PROPERTY CASUALTY360°

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Walking a fine line with soft fraud detection

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The FICO Insurance Fraud Survey makes for disturbing reading for those looking to combat insurance fraud.

While estimates of losses because of fraud ranged from 10% to 20%, the majority of respondents predicted a rise in fraud across most categories of personal lines insurance.

Hidden within these figures, but almost impossible to accurately evaluate, is the thorny problem of soft fraud. Lost among the headlines is the plain fact that soft fraud is often committed by normally honest policyholders. Good policyholders can inflate values advertently or inadvertently. A sense of entitlement may prevail, leading to opportunistic fraud.

Perpetrators are not easy to distinguish from honest policyholders. They pay their premiums on time, have good jobs and are unlikely to have criminal records. Unlike hard fraud, a small but worrying proportion of the public does not consider soft fraud a criminal activity. As many as 68% of respondents in a recent Insurance Consumer Fraud Survey of 2010 felt that insurance fraud occurred because people believed they would not get caught.

While it is in the interests of both insurers and honest policyholders to crack down on soft fraud, it is important that this sensitive issue is managed tactfully. It's prohibitively expensive for insurers to fully investigate every single claim, especially when the value is low. Moreover, efforts to detect and prevent soft fraud, which slow down claims processing, may have the unintended consequence of frustrating honest claimants, which in turn can be detrimental to retention levels. Thankfully, fraud detection systems are becoming increasingly sophisticated and insurers can now apply a range of measures to find a solution.

Detecting soft fraud

In its report, the "State of Insurance Fraud Technology," Cary, N.C.-based analytics software developer SAS reported that 81% of respondents used automated systems employing business rules to detect fraud. Perhaps claims with a value above a certain threshold are flagged, or claims that are not supported by a police report. Rules-based systems have the benefit of being simple to apply. However, they generate a large number of false positives and may not be well suited to dealing with soft fraud. Profiling policyholders according to criteria such as credit rating or other personal risk factors alone is not going to alert an adjuster to claims padding.

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Adopting predictive analytics

Predictive analytics solutions were employed by 43% of SAS respondents. With a wealth of information available to insurers about past claims, it becomes possible to develop a model of future claims.

The Coalition Against Insurance Fraud has noted that around half of insurers cite a lack of IT resources as the main stumbling block in implementing anti-fraud technology. As a new generation of anti-fraud solutions are brought to the forefront, more and more insurers will see a positive return on investment as they adopt powerful analytical tools to combat soft fraud. The potential gains are substantial. Increasing the detection of soft fraud will not only reduce costs, it may even act as a deterrent for what is, after all, an opportunistic crime.

Gloria Lee

Bankrupt and needing cash, the Las Vegas pet-shop owner tried to burn alive 27 terrified puppies locked in their cages. Incredibly, her own security cameras recorded the nighttime action.

She teamed up with her lover, Kirk Bills, who she let into the store via the back door according to the security footage. He spread gasoline from red cans around the store — and coated the locked cages full of cringing puppies. She tried to frame her husband for the deed and file a $100,000 insurance claim.

Luckily the fire fizzled. Lee received up to 14 years in prison and Bills up to a decade.

Martin Pang

His business in Seattle was struggling, so Pang started a warehouse insurance blaze that killed four fire fighters. Walter Kilgore, James Brown, Gregory Shoemaker and Randy Terlicker died when the floor collapsed and they were thrown into the burning basement. Seven other fire fighters just managed to escape a similar fate.

Pang then took thievery to new heights. From inside the penitentiary he supposedly tried to steal the identities of the investigators in his case, although he was not criminally charged. A court ruled in April that he must repay nearly $1 million to the families of the fire fighters. Pang had earlier received 35 years in prison.

Jose Urena

An NYPD cop who took an oath to defend the law, instead routinely broke it in serial fashion. Driving a Mercedes-Benzes drained Urena's bank accounts, so he launched a spree of false auto claims. Among them:

Urena lied that someone had vandalized his leased ML350. He used the insurance money to repair pre-existing damage. Urena then reported the car stolen the day before his lease expired. He had a cohort burn it, and cashed another insurance check for phantom repairs.

His next Mercedes proved too expensive so he rear-ended a U-Haul, trying to convince his insurer to declare the car a total loss. A Dodge Charger came after that. Urena was involved in a crash and made an inflated claim for pre-existing damage. He could spend up to three years in prison when sentenced.

Stephen Krawitz

Dozens of mostly elderly and low-income clients urgently needed insurance settlements that Krawitz had negotiated for them, but the Manhattan personal-injury lawyer stole their money — more than $1.9 million worth. One victim was a 96-year-old great-grandmother who hurt her shoulder in a car crash.

Krawitz also stole $65,000 from Robert Rough, who was dying of cancer. A car crash left him with severe nerve damage in his hands, costing him his business. Rough died without receiving any money.

Meanwhile, Krawitz lived in a $2-million home and sent his kids to private school. Krawitz will be schooled in a jail cell since he received up to 12 years in state prison.

Dr. Aria Sabit

Patients received useless and painful spinal surgeries so a neurosurgeon could steal $11 million from insurers. The Detroit doctor convinced many patients to get spinal fusion surgeries they didn't need. Sabit did surgeries on nearly everyone who walked into his clinic.

The pain continued long after a bungled surgery for some patients. He also sliced open and closed some patients without doing any repair work at all. Tonocca Scott must wear a back brace with a DVD case taped inside to keep his spine straight. He can sit for only a few minutes and has placed his dream of a computer-technology career on hold.

A repeat offender, Sabit pulled a similar scam in California, where he implanted unneeded devices and performed unnecessary surgery. Sabit could spend up to 11 years in federal prison when sentenced.

Jose Lantigua

Vacationing in his native Venezuela proved fatal, at least according to Jose Lantigua's death certificate. He supposedly died from an illness and was cremated there, except the Jacksonville, Florida, resident bribed bureaucrats to issue forged death documents in a fumbled plot to fake his death for approximately $9 million in life insurance.

He sought a passport using a North Carolina driver license in the name of a postal worker whose identity he had stolen. Lantigua's height, eyes, hair color and other identifiers were significantly different from Ernest Wills, Lantigua's victim. The fraudster will spend up to 12 years in prison when sentenced.

Theresa Fisher & Lindsay Hardgraves

Fisher and Hardgraves ran a surgery center in Orange County, California. Insurers were billed $71 million, much of it for uninsured plastic surgery charged as legitimate medical treatment. Over $50 million was paid to the women before the fraudulent scheme was discovered.

They bribed patients with tummy tucks, breast enlargements and liposuction. The tradeoff: The patients underwent insured surgeries they didn't need — endoscopies, colonoscopies and others.

Tummy tucks were billed as hernia operations. Nose jobs were deviated septums. Patients were also coached on how to fake symptoms and foil insurers. Fisher received three years in federal prison and Hardgraves five months.

William Worthy

More than 17,000 trusting consumers thought they'd bought legitimate health insurance only to find out it was fake. The South Carolina-based Worthy erected a large network of fake health insurers geared solely to steal premiums. It was one of the laThe ring stole up to $28 million in premiums, even fleecing church pastors with a bogus insurance plan. Consumers were often left with huge medical bills they had to pay themselves — more than $7 million total.

Worthy's unlicensed insurers routinely denied legitimate claims. He used the customer premiums to support a princely lifestyle and will possibly spend decades in federal prison when sentenced.rgest such scams in U.S. history.

Pierre Collins

The Minneapolis-area man beat his 10-year-old son, Barway, to death and then duct-taped his body and tossed him into the Mississippi River like cordwood for just $50,000 in life-insurance money.

Collins had paid the premiums just two days before Barway disappeared and he had also asked the insurer about raising the coverage on Barway from $30,000 to $50,000. For Collins, that was the market price of a child's life.

He owed child support for multiple children and was unemployed. Cell-phone pings placed him near the spot where Barway's body was found. After denying that he had nothing to do with his son's disappearance, he confessed earlier this year. Collins received 40 years in prison.

These convicted Hall of Shamers are helping to brand insurance fraud as a crime that society should oppose with greater resolve. And they are publicly positioning fraud fighters as effective crime busters intent on shining a light on a crime that impacts everyone.