US Life Insurance

Fraud Survey Report

Conducted by RGA and MIB

RGA/MIB US Life Insurance Fraud Survey Report

Fraud, misrepresentation, and anti-selection pose a significant financial burden to the life insurance industry, leading to an estimated $75 billion annual loss. As a result, insurance companies charge higher premiums to mitigate the financial impact. Furthermore, anti-selection hinders insurance innovation, increases the price consumers pay, and reduces insurer profits.

In early 2024, RGA partnered with MIB to analyze anonymized data from a contributory industry database, known as the MIB Data Vault. The analysis was further informed by expert interviews with leaders at seven life insurers, that provided insights into two types of anti-selective behavior, specifically churning and stacking. The results can be accessed on the RGA Knowledge Center.

To further understand the impact of fraud on insurers' business, in July 2024 RGA and MIB conducted an online survey of US insurers, the results of which were compared to a similar survey conducted by RGA in 2016. The survey's objective was to obtain insights into the scope of life insurance fraud in the United States, common mitigation practices, and challenges in combating fraud. A total of 25 insurance companies provided responses. The survey respondents were in life underwriting and risk roles.

The survey analysis provides valuable insights into industry trends and best practices to detect and combat this significant risk.

Key survey findings

- 96% of respondents are concerned about the risk of fraud for policies issued under Accelerated Underwriting (AUW) and are mitigating such risk by limiting face amounts, issue age, and the number of policies being issued.
- 60% reported limiting face amounts available for online policies, due to concerns with fraud, while 10% are not comfortable with online distribution.
- Post-issue auditing and evidence rechecks (e.g., MIB Plan-F, Rx/Dx) are the most common methods used to monitor potential fraudulent or anti-selective behavior.
- Insurers were most concerned about medical misrepresentation, which also was identified as the most costly type of fraud to combat.
- The top tools for fraud detection and mitigation begin explored by respondents are MIB In Force Data Solutions (Jumbo and/or Total Line) and identity verification.

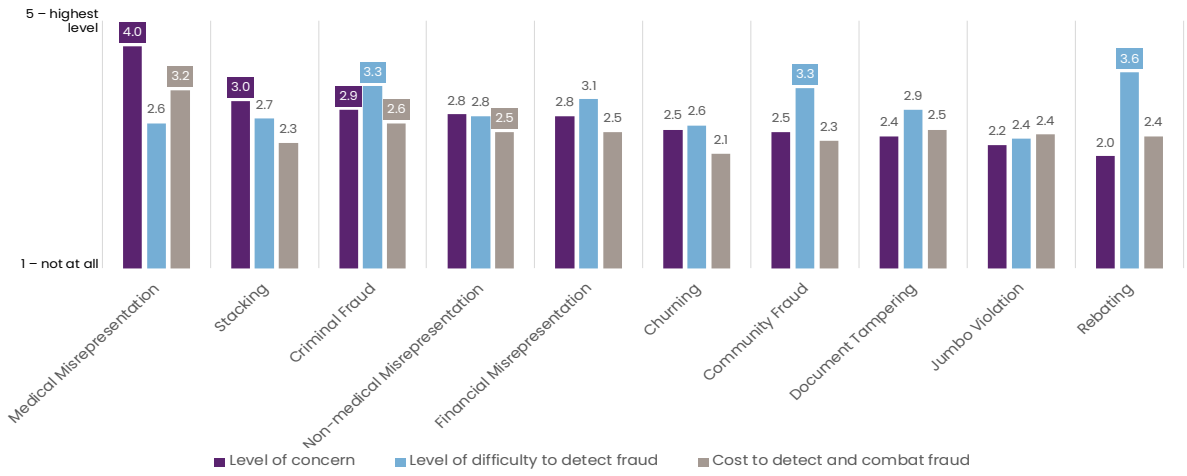
- Underwriting is the first line of defense in fraud detection and prevention, along with increased investment in training to identify red flags and the use of MIB databases.
- 84% of respondents reported having a designated team or individuals to investigate and prevent fraud; 32% reported using algorithms or analytics tools to flag questionable underwriting applications, an increase of 22% from our 2016 survey.
- Insurers anticipate future innovations to combat fraud, including the use of more data sources and AI tools, as well as application questions designed to improve proper disclosures during the insurance application process.

Respondent distribution and underwriting product profile

Nine of the 25 companies sell more than 50% of their new business through captive agents; 16 employ independent agents or brokers, while direct-to-consumer (D2C) is the main channel for two respondents. Other distribution channels included online, direct mail, and banks.

Sixteen respondents indicated that more than 50% of their new business in 2023 was fully underwritten; 23 respondents support AUW products overall. Eight reported underwriting simplified issue products, while five support guaranteed issue products. Final expense products are underwritten by two respondents.

Challenges by fraud types



Average level of difficulty or concern (5=highest level)

Respondents were asked about the level of concern with fraud, the level of difficulty to detect it, and the cost to detect and combat fraud. The survey findings indicated that US insurers had the highest level of concern for medical misrepresentation (with an average ranking of 4.0 on of a scale of 5), stacking (3.0), and criminal fraud (2.9). For the purpose of this survey, stacking is defined as a policyholder owning multiple policies to increase the amount of coverage, with a lower level of underwriting scrutiny than if a single large policy had been purchased. The effect of this is higher claim amounts than an insurer would expect to experience if the policy was underwritten for the full amount. Criminal fraud involves more significant insurance fraud such as forgery, falsifying underwriting evidence, and fake deaths.

It is interesting to note that stacking and churning garnered a higher level of concern during our qualitative interviews conducted earlier this year. Additionally, in our 2016 survey, agent fraud was cited as the second highest area of concern. Stacking and churning are estimated to cost insurers hundreds of millions of dollars of risk when evaluated using the MIB In Force Data Vault.

The types of fraud most difficult to detect include rebating (average ranking of 3.6), criminal fraud (3.3), and community fraud (3.3). Rebating refers to a type of agent fraud in which a portion of the premium or the agent/broker's commission on the premium is returned to the insured (or others) to incentivize the placement of business with a specific insurer. This is illegal in most states. Community fraud is attributed to travelers or typically nomadic people who conspire to conceal an illness or medical condition of the insured during the contestability period of an insurance policy for the purpose of the beneficiary receiving an early duration claim payment.

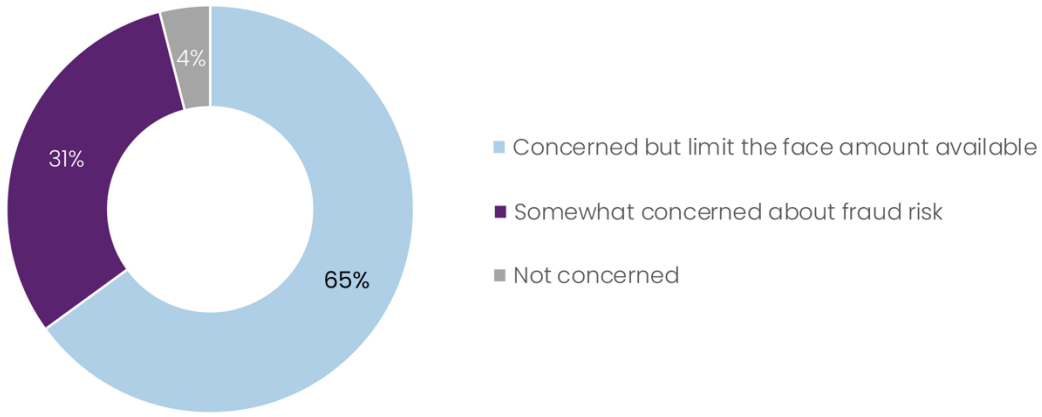
The most costly types of fraud to detect and combat include medical misrepresentation (with an average ranking of 3.2), criminal fraud (2.6), and non-medical misrepresentation (2.5) such as omissions of avocations, driving, or aviation-related disclosures.

As we examined data segmented by insurer distribution type, companies with primarily captive agent sales garnered higher levels of concern for stacking than churning. Respondents selling AUW products had higher levels of concern for anti-selective behavior than other types of products.

For more information about stacking and churning, see our qualitative research in an article on RGA's Knowledge Center: The Impact of Anti-Selective Behavior on the Life Insurance Industry.

Impact of fraud on AUW policies or online distribution

Accelerated UW concerns



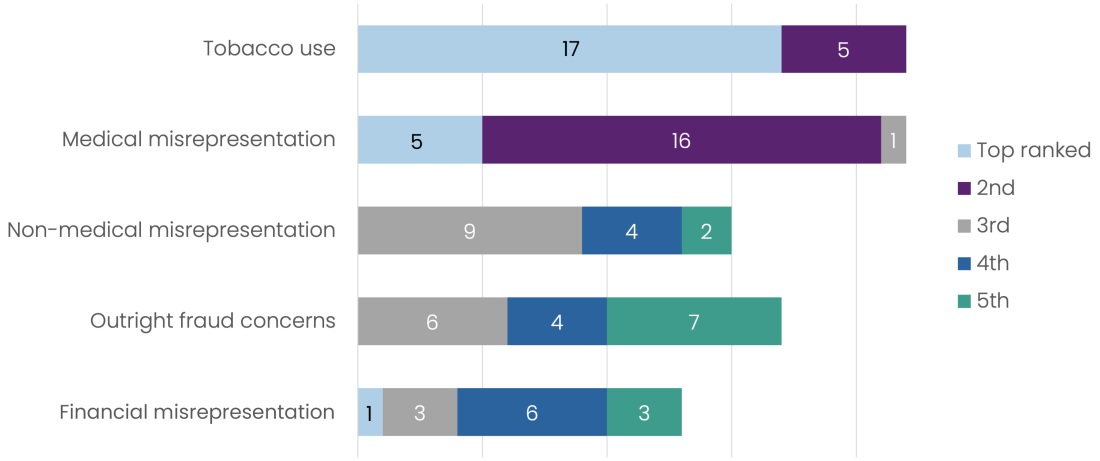
The cost of fraud has an impact on product types and distribution being offered by US life and health insurers. Ninety-six percent of insurers offering products with accelerated underwriting (AUW) reported being concerned with fraud, with 65% of those who use AUW limiting the face amount available and instituting age requirements to offset the cost of fraud.

Several insurers indicated limited face amount ranges between $500,000 and $2M and age groups between 18 to 45 or up to age 60 years. These risk mitigation measures are based on a focus on a lack of full disclosure without traditional underwriting to confirm BMI index, build, smoking or nicotine use, etc. A few participants have increased eligibility requirements including health and medical history.

Most common types of anti-selection, misrepresentation or fraud

Tobacco use by applicants was ranked as the most common misrepresentation, followed by other types of medical misrepresentation, meaning generally untrue or incomplete medical information being provided.

Rankings of most common types of fraud



An estimated average of 22% of cases are "kicked out" of AUW where fraud is suspected due to discrepancies between the applicants' disclosed information and evidence collected (based on data from 11 respondents).

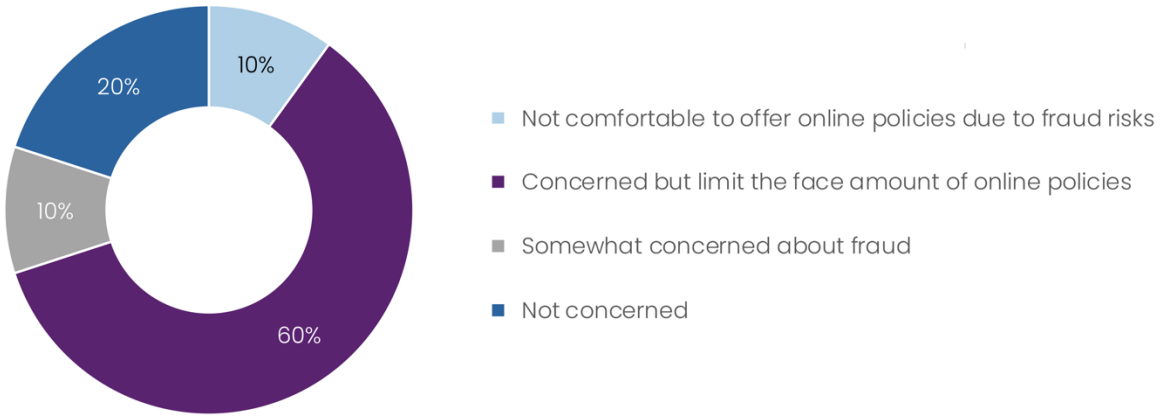
Respondents also indicated they are limiting the amount of written AUW business to minimize the volume and/or the cost of misclassification. There is a greater use of protective value requirements in the AUW triage process or criteria.

Respondents are primarily using post-issue methods to monitor risk for AUW programs, including:

- 74% - Post-issue auditing
- 70% - Post-issue evidence rechecks (e.g., MIB Plan-F, Rx/Dx)
- 52% - Random hold outs
- 13% - ID checks or validation
- One respondent indicated using a behavioral assessment tool

Fraud concerns are hindering online insurance distribution, with 10% reporting they are not comfortable with online distribution due to the risk. Of the respondents offering online distribution, more than half (60%) limit face amounts of online policies to guard against anti-selection risk.

Online distribution concerns



*Of companies with online distribution

Similar to AUW policies, insurers offering policies through online distribution apply limits to face amounts and age – ranging between $500,000 to $1 million and offered only to applicants from 18 to 45 years old. Term limits are also being used.

Notably, one insurer reported that they closed their online distribution due to fraud, providing the following insight:

> "We don't have DTC. We used to have a DTC distribution but closed out a few years ago. The amount of material misrepresentation was very high."

RGA notes that when an insurer allows the applicant to self-complete applications, there is significant potential for misrepresentation, whether intentional or unintentional. RGA notes that any selection point on an application is also an anti-selection point. This means that any time the customer is given a choice (selection point), that is also an opportunity for the customer to choose in their own interest and against the interest of the insurer (anti-selection). Behavioral science techniques help improve the customer journey, and having an examiner assist people with completing their application encourages better disclosures and reduces misrepresentation.

Individuals or teams designated for fraud investigations

Survey findings indicate that 84% have designated individuals or teams for fraud investigations, and 52% use a Special Investigation Unit (SIU). It was also common to have these individuals within Life Underwriting Units and Compliance roles. Insurers employed an average of five full-time employees (FTEs), a large increase since 2016 when respondents reported employing one FTE.

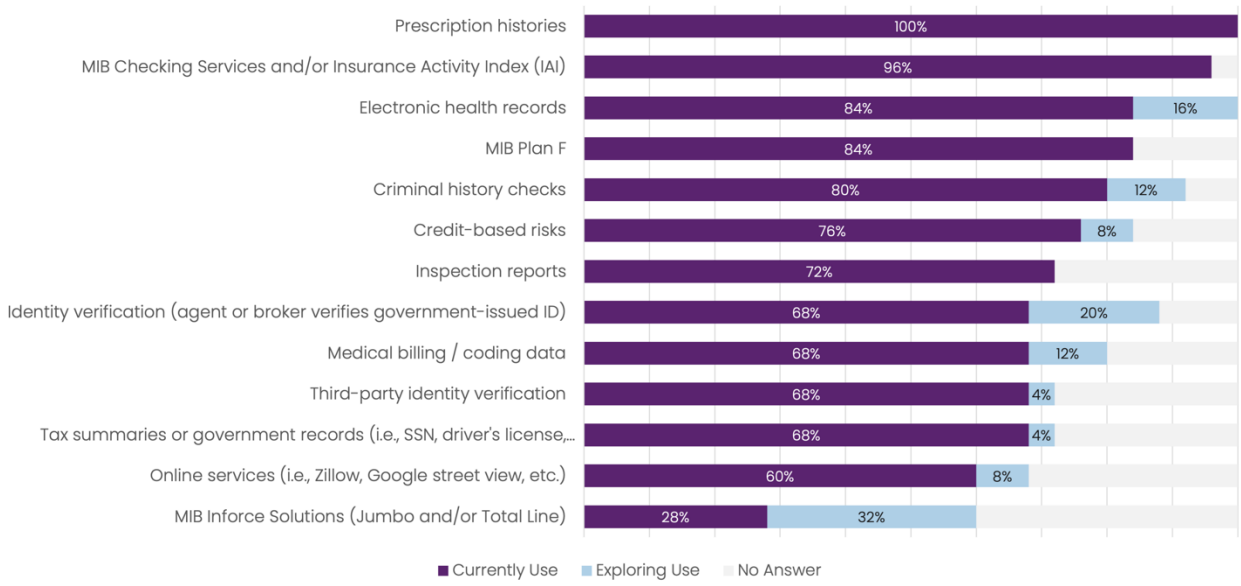
Tools to detect and prevent fraud

Tools have evolved and grown significantly since our previous survey, highlighting insurers' investment in preventing fraud and their increasing importance to the industry. These tools are intended to mitigate fraud during the application process. The list of available tools has grown since 2016, based on need. Nearly all respondents are using prescription histories and the MIB Checking Services or Insurance Activity Index (IAI) to help detect and mitigate fraud in life insurance applications. Electronic health records and MIB Plan-F are also used by 84%.

MIB In Force Data solutions (Jumbo and/or Total Line) and identity verification are the top two areas insurers are exploring.

Determining the types of fraud being targeted is important so the appropriate tools can be applied, and the trends and problems can be better understood.

Tools to detect and mitigate life insurance fraud



Underwriting continues to be the first line of defense in the detection and prevention of fraud, including agent fraud. Insurers are enhancing underwriter training to identify red flags, and the use of the MIB databases has increased.

Tools being used to identify agent fraud

88%	Training underwriting to identify red flags
80%	MIB databases
72%	Monitoring agent policy placement and behavior (cases and agents' books)
72%	Inspection reports/telephone interviews
68%	Monitoring blocks of business
32%	Vendor-provided tools (e.g., Fraudshare, Vector One, Prodigy)
8%	Other: Monitor mortality slippage and non-disclosure trends by advisor; monitor variable blocks of business
25 Respondents	

Algorithms or analytics used in underwriting for fraud detection

In line with the development of tools being utilized to detect and mitigate fraud, we have also seen an expected uptake of 32% of insurers using more algorithms and analytic tools to flag questionable underwriting applications. In our 2016 survey, only 10% reported their use.

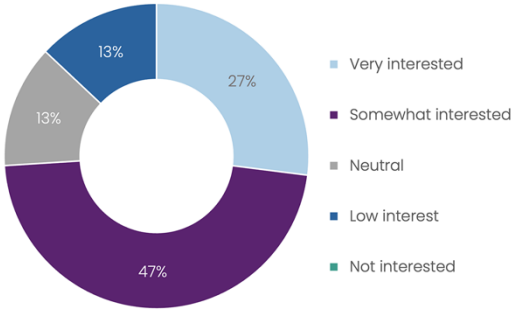
Respondents noted the use of Risk Classifier tools, credit scoring tools, and reports generated for unusual activity, such as speed to complete, time/location stamps, proximity between different applications, and intake methods. Other approaches include an algorithm to predict the overall risk of a potential insured to help determine what requirements are needed, as well as reviews of pending and in-force policies to detect fraud.

Other underwriting flags that respondents would like to consider but lack data to investigate include:

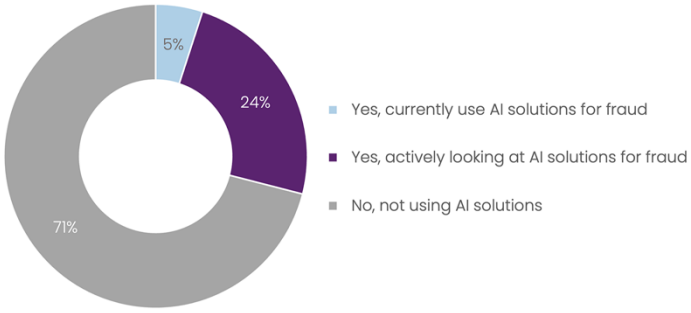
- Foreign national IDs and footprints; citizen checks
- Visa information
- Credible criminal background checks
- AML risks
- Income and net worth verification
- Improved employment checks

AI and data analytics to detect fraudulent applications

Interest in using data analytics or tools to detect fraudulent applications



AI solutions to detect or combat fraud



Seventy-four percent of respondents are interested or very interested in using data analytics or tools to detect fraudulent applications. One-quarter of respondents showed neutral or low interest in these tools. One respondent reported they currently use AI solutions to detect or combat fraud, while 24% are actively looking at AI solutions.

Looking forward: Future innovations for fraud detection and prevention

Data and data sources

Insurers continue to look for new and enhanced data and data sources to combat fraud. The survey findings provided the following examples:

- Biometrics to ensure applicant's identity
- Increased data sources with app questions to ensure proper disclosures
- Trustworthy databases for financial and medical histories
- Less traditional data sources to predict risk factors
- Deeper use of data, algorithms, and AI

Artificial intelligence (AI)

Respondents hope to use AI more to predict and detect fraud, including:

- AI-detection of unusual patterns of behavior
- Solutions for identifying questionable business
- Use of generative AI and AI-related tools
- Use of AI to provide a scored evaluation on a case as part of simplified issue/AUW

Fraud risk assessments

The insurance industry will continue to develop and improve verification methods and behavioral risk assessments. Some respondent examples include:

- Incorporation of more data sources associated with application questions to ensure the disclosure of known conditions or activities
- Tools to monitor and detect applicant behavioral flags
- Smoker propensity models
- Ability to detect financial fraud with income and worth verification tools, and tools to identify tobacco fraud and height/weight discrepancies
- Ability to flag a fraudster in underwriting platforms before they submit an application, such that the platform prevents them from clicking "submit" and provides "real-time" detection

Best practices for fraud detection

RGA recommends improving the customer journey and the use of behavioral science techniques to influence and educate people to complete their applications more accurately and encourage better disclosures. Where insurers are using a captive sales force, it would be helpful to have an examiner assist, when possible, to also enhance application disclosures and accuracy.

Other best practices include continued focus on underwriter training for fraud detection – identifying red flags and using the tools and MIB databases available. Insurers should ensure that their underwriting rules engines are modernized to align with fraud detection tools.

A continued practice of post-issue monitoring for anti-selective patterns is highly recommended, including the use of resources such as In Force Data Solutions (Total Line and Jumbo), MIB Codes, IAI, medical claims data, prescription history data, and Plan-F.

Insurers must continue to expand their use of data-driven tools and algorithms, as well as industry databases to reduce the cost of anti-selection to the insurance industry and consumers.

Conclusion

Fraud continues to be a concern for the life insurance industry and will remain so for the foreseeable future. The challenge of combating fraud is pervasive and will require more resources, tools, and enhanced data and data sources, including contributory databases such as MIB's Data Vault. We also see opportunities for implementing behavioral science techniques to improve disclosures and dissuade misrepresentation from applicants.

For more information about the survey, please contact:

Leigh Allen
AVP, Strategic Research
RGA
lallen@rgare.com

Trey Reynolds
Executive Vice President
MIB Group, Inc.
TReynolds@MIB.com

Colin DeForge
VP, Underwriting
RGA
Colin.DeForge@rgare.com

Survey Definitions

Accelerated Underwriting (AUW) - A fully underwritten process by which certain requirements are waived for a portion of applicants demonstrating favorable risk characteristics.

Churning - Replacing an existing policy with a new policy from another company for the purpose of generating additional commission revenue. This can impact insurer profits. While churning primarily relates to agent behavior, stacking also reflects policyholder behavior.

Community Fraud - Fraud that is attributed to travelers (or typically nomadic people) who conspire to conceal an illness or medical condition of the insured during the contestability period of an insurance policy for the purpose of the beneficiary receiving an early duration claim payment.

Criminal Fraud - Actions that are more significant than errors or omissions in applications. These actions could lead to criminal prosecution and could include forgery, falsifying underwriting evidence, as well as faked deaths.

Document Tampering/Altering ("Whitewashing") - Altered document checks being submitted to augment an insurance-related outcome.

Financial Misrepresentation - Inaccurate reporting of financial information, including income or net worth.

Jumbo Violation - Total coverage above a specified limit, for example, $65 million.

Medical Misrepresentation - Untrue or incomplete medical information provided on an insurance application.

Non-Medical Misrepresentation - Untrue or incomplete information related to avocations, driving, aviation, etc. provided on an insurance application.

Rebating - Returning a portion of the premium or the agent/broker's commission on the premium to the insured or other inducements to place business with a specific insurer. Rebating is illegal in the majority of states.

Stacking - A policyholder owning multiple policies to increase the amount of coverage with a lower level of underwriting scrutiny than if a single large policy had been purchased. The effect of this is higher claim amounts than an insurer would expect to experience if the policy was underwritten for the full amount.

Disclaimer and Copyright

This report is provided for information purposes only, and any user will be responsible for making its own independent investigation and judgment concerning its contents.

In developing this report, Reinsurance Group of America, Incorporated ("RGA") has relied upon the accuracy and completeness of a substantial amount of data and information supplied by various resources, including studies without independent verification.

Information contained in this report is not exhaustive and does not cover all issues, topics, or facts that may be relevant to your goals. Nothing contained in this report should be construed as rendering any form of professional advice.

The content of this report may include technical inaccuracies or typographical errors, and RGA may make changes or improvements at any time. RGA assumes no liability or responsibility for errors or omissions. RGA does not undertake any obligation to update or correct information if it is not, or is no longer, accurate or complete.

This report and any opinions and conclusions contained herein have been prepared for the benefit of companies which participated in the study. RGA, its subsidiary companies and each of their directors, officers and employees expressly disclaim all and any contractual, tortious, or other form of liability to any person in respect of any consequences arising from its use in reliance upon the whole or any part of this report or any of the information contained herein. By using this report any such third party hereby releases, holds harmless and forever discharges RGA, its subsidiary companies and each of their directors, officers, and employees from any and all claims, actions or causes of action of any nature whatsoever arising from its use.

©2024, Reinsurance Group of America, Incorporated.
All rights reserved. The contents of this report are copyrighted work of Reinsurance Group of America, Incorporated. Reproduction or disclosure in whole or in part in any medium without the express written consent of the copyright holder is prohibited. Requests for such permission should be forwarded to publications@rgare.com