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The Cost of Soft Fraud

Why Inflated Claims Are Eroding Insurer Margins More Than Hard Fraud

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ABSTRACT

Hard fraud, fabricated claims, staged accidents, and fictitious injuries attracts regulatory attention, enforcement resources, and industry-wide reporting because individual cases are large and visible. Soft fraud, inflated medical bills, exaggerated repair estimates, and slightly padded injury claims is individually small, extremely common, and structurally invisible to the SIU case selection process. Industry estimates consistently place soft fraud at 60% or more of total fraud incidents. The aggregate financial cost exceeds hard fraud in most portfolios. And it persists precisely because the data that would identify it systematically, the unstructured text fields where the inflation signals live, is not scored by most claims platforms. This paper makes the financial case for why soft fraud is the combined ratio problem that insurers are not measuring correctly, and explains why the detection architecture needs to change.

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The fraud most insurers are not measuring correctly

The insurance industry's public conversation about fraud is dominated by hard fraud: the staged accident ring that generates a six-figure settlement for a fictitious injury, the arson claim on a failing business, the phantom vehicle insured for more than it was worth. These cases are individually large, sometimes prosecutable, and generate the kind of evidence that law enforcement and regulatory bodies can act on. They are documented, reported, and tracked.

Soft fraud generates almost no individual case large enough to prosecute, almost no evidence that distinguishes it cleanly from a legitimate claim, and almost no referrals from the standard triage process. An injury claim that has been inflated by 30% looks, individually, like a claim for a slightly expensive injury. A repair invoice that has added two items not covered by the incident looks, individually, like a slightly high repair bill. Neither breaches a rules threshold. Neither triggers a handler referral. Neither reaches an SIU desk. Both are paid in full.

Industry analysis places soft fraud at approximately 60% of all fraud incidents, according to Perceptive Analytics citing insurance fraud research, while detection rates for soft fraud sit between 20% and 40% of estimated volume. The cost-of-investigation argument compounds the problem: the Coalition Against Insurance Fraud notes that the cost of formally investigating a USD 500 inflated estimate often exceeds the cost of simply paying it, which creates a structural economic incentive for soft fraud to persist at precisely the level where individual investigation is not worth initiating. The accumulated cost across hundreds of thousands of individually uninvestigated small inflation events is not small. It is the difference between a profitable and an unprofitable combined ratio.

Soft fraud accounts for an estimated 60% of all insurance fraud incidents and carries detection rates of only 20 to 40%. It persists because individual investigation is not economically rational per case. Systematic detection across the full claims population is the only architecture that changes that equation.

What soft fraud looks like in practice

Inflated medical and rehabilitation billing

The most prevalent form of soft fraud in motor and health lines is provider billing inflation: physiotherapy sessions billed at rates slightly above the documented treatment, treatment courses extended by one or two sessions beyond the clinical record, diagnostic tests ordered that are not directly related to the incident injury but billed against the claim. Each addition is individually defensible if queried. Collectively, across a provider's claim history, the pattern of systematic over-billing is detectable in the billing description fields of treatment invoices, which are free text.

No structured fraud detection platform compares a physiotherapy provider's billing descriptions across the claims of every insurer that has received invoices from that provider. The information to identify the inflation pattern exists in those descriptions. The architecture to surface it does not, in most markets.

Exaggerated injury duration and severity

A soft-tissue injury claim that settles for an amount consistent with a three-month recovery when the claimant's own contemporaneous descriptions in correspondence, call transcripts, and adjuster notes suggest a six-week recovery is a soft fraud case. The discrepancy is not in the structured claim fields. It is in the unstructured text: what the claimant said during the first notice of loss call, what the adjuster wrote in the case notes after the medical examination, what appears in the solicitor's correspondence about the injury's impact on daily life.

Identifying that discrepancy requires comparing text from multiple sources within a single claim, and comparing the patterns of those discrepancies across many claims to identify whether a particular medical practice, solicitor, or claims management company is systematically generating longer-duration injury narratives than the incident evidence supports.

Repair inflation and parts substitution

Garage and body shop invoicing inflation follows the same pattern as medical billing inflation: individually plausible additions that accumulate systematically. A workshop that adds a steering alignment check to every motor claim it processes, regardless of whether the incident could have affected steering geometry, is generating soft fraud across dozens of claims simultaneously. The word "alignment" appears in the invoice description field of every affected claim. No individual claim handler notices the pattern. No rules flag catches it. The billing description field is free text.

The combined ratio impact

Soft fraud's financial impact is most precisely expressed in combined ratio terms rather than in headline fraud statistics, because it accumulates in the loss ratio rather than generating the identifiable large claims that fraud statistics capture. Shift Technology research, published in its Claims Fraud Benchmark Report, indicates that 2 to 3 percentage points of a typical insurer's combined ratio are attributable to fraudulent claims, with effective detection capable of improving the combined ratio by 1 to 3 points. ZEB consulting analysis of the German market, where the GDV estimates over EUR 6 billion in annual fraud costs, suggests that insurers mastering fraud management can reduce their combined ratio by up to 3 percentage points.

The practical implication for a mid-size insurer: for a carrier with EUR 200 million in non-life GWP and a 65% loss ratio, gross claims paid are approximately EUR 130 million annually. If soft fraud accounts for 60% of a 7% overall fraud rate, the soft fraud component represents approximately EUR 5.5 million in annual losses. At a 20 to 40% detection rate for soft fraud using conventional triage, EUR 3.3 to 4.4 million of that is going uninvestigated and paid each year. At a 50% recovery rate on what systematic scoring would identify, the gap represents EUR 1.6 to 2.2 million in annually recoverable value, for one mid-size insurer, from soft fraud alone.

Across a portfolio of 500,000 claims a year at an average soft fraud overpayment of EUR 600 per affected claim and a 6% soft fraud incidence rate, the total annual soft fraud cost is approximately EUR 18 million, according to a methodology consistent with Perceptive Analytics' industry benchmarking. At current detection rates of 20 to 40%, between EUR 10.8 million and EUR 14.4 million of that is paid without challenge each year.

Portfolio parameter	Value	Basis
Annual non-life GWP	EUR 200 million	Representative mid-size motor and health insurer
Estimated loss ratio	65%	Industry benchmark; actual ratio varies by market
Annual claims paid	EUR 130 million	Calculated: GWP x loss ratio
Overall fraud rate	7%	Conservative estimate; Coalition Against Insurance Fraud cites up to 10%
Soft fraud share of total fraud	60%	Industry estimate: Perceptive Analytics citing fraud research
Annual soft fraud exposure	EUR 5.5 million	Calculated: EUR 130M x 7% x 60%
Soft fraud detection rate (conventional triage)	20 to 40%	Industry estimate from fraud analytics literature
Annually uninvestigated and paid	EUR 3.3 to 4.4 million	Calculated: exposure less detected share
Recoverable value at 50% recovery rate	EUR 1.6 to 2.2 million/yr	Calculated: uninvestigated portion x 50%

All figures are estimates based on published industry benchmarks. Actual results will vary by portfolio, market, line of business, and existing detection infrastructure. Sources: Perceptive Analytics insurance fraud benchmarking; Coalition Against Insurance Fraud; Shift Technology Claims Fraud Benchmark Report (2023); ZEB consulting fraud management analysis.

Why structured data scoring is not enough

Most modern claims fraud detection platforms score structured data: policy dates, claim amounts, claimant demographics, incident locations, repair cost totals. These fields are consistent, comparable, and suitable for rule-based and machine learning approaches. They are also, on their own, insufficient to detect soft fraud systematically.

Soft fraud signals live in free text. The adjuster note that records a discrepancy between what the claimant described on the first call and what the medical report states is free text. The repair invoice description that lists work inconsistent with the stated incident is free text. The first notice of loss narrative that uses templated language shared across twenty other claims filed through the same solicitor is free text.

A SAS Institute analysis cited by the Coalition Against Insurance Fraud found that unstructured data represents up to 80% of total claims data, and that between one-third and one-half of the variables used in fraud detection models in well-designed programmes come from unstructured text fields. Yet only 40% of insurers use text mining as an anti-fraud tool. The majority are making fraud detection decisions based on a fraction of the available information, specifically the fraction that does not contain the inflation signals.

Unstructured data can represent up to 80% of total claims data. Between one-third and one-half of the most reliable fraud detection variables come from free-text fields. Most insurers are not scoring them. The inflation signals they contain are being paid, not investigated.

Priimal Claim: A Vantage product

Priimal Claim scores every claim in the submission, including all free-text fields. Adjuster notes, first notice of loss narratives, repair invoice descriptions, and call transcripts are processed alongside structured claim fields. Vantage scores across six fraud flag types (Fraud Ring, Staged Accident, Provider Collusion, Inflated Repair, Duplicate Claim, Soft Tissue) and returns a prioritised investigation queue. The Inflated Repair and Soft Tissue flags address the specific soft fraud typologies described in this paper: repair billing inflation visible in invoice description text, and injury duration and severity inconsistencies visible in adjuster and claimant narrative fields.

Because every claim is scored rather than a triage-filtered sample, soft fraud cases that individually fall below referral thresholds are visible in the full-population output. The case queue includes the risk score, confidence level, flag explanation, and the specific text passages or data relationships that generated the flag. SIU investigators receive a prioritised list that includes soft fraud cases alongside hard fraud cases, allowing them to decide which to pursue based on documented evidence rather than threshold flags alone.

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