Soft Fraud

Soft fraud is the cancer of the insurance industry – a silent yet invasive disease that costs insurers roughly $32 billion a year, according to the Insurance Information Institute. Fraud that strikes property lines amounts to more than $40 billion annually, says the FBI. The Coalition Against Insurance Fraud says it’s difficult to settle on actual figures because reporting differs across various association and government entities. Most would agree that opportunistic fraud costs the average U.S. family from $400 to $700 per year in added premiums.

Unlike overt insurance fraud, usually committed by career criminals, soft fraud can be tough to detect because its perpetrators don’t look like other thieves. They’re friendly. They pay their premiums on time. They have good jobs. And, they think it’s OK to pad insurance claims.

In fact, a February 2013 poll by the Insurance Research Council (IRC) found that 24% of people believe it is acceptable to pad an insurance claim to make up for a deductible and 18% believe it’s OK to pad a claim to make up for insurance premiums paid in the past.

While opportunistic fraud infects all lines of insurance – from auto and workers’ compensation to healthcare and identity theft, this paper will focus on soft fraud in property contents claims.

Compared to other lines of insurance, homeowner’s personal property claims have the second highest incidence of fraud. According to the National Insurance Crime Bureau (NICB), the incidence of suspicious personal property claims rose by 46% between 2010 and 2013. As much as 85% of questionable property claims from 2010 to 2012 were related to contents. The two primary reasons for fraud referrals were fictitious loss and inflated damage.

Anatomy of a Soft Fraud Claim

Adjusters and special investigators see thousands of claims each year that could be soft fraud. Eric reports a stolen watch, and it just so happens that the watch was a Rolex valued at $15,000. Or was it? Jennifer reports a stolen flat screen TV. It was only two years old and was the largest HD TV on the market. True? Morris claims he had four Apple laptops stolen when his house was robbed. Were there really four of them? Andrew claims $15,000 in power tools, but data shows he lives in a 500-square-foot apartment.

The primary problem with soft fraud is that it’s frequently opportunistic and thus, it’s difficult to disprove claims without alienating customers. When investigators ask too many questions, policyholders allege poor service and 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, to reap the reward of saving a few hundred dollars? At an individual claim level, it’s often not worth the effort to dig deeper.
SIU: A Fine Line to Walk

What is the true responsibility of SIU directors? On the surface, the job seems clear cut. They are 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. Meanwhile, they must also efficiently manage their labor resources and demonstrate measurable value to the organization – further exacerbating the soft fraud dilemma.

Limitations to Behavior-based Fraud Detection

Today’s SIU director fights fraud by using a variety of tools and techniques, some of which may lack compatibility and can be counter-productive to one another. Adjusters manually send referrals based on a hunch or when they notice a wild deviation from the norm. Tips and leads may come in from law enforcement or other individuals – many times in the form of a database or bulletin subscription. Homegrown solutions are common, but can be challenging to scale as the organization grows.

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

Because of the complexity involved with the nature of fraud and its detection, there is no one-size-fits-all solution. This may be a good thing. Best-of-breed solutions tend to work well, but only if they complement each other or integrate back end data.

A 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. For example, an alert is generated if the claim exceeds a certain dollar amount, or if there is an excessive amount of claims filed within a certain period of time. If a claim is filed within days of a new policy creation or even a renewal, these behavior-based systems may raise an alert. The drawback to behavior-based fraud systems is that they can generate too many alerts, increasing the percentage of false positives. Also, smart fraudsters may wise up to the behavior-based approach, and adjust their tactics accordingly to avoid detection. Another concern is that business rules set up to catch behaviors are based on past fraud experience. They are prone to becoming outdated, rendering them useless to catch tomorrow’s newly hatched fraud schemes.

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Solution: Incorporate Claim Line Detail into the Mix

An alternative approach that is not vulnerable to evolving fraud tactics, is to expand fraud detection efforts to incorporate claim-line detail (while also integrating with rules and behavior-based approaches). Until now, fraud tools have 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. However, now with Enservio’s new ContentsAnalyzer™ Software as a Service solution, insurers can easily flag these types of padded claims. It is the first fraud solution of its kind to look at claim line detail, comparing and contrasting pricing data for signs of exaggerated or padded claim values that may point to opportunistic fraud.

ContentsAnalyzer examines the claim line items and their data outliers, determining what the usual contents are for a home of a given size, in a given zip code, on a given block. It compares the value of a line item with the average retail value and the replacement cost value of the same item with the same brand and age, achieving two important outcomes:

1. **If the person’s lifestyle isn’t in sync with the claimed items, the SIU is alerted.**
   Case in point: A policyholder submits a claim for kids’ sport equipment, but the policyholder has no children. Or, a policyholder submits a claim for a large number of power tools, but he lives in a small apartment with no garage. In each of these cases, ContentsAnalyzer detects an anomaly by comparing and contrasting the data available from multiple sources.

2. **If the value of the items submitted appears to be inflated or fabricated, the SIU receives an alert.**
   This may be as simple as the previous coffee pot example, or, an alert could be generated when the system compares the claimed items against norms for the policyholder’s geographic and demographic data. For example, if the claimant resides in a low income area, ContentsAnalyzer may detect an anomaly if a claim is submitted for two Rolex watches.

The solution’s patent-pending analytic model compares claim data in real-time with the billions of dollars of historic claims processed. Algorithms work in concert with the Enservio data warehouse that tracks real-time pricing data on more than 8 million consumer products. Pricing changes are updated nightly and factored in. This melding of multi-source data equips ContentsAnalyzer with a unique ability to detect both padded claims and claims that don’t make sense in particular environments.

Only ContentsAnalyzer can provide this level of accurate scoring and evaluation of a claim’s propensity for fraud, giving the SIU team an advantage in isolating fraudulent claims.

ContentsAnalyzer does not compete or attempt to replace existing tools that focus on demographics and/or an individual’s credit history. Instead, it is complementary in generating additional referrals that other tools are not designed to produce. Referrals from ContentsAnalyzer would go to the same SIU contacts and would follow the same workflow as other anti-fraud methods.
The end gain is a solution that determines 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 can lead to a positive ROI for the SIU as well as the carrier.

**ContentsAnalyzer: Hard Benefits to Soft Fraud Detection**

- Identifies soft fraud not detected by existing solutions
- Compares the value of each claim line item against external data points, such as average retail cost and replacement cost values
- Examines claim line detail for pricing irregularities, flagging padded claims and opportunistic fraud in real time
- Scores and analyzes the claim continuously throughout its lifecycle
- Complements existing work processes and tools
- Integrates with existing fraud detection and homegrown solutions
- Generates more quality referrals with less false positives
- Does not require lengthy end-user training or extensive IT support
- Upwardly scalable, able to handle vast volumes of data feeds
- Catches fraud before the settlement
A Soft Fraud Inoculation?

At Enservio, we believe the best way to prevent soft fraud is to detect it ... earlier, smarter and more efficiently. Insurance companies and their SIUs have tolerated the soft fraud epidemic long enough. It’s time to call out padded and fictitious claims for what they are, and change consumer perceptions. We owe it to all the legitimate policyholders who foot the bill for opportunistic fraud every year.

About Enservio:
Enservio works on the biggest challenge in property insurance – what’s inside. We provide a complete suite of software and service solutions to help property insurance carriers price their policies correctly, settle their contents claims quickly and accurately, pay their claims, and help policyholders get their stuff back. Founded in 2004, we are headquartered in Needham, MA, with offices and professional staff across the United States.