RGA 2024

Global Claims Fraud Survey

Fraud continues to be one of the most urgent challenges facing claims teams. In an ever-evolving landscape that includes a shortage of skilled claims professionals, the widespread use of new technologies, and increased product complexity, fraudsters are finding a variety of new opportunities to exploit. As a result, RGA's 2024 Global Claims Survey identified important developments in the fraud landscape compared to our previous review, conducted in 2017 and featuring data from 2016.

There is no consistent legal definition of fraud that can be applied globally. For the purposes of this survey, we defined fraud as follows:

- Organized fraud — involves criminal gangs that deliberately attempt to profit from insurance fraud to finance other criminal activity and/or launder the proceeds of their crimes.
- Deliberate fraud — occurs when a policy is taken out with the express intent of making a future claim for profit. It typically involves circumventing underwriting by a combination of misrepresentation and multiple applications. This approach avoids detailed medical and financial underwriting and allows an applicant to obtain significant cover (beyond what would be reasonable) without providing the necessary independent proof of income or health status. Claims are submitted with the expectation of profiting from the transaction. In countries with contestable periods, this form of fraud presents a significant challenge.
- Opportunistic fraud — occurs at the underwriting or claims stage. At the underwriting stage, applicants may misrepresent their health status to reduce their premiums; typically around morbidity claims, they might exaggerate their level of disability to obtain benefits.

RGA conducted the survey online in March and April 2024. Claims professionals from around the world responded based on fraud data from calendar year 2023. The survey's 83 respondents tripled the number of respondents from RGA's 2017 fraud survey, which was based on data from 2016.

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Executive summary

Despite ongoing efforts to detect and prevent it, fraud remains one of the most significant risks for life and health insurers. While artificial intelligence (AI) has opened new opportunities for fraudsters, it also gives insurers new tools with which to identify and combat fraud.

What does RGA's survey tell us about fraud globally, and how has it evolved since our last survey in 2017? When comparing current results with 2017, it should be noted that a significant increase in the number of respondents and geographic distribution affects the trending data.

Key findings from the 2024 survey:

- Fraud is the top concern among respondents for claims processing across all regions.
- 74% of respondents reported fraud cases globally are "the same" or "increasing" compared to prior years.
- Consumer (72%) and agent-assisted (42%) frauds were top concerns for insurers.
- Individuals or teams assigned to investigate fraud were reported by 78% of respondents, an increase of 15% from 2017 survey findings.
- Average processing time for suspected fraudulent claims takes three times longer than average claims processing time.
- Top fraud indicators used by insurers were:
    - Early claims
    - Industry-assisted fraud (agents, doctors, hospitals, others)
    - Unreasonable, inconsistent, or suspicious explanations
    - Industry or company databases/checks
- Fraud detection approaches differed by region and other factors, such as product type, claim amount, location, and contestability periods.
- Top challenges with regard to investigating fraud globally included difficulty obtaining evidence; resistance from claimants, doctors, and other relevant parties in cooperating with investigators; and personal data protection laws.
- 48% of companies reported AI-related fraud conducted to produce falsified medical or death records; they expressed less concern about deepfake photography, AI-assisted diagnosis, and voice cloning.

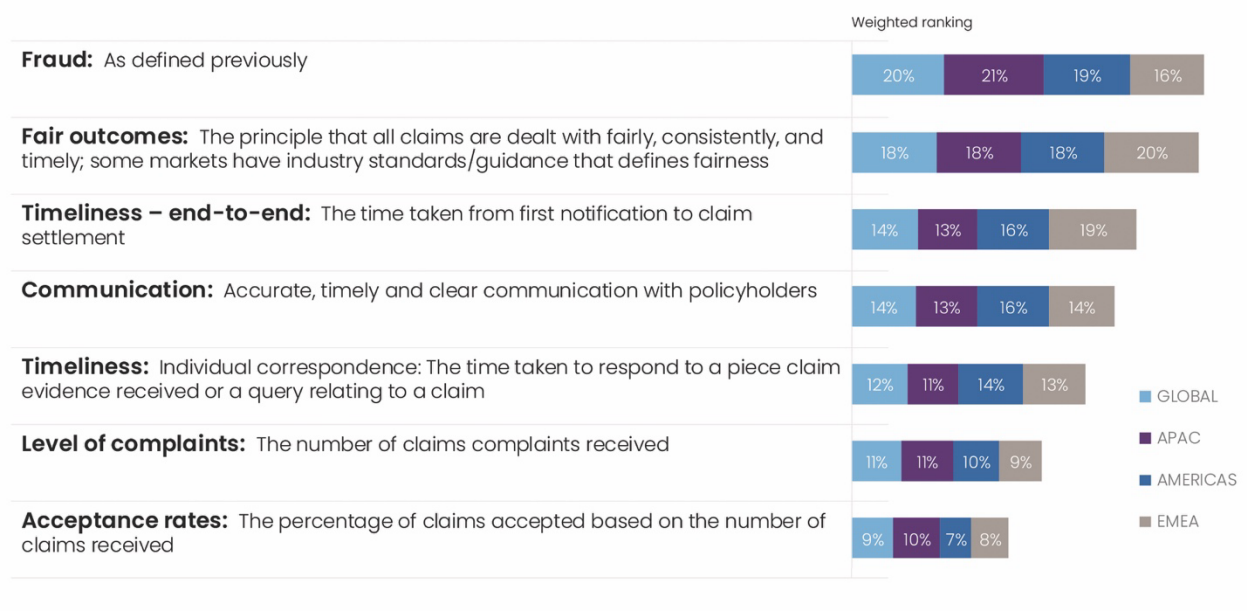
Global response

The largest proportion of responses came from the Asia Pacific region (APAC), including Australia and New Zealand, followed by the Americas and Europe, Middle East, and Africa (EMEA) regions, which should be noted in evaluating results.

Incidence of fraud

Globally, respondents indicated Identifying fraud as the most important factor in assessing claims. In EMEA, fraud ranked as the third-most-important factor. This is consistent with regulatory priorities in EMEA, where fair outcomes for consumers represent a prominent regulatory goal.

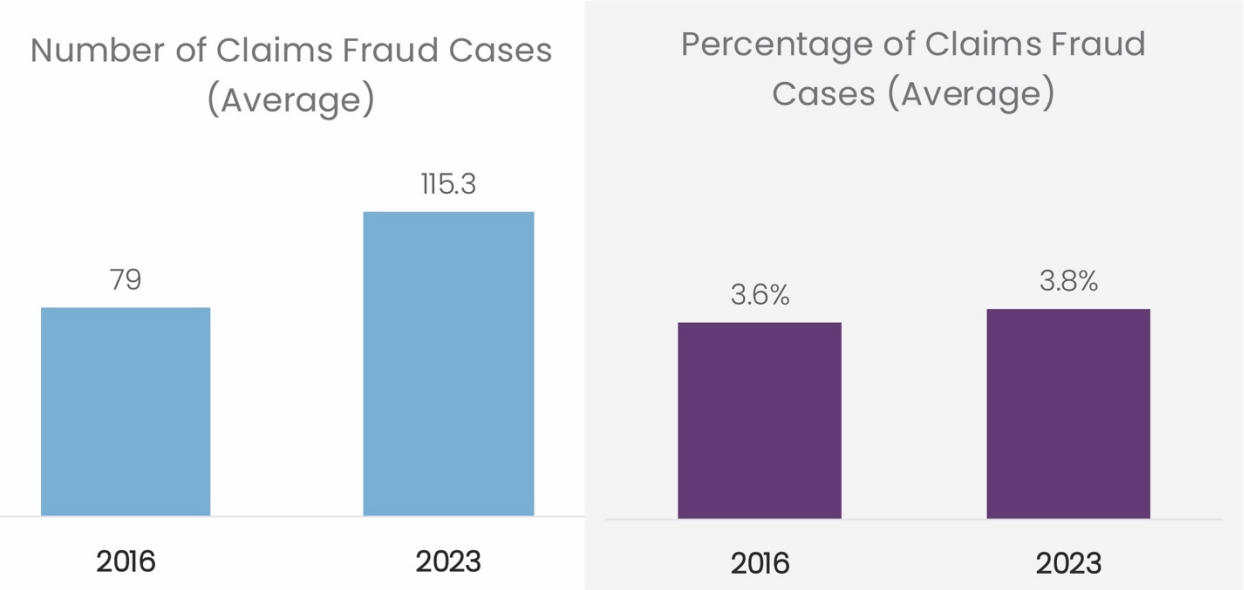
Figure 1: Importance of fraud when processing claims



Claims fraud

Survey results suggest that the global incidence of claims fraud — fraud discovered during the claims process — has increased slightly since 2016, with the global incidence at 3.8% compared to 3.6% previously.

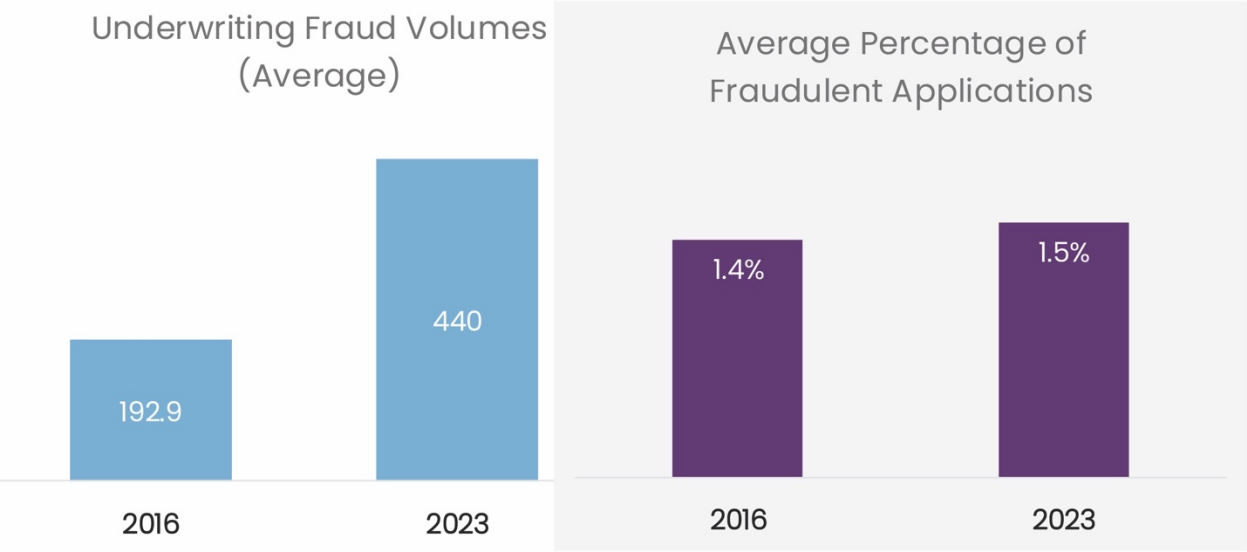
Figure 2: Claims fraud incidence



Underwriting fraud

Similarly, survey findings indicate little movement in the incidence of underwriting fraud, with global incidence at 1.5% in 2023, compared to 1.4% in 2016. For the purposes of the survey, we defined underwriting fraud as fraud discovered during the underwriting process, including as part of a post-issue verification/sampling process prior to a claim.

Figure 3: Underwriting fraud incidence



Participation in fraud

Respondents identified consumers as the main participants in fraud but reported other participants as well, with 41% of respondents indicating that agents had assisted claims fraud, 23% citing doctors, and 20% alluding to other individuals working in the insurance industry.

These numbers represent a reduction in agent-related fraud but a significant increase in insurance worker-assisted fraud. Worker-assisted fraud is of particular concern in the APAC region.

Figure 4: Roles aiding fraudulent claims and underwriting

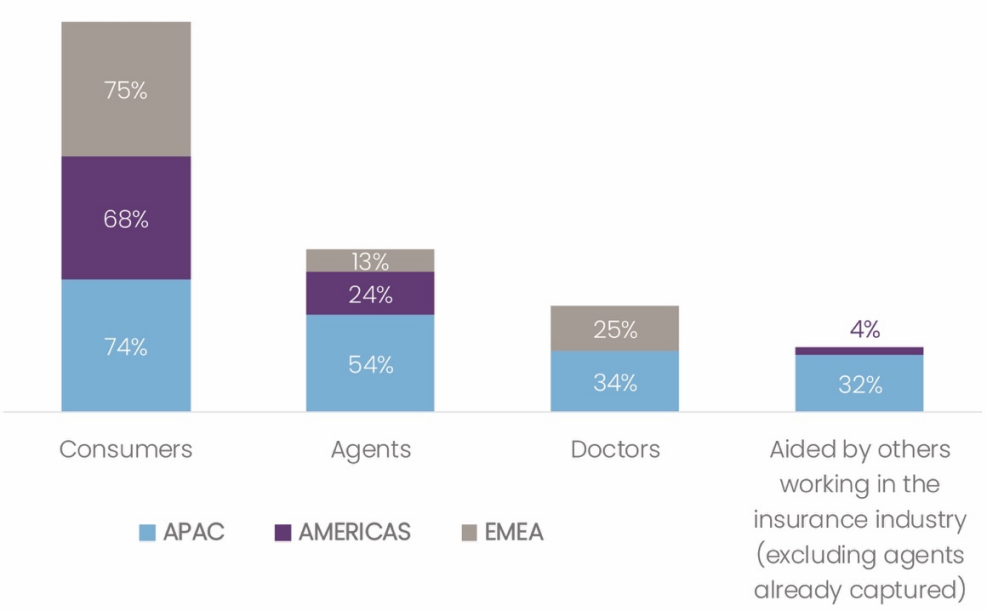


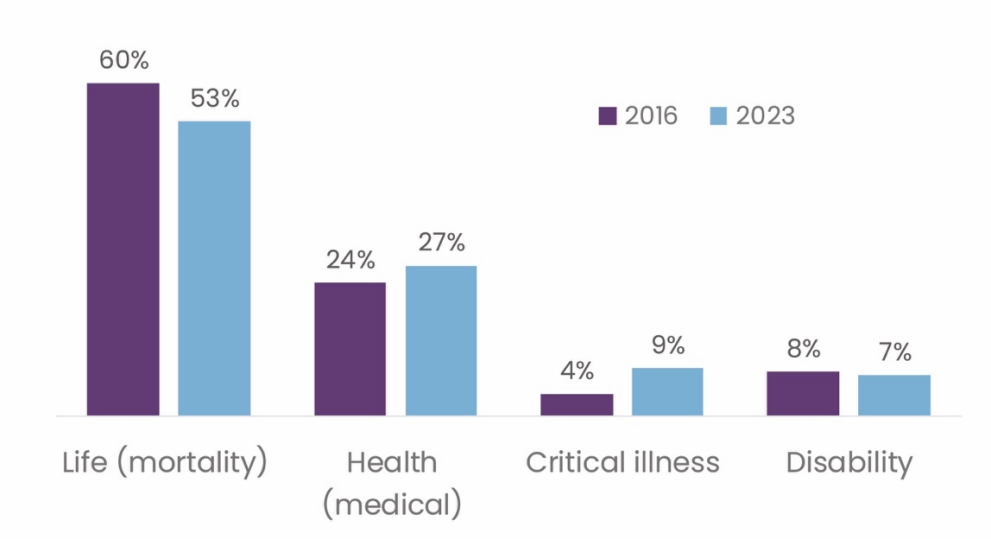
Figure 5: Examples of the types of fraud associated with distinct roles

Consumer	Agent	Doctor	Other
Misrepresentation	Coaching consumers	Collusion with patient	Organized crime
Falsified documents	Validating falsified documents	Overdiagnosis	Falsified documents
Working while claiming income protection (IP) benefits	Deliberate misrepresentation	Falsifying records	

Fraud by benefit type

Consistent with our 2017 survey results (based on data from 2016), respondents indicated that mortality benefits were most prone to fraud; this may reflect the general product mix among respondents and our broad definition of fraud, which includes opportunistic fraud. The survey results suggest an increase in fraud associated with health and critical illness benefits in 2023.

Figure 6: Fraud by benefit type



Identifying fraud

A growing number of insurers are creating specialized teams or appointing individuals to identify potential fraud, with 78% of respondents indicating they employ dedicated fraud specialists, up from 63% in 2017. The Americas leads the way in this regard, with 88% of respondents indicating they had specialized fraud teams.

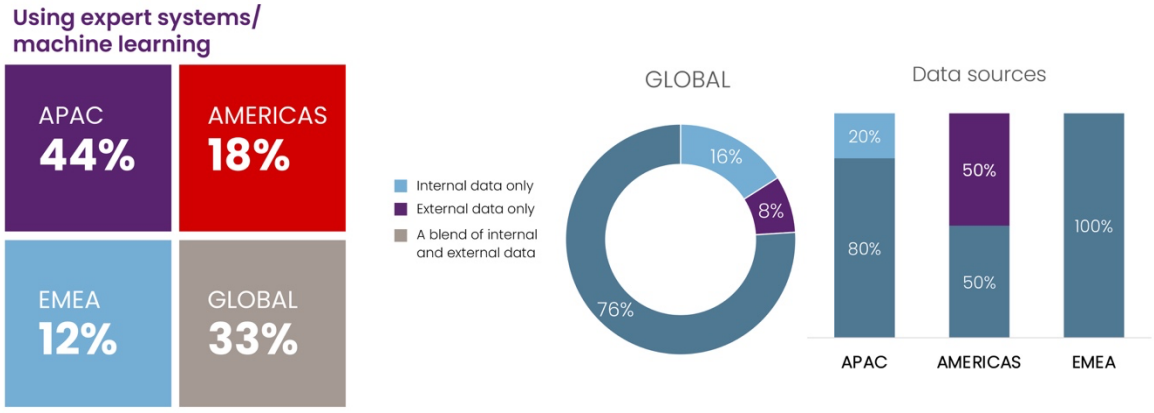
Survey results also reflect an increased focus on fraud training, with 82% of respondents indicating that their claims teams receive such training.

Two-thirds of respondents use established fraud indicators to help claims professionals identify fraud, and one-third apply expert systems in the fraud identification process. The use of expert systems is most prominent in APAC, with 44% of respondents using these systems, while the Americas (18%) and EMEA (12%) are less advanced in this area. Most respondents who use expert systems rely on a blend of internal and external data to validate claims and refine risk measures.

Figure 7: Top fraud indicators

1	Early claims
2	Past experience with clients, agents, doctors, etc.
3	Unreasonable behavior, inconsistent or suspicious explanations
4	Industry or company database checks

Figure 8: Use of expert systems and machine learning to identify potential fraud



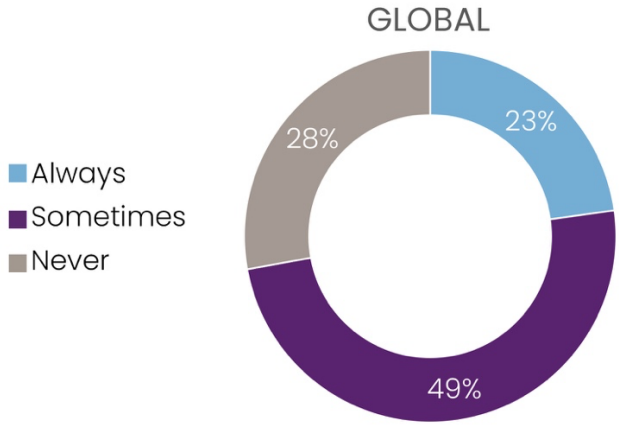
Another area of increased activity since RGA's previous survey is post-issue analysis of the in-force book prior to claim. Forty-five percent of respondents globally are conducting in-force analysis compared to 33% in 2017. The analysis of the in-force book could resolve issues arising from misrepresentation and improve claims acceptance rates, reducing the number of claims referred for fraud assessment.

In line with our previous survey report, we found no evidence of increased fraud at the end of any contestable period in markets where these exist.

Reporting and law enforcement

Twenty-three percent of respondents indicated they would always decline a claim when misrepresentation was a factor, rather than allege fraud. This is down from 37% in 2017, suggesting that insurers are now more likely to imply fraud than in our previous review.

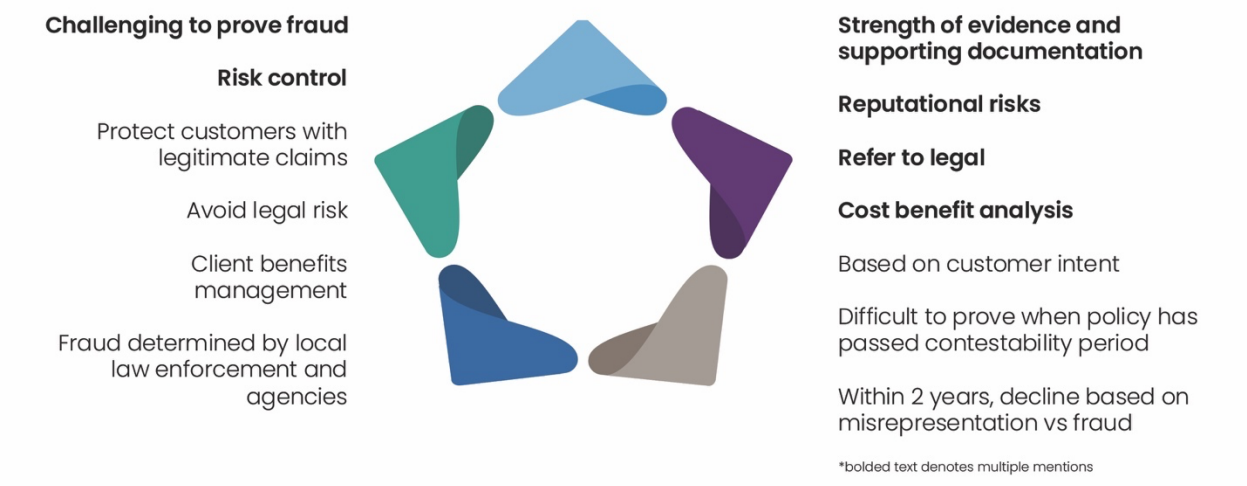
Figure 9: Insurers' choice to pursue fraud or rely on claim denial



Where significant fraudulent activity — such as identity theft, forgery, or criminal activity — was suspected, 45% of respondents indicated that they always contact law enforcement. This is an increase from 23% in 2017.

Reasons to refrain from alleging fraud are many and varied. The following represents the most common factors identified by insurers.

Figure 10: Reasons insurers choose to deny claims rather than allege fraud



Impact on consumers

The 2017 survey findings indicated that the investigation of fraud could take up to eight times as long as standard processing, although the overall average was 3.9 times. That equals 76 days compared to 19.2. Today the difference is down to 3.2 times the standard process, with fraud investigations taking 67 days on average, a reduction of nine days from the 2017 survey report.

Figure 11: Impact on end-to-end claims processing times

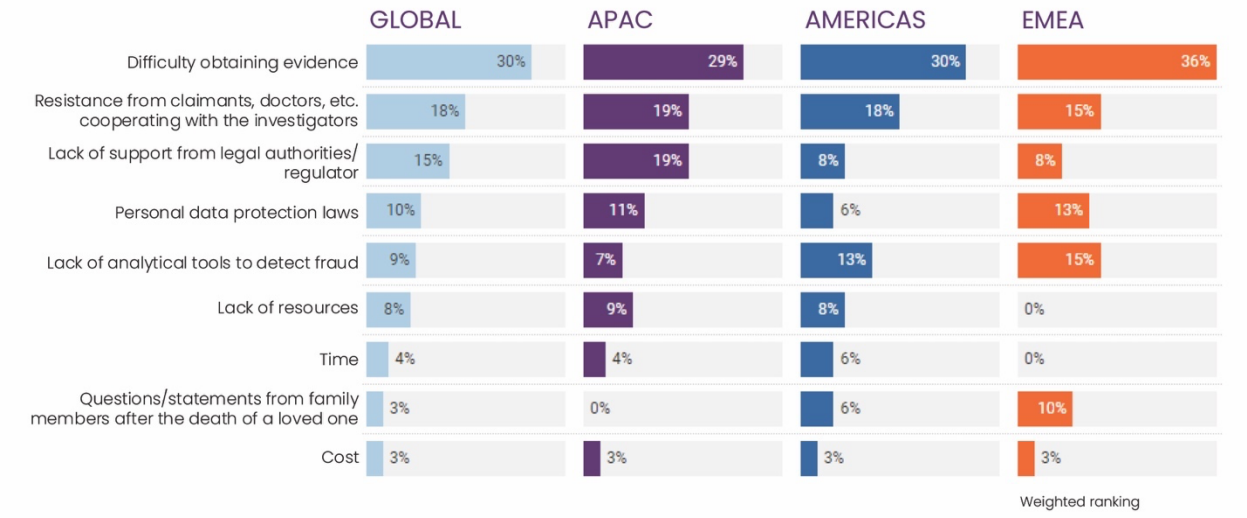
Although the industry should protect all consumers by investigating fraud, survey findings suggest insurers should also speed up the investigation process so those cases that do not involve fraud, following investigation, are dealt with in a reasonable period.

Challenges including the impact of AI

Key Challenges

The top challenge identified by respondents in combating claims fraud was difficulty obtaining evidence. Other factors included resistance from claimants, doctors, and other interested parties and a lack of support from legal authorities and regulators.

Figure 12: Challenges for investigating and combating fraud



The key issues are similar to those raised in our 2017 survey, although concerns around the cost and time involved in combatting fraud has decreased. This suggests insurers are more willing to invest in necessary measures.

AI

AI represents a new subject in our survey.

Respondents indicated they are already identifying AI-assisted fraud, and the main vehicle for this is the falsification of documents such as death certificates. There was significant variation by region, with 62% of respondents from APAC indicating that they had identified issues with fraudulent documents, compared to only 19% in the Americas.

Other forms of AI-assisted fraud — such as deepfake photography, AI-assisted diagnosis, and voice cloning — were detected but were much less prevalent.

Looking forward

Sixty-eight percent of respondents globally believe that fraud will increase in the next three to five years. Only 13% globally think that fraud will decrease in this period. Regional differences emerged, with 86% in the EMEA region expecting increases in fraud within this period.

The key drivers of the increase in fraud are economic factors, AI and other digitization, and organized crime.

Figure 13: Reasons why fraud is expected to increase in coming years

Respondents also saw the potential for a reduction in fraud in some areas. Key fraud-fighting tools identified for the years ahead include data analytics and risk modeling, digitization of the claims and underwriting processes, and increased collaboration across the industry.

Conclusion

In RGA's previous survey, we suggested that life insurance fraud was the perfect crime — low in risk and high in reward. Although that position has not changed materially, insurers and law enforcement agencies seem more willing to actively engage in combating alleged fraud where it exists and to prosecute fraud when appropriate.

Insurers in APAC are more advanced in fraud detection, using machine learning, well-trained and dedicated fraud prevention teams, and risk indicators to identify fraud. However, APAC is also the region where AI-related fraud appears most advanced, with three times as many insurers indicating they had experienced AI-assisted fraud involving falsified documents compared to their peers in the Americas.

AI is an area that creates opportunity for fraudsters, but it also gives insurers the ability to create tools to identify and combat fraud.

Fraud is at the top of the agenda for insurers globally. Despite challenges in gathering evidence, insurers are increasing efforts to tackle fraud and to keep pace with the technology that enables it.

Best practices suggested by the survey include:

- Employ a well-trained individual or dedicated team focusing on fraud identification and prevention.
- Identify market/product-specific risk indicators to assist the claims process.
- Use technology such as expert systems and machine learning to supplement risk assessment and help identify claims that can be settled in a fast and efficient manner.
- Collaborate with industry colleagues to identify those suspected of persistent fraudulent activity.
- Refer all suspected criminal fraud to law enforcement agencies.

Contact your local RGA office for claims support or for any questions regarding the survey, please contact Philip Thomas at phthomas@rgare.com.

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