CLM LEADING OUT LOUD INSURANCE FRAUD

WHAT TRENDS IN FRAUD HAVE TAKEN ROOT SINCE THE PANDEMIC BEGAN? WHAT ANTI-FRAUD TECHNOLOGIES HAVE BECOME "MUST HAVES"? AND FINALLY, WE HEAR A FEW OF OUR EXPERTS' FAVORITE FRAUD STORIES.

FROM YOUR INDIVIDUAL PERSPECTIVE, WHAT TRENDS ARE YOU SEEING IN INSURANCE FRAUD SINCE THE PANDEMIC BEGAN. WHAT CHALLENGES ARE THEY PRESENTING FOR INSURERS?

GEORGE PEREZ, CUSTARD INSURANCE ADJUSTERS: There are several trends I have noted since the pandemic began. The first is homeowner insurance claims, which have increased considerably. With more people spending time at home, and in some cases not employed, they are finding creative ways to add income to their households. I have recently noted that some insureds are filing questionable claims, collecting the claim payment, and not repairing the damages. Then they change insurers and submit a claim for the unrepaired damages once again, with a different date of loss. The second trend I have noted relates to workers' compensation claims generated by employees working at home. Determining the distinction between an actual claim and whether the employee was working when the alleged injury occurred continues to be a challenge for insurers.

JASON P. WALKER, ROLFES HENRY CO., LPA: While not fraud itself, the (rapid and significant) increase in the use of video conferencing to conduct examinations under oath (EUOs) is creating challenges that can make it more difficult to detect and prevent fraud. By way of example, it is not uncommon to conduct an EUO of an insured who is not represented by an attorney. In those instances, the claimant often provides sworn testimony from the claimant's home using whatever device and internet connection is available to that claimant. This prevents the party conducting the EUO from confirming, among other things, that nobody else is in the room and that the claimant is not communicating with others during the EUO. It can also create obstacles to creating a clear record vis-à-vis poor sound quality and difficulty reviewing exhibits.

JIM HULETT, VERISK: The makeup and context of claims, in general, changed notably around the second week of March 2020—the time at which many states began restricting public activity. Some new trends we observed during the pandemic include:

- An increase in questionable medical billing for telephonic health care, including chiropractic and massage therapies delivered over the phone.
- An increase in partial vehicle theft reports, including vehicle parts like catalytic converters.
- Increase in patterns of new loss activity, such as water damage and theft, following denied business interruption claims. This pattern suggests that business owners may have been staging losses to obtain coverage for loss of income during pandemic restrictions.

WHAT TECHNOLOGIES OR INNOVATIONS ARE BECOMING "MUST HAVES" WHEN IT COMES TO EITHER PREVENTING OR UNCOVERING FRAUDULENT CLAIMS?

JASON P. WALKER, ROLFES HENRY CO., LPA: The universe of information available through cell phone imaging, and the inability to obtain much of that information from any other source, puts cell phone imaging at or near the top of the list of most valuable investigative tools. Additionally, the programs used to organize, analyze, and search the data allow investigators to sift through tremendous amounts of data effectively and efficiently.

JIM HULETT, VERISK: The most important technology is instant, accurate claim scoring to help identify questionable losses. Increasingly, there is also a need for sophisticated analytics that incorporate predictive models and machine learning for proactive fraud detection. Industrywide data analysis is a critical aspect of that technology because it can provide a holistic view of involved parties for more accurate analysis.

Automated SIU referrals on objective criteria and claim attributes are another "must-have," especially considering the industry's momentum toward straight-through processing and low-touch claims handling, as well as the attrition of experienced adjusters and claims professionals.

GEORGE PEREZ, CUSTARD INSURANCE ADJUSTERS: The ability to conduct in-depth background investigations, which include social media, hospital/clinic canvasses, and criminal background checks are essential in the investigation and prevention of fraudulent claims.

Having a very strong database and/or software program to conduct these investigations has become a "must have" in the industry. I have noted that several insurance carriers are creating investigative divisions to keep the costs in house, as they need to have this information available to an adjuster or investigator to assist in the review of questionable claims.

WITH THE RATE OF DIGITAL ADOPTION AND AUTOMATION INCREASING, ARE NEW RISKS EMERGING? HOW CAN INSURERS ADDRESS THEM?

JIM HULETT, VERISK: One of the greatest risks is adopting emerging technology without properly understanding the exposures and challenges it can create. For example, data science algorithms in anti-fraud technology, even with the most advanced artificial intelligence, are insufficient on their own. These "black box" technologies create legal and regulatory risks and may lead to bias or ill-informed decisions. That's why we recommend a hybrid program that mixes highly reliable, fact-based business rules into all aspects of predictive modeling.

GEORGE PEREZ, CUSTARD INSURANCE ADJUSTERS: As a result of the pandemic and the stay-at-home mandates, the need for carriers to conduct investigations remotely became a realization. With virtual inspections, insureds may be asked to provide photographic evidence of the alleged loss. A fraudster can then provide photos of previous losses, which may have been claimed through another carrier, or even taken from the internet. Insurers need to have, and be prepared to utilize, advanced anti-fraud technology to combat this.

JASON P. WALKER, ROLFES HENRY CO., LPA: It seems to me that there has been an increase in phishing using email for purposes of obtaining money by fraud. For example, a fraudster hacks the e-mail account of a company's employee responsible for wire transfers. The fraudster identifies the forthcoming transaction and creates an email account with an email address nearly identical to the account of the bona fide sender/receiver. The fraudster, seeing an e-mail from a company employee requesting wire transfer instructions from the bona fide recipient, then sends the employee instructions for a wire transfer into the fraudster's account.

EVERY FRAUD INVESTIGATOR HAS A GOOD FRAUD STORY. GIVE US YOUR BEST ONE.

GEORGE PEREZ, CUSTARD INSURANCE ADJUSTERS: In our office, we call this story "The Banana Man," since this was an attempt to create a slip-and-fall claim with injuries against a major supermarket chain. Unknown to the perpetrator, the store had high-quality cameras around the area where he "created" the alleged fall using a banana he brought with him. We watched him very carefully lay on the floor next to the banana he dropped, where he then began screaming for help. It became very clear through the video review that he had fabricated the fall, and thus his injuries. His demand of $250,000 was met with a prosecution by the state department of insurance, where he later pled out. A great day for all involved!

JASON P. WALKER, ROLFES HENRY CO., LPA: Our firm was retained to assist with the investigation of a fire loss that destroyed an insured family's property while they were living in temporary housing after a cooking fire rendered the home uninhabitable. The insured's son went to a bar the night of the second fire where he drank to the point he was unable to drive. A good Samaritan at the bar offered to drive him home and used his operator's license to determine where he lived. As she drove away, she realized her favorite cigarette lighter was missing. The next morning, she saw a story on the news depicting the badly fire-damaged house where she had dropped the son the night before. She thought about her missing lighter and called police. ■

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