Companies in many industries are extolling the benefits of data analytics to generate new business opportunities and better serve customers. For insurers, there’s an additional benefit: early detection of fraudulent activity.

Insurance fraud affects not only every insurance company, "but virtually every consumer and taxpayer worldwide, and it shows no sign of easing," according to a 2013 report by research and advisory firm Aite Group. The firm estimates that claims fraud in the U.S. property/casualty industry alone cost carriers $64 billion in 2012 and will reach $80 billion by 2015.

Claims fraud detection is an area where insurance companies will "drastically" increase investments in the next three to five years, says Nicolas Michellod, senior analyst with the insurance group at research and advisory firm Celent, and author of the firm’s 2013 report "The Market Dynamics of Claims Fraud Detection."

"Growing numbers of insurers are adopting high-performance analytics such as predictive analysis," says James Quiggle, director of communications at the Coalition Against Insurance Fraud, a Washington-based anti-fraud alliance.

"Higher-power programs compact the time-space continuum for claims," Quiggle says. "Insurers can spot claims far earlier in the cycle, in close to real time. Investigations can begin faster, thus reducing payouts for bogus claims."

Nationwide Mutual Insurance Co. in Columbus, Ohio, "believes in the intelligent combination of data and analytics to detect and deter fraud from the point of sale to claim," says Rick Wahls, claims director, special investigations unit (SIU) at Nationwide.

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