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Eliminate insurance fraud and save up to 10% in paid out damages by standardizing the investigations process

W7 STANDARD

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Executive Summary

Of all paid out claims received by European insurers an estimate of 10% is expected to be fraudulent. This estimate contains both detected and undetected fraudulent claims.

The following list of reasons make prevention, detection and proving fraud challenging for insurance companies:

- Lack of internal structure in the process of special investigations.
- Limited legal options in case of fraud suspicion, or even when proven.
- Special Investigations departments stand alone; the overall organization is not as worried about fraud prevention.
- Outdated technology; which can go as far as depending on excel files and experience in the heads of individuals within the organization.
- Poor data quality; makes it virtually impossible to determine the cause of anomalies.
- Strict privacy laws; making it hard to investigate suspicious claims properly.
- Lack of (qualified) staff due to budget constraints.

In this white paper, we lay out the W7 Standard. Organizations that follow this Standard can optimize their overall investigation outcomes. When this happens more cases are successfully solved in less time, the evidence is more reliable, sanctions are easier to justify, and reclaiming the damage on the perpetrators becomes more fruitful.

Another benefit of this process is that it makes it easier to exchange data between different parties in larger investigations, as well as, with the financial intelligence unit. Cooperation becomes more effective, and cases are always complete, compatible, and easier to understand.

This white paper also explains how to substantially reduce workload by automating the first part of the process. Answering the first four questions of the W7 Standard as part of your fraud monitoring routines results in signals with an accurate indicator of suspicious activity, therefore the system generates less false positive alerts. Leaving more time for claim agents to properly handle and assess the generated true positive alerts, resulting in only relevant cases being sent to the special investigations unit.

An added benefit of the W7 Standard is that it makes organizations more compliant with privacy regulations as it is easier to shield personal data and to allocate authorizations.

compliant

Applying the W7 Standard to the audit trail as well as to the 'Standard' investigation process improves overall accountability of the results, relevant under the GDPR regulations/requirements. Accountable results are vital to justify proportionality for proposed sanctioning measures and to ensure that cases are eligible for lawsuits when and if necessary.

The never-ending battle against insurance fraud

All insurance companies deal with fraud. The European Insurance Federation believes that 10% of all paid out claims received by European insurers are fraudulent. Unfortunately, only a part of this estimate gets detected. Another part of that number is an estimation of undetected fraudulent claims.[1] This means that insurers are robbed of 10% of their profit every year.

[1] Insurance Europe. (2013). The impact of insurance fraud. Retrieved from https://www.insuranceeurope.eu/sites/default/files/attachments/The%20impact%20of%20insurance%20fraud.pdf

What makes it hard for insurance companies to prevent fraud is the fact that organized criminals are not the only ones committing insurance fraud. Some professionals and technicians also try to deceit insurance companies by inflating service prices or by charging for unrendered services. Even ordinary clients commit fraud to cover their deductibles or to make some money from filing a claim. Some clients lie on their insurance application form to get a lower premium. For example: on their car insurance application by underestimating the number of kilometers expected to drive each year.[2]

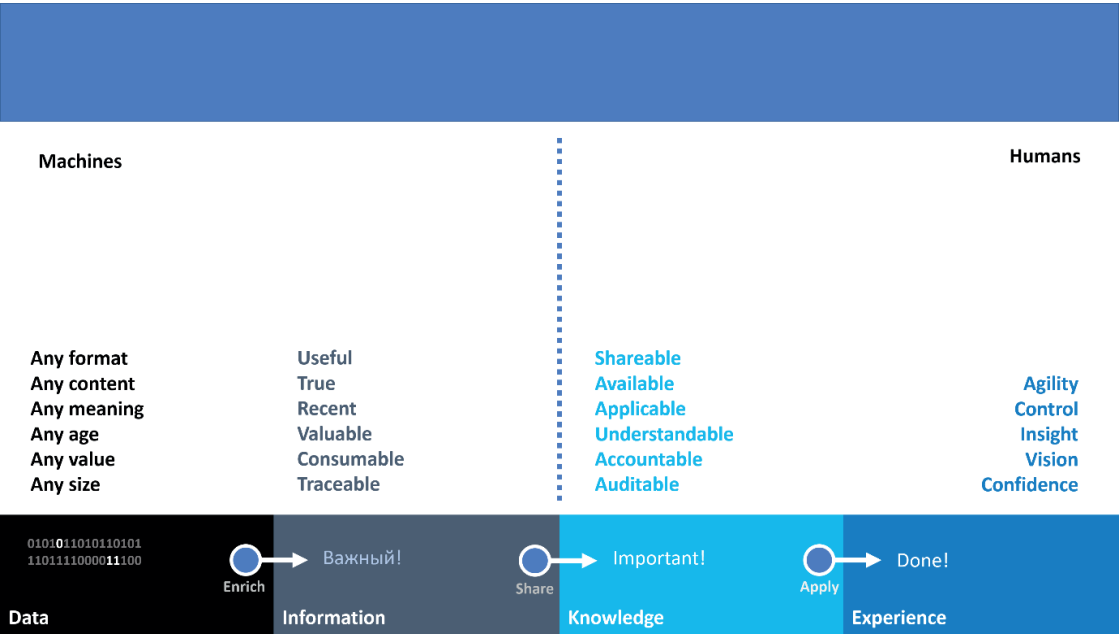
Even though insurance fraud directly impacts everyone who has insurance, part of the general public does not seem to be concerned with it. One out of five Americans thinks that it is acceptable to commit insurance fraud. 18% of respondents in a survey done by the Coalition Against Insurance Fraud did not mind misrepresenting facts on an insurance application to get a lower premium. In another study, 55% of respondents believed that it is more likely that people commit insurance fraud if they feel they receive poor service from an insurance company while 76% of respondents think that people are more likely to commit insurance fraud in a recession.[3]

Since it is so difficult to make assumptions about who commits fraud, the KYC process is not sufficient enough to rule out every potential fraudster. However, prevention of fraud is not the only struggle insurance companies have. They also have organizational challenges in detecting and proving fraud. The following problems form the core of this challenge:

- Lack of internal structure in the special investigations process; every individual has their way of working.
- Limited legal options in case of fraud suspicion; reporting fraud to authorities will not always translate into punitive action.
- Special Investigation departments stand alone; the overall organization is not as worried about fraud prevention.
- Outdated technology; which can go as far as depending on excel files and experience in the heads of individuals within the organization.
- Poor data quality; making it virtually impossible to determine the cause of anomalies.
- Privacy laws make it hard to investigate suspicious claims properly; part of a customer's data needs to be shielded to comply with those laws.
- Lack of resources; such as staff, budget, training possibilities to acquire the necessary skill set, and other resources.

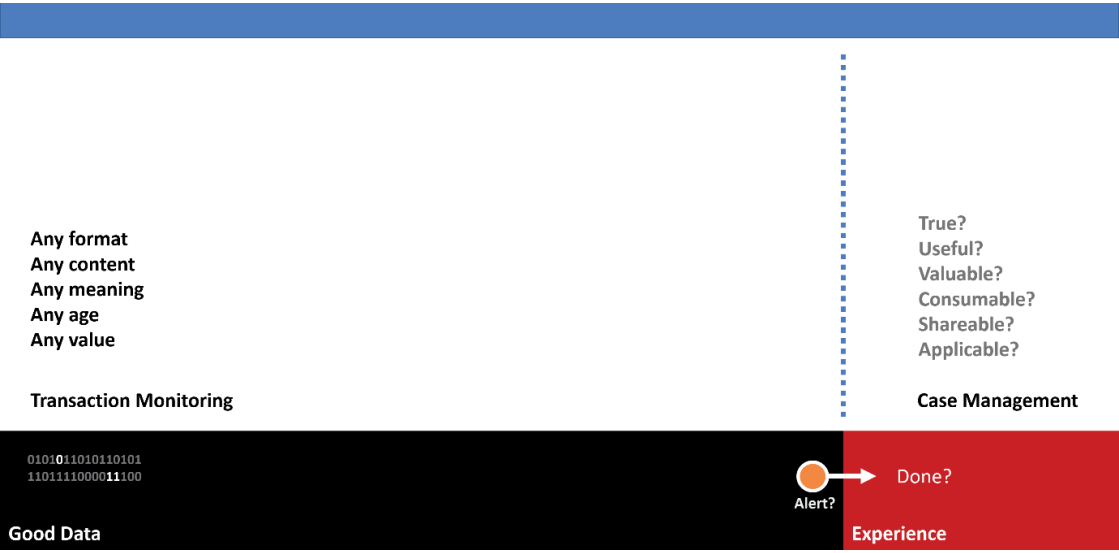
[3] Insurance Information Institute. (2017, November 6). Background on: insurance fraud. Retrieved April 9, 2018, from https://www.iii.org/article/background-on-insurance-fraud

All of these problems are solvable by implementing a standardized process and case file structure that makes it easier to detect and to prove fraud. This white paper explains what that process looks like and how to structure the investigation results in data files. Completed cases in organizations that follow this process all have the same quality. Those organizations can optimize their overall research results. When this happens more cases are successfully solved, cases are resolved faster, the evidence is more reliable, sanctions are easier to justify, and reclaiming the damage on the perpetrators becomes more fruitful.



Why processes are needed

The special investigations process relies heavily on the expertise of individual investigators. These are very skilled people with an extensive background in law enforcement fields or seasoned claims agents that have had additional investigative training. With their wealth of knowledge, special investigators are often capable of solving cases that can not be handled by the claims departments. The strength of both the claims department and the special investigators can be expanded by introducing a process that allows everyone to work in the same way, improving the quality of the cases.



Applying the W7 Standard sets a minimum quality threshold. When cases are all structured in the same way, and all have the same minimum quality, it becomes easier to share cases between parties and thus improve cooperation. The case results are more straightforward to analyze, and reporting of incidents to regulators becomes more informative and compliant. This translates into enhanced investigation outcomes which results in:

- an increase of successfully solved cases
- faster completion of cases
- improvement of case arguments
- better justification of sanctions
- more fruitful damage reclaims

All of these improvements increase the return on investment of anti-fraud measures. Making it possible to lower premiums and attract more clients.

The W7 Standard

With the current ways of working, even if fraud is detected, insurance companies have limited legal options. Besides notifying the law enforcement agencies of suspicious claims, their only options are to reject a claim and to collect evidence for use in a court. These measures can only be taken after a claim is proven to be false. Detecting the numerous fraudulent claims that go unnoticed each year, is a more precarious endeavor.

The W7 Standard is a process that makes it simpler to both detect and prove insurance fraud. This process asks to answer seven questions:

What? >> Worth? >> When? >> Where? >> Who? >> With? >> Why?

When signs of suspicious behavior are found, it is much easier to distinguish between true and false positives by answering the first four W questions. This makes the fraud detection process much more efficient leading to increased effectiveness of the Special Investigations Unit.

When it turns out that a claim has generated a true positive alert after answering the first 4 W questions, further investigation requires crossing the privacy barrier. Only by determining the probable cause can private data be added to the case and thus the "Who" question be answered. Once the perpetrator is known, the case can be completed by answering the "Why" and "What" questions.

If the answers to the first four questions give enough evidence to generate a true positive alert, the last three questions can confirm if a claim is fraudulent or not. The answers to all seven questions combined, form enough proof against a fraudster to give implications to the false claim.

How the W7 Standard helps prove a case

To determine probable cause, police detectives need at least to find out the means, motive, and opportunity a suspect had to commit a crime.[4] With the W7 Standard, the means, motive, and opportunity a person had to commit insurance fraud are easy to determine. The W7 Standard is, however more extensive because insurers need to adhere to different privacy rules, investigate on a larger variety of cases, and they have more limitations and restrictions than the police.

[4] COMMONWEALTH vs. MICHAEL M. O'LAUGHLIN. (2006, January 4). Retrieved April 9, 2018, from http://masscases.com/cases/sjc/446/446mass188.html

The opportunity someone had to commit insurance fraud is found through the answers to the first four questions:

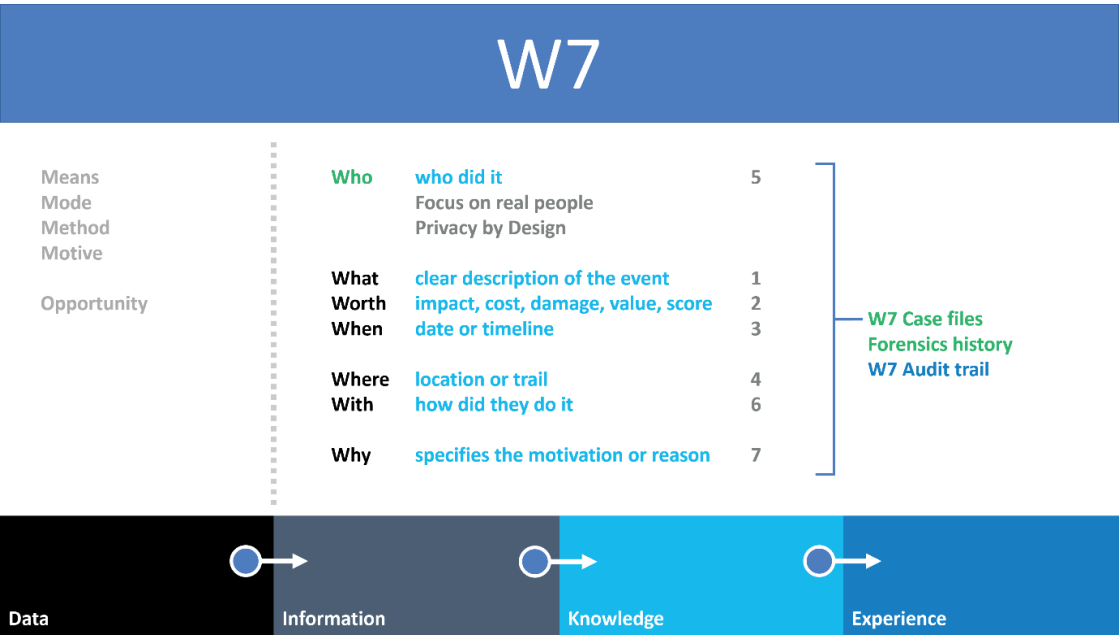
What: clear description of the event and the breached rule
Worth: impact, cost, damage, value or score
When: date or timeline for the event that occurred
Where: location or trail where the event occurred

If these four answers are irrefutably answered, it is allowed to add personal details to the case file (however, authorization and access should be restricted on a 'need to know' basis).

Who: who did it? Who else was involved?

The 'MO' (method of operation) is explained by the answer to the question 'with':
With: how did they do it?

The question 'why' explains the motive someone had to commit insurance fraud:
Why: specifies the motivation or reason



Automation

The use of the W7 Standard in forensic investigations might be familiar to seasoned investigators since it is part of the traditional research toolkit. New investigators, however, are keen on using modern tools such as data, technology, machine learning, and e-discovery for fraud detection and research.

Both ways of working do not have to collide. A part of the W7 Standard can be automated which makes it easier to:

- detect insurance fraud,
- comply with privacy laws,
- and, create an audit trail

Combining the W7 Standard and automation satisfies both old-school and new-school researchers. Making it possible to form a cohesive team where both experience and technology are indispensable parts of the fight against insurance fraud.

Detection

Whether or not a fraudulent claim is detected today, depends heavily on the attitude, experience, and knowledge of the claims agents. By implementing the W7 Standard, there are four clear things a claims agent can check to see if a claim is suspicious. Those are the “What”, “Worth”, “When”, and “Where” questions. If the answers to those questions lead to suspicions, the claim can be handed off to a senior claims agent who reassesses the answers to these four initial W questions. When suspicion is confirmed, that senior agent forwards the claim to the Special Investigations unit to find the answers to the questions “Who”, “With”, and “Why”.

By involving automation in this process, the “What”, “Worth”, “When”, and “Where” questions are answered by the system. The system generates a signal based on the answers to those questions. A signal is then shaped (validated) into an alert. That alert is handed over to and handled by a Special Investigations officer immediately. This Special Investigations officer determines if the claim really is fraudulent, by adding the final 3 W questions to the case investigation. If it is clear that the claim is fraudulent, the claim is rejected and directly reported to the authorities.

W7

Products
Services
Channels

Who?
What
Worth
When

ID REF IP ACC

Who?
What
Worth
When

Where

Customer | Actor

Humans

Who
What
Worth
When
Where
With

Why

W7 Case
Forensic history
W7 Audit trail

Real people

Using an automated system that automatically detects suspicious claims and generates signals, can save the Claims department much time, and the insurance company itself a lot of damages. The ideal system also learns from the history, feedback, and experience of the Special Investigators, which means fraud is detected easier and sooner. That can, in turn, lower the costs of anti-fraud measures as well.

Prospect name
Grace Mugabe

Date of Birth
23-07-1965

Event type
Sanction hit:
G Mugabe (1965)

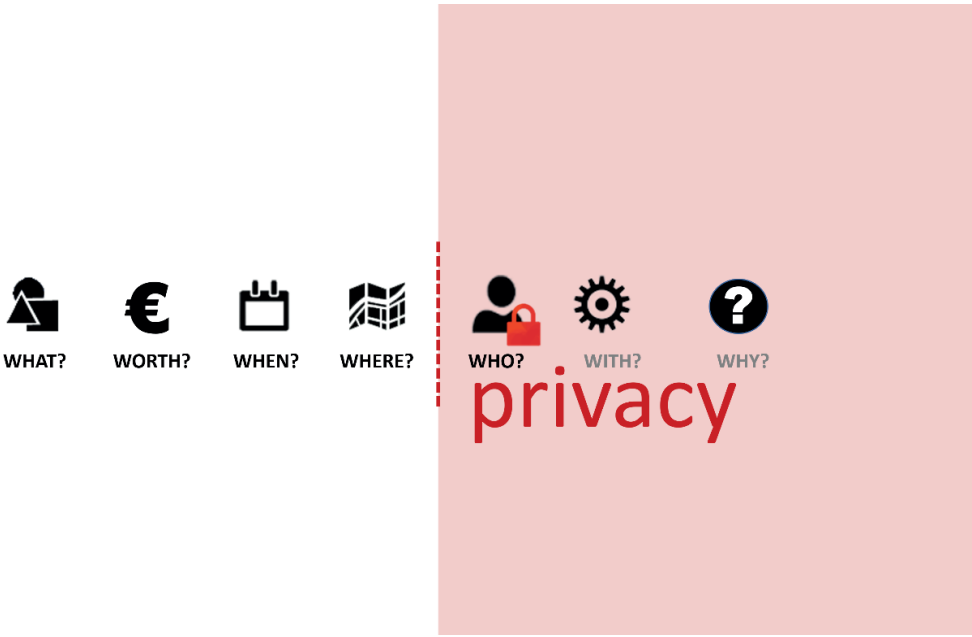
Reason
Matches: intial, surname and year of birth

Score
81%

List
OFAC SDN

Privacy laws

With the GDPR regulations, privacy laws are becoming stricter. Private data of customers is not supposed to be shared freely within the organization. Automating the claims process and especially the assessments and in-depth investigations of suspicious claims according to the W7 Standard means better compliance with the GDPR laws.



The above picture gives a visual representation of how automation works. The four questions to the left are all handled by the system. The system enriches data to create information that makes sense to humans. It can process data of any format, any content, any meaning, any age, any value, and any size. The information generated from the data must be useful, valid, recent, valuable, consumable, and traceable. Only if the system validates the first four questions against these requirements, it generates an alert, so just in those cases where fraud is suspected with an auditable probable cause, will personal data be viewed and only by an authorized special investigator. For all other customers, private information is shielded from being seen by anyone within the organization.

Audit trail

By applying the W7 Standard, an audit trail is automatically created and maintained throughout the process. That improves the overall accountability of the results which is also required by the GDPR regulation. The audit trail also helps in justifying the proposed sanction measures, and it makes cases eligible for lawsuits if and when needed.

audit trail

The audit trail is created by answering the 7W questions, but instead of looking at the incident and suspect, the questions are asked from the perspective of the researcher or case. The questions that must be answered to create the audit trail are:

- What was done to get to the reasoning behind the case?
- Weight of the sanctioning measures?
- When was the research done?
- Where were the facts used in the case acquired?
- Who was involved in the investigation?
- With what tools has the investigation been conducted or completed?
- Why does it explain the probable cause?

Buyer's guide

If you are looking to go beyond implementing a new process and want to automate part of that process to detect insurance fraud faster and easier, there are a couple of things you need to keep in mind while looking for a vendor. These are:

- Automation of data-driven investigations should use a reliable standard comparable to the W7 Standard.
- Validation of signals into alerts should be unambiguous and traceable.
- The system should comply with privacy regulations in general, and specifically with GDPR.
- The audit trail should at all times be maintained and be accessible.
- Automation should apply a learning loop to allow both the system and the organization to continuously improve its responsiveness and resilience against fraud and other integrity risks.

The system should furthermore:

- **Be flexible and use various data sources and monitoring models.** It should also be adaptable towards changing requirements and new insights during your investigation. That way you can change with circumstances as needed.
- **Be able to transcend claims level monitoring.** The ultimate purpose of any 'true positive' investigation is determining who is involved, and in what role, while respecting privacy restrictions.
- **Be able to integrate your old knowledge into the new technology** in such a way that it is not only always accessible but can also directly be used in your further investigations.

To find a supplier that can make your life as easy as possible, look out for the following:

- Find out if the supplier can help you **migrate your current data and knowledge** to the new solution or technology.
- Make sure the supplier **understands the dynamics facing your investigations as well as yourself** because they need to be sensitive to those changes and should not underestimate the complexities of your day to day work.
- Expect your supplier to **treat you as a partner**, having thorough knowledge and experience with the quality Standards your investigations need to live up to.

[5] LexisNexis, British Bankers' Association. (2015). Future Financial Crime Risks. Retrieved 22 December 2017 from https://www.bba.org.uk/wp-content/uploads/2015/12/Future-Financial-Crime-Risks-DIGITAL-final.pdf

Conclusion

Fraud is a serious problem insurance companies have to deal with. Eliminating fraud results in a 10% decrease of paid out claims. However, detecting and proving fraud is a real challenge. The fact that anyone can commit insurance fraud makes it hard for insurance companies to prevent it while identifying and proving it proves to be difficult due to the lack of relevant structure and resources in claims departments.

For insurance companies to efficiently combat insurance fraud, it is necessary to implement a standard process at least. The W7 Standard can help achieve a minimum quality level for cases. When all cases contain the same information and are structured the same, it becomes easier to share results with other parties for collaboration. It also makes it easier to comply with (reporting) regulations.

If insurance companies want to eliminate fraud to a minimum, they need to automate part of the process. By automating part of the process, fraud is detected more often and faster. This results in a reduction of costs and risk profile. Automation also makes it easier to comply with privacy laws as private data can be shielded from employees that do not have the authorization to view customers' data.

To find out more about how your company can reduce paid out fraudulent claims, contact our team at

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About the company

BusinessForensics has been offering software, know-how and a forensic view of any business since 1998 while discovering financial-economic crime risks and taking immediate measures.

The forensic platform provides real-time (big) data analysis of networks, transaction monitoring, fraud management, risk assessments and machine learning. This enables companies and institutions to act instantly on identified financial, and economic crime risks.

Compliance is shown by measuring ethical behavior, and trust improves by minimizing false positives on detected risks. Measuring good behavior through a reliable compliance system builds trust within your business; between employees and towards your honest clients alike. This reduces avoidable damage and strongly increases corporate agility.

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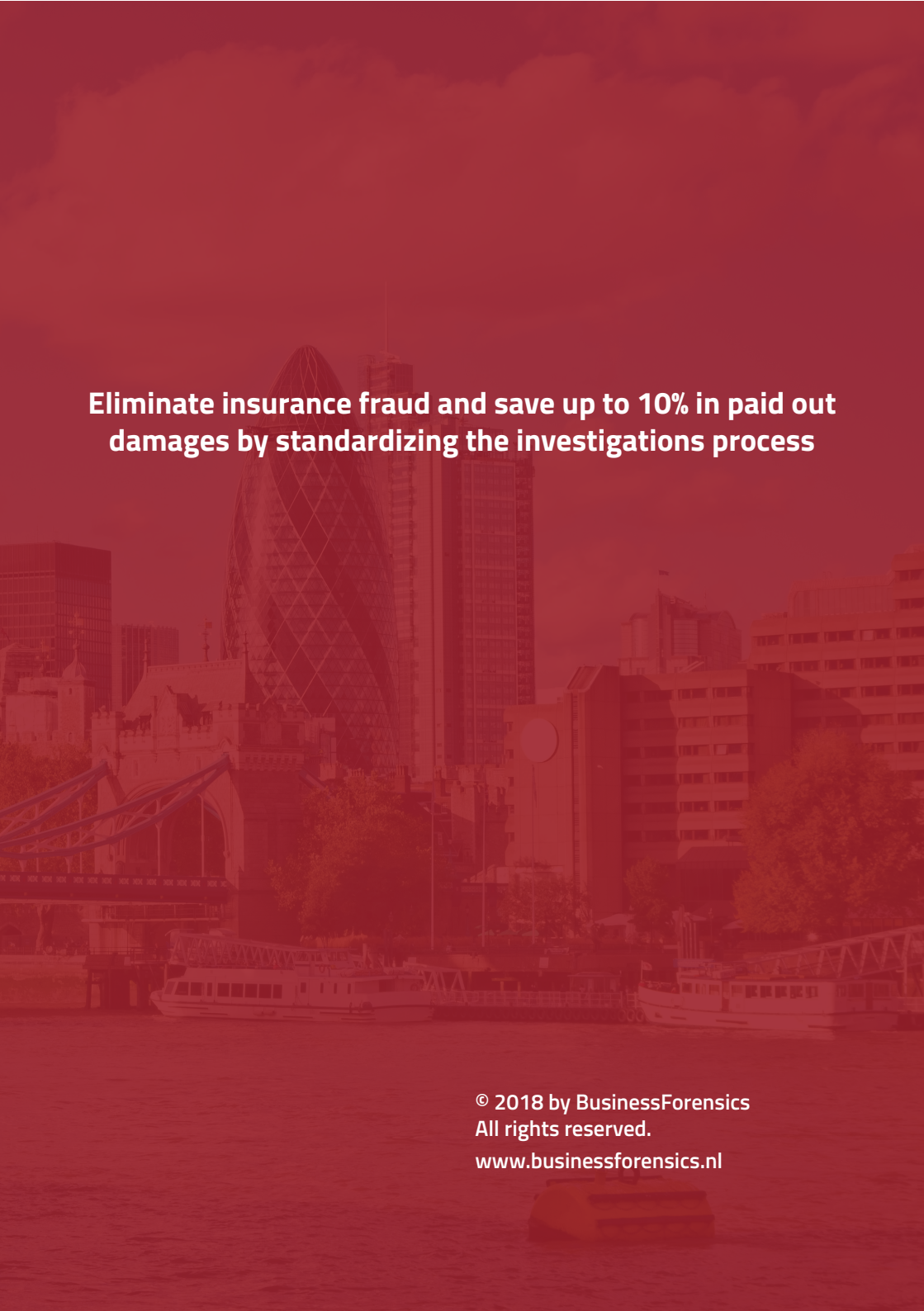

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