



# INSURANCE FRAUD REPORT

BY  FRISS

2018





**THIS INSURANCE FRAUD REPORT  
IS BROUGHT TO YOU BY**



**F R I S S**



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Dear insurer,

We have some interesting observations for you. Let's start with some numbers. In our 2018 Insurance Fraud survey, loss ratios were 73% in the US. On average, 10% of the incurred losses were related to fraud, resulting in losses of \$34 billion per year. By actively fighting fraud we can improve these ratios and our customers' experience.

It's time to take our anti-fraud efforts to a higher level. To effectively fight fraud, a company needs support and commitment throughout the organization, from top management to customer service. Detecting fraudulent claims is important. However, it can't be the only priority. Insurance carriers must also focus on portfolio quality instead of quantity or volume.

It all comes down to profitable portfolio growth. Why should honest customers have to bear the risks brought in by others? In the end, our entire society suffers from fraud. We're all paying higher premiums to cover for the dishonest. Things don't change overnight, but an effective industry-wide fraud approach will result in healthy portfolios for insurers and fair insurance premiums for customers. At FRISS, we call this honest insurance.

We conducted the Insurance Fraud Survey to gain a better understanding of the current market state, the challenges insurers must overcome and the maturity level of the industry regarding insurance fraud. This report is a follow up to the Insurance Fraud & Digital Transformation Survey we published in 2016. Fraudsters are constantly innovating, so it is important to continuously monitor developments. Today you are reading the latest update on insurance fraud.

For some topics we were able to compare the results of this survey with those from our 2016 study. Let me slide in a minor disclaimer: Over the years, individual respondents can change. Also, some questions have been modified, added, or eliminated based on current and emerging developments.

Our report explores global fraud trends in P&C insurance. This research addresses challenges, different approaches, engagement, priority, maturity and data sharing. The latter provides insights for online presence, mobile apps, visual screening technology, telematics and predictive analytics. Now that's what I call a major bingo on the buzz words!

At FRISS we support honest insurance. We believe continuous innovation and willingness to adapt are the key ingredients for success. FRISS invests over 20% of its revenue in R&D. The detailed findings and results of this survey provide valuable input for our product management teams. Together with our customers we strive towards a trustworthy insurance industry, healthy insurance portfolios and fair insurance premiums for everyone across the globe.

I would like to thank everyone who contributed to this research.

Enjoy reading!

Marc Mulder, CCO @ FRISS





# FRAUD-FIGHTING CULTURE

Fraudsters are getting smarter in their attempts to stay under their insurer’s radar. They are often one step ahead of the fraud investigator. As a result, money flows to the wrong people. Of course, these fraudulent claims payments have a negative effect on loss ratio and insurance premiums. Therefore, regulators in many countries around the globe created anti-fraud plans and fraud awareness campaigns. Several industry associations have also issued guidelines and proposed preventive measures to help insurers and their customers.



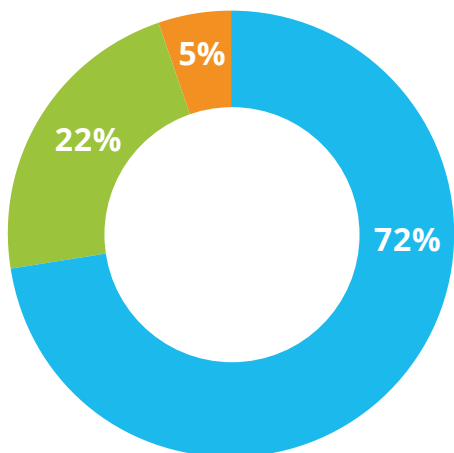
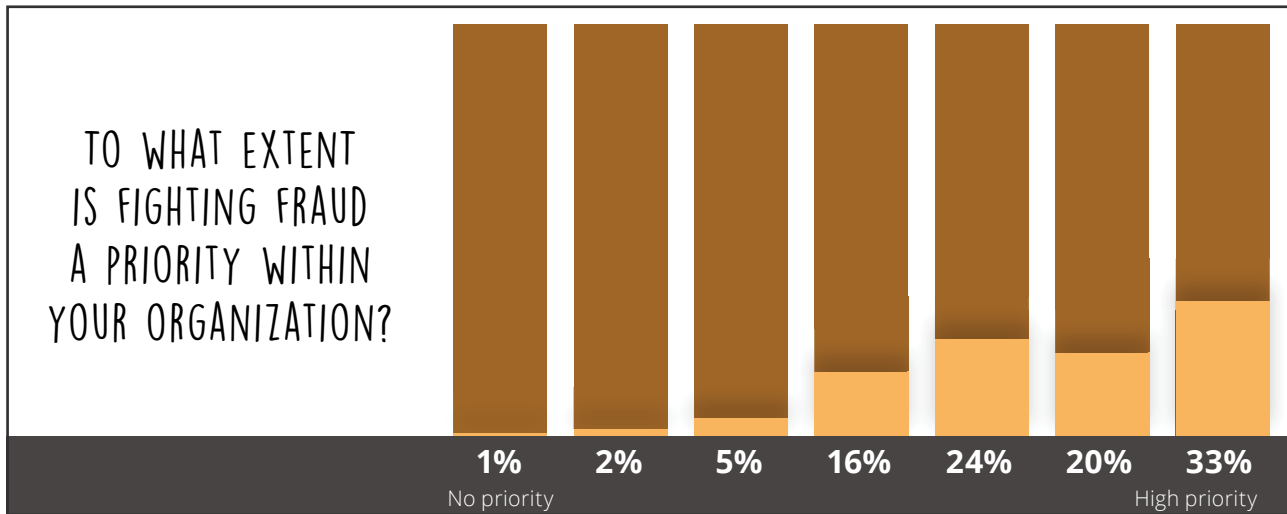
## WHAT SHOULD CHANGE TO CREATE A FRAUD-FIGHTING CULTURE WITHIN YOUR ORGANIZATION?





To help in the fight against fraud, insurers are investing in positive developments of modernization, including automated fraud solutions and the promotion of a fraud-fighting culture. In 2016, 7 out of 10 insurance professionals rated fraud a top priority. Now, the majority of insurers, 72%, have a fraud-fighting culture. However, only a third have a zero-tolerance policy against fraud.

**7/10  
Average  
Priority**



WOULD YOU SAY YOUR ORGANIZATION HAS A FRAUD-FIGHTING CULTURE (E.G. COMPANY WIDE FRAUD AWARENESS)?

■ YES ■ NO ■ I HAVE NO CLUE

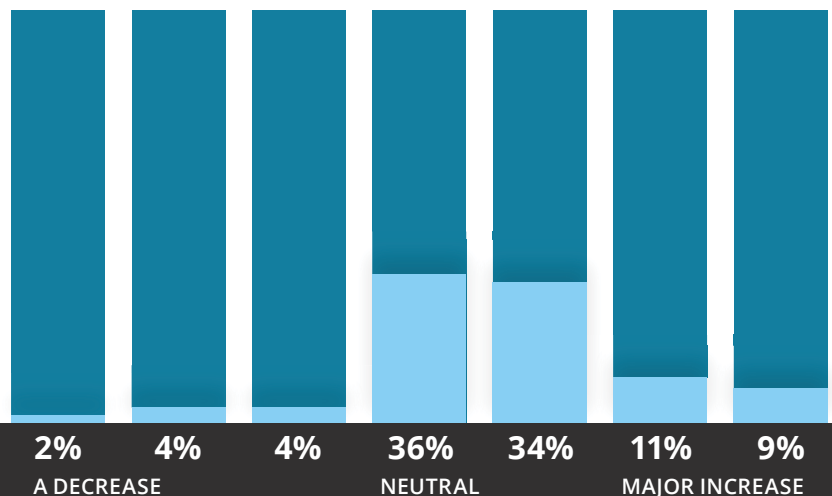
# ENGAGEMENT BETWEEN DEPARTMENTS

Fraud affects the entire industry, and fighting it pays off. US insurers say that fraud has climbed over 60% over the last three years. Meanwhile, the total savings of proven fraud cases exceeded \$116 million. Insurers are seeing an increase in fraudulent cases and believe awareness and cooperation between departments is key to stopping this costly problem.



\$116 MILLION  
SAVINGS IN 2017

TO WHAT EXTENT DO YOU  
SEE AN INCREASE IN  
FRAUDULENT CASES OVER  
THE LAST TWO YEARS?

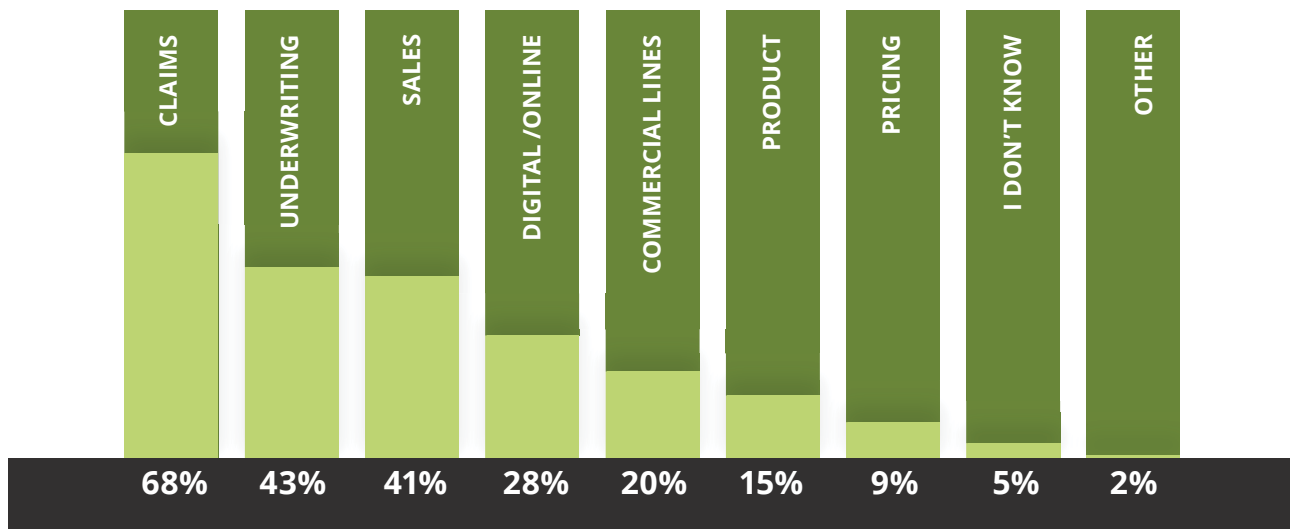


Insurers indicate that claims (68%) and underwriting (43%) departments need to be more engaged. Compared to 2016, there is no change in the perceived need for fraud engagement in claims departments. However, fraud engagement in underwriting departments has increased from 30% to 43%.



The vast expansion of the internet, the speed and capacity of mobile devices, and the power of our mobile applications have caused a major shift in distribution. Today, online channels are a central part in the distribution of insurance policies. Knowing Your Customer is therefore very important. Surprisingly, compared to 2016, digital/online departments are not found to be in need of more engagement to fight fraud.

WHICH DEPARTMENT(S) WITHIN YOUR ORGANIZATION NEED TO BE MORE ENGAGED IN FIGHTING FRAUD?



# WEAPONS TO FIGHT FRAUD



Companies like Google, Spotify and Uber all deliver personalized products or services. Data is the engine of it all. The more you know, the better you can serve your customers. This also holds true for the insurance industry. Knowing your customer is very important, and with lots of data, insurers now know them even better. You'd think in today's fast digital age, fighting fraud would be an automated task.

That's not the case. Many companies still rely on their staff instead of automated fraud solutions. 67% of the survey respondents state that their company fights fraud based on the gut feeling of their claim adjusters. There is little or no change when compared to 2016.

## WHAT FRAUD-FIGHTING RESULTS DO YOU MEASURE?

NUMBER OF FRAUDULENT CASES	55%
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SAVINGS IN CLAIM PAYMENTS	50%
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DETECTION RATE	40%
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LOSS RATIO	31%
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NUMBER OF REFERRALS	18%
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FALSE POSITIVES	16%
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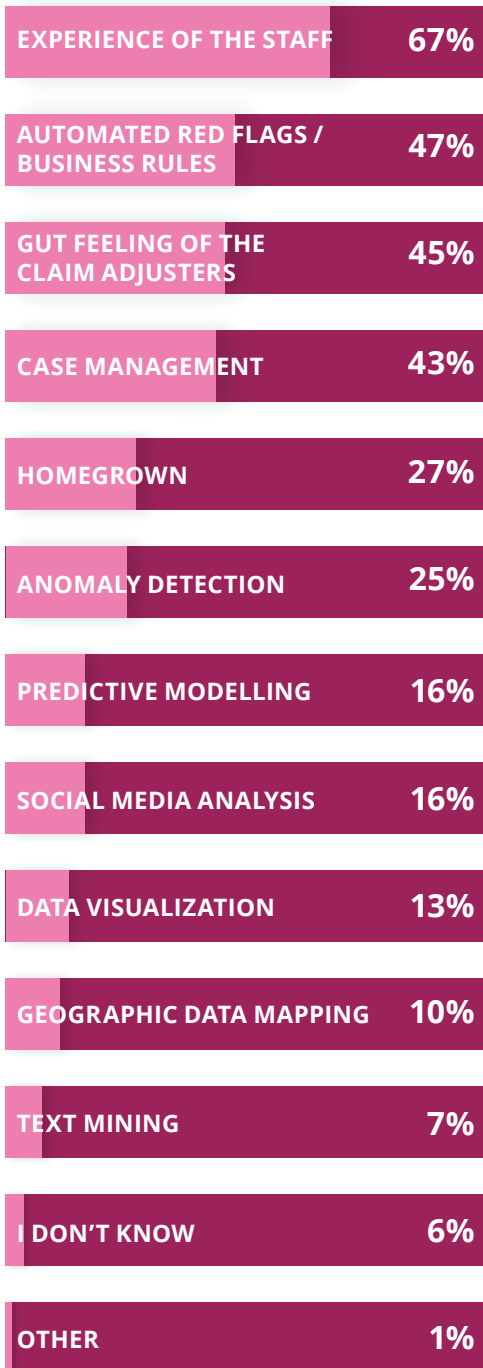
COMBINED RATIO	16%
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I DON'T KNOW	14%
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WE DON'T MEASURE FRAUD-FIGHTING RESULTS	10%
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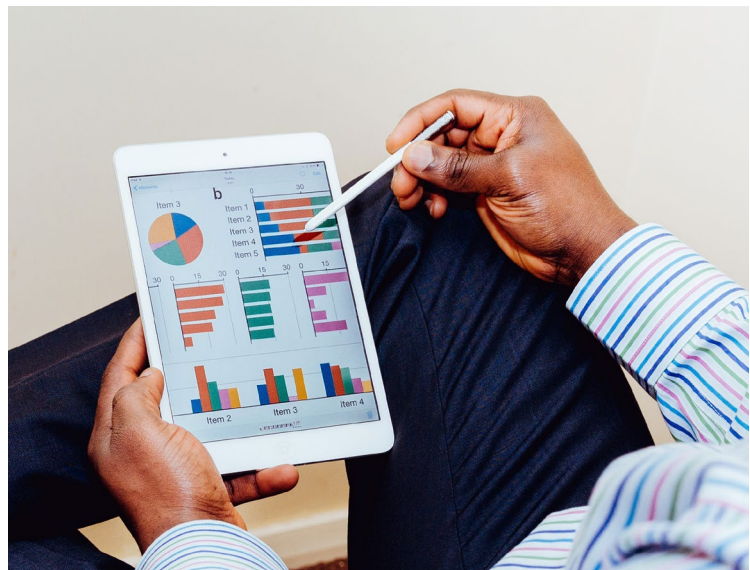
OTHER	1%
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## WHAT SOLUTION(S) DOES YOUR ORGANIZATION CURRENTLY USE TO DETECT FRAUD AND HIGH RISK CUSTOMERS?

Fighting fraud is still a manual operation within many organizations, making it a time consuming and error-prone process. 47% of our respondents from organizations with an automated solution say they are more effective at fraud investigation by directly recognizing claims that need further attention or require active follow-up.



**"THE SURVEY FOUND THAT 10% OF THE RESPONDENTS ARE NOT MEASURING FRAUD-FIGHTING RESULTS AT ALL."**

# FRAUD POOLS

Insurance companies would all benefit by joining forces and sharing information through fraud pools. It is the only way to track, fight and control organized fraud. This would help insurers learn about the latest fraud schemes and stay ahead of the game.

Fraudsters are always looking for the weak spot. Access to international fraud pools would prevent fraudsters from going from one country to another and from one insurer to another.

"JOINING FORCES WOULD LIMIT FRAUDSTERS' ABILITY TO COMMIT OPPORTUNISTIC OR ORGANIZED FRAUD."

Based on the survey, insurers are less willing to share data. The outcome has similarities with the Nash Equilibrium which states 52% of the insurers would benefit if they start with sharing data with each other.

Claims history and proven fraud case data are the most useful data sets in fraud pools. 54% of insurers exchange information on fraud and risk detection, and 18% of the insurers exchange information on fraud and risk prevention.



# DATA, DATA, DATA...



In the fight against fraud, insurance carriers face numerous challenges – many related to data. Compared to the 2016 survey results, there have been minor, yet important developments. Regulations around privacy and security have become stricter and clearer.

The General Data Protection Regulation (GDPR) is only one example of centralized rules being pushed from a governmental level. Laws like this improve clarity on what data can be used, how it may be leveraged, and for what purposes.

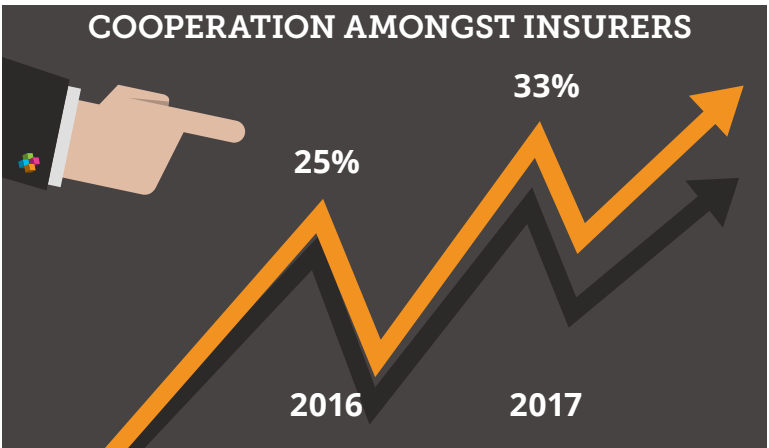
"INTERNAL DATA QUALITY IS A BIGGER ISSUE THAN EVER BEFORE. IN 2016, 30% OF INSURERS INDICATED INTERNAL DATA AS A CHALLENGE, AND IN 2018, THIS HAS GROWN TO 45%"



Indicating risks or detecting fraud is difficult when the quality of internal data is subpar. However, it is also a growing pain when trying to enhance the customer experience. To improve customer experience, internal data needs to be accurate.

Another growing challenge is cooperation amongst insurers. Fraudsters do not stick to a sole insurance carrier. They freely move between carriers by applying for new policies and filing claims. Borders don't stop them either.

If insurers would share data on fraudulent claims, repair shops, medical providers, images, and insured objects, this would increase their chances of stopping fraudsters early on. In the survey, 33% of insurers identified cooperation as a challenge which is an increase of 8% compared to 2016.



With the 2016 study in mind, it is no surprise that today even more carriers feel they work with outdated internal fraud systems. 20% of insurers work with outdated systems as compared to 14% in 2016. Apparently not all planned projects were executed or finished between then and now.

39% of insurers have a dedicated budget to fight fraud and 52% have planned a project to implement a fraud detection solution in the coming 12 months.

## WHAT ARE YOUR ORGANIZATION'S BIGGEST CHALLENGES IN EFFECTIVELY RESPONDING TO FRAUD?

INTERNAL DATA QUALITY	45%
INADEQUATE ACCESS TO EXTERNAL DATA	34%
COOPERATION WITH OTHER INSURERS	33%
DATA PROTECTION AND PRIVACY	30%
OTHER PRIORITIES WITHIN THE ORGANIZATION	28%
KEEPING UP WITH FRAUDSTERS MODUS OPERANDI	28%
INSUFICIENT INVESTMENT FROM YOU ORGANIZATION	21%
OUTDATED INTERNAL FRAUD SYSTEMS	20%
IT IS NOT A PRIORITY FOR IT AT THIS POINT	19%
ENSURING FRAUD IS A C-LEVEL PRIORITY	13%
EMPOWERMENT OF THE SIU	8%
AARGH, NOT A CLUE	7%
OTHER	1%



"ONLY 22% IDENTIFY UNBIASED  
DETECTION AS A BENEFIT OF USING  
AUTOMATED FRAUD DETECTION"



## BENEFITS OF USING FRAUD-DETECTION SOFTWARE

Fighting fraud can be a time-consuming and error-prone process, especially when done manually. This approach is often based on the knowledge of claims adjusters. But what if that knowledge leaves the company? The influence of bias or prejudice when investigating fraud also comes into play.

**"ONLY 30% OF INSURERS ARE  
LEVERAGING AI TO FIGHT FRAUD."**

With well-organized and automated risk analysis and fraud detection, the chances of fraudsters slipping into the portfolio are diminished significantly. This is the common belief among 42% of insurers. And applications can be processed even faster. Straight-through processing or touchless claims handling improves customer experience, and thus customer satisfaction. The survey reported 61% of insurers currently work with fraud detection software to improve real-time fraud detection.

Are the applicant and the owner the same person? Does the claim concern a ‘regular driver’ and how is this driver connected to the policyholder? All relevant details can be verified in real time, and outcomes of the screening can directly impact company performance. The survey shows 53% of carriers are working with fraud detection software to lower their loss ratio. 41% report that automated screening helps them with a consistent investigations process, and 39% enjoy benefits from higher investigator efficiency.

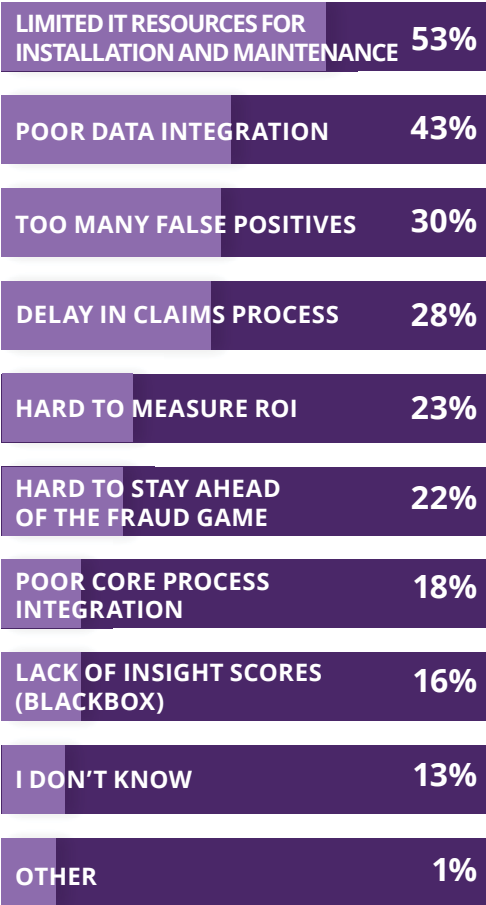
## CHALLENGES WITH AUTOMATED FRAUD DETECTION SOFTWARE

Fraudsters change the way they work constantly, and insurance carriers need to keep up with the latest technologies. Internal solutions often fall behind and lack the most up-to-date insights and knowledge offered by fraud detection software providers.

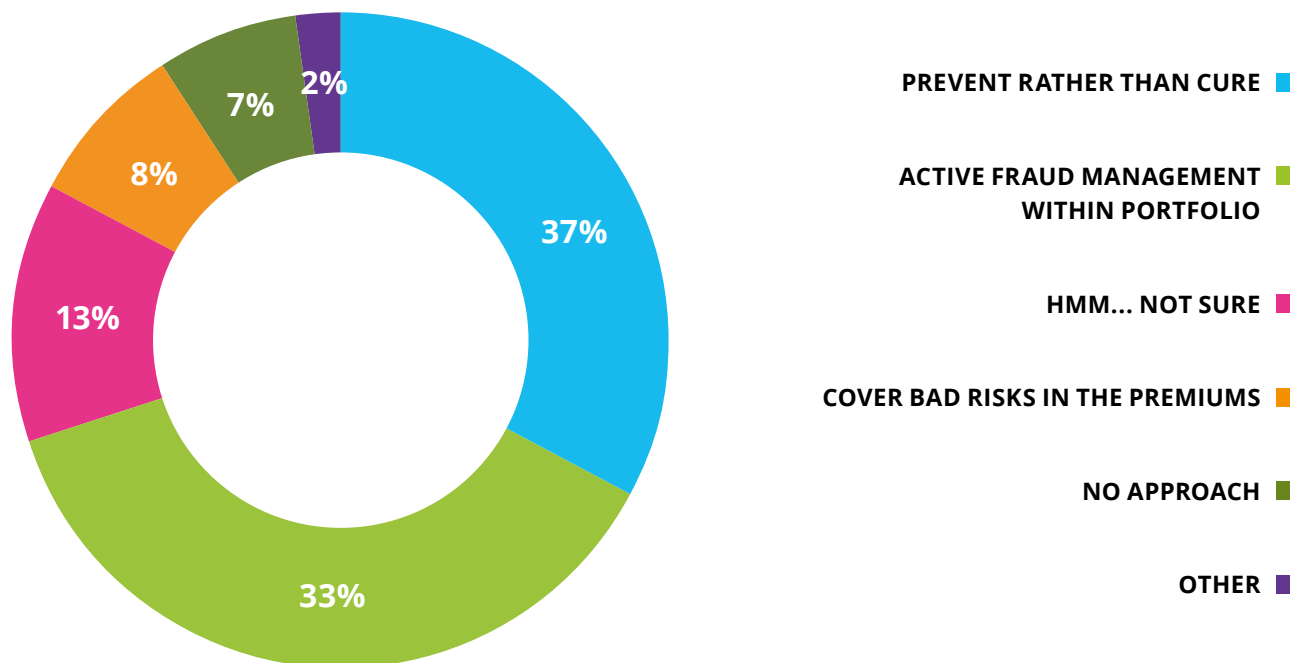
**“1/3 OF INSURERS RECEIVE TOO MANY FALSE POSITIVES BECAUSE OF LIMITED INTERNAL IT RESOURCES”**

Over half of our respondents reported challenges with software maintenance, typically because of limited IT resources. Data is the runner up at 43%. Nearly a third of insurers say they receive too many false positives from their automated solution. Insurers prefer actionable insights, otherwise known as “white box” AI. 16% of carriers feel they lack these insights in their fraud scores.

### WHAT CHALLENGES DO YOU SEE IN DEPLOYING FRAUD DETECTION SOFTWARE?



## HOW DOES YOUR ORGANIZATION APPROACH FRAUD?



**"INSURERS PREFER A WHITE BOX APPROACH TO GAIN BETTER INSIGHTS INTO THEIR FRAUD SCORES."**



## TO CONCLUDE

Compared to the results of the 2016 survey, much progress has been made in insurance fraud and risk detection over the past two years. Fortunately, insurance companies still believe reducing fraud is both socially and economically important. When it comes to fighting fraud company wide, carriers still struggle with organizational buy-in. Consistently updated systems working with quality data allow carriers to make good decisions quickly.

Fighting fraud is not only a claims department topic, it must flow through a carrier's DNA. International anti-fraud plans and regulations certainly help in paving the path for honest insurance, across carriers and borders. This will be important since fraudsters don't stop their efforts at just one insurance company. While industry awareness is growing, there are still many opportunities for improvement.





A large group of approximately 40 people, mostly men, are posing for a group photo on a grassy lawn in front of a modern, multi-story office building with large glass windows. Many of the people are waving their hands towards the camera. They are dressed in a mix of business casual and casual attire. The building behind them has a distinctive architectural style with cantilevered upper floors. The sky is clear and blue.

# ABOUT FRISS

FRISS is 100% focused on automated fraud and risk detection for P&C insurance companies worldwide. Their AI-powered detection solutions for underwriting, claims and SIU have helped 150+ insurers grow their business. FRISS detects fraud, mitigates risks and supports digital transformation. Insurers go live within 6 months, with fixed-price projects, and realize an ROI within 12 months. FRISS solutions help lower the loss ratio, enable profitable portfolio growth, and improve customer experience.

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**FRAUD**TALKS.com

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A global network for insurance professionals, leaders and decisionmakers to stay ahead of the fraud game and stimulate an honest insurance industry.

**FRAUDtalks Conference**

As an addition to the online community, we encourage insurance professionals, leaders and decisionmakers to connect in real life at our yearly FRAUDtalks conference. 6 acclaimed speakers will each dazzle the audience with an inspiring 18 minutes talk. FRAUDtalks brings a powerful program and an unconstrained vibe where insurance professionals can get connected and share ideas worth spreading.

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In this release: Blockchain, Insuretech, Internet of things, AI, Digital insurance, Machine learning, Online channels, and MUCH MORE!

CHALLENGES



DATA



ANSWERS

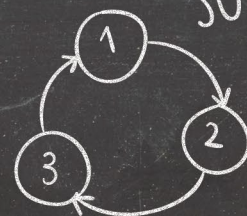
LATEST TECHNOLOGY



FOCUS



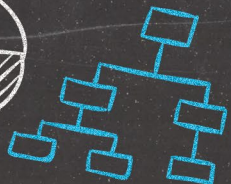
CREATIVE SOLUTIONS



FRAUD POOLS



SHARING DATA



ANALYTICS

IDEAS



HOW TO FIGHT FRAUD



FRAUD FIGHTING CULTURE



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