The hard problem of soft fraud

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Identifying soft fraud without offending policyholders involves a delicate balance.

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In the world of insurance, “hard fraud” is committed by sophisticated professional criminals who find ways to manipulate the insurance system and reap monies fraudulently on a more than occasional basis. “Soft fraud” on the other hand, is committed by consumers who see the opportunity to either “pad” a legitimate insurance claim or submit a fraudulent household claim on a one-time basis.

In the United Kingdom, for example, researchers at the University of Portsmouth examined some 40,000 claims handled by fraud investigators and found that the majority of cases tended to involve usually honest people indulging in an opportunistic low-value crime. The typical opportunistic fraud committed was making a claim for the equivalent of less than $1,000 for accidental damage to a computer, television or mobile phone. The research found that 82% of fraudsters submitted claims for accidental damages, since such claims do not require official documentation.

A February 2013 poll by the Insurance Research Council found that in the United States 24% of people believe it is acceptable to pad an insurance claim to make up for their deductible, down from 33% in 2002. While the good news is that the opportunistic insurance fraud is increasingly frowned upon by consumers, the fact is it still occurs at an alarming rate and the cost is significant. According to the Insurance Information Institute, soft fraud costs insurers roughly $32 billion a year.

The hard realities of soft fraud

Fraud affects every aspect of insurance, costing consumers $80 billion annually.

The role of the Special Investigation Unit at an insurance carrier is to stop fraud, improve efficiencies, pursue fairness and justice and support the overall claim process by ensuring the customer is paid the right amount. While SIU directors are expected to achieve these goals, they are expected to do so while avoiding any negative impact to customer satisfaction. The primary problem with soft fraud is that it's frequently opportunistic and thus, it's difficult to disprove claims without alienating customers. When insurance investigators ask too many questions, policyholders allege poor service and find a justifiable excuse to jump to another insurer.

Beyond the service issue, special investigative units (SIUs) wrestle with the risk/reward formula. Do they risk devoting time and resources to a claim, and possibly losing a customer, just to save a few hundred dollars?

Tools to fight soft fraud fall short

Many commercial tools focus on profiling policyholders and generating alerts on criteria such as credit score and other personal risk factors. While this information is useful, it's not a complete picture of insurance claims since it doesn't look at line-item claim details.

Another common approach is the use of business rules and algorithms that set up certain threshold values. Suspicious activity is flagged if a certain threshold is exceeded. The drawback to behavior-based fraud systems is that they can generate too many alerts, increasing the percentage of false positives.

Examining claim line detail via analytics helps identify suspicious activity

Fraud tools had been incapable of flagging claimed items with values that exceed market benchmarks. For example, a $50 coffee maker claimed at an inflated value of $500, would not have been flagged in the past. The latest trend shows technology that

can examine claim line detail, comparing and contrasting pricing data for signs of exaggerated or padded claim values that may point to opportunistic fraud. Demographic data can be pulled in and analyzed to determine what the usual contents are for a home of a given size, in a given zip code, on a given block. Line item values can then be compared against average retail and replacement cost values of the same item with the same brand and age, achieving two important outcomes:

1. If claimed items are markedly different than those on similar claims in the area, the SIU is alerted.
2. If the value of the items submitted appears to be inflated or fabricated, the SIU receives an alert.

Ideally, the end gain here is to determine if there is sufficient rationale for a more in-depth review of the claim. This reduces the number of false-positives while not overwhelming the SIU with too many superfluous referrals. The result is an increase in the percentage of successful investigations, which leads to a more streamlined SIU and an overall business outcome for the carrier.

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