. This could be a pre-deceased/fictitious/ bogus life, purchased from unknown parties, cases with terminal illnesses, etc. It is also observed that after the alteration in the regulations, such types of claims are being submitted

after 3 years of the policy.

3. **Forgery** – These are cases of document as well as signature forgery whereby fabricated/ tampered/manufactured documents are submitted. Signatures of customers are expertly tampered without their knowledge. Similarly, fake receipts are being issued against premiums and this is an intentional fraud.
4. **Document Tampering**

financial gains or the "get rich quick" method which drives the individual to committing a fraud. Additionally, the emotion of having been able to "afford the unaffordable" is another reason the individual resorts to fraud. Incidentally the "GREED" to make higher returns that what is feasible leads an individual to commit fraud.

A study conducted by Ernst & Young in June 2018 (Global Insurance Trend Analysis 2018) has revealed that in the last one year the Life Insurance industry is worth US$ 2.60 trillion and grew by 3.5% annually. Similarly, the Non-Life Insurance industry is worth US$ 2.10 trillion and grew by 2.8% annually. Losses on account of fraud in the insurance industry reached new heights. In USA, it is to the tune of US$ 200 billion approx., in UK it is US$ 3.01 billion approx. and in India it is US$ 3.41 billion approx. It is very difficult to gauge the exact magnitude of fraud in the insurance industry because of the fact that there is very little data on fraud. Companies do not want to disclose due to overall negative impact about the company. Regulators do not put such data in public domain as these are confidential and not for consumption of the general public. As such very little data is available on this matter.



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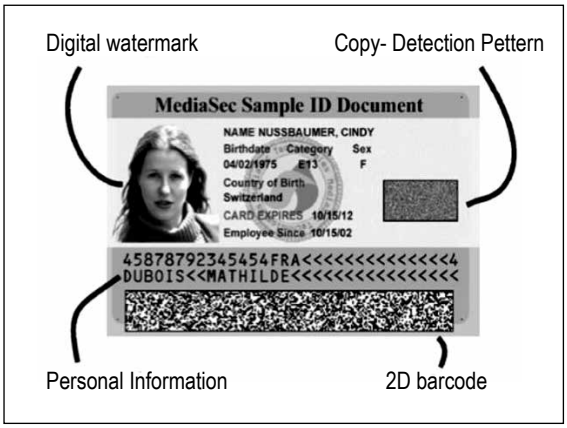


5. **Spurious policies** – These are typically sold over the phone. A fake policy document is sent to the customer and premiums are misappropriated.

In every fraudulent activity the following are interconnected: -

1. Personal justification of actions – where in the subconscious mind the actions have been rationalized and justified.
2. 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 ahead.
3. Financial or emotional force pushing towards fraud – in this there is always a feeling of making quick

Vulnerabilities of Insurance Industry Leading to Fraud

Operational Gaps

One reason for fraud manifesting itself in the insurance industry is the fact that there apparently are gaps in processes. Mostly insurance companies use multiple systems for its day-to-day functioning. The main functions involve cashiering, underwriting, issuance, policy servicing & payouts and finally claims. However, companies have multiple silo systems for these functions. These systems are not connected and they work on standalone basis. The data needs to be updated on all systems through the server on a regular basis so that the corrective actions can be taken, as applicable.

Underwriting gaps

Underwriting of proposals on the lives of individuals is the job of an insurance company. Underwriting is heavily dependent on the documentation. This could be id/address proofs, pancard, land documents, medicals as well as the proposal forms. The underwriting process has to be completely foolproof in order to ensure that the process

performs the necessary due diligence. Only where the underwriter feels that there is need of further details will they raise the need for the same. Human intervention should be kept at a minimum.

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. The degree of hacking depends upon the level of security that have been built into the systems, the firewalls that have been developed, etc. However, it would be pertinent to mention that all firewalls and the security levels can be breached and companies would also not be aware of the same as the hacker is "anonymous" and leaves behind "no digital footprints". 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 will of the hacker.

A study carried out by KPMG, Economic Times & Accenture has revealed that any insurance company will face on an average 113 breach attempts every year. At least 1/3rd of these attacks would be successful. The cyber insurance segment is growing between 50% and 100% annually. In the study 40% of those surveyed conveyed the message that unauthorized modifications to customer data was a major area of concern. However, companies are taking steps to ensure that this is kept at a minimum as it is believed that no security is 100% foolproof.

There are multiple ways in which a fraudster defrauds any company including the insurance company – life and/or non-life as under.

1. Whistle blowing mechanism – may not be actively encouraged within the organization.
2. Collusion with 3rd party – this is one area susceptible to fraud as the organization bleeds on account of colluding with fraudsters to defraud the company.
3. Vendor management & payouts – effective background checks are not always carried out as a result of which there is lack of due diligence. Thus there are possibilities of wrong/ incorrect payments made.

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.

a. Placement is the most dangerous step in money laundering as it involves cash deposit, wire transfer, money order, etc. The government is always looking for such large deposits.

b. The next step is layering which makes it more difficult to detect and uncover the laundering activities. It becomes very difficult for law enforcement agencies to detect such illegal proceeds because in this cash gets converted to monetary instruments, assets are bought with cash and then sold, etc.

c. The last step is integration where laundered money comes into the system mainly through the banking system and they appear a normal earnings. This is very difficult to detect and can only be detected with the help of informants. (FATF 1996-97 Report on money laundering typologies). The FATF or the Financial Action Task Force on Money Laundering was set up in 1989 by the G-7 countries to combat money laundering.

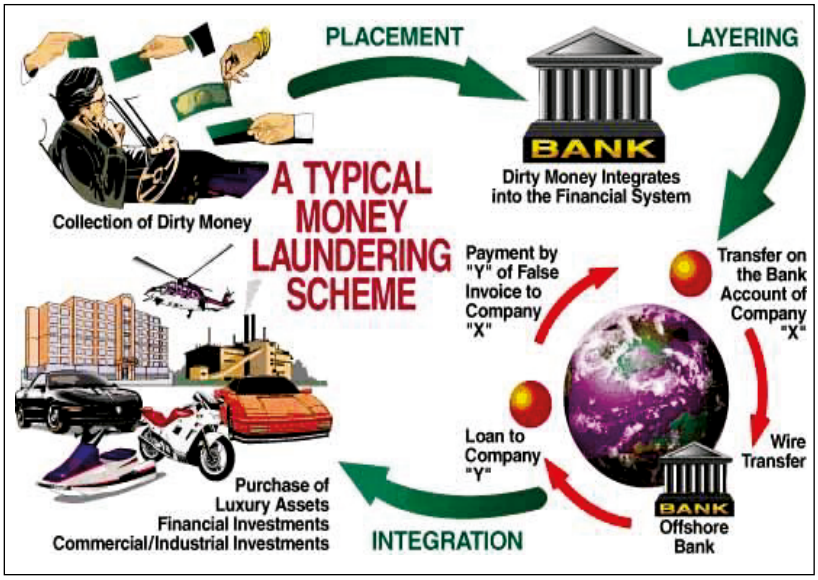
The insurance industry is continuously under threat of data leakage and cyber-attacks on its customer database. In the modern day everything is hackable and nothing is safe – not even standalone computers. It is possible to access the data without companies being aware that their database has been compromised.

FATF has developed 40 recommendations on money laundering and has three primary functions with regard to money laundering as under: -

1. Monitoring members' progress in implementing anti-money laundering measures,
2. Reviewing and reporting on laundering trends, techniques, and countermeasures, and
3. Promoting the adoption and implementation of FATF anti-money laundering standards globally.

Money Laundering - Process

Money laundered is integrated into the financial system through additional transactions until the "dirty (black) money" appears "clean". This money



also enters the insurance industry and is used for the purchase of bonafide policies. Once you opt for a payout, this money comes out of the company's books into the system as legitimate and legal money. The reason why money laundering is causing all countries to take a serious look at the various sources of funds as well as the transactions involved is due to the fact that it is extremely difficult to spot not only at the point of entry but very difficult to detect and remove once it enters the system. While India is a part of the FATF, the Parliament has passed the Prevention of Money Laundering Act 2002 to combat instances of money laundering, as applicable.

Some of the reasons why this industry is so susceptible to money laundering can be understood from the following: -

1. There is a lack of the necessary skill sets and investigative mindsets. Red flags raised need to be monitored closely. Any case where the source of funds is reportedly suspicious needs to be rejected and reported.
2. The insurance industry according to a survey made lacks analytical capabilities to accurately gauge the fraudulent transactions in the insurance industry. This allows fraudulent transactions to pass into the system and remain unnoticed. Innocuous looking payouts get generated and this converts the "unclean" money to "clean".
3. In India there is widespread use of demand drafts. India still does not possess all the tools to validate income sources for all types of occupation. In the unskilled sectors the favoured form of payment is cash. Not all in India have bank accounts and not all having bank accounts have internet banking facility. It has got a lot to do with the demographic background of person concerned and the literacy rates as well as the inclination to use modern banking methods. It becomes difficult to validate all such income sources.

Few Steps Towards Mitigating Insurance Fraud

These are some of the steps that can be taken towards mitigation of insurance frauds: -

1. Implement a foundational network – a solid foundation needs to be laid down which will also include a fraud detection strategy. Alongwith a solid strategy, we need to have a central repository which will house the data from all insurance companies and financial institutions. As per the regulations, CIBIL, IIB have started the process of collection of data. Over a period of time such institutions will help to fight fraud.
2. Use of data analytics in fraud detection – one needs to analyze past fraud, use a predictive modelling method, have a risk score, etc. to decide the propensity of fraud. This needs to be strengthened as this is one part of the strategy which can pinpoint the area where the fraud is likely to occur and necessary preventives steps can be initiated.
3. Continually review and rescore claims – by using a proper risk scoring mechanism one can detect patterns that reveal fraud. The risk scoring mechanisms needs to be reviewed and upgraded periodically.
4. Revise based on market conditions – criminals are always resourceful and we need to quickly adapt to changing circumstances in order to detect and prevent fraud. While security features in the systems help you to safeguard the company, quick adaptability helps to avert serious frauds.
5. Govt. may look at empowering the insurance companies to obtain the necessary documents for hospitals and other agencies, as applicable, at the point of claim payments. Similarly, they may be also be empowered so that they are able to obtain the necessary documents from various agencies at underwriting stage so that it is foolproof.

Managing Insurance Fraud Comprehensively

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Insurance Fraud

Fraud is a term that commonly refers to an act intended to swindle someone. With reference to insurance it refers to any intentional act of deception mainly for monetary gain i.e making profit out of a loss. Fraud can be either a claims fraud or an underwriting fraud. A few forms of frauds are as below –

Purposeful misrepresentation or concealment of a material fact while taking insurance coverage is an underwriting fraud. Example: Non disclosure/misrepresentation of actual income or nature/classification of work in personal accident insurance and workmen's compensation. Taking coverage for a building that never existed etc.

But the most common fraud is a claims fraud that occurs while claiming for an insured loss. Examples: Fake disability claims, Faking accidents/injury, theft, arson etc. Intentional damage of property after the occurrence of an insured peril to receive higher claim payouts or claiming for a loss which was not caused due to an insured peril, along with the actual loss. Inflating bills and misreporting costs especially in health, auto, marine and aviation sectors, using another person's identity to secure healthcare benefits etc.

Prophylaxis – Need of the Hour

It is always preferable to take preventive action and implement effective strategies rather than dealing with fraud after it happens and substantial loss is already

incurred. Nipping the fraud in its bud saves investigation, arbitration and litigation costs. Therefore stopping underwriting fraud not only keeps bad business out of the books but also puts a check to claim frauds. The first step to prevent fraud would be to foresee the likelihood of fraud to happen through fool proof fraud detection mechanisms. Insurance companies and the regulator need to direct resources towards deploying cost efficient and quick mechanisms for early detection of frauds.

Lookout Points

The first point in the life cycle of an insurance policy where fraud can occur is at the time of acceptance of a proposal wherein the first point of contact would be underwriters, agents and intermediaries. Therefore people accepting proposals need to be extra cautious and practise prudent underwriting which is indispensable to stop underwriting fraud.

Fraud can take also take place while the policy is active and running. For example changes may be requested by the insured during the tenure of the policy. Insurers should take this as an opportunity to re-explore if any loss has occurred or scope of loss is present. Periodic review of the nature of risk can give insights into the potentiality of fraud to occur. Additionally, increased rapport with the insured helps insurers in acquiring unmediated knowledge of the risk that is covered by them. Regular interactions with insured can boost the principle of Utmost Good Faith under which the insured should disclose facts about the risk that have a material bearing on the terms of insurance contract, as and when they occur.

The most common type of fraud is that which occurs at the time of claim. It could be either a soft or a hard fraud. Exaggerated claims constitute soft fraud where a loss actually happens but the insured claims more than what is incurred. This is an opportunistic fraud where the insured non objectively seeks reimbursement for additional costs like the time and money spent on claim preparation and reporting, stress undergone, to cover excess in the policy etc which are otherwise outside the purview of the policy. In some cases the narrative of the claims can be altered in a convenient manner so as to receive compensation for those damages that fall under exclusions of the policy. Hard fraud is a situation where a loss is fabricated to receive payment. These include false claims, faking accidents, taking insurance coverage for a non-existent property and scheming as if it got burned completely or starting the fire intentionally called as arson.

Apart from leveraging advanced technology to combat fraud, insurers need to be extremely vigilant and scrupulous. Strict anti fraud legislations should be devised and implemented to deter individuals or groups from making fraudulent claims.

Fix the Faucets That Leak More and Leak Often

Greater success can be achieved by focussing on those areas of insurance which are more prone to claims and wherein the numbers are more, irrespective of the claim amount. For example Health and motor insurance are bleeding portfolios incurring heavy losses almost every quarter with few exceptions. For such portfolios highly assertive automated systems should be in force to detect frauds, prevent them from happening frequently and if fraud occurs, these systems need to be flexible and accommodating

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enough to be tweaked so as to provide quick-fix solutions to prevent further damage. Apart from implementing these systems, companies should seriously contemplate on setting up In-House TPAs with respect to health insurance, keep a tight rein on hospitals charging exorbitantly for patients having insurance coverage and having a dedicated team of professionals on rolls (which of course involves multiple recruitment drives, training costs etc) instead of outsourcing which can help curtail a majority of fraud cases.

Fraud Detection, Managing and Reporting Through Automation-Data Analytics, Statistical Analysis and Predictive Modelling:

Increased diversification in insurance channels has also caused increase in number of areas where fraud can occur. It is here where the Insurance industry can harness the immense potential of automated data analytics in detecting fraud. Traditional statistical models which use sampling methods are based on stock data of earlier cases, are quite expensive and time consuming. These models will remain neither relevant nor viable in a few years owing to the ever changing fraud patterns (thanks to rapid changes in technology) and behaviours giving rise to a new set of fraudulent claims. Also, the trend of fraudsters evolving their practices to fool the fraud catching systems.

Analytics are capable of filtering out obvious frauds and detect novel ones. Digitisation and increase in usage of smart phones for insurance related activities has opened up doors to access traceable data which comprise of locations, credit history, contact details, no. of claims rejected earlier, defaulter acts/cases related to bank/bill payments etc from various sources. The different patterns and forms in which fraud occur can be analysed from a broader perspective using this data. When combined with data acquired from surveyors, claim adjusters, agents and third parties, it can help in building up a hybrid model which can formulate rules based on various parameters and rate or give a score, commonly known as suspicion scores to the claims. Higher the score, more likely is the chance for the claim to be fraudulent. **Social Network Analysis and Social Customer Relationship Management are** couple of such hybrid methods which are based on the above approach of pattern analysis and statistical methods. However, for all the machine based methods to be successful the data needs to be clean and precise.

Early detection of fraud helps significantly in reducing the cost to manage it. These fraud detection strategies help not only in preventing the occurrence but also hasten investigation procedures after the risk is identified and contribute to mitigation of fraud.

Furthermore, dedicated teams comprising underwriters, claims and IT personnel, auditors, surveyors and legal experts need to be deployed at operational levels so that they can have a thorough first hand filtration of claims using various computing methods mentioned above and report fraudulent/ seemingly fraudulent claims to senior management for further review. The remaining claims can be processed as per the regular policy conditions. This could prove to be a very meticulous and accelerated method to manage fraudulent claims and also save time in processing genuine claims. This should be a double delight for the insurers as on the one hand there is an almost accurate analysis of a fraudulent claim and on the other, genuine claims can be processed speedily resulting in heightened customer satisfaction. Not only the claims but the fraud managing teams can also proactively estimate the probability of a fraud before a proposal is accepted by applying predictive analysis techniques. The initial set up may be slightly difficult as it involves investment of time, man power and money especially for analytics related computing requirements but once it is integrated into the system it would be coherent.

Break the Vicious Cycle

Poor fraud management techniques lead to bad Incurred claims ratio (ICR). It has a ripple effect which not only involves losses to insurers but also results in increased pricing, burdening loyal customers and increased turnaround time (TAT) in settlement of claims affecting genuine claimants when they are most vulnerable leading to dis-satisfied customers. This can drastically influence the reputation of any insurance company. Heavy losses also lead to critical changes in re-insurance treaties which unfavourably impact many lines of businesses. There would be a decline in policy turnover/growth in turn leading to unhealthy cut throat competition in the market wherein companies would immoderately reduce premiums which do not balance the outgo, leading to poor claim settlement followed by an exorbitant increase in premium. This chain effect needs to be broken for the industry to prosper and needless to say that methodical and robust fraud management techniques play a pivotal role in achieving this objective.

Insurance and Fraud Management: Need to Overcome Creativity

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Fraud is an independent criminal offense, but it also appears in different contexts as the means used to gain a legal advantage or accomplish a specific crime. For example, it is fraud for a person to make a false statement on a license application in order to engage in the regulated activity. A person who did so would not be convicted of fraud. Rather, fraud would simply describe the method used to break the law or regulation requiring the license. Fraud is most common in the buying or selling of property, including real estate, personal property and intangible property, such as stocks, bonds, and copyrights. Central and State statutes criminalize fraud, but not all cases rise to the level of criminality. Prosecutors have discretion in determining which cases to pursue. Victims may also seek redress in Civil Court. It was recorded fact that, frauds burnt a Rs 45,000-crore hole in the Indian insurance industry's pocket in 2019.

Keywords

Fraudulent, Wrongful Gain, Scammers, Data Analytics, Suspicion Score, Layered Approach.

Meaning of Fraud

As per Cambridge English Dictionary fraud is someone who deceives people by saying that they are someone or something that they are not.

In another English Dictionary - wrongful or criminal deception intended to result in financial or personal gain.

Fraud is commonly understood as dishonesty calculated for advantage. A person who is dishonest may be called a

fraud. Fraud must be proved by showing that the defendant's actions involved five separate elements:-

- a false statement of a material fact,
- knowledge on the part of the defendant that the statement is untrue,
- intent on the part of the defendant to deceive the alleged victim,
- justifiable reliance by the alleged victim on the statement,
- injury to the alleged victim as a result.

These elements contain shades, which are not all easily proved.

First, not all false statements are fraudulent. To be fraudulent, a false statement must relate to a material fact. It should also substantially affect a person's decision to enter into a contract or pursue a certain course of action. A false statement of fact that does not bear on the disputed transaction will not be considered fraudulent.

Second, the defendant must know that the statement is untrue. A statement of fact that is simply mistaken is not fraudulent. To be fraudulent, a false statement must be made with intent to deceive the victim. This is perhaps the easiest element to prove, once falsity and materiality are proved, because most material false statements are designed to mislead.

Third, the false statement must be made with the intent to deprive the victim of some legal right.

Fourth, the victim's reliance on the false statement must be reasonable. Reliance on a patently absurd false statement generally will not give rise to fraud; however, people who are especially superstitious or ignorant or who are illiterate may recover damages for fraud if the defendant knew and took advantage of their condition.

In civil court, the remedy for fraud can vary. In most Countries a plaintiff may recover "the benefit of the bargain". This is a measure of the difference between the represented value and the actual value of the transaction. In some countries, a plaintiff may recover as actual damages only the value of the property lost in the fraudulent transaction. But most of the counties allow a plaintiff to seek Punitive (Penal) Damages in addition to actual damages. This right is exercised most commonly in cases where the fraud is extremely dangerous or costly.

Fifth, the false statement must cause the victim some injury that leaves her or him in a worse position than she or he was in before the fraud.

Fraud can be described as either hard or soft. Hard fraud is deliberate, calculated, premeditated and sustained. It has been planned with the primary intent to deliberately deceive for a financial gain. Soft fraud is more common; it is opportunistic fraud that has only occurred through circumstance or by chance.

The following are example of hard fraud:

The latest iPhone has just been released and someone wants one but can't afford it. They then submit a knowingly false claim to their insurer claiming their current phone has been lost or stolen or is damaged. Their aim is to get a pay-out for their old phone that they can use to buy the new phone.

The following are examples of soft fraud:

Someone has several possessions stolen items, so they submit a claim to their insurer. When filling in their claim form, they add extra items on to the list that they either do not own or that were not stolen.

Fraud can be divided into following groups –

- Constructive fraud
- Extrinsic fraud
- Intrinsic fraud
- Fraud in the inducement
- Fraudulent conveyance

Indian Legislation

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in cases where the fraud is extremely dangerous or costly. Where the fraud is contractual, a plaintiff may choose to cancel, or rescind, the contract. A court order states about the returns all property and restores the parties to their pre-contract status. In criminal law, the achievement of a practical result by false presentation. There is no need to make pecuniary profit out of the pretence.

There are various provisions regarding fraud in Indian Legislations –

The Indian Contract Act 1872 – As per section 17, Fraud implies and involves any of the following acts committed by a contracting party or his connivance or his agent with the intention of deceiving or inciting another party or his agent to enter into the agreement. ... A promise made without any intention of performing it. Any other act fitted to deceive.

As per Section 25 of t**he Indian Penal Code** - "Fraudulently" —A person is said to do a thing fraudulently if he does that thing with intent to defraud but not otherwise. Implications of fraud are found in these following sections of IPC namely, 421,422,423 and 424.

Section 421 of the Indian Penal Code - fraud considered with insolvency. The offence under it consists in a dishonest disposition of property with the intent to cause wrongful loss to the creditor. It will cover benamy transactions.

Section 447(1) of **The Companies Act, 2013** - "fraud" in relation to affairs of a company or any body corporate, includes -

(a) any act,

(b) omission,

(c) concealment of any fact or

(d) abuse of position committed by any person or any other person with the connivance in any manner, – with intent to deceive -

to gain undue advantage from, or

to injure the interests of – the company or of its shareholders or its creditors, or any other person, whether or not there is any wrongful gain or wrongful loss;

[here "wrongful gain" means the gain by unlawful means of property to which the person gaining is not legally entitled; and for "wrongful loss" means the loss by unlawful means of property to which the person losing is legally entitled.]

Under **Income Tax Act 1961** - Despite being aware of the necessity of tax, the incidence of tax fraud is always present. While accidental cases do happen, incidental fraud is a criminal offence and causes a decline in a State's growth. Penalties will be impose under the said Act, as nature of the fraud, mentioned in it.

Under **GST Act** - A person or thing intended to deceive others, typically by unjustifiably claiming or being credited with accomplishments or qualities feature. Where the tax amount unpaid exceeds Rs. 100 lakhs or more. While the monetary penalty under GST is 10% of the tax amount unpaid (as this will be higher than Rs. 10,000), a jail sentence is also applicable.

Under **SEBI** - One particularly well publicized area of fraud is Corporate Fraud. These types of cases are largely governed by the Securities Exchange Act of 1934, along with other rules and regulations propagated by the Securities and Exchange Commission. The Securities Exchange Act and the Securities Exchange Commission regulate anything having to do with the trading or selling of securities and stocks. They govern fraudulent behavior ranging from stock manipulation to insider trading. They also provide for civil and criminal penalties for corporate fraud.

Insurance Fraud

Fraud is an evolving threat that's on the rise in life insurance business. According to one study, 80 percent of life insurers experienced claims fraud in 2017, and 83 percent of the fraud has increased in the past 24 months. India is a huge market for insurance but the industry is bleeding losses due to fraud. Insurance fraud leads to around Rs 40,000 crore every year and makes up for 8.5 per cent of the revenue that the industry generates. Insurance fraud is an act committed to defraud an insurance process. This occurs when a claimant attempts to obtain some benefit or advantage they are not entitled to, or when an insurer knowingly denies some benefit that is due. Insurance fraud committed by exaggerating a legitimate claim. Insurance fraud is a crime committed mostly by "ordinary" and presume otherwise respectable citizens. Consistent with self-control theory, identifying persons with a history of reckless activities provides a means of separating many defrauders from their law-abiding peers. Fraudsters can use different types of schemes to deceive life insurers, and without the right systems and solutions, their tactics can go unnoticed.

Frauds are of different varieties and they mostly take place in rural and semi-urban areas where insurers do not have proper infrastructure to inspect or for that matter the local authorities, who are supposed to certify events, are corrupt. Organized fraudsters identify people

who are terminally ill and buy insurance on their behalf and share the booty with the family members. There is a nexus between fraudsters, doctors, lawyers and village (local) - level.

Most insurance fraud occurs at claim time viz. –

- events/losses that didn't happen
- staged losses — such as arson or vehicle theft
- exaggerated claims
- non-disclosure or misrepresentation of information

There are four common types of life insurance fraud: application fraud, death or claim fraud, forgery and phony policy fraud, which are briefly discuss as follows -

1. Application fraud

Application fraud is when a person knowingly provide incorrect information to his/her insurance company when applying for a policy. This is also called material misrepresentation. This type of fraud is responsible for two-thirds of disputed life insurance claims.

2. Claims fraud

It is also known as death fraud. Claims fraud is the type of life insurance fraud that is more likely to make the news or be the basis of a movie, as it can involve faking a death. This is when people attempt to fake their own death or the death of the loved one in order to collect a life insurance benefit.

3. Forgery

Most life insurance fraud doesn't involve the insured at all, but instead involves other parties accessing the policy and changing the policy owner or beneficiaries. Only the policy owner can change the beneficiaries or other details about a policy.

4. Call-on fraud

A fourth kind of fraud is when scammers pretending to be insurance agents "sell" fake policies to unsuspecting customers and pocket the premiums. Like other kinds of financial scams, these scammers use brand-name recognition to get in the door, then request cash or direct payments.

Consequences of Insurance Fraud

Basically there are two major consequences of insurance fraud, start from rejection of the application for insurance policy to rejection to policy being canceled and your claims denied to prosecution.

- Rejected applications or higher premiums
- Denied claims or canceled policies

Fraud Management

There are two sides of Fraud Management viz. fraud detection & fraud prevention. Fraud detection is a set of activities undertaken to prevent money or property from being obtained through false pretenses. Fraud detection is applied to many industries such as banking or insurance. In banking sector, fraud may include forging cheques or using stolen credit cards. Other forms of fraud may involve exaggerating losses or causing an accident with the sole intent for the payout.

Luckily, predictive modeling and advanced analytics are coming into play as essential tools for fighting insurance fraud. These tools can be automated, preventing the need for hands-on manual analysis. By continuously reviewing the claims by using suspicion scores, insurers can detect patterns that reveal fraud. The System supports the businesses affected by these events (such as Banks, Insurance, Media and Tele-communication), provides them with the tools required for the assessment, control and even prevention of these practices in order to limit and avoid money and image loss and leveraging the wealth of information provided.

The first step in fraud management is identification of Fraud - In Insurance fraud there are only two types of frauds viz. -

1. Medical Billing Fraud - Identify excessive billing — same diagnosis, same procedure. Identify excessive number of procedures, per day or place of service/day. Identify multiple billing of same procedure, same date of service.

2. Claims Fraud - Identify duplicate claims - Review submission of multiple/inflated claims.

The second step is to prevent insurance fraud:- Prevention is costly and detrimental to insurance companies' bottom line. To avoid expensive litigation and other costly measures, it is utmost necessary for the insurance companies move forcefully against fraud. As technology improves and automation processes become the norm, the chances for data manipulation, identity fraud and insurance fraud will increase. The insurance environment will quickly become a haven for fraudsters unless fraud prevention methods and tools are given prominence within technology discussions.

Insurance Companies shall not wait for the fraud to occur and deal with it

after the fact appears, instead of that, by adopting a proactive stance toward fraud detection and shall take actions and implement processes that identify potential fraud early and provide the ability to move quickly when fraud is detected. Moving from reactive to proactive fraud detection there are many methods by which we can implement this procedure, which are discuss briefly as follows -

a. Initial Structure

Without this basic work enables management to make better decisions about priorities, resource deployment and investments. A foundational framework can range from an "out-of-the-box" solution that automates the institutional knowledge of your claims professionals and enables workflow management to full social networking analysis of the parties involved in a claim. From there, insurers can add a multitude of scoring engines, third-party data captures, criminal history lookups and many other tools. An important aspect of fraud detection is having a culture in your claims staff that emphasizes the importance of recognizing, identifying and investigating suspicious claims. Empower your staff to be involved, and then the tools you deploy will function much more effectively.

b. Find out the relative level in potential fraud

Knowing the relative level of potential fraud, for every type of claim allows the best, and quickest, action to be taken to maximize special investigative unit (SIU) efficiency and savings. With limited resources to devote to fraud, it is important to make sure your investigations can be focused on the items that have the greatest potential

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for cost avoidance and successful identifications. For example, a theft claim involving the suspicious disappearance of expensive jewelry has a higher potential for being fraudulent than a stolen smart-phone or laptop. Examples of common false claim schemes include deliberately destroying property and misreporting the cost of auto repairs.

c. Role of data analytics

Fraud comes in all shapes and sizes. In general, insurance fraud can be divided into two categories: criminal fraud, which is perpetrated by professionals habitually trying to milk the system; and cultural fraud, which is a genuine claimant being opportunistic or exaggerating a claim.

Data analytics can be applied to detect fraud. By analyzing past fraud, insurers can use predictive modeling to produce what is called a "Suspicion Score," a value for the propensity of fraud. The process works like this: Adjusters simply enter data, and claims are automatically given a Suspicion Score to indicate the likelihood that fraud has occurred. The technology behind this involves utilizing data-mining tools and applying quantitative analysis. Even with automation and data analytics, the weakest link in fighting fraud can be your own employees. The importance of checks and balances cannot be stressed enough.

d. Review and Rescore claims

Success in combating insurance fraud comes from persistence and good timing. Above all, applies our arsenal of tools — including data analytics and predictive modeling — early and often. Claims should be continuously monitored for fraud potential. As an insurance company, it is imperative that you target the right claims, at the right time, with the right tools. Luckily, predictive modeling and advanced analytics are coming into play as essential tools for fighting insurance fraud. These tools can be automated, preventing the need for hands-on manual analysis.

By continuously reviewing and rescoring claims using Suspicion Scores, insurers can detect patterns that reveal fraud. Some claims score high immediately at first notice of loss, prompting your SIU to get involved immediately. For others, high scores do not show up until after the claim has been collected.

e. Adopt a layered approach

In judicial process it is tier system where as in the IT world, it's "layered approach" refers to using a variety of tools and technologies to tackle a challenge. Fraud is a complex, multifaceted problem, and no single method can detect all

fraud. Each fraud-detection method needs to be crafted to address a specific area. Different rules and indicators are needed for different types of policies and claims. Plus, fraudsters hide in multiple databases, so fraud-detection methods must search them all.

The modern insurance organization has a number of technology tools at its disposal to detect fraud. For example, videos, photos and even live-streaming can be used to document evidence at a car crash or crime scene.

f. Revise based on market conditions

Criminals are ever resourceful, so always be ready to quickly adapt to changes in the ways fraud is undertaken, as well as changes in your industry. For example, professional criminals are sophisticated enough to become familiar with the analytical approaches that insurance companies use to detect fraud, and to change their tactics when committing fraud. As fighting fraud becomes more proactive, insurers must spot new fraud trends early and take steps to stay ahead from the bad guys.

g. Implementation

Companies can use a combination of technology, tools and approaches to combat fraud. Through it all, industry leaders must never forget that their focus should not only be on the technology tools they use in detecting and fighting fraud, but also on the human beings in their own offices. Always emphasize fraud training and awareness, implement checks and balances, and be ready to adapt quickly to changing market conditions.

Following attempts, that insurers are taken to condense the frauds –

- Insurance claim personnel are given fraud detection training and if suspicions arise, the claim(s) are referred to specialist claims teams or investigators for closer review.
- Insurers have teams of specialist claims investigators. These personnel undergo insurance training and fraud detection training. They are the front line of the fraud detection sector for the industry.
- The general insurance industry has maintaining register of insurance claims, which is used to check whether full disclosure of claims history has been made and whether claims for the same loss are being made from more than one insurer. The ICR has been operating since 1999 and has over 7.5 million claims in the database.
- In case of fire Insurance, the insurance company appoints specialist fire investigators to check for suspicious circumstances that might indicate fraud.

Conclusions

- ❖ As India's insurance industry matures, fraud risk management is going to be a major concern for insurers and business leaders. Insurers will have to continuously monitor their processes and policies to manage and mitigate the risk of frauds.
- ❖ Every year, the general insurance industry pays around Rs 70,000 crore in claims mostly towards motor, health and marine cases. "If frauds reduce, claim ratio improves, it makes a case for lower premium,"
- ❖ Insurance fraud detection is a challenging problem, given the variety of fraud patterns and relatively small ratio of known frauds in typical samples. While building detection models, the savings from loss prevention needs to be balanced with cost of false alerts.
- ❖ This is urgently required as the Indian Insurance Act does not contain a definition for insurance frauds. "Neither do we have any specific laws connected to insurance frauds which are spelled out in the Indian Penal Code, 1860. The Indian Contract Act, 1872 also does not have any specific laws pertaining to insurance frauds.
- ❖ Integrated claims systems improve detection In order to help effectively prevent fraud leakage, life insurers with property/casualty books need to connect the dots on claims across multiple lines of business—and they need a systematic and automated way to do it.
- ❖ Life insurers can face a numerous challenges today. Some of those issues have plagued the industry for years—such as stagnant premium growth and low interest rates—while others are new—like changing customer expectations and disruptive innovations such as on-demand policies and self-underwriting.
- ❖ There are some barriers to effective fraud control, including that
  a. fraud is not self-detecting
  b. proving fraud is difficult
  c. fraud is a dynamic, constantly evolving phenomenon
  d. fraud control processes are not well understood
  e. lack of collaboration with law enforcement agencies
  f. return on investment in fraud detection is hard to quantify
  g. Prevailing other strategic objectives.

Authors View

- ✓ As technology improves the chances for data manipulation, identity fraud and insurance fraud will increase. The insurance environment will quickly become a haven for fraudsters unless fraud prevention methods and tools are given prominence within technology discussions.
- ✓ It takes a combined team effort (a collaborative approach) to fight back against insurance fraudsters. No individual organization or agency has the resources to single-handedly stop it. By combining resources and the expertise of insurers, law enforcement agencies, insurance fraud can be detected, deterred and prevented.
- ✓ Financial frauds are associated with sophisticated urban areas. But when it comes to insurance frauds, rural India has taken the lead due to various reasons. By creating database for fraudster, such malpractices may not be contained without strict punishments under penal code.
- ✓ Everyday policyholders may also try to be more creative with their insurance claims when the economy is in a down cycle. Keep your claims staff aware of the type of market conditions the policyholders are facing so the staff can be on the lookout for new and inventive fraud attempts that may be unknown to the software in place.
- ✓ Insurance Companies shall not wait for the fraud to occur and deal with it after the fact appears, instead of that, by adopting a proactive stance toward fraud detection and shall take actions and implement processes that identify potential fraud early and provide the ability to move quickly when fraud is detected. For the matter, we shall have dedicated department to control/prevent this risk (fraud).
- ✓ The absence of strict punishment or a jail term, like for criminal activities, there is a need to amend some laws that give access to insurers and/ or there is a need to draft separate law for such frauds, which will be supersede the existing provisions of pro-consumer statute – Consumer Protection Act.
- ✓ In case of Life Insurance fraud, Insurer being the trustee of widows money, it is strongly recommended to formation of fast tract Court for persons who found guilty.
- ✓ On similar ground of Credit Information Bureau of India Ltd (CIBIL), the government should make provisions of data bank to get the details of an individual's insurance history and his claims record whenever they get a new proposal.
- ✓ Alongside external fraud risk, there is possibility of internal fraud (Novel Fraud), the severity of such frauds can range from a slight exaggeration to deliberately causing loss of insured assets. There is need to put equal focus on this issue.

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The completion of this article (Insurance and Fraud Management) necessitates more than academic rigor. It culminates in the support of many Insurance Companies (both Life and Non-life and also PSU and Private), I would be thoughtless if I stop and didn't reflect upon those people – who have offered support and encouragement to complete this article. I would like to give a special thanks to following, for making my paper easier, interesting and research-full without which it had been not possible to author this script.

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Insurance Fraud: Eliminate Fraud, Do Not Endeavor to Manage It

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Abstract

Fraud, not only in insurance but in any field of human activity, is not something to be managed. Firstly it should not come up; secondly if it comes up it is to be eliminated, not managed, for fraud vitiates personal, social and commercial activities. It takes away the lubrication of honesty from social intercourse. Fraud is a deviation from normal activity of any individual. The International Association of Insurance Supervisors (IAIS) defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties." After defining 'fraud' the article proceeds to narrate and analyse two real life cases of fraud, one from USA and the other from India. It concludes suggesting one should never protect a fraudster. And appropriate law must be set in motion, like the PC Act or investigation agencies should be pressed into service.

Introduction

Fraud, not only in insurance but in any field of human activity, is not something to be managed. Firstly it should not come up; secondly if it comes up it is to be eliminated, not managed, for fraud vitiates personal, social and commercial activities. It takes away the lubrication of honesty from social intercourse. Fraud or acting fraudulently is a deviation from normal activity of any individual. The International Association of Insurance Supervisors (IAIS) defines fraud as "an act or omission intended to gain dishonest or unlawful advantage for a party committing the fraud or for other related parties."

The legal aspect

Let us understand 'fraud' from a legal definition given in the Indian Contract Act, 1872[i]. 'Fraud' means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent, with intent to deceive another party thereto or his agent, or to induce him to enter into the contract:— —'Fraud' means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent1, with intent to deceive another party thereto or his agent, or to induce him to enter into the contract\:—"

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

(2) The active concealment of a fact by one having knowledge or belief of the fact;

(3) A promise made without any intention of performing it;

(4) Any other act fitted to deceive;

(5) Any such act or omission as the law specially declares to be fraudulent. Explanation.—Mere silence as to facts likely to affect the willingness of a person to enter into a contract is not fraud, unless the circumstances of the case are such that, regard being had to them, it is the duty of the person keeping silence to speak, or unless his silence, is, in itself, equivalent to speech". Intent to deceive is the soul of 'fraud'. "A person is said to do a thing fraudulently if he does that thing with intent to defraud but not otherwise'[ii]

Forgery is generally a companion of fraud. 'Whoever makes any false document or part of a document with intent to cause damage or injury, to the public or to any person, or to support any claim or title, or to cause any person to part with property, or to enter into any express or implied contract, or with intent to commit fraud or that fraud may be committed, commits forgery'[iii]. The Institute of Internal Auditors' International Professional Practices Framework (IPPF) defines fraud as: "… any illegal act characterized by deceit, concealment, or violation of trust. These acts are not dependent upon the threat of violence or physical force. Frauds are perpetrated by parties and organizations to obtain money, property, or services; to avoid payment or loss of services; or to secure personal or business advantage"[iv]

In the early days of evolution of insurance it was used as a means of gambling – as insurance on the lives of kings (purchased by strangers) and this led to the banning of life insurance in France, Holland and Sweden during the sixteenth and seventeenth centuries.

Insurance and Fraud

Insurance frauds are always deliberate deceptions, by a company or against a company, by an intermediary or against an intermediary, by a customer or against a customer or customers. Fraud has always been considered a sensitive issue by the industry as well as the general public. The operation of insurance business does not stop at national boundaries and fraud / acting fraudulently makes its presence in all aspects of the business viz. life, non-life, health, agriculture, export credit guarantee, deposit insurance, re-insurance and retrocession.

Some situations where policyholders move for dishonest gains are through:

(i) deliberate suppression of facts in the proposal itself – suppressing age, personal and medical history, family history

(ii) suppressing facts sought by the KYC norms – I know a case where a proposer submitted a proposal in a Kerala office of an insurer but the party had no proof of address in Kerala; on enquiry it was revealed that he lived in Hyderabad. On the insurance underwriter insisting on proof of Hyderabad residence, he gave his driving licence, which showed that he lived in Punjab

(iii) submission of false claims, on the basis of false Death-certificate even when the assured is alive, claiming accident benefit when there was no accident at all, "padding" or inflating claims in non-life insurance etc.

(iv) organised criminals, dishonest professionals, insurance intermediaries and some employees too intelligently programme siphoning out of Company's money and wealth.

'The FBI estimates that the total cost of insurance fraud (excluding health insurance) is more than $40 billion per year. Insurance fraud costs the average U.S. family between $400 and $700 per year. In the late 1980s, the Insurance Information Institute interviewed claims Adjusters and concluded that fraud accounted for about 10 percent of the property/casualty insurance industry's incurred losses and loss adjustment expenses each year. Using this measure, over the five-year period from 2013 to 2017, property/casualty fraud amounted to about $30 billion each year. The figure can fluctuate based on line of business, economic conditions and other factors. The Coalition Against Insurance Fraud (CAIF) estimates that workers' compensation insurance fraud alone costs insurers and employers $6 billion a year'[v].

'Over 56% of life insurers surveyed said that they have witnessed a 30%

rise in frauds, while 7% said there is a spike of up to 50% in the same'[vi]. 'A report by the consulting firm Ernst & Young (E&Y), based on survey of insurance professionals, has said the rising transactions with third parties, data privacy concerns and gaps in operational processes have augmented financial crime risks in the life insurance sector[vii]. We have a good example for the notorious abuse of insurance in what is known as the "Blue Eyed Six". Intent to deceive, crime and abetment of crime are all involved in this insurance case; let us see it in detail.

The Blue Eyed Six[viii]

On July 8, 1878, one of the strangest murder plots in Pennsylvania history began with the purchase of four insurance policies in Lebanon County…. The life insurance policies on Joseph Raber should have earned the policy-owner's a large payday for 1878. They totalled more than $8,000 and insured the life of a man who his killers believed should have been dead already. Raber was an impoverished old man who lived in an old charcoal burner's shack in the mountains. He was too ill to work and depended on the charity of others to survive. Officially, "charity" was just what his four neighbours --- Israel Brandt, George Zechmanm Josiah Hummel, and Henry Wise -- were offering him. The type of insurance they bought was called assessment insurance, also known as "graveyard insurance." It was primarily sold to guarantee that the insured would have enough money to be buried when he died with a little extra for his survivors. The concept of assessment insurance was simple; the insured paid a premium to join a pool then when any of the members died, the rest in the pool were assessed a certain amount that was then given to the beneficiaries.

But Raber was relatively healthy and showed no signs that he would be dying anytime soon. The constant assessments required to stay in the pools quickly became a financial hardship for his insurers. They realized that they could not afford to let Joseph Raber live any longer. Just a few months after the paperwork was signed, the four conspirators hired two assassins to kill Joseph Raber. Israel Brandt approached his neighbor, Charles Drews, and offered him $300 to kill the old man and promised he would get the same amount from the other conspirators after the job was done. Drews, in turn, sought help from Frank Stichler, a local thief – the final blue-eyed man.

Around dusk on Saturday, December 7, 1878, Drews went into the tavern that was located at Israel Brandt's hotel and told people there that Joseph Raber was dead. That afternoon, he and Stichler had paid a call on Raber and offered him some tobacco if he would accompany them to Kreiser's Store. Raber agreed to go with them. The trip to the store had required crossing Indian town Creek on a crude bridge made of two twelve inch planks. Drews said Raber had a dizzy spell part way across, fell into the water, and drowned. The following day a coroner's jury examined the body and declared the death accidental.

But no one was fooled for long. Too many people in Lebanon County knew about the plot and word eventually reached the insurance company that had provided the policies. They pressed the local police for answers. They soon had a witness to what had occurred on the crude bridge – a man named Joseph Peters had witnessed Stilcher showing Raber into the water and then holding him under until he drowned.

Soon, all six men had been arrested.

Newspapers in America and overseas followed the case. It was the first time in the history of English and American law that six men would be tried together for murder. Reporters from distant cities came to the Lebanon County Courthouse to witness the proceedings. One of them observed that all of the defendants had piercing blue eyes; from then on, referred to them as "The Blue Eyed Six." The unusual nature of the crime and the striking nickname given to the killers inspired Sir Arthur Conan Doyle's Sherlock Holmes story, "The Red-Headed League."

After five hours of deliberations by the jury, all six were found guilty of the murder in April 1879, though one of the conspirators, George Zechman, was later granted a second trial and acquitted due to lack of direct evidence against him. The remaining five were sentenced to death by hanging'.

The Postponed Death[ix]

John had a life insurance policy covering risk on his life. The policy was in lapsed condition when he died on 5th April 2000. Premium on the policy was paid after death of the life assured. Exactly one month after the death, on 5th May 2000 it was registered in the neighbouring village with the government authority charged with the job. After obtaining the death-certificate the nominee of the policy gave an intimation to the insurer about the death and later submitted claim papers. The Agent of the company Alice extended all assistance to the widow in completing the claim papers etc. The insurance company paid the death-claim without any delay. After some days the life insurance office received a post-card informing that the insurer has been cheated and a false claim is paid since

John died on 5th April (and not 5th May) and that the policy was in lapsed condition at the time of death.

The Head of the insurer's regional office handed over the post-card to the Manager (Legal) and asked him to look into the bonafides of the claim. News-papers in the region followed a graceful practice of covering deaths reported in their 'Obituary page' free of cost and every news-paper devoted one page daily to report deaths. The Manager (Legal) collected a newspaper of 6th April 2000 wherein the death of John was reported with house name, family details and special accomplishments of John. So the post-card of the anonymous sender spoke truth. Legal action followed and the widow (nominee) Elizabeth reported that the Agent had collected Rs 20000 from her for 'the services rendered'. The widow claimed that she was illiterate and that the insurer's Agent had advised her to do all wrong things (like postponement of date of death, payment of premium after death etc.) and for whatever was done by the Agent the responsibility rested with the insurer and not the claimant.

Briefly Analysing the Cases

In 'the blue-eyed six' insurance was purchased for getting death claim on the life of a man on whom the proposers had no insurable interest. The life assured and proposers were not related. In those days neither relationship of any type nor insurable interest was a requirement for insurance. Fraud was the intention behind purchase of insurance. The proposers who were the beneficiaries desired death of the life assured and engaged two men to carry out their objective. Murder was carried out. Murder plus abetment of murder was the charge. Obviously the punishment was death penalty.

In John's case on enquiry from the insurance office the nominee was aware that the policy was in lapsed condition. However the Agent advised her to pay the premium and register the death in another village. The Agent only completed all the papers for claim and wherever witness's signature was required the Agent only signed. She assisted the nominee in registering the death in another village. The Agent took Rs 20,000 from the nominee. It was a clear cut case of fraud played on an insurer. In the court when all lies were exposed the lawyer of the nominee took the plea that she was illiterate and she was misguided by the Agent of the insurer for which the insurer must be answerable. The Manager (Legal) who represented the insurer told the court that this nominee is thirty-five years of age and all people between the ages six and sixty are declared literate by the government of the State. The court decided the case in the insurer's favour.

To Conclude

Insurance sector represents the society. All wrong-things in society will have its reflection in insurance sector too. If value-system of the society falls it is bound to cripple insurance industry as it is based on "trust'. If someone is out there to outfox the industry's goodness .he deserves to be handled with stern action. The perpetrator of fraud may be an employee, an intermediary or someone in the senior ranks of the company or a customer. He must be made to compensate the company and he should be shown the exit door. How does fraud creep in to the system of insurance company working? Insurance Industry has two excellent systems in working: (i) a strong and comprehensive corporate governance programme, which can be skipped only to land in a loss and (ii) insurance companies do have a thorough system of well laid processes and procedures in working.

Skipping of any stage in the procedures can lead to a loss, may be loss resulting from a fraud. So the inspection and internal audit team and the concurrent auditors cannot miss such lapses. It should come under their scanner. The senior management can take timely corrective action. Statutory auditors can also generally find out frauds in the nature of wrong payments, excess payments, unauthorised payments, repetitive and doubtful pay outs. At corporate governance level there will be many Board approved policies regarding various major expenses. It is always better to bring doubtful payments to the notice of senior officials of the company, that too in-writing. One should never protect a fraudster. That should be a Company policy. And appropriate law must be set in motion, like the PC Act or investigation agencies should be pressed into service.

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Insurance Fraud in India– Detection and Management

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'Would you agree that the only person who can take care of the other person you will someday be- is the younger person you are now?' – anonymous.

Abstract

The motive of the article is to understand insurance frauds, how to manage, and reduce these fraudulent activities to achieve a zero-harm goal. The insurance industry is an emerging sector in the Indian economy which deals with risk-taking of the unforeseen losses and builds trust amongst the customers and the stakeholders. The Insurance sector is at a constant threat caused by an alarming increase in the fraudulent activities affecting the trust of consumers, investors, and also the financial sectors. Reducing and controlling fraudulent activities has become a priority for the Indian insurance industry.

Keywords

Fraud, Insurance, Data, Analysis, Quality, Detection, Digitization, Trigger.

Introduction

Insurance is still an emerging market in the financial sector of the country. With an increase in awareness and financial literacy, we see a rise of investment in insurance policies amongst the people of India. Insurance provides security to the unforeseen risk suffered by an individual, organization, and the financial sector. According to a report by IBEF insurance industry penetration saw a steep increase in 2017 as it reached 3.69% from 2.1% in 2001 in terms of premiums as a percent of GDP and it is anticipated that the overall insurance industry is expected to reach $280 billion by 2020. As the country comprises of the population belonging from all

the spheres of economic strata, the premiums vary from minimal to high range based on the benefits that can be derived from the insurance policies.

As we see the insurance industry getting itself merged in the life of the population, a constant threat of fraud is always following them. Insurance fraud as defined by International Association of Insurance Supervisors (IAIS) has defined fraud as "an act or omission intended to gain a dishonest or unlawful advantage for a party committing the fraud or for other related parties", simplistically, we can define insurance frauds as the crime of acquiring money or property by deceiving people or organizations. According to business today India report, "Insurance Frauds Control Act; an urgent need in India" by SK Shetty, shows fraud has already blown a hole in the pocket of the insurance industry by ₹45000 crore in 2019. Minor unreported errors and mistakes lead to encouragement and occurrence of frauds in the organization, so treating those minor errors as triggers in detecting fraud and implementing proper measures to control them can help in protecting insurance industry from this threat. Insurance frauds not only affect the customer's belief on the insurer but also reduces the investors' trust and play a pivotal role in affecting the stability of the current economic scenario of the country.

The Indian Penal Code, Indian Insurance Act, and the Indian Contract Act doesn't define insurance frauds neither there are any laws pertaining to insurance frauds or even penalizing the act of fraud. Fraud is illegal and is done based on the will of the parties to purposely have a financial gain. Due to the absence of proper laws and severe penalties against the insurance frauds, the pursuant rarely wins and if wins the penalty is not enough to compensate for the loss incurred due to such fraudulent activities.

Types of Fraud

IRDA guidelines categorized insurance frauds as:

1. Policyholder fraud and/or claims fraud – Fraud against the insurer in the purchase and/or execution of an insurance product, including fraud while making a claim.
2. Intermediary Fraud – fraud perpetuated by an intermediary such as insurance agent, corporate agent, and third-party administrators (TPAs) or reinsurers against the insurer and or policyholder.
3. Internal Fraud – fraud/miss-appropriation against the insurer by a staff member.

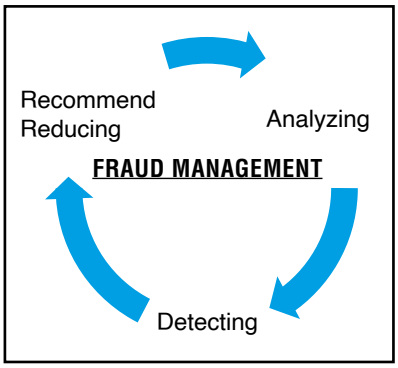
How to Manage Fraud?

The population is impassive about the severity of insurance frauds, they are not aware that frauds affect the premium rates, resulting in severe guidelines followed in the underwriting of policies. Honest customers are getting affected due to the long investigation for claim processing and this not only hampers the customers but also the service provider because their reputation in the market deteriorates and the country's economy can also see a downfall as the pace of the insurance sector is changing from time to time.

In 2013, IRDA has set up guidelines for forming the Insurance Fraud Monitoring Framework, where the organizations are asked to stipulate certain processes to regulate the varied kinds of risk that are faced by the industry. As per the guidelines, formatting Anti-fraud policy and setting up the Risk Management Committee (RMC) is mandatory by all the organizations to manage, detect, and combat the fraudulent activities.

All insurance companies should set up their standard anti-fraud policy and get it approved by the higher authorities, the anti-fraud policy should include the process for monitoring fraud, areas of interest of fraud, communicating with the law imposition agencies, the process of exchanging information in the organization to make the staff aware of the fraud and also setting up strong whistle-blower policy.

Detecting, analyzing, recommending / reducing are the steps that should be implemented by the insurers to manage and reduce such fraudulent activities.



Trigger

An alert system should be applied in the organization for early detection for any kind of threats and proper action should be taken out for restricting the threat. The alert can also be termed as a risk management trigger, which can be evaluated and controlled by various system functions or investigating through physical life. The triggers only notify the organization for an unusual pattern for a possible fraud that needs investigation before processing the claim.

Digitizing to Detect Fraud

The use of digital technology in the insurance sector has helped to reach out many, for booking of policies by agents, getting details of the organization, meeting up of queries of the customers/ agents, registering complaints or getting updated about new products and also for online claim submission of insurance. The plan for a fraud is initiated from registering for the policy to the issuance of policy by manipulating the details, and also during claim submission request. The evolution of the digital era has made organizational life easier by enhancing business progression and detecting frauds, while digitization is a boon, it acts as a curse for the criminals taking the help of digitization for committing fraudulent activities.

The anomaly of unanalysed unstructured data leaves a lot of space for a fraud going unnoticed. Adapting to the advancement in data analytics by analysing data quality, managing the data, deletion of unwanted data, social network analysis are effective ways in recognizing the fraud rings that are constantly surprising the industry by developing new scams.

The areas that need to be concentrated on while detecting fraud are customers, agents/brokers, applications, policies, providers, employees, participants, claims data such as multiple claims, immediate claim after policy being taken or after enhancement of sum insured, claims done by untraceable person where the given address is not reachable by the courier services. These data should be stored in a structured format for analysing as they act as triggers by conducting data profiling, deletion of mistyped data, standardizing the data, and then running the resolution to identify the hidden connections between the data. Triggers are based on the previous history of faulty data and link between the histories of concealed data between the participant's details. The low incident details can be achieved by a sampling of the data and analysing them.

Deciphering the data play a major role in the identification of the fraud rings. As the industry receives data in abundance, the quality of the data needs to be organized by sampling them according to the standards followed by the organization for analysing. After standardizing the data, Extract, Transform, and Load process is implemented for securing maintaining, and modifying the data for future references. Various software's are used for data quality. Analyzing the data gives a substantial result and helps in detecting frauds by the claim teams and investigating teams as there will be an increase in positive alerts for any suspicious claims.

Predictive analysis is used in big data analysis for fraud detection by using text mining and sentiment analysis. Text mining is done with the data received in an unstructured format via emails, social media, police documents, customer interaction notes, etc. Text analytics tools are used to check for new patterns of fraud. The story of the incident for which a claim request has been submitted for, gets altered from time to time, such minute changes can go for amiss by the claim officer, but by applying analytical tools it can spot the unusual patterns, and hence it can be stopped.

Social Network Analysis (SNA)

Social network analysis is investigating social structures with graphs and network theory (Wikipedia).SNA uses a mixed approach to analyse the data which includes the firm's business rules, statistics, network and the pattern of the cases to decipher the links. SNA helps in fraud detection by linking the patterns of how the claimants, participants, brokers/agents, investigators, providers are interconnected. Analysing the interconnection can help in scoring the claims, the high score indicates the chances of a claim being fraudulent. The graph theory in SNA represents the links between the individuals as well as the other resources and the links between individuals who have the tendency of linking up with the same kind of individuals who are involved in such fraudulent activities. Reducing the fraudulent activities by implementing an organisational and governmental intervention.

Organizational Intervention

1. Educating and creating awareness amongst the staff at all levels, the stakeholders, the third-party administrators, and to customers as well.
2. Inclusion of clauses in the policy, illustrating the actions that will be taken in case of fraudulent activities including the penalization and the punitive actions.
3. Training programs should be conducted by the organization for fraud investigation.
4. Whistle-blower policy or the reward system policy for any staff members alerting the organization for a suspected threat of fraud.
5. Introduction of advance digital tools for detecting and deterring frauds.
6. Dis-empanelment of the participant indulged in the fraud.

Government Intervention

1. The government must put regulatory actions against the licensed entities in the insurance industry.
2. As discussed above there is no specific insurance law in the IPC,

ICA, or Insurance Act of India, so insurance laws should be made and followed, more specifically for insurance fraud, and according to the regulations should be reviewed by IRDA.

3. Claw back provisions should be implemented for recovering the losses incurred due to fraud.
4. IRDA has also asked the licensed private and public organization to form their anti-fraud policy and Risk management team for the detecting and reducing fraudulent activities.
5. Awareness campaigns should be held by IRDA regarding the fraud and impact of fraud on the consumers and the employees of all levels in the insurance industry.

The Way Forward

The industry is doing a lot to prevent fraud but still, it needs stricter actions, penalties, and use to digitization to bring down fraudulent activities in the industry. The fraudster will always create a new way to carry out fraud in the industry, but the industry needs to be a step ahead for suppressing such activities, by adapting themselves to the updated visualization and analysing data. Cross-pollination of fraudulent activities details should be encouraged between inter and intra-organization to create a safe industrial environment. Each department should be trained with customized fraud detection and prevention. The IPC should include an act against Insurance Fraud, wherein one can ask for legal assistance to identify, punish, and penalize the fraudsters.

The insurance regulatory board should make a rule for the insurers to check the credit of the individuals seeking to buy a policy by doing a background check of the insurance and claim history, also asking the consumer to update KYC while purchasing the policy, should be made mandatory for verification. A periodic internal audit should be carried to monitor the fraud and should be reported to the IRDA about the fraud cases that are closed or still outstanding before the financial year ends as instructed by IRDAI in Insurance fraud monitoring framework. There should be recovery audits every year, corrective action plans should be planned, and necessary changes should be formulated in the existing policies for preventing any future fraudulent activities. An in-depth fraud monitoring assessment should be carried out across all the verticals of the organization to sight the risk factor and prepare proper measures to control in preventing the detected fraud.

Conclusion

"Corruption, embezzlement, fraud, these are all characteristics that exist everywhere. It is regrettably the way human nature functions, whether we like it or not. What successful economies do is keep it to a minimum. No one has ever eliminated any of that stuff." ~ Alan Greenspan

As mentioned earlier advancement in technology and digitization is not only helping the insurers and the industry but also the fraudsters who are using those technologies to try out new ways of scamming the industry. With the help of data, the industry is able to detect new fraud, because these data are generating new triggers to detect fraud and act on them to reduce it. Detecting and preventing fraud in the organization is not only the duty of the risk management committee but for all the employees and the fraud management strategy the organization is following. Proper anti-fraud policy, detecting and preventing fraud, adapting to technological and analytical advancements, the proper awareness campaign should constitute a standard fraud management framework.

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Introduction

India is a huge market for insurance, but the industry is bleeding losses due to fraud. Insurance fraud leads to around Rs 40,000 crore every year and makes up for 8.5 per cent of the revenue that the industry generates[1]. Insurance fraud is criminal or wrongful deception aimed at making wrongful personal gain or to deprive a victim of lawful rights from insurance contracts. Such fraud is perpetrated by both the insured and the insurance company. Insurance fraud from the insurer (seller) includes selling a type of insurance product as another type of financial products (insurance/ noninsurance), selling policies from non-existent companies, failing to submit premiums, and churning policies to create more commissions. Insured (Buyer) fraud can consist of exaggerated claims, falsified medical history, post-dated policies, viatical fraud, faked death or kidnapping, and murder. Though financial frauds are generally thought of as urban phenomenon, rural India has taken a lead. Despite of generally poor penetration of the both life and nonlife insurance, there are some districts where the insurers fear to tread as experience has been poor due to widespread fraud. Insurers have identified at least 80 districts across the country which have excelled in fraudulent claims over the past decade. They have identified rings that operate with the efficiency of a corporation with well-trained men and women who collect data with the efficiency of a 21st century start-up[2]. In fact, fraud is one of the reasons which are stopping spread of insurance in rural India.

Insurance as a business is much dependent on the basic principal of "uberima fide" or utmost good faith. In some of the rural areas the environment is so vitiated with frauds, that no insurance business may be conducted in these areas. No branch of insurance, be it life, be it crop, be it motor, be it health, be it accident is untouched by the stains of the fraud.

Life Insurance

In life Insurance there have been cases where the terminally ill people with

diseases like cancer are insured. This is facilitated by the fact that life insurance agents are under pressure to procure business under competition and not much of underwriting is being done. There have been instances where dead people are insured. Such fraudsters exploit sec 45 of the insured act, pay premium and do not put claim for 2 years[3]. There has been instances where the whole chain has been formed to defraud insurers including all the stake holders. Insurers are stumbling on strange cases where the police, panchayat sachiv, lawyers and family members are hand in glove to push claims where the policyholder is still alive, where a person is made to sign a policy on her death bed, and even where a policyholder is simply a fictitious character. While for ages insurance crimes have been a fodder for movies and thriller stories, what has surprised insurance companies this time around is the organized nature of the frauds and their rising number: cases of fraud have risen to 2-4 per cent of total rejected claims from well below 1 per cent a few years ago[4].

Health Insurance

Health Insurance is a business that is rife with rampant fraudulent practices. Hospitals and Medical practitioners are widely suspected to be part of ecology defrauding health insurers. Price of processes are inflated, Diseases and processes which are not covered are disguised as diseases and processes covered under insurance, pre-existing conditions are hidden, diseases faked etc. Many health insurance companies pay in cash for the hospitalization expenses incurred or reimburse the amount spent on medical treatment or surgery carried out. However, some view buying health insurance plans as a way of earning profits. These customers submit forged bills and claim money even if the insured have not been hospitalized or no medical expenses incurred on their treatment. Submitting inflated medical bills also amounts to fraudulent practices and classified as a kind of insurance fraud in India. In rural areas, there are some institutes who have few qualified medical practitioners on board for fulfilling legal formalities, but actual work is carried out by non-qualified personnel.

Accident Insurance

At least 150,000 people are killed in road accidents in India every year[5]. While a lot of people killed in such accident fail to get any compensation from accident insurance policy. There are some people who are not killed by accident get the benefit of accident insurance. In these cases, accidents have been faked. There has been one reported case with spread from Rohtak to Hisar, Haryana where the Haryana-based gang of fraudsters allegedly identified terminal cancer patients from rural, low-income backgrounds, got them to insure themselves with multiple companies by hiding their condition, waited for them to die, and then put their dead bodies through “accidents”.

Crop Insurance

This is a business which has seen huge claim out goes due to fraudulent practices. There were cases where farmers didn’t even cultivate anything and had yet paid up premium for crop insurance under Pradhan Mantri Fasal Bima Yojna Scheme and had received insurance money. Some had registered inflated land areas so that more compensation could be claimed. In some cases, the farmer would get a crop-sowing certificate from the land revenue officer. A few days later, he would go back to the officer saying he had changed his mind and would be sowing another crop and hence would need another certificate. The farmer would take these two certificates (the earlier one wasn’t cancelled) to two different banks and pay the insurance premium for both the crops, but sow only one crop. In these cases, insurance claims were admitted for both the crops[6]. As PMFBY, the largest yield-based crop insurance depends on area approach with yield being recorded through crop cutting experiments where sample yields are assessed at field level there has been widespread fraudulent practices In some areas. Here the yield as reported by agricultural department varies with market arrival report. The fields are preselected on random basis for crop yield assessment. Once the identity of the field has become common knowledge, the crop is deliberately neglected so that poor yield is reported. There are instances where proper harvesting is not done so that yield loss is due to bad harvesting rather than actual production. In the individual field-based approach there has been instances of collusion with assessors to report poor yield. There have been instances of crop loss being reported from fields where nothing has been sown in first place. In some areas crop damage is deliberately staged as market price for the produce is less than sum insured. In weather insurance, weather stations are tempered with so that claims may be received. This is facilitated by the fact, that most of the times Automatic weather stations are in isolated places left unattended.

Livestock Insurance

In India, cattle insurance claimants are required to cut off part of the deceased animal’s ear with the punched ear tag and submit it to the insurance company. This leads to concerns regarding the relatively primitive system’s vulnerability to fraud. When a cow or other farm animal such as a goat or a camel is bought, a veterinarian attaches a tag carrying a unique identification number to its right

ear. If the animal dies prematurely, the veterinarian will perform an autopsy and submit a report to the insurance company along with the severed ear. Many times, the ear is taken from the slaughterhouse and punched with a tag. The insurer is then informed over the weekend about the animals' death, and by the time an inspector arrives at the scene, the carcass is already decomposed, leaving only an ear and a medical report. In many cases, even the veterinarians and bank officials are in on the scheme[7]. This has led to insurance companies to shy away from livestock insurance business.

Motor Insurance

Tractors and other agricultural implements such as harvesters etc which are motor vehicle in nature are to be mandatorily insured as per Motor Vehicles Act. These insurance policies have their fair share of fraudulent claims. These vehicles may be used for purposes other than their intended purposes which are not covered under policies. Losses under such use are disguised as the loss under insurance cover. There are instances where sum insured has been inflated and losses inflated. There are instances where the tractor has been sold in different jurisdiction and shown as stolen/ fully damaged.

Remedies

As there are fraudulent practices harming insurance business there are remedies to reduce such practices. Some are to be taken by the insurers themselves and some may be taken by the government to help insurers.

- **The measures to be taken by the insurers:**
  - o a good quality internal collection of information,
  - o The development of prevention and detection measures with the establishment of computer facilities (IT systems), especially use of data analytics.
  - o increasing internal control operations,
  - o Centralization and information sharing with other insurers and with the authorities as regards serious cases.
  - o The setting up of a database of incidents for established scams.
  - o Awareness-raising and training of insurance employees.
- **The measures which government can provide:**

India does not have an effective insurance fraud law despite the fact that frauds burnt a Rs 45,000-crore hole in the Indian insurance industry's pocket in 2019[8]. Most of the advanced countries where the insurance industry has matured, have put insurance fraud laws in place. Insurance fraud is classified as a crime in all the states of the USA. In India, there is no specific provision in the Indian Penal Code for insurance frauds. A few sections that have some relevance are-Section 205-false impersonation for the purpose of act or proceeding in suit or persecution; Section 420-cheating and dishonestly inducing delivery of property; Section 464-making a false document including signs, seals and forgery and Section 405-criminal breach of trust. However, these provisions are not adequate to prosecute a fraudster legally under the current scenario of organized insurance frauds. Though there has been some discussion in recent times to enact a law to prevent health insurance frauds[9], a more comprehensive law is need of time.

Conclusion

Fraud is a complex, multifaceted problem, and no single method can detect all fraud. Each fraud-detection method needs to be designed to address a specific area. Different rules and indicators are needed for different types of policies and claims. Plus, fraudsters hide in multiple databases, so fraud-detection methods must search them all. The modern insurance organization has several technology tools at its disposal to detect fraud.

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Legal Challenges in Combating Third Party Insurance Fraud

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Abstract

The world we live in is quite unpredictable and we have to look out for the risks that can be controlled beforehand so that we can sustain our living. Here, Insurance plays a key role in mitigation of such risks and gives a sense of security and safety. However, insurance is necessary because sometimes it is mandatory as per the law, like- motor insurance. It is compulsory to have a Third-party motor insurance for every motor vehicle plying on road in India. Considering the alarming numbers of accidents, third-party insurance turns out to be a helping hand to a victim or his family. Poignantly, this is also not left unaffected by fraud.

The article depicts the modus operandi of third party fraud and highlights the legal challenges faced by insurer while dealing with claims and also the efforts put up by the legislation and judiciary for combating this menace.

Keywords

Risk, Third –party Insurance, Accidents, Fraud, Challenges.

Introduction

In today's world, mankind has broadened its perspective and pushed their limits in every aspect scheming the probability of growth. With this, often comes the oblivious evil. The insurance industry is a highly rated business at present which focuses on risk management with the anticipation of uncertain peril. The insurance sector is solely the balance between contingent gain and hopeful loss. However, this balance is now being misused and is taken for granted.

Insurance is a contract whereby one party, the insurer, undertakes in return for a consideration, the premium , to pay the other, the insured or assured, a sum of money in the event of the happening of a , or one of various ,specified uncertain events. In a layman's language, insurance is protection against something wrong or future uncertainties. At any time, all parties transacting in the context of this contract are legally required to act with the utmost good faith towards one another, which obliges them to reciprocally disclose all material information known to them. If we see in today's context, this basic element of insurance i.e. "Utmost good faith" is somewhere lost resulting into increasing number of insurance fraud. Although fraud has a particular meaning in legislation, the concept of insurance fraud is often used broadly in practice to encompass abuse of insurance, and is often used without implying direct legal consequences. The term 'insurance fraud' basically means the exploitation of insurance contracts through illegal means for financial enrichment.
The basic concept of insurance i.e., protection against eventual risks is exploited.

Third Part Insurance and Fraud

A third party insurance policy is a policy under which the insurance company agrees to indemnify the insured person, if he is sued or held legally liable for injuries or damage done to a third party. The insured is one party, the insurance company is the second party, and the person you (the insured) injure who claims damages against you is the third party. It is referred to as a 'third-party' cover since the beneficiary of the policy is someone other than the two parties involved in the contract.

In India, The Motor Vehicle Act made Third-party insurance as compulsory for all vehicle-owners as per the Motor Vehicles Act. However, it covers the insured's legal liability for death/disability of third-party loss or damage to the third party property. Since the third-party insurance cover is mandatory, all non-life insurance companies have an obligation to provide this cover. Keeping with the nature of this form of insurance, the industry as also seen a large rise of third party fraud in the recent past. The main reason for such frauds is the huge amounts of money involved in them.

In ***Govindan v. New India Assurance Co. Lt.,*** it was observed that third party risks insurance is mandatory under the statute .This provision cannot be overridden by any clause in the insurance policy. Further, it has been specified in Section 146(1) that no person shall use or allow using a motor vehicle in public place unless there is in force a policy of insurance complying with the requirement of this chapter. However, still there is not cent percent compliance to this law. People are driving vehicles without any insurance as they are unaware of consequences of non-insurance and this has also somewhere led to fraud. The chief motive in all insurance crimes or fraud is financial profit.

on hearing of a road accident, an advocate immediately rushes to the spot and influences the relatives of the deceased or injured, pays some advance towards initial medical expenses, arranges for necessary documentation to lodge and support an motor compensation case, conduct the trial and enjoys a very big share in the amount awarded.

Increasing numbers of fraud claims are affecting genuine accident claims and genuine policyholders. Due to fraud claims, insurers are bleeding from the losses of third-party insurance and somewhere, it is affecting Indian economy. Premium collected by insurance company is a public money and Insurance companies act as custodian to this money. Hence, fraud committed in motor insurance is against public per se.

How is it committed?

The modem operandi of a fraud claim generally goes like this: on hearing of a road accident, an advocate immediately rushes to the spot and influences the relatives of the deceased or injured, pays some advance towards initial medical expenses, arranges for necessary documentation to lodge and support an motor compensation case,

conduct the trial and enjoys a very big share in the amount awarded. It is not surprising to mention that there had been active connivance between the persons involved i.e. the driver, doctors/ hospitals, and advocates and in some cases the concerned police stations in manipulating an accident claim.

When is it committed?

There are various stages wherein fraud can be committed by different verticals/ people:

1) At the time of underwriting – by granting insurance cover by agents or others even after having complete knowledge that the vehicle has already met with an accident.

2) At the time of accident- by arranging or implicating / substituting vehicle and driver in the FIR.

3) At the time of Admission to Hospital- By registering falsely as Road Traffic Accident (RTA) case and by issuing False Medico-Legal Certificates.

4) At the time of filing application for compensation before the Tribunal -by giving false information to employment, income, age nature of injury, dependency and disability.

Types of Fraud in Third Party Insurance

Fraud in Third party insurance can be primarily categorised in following two types:

I. **External Fraud** -These are mainly done by outside sources and generally includes:

a) Implantation or substitution of vehicle especially when the actual offending vehicle was running without Insurance cover at the material time of accident.

b) Swapping of driver, especially when the actual driver involved did not have valid driving licence at the material time of accident.

c) Conversion of Non-RTA cases into RTA cases for compensation under Motor Vehicle Act.

d) False implication of vehicles in hit and run cases.

e) Filing cases at more than one tribunal for compensation of same deceased in same accident

f) Inflated or exaggerated medical bills

g) Addition of names of affected persons by the accident, either at the time of FIR or while finalising charge sheet.

h) Implanting fake eye-witnesses to the accident.

i) Implanting fake legal heirs or dependants of deceased.

II. **Internal Fraud**- These are mainly committed by person within the Insurance Industry and this may include:

a) Issuing back dated cover notes so as to accommodate the accident which has already been taken place.

b) Issuing fabricated and bogus cover notes or policy document.

c) Forging a cover note by interpolation of dates/name of insured/vehicle no.

d) Acceptance of cover without inspection of vehicle after expiry of the previous policy or after the loss has occurred in collision with the issuer of cover notes.

Legal Challenges in Combating Third Party Fraud

The challenge of fraud control is to effectively prevent (deter), detect and investigate fraud in an automated, high-volume, online transaction processing environment without jeopardizing the advantages of automation in terms of efficiency, timeliness and customer service.

Since third party claims are settled/ decided by court's intervention and since legal procedure is involved so there are various legal challenges which on one hand, adversely affects insurance companies to combat third party fraud and, on other hand benefits fraudsters by allowing their compensation claims. These challenges can be summarised under following heads:

1. Lack of Law

It is quite unfair that we do not have any law to deal with insurance fraud. Most of the advanced countries where the insurance industry has matured, have put insurance fraud laws in place. The absence of strict punishment or a jail term, like for criminal activities, is yet another hindrance in curbing frauds. Even if individuals are blacklisted, many find ways to relocate to a different region and operate with different bunch of people. Hence, there is need for a law to stop this menace to some extent.

2. Motor Vehicle Act – A welfare legislation

It is generally perceived that the compensation in accident cases of vehicles under the motor vehicles Act, 1988 and other relevant related laws, belong to the branch of social welfare Legislation which is based more on consideration that the society under the constitution of India wedded to socialism or the social justice is bound to provide for the victims of accidents and their dependents. The provisions of compulsory insurance coverage of all

vehicles are with this paramount object and the provisions of the Act have to be so interpreted as to effectuate the said object. This object is a key element in driving courts to pass favourable judgments to claim seekers. Under the garb of welfare legislation, many fraudsters succeed in swindling the entire system.

It is true that Motor Vehicles Act is a beneficial piece of legislation. Though court may lean towards the benefit of the victim of the accident, the actual assessment of the compensation has to abide by the legal parameters and the realistic consideration emerging from record.

3. Unlimited Liability

The Motor Vehicle Act provides for unlimited liability and limited defense of the insurance companies. The liability is unlimited only in case of motor vehicle. This is the only segment where the liability is unlimited. For say, aircraft liability is capped at Rs 5 lakh and railway liability at Rs 2 lakh.

On the bottom of the insurance policy, endorsement numbers are given, limits of liability are also disclosed and the typed portion runs as under:

> *"Such amount as is necessary under Motor Vehicles Act, 1939. Limit of the amount of the company's liability under section II-1(i) in respect of any one claim or series of claims arising out of one accident is unlimited."*

The question is whether these two recitals in the insurance policy are enough to saddle the insurance company with unlimited liability to pay compensation to the third party who was injured in this case. The Third party liability was not unlimited since beginning of the MV Act. For determining this question, section 95 (2) (b) of the old Act provided that subject to the proviso to sub section (1), a policy of insurance shall cover any liability incurred in respect of any one accident up to the following limits, namely :-

(b) Where the vehicle in which passengers are carried for hire or reward or by reason of or in pursuance of a contract of employment,-

(i) In respect of persons other than passengers carried for hire or reward, a limit of fifty thousand rupees in all;

(ii) In respect of passengers, a limit of fifteen thousand rupees for such individual passengers.

"There is no restriction that the Court cannot award compensation exceeding the claimed amount, since the function of the Tribunal or Court under Section 168 of the Motor Vehicles Act, 1988 is to award "just compensation". The Motor Vehicles Act is beneficial and welfare legislation. A "just compensation" is one which is reasonable on the basis of evidence produced on record. It cannot be said to have become time barred. Further, there is no need for a new cause of action to claim an enhanced amount. The Courts are duty bound to award just compensation."

Likewise, the word "unlimited" introduced in the amended Act and also in insurance policies since there is an agreement between the insurer and the vehicle owner that in the case of accident, the insurance company will be liable to unlimited extent to the third party.

Further, if we talk about statute itself, Sec 168 of of Motor Vehicle Act, 1988 provides for just compensation which is again left in the hands of judiciary to determine.

For an instance, Supreme Court in the recent case of ***Jabbar v. The Maharashtra State Road Transport Corporation,*** has observed that the court under the **Motor Vehicles Act, 1988**, can grant compensation of any amount in excess to that which has been claimed.

It can be further elucidated by Supreme Court judgment of ***Ramla v. National Insurance Company Limited***, wherein the apex court had observed that

> *"There is no restriction that the Court cannot award compensation exceeding the claimed amount, since the function of the Tribunal or Court under Section 168 of the Motor Vehicles Act, 1988 is to award "just compensation". The Motor Vehicles Act is beneficial and welfare legislation. A "just compensation" is one which is reasonable on the basis of evidence produced on record. It cannot be said to have become time barred. Further, there is no need for a new cause of action*

to claim an enhanced amount. The Courts are duty bound to award just compensation."

Considering all this, it is not out of place to mention that since compensation involved is unlimited so insurance industry, as compared to others, is more vulnerable to fraud. If Insurance Fraud was allowed to be a business then it would rank top most amongst highest profit making business. Insurance Fraud is very simple to operate, difficult to detect and even if detected very difficult to prosecute. It is often taken for granted that Insurance Fraud is victimless.

4. Non-binding nature of Criminal court judgments

The Judgment of a Criminal Court in a prosecution arising out of a motor accident, determining the guilt or innocence of the driver of the motor vehicle concerned, is neither conclusive nor binding on the Motor Accidents Claims Tribunals, dealing with a claim petition under Section 166 of the Motor Vehicles Act, and its findings as to the guilt or otherwise of the driver are wholly irrelevant for the purpose of the trial on merits of the claim petition before the Motor Accidents Claims Tribunal.

It is also well settled that an acquittal of the driver in a criminal case, the Claims Tribunal is expected to make an independent inquiry under Sec 166 of Motor Vehicle Act to reach a conclusion whether the negligence on the part of driver of the offending vehicle had been proved on the touchstone of preponderance of probability.

It is belaw of land that if conviction is recorded by the Criminal Court, it is the best ground to hold that the driver had driven the vehicle rashly and negligently, but, if the driver earns acquittal, that cannot be a ground for dismissal of the claim petitions". Due to these principles, it is easier for fraudster like Insured/ Owner and driver to collude with third party in order to claim compensation and then to escape from criminal liability by adducing favourable evidences.

This can be well explained by referring case of ***Geeta Devi and others v. Rajesh and Others***., the issue was examined in the specific context of a case where the acquittal was on the ground of the witness turning hostile. It was held that the Tribunal is not to be influenced by the fact that the eye- witnesses who had deposed before the Tribunal had turned hostile during the course of criminal proceedings. The Tribunal is required to adjudge the case on the basis of evidence produced before it and not on the basis of testimonies given before the Criminal Court.

5. Non-examination of eye- witness

An implication of the serious nature of criminal proceedings is the higher degree of proof that is required to convict a human being of a crime. It is established that civil proceedings use the system of 'preponderance of probabilities' to determine the rights and liabilities of individuals whereas criminal proceedings require the accused individual's offence to be proved 'beyond reasonable doubt'.

The Motor Accident Claims are summary proceedings so as to adjudicate the adequate amount of compensation in case of an accident and that a claim under the Act has to be decided on the touchstone of preponderance of probability rather than on the standard of proof beyond reasonable doubt which applied in criminal matters.

The Supreme Court in ***Sunita and Ors Versus Rajasthan State Transport Corporation and Anr.***, has held that the non-examination of the 'best witness' in a Motor Accident claims case is not fatal . The Bench further observed that:

This can be well explained by referring case of Geeta Devi and others v. Rajesh and Others., the issue was examined in the specific context of a case where the acquittal was on the ground of the witness turning hostile. It was held that the Tribunal is not to be influenced by the fact that the eye- witnesses who had deposed before the Tribunal had turned hostile during the course of criminal proceedings. The Tribunal is required to adjudge the case on the basis of evidence produced before it and not on the basis of testimonies given before the Criminal Court.

The approach in examining the evidence in accident claim cases is not to find fault with non-examination of some "best" eye witness in the case but to analyse the evidence already on record to

ascertain whether that is sufficient to answer the matters in issue on the touchstone of preponderance of probability.

In ***Dulcina Fernandes and Ors. Vs. Joaquim Xavier Cruz and Anr..*** , the Court opined that "no examination of witness per se cannot be treated as fatal to the claim set up before the Tribunal. In other words, the approach of the Tribunal should be holistic analysis of the entire pleadings and evidence by applying the principles of preponderance of profitability".

6. Non- availability of documents

As everyone knows, documentary evidence is indispensable to prove or disprove anything before the Court of Law. Mere suspicion of fraud is not enough to act as legal proof. The warning signs that trigger suspicion may be suggestive of a degree of risk, but often fail as definitive proof ("beyond reasonable doubt"). Thus, insurers contemplating a legal course of action had to arrange for specialized investigation but even that is not fruitful until we get access to all criminal or police documents. Few locations have geographical or administrative challenges due to which investigators and insurers are helpless.

7. Non-application of Evidence Act per se

The proceedings under the Motor Vehicle Act are akin to the proceedings in civil and criminal case and hence strict rules of evidence are not required to be followed in this regard. It is also settled law that the term rashness and negligence has to be construed lightly while making a decision on a petition for claim same as compared to the word rashness and negligence which finds mention in Indian Penal Code. This is because the chapter in the Motor Vehicle Act dealing with compensation is a benevolent legislation and not a penal one.

Steps Taken by Legislation and Judiciary to Minimize Third-Party Fraud

1. Formation of Special Investigation Unit (SIT)

Looking into the increasing cases of alleged fraudulent claims coming to the Motor Accident Claims Tribunal, the Apex in ***Safiq Ahmad vs Icici Lombard General Insurance Ltd., SLP No. 1110/17***, while taking note of fraudulent activities has categorically observed that:

"situation is very alarming and therefore, it is imperative for us to find out what steps can be taken to rule out filing of fake claims and what remedial measures cane be taken".

The SC appreciated an initiative of the Allahabad High Court to form an SIT to investigate such fake claims. This happened after Uttar Pradesh's Workman Compensation Commissioner filed a complaint before the State's Bar Council against advocates indulging in the fraud. It has further asked all the States to constitute a special investigation team (SIT). It further ordered that the practice of fraudulent claims be considered serious and the SIT should examine all aspects.

Hopefully, constitution of such a team will help in curbing fake claims filed under the Motor Vehicles Act.

2. Payment through NEFT

Compensation award by Motor Accident Claims Tribunal to victim or his family is generally made by way of cheque of Demand draft which is collected by Advocates. So, the other parties involved in fraudulent claims manage to get their share out of awarded compensation. Since now Courts are asking Insurance companies for payment by NEFT mode so money will be directly transferred to the beneficiary and there won't be any involvement of other entities. This will ultimately demotivate people to encourage or guide victim/ victim's family to file false injury or accident claims. Increased use of NEFT is expected to bring down the chances of fraud.

3. Compensation payment through Motor Accidents Claim Annuity Deposit Scheme (MACAD)

In an attempt to cleanse the motor accident claims jurisdiction fraught with an unholy nexus between lawyers, police and others much to the disadvantage of the victims, the Madras High Court has ordered that compensation should be deposited only by way of Motor Accidents Claim Annuity Deposit Scheme (MACAD).

Under the scheme, the compensation will be deposited only in the bank account of the claimant to avoid leakage. The claimant can have a regular monthly income. He/she/they will be entitled to lump payments, upon proof of need/ justification before the court concerned, in exceptional circumstances. But the rule will be to deposit compensation in annuities scheme to ensure that the claimants have control over the compensation and lives, to avoid the same being dissipated.

4. Limitation period under Amended Motor Vehicle Act, 2019

The Motor Vehicle Act, 1988 does not provide any limitation period

for filing claims for compensation. Absence of this was misused by many unscrupulous people by filing afterthought and delayed FIRs and compensation claims. Due to long gap between accident and claim filing, it was difficult for insurance companies to procure favourable documents or evidence to check genuinely of claims. Since now the Amended Motor Vehicle Act has prescribed limitation period and claim petition has to be filed within six months of the date of accident so there are some chances that numbers of fraudulent claims come down.

Conclusion

Third party insurance is made mandatory for all motor vehicle owners keeping in mind the best interest of victims of road traffic accident. While the reason to introduce it was a noble one, the unfortunate part today is that it is the most abused part of motor insurance that sees the occurrence of a large number of cases. These dayshird party fraud is one of the biggest frauds amongst others. It will not be an exaggeration to say that it has become one of the most profitable business for fraudsters. It is really surprising t how policyholders are abetting fraud.. Later on, other parties likes Advocate, doctors, police etc. all become part of this fraud. It is done either for some financial gain or out of sympathy towards victim's family. The compensation given to victimor his family is actually public money and Insurance companies are just act as custodians. This money is for genuine claim. However, nowadays it is very difficult to differentiate fraud claims from genuine ones and it results either in non-payment of compensation to genuine claimants or payment to fraudsters.

Insurance companies are waking up and taking all steps to overcome insurance fraud. Technology is being used as a weapon. Also, they are investing in the strategy, tools, systems, and resources to detect and prevent the new forms of fraud. However, all these efforts are futile if companies fail to prove fraud claims before the Court of Law. The onus lies on these companies to prove that fraudulent activities exist, for instance, knowing a claim is fraudulent is one thing, but proving this to be fraudulent is a different matter. Also, court's sympathy is in victim or claimant's favour which again makes it difficult for insurers to prove the point. Nevertheless, legislation and judiciary is now taking this issue of fraud seriously and is also inclined to eradicate it. However, the legal procedure and rules have handcuffed them. Now it is high time we scrutinize all claims from genuinety point of view else it will be too late to stop this growing threat to noble objective of insurance.

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Unlocking Insurance Fraud Through Technology

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Abstract

With the acceptance of insurance as a necessity, there has been an overall increase in the demand for insurance products. However, insurance frauds have also increased in an alarming proportion. Insurance frauds have always been an evil part of the system, however with the expansion of insurance into emerging markets and its digital offtake, fraudulent activities have also metamorphosed into sophisticated digital crime. This article gives a background on insurance frauds and details the initiatives taken globally to prevent such frauds. The various technological developments that are available for insurance fraud management and their importance in detecting fraud have also been detailed in the article.

Keywords

Insurance Fraud, Technology, Anti-fraud, Fraud Prevention, Predictive Modeling, Big Data.

Introduction

Be it television programmes, internet shows or book series- those based on crime fighting have always garnered a huge following. It is uncommon for these series or books to not add an episode or chapter on insurance fraud. Movies based on insurance frauds are a favourite among filmmakers as they most often end up being a good hit with the audience. While real life insurance frauds may not be as dramatic as presented in movies and books, it has its own share of suspense and theatrics. Take, for example, the 35-year old open case of Sukumara Kurup from Kerala. The incident is taught as a classic case of attempted insurance fraud and cheating. Sukumara Kurup allegedly faked his own death and in doing so, was involved in the murder of one Mr. Chacko who bore a resemblance to him. This was done in order to claim an insurance amount of Rs. 8.00 lacs.

While Kurup's family did not receive the insurance amount, the culprit is still at large. Incidentally, murdering of family members to claim insurance money is more common than one would expect. Only a few months back the murder conviction of Karl Karlsen from California, US was making news. He had killed his wife and collected the insurance money of $200,000 almost 30 years back; and in 2008, he killed his own son to claim an insurance amount of $700,000.

Insurance is defined as coverage by a contract whereby one party undertakes to indemnify or guarantee another against loss by a specified contingency or peril. The guarantee is usually provided on payment of a sum of money known as the premium. The insurance industry uses the premium amount to make its own investments and aims at balancing potential gains against unforeseeable losses. While insurance companies account for the possibility of payouts as a result of deaths, accidents, property damage etc., the entry of frauds upsets the entire mechanism. Take, for instance, the case of India's insurance industry. The country is one of the biggest markets for insurance and has a high insurance growth rate. A 2019 report by SwissRe ranked India 10th in terms of life insurance markets across countries. However, along with the rise in insurance penetration, the number of insurance frauds in the country is growing. According to a report by ET Insights, the Indian insurance industry loses close to Rs. 42,000 crore to fraud, and the amount is estimated to be approximately 8.5% of the premium collected.

Background to Insurance Fraud

Frauds in the insurance industry occurs when an individual or individuals attempt to defraud or deceive an insurance company in order to claim money to which they are not entitled. These frauds are usually described in terms of soft frauds or hard frauds. Soft frauds can be described as a deliberate omission or an intentional exaggeration of information provided to insurers and is usually equaled to the act of telling white lies. Hard frauds happen when a deliberate and planned attempt is made to defraud insurance companies by faking entire incidents. Sometimes, organized crime rings are involved in insurance fraud schemes aimed at swindling money from insurance firms. While soft frauds are dangerous because they are usually more difficult to uncover, hard frauds are just as perilous because of the nexus of scheming and planning involved in committing a calculated crime. The most common ways of committing an insurance fraud are described in Figure 1.

Global Fraud Prevention Measures

A 2017 RGA Global Claims Fraud Survey indicated that about 1 in 30 insurance claims are fraudulent in nature, but less than 2% of the fraud identified, resulted in prosecution. While many frauds go unnoticed by insurance companies, they also turn a blind eye to those frauds that are lower in value and where cost of legal action would be much higher than the returns from it. Because of the lower level of legal action that is taken, perpetrators conducting insurance fraud are aplenty. Insurance companies, over the years have been building up fraud prevention teams to identify and take care of frauds. While prevention of fraud is relatively easier in developed and organized economies, insurance firms in emerging economies like India find it difficult to regulate fraudulent behavior.

Figure 1: Types of Insurance Fraud

- ***Application fraud***- **it is the act of knowingly and intentionally providing false information on an insurance application.**
- ***False claims fraud***- **it is the fraudulent act of claiming for an incident that never happened or claiming for an event that is staged or claiming with falsified information.**
- ***Inflated claims fraud***- **it is the fraudulent act of wrongly inflating value and increasing the bill amount for claiming additional insurance money.**
- ***Fake death claim fraud***- **it is the fraudulent act of faking one's own death in order to claim insurance money.**
- ***Forgery and identity theft fraud***- **it is the act of a person illegitimately claiming the insurance amount due to another person or in somebody else's name by forging personal information.**
- ***Insurance company fraud***- **it is the fraudulent acts conducted by insurance firms or agents in diverting premium payments, denying valid insurance claims, failing to properly investigate claims and deliberately underpaying claims.**

Moreover, it is important that fraud prevention legislations laid out by the government works in tandem with those set up by insurance companies.

In the United States, most insurance companies have set up special investigation units, comprising of trained investigators, lawyers and accountants, to identify and investigate suspicious claims. While these teams deal with routine issues of fraud, more complex cases are dealt by the National Insurance Crime Bureau, which serves as a liaison between insurance companies and law enforcement agencies. As a joint initiative of multiple agencies, an academy that educates and trains investigators in fighting insurance crime has also been set up in the country. As of now, all states in America have laws aimed at classifying insurance frauds as a crime, which has made it easier for the insurance industry to take up prompt legal action. However, not all states have extensive regulations aimed specifically at insurance crime, and experts feel that limiting the legal framework and non-closure of loopholes may further increase instances of insurance fraud.

The initiatives of the European insurance industry to combat insurance crime varies between countries, but since frauds and fraudulent trends easily cross borders, many of the countries cooperate with neighboring nations on issues related to the matter. Insurances companies within the industry also cooperate in exchanging relevant information that helps in identifying possible frauds. The United Kingdom has an Insurance Fraud Bureau; likewise, many other European countries have formalized associations to train, manage, advice and investigate insurance fraud. Moreover, insurance agencies have also proactively engaged in tying up with law enforcement agencies like Interpol, Europol and local police to swiftly engage them during cases of fraud.

In Asia, both China and India are rapidly developing markets for insurance, leading to the need for increased fraud prevention policies. Chinese law enforcement allows a parallel between insurance fraud and the punishment meted out. The larger the amount of fraud, the greater will be the punishment. The Hong Kong Federation of Insurers introduced an Insurance Fraud Prevention Claims Database that uses cutting-edge AI technology to help detect different types of insurance fraud, especially those involving multiple claims and syndicates. In Singapore, the insurance association takes the help of citizens by rewarding them upto $10,000 for reporting insurance fraud. In India, the Insurance Regulatory and Development Authority (IRDA) has been set up as an autonomous body to ensure orderly insurance growth and for all related matters. To take care of fraudulent behavior, the IRDA has laid out an Insurance Fraud Monitoring Framework to address the overall issue of insurance frauds in India. There are also laws that take into account insurance scams; however, there is no law that specifically addresses problems in the insurance industry.

A claim for alleged back injuries was rejected by an UK insurance company when Facebook images showed the claimant performing gymnastics and training for a charity run.

Source: Insurance Europe

Most insurance companies across the globe have since long implemented traditional fraud detection methods as part of their application and claims process. These techniques include auditing of applications and claims on a random basis; flagging suspicious claims; and, scoring of insurance applicants and claimants based on propensity to undertake fraudulent behavior (Figure 2). These fraud prevention methods can provide good results in a prominently manual environment; however, currently most applications and claims for insurance are undertaken through digital modes and

Figure 2: Traditional Fraud Prevention Techniques

Internal Audit

- Random checks on sample claims leave a room for some fraudlent claims to go undetected
- Lack of experience of insurance fraud professionals results in lower detetion and investigation rate

"Red Flag" Indicator

- Rule-based indicators to detect suspicious behavior
- Red flags indicate the need to further investigate a claim and does not conclude the claim to be fraudulent

Scoring Models

- An advancement to rule-base techniques, wherein insurers provide scores to rule-based indicators (either manual or automated)
- Based on fraud propensity scores, claims are classified into verious segments such as high, medium and are subsequently referred to for further investigations

in such an environment, there are many fraudsters using sophisticated means to make a quick buck. In such a situation, fraud prevention backed by technology becomes crucial to the industry.

Technology- Enabled Fraud Management

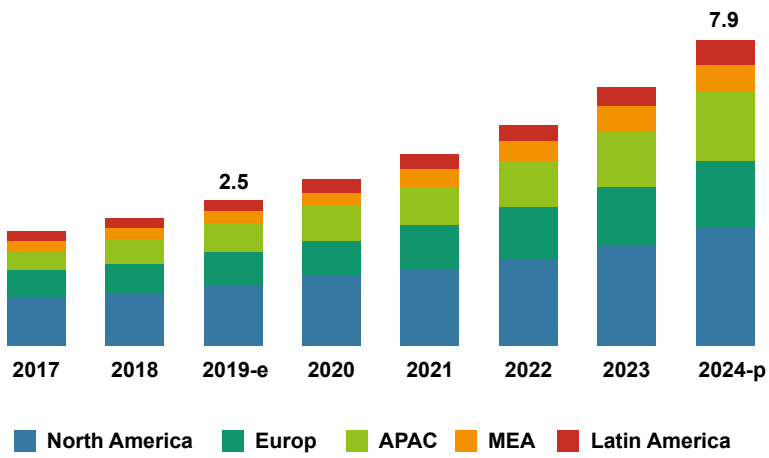
Across the globe, it is seen that the governments of most advanced economies are actively involved in supporting the insurance industry in fighting insurance crime while emerging economies are still figuring out the best ways to do it. However, insurance companies are ensuring that they are fit enough to fight their way through fraudulent insurance scams. In fact, according to a recent report titled 'Insurance Fraud Detection Market by Component, Application Area, Deployment Mode, Organization Size And Region - Global Forecast to 2024', the global insurance fraud detection market is expected to grow from USD 2.5 billion in 2019 to USD 7.9 billion by 2024, at a compound annual growth rate (CAGR) of 25.8% (Figure 3).

Insurance companies are constantly striving at strengthening their existing resources using technology. Apart from using traditional technological approaches that flag potential frauds, they are using a mix of various technology tools to enhance fraud prevention. For example, ISO Claim Search- a worldwide database containing records of insurance premiums and claims from participating insurance companies- has been in the business of identifying false insurance applications and claims for a long time now, but has also been constantly improving its own systems and algorithms based on previous anomalies found in participating insurance companies. Reports suggest that with the increase in the number of firms like ISO Claim Search that specialize in anti-fraud systems and software, even insurance companies are starting to look outside for affordable and superior technology, instead of developing and maintaining expensive in-house anti-fraud systems. This not only helps lower costs for these companies but also allows anti-fraud companies to have an integrated data network from several agencies; this further helps in detection and suppression of fraud across the industry.

The rapid adoption of technology-based measures like predictive analysis and artificial intelligence is one of the major ways in which fraud detection and prevention is expected to move forward. A 2019 study published by SAS Institute and Coalition Against Insurance Fraud found that around 40% of the respondent insurers were planning larger technology budgets, with focus on link/ social network analysis and predictive modeling. Link analysis, a data analysis technique used in network theory, is used to evaluate the relationships between various people, organizations and transactions and to analyze the possibility of fraudulent claims. Predictive modeling is also used to digitally analyze and identify mismatches between the claim and reality; the modeling method is very effective when used with other analytical tools. Likewise, artificial intelligence enables the disclosure of fraud even before claims are filed and payments are made. Blockchain is also being used in fraud prevention; the ability of blockchain technology to save transactions permanently and also provide data security in the process, is being used to provide a long-term transparency to the fraud problem. Companies in China have even incorporated the

Insurance agencies in Sweden use advanced key-readers to ensure that car keys submitted in support of claims for stolen vehicles are those belonging to the vehicles alleged to have been stolen.

Figure 3: Insurance Fraud Detection Market by Region (US Billion $)



Source: Insurance Fraud Detection Market by Component, Application Area, Deployment Mode, Organization Size and Region - Global Forecast to 2024

use of facial recognition and voice recognition softwares to ensure that insurance frauds through identity theft is avoided. Apart from checking social media accounts of risky claimants, companies use technology to go through the information available from smart devices of these claimants, like their smartphones and wearables. Evidently, insurances firms and other stakeholders are quickly leaning towards technology not only to market their products but also to identify frauds that miss the human eye.

Conclusion

While the use of technology in fraud management in insurance seems to be a matter of budget allocation and utilization towards ideal software, it is in fact a wider area of concern. Sharing of insurance data with counterparts is an important prerequisite to the use of blockchain and data analysis. Likewise, complete access to social networks, credit reports etc. would expand the fraud detection rates using artificial intelligence and link analysis. However, this need is not always matched by the privacy laws of the land. Many countries have privacy laws that don't allow sharing of personal data of applicants. This acts as a countering issue for insurances companies, who then think twice about investing huge amounts in anti-fraud technology. The inability to share sensitive data also prevents law enforcements agencies and companies specializing in anti-fraud systems in drawing patterns and trends in frauds.

In a contradictory situation, fraud prevention is an exhausting task for many fraud prevention stakeholders due to data overload. There is a huge amount of data available for analysis and there is an inherent level of difficulty involved in converting this data into useful form. However, insurance companies, in many cases, are tempted to use data to market their products today rather than develop it into actionable intelligence for risk avoidance in future. Further, most insurance agencies prefer to invest in anti-fraud software for use at the time of claim settlement rather than at the time of application. This is done mostly to avoid reduction in insurance sales and to avoid customer dissatisfaction; however, it can also lead to unscrupulous persons taking the system for a ride while in actuality, their activity could have been nipped in the bud. While claim based fraud investigations are more convenient, it does add to the premium of other honest customers and could lead to fraudsters going scot-free.

Taking the pain to detect and prevent fraud at the time of application can lead to a greater experience for both insurance providers and their beneficiaries, in terms of expenses and customer satisfaction. For this, predictive analysis has to become an integral part of front-line fraud detection rather than a term that is used for future budgeting goals. Parallely, it is also imperative that governments have regulations that not only help insurance companies in pooling and sharing data, but also have strict legal implications for breach of data and privacy. It is also necessary that regulations for quick disposal of insurance cases are made a part of the legal system. As the insurance industry moves towards complete digitization of all activities, development of adaptive and innovative tools that counter technically advanced frauds while fulfilling the needs of genuine customers, is the need of the hour. While the tasks of managing customer experience and fraud prevention can seem difficult to balance, the availability of the rights tools within an environment of cooperation among stakeholders is the key to the future of fraud management.

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TPA (Third Party Administrator) and Its Role in Controlling Health Insurance Frauds- A Study

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Abstract

Claim procedure has always been a critical and complicated stage in health insurance cover. Following the proper policy guidelines, on - time submission of medical proofs, ascertaining genuineness of the documents and quick settlement of the claims are some of the important features under such policies. Since this is a difficult task for the insurance claim department, they have outsourced the part of service by the way of TPA (Third Party Administrator). A TPA is involved with insurer and insured simultaneously and verifies all the presented medical records and treatment documents so that any form of misrepresentation or fraud can be avoided. In this way the TPA protects the companies from fake or inflated claims and the policyholder receives the correct claim. Though the TPA does not have any control on rejection or acceptance of the claim, as the final decision is of the company, TPA is an important source of information through whom certain frauds could be controlled.

Keywords

Claim, Frauds, Health Insurance, TPA.

Introduction

There are certain unavoidable situations of an emergency in one's life where one needs to go for the hospitalization of their near and dear ones. There is a need of medical aid during mishaps such as accidents or any disease. Medication and treatment are important in such situations but it comes with the bitter pill of monetary cost. Those who have savings or can make certain arrangements can breathe a sigh of relief and those who don't, have to face heavy financial crises. Growing

civilization and modernization has given birth to different lifestyle diseases and unfortunate events like COVID - 19. This has also contributed in increasing awareness towards the presence of Insurance in Healthcare sector. There are around 29 health insurance companies providing health insurance services currently in the market[1]. After people purchase the policy from the company, it becomes difficult for companies to keep a track of further activities which results in low quality of services to their insured and chances of increasing number of frauds. Thus, in order to solve such issues, The Insurance Regulatory and Development Authority of India (IRDAI) devised the concept of a TPA (Third Party Administrator). These are the parties licensed by IRDAI and hired by the health insurance companies. Their main function is to process the insurance claim following all the conditions mentioned in the health insurance policy. As soon as any person gets admitted in the hospital, intimation is communicated to a TPA. The TPA looks after the hospital expenses which are inclusive under policy and approved for the cashless claim or reimbursement. Further, they inform the company of the same. Thus, it is beneficial for insured as well as for the insurer. The Insured does not worry about the hospitalization expenses and he can take care of his loved ones. Similarly, the insurer also gets relief and surety that the medical expenses are genuine and there no chances of any inflated expenses or frauds.

Objective of the Study

1. To assess the role of TPA (Third Party Administrator) in controlling frauds in health insurance sector.

Frauds in Health Insurance Sector

It is a type of fraud which can occur by a person providing false or misleading information about health of the policyholder in order to provide benefits to them, insurance provider or any other intermediary like agents, TPA, hospitals or diagnostic centres involved in this policy. Frauds can take place at the beginning, by not providing the correct health information initially or during the time of treatment or at the time of claims through inflated or fake bills, charging in excess as compared to services provided, providing unnecessary services for monetary gain, billing at each step for a single procedure, falsifying diagnosis of the insured to justify tests and other procedures, etc[2]. Such frauds can occur with or without the knowledge of policyholder.

TPA in Health Insurance

"TPA or *Third Party Administrator (TPA)* is a company / agency / organisation holding license from the Insurance Regulatory Development Authority of India (IRDAI) to process claims - corporate and retail policies in addition to providing cashless facilities as an outsourcing entity of an insurance company"[3]. Along with the cashless facility, they also help in getting reimbursement claim from the insurance company on submission of valid medical reports and documents. They are the intermediaries between the insurer and policyholder[4].

As per the latest records of IRDAI, following is the list of TPAs currently providing services in India[5]:

Table 1 - List of Third Party Administrators (November 2019)

Sr. no.	Name	Sr. no.	Name
1.	United Health Care Parekh Insurance TPA Private Limited	14.	Health India Insurance TPA Services Private Limited/
2.	Medi Assist Insurance TPA Private Limited.	15.	Good Health Insurance TPA Limited
3.	MD India Health Insurance TPA Private Limited	16.	Vipul Medcorp Insurance TPA Private Limited
4.	Paramount Health Services & Insurance TPA Private Limited	17.	Park Mediclaim Insurance TPA Private Limited
5.	Heritage Health Insurance TPA Private Limited	18.	Safeway Insurance TPA Private Limited
6.	Family Health Plan Insurance TPA Limited	19.	Anmol Medicare Insurance TPA Limited
7.	Raksha Health Insurance TPA Private Limited	20.	Grand Insurance TPA Private Limited
8.	Vidal Health Insurance TPA Private Limited	21.	Rothshield Insurance TPA Limited
9.	Anyuta Insuance TPA In Health Care Private Limited	22.	Ericson Insurance TPA Private Limited
10.	East West Assist Insurance TPA Private Limited	23.	Health Insurance TPA of India Limited
11.	Medsave Health Insurance TPA Limited	24.	Vision Digital Insurance TPA Private Limited
12.	Genins India Insurance TPA Limited	25.	Happy Insurance TPA Services Pvt. Ltd
13.	Alankit Insurance TPA Limited		

Source: irdai.gov.in

Role of TPA in Health Insurance

The role of TPA begins from the day the policy is issued to the policyholder by the insurer.

1. Establishing Hospital Networks: Initially, TPAs had to arrange healthcare providers by building networks with hospitals. Along with hospitals, they also needed to have contacts with General Practitioners, diagnostic centres, pharmacies, dental clinics, physiotherapy clinics, etc6. Currently, they first need to have a service related agreement or memorandum of understanding with the insurance companies and after that they can inform the policyholders about their healthcare facilities networks and process of settlement of claims.

2. Maintenance of database and records: As soon as the proposal turns into a policy, the records of the policyholder are provided to the TPA. From that point, TPA has to maintain the records of the policy, issues the identity card and looks after the settlement of claims and grievances management. They support claim settlement in both ways; that of cashless kind and the other of reimbursement with valid documents and proofs.

3. Issue of ID card: The TPA issues ID (Identity) card to the policyholder which they require while availing the cashless facility of the network hospital. They can also opt for other hospitals in case of emergency or any preference on certain hospitals or doctors. In that case, they have to undergo reimbursement procedure with TPAs.

4. Customer Service: TPAs provide 24 hour services to their customers. The customer can make enquiry regarding cashless hospital networks, seek information regarding pre or post admission of the policyholder, follow - up on reimbursement status and other claim related queries.

5. Monitoring and collection of documents: The TPA monitors and collects all documents and medical bills in case of cashless option and in case of reimbursement; the documents are collected from the policyholder. In both cases, TPA carefully examines and audits the records and later submits those to the insurance company.

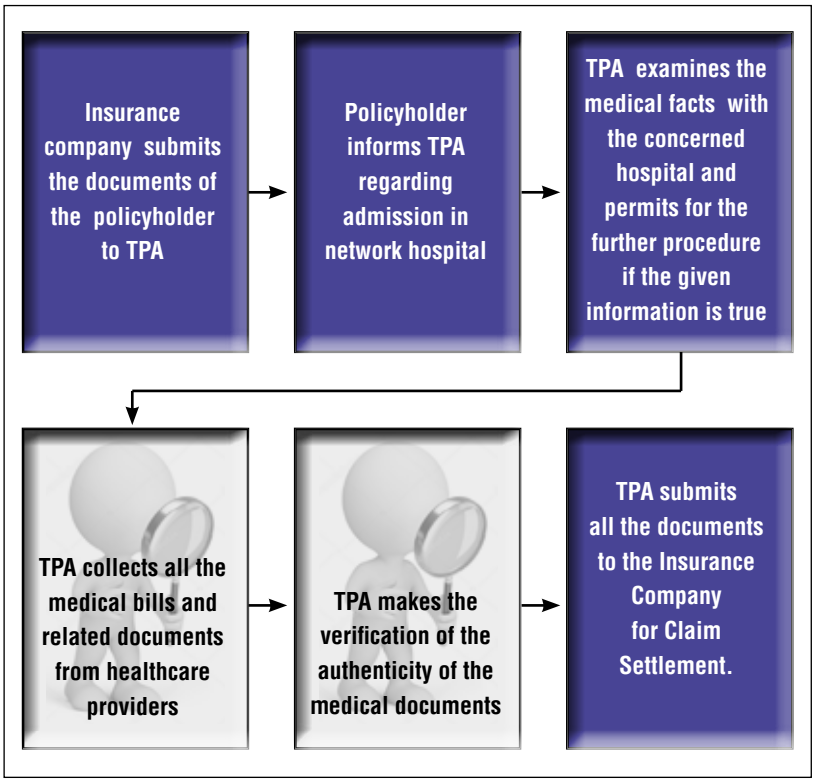
6. Claim Settlement: In case of cashless claims, policyholder informs the TPA regarding the treatment and other medical facilities required along with valid documents. Post – treatment, all the bills and records are shared by hospital to the TPA which are verified by the latter party as per the terms and conditions. These documents are forwarded by TPA to the insurance company so that they can directly pay the hospitals.

7. Value Added Services: They provided some of the additional services like checking the availability of beds in hospitals, arranging for specialised consultation, ambulance services and arranging various well - being program and lifestyle management. They also serve to the corporate sector in framing; customizing, designing and managing health benefits facilities for their employees.

Importance of TPA in detecting Health Insurance Frauds

As the TPA is a link between the Insurance company, policyholders and healthcare providers, they can, upto a certain extent, with their efforts protect

Figure 1 - Flow of Work for TPA and Sensitive Areas



Source: Researcher's Data

the occurrence of fraud from side of the policyholders and healthcare providers.

1. Specialised Services: Normally in case of other types of insurances, the claim settlement process is possible through the claim department of the respective insurance company. But in case of health insurance, a middle man, i.e. a TPA is appointed who helps the company by collecting all the bills and required documents from respective hospitals or from the insured. The TPA doesn't have any kind of control on acceptance or rejection of claim. This saves the time and efforts of claim department which could be utilised in detailed examination of documents submitted for the claim.

2. Involvement of TPA: Hospitalisation could be planned or accidental. In both cases, the insured or related person contacts the TPA as quickly as possible. This leads to inclusion of TPA throughout the whole medical process to give him first - hand information, reports and documents of the concerned insured. This can reduce chances of frauds like misrepresentation of billing, dates, location and providers of medical services.

3. Limited control on choice of TPA: Recently, IRDAI has allowed policyholders to choose their own TPA. This is majorly done by the regulator to provide the flexibility and good service experience to their policyholders. Choosing a TPA of their choice could on occasion increase the chances of fraudulent cases. So this flexibility is provided with certain conditions, one being that the insured has the choice of TPAs who are having service level agreement with the respective insurance company. The insurance company provides the list of TPAs amongst whom the policyholder has to choose for oneself. Thus, the flexibility is provided with certain limitations.

4. Strong Team of TPA: As per IRDAI regulations, TPAs are the professional unit having their own in - house doctors, who are registered with the Medical Council of India (MCI), management consultants, and information technology expert, legal and insurance consultants. In case of cashless treatments, medical referee of TPA carefully examines the admission eligibility of the case and accordingly healthcare providers are informed regarding the proceedings of the treatment. In case of reimbursement, all the submitted documents are carefully verified and audited before submitting it to the insurance company[6]. Thus, this team is set up by TPA to smoothen the claim settlement process and ensure that there no unnecessary treatments and fake or inflated claims.

5. Selection of network hospitals: As TPAs, they have a responsibility to build a hospital network for cashless services. They have to maintain due diligence and examine all the facilities of selected hospitals. Their physical and information technology infrastructure, previous records, management background are thoroughly verified[7]. In this way, TPAs try to curtail the chances of misrepresentation of bill amount or any other documents from the hospital end.

6. Detail investigation of suspicious cases: If the medical case is complicated, at times the TPA asks for a second medical opinion and they may also deeply investigate the records especially if there is a suspicious case of false or deceptive claims.

7. IRDAI Guidelines: Though IRDAI has permitted the services of TPAs under health insurance, they are attached with certain guidelines. If they fail to perform any of the operations in relation to claim administration, it can either affect the company or policyholder. This can result in the negative impression of TPA or cancellation of their license. Thus, in order to maintain their trust, TPAs try to have more authentication and quality standards in their work.

Challenges Ahead

1. On-time information: In case of cashless treatment, the policyholder has to inform the TPAs 7 days prior or immediately on emergency cases. The major challenges for TPAs are reimbursement cases where the policyholder has to submit the documents within 7 days after the discharge. Thus, e common standards are difficult to follow when it comes to verification of documents for the claim. In such cases, timely submission of documents is necessary so that TPAs and insurance companies can get the justified time to verify and settle the claim.

2. Strong Team: It is important for TPAs to strengthen their investigation team as compared to the ratio of policyholders and network hospitals they handle across the country. On one hand, less number or less qualified people in team could give rise to false or fraud claim settlements. On the other hand, training of TPA teams is complex wherein they require an extensive management and situational knowledge to handle client cases which are not homogeneous.

3. Detail Learning: IRDAI has approved TPA services so that each and every individual health insurance claim case could be verified in detail. Thus, the TPAs have to follow this requirement and the learning from each and every case; they have to take ahead, as future reference.

4. Volatile Future: Healthcare is highly volatile in nature. TPAs must have many hospitals under their network which can attract various insurance companies and policyholders in present. But in future, the situations can change, for instance like COVID – 19, wherein presently hospital bed occupancy for non - COVID patients has become a challenge. In such cases, reimbursement becomes a no - choice option with patients and TPAs.

5. Knowledge Gain: Health insurance companies are trying to include maximum health issues under their policies; some are planned and some are on urgency basis. For instance, some health insurance companies have started including COVID - 19 as one of the health issue in their policies. In this case, TPAs have to undergo quick acquisition of knowledge base regarding documents collection, verification procedures and reimbursement system.

6. Pressure: Though TPAs attract the business for the insurance companies, but at times, they also face a pressure from the company side to negotiate with hospitals and try to keep the claim ratio down.

7. Confidential Information: As TPAs are involved with multiple companies and policyholders, it becomes imperative for them to maintain the professional confidentiality of the data they possess to retain healthy competition in the market.

8. Private Health Care standard: In case of reimbursements, lack of accreditations and quality standards of the private health care can also lead to falsification in documents and bill receipts.

Conclusion

TPAs are not an old concept in the Health Insurance Sector, but in these times, they have become a significant link between the insurance company, policyholders and healthcare providers. No doubt, they are not the decision makers on the claim settlement, but they certainly are an important source on which such decisions are dependent. They are also one of the way through which the number of fraud or fake claims could be controlled by IRDAI and health insurance companies. Though their role in fraud detection is limited, from the side of policyholder and also healthcare provider, but with certain additions in the system, their role can also improve in fraud detections. The companies in future should encourage the role of TPAs right from the initial stage itself; in marketing and promoting of insurance products or arranging awareness programs or educating eligible or current clients, that will increase the contribution of clients. This awareness will reduce the number of false or fraud claims from the client side from the initial stage itself. With proper guidelines, more number of TPAs should be developed so that maximum hospital reach could be covered under cashless claim system. Even regularising the maximum private healthcare is necessary so they become eligible under cashless and at the same time, reimbursement possibilities should be minimized.

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Annexure

List of Abbreviations:

1. **TPA:** Third Party Administrator
2. **COVID:** Corona Virus Disease
3. **IRDAI:** Insurance Regulatory Development Authority of India
4. **ID:** Identity
5. **MCI:** Medical Council of India

Tryst with Fraud: Experiences of an LIC Claimsian[1]

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Abstract

Insurance and fraud are well connected. Compared to other forms of insurance, incidence of fraud is less in life insurance. Still it occurs, at times. Viewing each death claim from a vigilance angle is a solution to manage fraud in this area.

The article is a narration of some real fraud attempts and how they were managed. This is intended to remind the claimsians again and again to concentrate on different points during different contingencies.

A strong message is to be given that fraud will not be tolerated and punishment will be given for fraudulent attempts. Repudiation of claims will be done as per the existing rules and there should not be any leniency or loopholes. LIC's declared policy of "strictunderwriting and liberal claim settlement" had helped to a great extent in managing fraud.Continuation of the same policy is sure to yield results in future also.

Keywords

Suicide Clause, Repudiation, Relinquishment

Introduction

While I was working as a faculty member at LIC's Southern zonal training centre, I used to handle, among others, a subject titled "unique claim cases'' for the benefit of different sections of trainees. The purpose was to share my experiences gained from different types of claims in claims departments Whereas proposal is the beginning of a life insurance contract, 'claim' is the end of it. I had a unique experience of working as an Assistant, as Branch

Manager, and as Manager (claims) meeting Claims operations at different layers of administration. My above subject, also, gave thrust to proposal papers, duty of disclosure, suppression of material facts, suicide clause[2], section 45 of Insurance act-1938[3], claim repudiation etc. Some real-life cases of claims, I came across while settling claims, were narrated in Chairman's Club Member Agents' sessions, to impress upon them, the necessity of speedy submission of proposal requirements and revival requirements at the office, need of nomination etc. The message of "death is certain and life is uncertain" was endeavored to be clearly given. Some other real cases, which gave insight to be vigilant against insurance frauds, were narrated to Branch Managers. These cases, which were real, always gave better education to the trainees. Their reception of the concept was quick and sharp.

Majority of the claim cases I have dealt with, as a Sr. / Branch Manager and as a Claims Manager of LIC, were routine. But a few of them were unique, which will not fade from my memory for ever. That is why, even after about 2 decades, I am able to describe them without the support of any documents. But I know that the precious pages of our journal cannot be used to describe all such cases, and so, I am giving here only 3 or 4.

Fraud in Claims

In insurance, fraud, if at all, is associated with claims. Claim is the focal point of insurance contracts. My experience in insurance is limited to Life Insurance and so my 'claim' is always 'death claims'. I was convinced that a very small percentage of claims, may be around 1% of death laims, are made with fraudulent intentions. The high standards of claim repudiation and the firm stand of LIC, that fraudulent claims will not be entertained at any cost, have contributed a lot, in minimizing fraudulent claims in LIC. Once a death claim is repudiated by LIC, it is very difficult to get it settled.

Claim Investigation

The main tool of repudiation in death claim settlement is claim investigation. Usually claim investigations were conducted in early-claim cases where death occurred within 3 years of commencement. Depending on the nature of claim, the investigation officer will have to concentrate mainly on 2 aspects – One is regarding suicide clause where death occurred within one year of policy issue, and the other is regarding non-disclosure-whether assured had suppressed any material information on his life with a fraudulent intention of deceiving the insurer. Generally, fraud is revealed by concentrating on these 2 aspects.

It is very easy to find the elements of fraud in the investigation stage provided the investigating officer approaches the case with his eyes and ears open. Simple questions to the relatives or neighbors, like from where the deceased used to get medicines have yielded valuable results. The nominee's well taught stand was that the life assured had no illness and never consulted a doctor. For a question to the agent when he had first canvassed the deceased, the answer was that the assured only, had approached him for insurance. That, no doubt, was a fraudulent intention and had opened up a Pandora's box.

Approaching the insurer for insurance (about 25 years back) was rare, and moral hazard could be suspected. "Life insurance is seldom bought but sold only" was the dictum. When I was working as Branch Manager, one young man had approached me after office hours for a policy of Rs. 5 lakhs (A policy for Rs. 5 lakhs was covetable in 1995. The target, in first premium income. Of my branch was Rs. 72 lakhs, the highest, in the division!). After collecting his personal details, I requested him to come next day. I enquired with his neighboring agents and they told me that they will not entertain a proposal from him as he was uninsurable. He didn't turn up next day and I think a fraud was averted. Similarly, a kidney patient had also approached the office for insurance.

Suicide Made Accidental Death

I would like to share a challenging experience in claims-investigation when I was working as Branch Manager in 1995. As per the claim forms, an unmarried young lady, insured for Rs. 1 lakh with double accident benefit, was working as a Pigmy collection agent of a nationalized bank. She had died, within one year of policy issue, by accidental drowning in her home well. It was reported that she accidently fell from the wooden plank put across the side of the well, while drawing out water from the well. There were First information report and postmortem report by police, along with the papers confirming that it was an accidental drowning by slipping into the well while drawing water.

Her house was about 10 kms from my branch office. When I visited her house for investigation, the relatives of the deceased did not pay me much attention. But on my request, I was shown the well. I could observe the well clearly and it was adjacent to the house. It was a neat well with 2 meter diameter. There was a wall about 1 meter height around the well. Wooden planks, of more than 1 meter length, were placed on one side of the well to draw out water from the well using rope and bucket. Steps were there

to climb to the well wall- top to reach the wooden planks. Enough water was there in the well - nearly 5 meters below the ground level. It was clear that slight carelessness could lead to accidental fall into the well while drawing out water.

Then I went to the nearby bank, where she was working as pigmy collector. A friend of mine, working in a neighboring branch of the Bank, had already introduced me to the Bank Manager over phone. The Bank Manager informed me everything he knew about the deceased. She was irregular in remitting the collections from the customers to the bank. She had been given some warnings in this respect. She had a fiancé who belonged to a different religion. She had been giving entire money to him. Two days before her death, she had been given serious warning by the manager regarding collection money.

On my way back to the office, I had conversations with a nearby shop owner and with some agents regarding the deceased. I was almost convinced that it was a suicide case. She was worried over her financial commitments and also about her affair.

But I had no proof ! The accidental death was confirmed by the police investigation report. I was in a dilemma- Whether to recommend claim settlement or repudiation! I could not agree with settling a claim for Rs. 2 lakhs when suicide clause may be applicable. I consulted my Manager (claims) and also Senior Divisional Manager. They advised me to record my sincere observations.

On the basis of my observations, the claim was repudiated stating that it was a suicide case. The relatives made no representations as they also knew that it was a suicide, and no claim amount was payable as life assured committed suicide within one year of policy issue.

But after some months, a lawyer interfered in this case and a legal notice was issued against LIC. Ultimately, as per legal advice, we went for reconciliation and an exgratia amount of Rs. 50,000/- was paid which was only half the sum assured without double accident benefit.

In the above case, I think, there was no intention of fraud on the part of the life assured. But the nominee and the relatives had fraudulent intentions.

Suicide Termed Heart Attack

In the same branch itself, I had come across another suicide case within one year of policy issue. The life assured had intention of suicide and he took the policy. The sum assured was Rs. 50,000/-. He hanged himself in his house. Suicide clause was applicable. His father was the nominee. He removed the body from the hanging position and projected, that the death was due to heart failure. A government doctor had issued a death certificate, showing the cause of death as heart failure. While investigating, I came to know of the real fact from some loose talk around the neighborhood. A slight threatening helped me to hear the fact from the nominee himself. Next day, he had relinquished the claim.

Fraud by Forgery

Another death claim I still remember is that of an NRI. His death, due to natural causes was at Jeddah. But the premium on his policy of Rs. 50,000/- was not paid within days of grace. As a result, policy had lapsed and was not eligible for full sum assured. A meager paid-up-value was payable. The relatives understood this. They paid the premium at the servicing branch in India, and the policy was made in force. They prepared a forged death certificate showing the date of death, as the next day of premium payment. All other requirements were intact.

I was the Manager (claims) at the Divisional office at that time (2002).The above death claim file came to me, with the note recommending claim admission for the full sum assured. On going through the file, I specifically noted the date of payment of last premium which was just the previous day of death. Somehow, a doubt of fraud flashed through my mind. I kept that file with me and processed all other files. Afterwards, going through this file again, my eyes struck on the death certificate submitted along with the claim form. The certificate was signed by the Consulate General of Jeddah. When I scrutinized the signature of the Consulate General, I remembered that I had seen the same signature in some other older files. There was no clue or indication of that old file. I sorted all the foreign cases and ultimately won in my mission. It was a determined effort to raise a finger against fraud. I found out a file in which a certificate issued by the same Consulate General was available. With great anxiety, I compared the two signatures and to my relief, found that there were marked differences between the two signatures (of the same official). After that, it was easy. The office of the Consulate General was very quick to reply ,that the death certificate produced by the claimant in the above death case was forged. Because of the criminal act involved, the small amount otherwise payable was forfeited. We had an idea to register a complaint of fraud with CBI. But it was known that CBI will not entertain a case for such a low value. Hence we did not proceed further.

Fraud in Office

My tryst with fraud will not be complete if I do not mention about a claim fraud committed by an employee of our office. It is not strictly a claim fraud, but an insurance office fraud. Fraud was carried out at the maturity claims department of government salary saving scheme section by a single employee. Because of the control systems and audit, the fraud was detected early and criminal procedures were initiated against the employee. As far as I could know, the case is still pending with CBI even after about 20 years.

The employee concerned, was at the fag-end of his service – very cheerful, and went to any extent to help customers. He used to willingly share the work- load of his colleagues. He worked even after office hours. His modus-operandi is said to be re-settling the maturity claims already settled.Computer had not been introduced in the office at that time. He selected paid maturity claim files and removed all indications of claim settlement, prepared all claim papers afresh and sent the file with payment voucher to the accounts department. After receipt of account-payee cheque from accounts department, he himself will manage everything, and will see that the cheque in the name of policy holder is secretly taken by him. He got help of some outside banking intermediaries to discount the cheque. Where ever necessary, he also opened bank accounts in the name of policy holders, and money was drawn by misrepresentation.

I leave the other "unique claim cases" like, the one in which a dead policy holder (in the record of insurer) came to the office to pay premium on his life policy. Though they are fascinating and curious, they do not have much fraudulent dimensions.

Conclusion

Generally, people do not try to insure sick persons admitted in the hospital, as they know that, that intention of fraud will not work. Still I have come across cases, where sick persons were insured without disclosing illness and treatment details, with a hope that if they survive 3 years, their purpose is served. Generally, after 3 years of commencement of policy, investigation will not be conducted. I have also heard of a young man immediately after insuring for Rs. 5 lakhs with double accident benefit, dashed head-on in a motorcycle against a bus, and committed suicide. It is very difficult to prove suicide and fraud in such an accident case. But such insurance frauds are extremely rare.

Compared to the volume of claims settled in LIC, the incidence of fraud is minimal. Even this, can be avoided by verifying each case through a vigilance angle……BUT,… US President Mr. John F. Kennedy and Indian Prime Minister Smt.Indira Gandhi were assassinated, in spite of the best security precautions! ◼

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1. The word "claimsian" for claims department personnel was used by the author even before the word "LICian"was popular.

2. **Suicide Clause [as it stood in 2002; now this clause stands amended]**

   The suicide clause on an LIC policy is as follows — 'This policy shall be void if the life assured commits suicide (whether sane or insane at the time) at any time on or after the date on which the risk under the policy has commenced but before the expiry of one year from the date of commencement of risk. The Corporation will not entertain any claim by virtue of this policy except to the extent of a third party's bona fide beneficial interest acquired in the policy for valuable consideration of which notice has been given in writing to the branch where the policy is being presently serviced (where the policy records are kept), at least one calendar month prior to death.'

3. **Section 45 in The Insurance Act, 1938 [as it stood before the 2015 amendment]**

   45. Policy not to be called in question on ground of mis-statement after two years.—No policy of life insurance effected before the commencement of this Act shall after the expiry of two years from the date of commencement of this Act and no policy of life insurance effected after the coming into force of this Act shall after the expiry of two years from the date on which it was effected, be called in question by an insurer on the ground that a statement made in the proposal for insurance or in any report of a medical officer, or referee, or friend of the insured, or in any other document leading to the issue of the policy, was inaccurate or false, unless the insurer shows that such statement 1[was on a material matter or suppressed facts which it was material to disclose and that it was fraudulently made] by the policy-holder and that the policy holder knew at the time of making it that the statement was false 2[or that it suppressed facts which it was material to disclose]: [Provided that nothing in this section shall prevent the insurer from calling for proof of age at any time if he is entitled to do so, and no policy shall be deemed to be called in question merely because the terms of the policy are adjusted on subsequent proof that the age of the life insured was incorrectly stated in the proposal.]

Identification of Insurance Fraud and How to Tackle it for the Progress of the Industry

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Abstract

Insurance fraud has existed ever since the setting up of insurance as a business operation. Insurance fraud is an intentional act of misrepresentation, wrong or incomplete information, concealing facts and getting the illegal advantage. Insurance crimes also range in severity, from slightly exaggerating claims to deliberately causing accidents or damage. Insurance fraud poses a very significant problem towards our society. Governments and other organizations are making efforts to detect and prevent such activities. Now with the improvement of technology and with increase of our awareness fraud activities are easier to be detected.

Keywords

Fraudsters, Scammers, Hard Fraud, Soft Fraud, Investigation Report.

Introduction

Frauds are present in every sector whether it is financial or non-financial industry. There are different types of frauds. Insurance is based on the principle of indemnity where there is mutual benefit. Insurance fraud occurs when someone commits with the intention of obtaining some benefit wrongly to which they are not otherwise entitled or someone knowingly denies some benefit that is due and to which someone is entitled.

Frauds claims are wide ranging and are very diverse, and occur in all areas of insurance life insurance, non life insurance or health insurance. Fraudulent claims account for a significant portion of all claims received by insurance companies. *Various estimates indicate that fraudulent claims in the insurance industry could be about 10 to 20 per cent of total claims.* (source: fraud statistics, www.insurancefraud.org). This estimate varies from country to country and classes of insurance. Fraudulent activities also affect the lives of innocent people, both directly or indirectly as these crimes

cause insurance premiums to be higher. The impact of few fraudsters goes to many innocent policy holders.

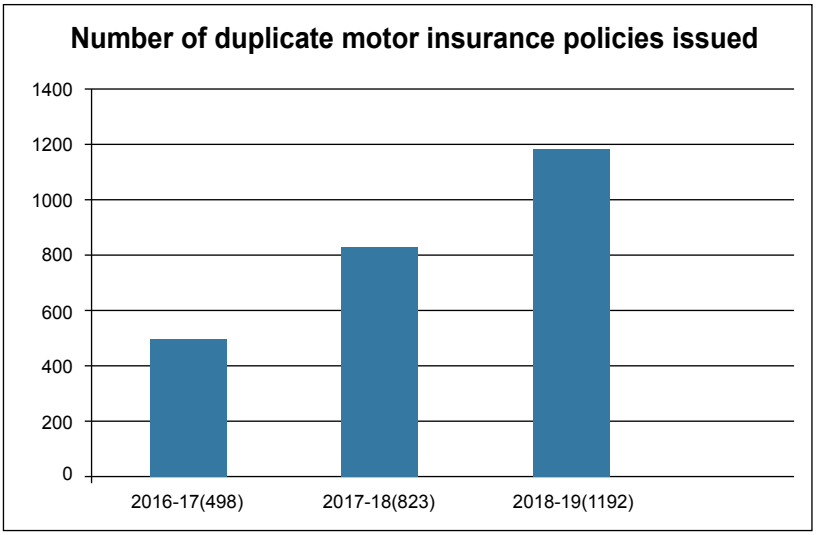
Causes of Insurance Frauds

There are different causes of insurance frauds but the most important cause of insurance frauds is greed. Maximum fraudsters take it very lightly and feel that committing fraud is lucrative and risk free. According to law, penal code, punishment for insurance fraud is mild, lenient in comparison to other crimes. So scammers may try to take advantage of the system.

The most common form of insurance fraud is increasing the amount of loss. Another reason behind the insurance fraud is in the case of over-insurance, when the amount insured is greater than the actual value of the property insured. In case of property insurance, the Sum insured is much higher than the market price. This condition can be very difficult to avoid, especially since an insurance company might sometimes encourage it in order to obtain more premium. This allows fraudsters to make profits by destroying their property because the payment they receive from their insurers is of greater value than the property which is destroyed.

Double insurance is another type of insurance fraud. When the same property is insured from two or more insurance companies and after the damage or loss the owner files claims in all the companies and may receive the claim amount from all the companies.

Insurance companies are also influenced by fraud because false insurance claims can be made to appear like ordinary claims. This allows fraudsters to lodge claims for damages that never occurred and so get payment with little or no financial loss.



(Source: The Times of India)

Classification of Frauds

Frauds are generally classified as:

1. Internal fraud and External fraud:

In internal frauds, the employees or mediators of the insurance company like the agents, surveyors, empanelled advocates, clerical people, managers, or higher officials, etc. are involved.

Whereas in external frauds, the policy holders, beneficiaries, medicine vendors, doctors etc. are involved.

2. Hard fraud and soft fraud:

Hard fraud is an intentional attempt to organize an incident or accident which seems to be the financial loss of the policy holder. Some of the examples of hard fraud are: In case of motor insurance hard fraud occurs when someone deliberately plans a loss, such as a collision, auto theft, or fire that is covered by their insurance policy in order to receive payment for damages. False unnecessary ill health, fictitious injuries which requires hospitalization in case of health insurance is also a type of hard fraud.

Soft fraud is far more common than hard fraud. It is sometimes also referred to as opportunistic fraud. One of the examples of this type of fraud is increasing the amount of the legitimate claims.

Effects of Insurance Fraud

Insurance companies strive to pay all genuine claims as quickly as possible. They conduct an independent investigation when there is any doubt regarding settlement of any claim or while processing a suspicious claim. After confirming a fraud case they pursue the following procedures:

(i) No payment of claims to the insured even the cost incurred for investigation may be taken from the insured.

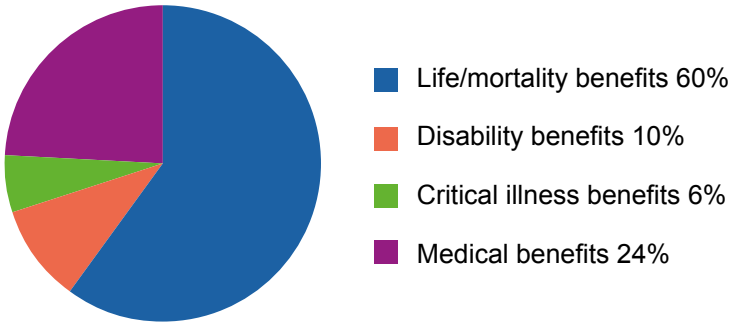
(ii) Immediate cancellation of insurance policy.

(iii) Immediate notice to other branches for such fraud activities for their awareness.

(iv) No further contract with the same insured.

(v) Reporting the case to the police for further investigation.

Benefits associated with fraud cases (RGA 2017 Global claim fraud survey)



(vi) Legal steps may be taken against the fraudsters.

Insurance Fraud Management

(i) The role of independent investigator

The appointment of an independent investigator in case of processing any suspicious claims is the first and foremost thing. On the basis of this investigation report further proceedings can be done. In case of smaller amount of claims company's own official can conduct the investigation procedure. The moral hazard related with the insurance should be considered while accepting any proposals.

(ii) The role of information technology

Information technology is a part of communication technology. With the use of IT we can store, retrieve, and transmit information as when required. IT helps us to detect any case of alleged fraud worldwide and to take decision promptly. Every organisation should equip themselves to be facilitated with IT. Computers, software, hardware, internet has reached to the nook and corner of our country.

(iii) Helping from legal bodies

Cooperation from company empanelled legal bodies is expected always. The case of scam, fraud is to be addressed properly. Along with strict and harsh punishments against the fraudsters financial reimbursement against expenses to carry out the investigation work should be recovered. Insurance fraud should not be treated as a negligent crime.

(iv) Training of officers, staffs, mediators

Proper training to the officers, staffs, agents, brokers, surveyors, investigators, empanelled advocates third party administrators to combat against insurance fraud is to be provided on regular basis. Different seminars, conferences, group discussions may be arranged to discuss with the topic. Participation of all irrespective of class and wage is to be made mandatory. Well trained, educated personnel are less vulnerable against fraud.

(v) Anonymous help

Persons inside or outside of the organisation may give information related to fraud cases unanimously. This should remain confidential. A toll free number or mail id may be provided where persons may provide information related to unethical issues. This system is very much popularised in many foreign countries.

(vi) Our moral and ethical sense

Our moral and social responsibility to combat fraud in every sector is always expected being a responsible citizen. Here in insurance sector also it is no different. Ethical business practice is also anticipated from insurance companies. Our personality, behaviour, attitude, background, cultural values affect the business environment in practicing moral and social responsibilities.

Conclusion

Now a day's the number of insurance fake claims have been increasing. So insurance fraud is a nationwide cause of concern. It is the challenging job for the insurance companies to identify and reduce insurance fraud in each and every section. Though insurers try to fight fraud, some will pay suspicious claims, since settling such claims is often cheaper than legal action against the fraudsters. Insurance fraud has also an impact on our society as insurance fraud facilitates other serious crimes. Insurance fraud should not be seen as an insignificant crime. The guilty should face serious consequences. Insurance industry must control fraud activities and commit to detect and prevent such activities. A criminal and civil stringent action and harsh punishment against the scammers, fraudsters and appropriate legal action against them is necessary.

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Insurance Governance for World's Largest Democracy

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Introduction

Our earlier abridged version of the Monograph, **"A Transformative Agenda for the Indian Insurance Industry and its Policy Framework"**, published in July – September, 2018 in this Journal, was about transforming the Indian Insurance Industry since financial services, including insurance, exert a major impact on the long term economic growth of a country. The regulator, as the Transformational Agent, must ensure right outcomes, and ensure competition with a level playing field that drives efficiency and efficiency that in turn drives growth. By contrast, protectionism and heavily regulated market makes firms less competitive besides, impacting the penetration which is the current currency.

Our following Monograph on **"An Implementation Agenda for Insurance Regulatory and Development Authority of India (IRDAI) to Transform its Regulatory Framework to serve The INDIA of 2022"** published in this Journal, was a result of a task given by the Ministry of Finance following in the wake of first Monograph, to come out with suggestions for specific regulatory changes. This involved challenging the status quo, and implied deployment of a principle-based regulatory framework aiming at prudential regulations dovetailed with minimum conduct standards.

There is a constant refrain from the regulators for more than two decades that 'the Indian market is not mature for far-reaching reforms', without ever putting forward a comprehensive, clear and balanced agenda: Not realizing that it is impossible to sustain the oldest civilization and the largest democracy in the world without its associated wisdom and intelligence. In fact, recent years have not seen any transformative leap: the regulatory changes are mostly transactional and sometimes tactical. There is also no integrated framework created by the IRDAI to ensuring "Ease of Doing Insurance Business" contrary to Government's policy stance as clearly articulated at different forums by the Hon'ble PM of India.

India has repeatedly demonstrated the ability to accomplish amazing things when there is a clear mission, political will and effective partnership between policy-makers and industry. The emergence of IT and pharma firms as global competitive players, and more recent progress in areas such as space exploration, Aadhaar, digital payments and data connectivity, show that nothing is impossible. 'Make in India', essentially 'for India', can also include 'for the world' when we choose to do so.

The Indian economy in recent times has thrown up two clear messages: First, incremental reform is incapable of coping with the disruptions. Second, the government needs to take a decisive approach on the financial architecture in India: It needs to take an axe to the system, as a scalpel will no longer suffice. This is true of insurance as well, as insurance governance continues to be lackadaisical despite low and barely moving insurance penetration levels in the last two decades: Whereas research has established that a 1% rise in insurance penetration translates into a 13% reduction in uninsured losses - a 22% reduction in the taxpayers' contribution following a disaster – and increased investment equivalent to of 2% of national GDP.

Since governance is the way rules, norms and actions are structured, sustained, regulated and held accountable; good governance is a way of measuring how public institutions conduct public affairs and manage public resources in a preferred way. This abridged version of the Monograph on **"Insurance Governance for World's Largest Democracy"** is yet another attempt to put the spotlight on right insurance governance in India, providing a well delineated and a collaborative framework for a fully insurance penetrated and insurance inclusive India. **The Change Makers**, especially IRDAI must agree on fundamental preferences as well as regulatory responsibilities, in the context of laying down **Right Insurance Governance in India**: That IRDAI is an administrative set up (a friend, philosopher and guide!) required to nurture talent, technology and capital to unleash market's 'technical' and 'distributive' potential, deploying right 'tools'; That 'protection' and 'promotion' go hand-in-hand – one doesn't go without the other; That the 'letter' and 'spirit' of regulations means outcome-based regulations following its 'letter' with minimalistic stance, and 'spirits' with maximalist stance rather than other way around; That in the growth of some of the leading global financial centers the respective regulators have each played a pivotal role, and have been extremely proactive in engaging with all stakeholders – much, therefore, needs to be done in India.

In our recommended charter, the IRDAI is part of wider 'stakeholder' universe, aligns with the macroeconomic objectives and social priorities and uses modern regulatory tools to bring about paradigm shifts. Since servicing and supervising the market as an "adult" (insurance market has completed more than18 years since its opening up) requires 'upscaling'; the IRDAI Transformation - with a complete mind set change from control and regulation to competition and transparency - with the active assistance of the Government, will have to be pursued. The fact that India is a single market for insurance significantly helps the Government and the IRDAI, in particular, to put its imprimatur in underwriting human endeavours. Our collaborative framework insists on total insurance penetration in India, led by a vision that embraces inclusion and champions reforms to encourage enterprise, not just to serve the macroeconomic objectives but to feed and strengthen them. The insurance regulator is reimagined as the ultimate Underwriter of sorts, underwriting human endeavours, who is required to challenge and change the status quo, applying behavioural economics propagated by Noble Laureate Richard Thaler of "nudging" with "libertarian paternalism".

The Inclusive Framework

Indian macroeconomic objectives require sector specific policy framework that enables institution building in regulatory space. Insurance being one of the key drivers of the economy, it is important to ensure that regulatory framework has the capability to take the industry in the desired direction while focussing on bridging the protection gaps identifiable at different stages of market development.

As we endeavour to build world class institutions, the first step is to identify the right governance imperatives to create an inclusive Indian insurance market. These include a **Vision** that provides for inclusion, **Right Reforms** that encourage and reward enterprise and entrepreneurs, and The Change **Makers** to set Indian Insurance on a growth trajectory forever.

1. The Vision

The Government's Vision for IRDAI must be to promote "Inclusive, fully penetrated insurance". The regulatory accountability following the above Vision should focus on IRDAI ensuring the following:

1.1. Provide Ease of Doing Insurance Business Framework

IRDAI will be required to have a leading industry service proposition, built on progressive and right regulations, excellence in processes, and technology such that life of users becomes better. This is possible when IRDAI assumes and discharges Single Window Ownership.

1.2. Protect Market Oversight

IRDAI market oversight has to include sustainable and profitable growth of its entities that is valued by all stakeholders.

2. The Right Reforms

The insurance regulatory space in India has evolved into a prescriptive, and micromanaged supervision. The obligatory 'Development' package has not been delivered in the last two decades. One of the reasons, in all fairness, has been the hardcoding of insurance and allied laws even before the regulator stepped on to the scene. Yet, it is equally true that the insurance regulator did not foresee blowing winds of change, in the wake of Insurance (Amendments) Act, 2015 that devolved many a 'power' to the IRDAI, however limited.

'Development Agenda' is best described in the 190th Law Commission of India Report, "The regulation of insurance requires a paradigm shift from just a supervisory and monitoring role to a development role so that the insurance business promotes economic growth". This, in turn, is possible through empowering the Providers/Users and the Market with 'Right Reforms' complemented with IRDAI discharging 'Single Window Ownership'. This is why ease of doing insurance business, the rule of law and clear tax laws are so important.

In one of the many instances, the amended Insurance Act permitted IRDAI to approach management expenses and procurement costs with a fresh perspective. As a Change Maker, the regulator had to be bold and take contrarian call to allow/bunch total of management expenses and procurement expenses. This was necessary to cater to demand led booster to the management of distribution rather than supply led controls, which has only created hunted psyche. Insurers need to be trusted as prudent managers, with full regulatory accountability for their management expenses/combined ratios/embedded values and have them under regulatory scrutiny, and not having to camouflage procurement expenses.

Lack of a regulatory vision would appear to be one reason why micromanagement continued despite 2015 developments; nor did the insurance regulator work on 'tools' and 'technologies' to provide 'Ease of Doing Insurance Business' Framework despite Government of India's policy commitment to providing 'Ease of Doing Business' Framework for its macroeconomy. Even the current macroeconomic target of getting India's GDP raised to USD 5 trillion has not led to regulatory rethinking since such pole-vaulting requires active sustenance from every single sector, including insurance.

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2.1. Ease of Doing Insurance Business Framework

It must be woven with right regulatory anchors and deploying right regulatory tools. Currently, a lot of 'regulatory

policy anchors and tools' that lay the foundation of the Indian insurance regulatory architecture seem to be at variance with modern equity/rationale. For example, all 'Conduct Regulations (Standards)' are issued to the Indian market as 'Prudential Regulations'; Regulations do not proclaim and adhere to Free Competition and a Level Playing Field; Conduct Regulations (Standards) are one size-fits-all for both high performing and poor performing entities; Regulations are not outcome based; Regulations focus on compliance rather than risks. The list goes on.

2.2. Principle-based Insurance Regulatory Framework

Prescriptive framework is generally an antidote to ingenuity and innovation, and is a debilitating, discernible everyday reality in the context of Indian Insurance. Ironically, there are no visible signs in the public domain to work on the right solutions as the principle-based approach lends itself effortlessly to the 'ease of doing insurance business'.

2.3. Taxation framework

In what is arguably one of the boldest reforms in the last 20 years, the Finance Minister of India cut the effective tax rate on corporate profits from approximately 35% to 25.2% for existing domestic companies and 17% for the new manufacturing companies established before October 23, 2023 provided the companies take no exemptions. The tax rates are now globally competitive, and by putting an end to exemptions, the government has greatly simplified the corporate profit tax system and thus eliminated numerous sources of bribes, harassment and tax disputes. Similarly, the insurance regulator has to now work with the tax authorities for a consistent, stable and simple tax environment which is essential for developing an inclusive insurance set up, and for setting up an internationally competitive insurance market place in India. With the protection gap in India at USD 8.5 trillion (Report by Swiss Re - Mortality Protection Gap: Asia-Pacific 2015), all possible reforms need to be unleashed to cater to an inclusive and fully insurance penetrated India. The insurance taxation framework must promote business activity, aid equality and must be easy to administer.

There are still issues around Taxation on Life Policies a) GST' for a Term insurance (protection) policy; Payment of GST, both at 'Accumulation' and 'Annuity purchases' b) Direct Tax: Income Tax Act, 1961 ('Act'), Parity between 'NPS' and 'Life'; Annuity Taxation; Act Exemptions. There are also issues around Non-Life Insurance direct taxation involving Minimum Alternate Tax ('MAT'), Computation of income of an insurance company as governed by the provisions of Section 44, statutory provisions or reserves made in accordance with IRDAI regulations and Non-life insurance industry investing in real estate; Reinsurance taxation around TDS on reinsurance premium under the provisions of Income Tax Act, 196, Rate of Income Tax applicable to Foreign Reinsurance Branches including Lloyd's, Reinsurance Export Services – Preferential Taxation at par with other countries; and various GST' provisions relating to non-life and reinsurance contracts.

Indian insurance industry provides an essential backstop for protection against risks; supports India's economic growth by generating funds for developing the country's infrastructure; and driving social security. A conducive and robust taxation framework for the insurance sector will help foster India's socio-economic objectives. Therefore, a good tax system has to promote rather than hinder economic activity, aid economic equality rather than inequality, and be easy rather than complicated to administer.

3. The Change Makers

The Central Legislature, the Central Government, and the IRDAI must together help convert the 'science of insurance' into implementable 'tools and technology'; the 'Single Window Ownership' for such a task has to remain with IRDAI:

3.1. The Central Legislature

The Government's Legislative Agenda to cater to "Inclusive, fully penetrated insurance" needs to adhere to the following principles:

- ⇨ Principles based primary legislations that align the objectives across related streams, and prudently avoid being overly specific in the primary legislations;
- ⇨ Strategic approach to set new directions, and empowering regulator with adequate powers to conduct insurance supervision through secondary legislations/ regulations, and allowing the flexibility to respond to the dynamic supervisory environment encountered;
- ⇨ Regulatory Accountability to promote effective and globally consistent supervision of the insurance industry in order to develop and maintain fair, safe and stable insurance markets for the benefit and protection of policyholders.

The Government's legislative agenda must ensure all primary legislations

such as Insurance Act and Allied Acts undergo prudential transformation to set new directions, and prevent them becoming overly specific. This is to allow IRDAI the necessary empowerment, flexibility with an accountability to respond to the dynamic supervisory environment, and allow it to provide 'tools and technology of insurance' to the Indian insurance market led by 'Ease of Doing Insurance Business Framework'.

3.1.1. The Insurance Act

3.1.1.1. The Foreign investment ceiling – time to allow 100% FDI

This issue should be looked at strategically; incremental reform is increasingly incapable of coping with the requirement of providing an inclusive and fully insurance penetrated India. A decisive and a new approach on the financial architecture in India should allow 100% FDI for insurance and reinsurance companies. The issues that need to be tackled frontally: a) Systemic worries are best met through robust regulations b) The Government must be cognizant of the Joint Venture arrangements which, more often than not, are a source of friction amongst partners and do not help transnational insurer bring all their experiences and expertise into the market when the dominant priority might be to increase market share, and raising valuations c) The 'Indian owned and controlled' shouldn't be the dominant priority especially, when it is pitted against the more pressing need to improve insurance penetration/density, bring the global best practices into the Indian market, and also bringing more capital into the insurance business. Once Indian regulated, it shall still be an 'Indian entity' notwithstanding 100% FDI, and will still benefit India and Indians.

3.1.1.2. Insurance Business in rural and social sectors/Obligations of insurer in respect of rural or unorganised sector and backward classes

The Government of India has already demonstrated demand led transformation through its marquee programmes such as PMSBY, PMJJY, PMFBY and PMJAY etc. that has reminded the policy makers that the market is not supply driven. Therefore, such market segments require an active understanding from a development perspective rather than enforcing supply side mechanism through quotas and penal regimes.

3.1.1.3. Obligatory insurance

The social objectives, with its set of mandates and penalties, under a commercial dispensation, are an anachronism and have the potential to impede efficiency which, in turn, impacts growth.

3.1.1.4 Principles based prudent man approach to investments

Regulator should be empowered for principles based prudent man approach to investments rather than mandating them in primary legislation. The Insurance Regulator should be empowered to allow overseas investments adequately diversified, to avoid excessive reliance on any specific asset, issuer, counterparty, group, or market and also to mitigate the risks associated with investments in domestic market. It is also important to have prudent man approach norms and correlate the underwriting disciplines and the performance of the insurers with the freedom they are accorded to deal with the investments of their funds.

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3.1.1.5. Principle Based Approach to Management of Distribution

The Act should leave the Regulator with all the authority to regulate and manage the intermediation including the penal provisions on the basis of solvency and prudent business norms. Within the ambit of the regulations, the insurers should be responsible for the recruitment, training, compensation and the conduct of the agents etc. under the principal-agent relationship principle.

3.1.1.6. Penalties

The upper limits of the penalties have been raised to new levels. To cite an example: up to ₹250 million in case of violation of the provisions relating to Investments; This tantamount to 25% of the capital prescribed for general insurance companies. These issues must again be left to the discretion of the

regulator and be part of the secondary legislation, as there are more than one way to discipline an errant player.

3.1.1.7. Access to Mutual/Cooperative Insurance

It is felt that the cooperative and mutual insurance business model is not sufficiently understood by policymakers, regulators or commentators in India. The concept of mutuality was devised where all the persons desirous of covering the risks come together and initially contribute pre-agreed figure out of which the claims are met and administrative expenses incurred. In the event, this is found insufficient, supplementary contributions are collected from the various participants. In this concept, the profit element is singularly absent and the participating groups are able to seek reinsurance at a cheaper rate and that too after going through their own retention and such like-minded societies group together retaining a substantial portion. This concept has been successfully implemented for Marine Liability Cover where sum insured is not mentioned in the Certificate and the participant's liability, be it contractual or legal, is a limit of Insurance. More than 90% of the world tonnage is covered under such associations collectively known as International Group of P&I Associations. In India, if one has to think in terms of at least coastal shipping to be served locally, the concept of Mutuality needs to be recognized under the Mutuality Act. If this is done, the Indian Ship-owners can then form an association to run the Mutual Insurance Organization to protect the contractual and legal liability of the participating Members.

The Insurance Act in India does not recognize mutual concept of Insurance which is in vogue globally. The mutual and cooperative sector is one sector that can change the face of deprived and destitute in India by putting people before profit, and that too seamlessly to protect the lives and the livelihood of millions who are otherwise not reached by commercial insurers. In the paradigm of developmental work, the 'pooling' and 'community' deliver best results.

3.1.2. The IRDA Act, 1999

The Chairperson, to be appointed by the Central Government, should essentially come from amongst the best of Indian/ Global professionals with appropriate background. Given the transformation agenda, the Chairperson cannot afford any apprenticeship in the basics of insurance, notwithstanding industry familiarity, as the job delivery starts from Day 1. The term of the office could vary from 5 to 8 years, and the maximum age could go up to 75 years – for necessary experience and sustained delivery. The choice of the whole-time / part time members be left to the Chairman/IRDA Board to be among the best of Indian/ Global insurance professionals and not just from among the public sector organizations. The term of the office could vary from 5 to 8 years, and the maximum age could go up to 75 years.

3.1.3. A New "The Indian Insurance Act – India Code for Laws relating to insurance contracts"

The laws relating to insurance contracts in India require a transformative vision. For instance, the principles of 'contract certainty' could be codified to adequately protect Policy Holders' interests, catering to a mechanism that is based upon 'Contract Certainty' (pre-sale) and 'Effective dispute resolution mechanisms' (post sales servicing), with Fraud Management standing guard at both ends. The primary legislations of the insurance, however, do not deal with the conduct of insured: Insurance being a technical subject initiating prosecution against misconduct of Insured under the general laws becomes difficult and most of the time remains inconclusive. Insurance is a business of trust. Insurers are considered to be the trustees of the premium paid to it by policy holders and capital funded to it by its shareholders. Unlawful appropriation of such money held with the trustee is a crime against the other policy holders and shareholders. This fact itself calls for a stringent penal provision to be embodied in the primary legislations to act as deterrent against people opting to indulge in such activities. Other than having stringent penal provisions in the primary legislations, it is also required to establish special investigation agencies with appropriate skill set to monitor, investigate and determine insurance misconducts including fraud. In this reference, precedents can be drawn from mature markets such as UK and US. Other than having statutory provisions to combat insurance misconduct including fraud, the legislature of such countries have facilitated constitution of special bodies for investigation and prosecution of insurance frauds besides monitoring fraud trends and advising Insurers and regulators accordingly.

3.1.4. Public Liability Act, 1991

The Act after its enactment in the year 1991following Bhopal disaster hasn't been updated / changed. For instance, arising out of an incident as defined in the Act, the compensation payable for fatal injuries is just Rs 25,000. The Act needs to be recast and realigned to reflect societal obligations to better protect the Indian consumers should an incident happen.

3.1.5. Ombudsman Scheme - Grievance Redressal Mechanism for 'Personal Line' insurances Redressal of Public Grievances Rules, 1998 (RPG Rules)

The present form of RPG Rules have certain anomalies, and it is necessary to convert the RPG Rules into a dispute adjudication procedure that can be relied upon by the retail customers and the insurers. An improved and fully empowered Ombudsman office should handle entire traffic of grievances as an adjudicative process, including the incorporation of an adequate appeals process.

3.1.6. Changes made to Chapter XI of the Motor Vehicles Act, 2019 dealing with Third Party Claims and its impact

It is important that Motor Third Party liabilities must be allowed to be managed as First Party Claims administration. In view of the Motor Vehicles (Amendment) Act, 2019 provisions, it is essential that the Indian Parliament / Central Government allow direct control and support to the insurance companies in the management of Motor Third Party Liability claims to make it much more inclusive, and provide efficacious, timely, just and fair compensation to the victims of Road Traffic Accidents.

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3.2. Central Government as The Executive

The general economic agenda of de-regulation and de-bottlenecking; Improvements in Global Competitiveness Index; World Bank's Ease of Doing Business Index; Promote India globally as an Arbitration Hub for Alternative Dispute Resolution processes; Letting Indian enterprises have a major role in improving the GDP growth rate; and to increase India's Geo-strategic reach in the new world order are all eminently linked to the insurance sector in their fulness. The insurance agenda must be pushed with the right note – bring regulatory seat to Mumbai, where the financial ecosystem is and where bulk of the insurance market operates from, to allow cross-pollination and interaction between the 'market' and the 'regulator' that will make the regulatory governance richer, and improve Ease of Doing Insurance Business.

3.3. Central Government as The Owner of Insurance Firms

There are two vital aspects with respect to Indian insurance governance: First, government's touch points conflict. It has a finger in every pie: Legislature; Executive; Super insurance regulator; A significant owner of the insurance firms controlling large chunks of the market in 'Life', 'Non-Life' and 'Reinsurance' segments, and a large buyer of insurance protections especially across Crop, Accident & Health and Life and Pension segments. The conflict of interests is an inevitability, which impacts governance. Second, and consequently, it is not easy to govern its own insurance firms either, and the following highlights may help:

3.3.1. Life Corporation of India (LIC)

LIC has been a crown jewel for the Indian economy. It is believed that if the LIC shares are listed on stock exchanges, it could emerge as country's top listed company in terms of market valuation. The public listing of LIC will lead to more disclosures of its investment and loan portfolios and better governance where there have been areas of concern. A recent report by Subhomoy Bhattacharjee in the Business Standard of February 27, 2020 under the caption of "LIC governance makes it a poor market bet" has further supported market concerns, "India does not have a sovereign wealth fund but if it did, it could look like the LIC. This did not happen by design, but the combination of a government-run life insurance business operating in a monopoly market until 2000 has made LIC a de facto one. The institution still does not fully report to the insurance sector regulator, being governed by a separate Act. It is one of India's largest employment generators. It is also suspected of having destroyed wealth because successive governments have used it to bolster the stock market and, of late, add to disinvestment receipts. The problems with LIC is that it provides

sub-optimal returns to the government, its shareholders, and to policyholders. To be sure, LIC will remain India's largest life insurance company for at least this decade. It has a market share 66.24 per cent in total first year premiums and 74.71 per cent in new policies. It has an investment corpus of Rs 31.9 trillion as of March 2018. But it rarely invests this money well. LIC's balance sheet shows, just about half its premium is used for building up its profit. This could be good news for policy holders, but bad news for shareholders. Even for policyholders, the data shows that only 51 per cent of policies last beyond five years, which means about half of the policyholders drop out early leaving LIC richer by the amount not claimed back. Therefore, LIC is profitable for "wrong" reasons. More LIC customers use its policies as an investment (essentially tax saving) avenue than as a life insurance product. Add to this the demands placed on LIC by successive governments. Participating in disinvestments was the most dramatic of those, but there are other less noticed impositions. LIC governance makes it a poor market bet, and the IPO plans for the state-owned insurer is likely to reveal weaknesses in its business model".

3.3.2. General Insurance Corporation of India (GIC Re)

GIC Re is notified as the 'Indian Reinsurer', and has a dominant position in India and has an international profile. It should logically lend its weight to let India become a Global Reinsurance Hub; and not continue to seek preferential treatments, which do not necessarily help it commercially. On the contrary, withdrawal of such crutches will help GIC Re to work on globally benchmarked specialisms, and not remain sheltered under protectionist policies at home. GIC Re could be the next financial sector crown jewel provided the Government understands that although GIC Re significantly reinsurers Indian insurance market, its sustenance and strength comes from its global play. It must be granted professional independence and support as befits an Indian multinational. Lack of this understanding saw its 2017 IPO receive a tepid response from the market, with little over half subscription coming from LIC. Also, its market capitalisation has been losing steam since then.

3.3.3. Non-life insurance companies

'New India', despite being the largest general insurance company in India, saw its 2017 IPO receive a nonchalant market response, with LIC subscription providing the life line. Its market capitalisation too has been losing steam disconcertingly. All PSU Non-Life firms, except 'New India', have been straining at the leashes in terms of solvency margins, marked by persistently underperforming core businesses. All firms have also experienced periods without permanent top leadership. The Central Government on 1 February, 2018 had proposed the merger of 'National', 'United India' and 'Oriental' Insurance into a single insurance entity prior to being listed on Indian bourses. This is work-in-progress even after two years. The continuing uncertainty around the future of these companies is taking a toll on their businesses – their collective market share that stood at 30.05% on the day of government announcement, has plummeted dramatically. Their 'Air India moment' is staring at their faces.

The PSU insurance companies have also been obliged to launch schemes at unviable low premiums. The government has created a Pradhan Mantri Jeevan Jyoti Bima Yojna – a term life insurance policy. In 2016/17, the second year of its operation, claims under this scheme exceeded premiums by 21%, making it unsustainable. An even worse outcome afflicted the Pradhan Mantri Suraksha Bima Yojna, which provides payment of Rs 2 lakhs for accidental deaths or grievous injuries. In this case, claims were a whopping 70% higher than the premiums. This is one of the reasons why government insurance companies, like the government banks, are not getting privatised. This is also the reason, it is part 'disinvestment' which is being pushed rather than ushering in governance changes.

Required Policy changes in the Indian PSU Insurance space

The PSU insurance firms (LIC/GIC Re, AIC and the four GI Companies), which are the Systemically Important Financial Institutions (SIFIs - The Financial Stability Board (FSB) refers SIFIs as institutions "whose distress or disorderly failure, because of their size, complexity and systemic interconnectedness, would cause significant disruption to the wider financial system and economic activity") deserve government's and IRDAI's attention to ensure that institutions such as LIC and GIC Re have significant footprints in the global sweepstakes; and the non-life firms are harmonized to service the Indian markets effectively. As the distress is obvious in at least few of the firms, Government's Transformational Agenda as an 'Owner' has to include all PSU insurance Companies' governance and management oversight by a fully independent, professional and empowered Insurance Board Bureau (IBB) to get them transformed into world-class insurance providers.

The Indian government, in January 2017 had approved the listing of country's four PSU Non-Life insurance companies and the lone state-run reinsurer GIC Re to ensure higher levels of transparency and accountability and to gradually bring down the government holding in these companies to 75% from the present 100%, after 2015 insurance amendments allowed government stakes to be brought down to 51%.

The divestment process started with GIC Re and New India in the late 2017 with not so encouraging results. Whilst divestment could be a one-time decision making, listing requires strong management turnaround processes, on a continuing basis. With banking sectors' afflictions also visiting the Indian PSU insurance space, following have become commonplace, in addition to its own:

1. Despite being a sector regulator, the IRDAI does not fully extend itself in regulating state entities;
2. There are managerial and structural issues facing the PSU insurance companies;
3. A consistent succession planning is not in place, especially at the top echelons despite some of the entities being listed companies;
4. There is a fear of 4 Cs (Courts, CBI, CVC and CAG) overhanging.

The PSU insurance firms must be granted professional independence and support as befit Indian companies servicing vital cogs of the Indian economy such as Health, Agriculture, Automobile and practically the entire Indian economy. Since the idea behind the merger of three non-Life PSU insurance companies into one is to create a single strong and better governed entity, reduce inter-company competition (it has been so cut throat that even in those business lines where the PSU insurance companies are largely dominant e.g. Energy, Aviation and Marine Hull etc. the results have been negative) so as to fetch better valuations at listings (also prop up the sagging employee morale, improve systems and unlock financial strengths), it is much more prudent to merge the three companies with Mumbai based New India, which is already a listed entity.

What is perhaps true of the banking sector is largely true of the PSU Insurance companies as well, in problem diagnostics. After almost fifty years of insurance nationalisation, government companies cannot still be seen as an enterprise driven by social purpose and political considerations – not policyholders' interests. Therefore, all the PSU Companies including LIC, GIC Re, New India (after the merger of other three companies with it) must be enabled real professional set-up working under the umbrella of a fully independent, autonomous and empowered Insurance Board Bureau (IBB), solely entrusted with the governance and oversight of the management of the PSU Insurers with diversified skill sets. As the dual regulation has been found to be ineffective and costly, let IRDAI be the sole regulator for the PSU Insurers.

The IBB will work on the next level of governance standards for the PSU entities under its charge:

1. The IBB will independently set all policy standards for the PSU Insurers under the "delegated authority" from the Government of India;
2. The Board will negotiate fresh paradigms and independence for its entities' accountability to CBI, CAG and CVC, as proposed by YV Reddy, Former Governor RBI in a speech in 2002 (Indian Banking: Paradigm Shift in Public Policy);
3. The Board will consist of best of professionals from Government, PSU, Indian Private and Global Private Sectors;
4. Setting up of independent boards with diversified skill sets for the PSU companies: Checks and balances to ensure independence of independent directors;
5. All the PSU Companies will be run professionally by the best of professionals with full autonomy and an eye on the best of class servicing ensuring profitability against the current ethos of Top Line chase;
6. Audit quality indicators to be made public, to increase transparency: Indian Accounting Standards implementation for all entities;
7. The PSU entities would be encouraged to use business surpluses to augment capacities rather than be pressured to share them as dividends;
8. The PSU entities would be encouraged to charge risk based pricing to service government sponsored schemes in life, crop, accident and health segments. If the private insurers are finding the PM Crop insurance costly and pulling out, the PSU insurers should be doubly careful because of their higher management expenses; extremely low reinsurance commissions; delays in getting the premiums from the state governments that could put their cash-flow management under severe stress; political intervention in claims settlements; and continuing manually operated crop cutting experiments in a lot of cases.

Moreover, the contagion through co-insurance mechanism would spare none of the government owned non-life insurer.

9. There has to be a need for wide-ranging human resource policy changes, in line with the competitive environment and compensations that will include short term variable components, need for better incentivizing and allowing compensations through long term stock options, and an eye for long term succession planning;
10. The IBB will be accountable to the Government for all the financial parameters, as agreed. Among other things, the IBB will be responsible for a sustained and solvent insurance companies.

Structural measures take time to work their way through the system. But even the announcement effect of structural reforms can be stunning. If for example, the government were to put out a roadmap for giving up its majority stake in PSBs (read PSUs), it will go a long way in shoring up sentiments. Before this, however, if the IBB is made successful by the Government, it might render the debate - whether to bring down government holdings below 51% - as insignificant and inconsequential.

Structural measures take time to work their way through the system. But even the announcement effect of structural reforms can be stunning. If for example, the government were to put out a roadmap for giving up its majority stake in PSBs (read PSUs), it will go a long way in shoring up sentiments. Before this, however, if the IBB is made successful by the Government, it might render the debate - whether to bring down government holdings below 51% - as insignificant and inconsequential.

3.4. The IRDAI

It must cater to the Vision of "Inclusive, fully penetrated insurance", and fulfil macroeconomic target of adding 1% insurance penetration by 2025. The Chairman, IRDAI, as the CEO of the Indian insurance market, has its tasks cut out. The agenda for 'Inclusion' has 'Development' and 'Supervision' go hand-in-hand, and the Macroeconomic agenda is best possible through empowering the Providers and the Market with 'Right Reforms'. The IRDAI, as the leading Insurance Change Maker, must work through 'Good Governance', as road mapped, to give Indian insurance market affordable choices to demand and get right insurance services and solutions. Besides, it must work on significant priorities such as: Promoting India as the 'Reinsurance Hub', an Insurance ADR Hub, and help establish a Country Risk/Management framework etc.

Good governance will require a Credible, Responsible and Proportionate Regulatory architecture in line with global best practices, duly localized and supported by:

1. A robust, proficient and transparent legal, regulatory and tax environment as well as modern Dispute Resolution Mechanisms;
2. The ability to attract and develop talent, and build a strong infrastructure of supporting services;
3. A commercial and entrepreneurial business environment.

A proactive IRDAI, in its undiluted Vision and tasks, would have to summon the best modern 'tools'. The current vertical ownership for the five Whole Time Members is along business/functional lines ('Life'/Non-Life'/'Distribution'/'Actuarial'/'Finance'), which neither caters to the 'development' priorities not does it distance 'Conduct Standards' from 'Prudential Regulations'. This is the reason perhaps everything is 'prudential' currently. Therefore, revamp is necessary, with the Whole-Time Members allowed to lead 'new' verticals such as:

1. Member, Development (to cater to the 'Development' of the entire 'insurance sector')
2. Member, 'Prudential' and Risk Management (including Enterprise Risk Management embedding capital adequacy, risk management and governance);
3. Member, 'Conduct' Management (including Audit & Compliance, and protection of policy holders interests);
4. Member, Finance & Investments;
5. Member, Legal (including policy and regulatory enforcements)

The part time members can be more specialised functions depending on the requirements. The choice of the whole-time / part time members should be left to the Chairman/IRDA Board, to be chosen from among the best of Indian/

Global insurance professionals and not just from among the public sector organizations. Besides, the Regulator is required to create specialized knowledge, flatter organisational structures, and accountable ownerships within IRDAI; regulator must ensure good mix of talent from both the private and public sectors, even on secondments; and for a high performing culture, best practices and inspirational leadership, the direction should come from a revamped Insurance Advisory Committee having the best of Indian and Global financial/insurance/ reinsurance leadership, along with sectoral experts such as Healthcare, Agriculture, Technology, Marketing, and Corporate Governance etc.

Once the 'Ease of Doing Insurance Business Framework' is ready, built around leading service propositions, right regulations, tight processes, the IRDAI as the Change Maker, would be required to launch forth to 'influence the choice architecture of people'; switch from economies fundamentally being in equilibrium to a mode where there is a constant disequilibrium with economies spiralling around in vicious or virtuous cycles; and use behavioural economics, particularly the idea of a "nudge" in policy design. Behavioural economics provides the necessary tools and principles to not only understand how norms (policies) affect behaviour but also to utilise these norms (policies) to effect behavioural change.

4. The Technology that acts as a Catalyst

Start-ups are rewriting India's economic roadmap. By supporting start-ups, risk-takers, and wealth-creators building for a better future, India can accelerate its transformation into an economic powerhouse. InsurTech is neither just about technology, nor finance, it is about innovation and inclusion. The Indian insurance market, therefore, deserves this game changing tool:

4.1. Insurance Sandbox

Within insurance, the "Sandbox environment" must primarily cater to business propositions such as "Insurance Solicitation or Distribution" and "Insurance Products" rather than 'Underwriting, Policy and Claims Servicing' since these are operational mechanisms that can be fast tracked through direct regulatory clearances;

4.2. Federalisation of Technologies

InsurTech can also bring about federalization of technologies provided the "New Business Models" are allowed to cut through current silos of 'life'/'non-life'/'reinsurance'/'banking'/ 'capital markets' etc., and usher into a single "Sandbox environment" across all the financial services at IFSC, GIFT, Gandhinagar;

4.3. India and Global Developments

India must learn from global developments where there are two broad models available: UK/Singapore and China - In UK, the FCA and PRA have brought together experts of many disciplines to monitor FinTech developments to cater to "community of interest". The Bank of England also runs a FinTech accelerator. The FCA's innovation department works with twin objectives: Policy engagement and Services for InsurTech firms. The FCA has the largest team dedicated to innovation in Europe – Project Innovate. It has both a regulatory sandbox and an innovation hub, through which firms can request direct support from a dedicated team. In Singapore, the MAS believes that a key driver to transforming Singapore into a smart financial centre is the provision of a regulatory environment that is conducive for innovative use of technology; The InsurTech market in China isn't led by the small startups: large digitally savvy incumbents or large internet companies command the emerging and still-growing market. The Chinese insurers take the lead and drive innovation internally.

Epilogue

If inclusion has an anchor value, insurance sector should have received complete transformation push much earlier as it has therapeutic values and contributes to stabilise macroeconomics; reduces risks; builds resilience; helps usher in structural reforms leading to bridging of protection gaps. India is not just the largest democracy, but the oldest living civilisation on earth, and the inclusive insurance governance will help perpetuate this living reality with renewed health and agility. Yet, the Indian insurance penetration of 3.69% of the GDP is pitted against the global average of 6.3% (Penetration rate is measured as the ratio of premium underwritten in a particular year to the GDP), and the Indian insurance density of USD 59.7 is staggeringly low compared to the world average of USD 638 (Insurance density is defined as the ratio of premium underwritten in a given year to the total population, measured in US$ for convenience of international comparison). Given what insurance can do for an inclusive India, insurance transformation cannot wait longer. Further, in building the First-World India of tomorrow the endeavour should to be to start building world class institutions from today, drawing lessons from best global practices.

Avoid Pitfalls in Stock Market Trading and Safe Guard Your Life Savings

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As a Panel Member in the SEBI Mandated investor disputes mechanism of NSE/MCX, I come across small investors losing big chunks of their life time savings just because they did not follow simple precautions.

Hence in this brief paper, I am highlighting some simple precautions to be taken by investors:

I) **Don't be greedy or look for quick buck.** Trading in stock markets is not without risks. Given the volatile nature of stock markets, the chances of losing money are as frequent as the chances of gaining. Big Trades can give big losses.

II) **Read Member – Client Agreement.** In the Stock Exchange parlance, investor is referred to as "Client" and the Stock Broker as "Trading Member". Often investors give a blank signed Member-Client Agreement. This can be misused by the Stock Broker / his employees. Please fill in the key columns, like 1. Your complete name and address, 2. Your mobile number 3. Your email id 4. Whether you opt for e-contract notes or contract notes in physical form 5. Clearly fill in the segments in which you will be trading (For example, cash, derivative, commodity etc.).

III) **Insist on a copy of the Member-Client agreement** duly signed by the Stock Broker and verify them before you start trading.

IV) **Don't reveal any pass words** to the Stock Broker, his Authorised Person or his employees.

V) **Stock Broker lives on brokerage but the risk is yours.** Hence the more the trades, the more his earnings. But the risk of gain or loss is on you. Don't rely on investment tips given directly or indirectly by the Stock Broker, his Authorised Person or his employees. Rely on your own well considered assessment.

VI) **Check SMS/Contract Notes.** If you have opted for e-contract notes, lodge an immediate e-mail complaint followed by written complaint if you notice any discrepancy between your orders (for buy/sell /brokerage charged, etc.) and the transactions as recorded in the contract note. If you have opted for physical contract notes, lodge an immediate written complaint if any discrepancy is noticed. **Don't rely on oral complaints and oral clarification; they are of little value.** Check SMS alerts received by you on transactions during the day and complain in writing if there are discrepancies.

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VII) **Don't enter the derivative segment** unless you have knowledge and expertise on derivative (futures /options) trading.

VIII) **Don't trade on borrowed money.** Resists taking loans from Banks, NBFCs, etc d to fund margin/short falls in trading account with the Broker.

IX) **Think before giving a Power of Attorney** to the Stock Broker. POA is not mandatory. If you decide to give POA, give a specific POA limiting it to, say, transfer of securities for margin purposes or for settlement of trades and that too for a specific period. Don't give POA to persons / entities other than the registered Stock Broker.

X) **Lodge prompt written complaint to SEBI / the Stock Exchange** on any dispute/grievance. This can be done electronically through their website.

Critical Questions on Covid19 and Management of Behavioural Safety Interventions: India Case Study

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Abstract

In the present conditions of Covid19, it is very critical for everyone to redefine what is safe behaviour and spot-correct it for safety of self and others. This article addresses some behavioural safety aspects of Covid19 in terms of why people take risks as they do; what are the similarities and differences between Covid19 and behavioral based safety (BBS) management, since both interventions are driving behavioural change; how to implement BBS after lockdown in plant, and the behavioral challenges and solutions for containment of Covid19.

This paper is based on qualitative methodology using interviews, group discussions, field surveys. Objective is to review the current conditions and enable people to access this researched information for effective management of behavioural safety interventions. Implications are discussed for best safety culture.

Keywords

Covid19 Questions, Behavioural Safety, Culture, India.

Introduction

Covid19 impacted all countries, this article is about India's behavioural safety

culture among its huge population. Behaviour based safety (BBS) is a culture of caring for people around, to ensure "0" harm. Safety is not ingrained in our behaviors in our cultural context. Let us not even assume that due to COVID-19, safety would stay in our behaviors. We have got it temporararily in our behaviors. Until it is emphasized on continuous basis, these Covid19 at-risk behaviors would re-emerge, and it would become a threat to our human resources and economy of our country again.

According to WHO (2020), one of the most critical elements of reducing this virus transmission is behaviour of people. During this scenario, to combat Covid19 permanently, the governments (along with public private partnerships in all states) are trying harder to engage citizens and businesses of the country toward health and safety behaviors and mindsets. What is most compelling today is to engage the human mind with work during lockdowns. The government, the workforce and managements are finding ways in this direction through brainstorming discussions so that the economy can come back on track in all countries (ILO, 2020).

Also, there is a need to understand that in present conditions, the businesses that are going to survive are those whose health, safety and environment (HSE) systems are behavior-based, and are not merely reflected in documentation. The business leaders of the country must underline this. Further, the business journey is focused on safe behaviours involving people from top to bottom. The leaders must see these changes in ways that gain and maintain the trust of their people (Accenture, 2020). Another major challenge posed by Covid19 is that people are finding it harder to adjust and internalize new behaviors expected during lockdown. Human minds are hard-wired. Imbibing new behaviors such as distancing etc. takes much time for most people, because behaviors are rooted in cultures. BBS is an application of behavioural science precautions is critical since any unsafe/ at-risk behaviour at any place by anyone would certainly lead to incidents and illnesses.

Objective

Behavioural safety approach is a training methodology to emotionally sensitize and empathize all including top leaders towards inculcating an interdependent safety culture. An objective in this article is to review the current conditions of Covid19 and enable people to access this researched information for effective management of behavioural safety interventions. In India, BBS is also referred as Bharat Bane Surkshit (Nation becomes safe), in which the responsibility lies on the shoulders of all corporates and citizens, for implementing BBS and saving human life from incidents/illnesses.

Methodology

This paper, is based on qualitative methods using personal interviews, group discussions, and field surveys. This study is part of an ongoing interdisciplinary intervention of behavioural science, management and industrial safety disciplines, which is a national longitudinal action survey in India. For this research paper, a total of about 1000 persons were approached through remote data collection techniques. These research participants had already implemented behavioral safety at their sites. The research participants included, the CEO, Directors, managers, heads of departments, safety professionals belonging to the public and private industrial sectors such as chemicals, construction, gas, power, and steel across Indian locations. Their responses to the Covid19 related questions were collated and thematic data analysis was used to reflect the findings. Interestingly, as part of this action survey, the participating organizations also started implementing Covid19 related new behaviors at sites.

Results and Findings

This research explored the following critical behavioural safety aspects of Covid19.

Research Statement 1: Why do people take risks as they do?

Psychologically, people don't change with a change in safety definitions, which introduces risk into their life. Also people define safety differently for others from themselves, and the gap remains narrow between compliance and compromise at various on the road and work situations. Risk-taking behaviors vary among people, cultures and countries. Risk perception of Covid19 is based on risk consequences being felt as immediately visible, which it is often not. Hence people keep taking risk. Also the risk perceptions depend upon the antecedents, the social realm and cultural backgrounds of people (Jens, 2019). According to Susan Michie (2020), given the differences in behaviours and their contexts, the factors maintaining them differ as do the ways of changing them. As a citizen, when we don't follow safety practices in general on a daily basis, our risk perception remains low. Moreover, we don't conduct new safe behaviours (social/physical distancing, wearing face mask, hands hygiene etc.) as they are not in our cultural background. As

soon as, the lockdown enforcement is relaxed, we come back to our old behavioural patterns, possibilities of Covid19 spread exist and our risk-taking behaviors remain high. In order to prevent or circumvent this, we need to spread safety messages through multiple ways such as media, government, motivational speeches on a continuous basis. Behavior based approaches are long term interventions to contain HSE (health, safety environment) risks. The lockdown enforcement, political thought process etc. are temporary and short-term responses to these pandemics. Hence the managements ought to prepare accordingly.

We need to think even beyond vaccine for Covid19, as our most critical action is needed to contain the spread of the health risks through behavioural safety initiatives and interventions across all levels, areas and sectors in the country. We are at the crossroads. Today the issue is not only tackling the Covid19, but to address and reinforce the overall safety culture as a national agenda of the governments as planned interventions for saving human life before the incidents. Henceforth, we need to adopt the new set of these desired behaviors as a SOP and work-life styles to say goodbye to such risks. It is time to reflect on our company's cultural values (Berman and Thurkow, 2020).

A most critical question remains, would lockdown exit mean that we exit the risk of Covid19? Post-lockdown is a more critical period when people are less alert about the risk exposure. The answer lies within everyone in terms of how we handle the post-lockdown risks around, when we go out, whom do we meet etc. Thus, being careful and alert or not would render everyone safe or unsafe. According to Cloete (2020),

A most critical question remains, would lockdown exit mean that we exit the risk of Covid19? Post-lockdown is a more critical period when people are less alert about the risk exposure.

much of the expected impact originates from behaviour and lifestyle changes. Lockdown essentially introduces a slowdown in everyone's life. Hence adjusting to slower life conditions as compared to the faster life styles would take time.

Another vital question or at-risk behavior is why certain groups of people are not cooperating in fighting Covid19 despite government's support and resources being made available. Is it because they have not internalized safe behaviours yet, or not understood the consequences of this disease. That's one reason that the chain of Covid19 is not being broken. How to achieve over this behavioral aspect is critical. Is it because of the crisis that has increased in the personal, professional and economic life of vulnerable section of society? Cricket stars urged that the country can be successful in its fight against Covid-19 only if people co-operate (India Today, 2020). It seems that these people are still following the pre-covid19 unsafe behaviors as contextualized in their cultural practices. Un-risking the present context would require sustainable and focused efforts along with Covid19 implications and impact on human lives. Hence, Covid19 fatalities would continue till people adopt a required culture of safe behaviours.

Research Statement 2: What are the similarities and differences between Covid19 and behavioral based safety management, as both interventions are driving behavioural change?

People normally take at least 2-3 weeks to understand and adapt to the new behavioural changes expected in a new environment such as lockdown in the context of large public of a nation. Some deviations to these new behaviors may appear and reappear for few weeks till people adjust and exercise self-control, irrespective of a place/country, and we deal with the implications thereof, and keep innovating/ developing new solutions. We come across similar deviations while implementing behavior based safety at industry sites.

Secondly, when could we say that we have achieved zero number of people with Covid19 ? What are its implications and solutions? It would depend, not only on lockdown enforcement, mass education and awareness, social / physical distancing, motivational speeches, economic relief packages but also on continuous identification of cases through testing, re-testing, quarantining, monitoring, treatment, innovation etc. as a long term perspective. Any such country-wide or global multilevel socio-medico-economic-behavioral intervention requires rigorous follow ups throughout for a year or so, failing which the chances of relapse/reoccurrence are equally high. We need to be ready for its long-time implications and solutions of any such pandemic social health issue. In brief, such interventions have to become a part of the existing safety health environment (SHE) management style in order to avoid relapse and achieve zero-corona-virus case or zero at-risk behavior at sites.

What are the similarities and differences between Covid19 and BBS management, as both are driving behavioural change? Negligence of both can cause havoc. Both can be controlled through behaviour. To save humanity, we need to focus on our behaviour which alone will ensure our victory in this hour of peril.

BBS management and Covid19 management seem to be similar. For Covid19 the steps are : 1. Make him aware about Covid 19; 2. Educate him why precautions are necessary; 3. Tell him what is the risk; 4. Ask him what is missing; 5.Take promise that he will follow throughout; 6.Thank him.

Both Covid19 and BBS can lead to high severity if not corrected by taking adequate precautions in terms of behaviour (self as well as others), here everyone's safety is interdependent. Another similarity is that both are observable, measurable, implementable and curable. If Government wants, it can implement HSE systems. All behavioral changes will take place. We have seen harsh punishment like police beating the violators but it was appreciated and supported by everybody including media. When safety professionals advice management to take action against violators, they find excuses to save them. Now the government is implementing all safety measures, not the safety professional. The national safety council (NSC) should clamp down like WHO. But, on the contrary, as seen in past few decades, the safety enforcement in industry is poor by <30%. That is why, precisely, the behavioural implementation is recommended in all world safety standards (Kaila, 2019).

A similarity between Covid19 and BBS is that we care for each other. Both lead to positive, sustainable, environment friendly behaviour among human. Whereas BBS management nurtured through a harmonious and cohesive way, Covid-19 pandemic is working through a fear-based approach which is opposite to BBS. According to an executive director of India Glycols, an application of BBS is the need of the hour. Wearing PPEs and staying at home are very much the desired behavioural aspects. During Covid19, the Police have become the observers and they also need BBS training. Of course, there are exceptions with some police people trying to counsel the public in a positive way. In many cases, they are not polite and many among the public also don't understand being polite, despite advices from leaders, celebrities and media. Patience and politeness are the keys of any behavioral change intervention. Moreover, control by oneself (self-observation of social distancing, face mask etc.) in community sites is very crucial for one's own health and safety, when one is not certain about infection spread from another.

Level of Management of Safety Risks are: 1. Reactive safety, 2. Dependent safety, 3. Independent safety, 4. Interdependent safety. In Covid19, we are almost operating at level 1 & 2. We have reacted to the situation proactively and are now dependent on the governments actions for our citizen's safety. For example, during such time as we are dependent on parents, we keep committing mistakes; as soon as we become independent, our behavioural alertness is increased/ multiplied.

If we wish to go to level 3 & 4, then we need to open/exit lockdowns, everyone is supposed to manage the personal risk on his/her own. We need to understand here that our behavioural alertness is highest; when risk is known/well-defined. For example, we are at high risk during daily morning/evening's city peak traffic time, and we are highly alert at that time for road driving behaviors knowing the risks involved. Presently, in Covid19, we reached a situation when everyone is aware of risks. You are aware, you need to be alert and alert others as well.

Also, an enforcement for facemasks and physical distancing is not relaxed in level 3 & 4. It is considered a violation if people don't wear PPE or maintain social distance at all places etc. Companies also thought of a new better safety idea during this Corona virus lockdown time that would be practiced in the times ahead at sites. The responses included:

1. our management took benefit of e-learning during this lockdown period. We arranged audio conference for further action on safety implementation.

2. We started comprehensive training program on BBS for the workers who are residing in company premises. We have trained two of them through video conferencing and assigned them to train all other workers. By doing this, we have engaged all of them for 4 hrs. This is also helping them to get rid of anxiety. We are maintaining 100% social distancing on a daily basis.

3. Preparing in time - we started temperature scanning from 12th February 2020.

4. Using a device to proactively ensure de-energisation of electrical equipment in addition to conventional LOTO (lockout tagout) to eliminate human intervention, using AI (artificial intelligence) to enhance safety.

Research Statement 3: How to implement BBS after Lock down in plants?

a. We need to add a New Behavioral Category "Lockdown Behaviors" in BBS observation checklist and communicate to all employees through different media for implementation at site.

b. Each area in charge must conduct daily small group TBT (tool box talk) to convey the principles of lockdown (social/ physical distancing, face mask, no spitting, hand hygiene etc.) while observing and spot-correction of at-risk behaviors.

c. Each area in charge must Display Sign-boards at all respective areas/ entry/exit etc. as below in English and Hindi

   - Maintain Safe Distance
   - Keep Wearing Face Mask
   - Follow Queue at entry/exit
   - Don't Touch Surfaces
   - Request each other to do so if they don't
   - Convey all the above on Public Address System (PAS)

d. Occupational Health Centers (OHC) must conduct random medical/ COVID19 specific tests for further actions. All employees entering should be checked at the gate with infra-red thermal cameras for fever.

e. This is the time when all Safety, Health and Environment (SHE) teams must coordinate actively for behavioural implementation of procedures and guidelines through departments.

f. There are similarities between BBS and lockdown implementation as both are people-based and behavior based. This is an opportunity to strengthen BBS further at sites.

HSE Vice President of Dorf Ketal company said, "we made the changes accordingly and advised all BBS observers at sites to do observations/ spot corrections accordingly as mentioned above". This indicates the role of leadership guidance/thrust all over in organizations. A safety head said, "power plant being essential services, is continuously in operation and uninterrupted electricity is provided while ensuring all required safety precaution to prevent COVID 19.

Organizations need to provide feedback to all employees every single day using multiple communication channels to keep people informed about the company's responses to the crisis (Cooper, 2020). According to a Director of DCM Shriram, these are the thoughts and actions in order to change post-Covid behaviours to prevent further spread and for resuming operations safely. Above all, it is high time, each citizen and employee plays the role of a safety catalyst in promoting interdependent safety culture everywhere. Governments alone cannot achieve the target of zero number of people with Covid19. Sooner or later it is important for society that the public and each person understands one's significant role in critical times in favour of human race by contributing safe behaviours each day. Be an active observer.

Research Statement 4: What are the Behavioural Challenges and Solutions?

Everyone is aware and unaware of his as well as other's safe/ unsafe behaviors. Moreover, everyone needs correction as well as can contribute towards behavioural changes in others.

1. According to Betsch, et al. (2020), behavioural insights for COVID-19 are of critical importance. Behavior remains a challenge for safety implementations. Hence regulated training, retraining, monitoring, measurement, rewarding, should continue by respective area incharges.

2. Fear and Stress: everyone is feeling low these days with Covid19. Keep listening and talking to people. Keep the environment positive. Personal and group counselling is right approach that would keep organizational morale up.

3. How to mobilize people to be safe: continuously engaging people mentally through mass-communications helps to mobilize them for behaving in a safe way. For example, in Mumbai local trains, people travelled on rooftops of electric trains due to overcrowding. Everyday a couple of persons would die. Then the Railways decided to communicate in every local train every 3 minute through public address system, that "the overhead wires are flowing with 20,000 volts, traveling on rooftop of trains is deadly". This communication went on for year by year. Today we don't see such fatalities in Mumbai public trains.

4. Maintaining peace of mind during free non-work times has become real difficult for most people. Some people are mature enough to maintain their emotional balance by engaging in yoga, meditation, new learning, pursuing hobbies, writing, reconnecting with old friends etc.

5. How to be creatively joyful during non-work times: un-routine your activities, un-knot your daily

practice, do what you don't do, engage in new thoughts and actions, but all this within Covid19 laid down rules. This would re-energize yourself and remove boredom in nonwork situations.

6. Further challenges : Because of unavailability of sufficient testing kit (resources), only limited testing per day is possible in Gujarat, our media should give a positive news who came out from Covid19 (praise is more required to motivate and give courage for others), and still people take it easy due to lack of knowledge and are not sincere and serious.

7. How to get difficult persons engage in safe behaviours is a major challenge. Peer-based approach in respective areas seems workable as people are known and acceptable to each other, and the local leaders (Panchayats) are influential to facilitate safe behaviours in present times of Covid19 which was initiated on video conferencing on 24th April 2020 by Mr. Narendra Modi, our great Prime Minister of India.

Research Statement 5: Despite testing, tracing, and tracking, Covid19 is spreading. Can we say that this spreading chain is behavioural in nature, how do we break it?

Yes, this chain begins from one to another, and one to many, knowingly or unknowingly, and hence logically, is truly behavioural in its nature. As in BBS implementation, we train and involve many observers to spot-correct at-risk behaviors, similarly we need to create a chain of behavioural safety active observers and mentors (such as social and community workers etc.) in each area and location who will keep an observation like a targeted missile to attack its objectives. Keep multiplying such observers to increase speed in breaking the Covid19 spreading chain. This is to be followed across the nation. This dedicated chain of observers would break the chain of Covid19 spreading in communities by observing and spot-correction of Covid19. Police and political workers should be avoided in this approach as they often use negative approach (fear, compulsion, threat). If it is a people-driven support framework like a tested behavioural science BBS approach. COVID-19 pandemic can be brought under control by massive and rapid behaviour change. To achieve this we need to systematically monitor how different individuals perceive risk and what prompts them to act upon it (Betsch, 2020).

An executive director of ONGC said, "human beings today, can live in 100 % isolation. Complete isolation is a must for stopping the spread of Covid. So success rate is a function of isolation effectiveness. According to a senior manager at Tata projects, "prevention by social/ physical distancing is the only solution". A safety professional of GAIL stated that there is an immediate need for developing local contingency plan in small pockets. Like all societies, muhallas (old settings) should prepare contingency plans which should be led by one expert. Be it sanitisation etc. or other proactive measures, there should be proper planning for action in case there is a case of Covid19. Proper plan should include post planning after recovery stage. There should be some special team for controlling psychological effect also. Top most thing is that people should be disciplined and obey the directions given by the team". As per opinion of a HSE Manager of Dorf Ketal: spreading of the chain is more due to behaviours and reasons such as Overconfidence, Lack of awareness about consequences, Inadequate precautions, Improper communication, and Lack of resources in terms of adequacy and accuracy of testing.

Covid19 is indeed a behavioral issue. The administration/ police need to be trained on this matter. Also, media, celebrities and prominent/ respected personalities need to constantly address the public. Politicians may not be doing enough. According to a CEO of a chemical plant, more symptomatic testing by Government is needed, asymptomatic private testing to be made mandatory for running establishments post-lockdown and alternate worker shifts along with 50% attendance allowance to ensure physical distancing, and for Red & Hot Zones, lockdown should continue as people are increasingly violating lockdown as number of Covid19 persons increased.

According to a safety manager at Hiranandani Constructions, "the identified hotspots are sealed by local police CRPF and other means, so no civilians are allowed outside, thus now the number of Covid 19 persons rose due to emergency services personnel like,1. Police, 2. CRPF, 3. Municipality workers, 4. Doctors, Nurses, 5. Ambulance drivers, Medicine vehicle drivers and other emergency material transport drivers, 6. News Reporters, Cameramen, photographer, 7. Other emergency aids servants and shop keepers.

- A list of above personnel to be prepared for each Hotspot management. They must be separated from their respective families to break the chain.

- If possible PPE Kit to be distributed to all these groups of personnel, not only for hospital personnel, in order to restrict such person from infection of Covid19 virus.
- Now focus on the people who live in the Hotspot areas: categorize their requirements to safe supply chain management.
- Complete lock down for people living inside hotspot.
- The areas like Dharavi (a biggest slum in Asia) where people have to use common toilets, bathrooms should be provided with temporary latrine facility which can be accommodated in the room only by small partition. In India, most numbers of Covid19 positives came from densely populated areas as TV channels reported.
- One important thing is that via the public address system, people should be made aware that they shall not take fever tablets on their own so that early identification of this virus may be possible".

A veteran safety professional said, "the only way is to wear mask and don't touch anywhere outside your home. People are not following this, hence Covid19 is spreading". But TV channels reported that though number of people with Covid19 has increased, most of these affected people could be in early stage of Covid19.

Implications

Ironically, a safety expert admitted that Covid19 is a natural course of pandemic in the sense that the water, noise, air pollutions were found to be much lower than before during lockdowns. With Covid19, BBS intervention spreads from industry to country, and people became more safety-minded than before. But unexpectedly, the state government's low concern for life safety of large numbers of contractual labour is reflected during lockdown for transportation to their hometowns, and they were forced to walk hundreds of miles.

While there is much we cannot control with COVID-19, there are specific behaviors that will reduce the risk of viral exposure for ourselves, our co-workers, and our communities. Decades of research show the power of behavioral science in increasing the consistency of safe behaviors. The spread of COVID-19 serves as an important reminder of what organizations can gain by incorporating a behavioral component into a comprehensive exposure-reduction process. The behavioural science principles and an approach toward change implementation drive is almost similar for both community and organizations. One is captive and another is an open situation.

Behaviors are rooted and wired in cultures. We, in India, have not emphasized safety behaviors in our culture and many a times, unsafe behaviors are justified. That's the prime reason that it's becoming so hard to break the Covid19 spreading. All countries witness today how difficult it is to sell the value of safety to its own citizens. In this regard, behavioural reinforcements are the major factor to ensure that people are adopting new behaviors related to COVID-19. People will take shortcuts and violate. Active observers will not fail to spot-correct such at-risk behaviors, be it anywhere, at workplace or public place, or residence. A safety manager said, "we at Agrocel company, started spot-correction and employees are spreading the message to each other to follow COVID19 precautions". Companies develop a faith in behavioral safety programs and gradually, it becomes their corporate value and culture.

In India, we still need to observe. Currently there is not much improvement in many States of India, people who have Covid19 are increasing. Remote areas are not affected by Covid19 as they are untouched by crowded population. At Factory site: social/ physical distance is maintained. Handwash every hour. Work from home for majority of people who are not needed at site. Nose mask is compulsory for all. It is important to let people know that during lockdown when factories operations are being managed with less workforce, the employees need to be doubly cautious as two fatal incidents occurred at a site in Tarapur, Maharashtra, India.

According to a senior safety professional from DCM Shriram, the main reasons that has actually increased the number of people who have Covid19 included: the lack of risk anticipation due to Covid! "If it had not happened to me till date it will never happen to me as I am immune, false sense of mental immunity. Its similar to typical safety mindset. I am working here in this plant for last 25 years, never ever got injured nor see any hazard here which poses high risk. Do not see others carrying corona/suspected patients as risk. Till Covid19, wearing of face mask and social/ physical distancing is included in BBS checklist". He added further, "This is purely a behaviour of maintaining safe physical/social distancing (SD) in true sense and just not for name sake. I know many essential services/industries

are being operated without any SD compliance which makes entire efforts futile. This is similar to our 'at-risk' behaviours at the work place which can cause serious accidents if not corrected. Same is the case here too".

An ex-executive director of India Glycols stated that the steps mentioned below would have helped or lack of them was the cause of spread of Covid19 in India.

1. We were a bit late in anticipating what was coming. Lockdown should have been announced in the first week of March 2020.
2. Monitoring activities and prompt actions (This could have avoided Nijamuddin episode).
3. Applying BBS, especially by police/ admin, for a better public response.
4. Quickly Creating more hospitals through makeshift arrangements (say, by converting gymnasiums, convention halls etc. to hospitals).
5. Promptly procuring/ distributing PPEs and testing kits for identification and containing the spread.
6. Allowing vendors to deliver essential items at door steps while closely monitoring the health of these distributors. Inviting volunteers and poor people (on payment basis) facilitate this distribution. This would have avoided more people rushing to shops.
7. Overall monitoring of people movement through more drones.
8. Donations were collected prominently by Centre only (through PM Cares) and not by states. There was perhaps more potential for contributions from willing public to help this cause.

Our speed of decision-making based on accurate data as well as actions determine what we achieve in managing the risks and their consequences. In India, we lacked in speed of decision making, and timely management of above mentioned points Moreover, Tablighi Jamat participants further spread Covid19 in Indian States as per media reports (Sharma, 2020). There were attacks on people, police, media and medical personnel during Covid19 times, which posed a greater and scary challenge to government, corporates and everyone else. Also, in India, people normally need many reminders to change for safe behaviours as compared to New Zealand or Australia and other countries. That's the prime reason, breaking the chain of Covid19 spreading becomes so difficult.

This is a period of change and challenge for the human race. Stress, anxiety, irritability, fear are the experiences of adjusting to new behaviours during Covid19 (Hoof, 2020). People would explore new definitions of their own behavioural safety. People have to deal with their own cognitive confusions. It would be surely a long-term affair. Employees would need to brainstorm for new work formats in order to avoid Covid19. According to chairman of Maruti Suzuki, the key for us is to prepare workers with many health and safety measures that are here to stay (Business Standard, 2020). Covid19 pushed corporate to implement HSE measures more seriously than before.

According to safety practitioners, we have to live with this now like other diseases, the earlier we accept, the better it would be. Probably, human beings would learn to live with certain viruses with more safety precautions as we progress to deal with or without Covid19. Behaviour and attitude are the reason for increasing Covid19 cases across the globe. Hope post-Covid mindset of people would be positively different in terms of their spiritual insights, re-balancing person-environment-fit, compassion, tolerance, adjustment, understanding, patience, and so on. Pray, All be safe. Don't get scared, rather resolve it. Share motivational positive messages of strong determination to fight and break Covid19 spreading chain (WHO, 2020). A senior psychologist said, "develop immunity system by right lifestyle and keep high quality hygiene in regular behaviour".

Human life is more valuable than the business or economy. So, let the countries understand clearly that lockdown exits in particular places are logical only when the number of Covid19 persons have significantly decreased. Till then, let the businesses be allowed with minimum workforce, online, work from home or another innovative formats. In India especially, the spread of Covid19 persons has taken a complicated political, religious, socio-cultural, communal base (Mufsin and Muhsin, 2020). Some opposition parties made it difficult instead of being a support in this human cause. For various reasons, people have been hiding that they have Covid19 which increased the incidence of this problem multi fold. As a result of all this the Covid19 chain could not be broken. Hence, most strict measures are needed by our central/state governments as soon as possible failing which the problem is likely to get further intensified.

Covid19 challenged everyone with respect to their survival.. A plant manager said, "for survival, boost our immunity through, positive thinking, take care of hygiene, healthy diet, listen

good music, pray to god". According to an HSE general manager, "It will teach human beings many things like: how to survive in worst situation, what is real nature, to become closer to your own family, importance of PPE, the learnings from our Honourable Prime Minister's leadership action/reaction/calmness and the way he handles each one of us".

Certain indirect behavioural implications of Covid19 are also likely to emerge. Hugging (as against physical distancing which is a reflection of human bonding that people use in many cultures across the globe), it seems Covid19 would take that away from human race, or people would be afraid of it. Similarly, handshaking as an expression of human touch may become a thing of the past. Globally, Covid19 has also become the reason for cold war between China and many countries that are severely affected by this Chinese virus as it is called by the American President. Most affected countries are against China as COVID-19 emanated from there and spread to many countries (Awasthi, 2020).

Behavioural revolution is needed which means a change into a set of safe behaviours to contain Covid19 and break its chain from spreading further. How is it possible or is it too much to expect from everyone in the country? How to revolutionize safe behaviors to combat Covid19 before losing more lives? This Covid19 has made people, industry and the nation more alert and safe than before. People are taking care of each other, the rich of the poor, the strong of the weaker, and the educated of the not so educated. People across the globe would have better sense of their personal health, safety and environment due to COVID-19 experiences that came with lots of pain and hurt. Business leaders would be more alert for HSE systems in their organizations. Hence this behavioral revolution would leave nations economically safer and stronger than before (Biswal, 2020). Sadly, Covid19 is the hardest way of teaching safety to mankind. In present conditions, the safe behaviours are well defined, only option is to follow them or get badly hurt as holds true for companies or communities across the globe. The governments have set safety procedures and are also reinforcing them. Unfortunately, people would surely face consequences if these are not followed. An individual's safety is his personal responsibility. However, Countries/ corporates should not give up till the safety culture is evolved and followed by people.

A big challenge of Covid19 is that people are not able to maintain physical distancing because it has never been part of their culture (fig.1). Culture drives the behaviors. They need observers to correct them on-the-spot repeatedly. In present times of Covid19, the same thing is happening that all of us, subconsciously are not maintaining physical distancing, be it media person, doctors, police. Everyone is getting affected. Same behaviors would repeat at work sites as well. We can't observe ourselves, but we can observe others. Hence make it a point of spot-correction for everyone daily. Announce it every hour on public address system whether people are observing their co-workers around and correcting on-the-spot. One observation a day, keeps the risk away. Make safety observations a part of an individual performance at sites. Observations help save lives. Leaders need to get focused on it for the safety of their human resources and business. Safety culture is a function of leadership initiatives and employees/workmen/ everyone's involvement on a continuing basis. Also, it boils down to the family safety cultures which vary across cities, districts, etc. Some families are more safety conscious than others. Moreover, people have taken Covid19 non-seriously. In India, people are roaming around in spite of the lockdowns being extended. Safety seems far away from their actions. That's why Covid19 positive numbers have increased. People don't understand safety being idle without working. Especially, in a cosmopolitan city like Mumbai, people understand safety while working. People have predominant work motives.

Now largely people, right upto the village level, are much aware about the risks

Fig.1: Lack of social distancing during lockdown

associated with Covid19. Now people are supposed to maintain physical distancing etc., which they didn't do earlier. The difficulty is balancing between old and new behaviors of following physical distancing, wearing mask, handwashing. Hence when they maintain these behaviors, they will sometimes go back to original behaviors, which would pose greater risk to everyone around. It is not easy for people to adopt new behaviors, they do what they see around most of the time. Monkeys see, monkeys do. Thus, imbibing new behaviors is a gradual process, which essentially requires continuous monitoring and handholding by corporates and communities. People intend to remain non-compliant toward a new set of behaviors as they perceive it to be a temporary phenomenon. More importantly, people need to be alerted repeatedly by observers around whenever they engage in any such at-risk behaviors. It all depends upon how an aware person or observer effectively conveys the risk to the less aware for his/her safe behaviour and spot-correction, which is called a risk based conversation (RBC). Citizens ought to observe and save each other, this is the essence of behaviour safety approach. Because, this is the time when the governments have taken lots of measures and Covid19 numbers are still rising. Public cooperation is low as rising Covid19 numbers lead us to say that the people are violating lockdown rules. Hence, public can no longer depend upon governments for their safety. Public has to help themselves as per Covid19 rules laid down by their governments, failing which we would surely witness more fatalities taking place in near future. This behavioral shift is very critical, till the public adopted independent safety culture, Covid19 fatalities would most likely continue. Public cooperation needs to be strengthened through NGOs, religious/ community groups, corporate social responsibility. CSR funds can be spent on activities related to addressing Covid-19 impact (Financial Express (2020). Companies integrate social and environmental concerns in their business operations and interactions with their stakeholders. There are nearly 10,000 CSR projects in India. Moreover, India has more than 3.2 million registered non-government organisations (NGOs). These resource groups and expertise are capable to mobilize social policy and programs into achievable results. These initiatives would take us further from reactive and dependent safety cultures to independent and interdependent safety cultures for saving human lives. Thus, behavioural changes in a safety culture are achievable subject to certain presuppositions and preconditions as discussed. A safe person is considered to be the one who is alert, and observes and spot-corrects unsafe behaviour of others. Further, it is high time to focus on economic activity, as the number of people who are violating lockdown rules are very small as compared to those following. The economic slap is harsher than the disease itself. So focusing on economy with safety measures would normalize the situation with positive energies. People should not get scared if Covid19 numbers rise, rather be bold enough to be a part of the economic activity. Those who violate SOPs/get affected by Covid19 would be managed by the governments' systems. It is crucial to understand that nearly 99.9% of India population are obeying lockdown rules hoping that if they continue safe behaviours, then only they can take the economy forward. However, it is crucial to realize and underline that the intervention effects of behavioural safety changes (Nilsen, 2006) at the national level in India would be gradual and long-term in nature especially when the existing safety culture is poor, reactive and dependent. This would help the concerned agencies remain focused towards policies and programs requiring large financial investments.

The difficulty is balancing between old and new behaviors of following physical distancing, wearing mask, handwashing. Hence when they maintain these behaviors, they will sometimes go back to original behaviors, which would pose greater risk to everyone around. It is not easy for people to adopt new behaviors, they do what they see around most of the time. Monkeys see, monkeys do.

Countries expect only safe behaviour (from citizens) which is the strength of our economies. Countries would have better economies if they have increasingly safe behaviours from their citizens.

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How the General Insurance Industry Could Roar to Life After Lockdown is Lifted

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There will be very muted growth, if at all, for the insurance industry in the first quarter of financial year 2020-21, but the Covid-19 pandemic may serve as an inflection point when Indians realize the importance of insurance. The non-life insurance sector posted an 11.7% increase in premium income to INR1.89tn ($24.7bn) in the year ended 31 March 2020 (FY2020), compared to the previous financial year. In comparison, total premiums increased by 14% in the non-life sector in the 11 months to February 2020. Among non-life insurers, standalone health insurers saw a 27% jump in gross direct premium to INR144.1bn in FY2020, reflecting in part the increase in purchases of health insurance products amidst the COVID-19 pandemic. Other non-life insurers (excluding two government owned specialist insurers) saw a 9.5% growth in gross premiums in FY2020 compared to the previous financial year. Listed New India Assurance was the largest company in the sector with a premium volume of INR267bn, growing by 11.7% over FY2019. For the month of 2020 alone, when the pandemic worsened, the combined GWP of non-life insurers (including specialized state owned insurers) declined by 10.7% to INR157.85bn, compared to March 2019. General insurers reported a fall of 15.3% in premium collection to INR133.86bn in March 2020, whereas standalone private health insurers increased business by

4.3% to INR18.07bn. Specialized state owned insurers, namely, Agriculture Insurance Company of India, recorded a surge premium collection of INR5.91bn in March 2020. Among the general insurers, state owned companies posted a 13.9% decline in GWP to INR67.08bn while private sector general insurers saw business fall by 16.6% to INR66.78bn in March 2020.The weak March 2020 performance is attributed to the lockdown announced by the government aimed at curbing the spread of COVID-19. Bank branches which are a major channel of insurance sales operated with skeletal staff while agents were unable to travel to meet prospective clients due to transport restrictions. A summary of the GWP of non-life insurers in FY2020 is as follows:

Figures in INR m	FY2020	FY2019	Change	Mar 2020	Mar 2019	Change
General insurers	1,641,928	1,599,450	+9.5	133,863	157,871	-15.3
Standalone health insurers	14,410.0	113,540	+26.9	18,072	17,322	+4.3
Specialized insurers	106,128	81,484	+30.2	5,911	1,437	+311.3
Agriculture Insurance Co	95,376	69,009	+38.2	5,172	(46)	-
ECGC	10,752	124,75	-13.8	739	1,483	-50.0
Total	1,892,155	1,694,484	+11.7	157,847	176,729	-11.7

Fear of Lapses in Insurance Coverage

In a development, the IRDAI announced several measures aimed at ensuring continued proper service to policyholders and customers. All insurers have been asked to maintain continuity of business operations through alternative modes including telephonic and digital contacts. Large corporations risk lapsing insurance policies for their plant and machinery as well as employees, as both insurers and businesses are forced to shut shop because of coronavirus-related lockdowns in several parts of the country. All insurers have also been asked to display on their websites, information on the functioning of their offices and alternative arrangements made for premium payments, renewal, and settlement of claims and lodging of other service requests. In addition, the IRDAI has permitted the following relaxations:

1. In case of life insurance policies, there is a grace period for payment of renewal premiums. Insurers have been asked to enhance the grace period by an additional 30 days if desired by the policyholders.
2. In case of health insurance policies, the insurers may condone delay in renewal up to 30 days without deeming such condonation as a break in policy. However, insurers are requested to contact the policyholders well in advance so as not to have discontinuance in coverage.
3. In case of board meetings of insurers, the meetings due till 30 June 2020 may be held through video conferencing or other audiovisual means.
4. In case of submission of monthly returns for the month of March 2020 by insurers and insurance intermediaries, an additional time of 15 days will be allowed. Similarly, for quarterly returns, an additional period of up to one month will be permitted.

The IRDAI appeals to all the insurers, insurance intermediaries and distribution channels to be sensitive to the needs of the policyholders in these trying times, while policyholders are urged to cooperate. The government has made it mandatory for all employers which resume functioning as the lockdown gets over, to provide medical insurance to their employees. In cases where offices are not functioning fully or partially, the policyholders are mandatorily be notified by SMSes, e-mails,and press release in addition to display boards and pamphlets in the brand offices.

Suspending Dividend Payments for Fy2020

The IRDAI directed insurers, in view of the emerging market conditions, and to conserve capital in the interests of policyholders and the economy at large, to take a conscious call to refrain from paying out dividends from profits pertaining to the financial year ended 31 March 2020 (FY2020), till further instructions. This position shall be reassessed by the Authority based on financial results of insurers for the quarter ending 30 September 2020.The move follows a similar order given by the

Reserve Bank of India's (RBI) to banks. Insurance industry experts though voiced mixed views on Indian insurance regulator asking listed and unlisted insurers to refrain from paying dividends to shareholders from profits pertaining to FY2020. This is an advisory at best and an extraordinary one at that. But we are in extraordinary circumstances and the regulator wants to pre-empt any possible criticism at a later date that it did not even forewarn insurers. On this decision insurers have different views. Some industry players say that the IRDAI should allow insurers to pay dividends on a case-to-case basis than issuing an omnibus directive. Others say that the IRDAI should focus instead on helping general insurers generate underwriting profit.

Formula for Determining Auto Third Party Obligations

A report published by the Insurance Information Bureau of India said that out of around 220m vehicles in India as at 31 March 2019, the percentage of uninsured vehicles was 58%, even though auto TP cover is mandatory in the country. The percentage of vehicles which do not renew their insurance after the first year is high at 52% on average. Nearly 70% of the total number of vehicles in India consists of two wheelers, the working group report notes. Currently, two-wheelers form the bulk of vehicles plying the roads without insurance coverage. A working group of the insurance regulator, IRDAI, has recommended that motor third party (TP) obligation of non-life insurers be determined, based on the number of vehicles insured. Each non-life insurer is mandated to write a certain amount of motor TP business every year. Currently, the motor TP obligation is based on the premium income an insurer collects in any given year in this class of business. Motor third party insurance being an integral part of every individual vehicle, the monitoring of insurance of such vehicles (by every insurer) most appropriately should be on the basis of the count of such insured vehicles rather than (indirect/derivative) evaluation of premium derived from the insurance of such vehicles.

The working group has recommended three broad vehicle classifications – two wheelers, private cars, and others, and that the motor TP obligation for each insurer should be arrived at for each vehicle category. So now, no longer can insurers underwrite a larger ticket size of private cars or commercial vehicles and cover up for two-wheelers. This is because the current basis of relying on premium collected does not reveal the vehicle types covered by an insurer. Thus, insurers are inclined to underwrite risks of certain kind of vehicles which may be more profitable than others In the new formula, each insurer's obligation will depend on their market share as well as the number of uninsured vehicles of as determined by Insurance Information Bureau of India for each category of vehicles. So, large insurers have to underwrite more TP business. The change in formula will mean that insurers will be mandated to write additional business to get uninsured vehicles covered by motor TP insurance. A new insurer licensed to underwrite motor insurance for the first time may be exempted from the application of the obligatory requirement during the first two financial years of its operations including the financial year in which its operations are started. A report published by the Insurance Information Bureau of India said that out of around 220m vehicles in India as at 31 March 2019, the percentage of uninsured vehicles was 58%, even though auto TP cover is mandatory in the country. The percentage of vehicles which do not renew their insurance after the first year is high at 52% on average. Nearly 70% of the total number of vehicles in India consists of two wheelers, the working group report notes. Currently, two-wheelers form the bulk of vehicles plying the roads without insurance coverage.

Relief from Insurance Regulator

The General Insurance Council (GIC), the representative body of non-life insurers, is lobbying the IRDAI to relax certain regulatory requirements, particularly those related to the solvency ratio, particularly because of the current COVID-19 crisis. In a letter to the insurance regulator, GIC said that given the huge mark-to-market loss in equity investments in March, the IRDAI should waive the requirement for insurers to account for diminution in value in equity investments when they finalize their financial statements for the year ended 31 March 2020. Many insurance companies may see their solvency ratio fall below the required minimum level of 1.5 due to COVID-19 which has battered the stock market. While insurers ignore mark to-market-gains, they are required to recognize mark-to-market losses in their profit and loss accounts. Though the virus made a relatively delayed entry into India, the scare, the preventive shutdowns and the economic decline are unprecedented and the adverse impact on financial markets is quite telling. Without exception, the non-life insurance sector is severely burdened and we are afraid we will have difficulty in meeting certain regulatory requirements.GIC also said that companies could be allowed

to consider mark-to market position as on 29 February 2020 as the basis of computing solvency. Alternatively, the IRDAI may relax the minimum solvency requirement of 1.5 times for the time being, on the same lines as the regulator had relaxed it at the time of dismantling the motor third party pool. Also, the insurance industry needs to provide for stressed debt investments as the same is not allowed for income tax assessment till the investment is written off. In view of the huge provisions made by the industry and the same disallowed for the purpose of income tax purpose, DTA (Deferred Tax Assets) created for such differences need to be allowed for solvency computation. Furthermore, GIC sought IRDAI's forbearance in the compliance requirement of limits on rural and social sector obligations.

Policyholder's Interest

Insurance Regulator has issued detailed instructions for Indian insurers to meet the challenges emerging from the developing COVID-19 pandemic. Insurance, being a critical requirement of the population, has been exempted from the lockdown. However, insurance companies and other regulated entities are advised to operate their offices with absolutely necessary staff so as to maintain essential insurance services including claims settlement, authorization for hospitalization, renewal of insurance policies and such other activities. In all the operating offices, extreme care needs to be taken by all concerned to maintain prescribed hygiene, social distancing etc. The IRDAI press release also contains an exhaustive list of safety measures that include several steps to streamline communications with major stakeholders of the companies.

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1. Communication strategy: Insurers have to prominently display on their website a dedicated helpline number for policyholders and another help line number for other stakeholders including agents and intermediaries. Adequate arrangements may be made to service all the policyholders and other stakeholders satisfactorily through these help lines. The regulator has also instructed insurance companies to display frequently asked questions for COVID-19 claims prominently on their websites.

2. Business continuity plans: Insurers have also been asked to put in place a business continuity plan (BCP) which inter-alia deals with processes, transactions, reporting and customer services to be handled in a seamless manner to take care of the present situation. A copy of the same will have to be submitted to IRDAI. Insurers will have to set up a crisis management committee to monitor the current situation on real time basis and to take appropriate timely decisions on the following issues:

a. Issues pertaining to safety of staff, policyholders, intermediaries and agents
b. Assessing new challenges that may emerge on a day-to-day basis and measures to mitigate them and
c. Adopting necessary measures to minimize business disruption.

The crisis management committee will also be required to provide regular inputs to the risk management committee of the insurer.

The risk management committee will evaluate all major risks and shall devise necessary mitigation measures. Any severe impact on the operations or capital requirements or solvency margin shall be promptly communicated to the authority.

3. Cyber risks and data security: IRDAI has also focused on cyber risk and data security. Due to enhanced remote

working, it is possible that there could be an increase in the number of cyber attacks on personal computer networks. IRDAI has asked the insurers to take precautionary measures to address such cyber risks and to mitigate such risks as soon as they are identified. It has asked the insurers to educate their staff of possible cyber risks and the associated safeguards to be taken by the staff while working from home.

4. Products: IRDAI has asked insurers to devise appropriate insurance products that would provide protection from risks arising out of COVID-19. The press release said, "The authority is committed to process such product approval applications on a fast track mode.

5. Policy servicing and claims: Insurers have been asked to make special efforts to enable the policyholders to pay premium using digital methods by educating them through SMS, emails etc. IRDAI has said, claims arising on account of COVID-19 should be processed expeditiously. Insurers are encouraged to adopt simplified/ expedited claim procedures for such cases. In addition, other claims should also be processed within the prescribed period by making special efforts.

6. Grievance redressal: The normal response time for policyholder complaint redressal is 15 days, due to the prevailing lockdown situation, an additional 21 days is allowed in respect of all complaints which are received on or after 15 March 2020 and up to 30 April 2020. However, this additional response time is not applicable to complaints pertaining COVID-19 for which the extant timelines continue to apply.

7. Travel insurance: In cases where insurers have issued travel insurance policies which were/are valid between 22 March 2020 and 30 April 2020, an option may be provided to the policyholders to defer the date of travel without any additional charge.

IRDAI has again asked the insurers to take note of the circulars already issued by the authority with respect to insurance covers for COVID-19. The insurers should keep their respective boards informed of the actions taken by them in dealing with situations arising out of COVID-19. The authority is constantly evaluating emerging impact of COVID-19 on the insurance sector and will issue suitable instructions from time to time as considered necessary. Also, digital payments and other online facilities are to be ensured for smooth delivery of services and entertainment of claims.

Extension of Renewal Dates

With the entire country under lockdown for COVID-19, the government has extended the renewal date for health and motor insurance policies. The extension is for people whose renewal dates for health and motor vehicle insurance policies fall in the lockdown period. The notification also says that the order came into effect on 1 April. The policyholders whose motor vehicle third party insurance policies fall due for renewal during the period on and from 25 March, 2020 up to the 14 April, 2020 and who are unable to make payment of their renewal premium on time in view of the prevailing situation in the country as a result of coronavirus disease, are allowed to make such payment for renewal of policies to their insurers to ensure continuity of the statutory motor vehicle third party insurance cover from the date on which the policy falls due for renewal. The IRDAI considering the prevailing situation in the country asked life insurers to extend the grace period for payment of renewal premiums by an additional window of up to 30 days if policyholders want it, which was accepted by the industry.

Solvency Margins

Insurers are required to adhere to the applicable accounting standards framed by ICAI (Institute of Chartered Accountants of India) and the authority's regulations/circulars on preparation of financial statements and valuation of investments. While insurers ignore MTM gains, they are required to regard MTM losses as expenses. The IRDAI rejected a request from general insurance companies for a blanket relaxation of solvency margins in the face of the COVID-19 pandemic. However, it said specific cases would be considered on merit. The Council, which represents general insurers, asked for relaxation in calculating available solvency margins (ASM) on account of delays in tenders related to government schemes and delays in receiving subsidies.

The authority doesn't see the need for general relaxation. However, any specific issues would be considered on merit. The GI Council had also said that given the huge mark-to-market (MTM) losses in equity investments during March, IRDAI should allow firms not to account for diminution in the value of equity investments while finalizing accounts for the financial year ended 31 March 2020. The GI Council had also requested that firms be allowed to consider MTM position as on 29 February 2020 as the basis of computing solvency. "Alternatively, IRDAI may relax the minimum solvency requirement of

1.5x for the time being," the letter had suggested. Many firms may see their solvency ratio fall below 1.5 due to the crisis.

No Fresh Capital Gearing Treaties

The IRDAI has warned insurers against entering into fresh capital gearing treaties, and to phase out existing treaties. The regulator says that it has observed that some insurers have entered into such arrangements in various forms including Quota Share Reinsurance Treaty. In a circular dated 28 March, addressed to general insurers, health insurers and specialized insurers. The terms of these treaties have been examined, and the Authority is of the considered view that such capital gearing treaties are of the nature of financial arrangements and not primarily a risk transfer mechanism. It appears that insurers have adopted these arrangements in order to improve the solvency margin ratio. The IRDAI thus directs the insurers to adhere to the following:

a. no insurer shall enter into any fresh capital gearing treaties effective from the date of issuance of the circular (28 March); and

b. Insurers which have such treaties on their books as on the date of issuance of the circular shall take the following steps:

1. Submit Board approved action plan to the Authority by 30 June 2020 for phasing out the treaties along with timelines such that there is compliance with solvency stipulations. The plan of action shall also include an assessment of any requirement for capital infusion and sources of funds for the capital infusion where required due to prospective closure of these capital gearing treaties.
2. the direct insurers (cedents) shall create appropriate reserves towards Unearned Premium Reserves, Premium Deficiency Reserves, Outstanding Claims Reserves (including IBNR/IBNER) in accordance with IRDAI regulations. Further, such treaties have to be accounted for in their financial statements, based on the principle of "Substance over Form".

Establishing the International Financial Service Centres

The Finance Ministry has issued a notification establishing the International Financial Services Centres Authority (IFSCA) to unify supervision over all financial services in international financial services centres (IFSCs) in the country. IFSCA will be headquartered in Gandhinagar in Gujarat, as per the notification. Currently, the banking, capital markets and insurance sectors in an IFSC are regulated by multiple regulators such as Reserve Bank of India (RBI), Securities and Exchange Board of India (SEBI) and IRDAI. The notification brings into effect certain provisions of the IFSCA Act, 2019. The central government has refrained from fully enabling the new authority with all its powers as envisaged in the Act. While allowing for the appointment of IFSCA members and other employees, setting up of funds and exemption from taxes, the government has not affected fully provisions for IFSCA pertaining to the regulation of financial products, financial services and financial institutions and its abilities to transact in foreign currencies and make rules. This means that the main function of the IFSCA will be to regulate financial products such as securities, deposits or contracts of insurance, financial services, and financial institutions that have been approved by the relevant regulator for the particular financial services sector.

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The IFSCA board will comprise a chairperson, and one member each nominated by the regulators, SEBI, RBI, IRDAI and the Pension Fund Regulatory and Development Authority. There will also be two members from the central government and full-time or part-time members. A working group

of the insurance regulator, IRDAI, has recommended that motor third party (TP) obligation of non-life insurers be determined, based on the number of vehicles insured. Each non-life insurer is mandated to write a certain amount of motor TP business every year. Currently, the motor TP obligation is based on the premium income an insurer collects in any given year in this class of business. Motor third party insurance being an integral part of every individual vehicle, the monitoring of insurance of such vehicles (by every insurer) most appropriately should be on the basis of the count of such insured vehicles rather than (indirect/derivative) evaluation of premium derived from the insurance of such vehicles", the working group said in its report.

The Insurance Regulator has cautioned the general public about cyber fraudsters in insurance. There are occasional reports of fraudsters offering insurance with unusually low premium from fake entities through online and digital mode. The customer should take due care and verify the genuineness of the website, insurer, intermediary and agents before making any online payment. Insurance should be bought only from insurers and intermediaries registered with the IRDAI and the agents duly appointed by the insurance companies. The approved list of insurers and intermediaries can be checked from IRDAI's portal, while agents' authenticity can be verified from the portals of respective insurers. Marketers have a unique opportunity of being the customer's confidante by assuring them that their interests are safeguarded. During such crises, financial concerns can seem daunting and add to the burden. India is still reeling under the impact of Coronavirus and lockdown. It has a wide-ranging impact across the sectors of the economy. In some cases, the impact is minimal and short-lived. However, in case of some sectors like insurance, the impact is going to be negative in the near term as it will be hit from multiple directions. In the long run, it is expected to change the way Indians look at protection cover and bring some long-lasting positive changes in the very long run. However, both general and life insurers will see a setback in terms of lower income on their investments and erosion of value. Also, the portfolio risk will be huge and might have to face sharp markdowns and higher market-to-market losses while arriving at the fair values of their investments due to sharp market correction. Post lockdown, growth for the motor insurance segment would also get restricted as the IRDAI has deferred price hikes for now. Also, it is still not clear as to how the liquidity crunch (cash flow pressures) at medium and small businesses impacts demand for other general insurance segments such as fire. With the rise in the number of coronavirus (COVID-19) cases in India, general insurance companies are set to come out with new package rates for treatment.

Merger of PSU general insurers is at an advanced stage. The government had raised nearly 17,500 crore through initial public offerings in New India Assurance Co Ltd and General Insurance Corp of India Ltd, the only listed state-owned non-life insurance companies. Though insurance offices are included under the list of exempted services under the lockdown however with general restriction on movement there is hardly any chance of new business. Insurance players with robust digital infrastructure should fare better than others, if there is a sharp rise in COVID-19 cases, as seen in China and Italy. One of the biggest challenges for insurers could be enabling alternative work arrangements for their employees and sales force such that they are more resilient and able to deal with increasing claims and shorter response times. Even when the dust settles with weakness in economy is bound to persist in the near term with threat of pay cut and job losses. Many of the answers lies in the next few weeks as how India tackles the corona issue. There have also been some proactive steps taken by the industry on product innovation front. IRDAI has asked insurers to come up new need-based products for coronavirus, and for which, a few insurers have come up with such need-based specific products to cater to the current requirement. These are defined benefit-based product where the benefit is paid on occurrence of the event and no bills are required. The industry has done well to find an opportunity even in such a situation however it still depends heavily on offline distribution which is bound to suffer. The prospect of industry getting back its momentum will depend both upon the time that India takes to recover from coronavirus and market crash.

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Role of Insurance Sector After Lockdown

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To begin with I wish to share an incident occurred about 30 years age. I was employed as Company Secretary in Sugar Mill. I wish to clarify that in those days sugar mills were mini towns having their own shop and even a PDS outlet for employees and neighbouring villagers. The owner of the shop was a handsome youngman with a small kid. He was thoroughly gentle but had the habit of drinking wine and fond of meat. He contracted jaundice and after prolonged treatment and restricted food, he was cured but the doctor had clearly advised to stay away from both these things at least for three months and even he intended to eat meat it should be cooked without spices and negligible fat, preferably boiled and in small quantity. He followed the advice for about 40-45 days but he could not control himself and not only drank wine but ate spiced meat with result that the jaundice returned. His immune system was not strong enough to handle the relapse and the end was sad.

I have told this incident to warn one and all that post corona will be similar situation and any complacence could lead to devastating results. Preliminary Reports from China indicate that there are repeat cases of persons cured after corona. More disturbing are the reports that several symptom free persons are tested corona positive. The two reports present a bleak picture in the sense that there is no guarantee that the patients cured for the time being will not get the infection again and the other gloomy picture is that China may be entering 3rd stage of virus of community infection where the source of infection is not known. This is nerve rending as still the world is far from developing fast

mass testing, or producing a successful vaccine and sure and complete treatment.

When the lockdown is lifted these challenges will be before us and I am of the firm opinion that as is being contemplated in some circles the lifting of lockdown should be in phases. The plan of government to divide the country's districts in different Categories on the bases of spread of corona infection is a welcome idea in right direction to control the disease and also permit life to move towards normalcy. The areas with higher incidence of corona should be sealed and isolated while areas completely free from any signs of epidemic should be given greatest freedom to resume life on as normal basis as is practicable.

The protective measures to be observed have to be followed in the entire country including foreign travel from and to India. Simultaneously the efforts have to be continued for development of faster and more responsive mass testing along with search for effective vaccine and proper & reliable treatment. The facilities created so far, not only has to be maintained in state of the art manner but fresh addition of capacity is the need of the hour. Once the vaccine is developed it has to be administered like mission as was with malaria, Pulse-polio, Child vaccination, etc.

There is also the question of help and rehabilitation of persons who have suffered due to stoppage of all economic activities and loss of earnings to several people. The government is providing help to certain categories of poor but still there are millions of persons in the unorganized sector who have no recourse to join government schemes and there are persons who cannot join the schemes due to inherent provisions.

Take the case of Insurance Agents and Surveyors. Both play important role in Insurance sector and both are at the end of chain. The agents get income from the commission they earn on the premium underwritten by them while Surveyors get their income by way of Fee after a claim is reported and settled. With economic activities at halt there is little possibility of earnings by both these groups. Remember, both do not get any salaries but all have their fixed expenses which cannot be put on hold. How these people will be provided help is an important issue which the policy-makers have to consider.

All these require concerted and continuous sincere efforts and will have to be continued in the months to come.

Then there will be loss to business community. Several Transport vehicles were stranded due to lock down, many containing fresh fruits, vegetable and other perishable commodities. We cannot be sure that all these goods have been delivered safely to their respective consignees. The application of force majeure will do injustice to the traders/ transport community in such cases. The Insurers and the Government both will have to devise a scheme to mitigate hardships of these persons.

Again, there will be industrial units/ Factories where goods in process, semi-finished and unpacked finished goods are lying which could not be processed /packed or preserved due to sudden stoppage of work. Several of these units would not be having LOP but they will have to helped, force majeure or otherwise. Considering stuck material in machines there will be claims for machinery damage also. It is the responsibility of Insurance Community and Government, both, to provide relief to these units and their owners. Thus the Insurance Companies will have to entertain and settle the claims not only in health sector but also in non-medical sector like engineering, Marine Cargo and LOP besides some claims in motor segment also. The Insurance Sector the world over will be under financial pressure including both Primary Insurers and Re-insurers along with re-reinsurers as well as those with forms of insurance management like captive units and securitization units.

The business community as a whole will face another common problem. Due to closure of sale during lock down and limited activity expected to be permitted after the situation appears under control, they will not be able to generate enough cash to meet the expenses of salary which is primary concern and further interest and taxes where the government has to mediate and provide relief to all concerned. This can be in the form GST holiday for at least 3-6 months, waiver of interest and penalties for late payment. They may also need direct cash assistance to meet expenses of salaries and similar other essentials. Then there is question of Income Tax dues – final tax after return is completed and files and advance tax which will be due on 15th June.

The public at general also need help in payment of their dues of electricity, landline and mobile phones. It is to be considered in right spirit as there are several old persons who are not getting any pension and are solely dependent of the rental income. The Government has announced relief to tenants in payment of rent and has issued advisory that land lords should not press for rent and evict the tenants so it is natural that the landlords are also given relief accordingly. We can hope that government will consider such persons also.

The post lock down scenario is difficult to .imagine. We must remember that rope is rejoined but the knot remains. To consider post lock down economy, we should begin with whether the virus could or would be finally controlled. The reports from China who was supposed to have checked the corona virus are disturbing to say the least. New cases as well as repeat cases and the cases without symptoms are alarming as the China may be entering the 3rd phase if community infection. The world has not developed faster testing kits in such numbers to test each and every person even in a given locality. Mass testing is an option but I do not think it is faster enough and could contribute significantly in containment of virus. Now let us be more optimistic and assume that China and the World would be able to conduct such tests in huge numbers and epidemic is controlled for the time being.

The next thing to consider is that doctors and health experts are opining that the virus will not survive the temperature above 30 degree C. However this temperature is not reached in half of Europe. Second thing, the summer is naturally followed by rains and winter. We know that titnes virus remains dormant in our body for 15 years when it can surface. Hibernation period of corona virus is yet to be studied. We have titnes vaccine but the world is presently in development of vaccine for corona. Its effectiveness will be known after time. Similarly medicines for corona disease are to be developed and tested and only the time will tell how successful we have been. So not being unduly pessimistic we have to watch the future at it unfolds. Whether virus becomes active again during rainy season and aft rewards in winter and I wish to be optimistic that the efforts of our medical and scientific fraternity will be successful and in due course and sooner than later the virus will be under full control.

Mean while the life has to resume and not only in India, but the world over safety norms will have to be followed like social distancing, use of masks and frequent washing of hands with soap or sanitizer. There has to be some relaxation everywhere so that life begins to flow albeit halting and I hope soon it will pick up speed. I have great faith in Indian Economy and I am not sure about other countries. I am now 67 and I faintly remember the war with China and I only recall contributing old clothes etc to the dependents of martyrs of the war. We came out of it successfully, only to face a war with Pakistan in 1965. I was too young even then but I do remember that Our Prime Minister Lal Bahadur Shastri had asked the country to observe a day every in fasting to save foodgrains of less privileged. He also coined the slogan “Jai Jawan Jai Kisan” to boost the morale of armed forces and farmers of the Country. Then there was another war with Pakistan in 1971 when East Pakistan was made in to present day Bangla Desh. About a lac solders were taken POW but the country finally managed to come out winner after this war also. Then there was debatable period of National Emergency in 1975 and then failure of coalition government and financial problems.

Next shock was from America when Lehman Bank collapsed and the world was thrown in to recession. There were financial and Share Market Scams were in our Country also. Notable among these was Harshad Mehta, Sanjay Somany, Ramalingum Raju of Satyam computers. We came out of all such scams and shocks as winner in final outcome.

Currently we are facing the defaulters like Vijay Malya, Neerav Mody, Mehul Choksi and others, but, these are strictly the financial matters with no social and health repercussions. The matter of corona infection has affected our social fabric and we have to cope with health issues also.

At the beginning I narrated the case of relapse of a disease which was known and cure was available but now we are dealing with a disease which is little known and there is no certain cure available till writing of these words so we have to follow old saying “prevention is better than cure”. That is to say that in time to come we will have to take precaution like wearing mask, maintain social distancing, sanitize surfaces and our hands with frequent washing with soap or a alcohol based sanitizer as per recommendations of WHO and other health experts.

As I said earlier I have great in resilience and strength of our Economy, We will be able to recover from the effects of Corona pandemic although it will take time and we will have to have patience and perseverance and we will be winner in the long run. There may be opportunities behind these developments as several countries and their companies are now vary of China are planning to go elsewhere. India can be one such destination but for that we have to show that we can handle any situation with ease and dispatch and also lead the path for others to follow.

In the end I sincerely hope that my averments will get the attention of right persons and necessary steps will be taken.

Introducing Takaful in Uganda: An Exploratory Study on Acceptability, Possibility and Takaful Model

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Abstract

Insurance has been widely used as a risk mitigation tool in our personal lives as well as in business world. It is not deniable that insurance has become part of parcel of our daily lives and it provides the benefits and protection to us when we are unfortunate. However, the concepts of riba (interest), gharar (uncertainty) and mysir (gambling) inherited in insurance principles and practices are prohibited from the Islamic perspective. The Muslim scholars introduced *takful* to replace the conventional insurance. Tremendously, *takful* is at high growing rate and penetrating into both Muslim and Non-Muslim countries. However, to the extent of our knowledge, there are no takaful operators in Uganda even though it has a fast-rising Muslim population. Thus, the aims of this study are to examine the acceptability and possibility of offering *takful* in Uganda and to propose the most suitable takaful model that should be engaged by the takaful operators and policy holders. The findings from 108 Muslim and non-Muslim respondents show that acceptability of *takful* by Ugandans regardless of Muslims or non-Muslims is very high and there is possibility that *takful* products can be marketed in Uganda. It seems regardless of the religion, *takful* seems to be accepted by Ugandans. Moreover, 10 *Shari'ah* scholars and 5 consultants opine that hybrid model, i.e. the combined concept of wakalah and mudarabah, will be the most

suitable model for Uganda. Hence, future research should examine the perception of regulators to introduce *takful* and economic viability of the proposed model.

Keywords

Acceptability, Possibility, Takaful, Insurance and Uganda.

1.0 Introduction

Muslims account for around 25% of the world's total population, but despite rapid growth in recent years, insurance sales within the Muslim population remain a small fraction of the total insurance market. Historically, the incompatibility between conventional insurance and key tenets of the Islamic faith has acted as a significant barrier to sales. These differences have led to very low penetration rates and have left many Muslims with little external protection for their dependents or possessions.

The development of Takaful, which originates from the Arabic verb 'kafalah,' which means 'to help one another' or 'mutual guarantee,' has been driven by a need to overcome these obstacles and create an insurance proposition that is fully compliant with Shariah (Islamic law). It offers Muslims a valuable risk management tool and the first true alternative to conventional insurance in both the life and non-life sectors that is acceptable to the Muslim faith.

For non-Muslims, Takaful products potentially offer an alternative source of insurance protection—with different investment objectives, an approach to surplus distribution, and an oversight system with an ethical dimension. Hence in Malaysia, for example, non-Muslims account for more than 60% of the total Takaful premiums. In addition, its insurance penetration rate is 5.1% and thus, it is the highest penetration rate among the potential *takful* markets; namely, Turkey, CIS region, Russia, Bangladesh, Indonesia, Pakistan, Egypt, Nigeria, Algeria and Morocco. However, to our knowledge, there is no survey conducted to examine the Ugandans' acceptability of *takful* products and possibility of introducing it. Therefore, the aim of this paper is to find out the acceptability and possibility of offering *takful* in Uganda.

2.0 Insurance in Uganda

Modern insurance was introduced to the country during the colonial era. The first locally owned insurance company, the East Africa General Insurance Company (EAGEN), was incorporated in 1946, followed by National Insurance Corporation (NIC) in 1964.

Prior to that, only agencies and branch offices of foreign insurance companies, mainly from the United Kingdom, Uganda and America that numbered about 95 were in operation by Independence in 1962.

Today, there are 31 licensed insurance companies, 28 insurance brokers and over 800 agents. The Insurance Regulatory Authority (IRA) established in 1996 to ensure the effective administration, supervision, regulation and control of the business of insurance in Uganda has raised confidence in the industry (IRA Report, 2018).

To further boost this confidence, a number of insurance and brokerage companies have invested heavily in public awareness. IRA and the Uganda Insurers Association have also embarked on an extensive awareness campaign. The IRA also has a complaints' bureau, a toll-free line and online complaints' facilities.

3.0 Takaful as an Ethical Based Insurance

According to Mahmoud (2008), Takaful means jointly guaranteeing among the participants. It is founded on the concepts of mutual cooperation and risk sharing (Usmani, 2007; Zuriah & Redzuan, 2009). According to the definitions provided by Malaysian Takaful Act (1984), AAOIFI's Accounting, Auditing and Governance Standards for Islamic Financial Institutions (2004/2005) and Islamic Financial Services Board (IFSB) and International Association of Insurance Supervisors (IAIS), Takaful is a system in which the participants contribute with the intention of helping among the participants in the case of misfortune.

If the history of the insurance idea is examined, it has been started before the time of the Holy Prophet Mohammed (s.a.w.) (Klingmuller, 1969). During the ancient time, the concept of 'Aqilah' is used to pay the compensation to the heir of the murdered person by the close kin of the (Billah, 2003). There has been a steady expansion of unconventional insurance practice in the 20th century in both Gulf and other non -Muslim states. Nowadays, there are more than 200 players compared to less than 10 players in early 80s. Therefore, it can be summed that Islamic or unconventional insurance has been widely spread to unconventional environment because the ethical aspect has been incorporated in the Islamic insurance.

4.0 Literature Review

Products cannot survive long in the market without solid consumer support with profitability dependent on product demand. It is thus important to conduct market surveys to predict the viability of new products before their launch. This section discusses selected thoughts and findings of contemporary scholars in the takaful market.

Swartz and Coetzer (2010) reemphasize the role of takaful. The coverage of

insurance for the poor is only 3 per cent in India where the majority of the population is in the low-income bracket with most unaware of the importance or availability of insurance. As takaful is based on shari'ah, it is free from prohibited elements such as uncertainty, gambling, and interest which can lead to social injustice. Takaful works as an alternative insurance product intended for all, not just for Muslims. As takaful products are offered in non-Muslim countries, this industry needs more participation from non-Muslims. In order for takaful to grow further globally, creating awareness about takaful is essential.

Ab Rahim and Amin (2011) examined 176 respondents to determine factors for takaful acceptance. He used convenience sampling and a self-administered questionnaire. The questionnaire was constructed according to a five-point Likert scale. Factor analysis and multiple regression were used. Based on 175 participants out of the 176, they found that attitude, subjective norms and amount of information influenced takaful acceptance.

Hidayat and Rafeea (2014) measured the level of awareness of takaful among people in Bahrain. They too used a five-point Likert scale questionnaire. Based on 150 respondents, they found that awareness of takaful is generally high in Bahrain and that level of education is a significant factor contributing to level of awareness. In their study, education was divided into high school, diploma, bachelor and postgraduate. They suggest to enhance public awareness of takaful and its principles in Bahrain, takaful companies need to advertise more, organize frequent workshops and free courses, and send their employees for training on takaful. They further suggest universities and institutes of higher learning offer courses related to takaful.

Kamil and Mat Nor (2014) examined the factors that can influence the choice of takaful over conventional insurance in Malaysia. They conducted in-depth interviews with two takaful operators and two customers. Interview questions were open-ended and a semistructured interview format was adopted. Data were coded to maintain the confidentiality of interviewees. Their interview results showed that customers' awareness of the concept of takaful and its compliance with shari'ah was clear and adequate. In promoting takaful products to customers, operators ought to think that they are performing acts of worship (ibadah) and disseminating knowledge. Based on the current status of the takaful business, its growth is slow compared to conventional insurance in the Klang Valley in Malaysia.

Md Husin and Ab Rahman (2013) reviewed existing literature regarding factors for consumers to participate in a family takaful scheme. They found that participation in the family takaful scheme was not only affected by attitude, subjective norms, and perceived Impact of internal forces behavioral control but also by moderating factors like demographic variables, consumer knowledge, situational factors (such as budget constraints), time restraint, lack of effort and consumer' level of religiosity.

Ab Rahim and Amin (2011) examined the determinants of acceptance of Islamic insurance among Malaysian bank customers. Their questionnaire was constructed according to a five-point Likert scale, ranging from strongly disagree (1) to strongly agree (5). They employed factor analysis and multiple regression. Based on 176 respondents, they found that attitude toward the products, subjective norms (measuring the extent to which an individual's decision can be influenced by friends, parents and religious organizations) and knowledge about the product influenced the respondents' acceptance of Islamic insurance.

Aziz et al. (2011) studied the impact of factors such as product knowledge, awareness, advertising, and benefit of the product on the perception of 300 government servants toward Islamic motor insurance in Malaysia. Their questionnaire had 60 statements related to perception, and four contributing factors. Five statements each were used to represent perception and contributing factors. This study also used a five-point Likert scale.

According to Pearson correlation analysis and multiple regression, all four factors strongly contributed to a favorable perception toward Islamic motor insurance in Malaysia. Amin (2012) used survey questions to examine the determinants of takaful acceptance in Malaysia. Multiple regression results showed that attitude, subjective norms and amount of information influenced takaful acceptance.

Redzuan et al. (2009) explored the economic determinants of family takaful consumption in Malaysia. They used time-series data over the period from 1985 to 2007. The dependent variable used in their study is consumption of family takaful (operationalized by contribution per capita and contribution per worker); their independent variables were income, interest rate, inflation, rate of return for saving and stock composite. By using multiple regression, they found that income per capita was a good estimator of the demand for the products, while long-term interest rate and composite stock index had a significant relationship with participation in family takaful. Other factors such as

inflation and savings rates did not appear to significantly influence family takaful purchase.

Aris et al. (2009) sought to determine the extent to which Malay Muslims in Malaysia accept family takaful. Based on 196 respondents in the Shah Alam area, Malays seemed generally aware of takaful. When respondents were asked whether they thought takaful is insurance, Islamic insurance or a savings and investment fund, 6 per cent did not answer.

The authors interpret this to mean that the nature of takaful is unclear to some respondents, even though their percentage is not significant. Factors such as lack of information, minimal returns, dissatisfaction with takaful agents' service and confusion regarding difference between insurance and takaful, meant that they did not give priority to takaful. Their lack of confidence with takaful seemed to hinder Malays from purchasing family takaful. The authors suggested that takaful operators need to innovate the products for protection, education, and investment purposes.

Alsalih and Napier (2012) compared Muslim consumer preferences for takaful and conventional insurance in the UK and Saudi Arabia. The total number of respondents in their survey was 1,067, comprising 387 from the UK and 680 from Saudi Arabia. They used a survey questionnaire and t-statistics to make the comparison. Key findings from their paper report that, overall, respondents were more aware of general takaful compared to family takaful products. Respondents from Saudi Arabia were more concerned with shari'ah compliance of the products compared to UK respondents. In addition, respondents from Saudi Arabia tended to distinguish between takaful and conventional insurance, as opposed to UK respondents, who did not show concern for the distinction.

Most studies comprehensively cover the extent of consumers' awareness, preferences and the determinants that persuade them to engage with the products. Most have conducted surveys, and some have conducted in-depth interviews to achieve their research objectives.

However, studies on takaful in Uganda are rather limited; hence, this paper plans to provide findings in this unexplored area.

5.0 Research Methodology

Since this study focuses on the acceptability and possibility of *takful* in Uganda and this is an exploratory in nature, questionnaire survey has been conducted. Questionnaire is constructed by using likert scale ranging from 1 to 5, where 1= strongly disagreed to 5= strongly agreed. The sampling method used in this study is quota sampling and this method is recommended for the exploratory nature of research (Sekaran & Bougie, 2010). Questionnaires are distributed to 108 Muslims and Non-Muslims in Kampala city. In addition, the experts are interviewed to know which *takful* model will be the best suitable model during the initial stage of offering it. Sekaran and Bougie (2010) further state that qualitative data achieved by interviewing folks at the exploratory stage might help to get better understanding and it is crucial for descriptive studies. The interviewees are the Sharia's advisors, and consultants who have experienced elsewhere in other countries in providing the advisory service to set the Takaful operators. Delphi technique is used for interview.

5. Findings

5.1 Profile of the Respondents

The profile of the respondents can be referred to Table 1. Total questionnaire of 108 were distributed. There were

Table 1. Profile of the respondents

Questions	Frequency	Percentage
Gender of the respondent		
Male	67	62.04
Female	41	37.96
Respondent's Age		
Below 18 years		
18-25 years	6	5.56
26-33 years	36	33.33
34-41	48	44.44
42-49	14	12.96
Above 50 years	4	3.70
Respondent's Education Background		
No education	4	3.70
Primary level	6	5.56
Secondary level	20	18.52
University/Tertiary	78	72.22
What is your religion?		
Muslim	46	42.59
Non-Muslims	62	57.41

46 Muslims respondents (out of 108 questionnaires distributed) and 62 non-Muslim respondents (out of 108 questionnaires distributed). Overall, response rate is 74.6%. Most of the respondents are male. Most of the respondents' age range is 34-41. In the case of education, majority of the respondents have attained University or Tertiary education and followed by secondary education. Majority of the respondents are Non-Muslims since the total number of Muslim respondents is 62 while that of non-Muslims is 46.

5.2 Acceptability of Takaful in Uganda

In order to examine the acceptability of *takful* products, six questions are asked to the respondents and the findings are discussed in Table 2.

Among the respondents, majority of the respondents (51.85%) have insurance policy. 94.44% of the respondents believed that *takful* products should be offered in Uganda.

When the respondents were asked whether they want to participate if *takful* products are introduced, 92.59% of the respondents indicated that they would like to participate. 3.70% of them were undecided.

75.93% of the respondents responded that if takaful products are available in Ugandan market, they prefer to choose takaful products and 57.41% of them believe that religious factor does not play an important role in this decision. Moreover, 92.45% of the respondents wish to have *takful* products in Uganda since it can provide protection to all the participants regardless of the religion.

Therefore, it can be summarized that the acceptability of *takful* is very high in Ugandan market.

Table 2. Acceptability of Takaful

Questions		Frequency	Percentage
1. Currently, do you have an insurance policy?	Yes	56	51.85
	No	52	48.15
2. In your opinion, should Islamic insurance (takaful) be offered in Uganda?	Yes	102	94.44
	No	6	5.56
3. If Islamic insurance (Takaful) products are available, are you willing to participate?	Yes	100	92.59
	No	4	3.70
	Not Sure	4	3.70
4. If Islamic insurance products are available, are you willing to switch from conventional insurance to Islamic insurance?	Yes	82	75.93
	No	4	3.70
	Not Sure	22	20.37
5. If there is an option to choose between conventional insurance and Islamic insurance (Takaful), do you think it is due to religious factor you choose Islamic insurance (Takaful)?	Yes	36	33.33
	No	62	57.41
	Not Sure	10	9.26
6. Islamic Insurance (Takaful) can show to be a solution for Muslims and non-Muslims to seek insurance protection at the same time abiding with shariah law.	Yes	98	92.45
	No	6	5.66
	Not Sure	2	1.89

5.3 Possibility of Introducing Takaful in Uganda

In order to examine the possibility of introducing *takful* in Uganda, ten questions were asked to the respondents. It was found out that there is a strong support for introduction of *takful* products in Uganda. The findings are discussed in Table 3.

The respondents firmly believe (the mean value of 4.26) that it is a good opportunity for the existing insurance operators to extend the product line by introducing *takful* products. The respondents are asked whether *takful* has a good potential for fast development in the insurance market, the mean value of 4.31 evidences that *takful* can penetrate the insurance market with rapid growth in gaining market share. Furthermore, the mean value of 4.35 indicates that the existing insurance operators will be able to attract the Muslim customers. Consequently, *takful* can help the current insurance operators to get more *takful* contribution or premium and directly it will result in higher profitability for the insurance operators.

When offering *takful* products in the future, most of the respondents strongly believe (mean value= 4.44) that Islamic Insurance products should be adequate to meet the needs of all sectors of economy both at corporate and individual level. Moreover, it is strongly recommended that *takful* should fulfill the needs of everyone regardless of the religion (the overall mean value of 4.49). Respondents strongly (mean value of 4.46) expect that the participation in *takful* is more beneficial than participation in traditional conventional insurance because the participants are entitled to receive the surplus or profit portion.

Table 3. Possibility of introducing Takaful in Uganda

Questions	Mean	Standard Deviation
Takaful provides a new business opportunity for the insurance operators if they want to extend the product line.	4.26	0.73
Takaful has a good potential for fast development in the insurance market.	4.31	0.61
Takaful provides wide range of opportunities for existing insurance operators to attract the Muslim customers.	4.35	0.62
Takaful products should be available to meet the needs of all sectors of economy both at corporate and individual level.	4.44	0.63
It is certain that Takaful will be beneficial for both Muslims and non-Muslims.	4.49	0.64
It is believed that participation in takaful is more beneficial than participation in traditional Conventional Insurance because surplus (profit) will be distributed back to the participants.	4.46	0.79
Takaful may reduce unemployment and poverty among Muslims since it is important to have Muslim employees, e.g. agents, to promote the unconventional insurance products	4.32	0.64
It is said that takaful helps the weaker and unlucky people of the society through various products.	4.24	0.61
There is no doubt that a huge potential for takaful in Uganda exists, but it will need some strong supporting policy to make it a reality.	3.70	0.72
Muslim population in Uganda is increasing that creates a gigantic potential for takaful and hence, Uganda should have takaful.	4.16	0.51

The respondents also strongly believe that introducing *takful* will reduce unemployment and poverty among Muslims since it is important to have Muslim employees, e.g. agents, to promote the Islamic insurance products. It has been supported by the mean value of 4.32. In the case of discharging the corporate social responsibility of the insurance operators, the respondents strongly (the mean value of 4.24) expresses that insurance operators will be able to help the weaker and unlucky people of the society through various *takful* products.

It is undeniable that a huge potential for *takful* exists in Uganda, but the overall mean value of 3.70 shows the respondents strongly believe that there is an urgent call for the strong supporting policy to introduce *takful* successfully. Majority of the respondents strongly agree (the overall mean value of 4.16) that takaful should be offered since Uganda since the Muslim population in Uganda is increasing that creates a gigantic potential for *takful* and hence, Uganda should have *takful*.

5.4 Findings from Interviews

Since both Muslims and non-Muslims in Uganda are willing to engage with *takful* products, experts were interviewed to explore which *takful* model will be the best suit model to offer. The interviewees are selected from Malaysia since it is one of the leading countries in Islamic finance. Delphi technique is used in conducting the interviews, after the third round of the interviews to 10 *Shari'ah* advisors and 5 consultants, it has been concluded that the following model, i.e. hybrid model based on the combined concept and *Wakalah* and *Mudarabah*, will be the most suitable model to be used in the Ugandan market. The proposed model can be referred to the following chart.

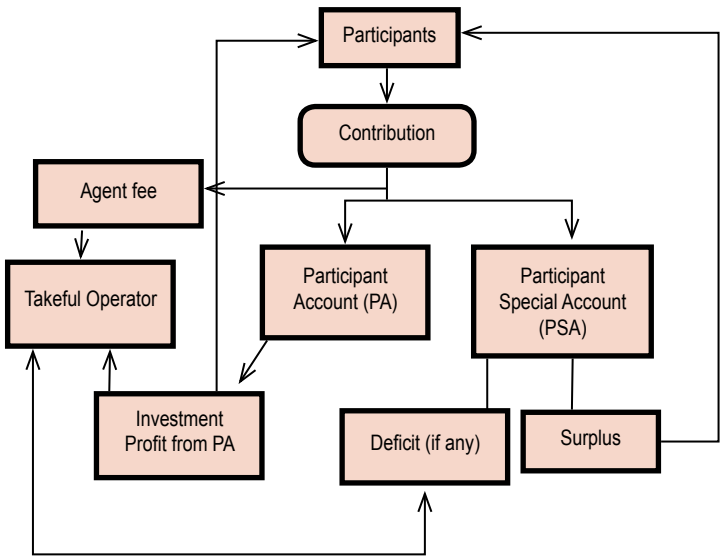

Figure 1: Takaful Model

When the participants make the contribution, the agent fee will be paid to the Takaful operator. The balance of the contribution amount will be allocated to the participant account (PA) and the participant special account (PSA). PA is the participant's personal account and it belongs to the respective participant only. Takaful operator will utilize the money from PA account for the investment and any proceed is distributed between the Takaful company the participant. PSA can be termed as Takaful risk fund which is pooled from all participants in order to help mutually among the participants in the case of misfortune. Similar the PA, Takaful operator will use the amount in PSA for the investment. In addition, this account will be used to pay the expenses related to *retakaful* and claims. If there is any surplus (the profit from the investment exceeds the expenses), will be channeled to the participant. However, in the case of deficit (the profit from the investment is less than the expenses incurred), interest free loan will be given by the shareholders to the PSA. In sum, Takaful operator will be getting *wakalah* fee and the profit share from PA while taking their responsibility of managing the Takaful risk fund and taking care the deficit. Participants will enjoy the claims, profit from PA and surplus from PSA.

6.0 Conclusion

When the historical development of insurance is examined, it is undeniable that insurance becomes part and parcel of our daily life. However, due to the involvement of prohibited and unethical elements such as interest, gambling and uncertainty in conventional insurance, it is necessary to move a step forward to find a way to overcome this problem. One way is to adopt takaful instead of conventional insurance. Therefore, this study examines the acceptability and possibility of introducing *takful* in Ugandan market. The findings from the questionnaire show that *takful* is accepted regardless of religion and there is high possibility to introduce it. In addition, the interview results from 10 *Shari'ah* advisors and 5 consultants propose the best suit *takful* model in Uganda. This study limitation is that the opinions of insurance operators and regulators from Uganda have not been included and hence, this limitation should be further examined. In addition, only respondents from Kampala city are covered in this study and thus, in future, the survey may cover all the districts in Uganda. However, it will not affect the generalization of the results since it is believed that this research finding will open up the eyes of the Ugandan government to offer *takful* in Uganda for the benefits of all involved parties. In addition, the results of this research give the hope for Ugandan Muslims to offer *takful* products in future.

Takaful operator will utilize the money from PA account for the investment and any proceed is distributed between the Takaful company the participant. PSA can be termed as Takaful risk fund which is pooled from all participants in order to help mutually among the participants in the case of misfortune.

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5. The issues that are raised in the case should be focused and must be effectively presented without any ambiguity or contradictions.
6. All the referenced material should be adequately and accurately cited at the end of the case.
7. Discussion questions can be provided at the end of case (optional).

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5	Industrial Risk Inspection- Methods & Reporting	18 Sept., 2020	10.00 am - 01.00 pm	Rs. 1500/- + 18% GST
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