EIS™®

Maximize Savings and Minimize Risks. Revolutionize Claim Management with AI & Machine Learning-Enabled Fraud Detection from EIS.

In this use case, you'll see how EIS helps you:

▶ Improve fraud detection and accuracy and catch fraudsters faster while decreasing claims leakage and enhancing your loss ratio.

▶ Increase fraud case referral accuracy and make the investigation process more efficient, minimizing employee workload, and improving employee experience.

▶ Use advanced technology to enhance collaboration and consistency while gaining straight-through processing capabilities, without the need to hire additional talent.

▶ Improve brand image by demonstrating a commitment to protecting policyholders, enhancing insurer reputation, and increasing customer satisfaction.

"Insurance fraud is not a victimless crime. Its impact extends beyond insurance companies to policyholders who pay higher premiums, businesses that absorb increased costs, and communities that are less safe and secure due to fraudulent claims."

– Michael McRaith, former director of the U.S. Department of Treasury's Federal Insurance Office.

The Staggering Financial Losses of Insurance Fraud:

Insurance fraud results in massive financial losses for the insurance industry every year. The Federal Bureau of Investigations estimates non-health insurance fraud costs American consumers over $40 billion annually, with the average US family paying between $400 and $700 per year in increased premiums.

£12,283 /claim

In the UK, the Association of British Insurers reported that the average cost to detect a fraudulent claim was £12,238 in 2021.

Technology Challenges for Insurers

Insurers face several technological obstacles in combating fraud, including early detection, managing a large volume of claims, and needing to integrate with multiple systems.

Data quality and integration

Due to the vast amount of data insurers generate and use, ensuring data quality and proper data integration is difficult. Inaccurate, incomplete, or outdated data can impede fraud detection algorithms and lead to false positives/negatives, and contribute to claims leakage.

Legacy systems

Many insurers still rely on outdated legacy core systems that aren't designed to handle modern fraud detection. Limited integrations hinder their ability to detect and prevent fraud, reduce claims leakage, and adopt advanced data analytics, artificial intelligence (AI), and machine learning (ML).

Scalability

As the volume of claims data continues to grow, insurers need fraud detection and claims leakage management systems that can scale effectively.

Real-time analysis

Fraudsters are constantly evolving their tactics. Implementing real-time and continuous analysis with AI and ML helps insurers detect and respond to emerging fraud patterns and claims leakage issues as they occur. However, implementing real-time analysis can be challenging due to computing demands for real-time processing.

Privacy, security, and compliance

Insurers must balance protecting sensitive data with detecting fraud, requiring investments in security technologies, compliance with data privacy laws, and up-to-date security protocols to handle emerging threats.

Use Case Scenario

Insurers are adopting advanced AI technology to address challenges in fraud detection, enhancing their ability to identify fraudulent activities and improving their financial outcomes. This use case examines how the integration of sophisticated AI tools helps insurers bolster their fraud detection capabilities.

John is a policyholder with Best Insurance Co., who files a fraudulent claim for an auto accident. His claim goes through the initial digital First Notice of Loss (FNOL) process, setting off an automated fraud detection mechanism. Following this initial screening, the claim is sent to the Special Investigations Unit (SIU) for a more in-depth review.
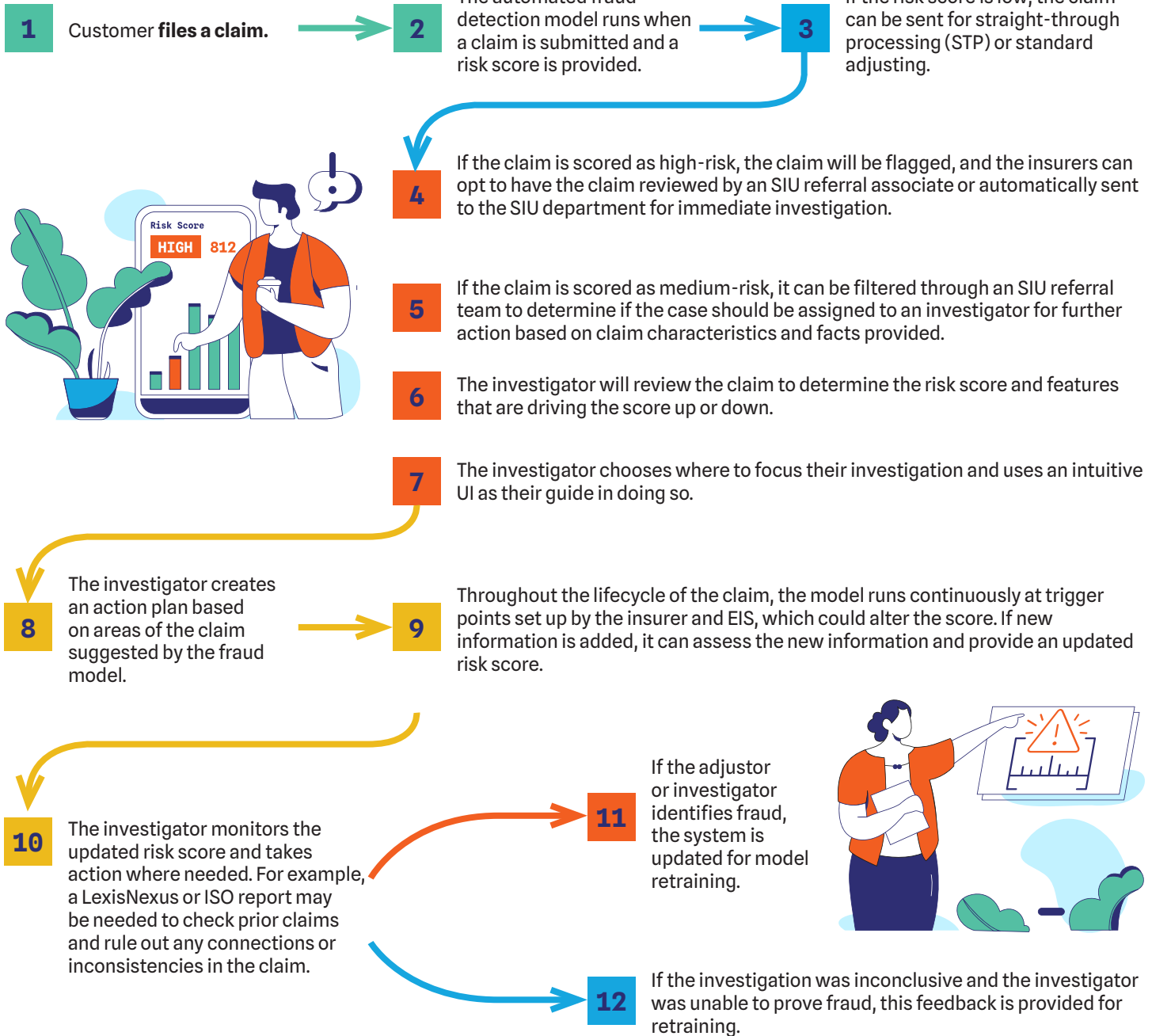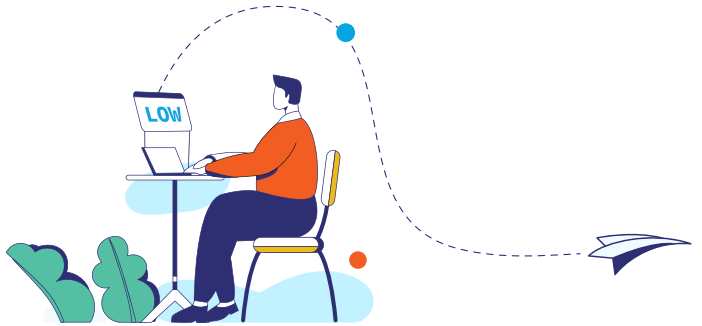
To investigate John's claim, an AI and ML-driven solution assigns a Special Investigations Unit (SIU) investigator to examine the aspects of the claim that elevated the risk score. The investigator uses a user-friendly and intuitive interface, enabling them to concentrate on the most suspicious parts of the claim, such as overstated or fabricated damages.

Throughout the investigation, the second part of the fraud model continuously assesses new information in real-time that may affect the risk score. The investigator keeps an eye on the score and takes appropriate action, like running a LexisNexus or an ISO report to check for prior claims that may indicate fraud.

If the investigator identifies fraud, they can provide feedback on the claim, which is then used by the model for retraining to better assess future claims. If the investigation is inconclusive, this feedback is also provided for retraining purposes.

Best Insurance Co. can now effectively detect and prevent fraud while minimizing the risk of incurring fraud-related losses, thanks to this approach.

Fraud Detection Steps

1 Customer **files a claim.**

2 The automated fraud detection model runs when a claim is submitted and a risk score is provided.

3 If the risk score is low, the claim can be sent for straight-through processing (STP) or standard adjusting.

4 If the claim is scored as high-risk, the claim will be flagged, and the insurers can opt to have the claim reviewed by an SIU referral associate or automatically sent to the SIU department for immediate investigation.

5 If the claim is scored as medium-risk, it can be filtered through an SIU referral team to determine if the case should be assigned to an investigator for further action based on claim characteristics and facts provided.

6 The investigator will review the claim to determine the risk score and features that are driving the score up or down.

7 The investigator chooses where to focus their investigation and uses an intuitive UI as their guide in doing so.

8 The investigator creates an action plan based on areas of the claim suggested by the fraud model.

9 Throughout the lifecycle of the claim, the model runs continuously at trigger points set up by the insurer and EIS, which could alter the score. If new information is added, it can assess the new information and provide an updated risk score.

10 The investigator monitors the updated risk score and takes action where needed. For example, a LexisNexus or ISO report may be needed to check prior claims and rule out any connections or inconsistencies in the claim.

11 If the adjustor or investigator identifies fraud, the system is updated for model retraining.

12 If the investigation was inconclusive and the investigator was unable to prove fraud, this feedback is provided for retraining.

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Key Features List

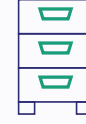|					
Light-Weight, AI Native	Proprietary ML Decision Engine	Seamless Integration Capabilities	Continuous Fraud Assessment	Over 140 Pre-Packaged Features	Reporting and Analytics
Predictive Modeling	Anomaly Detection	Behavioral Analysis	Social Network Analysis	Text Mining	Third Party Data Integration and Data Workflow

ClaimSmart: The EIS Solution for Advanced Fraud Management

ClaimSmart

ClaimSmart™ is our innovative, AI and ML-powered claims solution designed to enhance insurance claims processes for everyone involved. Key features include:

ClaimPulse

ClaimPulse™ integrates seamlessly with your existing claims systems — whether they're a part of EIS Suite or not — to streamline claim reporting, processing, and payment.

Digital First Notice of Loss

As the initial point of contact for a customer or broker reporting a claim, this feature transforms the claim reporting experience across all business lines, and in any language. The interface guides the user through sharing relevant and needed claims information, including reflexive questioning based on answers and policy coverage. This loss data is mapped to your core claims system to make the entire downstream processes easier and quicker.

This feature can also enable straight-through processing (STP) during FNOL for a "quick start" claims process in reporting a claim, and for things like reserving a rental vehicle, and selecting a repair shop in one experience without delay

Automated Claims Processing Layer

This advanced automation layer manages the entire claims journey from the initial loss report to resolution. It includes a sophisticated workflow engine with foundational workflows tailored for various needs, like auto repairs, car rentals, and property repairs. These workflows significantly reduce manual intervention, enhancing operational efficiency and accuracy.

EIS Digital Portal

With an easy-to-access portal, policyholders can track their claim status in real time and take any needed actions. This facilitates a transparent, efficient, and mostly automated communication channel between the insured and the insurer, boosting customer satisfaction and loyalty. With no more need for the traditional, time-consuming phone and email tag between an insured and claims adjuster, customers are far less likely to churn at renewal.

ClaimGuard

With a sophisticated, proprietary machine learning model that drives fraud detection and risk scoring, ClaimGuard™ analyzes all claims for potential fraud. The ML model uses hundreds of evolving scenarios to score every claim and detect fraud patterns. This provides faster processing of legitimate claims, enhances transactional trust, and ensures only the necessary claims take up the valuable time of your claims investigators.

Continuous fraud assessment

Continuously monitor a claim's lifecycle and transaction points with updated fraud scoring and risk insights at each step. Our solution seamlessly integrates with your existing policy or claim management systems and leverages your internal or external partner data to enhance fraud detection.

Advanced reporting dashboards

Our fraud detection solution provides real-time risk scores and intuitive dashboards in a user-friendly UI for claim adjusters, managers, and SIUs to navigate and manage claim investigations. Users can easily see where the underlying risk of each claim is, and know where the recommended areas of focus should be in the investigation. Plus, with the ability to embed actionable guidance from management, insurers can make sure investigative and compliance standards are met.

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Real World Results

Insurers are using EIS to combat the costly problem of insurance fraud. Here are a few real-world results insurers have seen.

Detection Rate

87%

of all fraud cases scored as **HIGH** were closed as fraudulent

False Negative Rate

Claims scored as **LOW** were correct in all but

.03%

of cases

Time to Detect Fraud

Claims can be identified and scored

within minutes

of FNOL

Return on Investment

With our ML model, straight-through processing, and a special investigations unit, insurers see an ROI of over

200%

Insurers face a significant challenge in detecting and preventing fraud. With ClaimSmart, EIS offers a powerful solution leveraging years of proven fraud algorithms. By deploying AI and ML in ClaimSmart, insurers can quickly identify fraudulent claims and take the necessary actions to prevent financial losses. By investing in fraud detection technology from EIS, insurers can safeguard their financial stability, reputation, and stay ahead of the market.

Sound interesting? We should chat.

Learn more about how ClaimSmart is helping ambitious insurers reduce fraud

BOOK A CALL

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