FORCE for Health Insurers

DETECT FRAUD, REDUCE FALSE POSITIVES, AND IMPROVE INVESTIGATOR EFFICIENCY

Fraud losses represent an increasingly complex and difficult-to-manage risk that is impacting the profitability of every health insurance company. It is estimated that healthcare fraud, waste and abuse cost insurers between $400 billion and $500 billion dollars per year globally.

Simply passing costs onto the policyholders is no longer a viable option. Insurers must proactively address all sources of fraud, from individual policyholders and providers to sophisticated fraud conducted by networks of organized criminal rings.

High customer service expectations and prompt payment standards, combined with many insurers' limited analytical capabilities, are making it increasingly difficult to detect fraud, waste and abuse cases. In addition, growth in organized crime rings fueled by technological advancements have rendered traditional fraud detection methods unsuitable to cope with the complexity, speed and velocity of emerging fraud schemes. A different approach is required; one that can analyze the behaviors of both providers and the insured across multiple claims.

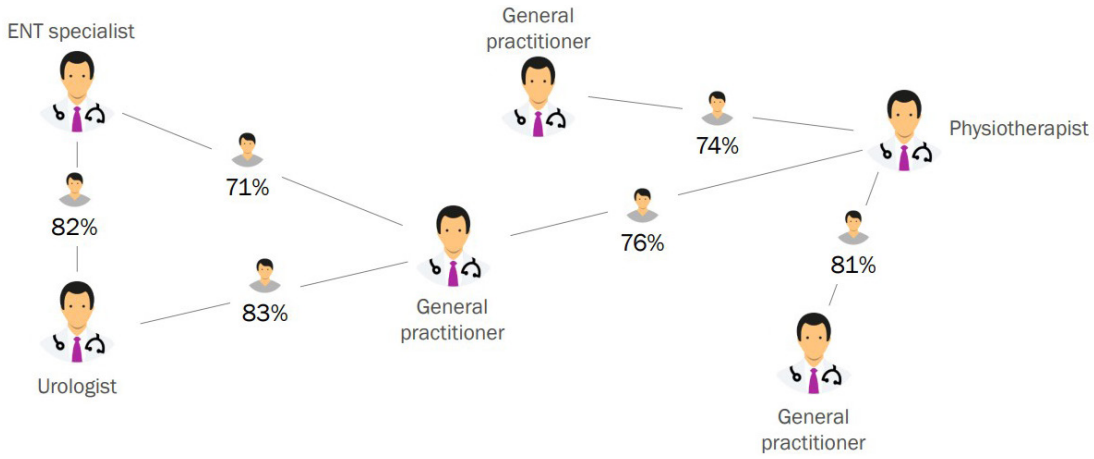
Force is the only AI-native, SaaS-based fraud, waste and abuse detection solution designed to meet the evolving needs of the global health insurance industry.

FORCE FOR HEALTH INSURERS DELIVERS:

- Hundreds of health insurance-specific fraud scenarios and data models
- Prioritized and actionable alerts
- Intuitive user interface and network link visualization tool
- Easy integration with existing claims platforms
- SaaS deployment model

KEY BENEFITS:

- Identify more fraud, waste and abuse cases
- Superior network fraud detection
- Reduce fraud losses and improper payments
- Fewer false positives and negatives
- Improved investigator efficiency
- Faster path to ROI with SaaS deployment
- Continually updated fraud models and other enhancements
- Deep healthcare data science expertise



Force for Health Insurers effectively identifies individual and provider fraud suspicions

Find more fraud, waste, and abuse with FORCE

Using a unique approach that combines sophisticated AI and data science expertise, Force replicates the deductive reasoning of an insurer's best investigators and fraud handlers, applying this reasoning capacity at scale for increased accuracy and efficiency.

AI-NATIVE DECISION ENGINE

Force scores each claim against an evolving library of hundreds of fraud scenarios to detect claims matching fraud patterns. Force then applies a range of AI techniques to each claim, including:

- Automatic anomaly detection validated by human expertise
- Algorithms that use "privileged learning" provided by fraud handlers claims classifications
- Natural language processing (NLP) of text variables

THIRD-PARTY AND UNSTRUCTURED DATA ANALYSIS

Force is able to analyze a range of structured and unstructured data – including scanned documents, images, and videos—along with external data sources such as location and medical codes (CPT-4 and ICD-10) to uncover fraudulent activities that would otherwise go undetected.

DATA CLEANSING AND ENTITY RESOLUTION

Force consolidates all relevant claims data using embedded data quality routines and health insurance-specific data models to ensure greater data accuracy. Force denoising algorithms cleanse the data, reconstruct claims and identify hidden individuals.

NETWORK LINK VISUALIZATION

Force's AI models identify correlations within the insurer's full data set, build and connect the "social networks" of related entities, and detect and extract only the most highly suspicious "sub-networks" within the larger networks.

DEEP INSIGHT INTO FRAUD SUSPICIONS

Force provides investigators with greater insights into fraudulent activity by providing them with simple reasons as to why a transaction or entity is suspect. This simplifies and accelerates the triage and investigative processes, enabling investigators to focus on cases most likely to yield the highest return.

ACTIONABLE, SPECIFIC ALERTS

Force provides prioritized, scored claim alerts and fraud network alerts to claims handlers and SIU investigators. Teams can easily view and manage fraud scenarios and indicators, along with third-party data, maps, and network visualizations in an intuitive interface.

The National Health Care Anti-Fraud Association (NHCAA) estimates that the financial losses due to health care fraud are in the tens to hundreds of billions of dollars each year—money that cannot be spent on improving the quality of healthcare.

Applying Force's AI-native technology to the claims process can quickly and significantly increase the discovery of fraud, waste and abuse cases. The result? Force prevents fraud proactively, rather than detecting improper payments in hindsight.

Effective fraud detection is a win-win-win scenario for the patient, provider and health insurance company.

Learn more about Force AI-native fraud detection at shift-technology.com

About Shift

Shift Technology delivers the only AI-native fraud detection and claims automation solutions built specifically for the global insurance industry. Our SaaS solutions identify individual and network fraud with double the accuracy of competing offerings, and provide contextual guidance to help insurers achieve faster, more accurate claim resolutions. Shift has analyzed hundreds of millions of claims to date, and was named by CB Insights to the 2018 Global AI Top 100. For more information please visit www.shift-technology.com.