2022 Focus December Conference
December 1, 2022
New York, New York

The Evolution and Future of Insurance Fraud Detection

Insurance fraud is an 80-billion-dollar problem for the industry and consumers. There are over 160 fraud schemes across all lines of insurance. The industry's current shift toward digitalization requires the claim professional to consider new processes to recognize, document, and remedy suspected fraudulent claims to a proper conclusion and comply with regulations. Introducing cutting-edge technologies with a robust claims process is the key to successful outcomes.

Fraud Detection – Where We Have Been and Where We are Going

In 1944, the movie *"Double Indemnity"* was released with an all-star cast acting in a story about love, murder, and insurance fraud. Barton Keyes, a Claims Manager (played by Edward G. Robinson), could discover and stop fraudulent claims by relying on the "little man" inside of him to alert him to the nefarious behavior of a claimant. Mr. Keyes relied on his years of experience in adjusting claims to recognize suspicious claims and stop paying them. Likewise, insurance carriers have relied on experienced Claims Examiners and SIU personnel to recognize, investigate, report, and resolve suspected fraudulent claims appropriately and efficiently. Unfortunately, many of these suspect claims continue to go undetected, becoming lucrative schemes for charlatans and organized crime groups.

In the last 35 years, we have witnessed a growth of anti-fraud programs by government agencies, consumer protection groups, law enforcement, and state legislatures. For example, during the early days of fraud detection, investigators relied on the former International Crime Prevention Association (ICPI) and the National Automobile Theft Bureau (NATB) for information on suspected insurance fraudulent claims referred to them by insurance carriers. In addition, the Property Loss Index Reporting Bureau (PILR) was checked daily for information regarding claimants involved in suspicious claims. Eventually, agencies and companies merged (ICPI and NATB merged to create the National Insurance Crime Bureau – NICB) and continue to service

the insurance industry by providing critical information to insurance carriers and law enforcement agencies. In addition, several professional insurance industry organizations have grown and gained a powerful presence for educating professionals on fraud awareness, continuing education programs, and a resource for legislative entities in understanding how significant the insurance fraud problem is in the United States. Finally, government agencies and legislators have relied on these professional associations for data and guidance in crafting effective anti-fraud laws and claims to handle best practices and regulations.

The growth in anti-fraud programs caused an increase in Special Investigation Units (SIU) in the insurance industry. The National Association of Insurance Commissioners (NAIC) also expanded its committees and workgroups by adding the Anti-Fraud Taskforce, which was responsible for developing a model fraud act, and training programs for regulators and the industry. Over the years, claims professionals, fraud investigators, law enforcement, and academic groups have developed indicators and red flags for suspected insurance fraud schemes.

Also, claims handling has changed from all paper claim files, supporting information, and reports to how claims are received and processed. The fraud has morphed into more sophisticated schemes due to the ease of how information is discovered, received, and processed. Nevertheless, staged collisions still occur. Slip-and-fall scams occur daily, and nefarious legal and health care professionals facilitate the schemes with their services. So, what is different today compared to yesterday, and why does the insurance industry need to change how suspected fraud is detected? Moreover, what technology can insurance carriers embrace and leverage to be successful in reducing fraud? The answer is big data, digitalization, and artificial intelligence!

Current Issues and Trends

In early 2020, the United States and local governments enacted emergency laws that closed certain types of businesses, mandating who and what could remain open with specific safety protocols to mitigate the spread of Covid-19. People suddenly started working from home, vehicle traffic was reduced on our highways, and Government aiding programs with additional funds for payroll protection and unemployment. Medical facilities stated treating patients via "telemedicine." Telemedicine networks were created with the assistance of marketers, durable medical equipment vendors, and doctors. Over 242 new procedural technology (CPT) codes were submitted for adoption by healthcare providers for telehealth. What was once not allowed, health care providers and patients freely communicated, and, in some cases, injuries were diagnosed and treated virtually. This action allowed fraud schemes to flourish, causing problems for criminal insurance fraud investigations. Telemedicine allowed fraud and abuse schemes to become scalable in that the marketers collected the claimants, and

telemedicine companies linked to medical providers engaged in various kickback schemes. In addition, the Pandemic accelerated us into the new "hybrid-work environment" with people working from home. An interesting trend in the workers' compensation and disability lines of business is claimants submitting claims for injuries occurring in their homes while working. For example, the ubiquitous trip and fall incident will be difficult to identify, confirm and investigate. Risk management must change for the new hybrid workplace, including new types of data and predictive analytics with artificial intelligence to identify and mitigate fraud and abuse.

The current inflation in our economy may or may not bring a recession. During the 2007-2008 Recession, some exciting trends and spikes occurred in specific insurance fraud schemes. These schemes are worth mentioning because history seems to repeat time after time. For example, in 2007-2008, when investments diminished and mortgage loans defaulted, there was a spike in the recreational vehicle (RV) claims (e.g., theft and arson), stolen automobiles, homeowner theft claims, and staged automobile collisions. Claims Examiners must know the indicators and red flags for these fraud schemes to handle the suspicious claim appropriately. The organized criminal enterprises preying on insurance carriers flourished in this period because plenty of people were willing to engage in the fraud because they were desperate. These organized groups know the claims process backward and forwards and specific insurance companies to stay away from because of their strong SIUs, and the carrier's reputation for investigating claims. These groups prey on the carriers that do not do an excellent job verifying a loss by asking good questions while scanning for indicators and red flags for suspicious behavior.

The property and casualty industry is also dealing with increased disaster-related fraud schemes and the rising severity of property claims. The change in our traditional storm seasons, combined with the increase in the intensity of the storms, has caused several insurance carriers to go out of business in the Southern States. The assignment of benefit (AOB) schemes, public adjusters, and predatory law firms in Florida and other states exacerbated the problem driving up litigation and settlement costs. These bad actors are working in concert in filing and negotiating claims on behalf of the insured. Insurance carriers do not have enough resources for claims processing, causing the increased severity and litigation. Artificial intelligence is a force multiplier in the claims process and can quickly fill the gaps in resources for the insurance carrier. For example, the A.I. can marshal the relevant data into actionable insights for the Claims Examiner to recognize, review and take the appropriate action to avoid litigation and reduce the severity. A.I. can also recognize claims that can be expedited, saving time and valuable resources while simultaneously benefiting the customer.

Current Problems in Identifying, Investigating, and Reporting Suspected Fraud

One of the pandemic results is the *"Great Resignation,*" or, more appropriately, the *"Great Career Change.* "The insurance industry is starting to experience a significant brain-drain with Senior Claims Examiners retiring or switching careers, and executives are struggling to recruit younger adults to enter a career in insurance. Think of the ramifications of the loss of experienced claims personnel; one, the vast institutional knowledge quickly disappears, and two, the ability to recognize a suspected fraud scheme brings unnecessary costs in settling the bogus claim. In addition, it takes time to hire and train new Examiners. The organized crime groups know this and will focus their efforts on insurance carriers constantly struggling with personnel resources. Meanwhile, the fraud goes undetected.

The automobile line of business saw some interesting trends in 2020 and 2021. The number of collisions decreased, yet the severity increased due to more high-speed accidents. Supply chain issues emerged for automobile repairs causing people to take advantage of the situation (think of the fraud triangle and funnel in claims). Social media (Facebook, TikTok, Instagram) facilitates this behavior as people encourage others to try something. A significant problem in addressing these types of claims was that field adjusters were limited in conducting fieldwork.

In the last 40 years, the insurance industry, government agencies, law enforcement, and consumer protection groups have promulgated and published indicators of fraudulent insurance schemes and how to spot them. These indicators have served the insurance industry very well and need to be constantly updated to reflect what is occurring in the current economic conditions. Unfortunately, organized crime groups know these indicators more than most Claims Examiners and avoid them in carrying out their schemes. These groups are in the claim's ecosystems daily, preying on unsuspecting carriers. As a result, billions of dollars are stolen annually by the fraudsters! Insurers' results are an increased level of allocated loss adjustment expense (ALAE), adverse loss experience, higher claim severity, and unanticipated financial deterioration.

Solutions for Today's Problems and the Future

The first thing we need to do is get back to the basics. The claims industry has been "experience starved" for quite some time because of an experienced layer of claims professionals leaving the profession. In addition, a decades-long decline in training and multi-line claims handling experience combined with the limited ability to attract new talent to the profession exacerbates the problem. At the same time, the burden of work volume has

increased on the individual adjuster without the assistance of better tech-enabled workflows. For the insurance industry to effectively deal with all these increased pressures during the Covid work era, some things must change…and fast!

The challenges for claims organizations include "social inflation," excessive punitive damage awards, and a generally increased level of distrust and class resentment. This combination of less experience, more work with limited tech assistance a more adverse damages environment calls for changes to help protect the risk industry's customers and its profitability. Bringing innovation (rather than disruption) to the next generation of claims handling with technology-enabled best-in-class processes, workflows, and templates is a way to overcome these challenges. Better technology work tools will attract younger and better talent and empower them to perform beyond their years of experience. In addition, technology products that inform and drive best practices will lead to better-trained claims handlers and better outcomes.

Three Steps to Quickly Fill the Gaps

1. Fill the gaps in the business process with the correct data and insights. There are millions of data points within a claim file. The unstructured text is the new gold for discovering hidden insights to manage and reduce the severity, identify patterns of suspicious behavior, and predict litigation several weeks before a summons and complaint are filed, or better yet, even before an attorney gets involved.
2. Embrace continuous training for the claims team. Treat every day like a training day. Insurance fraud schemes (all 160 across all lines of business**)** ebb and flow to some geographic regions and current economic conditions. Does the Claims Examiner working from home in Ohio know the current trends in Southern California for property and casualty claims? Does the Claims Examiner working from home in Washington know about the AOB schemes ongoing in Florida? A robust A.I. solution that identifies the indicators of a suspected fraud scheme can act as a behind-the-scenes ‘cyber trainer’ and supervisor for your claims team. Your new examiners will quickly learn from the A.I. spotting suspicious behavior and help them advance more efficiently instead of waiting for training conferences.
3. It is an iterative process! Fraud identification and handling can occur in any critical phase in a claim's lifecycle. However, at the beginning of a claim, the following action steps must be initiated timely to comply with government regulations.

The six-time quadrants of an insurance claim are:

I. First Notice of Loss
II. Coverage
III. Investigation
IV. Evaluation
V. Negotiation
VI. Settlement

The right A.I. system constantly scanning claims data throughout these time quadrants is essential to identify and recognize suspicious behavior by claimants.

Contemporary and Future Technology for Fraud Detection

The use of artificial intelligence is growing in the insurance industry. Contemporary A.I. solutions leverage machine learning and natural language processing together to provide the best solutions for insurance claims processing. The growing lack of staff resources mandates that carriers start utilizing new technologies to help fill the gaps. Digitalizing the underwriting and claims processes require new techniques to spot potential fraud schemes before settlement. Insurance carriers need to think differently with the new breed of entry-level examiners joining current staff who may not be sophisticated users of technology. Executives must think differently and encourage managers to train and develop staff to keep up with the technology changes and embrace them.

Define, Partner, and Organize

Now that many claims organizations have completed the initial round of digital transformation with the implementation of enterprise operating systems (EOS), they have the beginning technology skeletal structure in place. It is now time to work to address what these broad general platforms do not deal with at a level of detail. Adding off-the-shelf pieces of technology that address specific areas in greater detail can be integrated with an application programming interface (API) into the more extensive operating system. The implementation of the EOSs is the beginning of the journey. In addition, much low-hanging fruit in improved defense cost containment (DCC) is available outside and adjacent to the EOS. The claims organizations that will achieve the best outcomes will move to this next level of technology deployment. Examples of this build-out of the technology platform are tools that early on identify potentially fraudulent claims or ones that are likely to go into litigation or present excessive damage exposure and tools that bring best-in-class workflows to the handling of the more problematic litigated claims for both the claims professional and counsel. These two examples are made even more potent when they are implemented to work together. As a result, those claims with indicators of the most significant exposure are given the most

~~outstanding~~ attention. When these steps are taken, the risks are more clearly defined, and the claims professional and counsel are partnered with the tech tools to organize their actions where they can have the most significant impact.

Regulation of A.I. and Transparency

This year, the National Association of Insurance Commissioners (NAIC) created the Big Data and Artificial Intelligence Committee to manage the growth and concerns about the technology deployed in the insurance business. One of the main concerns of the regulators is how a "black box" full of algorithms and models render suggestions for underwriting and claims decisions that potentially discriminate against protected class individuals. Consumer protection advocates and the insurance industry are paying close attention to the Committee's work. A model act and guidelines are expected to be published in 2023. In addition, the NAIC is working on model acts and regulations for using A.I. in claims and underwriting. There are potential impacts on fraud identification, reporting, investigation, and ratings. Insurance carriers need to get ahead of any potential regulation issues now!

The potential to be more transparent with the insured's involvement has never been more critical than now. The evolution of the omnipresence of technology in our lives has brought an increased ability and corresponding expectation that processes will be transparent and information will be readily available. Self-help and real-time learning have become the expected norm. In the insurance ecosystem, this expectation is met in customer acquisition, retention, and quality underwriting. Anyone can go onto the internet (even through their phone) and get various quotes for coverage in a matter of minutes. This is an increase in customer service that brings the purchase of insurance in alignment with the way we buy everything else in our lives. This is a tremendous InsureTech stride forward for the risk industry. Some similar signs of progress are also being made in resolving standard personal lines claims in the automobile or homeowners' areas. These are significant customer selection and service improvements reflected by self-help and transparency. Unfortunately, this progression of improvement has not yet made it to the litigated claims process.

Those carriers that achieve this will be market-leading in word-of-mouth customer acquisition (Google ratings) and customer retention. A litigated claim ranks as an important event in a customer's personal or business life. Frequently, the insured is left on the sideline as to the progression of the litigation. This is a loss of a valuable member of the defense team. The insured may often be in an excellent position to call out indications of fraud on the claim. Transparency with the insured and their involvement helps in customer relations and may help get a better resolution. Litigation management tools that enable the awareness and involvement of the insured, along with the claims professional and counsel, will enable these

better outcomes and deliver the better customer service that comes with an involved and informed insured.

Conclusion

Insurance fraud continues to be a significant problem in 21st-century claims. The digitalization of the underwriting and claims process requires new approaches with technologies to identify suspected fraudulent claims. Claims Management and Examiners must embrace these new technologies, so they have more time to handle these sensitive claims to the proper resolution. Regarding artificial intelligence for claims, we are still driving cars with tailfins, but the early results show significant promise in the effort to identify and stop fraud.

Authors

John Standish
Dwayne Hermes
Melissa Hill

August 22, 2022