executive brief

FICO

FICO Insurance Fraud Survey Highlights 2013
Insights Into Insurance Fraud Trends

Insurance fraud is on the rise

That's the consensus of a majority of respondents to a 2013 survey commissioned by FICO. With just a few exceptions, most survey respondents expect most categories of personal lines to experience an increase in fraud losses of 10% to 20% or more in 2012 versus the prior year. A majority of those surveyed, more than 60%, attribute the continued rise in fraud, more than any other factor, to sustained economic hardship in America.

FICO and PCI fielded the survey to gain insights into fraud trends from insurers themselves. Which categories of insurance are likely to be most vulnerable to fraud? What types of fraud schemes are carriers most concerned about? What is the economic impact on carriers and their customers? And what remedies are the industry implementing to help turn back the rising tide of fraud?

The survey set out to answer these questions and others. Among the key findings:

For many insurers, the economic impact of fraud is greater than assumed.

Conventional industry wisdom has held that fraud losses average around 10% of claims volume. According to the survey, around 35.4% of respondents estimated that fraud costs their companies between 5% and 10% of claim volume, and another 21% estimated 5% or less. Significantly, however, more than 30.5% of the participants pegged the loss rate between 10% and 20%, a level that is likely to set off alarms for many insurers.

Personal property, auto and workers' compensation are considered most vulnerable.

Some 57% of respondents anticipate an increase in personal property fraud by individual policy holders. Around 58% said the same for personal auto insurance fraud, and 69% expect a rise in workers' compensation fraud.

Fraud by organized rings is widely expected to increase.

Only around 11% of respondents view criminal gangs as the number-one factor driving insurance fraud increases. Yet 61% expect to see an increase in auto insurance fraud perpetrated by organized rings, and 55% believe the same for workers' compensation fraud. This underscores a growing need for solutions that enable insurers to identify organized criminal activity. Some 30% of respondents report that they are already using link analysis in their efforts to detect fraud today, applying predictive analytics to find patterns among different claims that suggest organized activity.

Upgrading analytics and detecting fraud prior to claim payment are the highest priorities.

When asked to identify their major priorities in the fight against fraud (from a list of 12 choices), 52.2% cited the detection of fraud in a claim before it is paid, and 39.6% cited adopting or upgrading their fraud analytics capabilities. These two top priorities go hand in hand—predictive analytics offer the most effective and efficient solution for accurately detecting fraud early in the claims process, enabling carriers to sharply limit their losses due to payments against fraudulent claims.

Analytics-powered solutions are gaining ground over rules-based systems.

About 45% of the survey respondents said they are using predictive analytics for fraud detection in their operations today, compared to around 29% using rules-based systems in an attempt to stop known types of fraud. This is a strong indication that analytics-powered solutions are becoming more widespread, although there is still plenty of room for adoption in the industry. Besides being more efficient and yielding fewer false positives compared to stand-alone, rules-based systems, analytics have the advantage of being able to adapt quickly to new and emerging fraud schemes beyond those already known.

Investigative resources are under pressure.

Around 54% of the respondents surveyed employ anti-fraud teams, either centralized or dedicated to specific lines of business. However, only 20% cited the hiring of additional special investigative unit personnel among their major priorities. This suggests that many of the insurers surveyed continue to face headcount constraints, and need to figure out ways that smaller teams can work larger caseloads. This helps explain why the expanded use of analytics was cited as a major priority more often than the addition of staff. Analytics can alleviate much of the burden of claims review and help investigators focus more effectively on claims more likely to be fraudulent.

Fighting Back: How FICO is working with insurers to find more fraud and mitigate losses

Just as insurance fraud is escalating, so too is FICO stepping up its efforts to help the industry root out fraud. A key example is the FICO® Claims Fraud Solution, specifically designed to detect the likelihood of fraud early in the claims process.

As noted earlier, detecting fraud before claims are paid and upgrading analytics were mentioned most often (from a list of 12 choices) by survey respondents as their main fraud-fighting priorities. The FICO® Claims Fraud Solution addresses these priorities squarely: It provides the most advanced predictive models yet to analyze claims, and it detects suspicious claims early in the process, well before they are likely to be paid. By catching fraud before bad claims are paid, insurers not only avoid fraud losses, but also minimize their recovery costs.

Other important advantages of the FICO® Claims Fraud Solution include:

- **Protecting good customers:** The challenge of finding fraud is compounded by the growing volume of claims and the pressure to process them quickly. By pinpointing fraud accurately with fewer false positives, the FICO solution also accelerates claims processing by automatically clearing the vast majority of claims for settlement. Carriers can therefore fight fraud more effectively without alienating their good customers.
- **Uncovering organized fraud with FICO® Identity Resolution Engine:** Along with robust and highly accurate fraud detection, FICO's models incorporate Link Analysis, which enables them to find connections among apparently disparate activities to uncover organized fraud. Link Analysis allows investigators to quickly research a number of claims linked by as little as a single detected item indicating the possibility of a fraud ring. Meanwhile, the data pool generated by Link Analysis continually improves the models' ability to recognize new types of fraud.
- **Improving SIU effectiveness:** The FICO solution enables investigative units to be more effective by focusing on genuinely suspicious claims, trends and patterns earlier in the process. It increases efficiency and productivity by prioritizing claims for investigative review based on a scoring system reflecting the likelihood of fraud. And it saves substantial review time by pointing investigators directly to the reasons any particular claim was flagged.

Conventional, rules-based detection systems target specific types of known fraud. In contrast, the FICO solution includes a rules component, but adds a powerful predictive analytic dimension. Unlike hard-coded rules, analytics models are continuously learning from data accumulated from new claims. They notice behavior too complex, subtle or new to write rules against and perceive variations too small to reach rules-based thresholds. And they detect emerging fraud schemes as well as deliberate attempts to evade rules-based detection.

With the FICO® Claims Fraud Solution, insurers can potentially find up to 50% more fraud over rules-based systems alone, with fewer false positives. And most insurers will see full ROI in a matter of months rather than years. In fact, the FICO solution doubled the fraud detection rate for a prominent UK auto insurer and uncovered more than $400,000 in suspected fraud within nine days of going live. And a leading Chinese carrier saved more than $112,000 in the first month of operation by avoiding payment of fraudulent claims.

FICO will continue to work with the insurance industry to better understand the ever-changing nature of fraud and deliver analytic solutions with the power to dramatically reduce its impact.

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