SHIFT

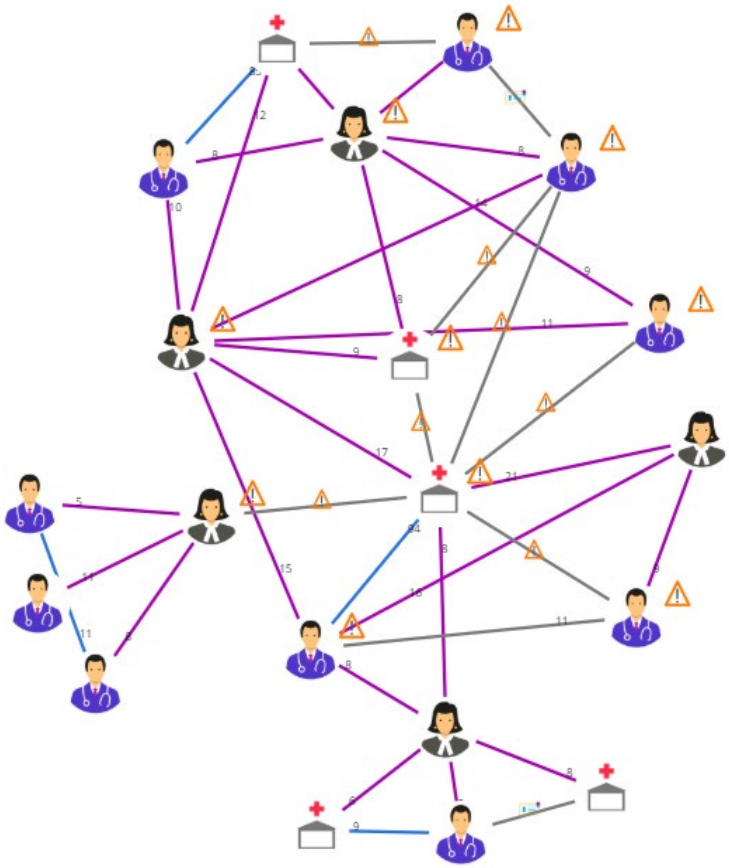
Customer Story

Pan-Asian Insurer

Pan-Asian carrier increases straight through claims processing by detecting fraud, waste and abuse in real time

Since its foundation in the early 2010's, this multi-line pan-Asian insurance company has grown rapidly across the region. Establishing itself as an innovative, dynamic player across several key markets, including Hong Kong & Macau, Thailand, Indonesia, the Philippines, Singapore, Vietnam, Japan, and Malaysia.

When this carrier entered the Singapore insurance market, it quickly established a reputation for utilizing the latest digital technology to change the way people feel about insurance. By delivering on this vision this carrier is now the largest online insurance company in Singapore.



At a glance

Situation

- A pan-Asian carrier was experiencing a considerable amount of fraud, waste, and abuse

Solution

- Claims Fraud Detection

Results

- Shift Claims Fraud Detection analyzes over 500,000 claims annually
- Positive ROI within 6 months
- Improved customer experience with larger percentage of claims STP after deployment

Learn more about how Claims Fraud Detection can help detect fraud with twice the accuracy of other solutions at shift-technology.com

The Situation: An urgent need to accurately identify suspicious activities in real time

Prior to working with Shift, this carrier relied on a business rules-based solution in its Employee Benefits line of business. Its claims handlers manually processed hundreds of thousands of claims annually to identify suspicious activities. The inefficiencies in this process resulted in a considerable amount of fraud, waste and abuse.

To improve fraud detection, increase the number of claims that could be straight through-processed (STP), and improve the customer experience, the insurer recognized that it needed a new solution to identify potentially fraudulent activities in real time.

The Solution: Identifying fraud, waste and abuse cases in real time with an AI-native engine

Processing over 500,000 claims each year, this carrier recognized that to provide an exceptional customer experience it needed to pay claims faster and more efficiently. At the same time, it needed to improve its ability to identify fraud, waste and abuse cases in real-time. After an extensive search, it selected Claims Fraud Detection.

The insurer was drawn to the solution because it could help them find fraud quickly—prior to claim settlement and payment. Claims Fraud Detection was attractive thanks to its ability to analyze textual information in claims handlers' notes, identify outliers using anomaly detection, and recognize provider fraud using link analysis technology. In addition, the technology's SaaS-based delivery model and excellent client references gave the insurer company confidence that the solution could be deployed quickly and successfully.

The project began with Shift Data Scientists extracting and consolidating data from three different legacy systems. This data was then merged with external third-party data, something that was not possible before using the carrier's in-house solution. Shift initially developed fourteen different fraud models to identify fraudulent activity. These included duplicate claims, overcharging, bundling, and excessive mitigation costs. Since Claims Fraud Detection went into production, five additional fraud models have been identified and deployed. "The collaboration between the Shift team and our company was fantastic. Shift really understood our business," says the insurer.

The Result: Immediate cost savings and increased straight through claims processing

The solution was launched as part of a larger claims workflow automation project. Within the first few months the solution had saved the carrier over $100k. According to the insurer, "We are really happy with the results we have achieved using Claims Fraud Detection."

Working with Shift has enabled the carrier to do more in-depth investigative analysis thanks to a more granular view of claims data. According to the insurer, "80% of the fraud cases identified as suscpicious by Claims Fraud Detection would have gone undiscovered before." For example, new cases were identified by using anomaly detection to discover that certain medications were being over-prescribed, and by using link analysis to identify provider network fraud.

In addition, using Claims Fraud Detection has helped with the ability to support same day claims processing, resulting in improved customer experiences. "When handling as many claims as we do, this is an important competitive advantage," according to the insurer.

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>
> Samuel Klaus, Head of Fraud

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About Shift Technology

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 billions of claims to date, and is the Frost & Sullivan 2020 Best Practices Award Winner for Global Claims Solutions for the Insurance Industry.

Learn more at **www.shift-technology.com**