



Fraud in insurance on rise

Survey 2010-11

Foreword



India is one of the fastest growing economies among BRIC countries, and so is the case with the country's insurance sector. Ernst & Young has conducted the Insurance Fraud Survey to assess the fraud scenario, the potential risk exposure, the economic impact and the industry practices to counter fraud risk.

The significant role fraud plays in negatively affecting the insurance sector is often under-reported or discounted. It is a general consensus in the market that fraud cases have significantly increased in the last one year. Claims/Surrender-related fraud is the biggest concern for insurance companies, and the majority of respondents feel that more anti-fraud regulations are the need of the hour. Fraud risk in insurance is a complex matter, which affects both the parties – insurers as well as policyholders. Frauds increase the cost of insurance, resulting in insurers losing to their competitors, and at the same time, policyholders paying higher premiums.

Some of the findings revealed through the survey are:

- ▶ There have been increased incidences of fraud over the last one year.
- ▶ Fraud risk exposure from claims or surrender is a major concern area for industry players. They have emphasized the need for increased anti-fraud regulations in the area of claims management.

- ▶ Frauds are driving up overall costs for insurers and premiums for policyholders.
- ▶ There is a need for a more robust data analytics tools to effectively detect red flags.
- ▶ It's imperative to screen all the key vendors.

Fraud risk poses a very big challenge for the insurance sector. Business leaders are aware of the need to address this risk, but the lack of a comprehensive and integrated approach to fraud risk management continues to be a concern. The increasing number of frauds and the growing degree of risk necessitates that insurance companies regularly review their policies, build in checks and use new and advanced technology to avoid such issues. However, no system can be foolproof, but a proactive and dynamic approach can make a company ready to counter fraudsters and gain an edge over its competitors.

We take this opportunity to express our gratitude to people and organizations who took time to respond to the survey. The report and its findings would not hold the same value without the support of the respondents and all those who made this survey possible.

We earnestly hope that you will find this report relevant and insightful.

Arpinder Singh

Partner and National Director
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As India's insurance industry matures, fraud risk management is going to be a major concern for insurers and business leaders. Insurers will need to continuously reassess their processes and policies to manage and mitigate the risk of fraud. Fraud risk in the insurance value chain can emanate from internal and external factors. **The risk of employees misusing confidential information and colluding with fraudsters is on the rise and insurers will need to put in place internal checks and balances to minimize such issues.** External fraud risk can arise at various stages, e.g., registration of clients, underwriting, reinsurance and the claims process. The severity of fraud can range from a slight exaggeration to deliberately causing loss of insured assets. The essential components of fraud are the intent to deceive and the desire to induce an organization to pay more than it otherwise would.

Fraud detection and management should be a proactive process, which includes identification of suspicious claims that have a high possibility of being fraudulent, through a computerized statistical analysis. Approximately 8% of life insurance portfolios need reinsurance and identification of high value policies to monitor and investigate fraud risk, which mitigates such risks to a large extent. Insurers need to put in place fraud investigation teams (with the right credentials) that work in tandem with law enforcement agencies to weed out fraudulent claims. **It is also important for the industry to build a shared or centralized database to share information related to frauds.**

The overall impact of frauds is a significant cost for the industry as well for policyholders.

Study the details of the survey findings.

Ashvin Parekh
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EMEIA* point of view

These survey results reflect a similar pattern to what the more mature UK insurance sector experienced, and to some extent, is still witnessing. Some level of fraud in the insurance sector, particularly in the area of claims, is an unfortunate fact of life. Insurance companies are prepared to accept fraud incidences and loss as one of the costs of doing business - but only as long as it is managed and kept within reasonable limits. The reason for this is the law of diminishing returns. This implies that the cost of eradicating fraud will at some point outweigh the amount that can be saved. It is therefore necessary to identify what is acceptable to shareholders and policyholders, and to strike the right balance between the cost of prevention and detection, and the losses suffered through fraud. One of the challenges in striking this balance is how one identifies and measures the real cost of fraud to an insurer.

General trends show that an increase in fraudulent incidences, as revealed by this survey, are helpful, but rarely enable a complete understanding of the true cost or causes. It is

only when additional and sophisticated investment in fraud screening and detection systems is made that a true sense of the scale of the problem can be identified and appropriate steps taken in response. The UK experience reflects this, and as more than ever before has been done over the years to combat the rising cost of fraud to insurers and policyholders, a clearer picture of the wide range of frauds suffered and their financial consequences has become evident. As a result, insurers have been able to take effective and cost-efficient measures to drive down the losses they suffer.

Today, all the major insurers in the UK have their own experienced fraud investigators, and most use advanced data analytics to help them identify transactions and patterns that look unusual and warrant closer scrutiny.

Furthermore, there are now well-established systems that aid collaboration between insurers in their attempt to combat fraud at a sector level, rather than simply at an individual company level.



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US point of view

The global economic slowdown, combined with advances in technology and global corporate competitiveness, has raised a storm for all the elements of the fraud triangle – pressure, opportunity and rationalization – to proliferate in today's economic environment.

US insurers and regulators are highly focused on the convergence of these issues as fraudsters see the former as one big wallet from which to pick-pocket dollars during tough times. The US witnesses some of its largest insurance frauds in the area of medical claims, as in India. Medical and Medicaid (government run) fraud arrests and convictions clearly outpace other insurance fraud schemes in the US by almost 2 to 1 according to figures provided in the publication The Coalition Against Insurance Fraud 2010. The US Congress, with its sweeping healthcare reforms, established a Health and Human Services Department, and proposed a budget of US\$1.7 billion to fight healthcare fraud. This included expanding its fraud strike force program. However, classic insurance frauds such as the business arson of the Eldorado Springs, Mo are still prevalent. In the case of Dan Thorton burning down the office building he owned, he was caught on video camera from a nearby department store buying cans of kerosene and the gloves, black shirt and pants that were found at the scene of the crime. Then there was the Los Angeles Interior designer, Ronal Hunt, who collected US\$150,000 on workers' compensation packages, and showed up on a reality TV show earning US\$400,000 for fixing up a home on the Home & Garden channel. He was ultimately recognized by a fellow employee.

Clearly an area for development in the Indian Insurance model appears to be the need for a more robust anti-fraud program, with over 40% of the respondents reporting that they do not have a dedicated anti-fraud department. In comparison to the US, these issues exist, but possibly for different reasons. Actually, insurance companies in the US have some of the best anti-fraud programs and detection methods in the world, but a fraudster always finds a way to circumvent those controls. Furthermore, due to the nature of

the insurance business and the multitude of parties involved (brokers, agents, adjusters, claims managers, insurers and experts), insurers have to deal with fraudsters who find a way to squeeze some funds out of the system.

One of the challenges faced by insurers in the US is that at times there is so much focus on fraud within their organizations that the message may actually be silenced due to overkill when no one group or person coordinates fraud prevention efforts company-wide. **Insurance companies, like others, are challenged in the post-Sarbanes Oxley world with the question, "Who owns fraud?"** To address this issue, US federal sentencing guidelines on rules related to corporate compliance and ethic programs were amended in 2010, calling for more proactive plans that are "real" and include training of employees, vetting of vendors, as well as testing of controls and executive sponsorship from the top down. Broker bid rigging in and collusion between major insurance brokerage houses, which only occurred a few years ago in the US, seems to be prevalent in India's insurance market today, along with the added abuse of "mis-selling," which is often hard to detect without proper oversight or by an uneducated buyer.

Ernst & Young's India Fraud Insurance Survey provides a well-defined map for insurers on the wide-reaching issues of fraud and what other companies in India are doing, as well as on areas on which they need to focus their efforts. I found of particular note that collusion (29%) and fake documentation (24%) make up more than half of the prevalent underlying issues. The survey can serve as an effective tool for insurance company executives. to rethink their fraud- prevention tactics.

We have found in the US that typically internal audit tests are not designed to test for corruption. We have had to design tests that are specific to the fraud at hand and aggressively test the transactions, based on a risk-based approach, of particular operating units rather than perform an enterprise-wide test. Only in the past few months have we seen companies implement these new ideas, but we believe it will eventually recast the forecast for the fraudster.



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Executive summary

The Institute of Internal Auditor's 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."

India, one of the fastest growing economies in the world, has a burgeoning middle class, and has witnessed a significant rise in the demand for insurance products. Over the last 10 years, the insurance industry has grown at a capital annual compounded growth rate (CAGR) of around 20%. However, with the exponential growth in the industry, there has also been an increased incidence of frauds in the country. Insurance fraud encompasses a wide range of illicit practices and illegal acts involving intentional deception or misrepresentation.

The industry has witnessed an increase in the number of fraud cases in the last one year. **Organizations are waking up to the fact that frauds are driving up the overall costs of insurers and premiums for policyholders, which may threaten their viability and also have a bearing on their profitability.**

Hence, companies need a more vigorous fraud management framework. Although this survey focuses on retail insurance, frauds related to commercial insurance claims and third-party claims are also on the rise. The sophistication of fraudsters in the area of commercial insurance claims and third-part claims makes it all the more difficult for organizations to detect and control fraud in time.

Fraud impacts organizations in several areas including financially, operationally and psychologically. While the monetary loss due to fraud is significant, its full impact of fraud on an organization can be staggering. Its loss of reputation, goodwill and customer relations can be devastating. As fraud can be perpetrated by any employee within an organization or by those outside it, it is important for companies to have an effective fraud management program in place to safeguard their assets and reputation.

This survey is an attempt to provide a definitive insight into the antecedents of insurance fraud, its aftermath and measures to help safeguard against them.

The findings presented in this report are derived from responses to a questionnaire sent to individuals representing India's largest public and private insurance companies, both life and non-life. The questionnaire sought the views and opinions of the top management of these companies on various issues ranging from identification of fraud areas, the impact of fraud, areas that needed anti-fraud regulations to methods of fraud detection in the industry.

Our report highlights and summarizes the key findings of the survey, which establishes the fact that fighting fraud and mitigating fraud risk are gaining importance for organizations across all sectors and industries.



Rise in the number of fraud cases in last one year

40% of the respondents indicated that there has been a rise in insurance fraud cases during the last one year

Figure 1: Rise in fraud cases in insurance companies during the last one year

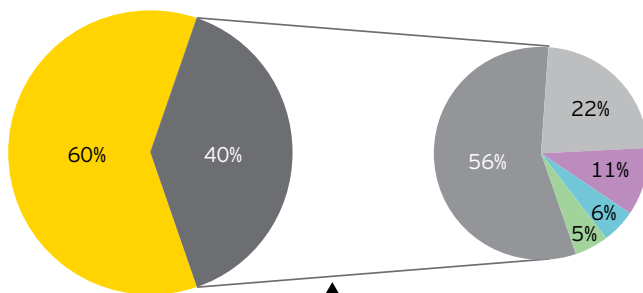


Chart represents break-up of responses by % for increase in fraud cases during last 12 months

- No, fraud cases have not increased
- Yes, fraud cases have increased
- Up to 20% increase in fraud cases
- Between 31% & 40% increase in fraud cases
- Between 21% & 30% increase in fraud cases
- Between 41% & 50% increase in fraud cases
- Above 50% increase in fraud cases

The key motive for all insurance crimes is financial profit. Insurance contracts provide the insured and the insurer with opportunities for exploitation. **According to the survey -**

- ▶ 40% of the respondents felt that fraud cases in insurance companies have gone up substantially in the last one year.
- ▶ Furthermore, among the respondents who felt there has been a rise in fraud cases, almost 56% were of the opinion that they had gone up by up to 20% during this period.
- ▶ Another 22% of the respondents indicated that fraud cases have increased by 31-40% during the last one year.

The three broad categories of fraud are:

- ▶ **Policy holder and claims fraud:** fraud against insurer by policyholder and/or other parties in the purchase and/or execution of an insurance product
- ▶ **Intermediary fraud:** fraud by intermediaries against insurer and/or policyholders
- ▶ **Internal fraud:** fraud against insurer by employee on his/her own volition or in collusion with parties that are internal or external to insurer



Claims/surrender-related fraud a concern for insurers

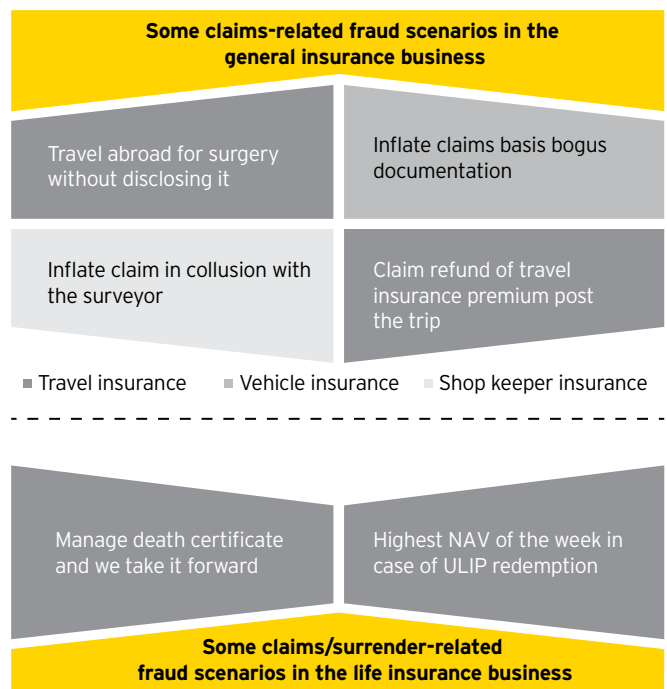
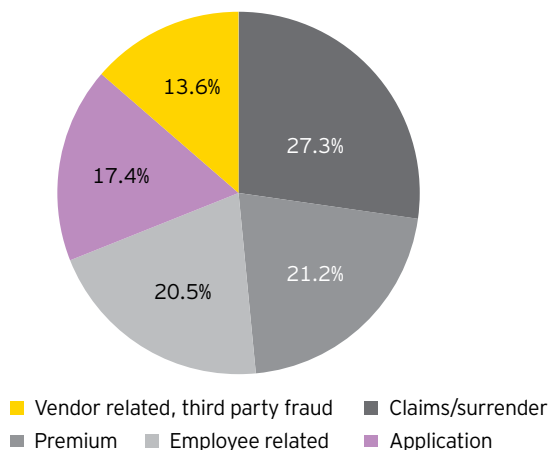
According to the survey, claim/surrender, premium and employee-related frauds number among top three fraud risks.

There are different types of insurance frauds, which occur in all areas of insurance. Insurance crimes also range in severity, from marginally exaggerated claims to ones that deliberately cause accidents or damage. Insurance companies have five key areas of risk exposure. These are related to -

- ▶ Claims or surrender
- ▶ Premiums
- ▶ Applications
- ▶ Employee-related fraud
- ▶ Vendor-related third party fraud

In the business of general insurance, a large number of frauds occur in health insurance, and these pertain to overstating of claims or involve the manipulation of the documents of non-existing hospitals, pharmacies, etc., or to cover up non-disclosure of facts at the proposal stage. It has been observed that there are a higher number of fraudulent cases in the case of hospitalization benefits and personal accident policies. According to an Indian association, "Out of the total outgoings in health insurance, nearly 25% are fraudulent claims."

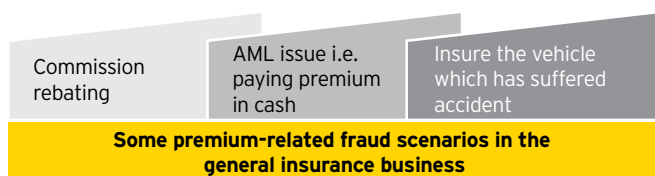
Figure 2: Fraud risk exposure faced by insurance companies



Nearly 27% of the respondents find that the insurance companies face maximum fraud risk exposure in the area of claims or surrender.

Around 21% of the respondents feel that the insurance companies face significant risk exposure in the area of premiums.

In life insurance, as well as in general insurance, commission rebating brings greater competition to the insurance marketplace and enables consumers to reap significant savings. This is the most fraudulent area of premium-related fraud.



The findings of the survey are supported by increasing reports of fraud in the media. Some examples of employee related fraud are:

- ▶ The CBI registered a case against the Divisional Manager of the company for allegedly collecting money from customers and issuing cover notes to them, but neither the money nor the cover note was deposited with the Insurance company¹.
- ▶ A former employee of one of the biggest private life insurance companies allegedly cheated the company's customers by issuing fake receipts².

Nearly 21% of the respondents felt that employee-related frauds are the other significant risk exposure faced by organizations.

1. "CBI registers a case against Divisional Manager of United India Insurance Co. Ltd., : Huge Assets Recovered," <http://www.presstrust.com/node/458283>, accessed 24 December 2010

2. "Employee held for cheating company," <http://articles.timesofindia.indiatimes.com/2010/may/26>, accessed 24 December 2010

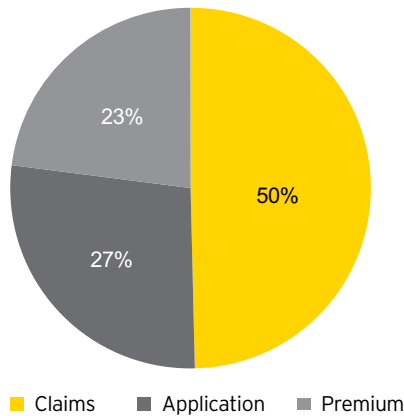


Areas that need more stringent anti-fraud regulations

Around 50% of the respondents expressed the need for increased and more stringent anti-fraud regulations in the area of claims or surrender.

Fraud risk arising from claims or surrender being the key concern for most insurance companies calls for more stringent regulations. If claims-related frauds can be detected in time, it can help insurers save significantly on costs. The survey indicates that almost one out of every two respondents feel that more strict anti-fraud regulations are needed for effective and transparent claims or surrender management.

Figure 3: Areas that need more stringent anti-fraud regulations



It is estimated that India's health insurance sector is losing around INR10 billion on false claims every year. Apart from depleting the financial resources of insurance companies, fraudulent claims or surrender also affect policy holders adversely, since the latter have to pay higher premiums for insurance products. The respondents emphasized on the urgency of preventing fraudulent claims or surrender to plug revenue losses.

As claims or surrender is prone to fraud or value inflation, handling of claims or surrender affects the long-term sustainability of a company's profits. To manage fraud, companies can adopt a hybrid approach to detection, using a combination of profiling rules to filter fraudulent transactions with advanced analytics software.

Some measures taken by general insurance companies to check fraud in the reimbursement of mediclaim policies is denial of the claims of policy holders if they fail to submit their papers after their discharge from hospitals within the stipulated timeframe. Insurance companies have so far taken a lenient approach on this aspect.

According to an industry expert, "India should take a leaf out of the US, where, to prevent losses over INR1,320 billion annually to healthcare insurance frauds, the government has introduced Health Insurance Portability and Accountability Act (HIPAA) that makes insurance frauds a criminal offence liable to imprisonment of over 10 years and financial penalties, depending on the nature of the crime."

According to an official of an insurance company, " From our investigation and experience, we have realized the fraudsters are the only beneficiary because of the delay or long span of time allowed to submit the paper. The more the time available, the easier it is to prepare fake documents. It is difficult to carry out investigations for claims/surrender, which come several months after discharge from hospital."

According to 27% of the respondents, applications constitute the second-largest risk exposure, which needs anti-fraud regulations. **The very nature of the industry, where the bulk of the business is channeled through intermediaries, makes it vulnerable to money-laundering activities.** The quality of Customer Due Diligence (CDD) carried out by intermediaries and Suspicious Transaction Reports (STRs) are areas of concern for Anti Money Laundering (AML) compliance. Furthermore, money laundering exposure by agents, who

convert cash to cheques or demand drafts, is a prominent fraudulent area. The challenges in Know Your Customer (KYC) compliance include the use of agents, lack of a central database and misleading customer profiles.

Some recommendations to allay mounting concerns relating to money laundering include:

- ▶ an agent KYC score card,
- ▶ a centralized KYC database,
- ▶ a unique identification code for the insurance industry,
- ▶ a risk-based approach, and
- ▶ the use of intelligent software for transaction monitoring and screening against negative lists and third party databases.



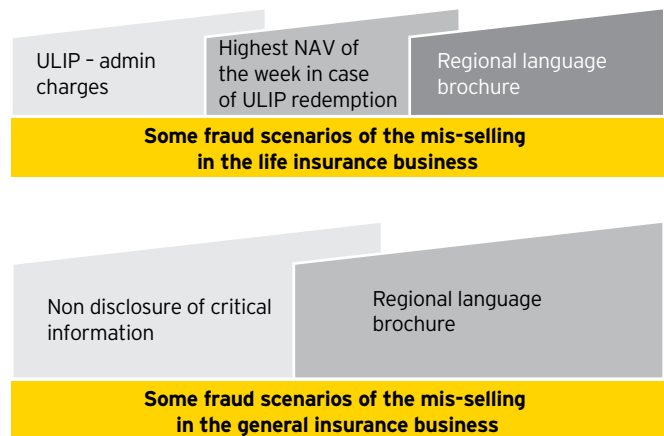
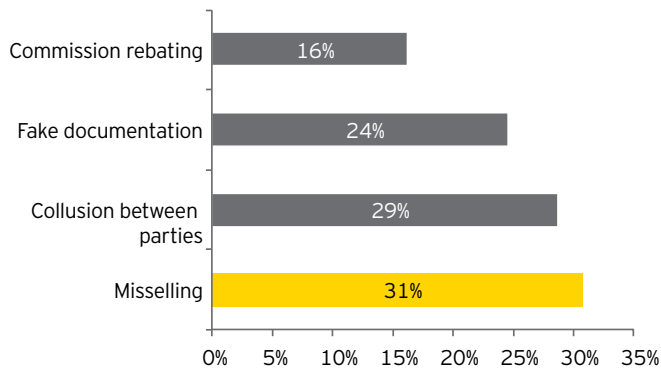


Types of fraud affecting insurance companies

Nearly 31% of the respondents indicate that insurance companies are most affected by mis-selling due to premeditated fabrication and/or fraudulent misrepresentation of material information, as compared to the different types of frauds that affect insurance companies adversely. Insurance continues to be mis-sold with senior citizens being the softest targets as they do not understand new products. Recent media

news highlights the prevalence of this kind of fraud, "A 74-year-old man was fraudulently sold four insurance policies and two pension plans by a clutch of bank executives, who obtained his personal details on the pretext of opening a bank account." Measures such as mystery shopping can provide some relief by identifying and eliminating mis-selling.

Figure 4: Different types of fraud affecting insurance companies



The Insurance Regulatory and Development Authority (IRDA) has put in place a significant regulation to bring about transparency in the selling process by stipulating that " ... all insurance companies (life and general) have to resolve complaints from policy holders within 14 days and any failure to do so will attract penalty. Any failure on the part of insurers to follow this procedure and time frame will attract penalties by the IRDA."

Collusion between parties (29%) and fake documentation (24%) are the other critical types of fraud that affect insurance companies. The former mainly occurs in collusion with patients, who are undergoing a particular treatment and are made to sign for more expensive procedures by hospitals. In some cases, hospitals claim money for patients who have not actually been admitted to these hospitals. Such patients are paid a small amount by such hospitals, which claim large amounts from insurance companies. In other cases, manipulation of documents is common in the segment. India Forensic Research indicates that medical bills are the most commonly forged documents.



In its quest to restrict unfair practices, IRDA has formulated the Insurance Regulatory and Development Authority (Protection of Policyholders' Interests) Regulations, 2002. To counter the increase in the number and complexity of frauds, IRDA has announced draft regulations for open market consultation, to reduce "unfair practices" and the "information gap" in domestic insurance.

Some of the proposed regulations:

- ▶ An amendment of IRDA's regulations to protect policyholders' interests and issuance of key feature documents for insurance products
- ▶ Guidelines on distance marketing and sale process verification of insurance products
- ▶ Standardization of terms and conditions on unit-linked insurance products
- ▶ IRDA's acquisition of a database for the distribution of insurance products

In its bid to check financial fraud, IRDA has made it mandatory for all insurers to obtain a recent photograph of new customers.

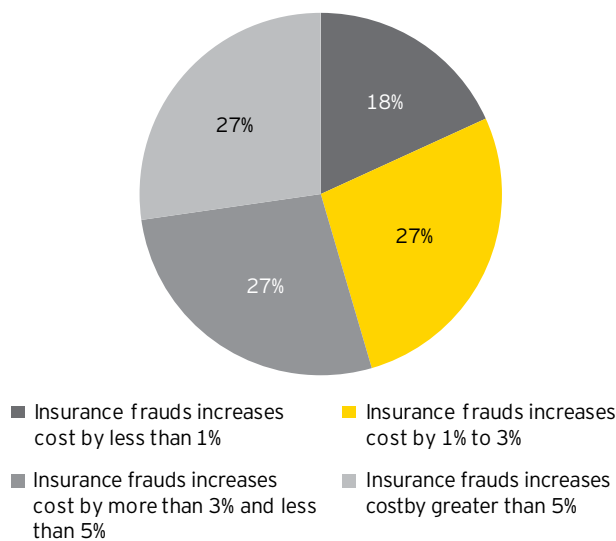


Frauds adversely affecting both insurer and consumer

According to more than 80% of the respondents, insurance fraud can increase costs for the insurer by at least 1% and can go up by more than 5% in certain cases.

Insurance fraud can pose a serious risk for insurance companies and may result in additional costs for their policy holders.

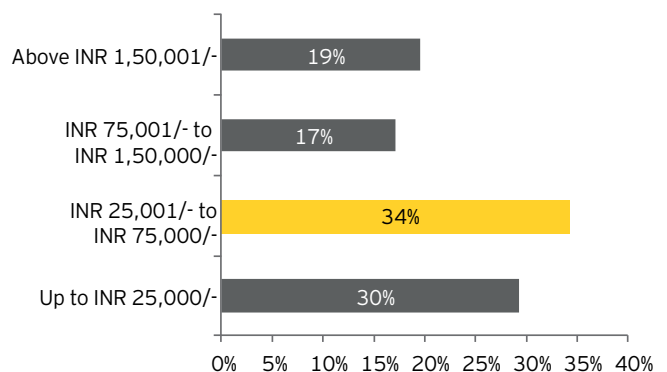
Figure 5: Insurance fraud driving costs for insurer



According to an industry expert, "Health insurance leads with an estimated loss due to false claims/surrender costing the general insurance segment INR6 billion every year – around 10-15% of the total claims paid. The segment has seen very high claims/surrender ratios, which, coupled with fraudulent claims/surrender, have become a matter of concern for insurers."

India's insurance sector is heavily affected by fraudulent claims or surrender. According to one of the studies conducted in the country, its insurance sector incurs a loss of more than 8% of its total revenue collection in a fiscal year.

Figure 6: ticket size of each fraud in an insurance company



Fraudulent activities also affect the lives of innocent people, both directly through accidental or purposeful injury or damage and indirectly, since these crimes cause insurance premiums to be raised.

According to the survey, one out of every three respondents indicated that the average ticket size of each fraud in an insurance company can be anywhere between INR25,000 to INR75,000.

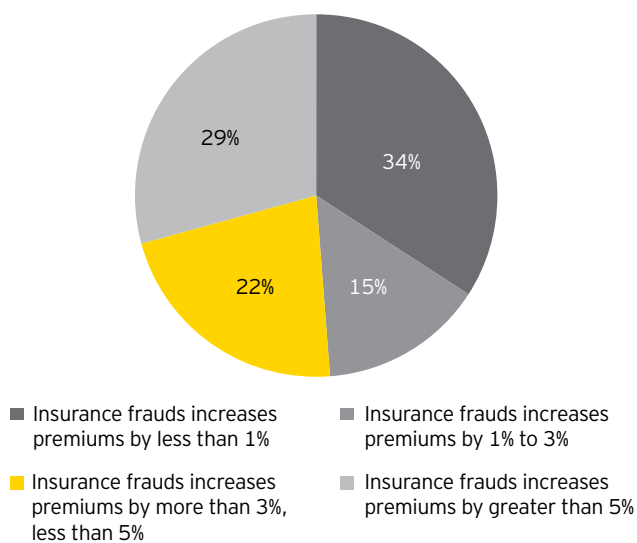
Will it be correct to say that premiums are not only calculated on the basis of the underlying risk of an asset and time period, but also on the number of fraud incidences?

Consumers are directly affected by insurance fraud even when it is not committed by them, because insurance companies are forced to charge them higher premiums to compensate for the funds they lose due to fraudulent activity.

In the case of insurance companies, increased competition is already exerting downward pressure on premiums.

According to two-thirds of the respondents, fraud can increase premiums for policyholders by up to 3%. This is an additional cost for those who have been paying their premiums diligently to compensate for frauds incidences in the industry. Out of the respondents, around 22% believe that premiums may rise between 3-5%, while 15% are of the view that premiums can increase by more than 5%.

Figure 7: Insurance fraud driving up premiums for policyholders



More than 50% of the respondents feel that frauds drive up the premiums for policyholders by more than 3%



Dedicated “anti fraud” department the need of the hour

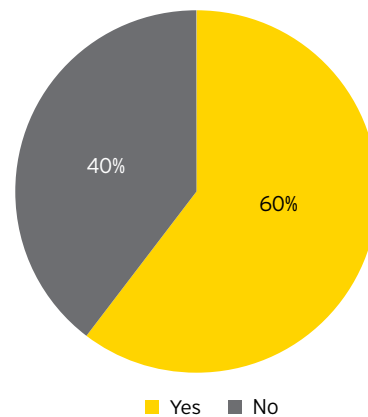
Around 40% of the respondents reported that their organizations do not have a dedicated anti-fraud department.

Fraud can be perpetrated in many ways. Therefore, an insurer should adopt a holistic approach to adequately identify, measure, control and monitor fraud risk. For an insurance organization, its fraud management strategy should form part of its business strategy and be consistent with its overall mission and objectives.

Detection of insurance fraud should be in two steps:

- ▶ The first is to proactively identify suspicious claims or surrender that has a high possibility of being fraudulent. This can be done by conducting data analysis using various forensic tools or by putting in place an effective fraud risk assessment framework. Additionally, insurance companies can provide their stakeholders with a fraud-reporting mechanism.
- ▶ Regardless of the mode of implementing step one, the next step should be to investigate these fraud claims or surrender and conduct further analysis.

Figure 8: Organization with a dedicated anti-fraud department



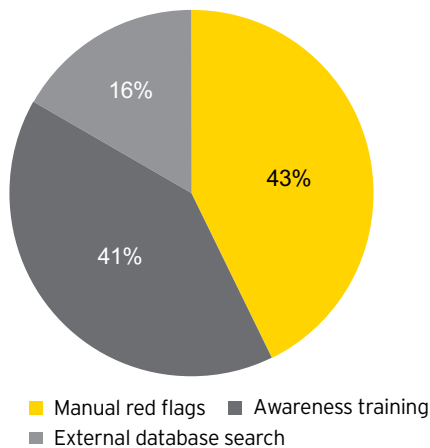
According to India's Ministry of Labour and Employment's advisory note, which was sent to insurance companies, "It is in the interest of insurance companies to spend time and effort on an effective monitoring mechanism to ensure that claim ratios are realistic, manageable and correct." In a data-driven industry such as insurance, companies will not only need to compete in terms of their product offerings, but will also be required to leverage business intelligence-enabled analytics to attain a competitive edge.



Different means employed to detect fraud

Around 43% of the respondents use manual red flags as a means to detect fraud in their organizations.

Figure 9: Means used to detect fraud



Due to the huge volumes involved, it would be far too expensive for insurance companies to have their employees look into all indications of fraud. Instead, they can use data analytics techniques for proactive fraud monitoring, which may help to identify fraud close to its occurrence.

Awareness training (according to 41% of the respondents) is the second-most popular tool used by insurance companies to detect frauds.

Within these organizations, 50% of the respondents claimed that screening is carried out for less than 25% of the key vendors and employees. Insurance companies can be exposed to increased risk of frauds by not screening prospective key vendors and employees, which could result in increased costs and reduced customer confidence. An insurer should establish and maintain an incident database, which contains the names of employees and their family members, policyholders, claimants and parties who have been convicted of fraud or have attempted to defraud it.

"Increased vigilance would definitely increase costs for insurance companies, but it would be worth the effort as they would save money when cases of fraud go down," points out an eminent industry leader.

Figure 10: Screening of all prospective key vendors and key employees for red flags

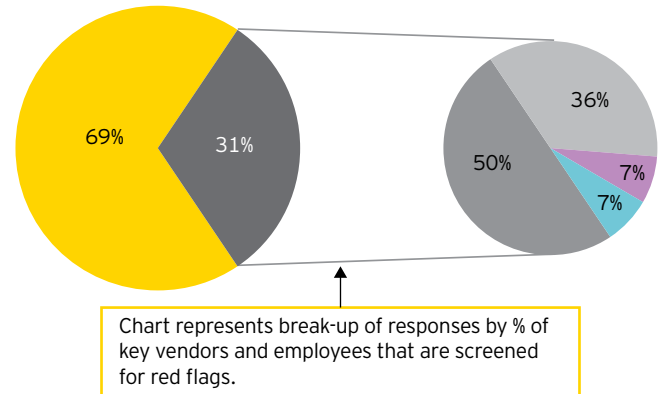


Chart represents break-up of responses by % of key vendors and employees that are screened for red flags.

- Yes, organization conducts screening
- No, organization does not conduct screening
- Screening is done for less than 25% key vendors and key employees
- Screening is done for between 25% & 49% key vendors and key employees
- Screening is done for between 50% & 74% key vendors and key employees
- Screening is done for between 75% & 99% key vendors and key employees

According to the survey, one-third of the respondents reported that their insurance companies don't screen all their key vendors and employees.

Some examples of the modus operandi used by vendors and employers to commit fraud:

- ▶ The suspects allegedly stole the identities of both doctors and patients, and set up phantom clinics and bank accounts. Authorities say they used the names to submit bills, and then got back large sums of money from insurer by making fraudulent claims/surrender.
- ▶ An Indian citizen working in the Insurance claims division of a Delhi-based BPO, which handled the UK Insurance firm's business, was arrested over fears of a major scam. The suspect was handling the insurance details of hundreds of UK customers. The 30-year-old is feared to have been using the identities of UK insurance customers to make false claims for up to two years."

To discover fraud, it is critical to establish the appropriate source and implement the medium to make the process robust and effective. The survey indicated that the use of whistleblowers is the most frequently used mechanism by means of which fraud is unearthed by an insurance company. The next preferred mechanism is internal audit.

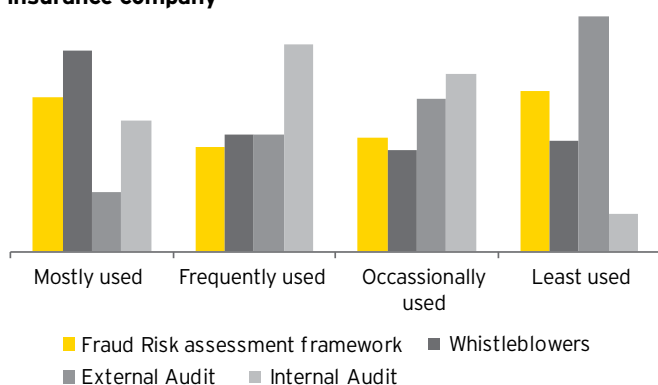
The results of the survey indicate that business leaders are aware of the need to address fraud and implement fraud prevention initiatives, but a comprehensive and integrated approach to fraud risk management continues to pose a significant challenge. However, effective management of fraud risk by a company is essential for its regulatory compliance, the growth of its business and to enable it to attain a competitive edge in the market.

An organization needs to adopt a definite methodology to identify and address risks of fraud within it. Some of the areas that a good fraud risk management process should cover include:

- ▶ A well-defined whistle-blowing policy
- ▶ Periodic fraud risk assessments
- ▶ A pre-employment screening
- ▶ Vendor background checks

National and local governments, especially in the last half of the Twentieth Century, recognized insurance fraud as a serious crime, and are striving to put in place effective measures to identify and punish, and more importantly, prevent this practice.

Figure 11: Mechanisms used for discovering fraud in an insurance company





Ernst & Young's point of view

The insurance market in India is evolving rapidly in the face of market and regulatory changes and the resultant impact on the competitive environment. The decade since the opening up of the market to private and international participation has seen the market grow rapidly, adding new products, distribution channels, geographies and customer segments as it has evolved. This enhanced market reach and impact has also seen regulators becoming increasingly vigilant on matters of policy-holder protection. The increased span of the businesses of the various market players and intense competition pose significant profitability-related challenges for the industry. In this environment, it is imperative for the industry as a whole and for the various market participants to identify and prevent fraud in the various segments of the insurance value chain from business acquisition to claim payouts, both in the life and the non-life insurance markets. **The more successful organizations have already begun focusing on this area and have seen benefits accruing to them in the form of the**

enhanced risk profile of their businesses, greater bargaining power with their various suppliers and stakeholders, higher customer satisfaction, and last but not the least, a significant improvement in their profitability. The insurance regulator is, at the same time, focused on speedy redressal of customer grievances – a centralized database of fraud-related data would, in this regard, go a long way in improving industry performance. Individual insurance players and the industry as a whole would thus benefit greatly from an institutionalized and integrated fraud management program that identifies the areas that are more prone to fraud, creates a framework for tracking and monitoring the processes and transactions to identify potential fraud and leakages therein, builds analytical tools and capabilities to identify and mitigate quantum of losses from various fraud incidences, and finally, increases levels of awareness in this regard, both within organizations and in the industry as a whole.



Samir Bali
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To sum up

In the insurance industry, fraud has always been considered a sensitive issue. The million dollar question continues to be, **“Are insurance companies quick to respond where they suspect fraudulent activities to exist?”** 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. Fraudulent claims and surrenders account for a significant portion of all claims and surrenders received by insurers, which also adds up to their overall costs. This is also confirmed by the findings of our survey.

According to our survey report, there are various types of insurance frauds, which occur in all the areas of insurance, e.g., as claims and surrenders, fake documentation, mis-selling, collusion between parties, etc. All insurance fraud can be classified under the categories of soft and hard fraud, as describe below:

- ▶ **Hard fraud:** This occurs when people unlawfully obtain money from insurance companies by a reporting a false injury or accident.

- ▶ **Soft fraud:** This happens when people either lie to their insurance companies or hide certain information for financial gain.

Today, when India's insurance industry is working toward reducing costs, one of its main focus areas to control or reduce costs is by proactively arresting fraud, which can be achieved through an effective fraud risk assessment (FRA) program.

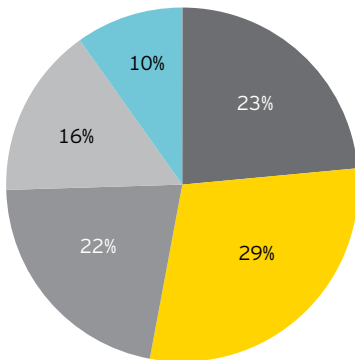
Some of the essential characteristics of a FRA program include:

- ▶ Effective policy holder and vendor due diligence process
- ▶ Effective claims validation
- ▶ Mystery shopping, i.e., gathering market intelligence relating to tied and corporate agents, brokers, etc.
- ▶ Channel reviews pertaining to tied agency, bancassurance and tele calling
- ▶ Contract compliance reviews including review of advertising expenses, intellectual property (IP) compliance, etc.
- ▶ Effective fraud analytics and electronic dashboards



Annexure

Profile of respondents (51)



- Agents
- CXO
- Internal audit & head compliance officer
- MD/Director
- Middle management

References

- ▶ Insurance Regulatory and Development Authority (IRDA)
- ▶ "Insurance frauds," Wikipedia, accessed 09 November 2010, http://en.wikipedia.org/wiki/Insurance_fraud



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Dealing with the complex issues of fraud, regulatory compliance and business disputes can distract you from your effort to achieve your company's potential. Better management of fraud risk and compliance exposure have become a critical business necessity - no matter what the industry sector. With more than 1,000 fraud investigation and dispute professionals across the globe, we assemble the right multidisciplinary and culturally aligned teams to work with our clients and their legal advisors, to give them the benefit of our broad sector experience, deep subject matter knowledge and the latest insights from our work worldwide. This is how Ernst & Young makes a difference.

FIDS India

- ▶ **Deep competencies:** Our FIDS team has specific domain knowledge, along with wide industry experience.
- ▶ **Forensic technology:** We use sophisticated tools and established forensic techniques to provide the requisite services to address individual client challenges.
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