Fraud Referral System

South Carolina Department of Insurance

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https://doi.sc.gov

VERSION 1.0.0

03/01/2022

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1. PROJECT PROBLEM STATEMENT

The occurrence of Insurance Fraud rises every year in South Carolina. The Office of the Attorney General has been combatting this problem since 1994 without an increase of annual resources. Insurance companies pass the cost of insurance fraud to consumers.

The availability of funds allocation and legislative mandate created the Fraud Division in the Department of Insurance to replace the one in the Office of the Attorney General. This new Division should demonstrate with their increased resources a better effectiveness in dealing with the fraud problem. This can be achieved by streamlining and improving the information intake into the investigative process. Better tracking in place will also provide constant feedback on the effectiveness of the unit.

Our Agency's mission statement states that we protect insurance consumers. That partly means that we want our consumers not to be unduly burdened by the thievery of others. Our director in partnership with SLED and the Attorney General's office continued to try to get additional resources throughout the years.

We all want to reduce insurance fraud so consumers can pay a fair premium for their coverage. What is the best way of processing and handling all the fraud complaints for South Carolina coming in from various source?

To do that, our Fraud Division should be outfitted with the best process and tools that they can use in identifying and investigating fraud. An information system is needed to help manage and deal with the number of South Carolina fraud complaints coming in from various sources. The creation of that information system is what this project is about.

2. PROJECT DATA COLLECTION

Collecting data for the project had the following goals

1. Identify the best source on incoming fraud complaints data.
2. Identify the size and complexity of the incoming data.
3. Identify the size of specific fraud issue and see if there are patterns in the type, size, and location of the fraud.
4. Identify previous measures used by the Attorney General's office that would still be good measures for effectiveness.

Data was collected in the following ways

1. Discuss with NAIC what sources of complaint data they have.
2. Collate all the annual reports from the Attorney General's Office from the time they started publishing it in 2003 to 2020
3. The third collection method is to download past data from the Online Fraud Reporting System of the National Association of Insurance Commissioners and inspect the data.
4. The third collection method is to do interviews with people who worked in the Attorney General's Office to help make sense of the information published in their annual reports.
5. The fourth collection method is to get the perspective of the new employees in the new division on how they would approach the processing of fraud complaints data.

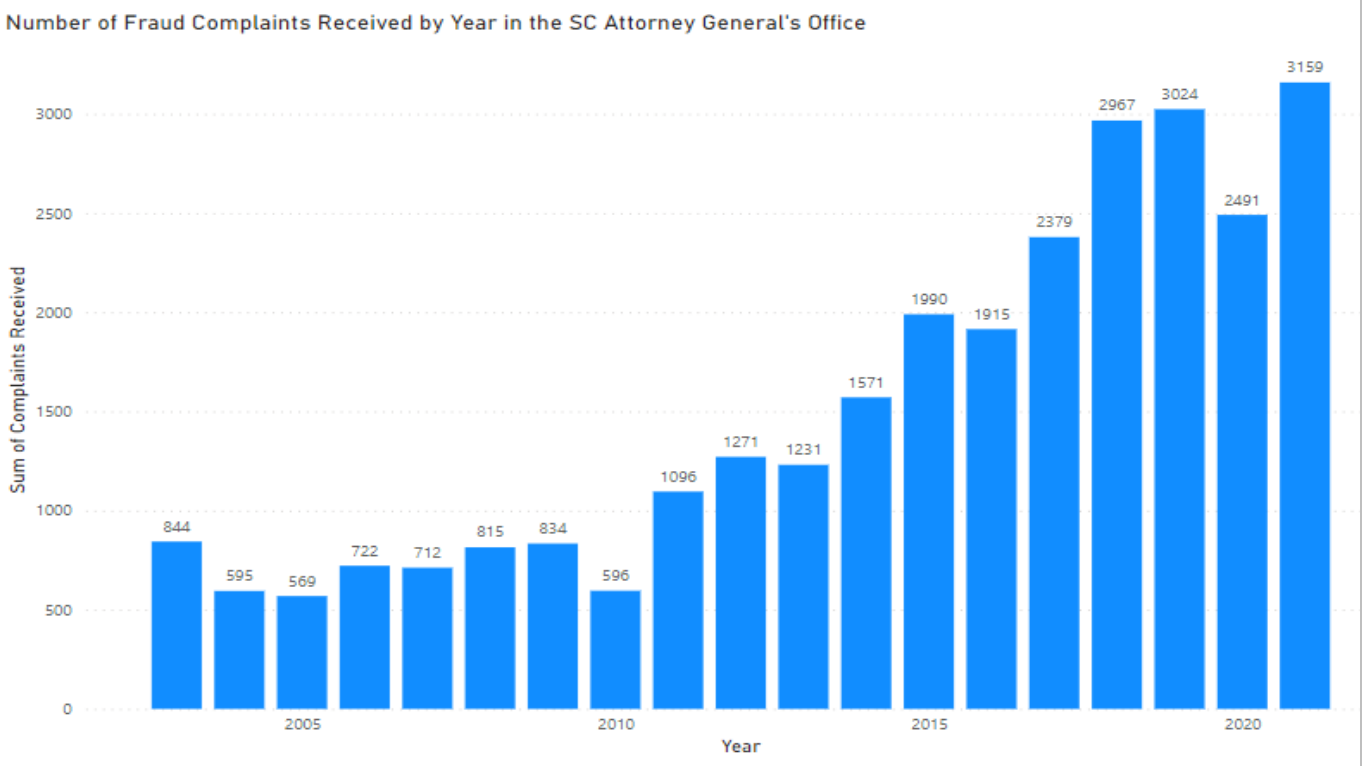
Important Operation Definitions include

1. Insurance Fraud - What is the best way of processing and handling all the fraud complaints for South Carolina coming in from various source?
2. SLED (State Law Enforcement Division) Investigations – is the main means by which fraud complaints are investigated.
3. RFI (Request for Information) – is the process by which additional information is obtained from the fraud complaint submitter.
4. NAIC OFRS Database – is the National Association of Insurance Commissioners Online Fraud Reporting System is the national database of submitted fraud complaints from all the states submitted to the National Insurance Crime Bureau and the NAIC submission portals. These complaints are both submitted by companies and individuals.
5. NICB - is the National Insurance Crime Bureau. It is the source of most the fraud complaints received by the department.

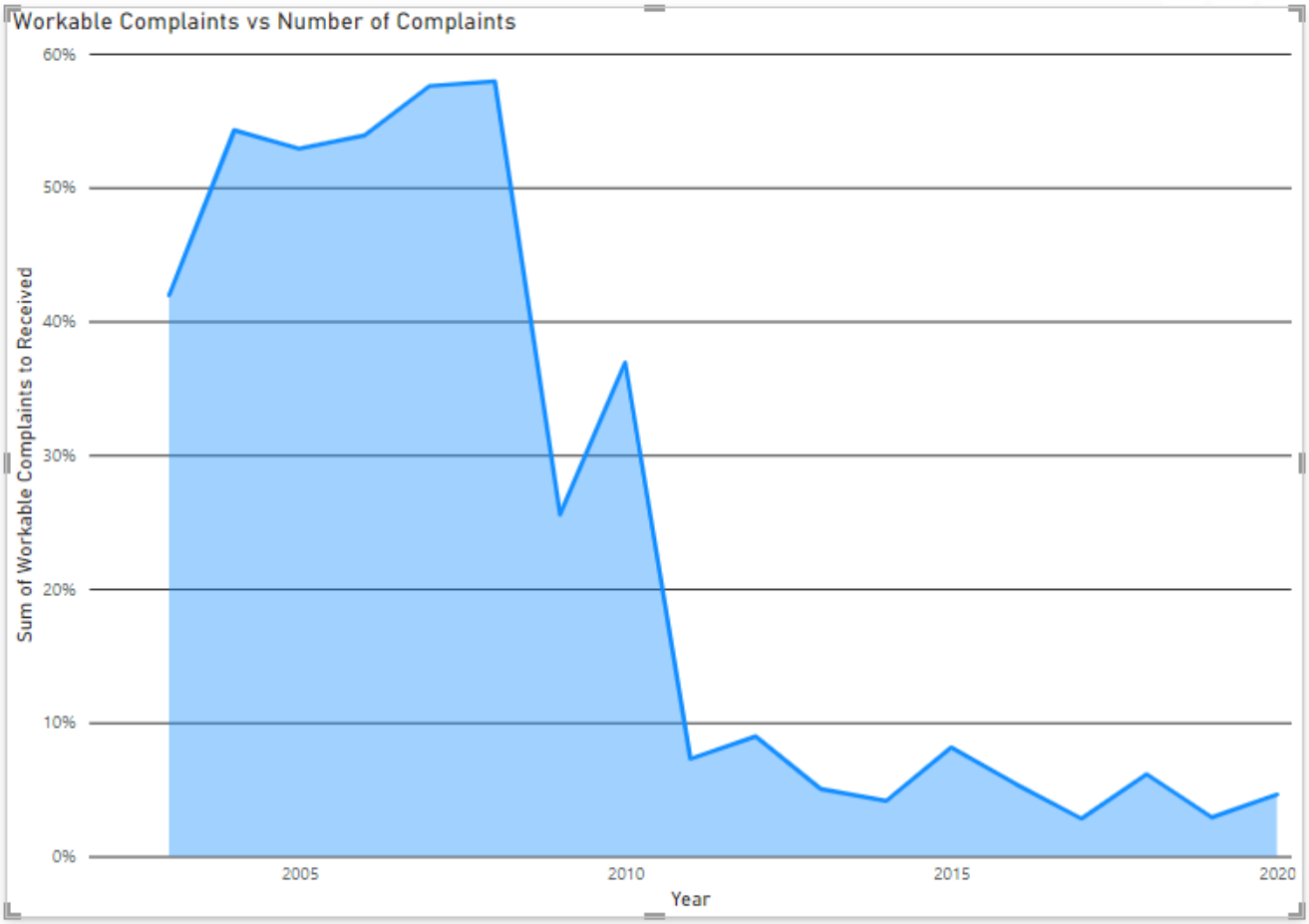
3. DATA ANALYSIS

Some of the key findings from the data are:

1. Insurance Fraud complaints continue to rise every year. This is graph from the yearly data provided by the SC Attorney General's Office. The last figure for 2021 is the gross count of all the fraud complaints for SC collected by the NAIC OFRS system.



2. The number of workable complaints (most likely to lead to a conviction or civil penalties) compared to the number submitted complaints have slowly dropped as the years passed. At first, I thought that the AG's office was simply not pursuing some cases for lack of resources. My interview with a former employee however revealed that over the years they learned that some cases are not worth the effort (e.g., fraud amount too small, hard to prove). The reviewing attorneys has just scrutinized them more closely.



3. The number of cases carried over from previous years are getting smaller every year. There were even years when there were no carryover cases from previous years. The former employee also had something to say about this. Recordkeeping quality has dropped after a head administrative assistant retired in 2018. The 2019 report has more case highlights than numerical reporting (my opinion).

Year	Complaints Received	Files Opened	Workable Complaints to Received	Carried over from previous years	What's New
2003	844	354	41.94%		
2004	595	323	54.29%		
2005	569	301	52.90%	56	
2006	722	389	53.88%	68	
2007	712	410	57.58%	143	
2008	815	472	57.91%	216	
2009	834	213	25.54%	238	
2010	596	220	36.91%	213	
2011	1096	80	7.30%	189	Information Only Referrals
2012	1271	114	8.97%	247	
2013	1231	62	5.04%	91	
2014	1571	65	4.14%	83	
2015	1990	162	8.14%	50	
2016	1915	103	5.38%	79	
2017	2379	67	2.82%	76	
2018	2967	182	6.13%	55	Organized Rings
2019	3024	88	2.91%		Highlighted Cases. Backlogs?
2020	2491	115	4.62%		Highlighted Cases. Backlogs?
2021	3159				From OFRS Count

The system development process has already encountered some challenges since it's start.

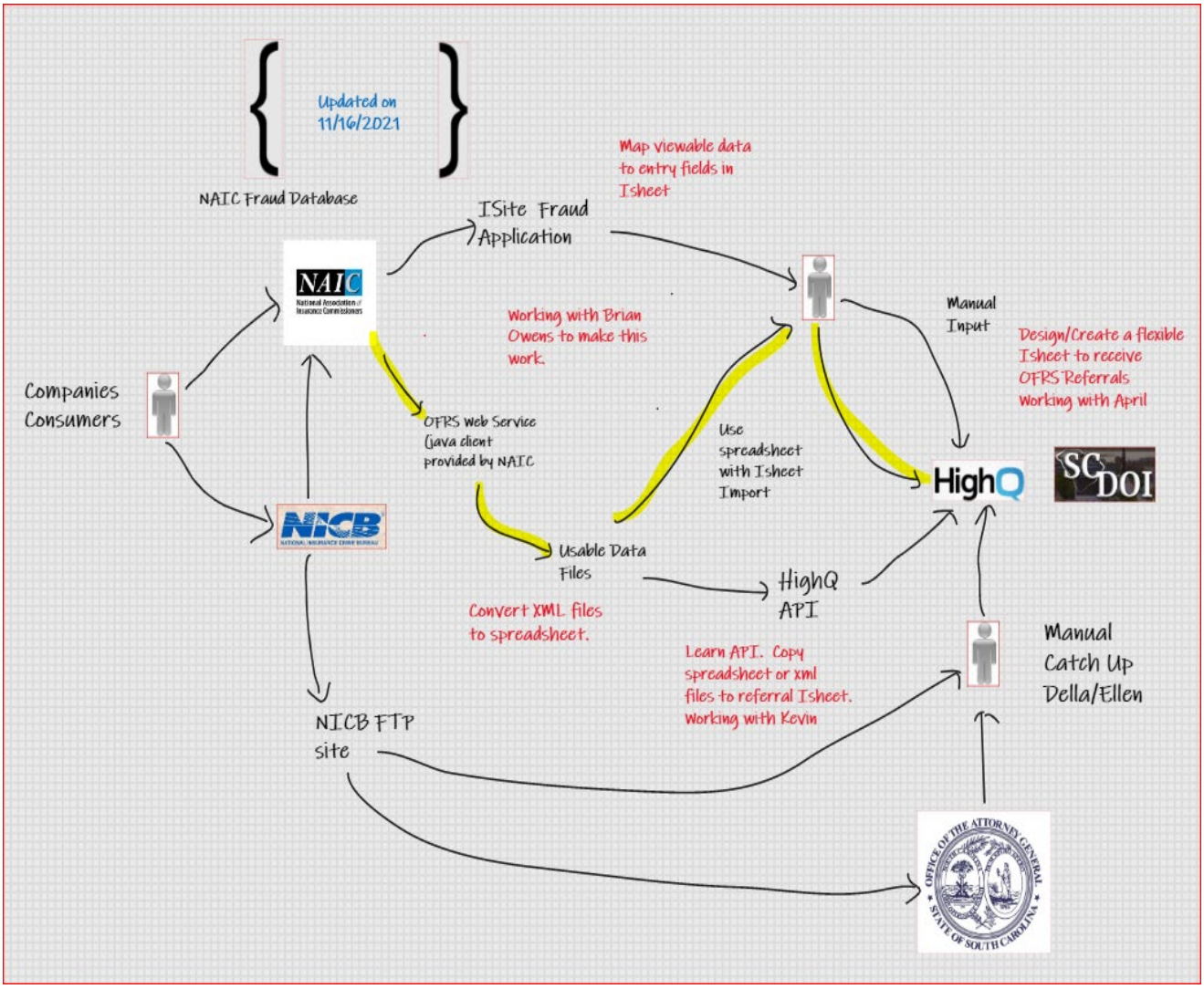
1. The base framework (HighQ) for the system environment was selected and rented when the major use (Director of Insurance Fraud) of the system was not yet hired.
2. Although it's a robust system for the purpose it was built for, the consultants are more accustomed to customizing the system for legal offices for the private sector. The software selection process could have benefitted from inputs from the major user especially with how steps are to be carried out. The business users are also constrained by the way the framework does its functions. The committee that did the selection (was not included) has underestimated the amount of customization that has to be done to make it work as expected.
3. The main coordinator for the review of complaints, who is a crucial person in moving these complaints to the next stages resigned recently. This left the function of initial review to a couple of experienced paralegals who have much less experience in fraud cases and added the requirement that attorneys get involved earlier in the process.
4. The fraud division's employees seemed to be not experienced in a methodical and engineered development process. It was after insisting that the process be drawn out in paper that we started to see progress in fleshing out the nitty gritty parts.
5. Initial workflows were already created before the process was thought out in detail by the major user (Director of Insurance Fraud).

The data only says that tracking of cases should be more visible, especially after the review process. All that the data really requires is an organized way of tracking. The existing data may suggest what numbers to track, but the efficiency of the new processes can only be evaluated after about a year in operation.

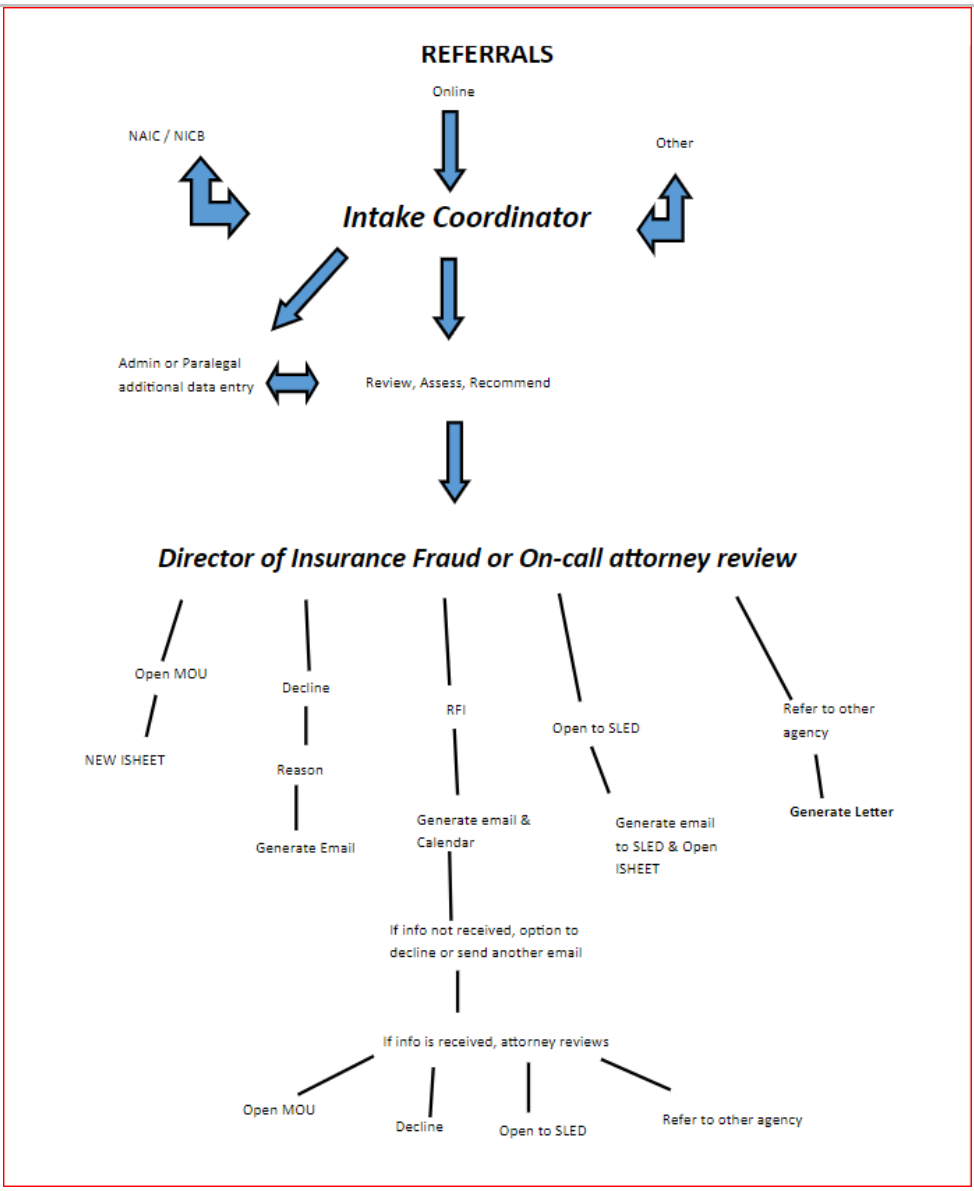
4. IMPLEMENTATION PLAN

The implementation plan would proceed this way.

1. Map out the new process that brings external data from source to the Fraud Referral System. Phase 1 is highlighted.



2. Map out the new process from complaint data intake to final status (charged, prosecuted, declined). Here's a section that illustrate the referral review part of the process.



3. IT Applications will build an xml file to spreadsheet conversion program so it can be imported into HighQ as Phase 1.
4. IT Applications will utilize HighQ API to move data from xml to an Isheet as Phase 2.
5. Build a reference workflow that goes through the process until referral closing. The potential issues here are the framework will not be able to handle the required functionality.
6. Test out the workflow on a previous day's influx of fraud complaints from OFRS.
7. Test measurement statistics.
8. Train internal staff to handle changes in workflow in HighQ.
9. Explore the use of Analytics in finding patterns in the data that might help identify patterns and connections between the fraud cases.

The key stakeholders are all instantly communicated within Microsoft Teams.

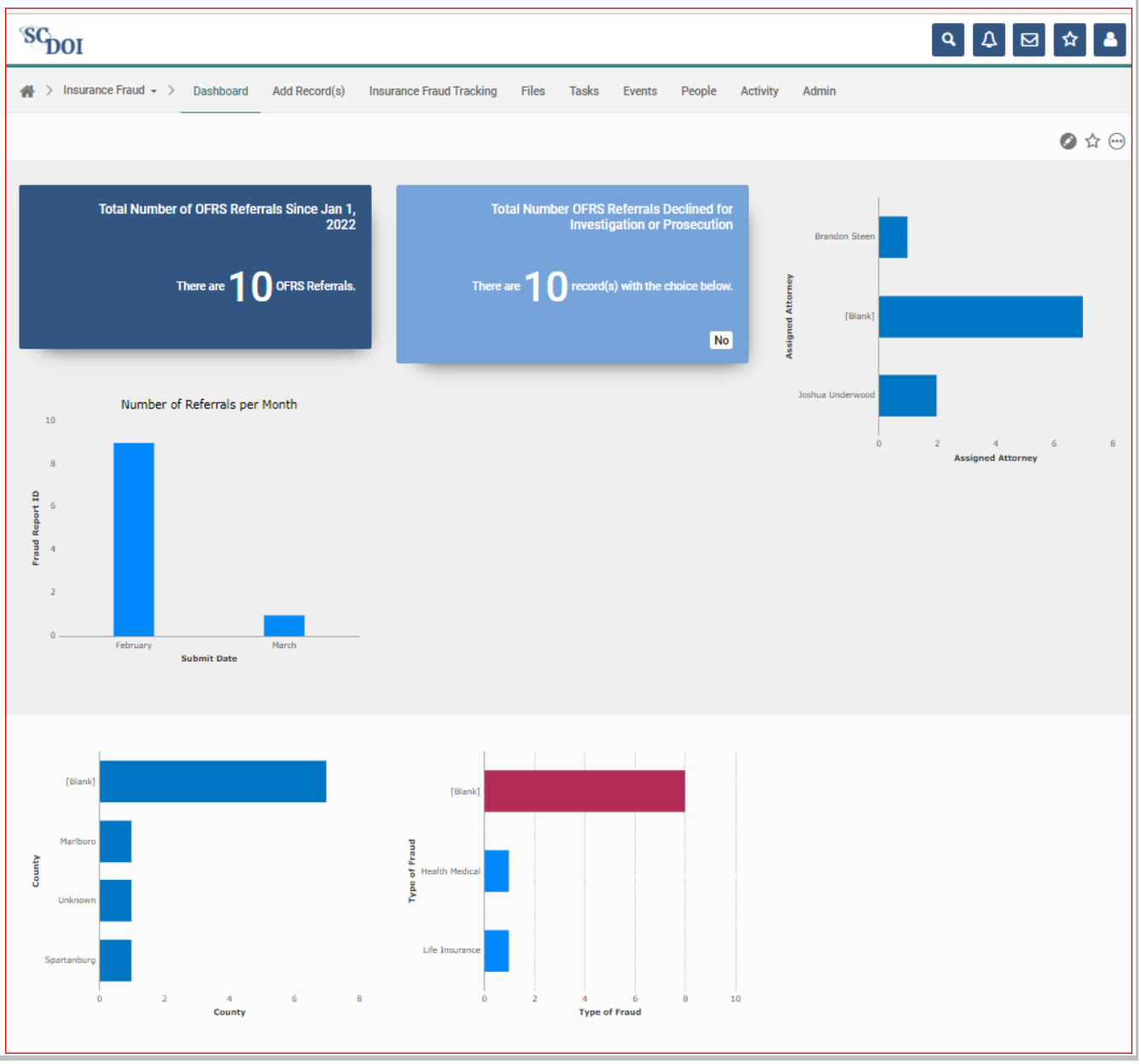
The cost for the year has already been set so if we don't require new additional budget, we are ok.

Other than HR rules, Agency and IT policies, the fraud unit can pretty much set their operating procedure.

5. EVALUATION METHOD

The solutions chosen (Custom Framework (HighQ) plus workflow customization with consultant and internal development team) should be evaluated after some period of operation.

1. How fast does a complaint move from intake to be settled in a resolution? This would be measured by the time (captured when a part of the workflow is started) to the resolution time.
2. Using the Attorney General's measure (incoming counts, case opened, deferred, prosecuted, etc....) how are we doing comparatively? I have set-up some dashboard counts that give instant feedback as to what the status of the referrals are since January 1, 2021. This is from a test processing in January.



3. What would be tricky to measure is how good is the fraud unit in identifying cases that are not worth pursuing? The better they are at this, the more it may seem that they are pursuing less investigations.
4. We may need to revisit how mapped processes really worked with real life scenarios. Is it preferable to receive all those task and notifications instead of just dealing with it on an incremental basis?

6. SUMMARY AND RECOMMENDATIONS

1. To do nothing about Fraud is not an option. We would not want SC to be an easier location to do insurance Fraud.
2. At this point we are getting a clear idea on how this process could work.
3. For this new fraud unit, I think the best learning would be to start using real life work as soon as possible and learn from that rather than endlessly tweaking on how something would work.
4. We should as much as possible use the established steps of working through projects. I can only lead by example in this.
5. We should strive to produce a workable process and not for perfection or we will never finish.
6. It would be good if measurements are also accompanied by the story behind the numbers.