STRATEGY MEETS ACTION

Claims Fraud In The Digital Age:

The need for new solutions

Shift Technology

"New solutions to the evolving yet age-old problem of fraud are required. Today's claims leaders need nimble, extremely accurate, and scalable technology that will bring the power and value of AI-native solutions to fraud identification."

Karen Furtado, SMA Partner

Authors: Karen Furtado, Partner
Mark Breading, Partner

Publication Date: May 2019

This Use Case Study is based on SMA's ongoing research on claims fraud in insurance. Shift Technology has purchased distribution rights.

Executive Summary

Fraud in the insurance industry is virtually as old as the industry itself. However, despite insurers' use of technology, process steps, and specialized roles to stem the flow, fraud still represents approximately 10-20% or more of premium revenue, depending on the product and geographic location. Most assuredly, fraud is not a simple cost of doing business.

Human nature will probably always drive opportunistic fraud. However, organized crime networks have become prevalent, increased in sophistication, and in some geographies, are ramping up. As insurers become more digital, fraudsters can use the electronic world to "hide" in. The increased digitization of legitimate processes and transactions means that insurers must also match the illegal activities of fraudsters with new, sophisticated technology or risk becoming a target of choice – adversely impacting financial results.

For many reasons, real-time decisions are rapidly becoming table stakes. Inclusion of the right data at the right time is essential in order to execute at appropriate levels. Real-time, digital data sources such as photos, voice, and videos are true game-changers, not only for sales and service but also in detecting and managing fraud. In addition, there is an urgent need to provide access to underlying data/evidence to empower investigators.

Fraudsters rely on claims complexity to remain undetected. While first notice of loss is the most common point for fraud detection activities, it is critical that anti-fraud capabilities remain engaged throughout the lifecycle of the claim so that new participants with nefarious intentions are identified.

Various types of technology – case-based reasoning, rules engines, basic predictive analytics – have been employed over time by the insurance industry to identify fraud. The downside is that many of these technologies have generated too many false positives which slow down processes and negatively impact service levels for good customers. In today's hyper-competitive insurance market, no insurer can afford these outcomes.

New solutions to this evolving, yet age-old problem of fraud are required. Today's claims leaders need nimble, extremely accurate, and scalable technology that will bring the power and value of AI-native solutions to fraud identification. Claims executives are wrestling with a growing shortage of experienced claims professionals. These precious human resources must be supported by technology that will laser-focus their time on high-value tasks and automatically move valid transactions through to conclusion. AI-driven fraud management is a key element in an overall claims automation strategy.

New Solutions to Fraud Are Needed Today

Due to the dynamic nature of fraud in today's digital world, new solutions are imperative. Without them, insurers will continue to repeat the same results and not gain an upper-hand, which is required to change financial results trends.

Machine learning is meant for today's data environment. Machine learning (ML) is now one of the most frequently mentioned transformational technologies in the insurance industry. To many claims professionals, it may seem like hype. But the reality is that machine learning is the answer to dealing with the avalanche of structured and unstructured data that flows into claims organizations daily. It also remains an untapped source of insight. Fraudulent associations at a case level and provider level, in a constantly shifting data landscape, are very difficult to establish without the appropriate technology.

Predictive models have drawbacks. In recent years, predictive models have been utilized in fraud detection. While certainly better than rules engines, they can be too rigid to respond to rapidly changing business environments. Fraudsters are nimble and change their activities regularly. Models that rely on quarterly or bi-annual refreshes cannot hope to keep up with this changing behavior. Models must refresh in real time or near real time to be effective.

AI-native technology accelerates outcomes. AI-native technologies are inherently architected and engineered for their value structure versus being retrofitted into existing legacy environments. This allows the ingestion of mission-critical data sources, such as a library of fraud scenarios, to be a base for even more data sources and to drive insights that more traditional technologies cannot deliver. Insurers rarely have this level of data and expertise to draw upon.

Leveraging machine learning and AI-native solutions to implement solutions rapidly is of high value to insurers, as illustrated in the following case.

Rooting Out Fraud for a Commercial Carrier

A leading provider of commercial insurance knew that undiscovered fraud was impacting their bottom line. After an extensive evaluation, the insurer determined that Shift Technology's FORCE was the only solution able to meet their requirements for quickly, efficiently, and accurately identifying the most potential fraud in their claims process. Their faith in FORCE's capabilities was rewarded when the solution identified enough potential fraud during the initial set-up phase to pay for the project going forward. Of equal importance to the insurer was the combination of deep insurance expertise and an approach that promotes the close collaboration that Shift brings to the table. It is those qualities the insurer believes allowed Shift to get its model up and running within four months, as promised. And to date, it far exceeds expectations for how quickly the project generates tangible, measurable results.

The data environment has radically changed. Today's data environment is fundamentally different, even from five years ago. Fraud models that take advantage of the full gamut of new external sources – aerial imagery, weather, social media, telematics – will be more accurate and robust. Additionally, being able to analyze the metadata within photos – for example, time stamps or duplicate images – builds greater value from the data and generates stronger actionable results both from a fraud detection perspective and a valid claim perspective.

Analyzing both unstructured and structured data for fraud can deliver new insights. The key is that traditional sources must be integrated with new data sources for previously undiscovered insights. The information below from a travel insurance provider illustrates this idea.

Providing Travel Insurance Claims Handlers With the Tools and Information They Need to be Successful

In 2016, a leading provider of travel insurance realized that fraudulent claims were costing them a significant amount of money. Yet they did not have a dedicated fraud team tasked with spotting and investigating potentially fraudulent claims. They chose Shift's FORCE solution to enable claims handlers to think like an SIU by identifying possible fraud cases, explaining the rationale for why a claim was flagged, and recommending natural "next steps" for investigating the claim. Key to their decision to choose FORCE was the technology's unique capability to incorporate both structured and unstructured data into their models and scenarios. FORCE delivered a positive ROI within four months of going live, and the insurer estimated its yearly ROI for the project to be between 500 to 600 percent. FORCE is currently processing an average of 60,000 claims annually.

Not to be neglected is insurer-proprietary data specifically about the claim and the policyholders. This data provides valuable context and further shapes results.

SaaS+ is a game changer. SaaS solutions hold high value for insurers needing to generate business value quickly and minimize IT involvement and cost, both at the time of initial implementation and for maintenance. With a SaaS+ approach, all services are included and feature and function enhancements and ongoing model refreshes are standard, unlike traditional on-premises software that requires a services contract and related expenses. However, for many insurers, the new world of AI and ML is daunting or virtually unattainable because skills to utilize and institutionalize the insights are not in-house, from either a technology or claims business perspective. A technology partner using the SaaS+ approach brings additional critical service capabilities such as AI and ML skills, deep data scientist partnerships, and transparent analytics, which are imperative.

Adjustors need reason support, not just alerts. Critically important for individual claims adjustors is a technology that does not just deliver a flag that something appears fraudulent, but rather provides reasoning behind indications, prioritization, and packaging information for SIU and the individual adjustor/investigator. This type of information may also provide useful evidence for the prosecution of the perpetrators.

Augment, not replace, human expertise. While the focus of fraud detection appears to be on technology, it is critical to understand that the entire "raison d'etre" resides under the umbrella of supporting human decisioning. The

technology should identify and manage no-touch transactions, which are generally high in volume. It should leave adjustors and investigators with more time to utilize their skills to address complex claims issues, including fraud, and more time to spend with claimants who need their help during a difficult time. Additionally, AI and ML can most assuredly augment functionality within existing systems. These are not either-or scenarios – they are holistic strategies.

Capability Description

Fraud may occur at any point along the claims process. But there is often a tendency to believe it happens right out of the gate during FNOL. However, legal, medical, and services practitioner fraud generally happen well into the claims execution process.

Models must live at all transaction points. Models must continue to actuate all along the value chain and aggressively learn the behavior variables of each participant in the claims process. Data and behavior for medical practitioners will vary markedly from building contractors and, again, will be different from policyholders. Models must adjust accordingly. And they must adjust in the details and relevant data, based on who within the claims organization is involved – FNOL, claims investigation, or SIU.

Detailed information at the right time. It is critical that claims personnel be shown the specific drivers of the fraud indication so that they can focus on those unique characteristics in their investigation and not have to go back to square one. This is particularly true of medical treatment correlations that can be complex and buried in a great deal of non-relevant data.

Assuming that one-size-fits-all models are adequate is a costly mistake. A US-based P&C insurer wanted to be certain that identified claims were relevant, as indicated below.

When Rules Aren't Enough

A US-based P&C provider was addressing fraud through a rules-based system that was successfully flagging some potentially non-meritorious claims for investigation, but their fraud team believed it wasn't enough. Having already invested in a technology solution that was working to a certain degree, the insurer was specifically looking for something that would very quickly add incremental value by identifying a greater number of claims for possible investigation. Since going live, FORCE has consistently identified 73 percent more potential fraud than the previously installed rules-based solution. The insurer is currently processing more than 15,000 claims per month through FORCE and reported that their use of Shift for fraud detection generated a 3X return on investment in less than three months.

Straight through processing critical. Claims organizations are focusing on straight-through processing (STP). This is a customer satisfaction issue as well as a way to contain expense. A significant element of an STP initiative is to be able to identify which claims may be fraudulent and which ones aren't. Traditional fraud management frequently isolates fraud in one location – the SIU unit.

Insurers are coming to understand that providing a consistent customer experience is vital. A centralized platform can facilitate the experience since there are many important points of fraud execution, and integration with modern core systems are elemental to STP. A European auto insurer dealt with this very situation.

A Centralized Platform for a Consistent Customer Experience

A leading European provider of automobile insurance wanted all customers to receive the same phenomenal claims experience independent of how the policyholder had purchased coverage (direct or through agents). Already reaping benefits from Shift's fraud detection solution FORCE, the insurer looked to Shift's latest solution that applies the same advanced artificial intelligence, data science, and insurance industry expertise to the challenge of claims automation. A key factor in the insurer's decision to work with Shift was the company's demonstrated ability to seamlessly integrate its technology with existing legacy systems, a key concern for the deployment. The centralized claims automation solution delivered a consistently excellent customer experience. In addition, the insurer was able to match the customer with the most convenient garage in their repair network that specializes in the type of work needed, to ensure that the job is done right the first time and keep costs low for both the insurer and their customers.

A comprehensive fraud strategy is an integral part of an overall claims automation strategy. And it is more than the electronic management of transactions and processes, it's also about the data that is collected that can inform other processes such as underwriting and subrogation.

SMA Summary

The insurance industry and individual insurers have employed significant initiatives over the years to fight fraud. The level of collaboration, the sophistication of anti-fraud groups and databases, and the establishment of SIUs have resulted in the identification of enormous volumes of fraud and the prosecution of many fraudsters. Unfortunately, all of these efforts have just allowed the industry to tread water, with fraud still estimated as consuming 10-20% of the premium dollar. Much of this is due to the sophistication of the organized crime networks and the rapidly evolving digital world.

"Shift Technology is a leader in this new era of fraud solutions, harnessing the brainpower of a cadre of data scientists and the computing power to leverage machine learning. This combination is required for the real-time, data-rich world where fraud patterns change more frequently and the potential for fraud increases."

Mark Breading, SMA Partner

This sets the stage for the need for a new era of fraud management led by AI-driven solutions that can capitalize on the wealth of data from many sources. The old rules, processes, and technology solutions are no longer good enough. In fact, insurers that stick to the old methods are at risk of having even more fraud perpetrated against them. Shift Technology is a leader in this new era of fraud solutions, harnessing the brainpower of a cadre of data scientists and the computing power to leverage machine learning. This combination is required for the real-time, data-rich world where fraud patterns change more frequently and the potential for fraud increases. Insurers seeking to address fraud in the digital era should consider Shift Technology as a partner.

Shift Technology

About Shift Technology

Shift Technology, founded in 2014, has developed an AI-native, purpose-built fraud solution for the global insurance industry, deployed via a SaaS model. Based in Paris, Shift Technology now has a footprint of over 70 insurer and anti-fraud customers in Europe, North America, and Asia. With the recently announced funding round of $60 million, the company has raised a total of $100 million in capital and has rapidly matured both in terms of business organization and solution capabilities. The foundational strength of the company is its world-class data science capabilities and extensive insurance claims experience. Shift's FORCE solution is being used for a wide variety of fraud scenarios and is applicable across multiple insurance lines of business. In addition, insurers are discovering that the insights gained from the analysis of new data sources enable increased claims automation across the value chain.

STRATEGY MEETS ACTION

About Strategy Meets Action

At Strategy Meets Action, our clients advance their strategic initiatives and accelerate their transformational journeys by leveraging our forward-thinking insights and industry expertise. Strategy Meets Action is a consulting firm that works exclusively in the P&C market offering both retained services and project-based consulting services.

Additional information on SMA can be found at **www.strategymeetsaction.com**.

Karen Furtado, Partner. Karen can be reached at 1.978.239.2741 or via e-mail at **kfurtado@strategymeetsaction**.com. Follow Karen at **karenfurtado** on LinkedIn and at **@karenmfurtado** on Twitter.

Mark Breading, SMA Partner, can be reached at **mbreading@strategymeetsaction.com** or 614-562-8310. Follow Mark at **markbreading** on LinkedIn and **@BreadingSMA** on Twitter.

