



Business Impact

“The total cost of insurance fraud (non-health insurance) is estimated to be more than \$40 billion per year. That means insurance fraud costs the average US family between \$400 and \$700 per year in the form of increased premiums.”

– Federal Bureau of Investigation
www.fbi.gov/publications/fraud/insurance_fraud.htm

Challenges

- **Changing tactics.** Fraudsters actively test rules and thresholds to find ways to operate around them or under them, and they constantly change elements of their identities, which makes it difficult to match a new claim to a previously known fraudster.
- **Growth of organized crime rings.** Organized crime syndicates are drawn to the low-risk, high-return nature of insurance fraud.
- **Poor data quality.** Disparate systems and the inability to view claims or integrate data from suppliers and third parties means data is often incomplete and unreliable.
- **Siloed business units.** Different departments often use disparate legacy solutions that are not integrated, making it almost impossible to spot suspicious activity across product lines.
- **Limited resources.** There aren't enough expert adjusters and investigators to detect and examine all suspicious activity.

How can we detect and prevent fraud *before* claims are paid?

YOUR GOAL: Decrease fraud losses, reduce false positives and increase investigator efficiency

Fueled by technology advancements that have made crimes such as identity theft and claims manipulation both easy to commit and hard to detect, fraudulent activity continues to grow and attract a variety of criminal types. As a relatively low-risk, high-return activity, claims fraud holds particular appeal for organized crime syndicates, who account for a growing proportion of insurance fraud.

Most insurers have implemented sophisticated computer systems to identify fraud as soon as possible after it occurs, and they factor these losses into their rates as a cost of doing business. Recovery of losses after the fact is slow, if it happens at all.

What about preventing fraud before it happens? It is estimated that 10 percent of all claims are fraudulent, and that less than 20 percent of those fraudulent claims are detected or denied. Clearly, there's room for improvement – improvement that could mean millions to hundreds of millions of dollars in savings.

OUR APPROACH

For many insurers, fraud investigations are handled in a reactive manner, and the only proactive initiative is dependent on the experience or intuition of the person processing the claim. Trends and patterns aren't obvious, and dormant exposures aren't visible. Proactively uncovering fraudulent claims requires extensive data gathering and analysis, but such information is often difficult and time-consuming to obtain. SAS approaches the problem by delivering software and services to help you:

- **Enhance information credibility** by integrating disparate data sources – including third-party sources – regardless of format and applying embedded data quality techniques to ensure accuracy.
- **Find fraud *before* claims are paid** using a hybrid of business rules, predictive analytics and social network analysis techniques to uncover hidden relationships, detect subtle patterns of behavior, prioritize suspicious cases and predict future risks.
- **Reduce false positives** with an advanced scoring engine that uses independent and combined scores, including scoring of associated networks.
- **Improve investigator efficiency** with advanced case management tools and an intuitive interface that lets them produce complete dossiers of networks surrounding a case, visualize data from multiple angles, perform interactive queries and generate meaningful reports.
- **Measure program performance** by defining and monitoring key performance metrics via a dashboard environment to determine how effective and efficient your programs are at deterring fraud and improper payments.

SAS delivers a complete solution for claims fraud management, enabling you to detect and prevent both opportunistic and professional fraud across multiple lines of business.



THE SAS® DIFFERENCE: Better, faster fraud detection, fewer false positives

Recognized as the industry leader in analytics and with more than 30 years of experience in insurance, SAS delivers a proven foundation along with best practices that tie together all the essential areas of claims fraud detection and prevention. The industry-leading SAS Fraud Framework gives you the ability to develop a cohesive strategy for managing claims fraud with comprehensive:

- **Detection and alert generation** that enable real-time detection of suspicious activity using a combination of analytic techniques to determine the likelihood of claims fraud.
- **Alert management capabilities** that let you assemble alerts from multiple monitoring systems to enable investigators to prioritize and triage suspicious claims.
- **Social network analysis** for going beyond individual views to analyze all related activities and relationships at a network dimension.
- **Case management capabilities** that provide a systematic means for capturing and displaying all information relevant to an investigation.

No other solution available provides the same level of detection, automation and power that you get with SAS.

CASE STUDY: AXA OYAK

■ Situation

The result of a partnership that combined the insurance activities and resources – as well as the interests – of AXA and OYAK in Turkey under one roof, AXA OYAK has sought innovative strategies and technologies to improve the company's product profitability. Key to doing that is reducing losses due to fraud. But to justify the venture, the company had to ensure that whatever solution they adopted to predict and prevent fraud would cost less than the actual losses suffered due to fraud.

■ Solution

SAS delivered a solution that included:

- Data integration capabilities to recognize and combine duplicate data records like customers and claims to provide more accurate analysis.
- Advanced analytics that provide the ability to segment data to uncover certain relationships are red flags for fraud-related losses.

■ Result

- Paid claims have been reduced by up to 7 percent.
- An increase of 30 percent to 45 percent in the technical profitability of auto insurance accounts.

■ The Vision

Data integrity

What if your data was cleaned as part of your data integration process so you could be confident in its integrity throughout your organization?

Fraud prevention

What if you could predict the likelihood that a claim would be fraudulent and flag suspicious activity for further investigation so you could not only uncover fraud, but stop fraudulent payments before they occurred?

Alert prioritization

What if you could prioritize and assign resources to potentially fraudulent claims based on workload and skill set?

Network visualization

What if you could visualize and identify linkages among seemingly unrelated claims?

Investigation optimization

What if your investigators could produce complete dossiers of networks surrounding a case using an intuitive interface that also enabled sharing of knowledge and best practices?

SAS FACTS

- More than 1,000 insurance companies worldwide are SAS customers.
- SAS has more than three decades of experience working with insurance companies all over the world.
- SAS customers make up 92 of the top 100 companies on the 2009 FORTUNE Global 500® list.

Learn more about SAS software and services for insurance at:
www.sas.com/industry/ins



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