Shift

SHIFT TECHNOLOGY **INSURANCE PERSPECTIVES**

VOL. 2 2021

Editor's Note

According to the Coalition Against Insurance Fraud, in the United States, consumers collectively lose more than $80 billion as a result of insurance fraud every year. It is also estimated that as many as 10 percent of all P&C insurance claims contain some element of fraud. To ensure that claims are settled as quickly, accurately, and fairly as possible, the ability to mitigate the impact of insurance fraud remains a critical priority for carriers around the world.

Claims fraud detection is where Shift got its start, and in this edition of Shift Technology Insurance Perspectives we turn our attention back to claims fraud and strive to answer a handful of interesting questions. What is the leading hallmark of a suspicious claim? What strategies and approaches are proving to be most effective in the discovery and investigation of potentially fraudulent claims? How is third-party data supporting the fight against fraud? Is the industry witnessing any constants when it comes to claims fraud?

As always, a big "thank you" goes out to the Shift team of data scientists that help make this report a reality.

United States consumers lose $80B+ every year to insurance fraud

What makes a claim suspicious?

There are several factors that may indicate a claim is fraudulent. Do the parties involved in the incident know each other or have some other connection? Did the incident involve individuals from the same neighborhood, but take place hundreds of miles away? Was the claimant's home the only one damaged in a supposedly major weather event? Are there widespread connections between multiple parties—claimants, service providers, lawyers, medical professionals—involved in a claim? These are all things that claims professionals may look for when trying to determine if a claim should be settled without delay or referred for further investigation.

However, there is one factor that consistently appears to be a leading indicator in identifying potentially fraudulent claims. We see in our data, both in the Americas and across Europe, that policyholder history provides incredible insight into potentially fraudulent claims. This is born out not only when looking at the insurer's own internal claims data, but also when carrier data is supplemented by third-party external data such as that aggregated by the National Insurance Crime Database (NICB) in the U.S. or the European Common Loss Adjustment (ECLA) database in Europe. Policyholders that have pursued suspicious claims in the past are likely to do so in the future. In the U.S. we have witnessed a seven percent year-over-year increase in accepted alerts (e.g. those alerts deemed worthy of further investigation) when internal claims data paired with third-party data has indicated a history of suspicious activity.

The importance of third-party data in fraud detection

Specialized databases can provide important information and insight into the nature of an insurance claim. At the same time, other data sources are helping to provide significant clarity into whether a claim warrants investigation or not. In Europe, insurers that incorporate external data sources as part of their fraud fighting strategy are increasing the number of alerts indicating a claim may be fraudulent. Cross-checking claim information with outside sources, such as news stories about the incident, has generated a 7 percent increase in savings year-to-date when compared with the same time period last year.

> "The ability to see the interconnections between providers...is proving incredibly valuable in helping insurers avoid paying for illegitimate claims."

In the U.S., we are seeing a greater focus being paid to identifying claims which may be related to what could be identified as "major cases." In these situations, individual providers or provider networks are being closely monitored and claims data is augmented by third-party sources such as news organizations, professional associations, government regulatory agencies, and others. The ability to see the interconnections between providers, get an understanding of a provider's professional standing (e.g. have they lost their license to practice, have they been convicted of a related crime, do they have known criminal associates, etc.) is proving incredibly valuable in helping insurers avoid paying for illegitimate claims.

Opportunistic fraud trends

Interestingly, despite the evolution of fraud fighting technology and strategies, the incidence of some types of fraud remain fairly constant. When we look at the data pertaining to opportunistic fraud, we see that things have remained fairly stable. In the United States, Shift has witnessed a one percent increase year-over-year in alerts aligned to post-accident policy subscription, a common form of auto insurance fraud. We have seen that suspicious injury claims in those states that require Personal Injury Protection (PIP) insurance have only increased two percent.

Perhaps not surprising, trends in opportunistic fraud in Europe are similar to those seen in the United States. Post-accident policy subscription alerts increased by four percent year-over-year while suspicious alerts aligned to what Shift refers to as “well known fraud patterns” increased by one percent.

Conclusion

Fraud remains a critical challenge facing the global insurance industry. As such, insurers are implementing new strategies and approaches to not only uncover more potentially fraudulent claims, but also investigate them more efficiently. What we see in our data is that insurers that take a holistic approach to fraud detection and use a combination of internal and external data sources to fuel their models are generating increasingly positive results, uncovering more potential fraud, and decreasing payments for illegitimate claims. We are also witnessing that opportunistic claims—those where an individual policyholder may look for an payout—are still plaguing carriers.

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.

Shift

Learn more at www.shift-technology.com