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A call to action
Identifying strategies to win the war against insurance claims fraud

Contents

Executive summary

Insurance claims fraud is estimated to cost property and casualty (P&C) insurers $30 billion annually, eroding profit margins and driving up premiums for many consumers. With losses mounting from fraudulent claims, fraud management has moved higher on the agenda of senior management.

Many companies have taken steps to improve their ability to identify and address fraudulent claims, but these efforts have typically been fragmented. Effectively addressing claims fraud rests on four pillars of an integrated fraud management program:

- Develop a fraud management strategy
- Align the operating model
- Improve information quality
- Leverage advanced technology tools and analytics

These four pillars encompass a strategy that clearly articulates fraud management goals; the organizational structure, business processes, and workforce skills required to execute that strategy; the ability to integrate quality internal and external information; and the tools to promptly identify fraud. The ability to move beyond piecemeal efforts and adopt an end-to-end vision of the fraud management process can make a big difference in the ongoing war against fraud.

Explosion of insurance claims fraud

Insurance fraud can be defined as "a deliberate deception perpetrated against or by an insurance company or agent for the purpose of financial gain."[1] When one thinks of insurance fraud, it is common to think of so-called "hard" fraud, that is, when someone deliberately fabricates a claim, fakes an accident, or coordinates a complex scheme involving multiple parties such as agents, doctors, attorneys, claimants, and witnesses. Yet, the lion's share of fraud is due to "soft" fraud, in which a claimant exaggerates the value of a legitimate claim or misrepresents information in an attempt to pay lower policy premiums.

The economic impacts of fraud are enormous. The Coalition Against Insurance Fraud (CAIF) estimates that fraud for all types of insurance costs $80 billion annually, or $950 for each family, making it the second largest economic crime in the United States after tax evasion.[2] Looking only at P&C insurance, fraud is estimated to amount to $30 billion in losses and loss adjustment expenses each year, accounting for 10 percent of the total payout.[3] At present, workers' compensation and automobile insurance lines of business represent the larger fraud areas for the P&C industry.

Fraudulent claims can have an enormous impact on the bottom line of an insurance carrier. According to the Insurance Research Council-Insurance Services Office, almost half of P&C companies report that between 11 and 30 cents or more of each premium dollar is lost to soft fraud alone.[4]

Not only does fraud impose large costs, the number of fraudulent claims is growing rapidly. The National Insurance Crime Bureau (NICB) reported that in 2011 questionable claims for the first time had exceeded 100,000 referrals and had increased by 19 percent compared to 2009,[5] and specific categories saw even larger increases, such as casualty and miscellaneous claim types.

Figure 1. 2011 Questionable claims: Distribution of associated referral types

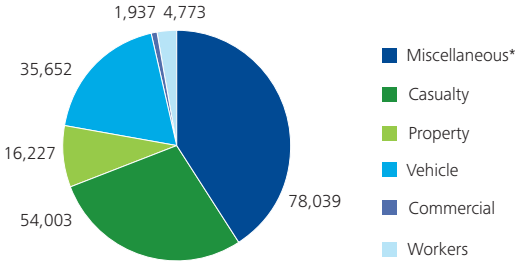
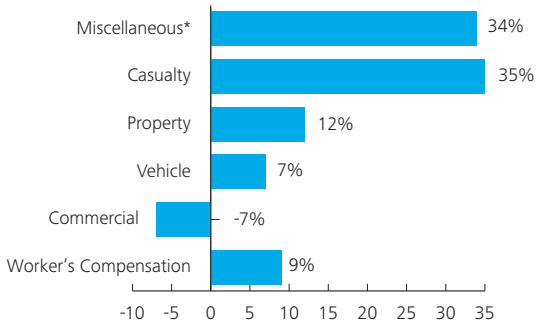


Figure 2. Increase in questionable claims: 2009 – 2011 Percentage increase by claim types



*NICB categorizes "Miscellaneous" to include all questionable claims referrals pertaining to premium avoidance, application misrepresentations, medical provider, organized ring activity, catastrophe, agent/adjuster fraud, fictitious loss, questionable/false documentation, vendor fraud, lack of cooperation from insured, and extensive loss history.

The four largest categories with Miscellaneous questionable claims were: (1) Prior losses/damage, (2) Lack of cooperation, (3) Fictitious losses, and (4) Misrepresentation in statements.

Source: Deloitte Analysis, NICB

Barriers to addressing fraud

With fraudulent claims accounting for up to 30 percent of the premium dollar and with the number of claims rising, senior management is now recognizing the importance of reducing claims fraud in the P&C industry. However, insurers face many barriers in the battle against fraud.

Lack of a collective industry approach

While the NICB has played an important role in encouraging coordination across the industry, most carriers largely work independently on fraud. For example, while 42 states and the District of Columbia have set up fraud bureaus, there is a lack of consistency in organization, approach, and oversight. As a result, leading practices are often not shared and efforts to deter fraud have not received public attention.

Limited legal options and enforcement power

In prosecuting fraud, the onus is placed on the carrier to demonstrate that a claimant is fraudulent, and even where this is possible the legal process is lengthy and inconsistent. Additionally, the lack of consistent and specific immunity protection for a carrier, particularly when collaborating with other carriers, creates additional barriers to effectively addressing fraud. State and federal regulations are often unclear regarding the actions a carrier is allowed to take and the coverage and powers extended to state fraud bureaus.

Increased potential for fraud in personal injury protection states

Losses in personal injury protection (no-fault) states are growing quickly and fraudulent claims appear to be a significant factor. For example, according to the Insurance Information Institute, staged auto accidents and excessive or unnecessary medical treatments added an estimated $1 billion to the costs of Florida's no-fault insurance system in 2011.[6]

Problems with legacy systems and data quality

Many carriers continue to rely on legacy policy and claims applications, cobbled together with an array of "bolt-on" tools, which make it difficult to integrate information across the organization when handling a claim. Compounding the problem, many companies have been plagued by data issues—inconsistent formats, poor quality, and insufficient granularity—that inhibit effective decision making.

Ongoing talent crisis

Many carriers are faced with an aging workforce among their most experienced claims adjusters and Special Investigations Unit (SIU) staff and find it difficult to replace the accumulated knowledge and experience of these retiring seasoned workers with new recruits. Further, over the last decade many carriers have slashed headcount in an effort to reduce operating expenses. The result has been larger caseloads for claims and SIU staff, making it more difficult for them to devote the time required to investigate potentially fraudulent claims.

Tolerant consumer attitudes

Despite the fact that fraud drives up premiums, many consumers have surprisingly tolerant attitudes towards insurance fraud. A 2008 survey by the Coalition Against Insurance Fraud found that roughly one in five U.S. adults—45 million people—felt it was acceptable to defraud insurance companies under certain circumstances.[7] The survey also found the number of consumers that felt various types of insurance fraud (e.g., misrepresenting facts on an insurance application, inflating a claim, or misrepresenting an incident to be paid for an uncovered loss) were unethical had declined over the previous decade.[8]

Adopting an integrated fraud management framework

While many insurers have invested resources in an effort to improve fraud management, few have taken a broad or integrated approach. Some companies have invested in improving data quality and adopting technology tools, but still lack the business processes, workforce competencies, and organizational structure needed to act on the insights gained from data analysis. Other companies have worked to enhance their operating model, but have failed to develop a clear strategy of what they hope to achieve.

Although these efforts can yield some benefits, they are unlikely to capture the potential synergies among the different aspects of fraud management. An effective operating model supports implementation of a fraud management strategy. Access to consistent, high-quality data and the latest tools and analytics provides the opportunity for an operating model to reach its full potential. And development of advanced analytics capabilities requires both high-quality data as well as an operating model that can act on the insights generated.

An integrated approach addresses all four pillars of an effective fraud management program (Figure 3).

Figure 3. Developing and executing an integrated action plan for claims fraud management

	Recommended actions	Questions to address for execution planning
Strategy	Establish an integrated fraud detection, management, and prevention philosophy and strategy	• What is the "end goal" we would like to achieve? • What is our vision and plan of action to address fraud? • What specific areas of fraud should be prioritized ?
	Increase industry collaboration and sharing of leading practices to combat fraud	• How do we increase industry and regulatory support for stronger fraud measures? • How do we incent industry stakeholders to employ common fraud philosophies and standards as well as proactively share leading practices?
Operating Model	Establish clear fraud management goals and performance objectives across the national and global enterprise	• What fraud-specific business objectives and milestones are we trying to accomplish and by when? How do we define success? • What are the performance metrics we should monitor and report on? How do we incent employees/partners to drive desired/targeted outcomes? • How do we measure the impact of our fraud programs and investments?
	Organize for execution with clear line of sight and accountabilites across business units and geographies	• How do we effectively and efficiently organize and deploy our resources to address the fraud challenge and execute on our enterprise priorities? • How do we continue to grow our institutional knowledge and capabilities on fraud management?
Information Quality	Institute consistent standards for data capture and information quality	• How do we effectively manage the quality, consistency, usability, security, and availability of fraud information enterprise wide? • How do we transform data into a consumable asset to deliver hindsight, insight, and foresight into fraud?
	Improve anomaly detection and management	• How do we standardize and the better utilize data, both internal and external, to improve identification of claims with potential for hard or soft fraud? • What actions can we take to improve the timeliness and quality of fraud referrals?
Tools and Analytics	Implement event and rules-driven workflow	• How can we improve workflow to deliver insights and trigger appropriate actions on fraud as early as first notice of loss?
	Develop and grow integrated analytics capabilities	• What enhancements to our "ecosystem" (data, systems, tools, capabilities, and business rules) will drive improved performance on detection, prevention, and management of fraud across the claims lifecycle?

1. Develop a fraud management strategy

Companies need to develop a fraud management strategy that identifies the end goal to be achieved, the resources required, and the action plan. A strategy should first address the high priority areas that generate the majority of the company's fraudulent claims.

A critical question is how aggressive and visible a company wants to be in pursuing potentially fraudulent claims. The claims experience is a moment of truth for insurers—one that can determine whether a policyholder becomes a loyal customer or switches to a competitor. There is a delicate balance between attempting to limit losses by aggressively pursuing every potential instance of fraud on the one hand, and seeking to avoid mistakenly identifying legitimate claims as suspicious, which can damage customer relationships. Having a strong process in place to differentiate true cases of fraud from false positives is essential.

In addition, companies need to decide whether they will take a truly public stance against fraud, and if so, how they will collaborate with other companies to share leading practices and raise the visibility of fraud prevention. Although fraud is a systemic issue, each company largely acts on its own. Companies can benefit from sharing leading practices and information with other carriers so the industry forms a united front against fraud.

2. Align the operating model

A fraud operating model supports and enables a company's fraud management strategy. In light of its fraud strategy, a company needs to put in place the required resources, organizational structure, business processes, competencies, and training.

Responsibilities for fraud management should be clearly defined and assigned across business units and geographies. For example, companies should define the guidelines for referring suspicious claims to the SIU and whether the SIU will handle claims for many types of fraud or only for hard fraud. For example, a typical organizational consideration is the level of administrative support that can be applied in SIU referrals and in basic background checks and research. Such consideration can be very meaningful in terms of overall referral cycle time and associated handling expense.

Clear metrics promote the appropriate behaviors to achieve the desired goals and measure successes, and fraud objectives should be incorporated into performance goals, evaluations, and compensation decisions. Companies should look to recruit professionals with the core skills in fraud investigation and provide training to continue to develop the skills of existing professionals, both SIU staff and other claims professionals.

Central role of execution

While all four pillars of an integrated fraud management program are important, many companies find that developing an effective operating model is their highest priority and provides the foundation. Companies should develop these implementation capabilities and the ability to act on the insights from data analysis.

Companies should consider all aspects of the enterprise operating model—including organizational structure, business processes, technology, data, workforce, sourcing, channels, products, and locations—and assess how each of these components can support the following basic fraud management capability building blocks:

- Assessment: Centralized fraud assessment process that can identify the highest risk areas
- Prevention: Strong fraud controls informed by data and rigorous processes
- Detection: Early-warning systems that identify fraudulent or suspicious claims by locations, channels, and products
- Investigation and corrective action: Consistent procedures and processes to identify, triage, and refer suspicious claims and perform analysis of root causes
- Governance/support: Centralized governance structure with clearly-defined roles, responsibilities, and decision-making authority, supported by appropriate senior management involvement

In an effort to reduce costs, many insurers have sharply increased the workloads of their claims adjusters and kept staffing at their SIUs to a minimum or outsourced this function to a third party. Today, more companies are coming to realize that it may be necessary to hire additional staff and bring their SIU back in house if they are to proactively address fraud.

A fraud strategy can have implications for where operations are located. For example, a company that receives a high percentage of potentially fraudulent claims in certain states may decide that the SIU should be decentralized and local offices placed in these locations.

3. Improve information quality

Developing consistent standards for data capture and quality allows insurers to unleash the potential of the information embedded across their organizations. Data standards should also incorporate open-text data, such as adjuster notes, e.g., by using text mining applications. Today, however, many companies face challenges in sharing data and insights between the underwriting and claims functional areas or lines of business. For example, there are similar fraud patterns and issues across many casualty lines (e.g., workers' compensation, bodily injury, and Personal Injury Protection (PIP)) and having a capability to look across these coverage types for commonality can be critical to success. When a claim is submitted, many companies are unable to determine whether the customer has filed suspicious claims with other business units in the past.

Companies should also look to take advantage of external data sources to enhance their fraud detection and management capabilities, e.g. information on prior claims the claimant has filed with other insurance companies or lawsuits they have been involved in. Companies can tap an even wider array of relevant information such as financial transactions, demographics, purchasing behavior, and information posted by consumers on social media sites.

4. Leverage advanced technology tools and analytics

Technology tools such as advanced analytics and predictive models allow companies to analyze internal and external data sources to identify those claims with a higher propensity to be fraudulent. By detecting patterns or anomalies in large databases (both in structured and unstructured data), these analytical tools can identify potentially fraudulent claims and enable the referral of potential cases to SIU or other employees for further investigation. While traditional approaches primarily focused on detection after payments were made, these have now been significantly bolstered by predictive modeling, claims scoring, and other tools that attempt to uncover fraud before a payment is made. Further, they can often identify potential cases of fraud at the First Notice of Loss (FNOL), rather than waiting weeks or months for an adjuster to review a claim, thus reducing costs to the company and in some cases avoiding loss costs outright. Advanced analytics can even assess the propensity of an individual to engage in fraud before it has occurred, and thus can be used in the sales and underwriting process before a policy is sold. These uses of advanced analytics have been reported to have produced reductions in fraud loss of 20 to 50 percent for some carriers.[9]

Reports from the front lines

Some leading companies have made significant progress in implementing breakthrough fraud management strategies.

Taking a public stance

One of the top 10 personal lines carriers has made fraud management a strategic priority—promoting a culture that does not tolerate fraud, taking a public stance on the issue, and aggressively pursuing prosecutions. At the same time, the company collaborates with its competitors on fraud by sharing information and working to stimulate national awareness.

This strategy has been supported by significant funding, with more than 500 SIU-oriented professionals nationwide, far more than for similar companies. The company has also dedicated full-time professionals to fraud management, developed metrics to measure progress, and incorporated fraud management metrics into performance evaluation and compensation. To provide decision-making support, it has built a data warehouse that allows information across the enterprise to be easily accessible and has invested in the latest analytical tools.

Building organizational capacity

Another top 10 personal lines carrier has focused its efforts on improving its operating model by enhancing its business processes and investing in substantial additional resources. The company invested heavily in a business process reengineering effort that included its fraud management capability. It has since relaunched an integrated fraud management process that employs a "full claims life cycle" perspective, from FNOL through to loss settlement and recovery. The SIU function is now centralized and supported by regional expertise as needed. An element in the company's approach was rebuilding core fraud investigative skills, e.g., by hiring former FBI professionals and private investigators. In addition, it separated and distinguished investigative skills from the basic administrative skills required to support the SIU referral, preliminary investigation, and reporting.

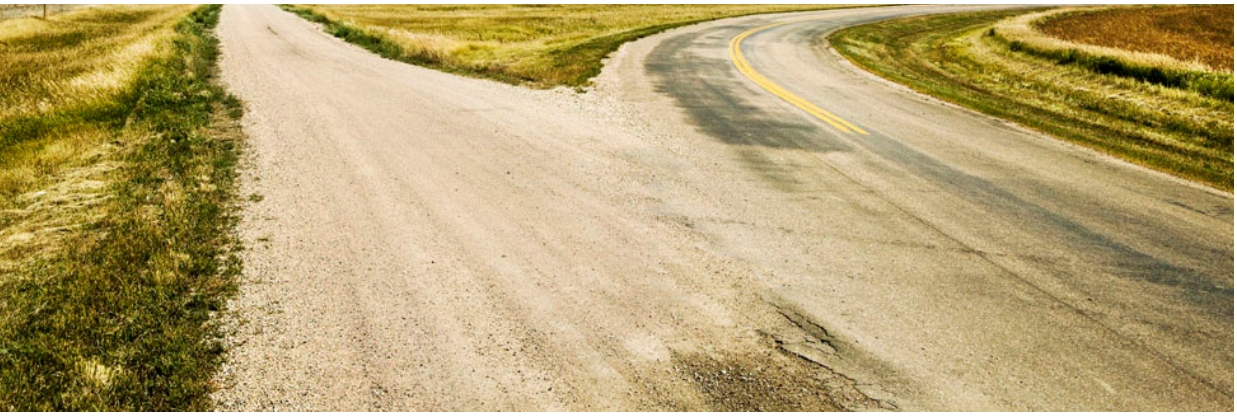
Building a data-centric culture

A top 15 personal lines carrier has focused on employing data as a competitive advantage and differentiator. It has invested in creating high-quality, consistent data, making it easily available across the organization, and integrating an array of external data sources. This organization has a passion for data quality and integrating information across functional areas. The wealth of high-quality and diverse data was a prerequisite and provided a foundation for subsequent investment in fraud analytics tools and technologies and highly-skilled resources to support them. The insights gained have allowed the company to become more sophisticated than many of its competitors in segmenting risks and also provided similar benefits in fraud management capabilities.

Impact of advanced analytics

A top 15 P&C carrier decided to implement advanced analytics and claims predictive modeling to support fraud referrals in its workers' compensation and auto bodily injury lines of business, which it had identified as the areas offering the greatest opportunities. The models use both company data and also external data sources to identify potential fraudulent claims. Even before a claim is submitted, the models can identify policyholders who are more likely to submit fraudulent claims, which is useful in underwriting. These predictive models have resulted in improved results in such measures as the quality and timeliness of SIU referrals and SIU acceptance. In addition, they have increased efficiency by involving SIU much earlier in the claims process, reducing the time between FNOL and referral to SIU. A process that once took months to make SIU referrals is now happening in days or a few weeks at most.

The road ahead



An integrated approach to fraud management offers insurers the opportunity to make demonstrable progress in combatting the rising tide of claims fraud. The goal is to identify fraud much earlier in the claims management life cycle and to handle these claims with a new sense of urgency, promptly and accurately referring them to SIU claims investigators with specialized backgrounds and skills in handing fraud. Throughout the process, it is essential to document and share fraud case experience and to continuously learn and apply these concepts. By publicizing these efforts, sharing information, and collaborating more closely, insurers can help raise industry awareness of the issue and also gain a reputation for having zero tolerance for fraud. However, insurers may not be as effective in the battle against fraud on their own or in isolation. Heighted awareness and collaborative action by governmental entities, law enforcement, and society as a whole can play in important role in achieving real and meaningful progress.

Companies should keep in mind that fraud management is only one element of the claims process. They should also work to increase customer satisfaction among the vast majority of customers who submit legitimate claims and deserve prompt and fair claims service. Creating a fraud process that reduces the false positives and retains good customers is one important step in this effort.

The battle against fraud is ongoing. But insurers that adopt breakthrough strategies can gain the upper hand in managing this persistent challenge to the bottom line.

Endnotes

[1] Insurance Information Institute (http://www.iii.org/issues_updates/insurance-fraud.html)

[2] Coalition Against Insurance Fraud (http://www.insurancefraud.org/fraud_backgrounder.htm)

[3] Insurance Information Institute (http://www.iii.org/issues_updates/insurance-fraud.html)

[4] Insurance Research Council-Insurance Services Office (2002)); NICB (https://www.nicb.org/newsroom/news-releases/2011-qc-analysis).

[5] National Insurance Crime Bureau (https://www.nicb.org/newsroom/news-releases/2011-qc-analysis). A "questionable claim," as classified by the NICB, is a claim that is referred by member organizations to the NICB for closer review and investigation based on one or more indicators of possible fraud. A single claim may contain up to seven referral reasons. Referral reason categories of claims include - property, casualty, commercial, workers' compensation, vehicle

[6] Insurance Information Institute (http://www.iii.org/press_releases/florida-drivers-pay-a-fraud-tax-that-is-risingand-contributes-to-higher-premiums-for-honest-drivers.html)

[7] Coalition Against Insurance Fraud, http://www.insurancefraud.org/consumerattitudes.htm

[8] Coalition Against Insurance Fraud, http://www.insurancefraud.org/consumerattitudes.htm

[9] "Insurance Fraud," Insurance Information Institute, June 2012, http://www.iii.org/issues_updates/insurance-fraud.html

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