

A new era of P&C claims management

Handling claims in an increasingly digital, analytic, and flat world



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Analytics come of age

From the moment a customer notifies an insurance company of a loss, there is valuable data created that insurers can use to build models to predict the severity of the claim. There are claim characteristics, insured characteristics, call transcripts, pictures, and environmental factors that can feed these models. Property and casualty insurers can use advanced systems to analyze that data when the claim comes in. They can also leverage complex event processing systems to parse the additional information that comes in throughout the adjudication process, in real-time, to infer and predict events and patterns. Such in-

the-moment data analysis can enable carriers to take the right action at the right time to improve outcomes.

Imagine a physical therapist and chiropractor are added as new medical providers on an existing personal injury claim. That could be flagged automatically as such a combination has been shown to increase the likelihood of overtreatment, also known as soft fraud. The introduction of such new information in conjunction with certain other circumstances could also trigger an immediate independent medical examination that might prevent mounting and unnecessary medical bills.

enable insurers to address potential loss-making claims issues proactively.

Insurers can also use a variety of structured and unstructured data to predict the frequency of certain types of claims (general liability, workers compensation, and bodily injury, for example), how long the claim will take to pay out, the risk of subrogation or litigation, and the chance that a claim will close without payment.

Applying advanced analytics throughout the claims management lifecycle has a direct impact on the bottom line. By predicting the frequency and severity of certain types of claims, and the likelihood that a claim will close without payment, insurers can better manage their cash reserves, improve investment outcomes, and more rationally align the resources dedicated to a claim with its value to the company. By having more accurate forecasting of the risks of subrogation, litigation, and fraud, insurers can identify those at-risk claims earlier and

A robust analytics model may monitor up to 30 variables that will automatically trigger a reevaluation of a claim's fraud potential if any of those factors changes over time. These models





manage them more effectively. Finally, carriers can feed this claims intelligence back to the underwriting team in order to improve their actuarial models. In fact, insurers who leverage analytics technologies to make sense of the growing amount of internal and market data available ultimately will gain competitive advantage, according to a report released by PriceWaterhouseCoopers⁶.

Divining better outcomes with data

By using advanced analytics throughout a claims lifecycle, property and casualty insurers can introduce a number of new processes to optimize claims adjudication from the first notice of loss all the way through payout.

A top five U.S.-based property and casualty carrier built a predictive model to better understand the key drivers of claims severity. It then used this intelligence to inform a new operational process for automatically routing a new claim to the best adjuster according to the specifics of the case. Along with routing the claim,

the system also delivered a set of next-best actions for the claims adjuster to optimize loss ratios, adjustment expenses, and customer satisfaction. By getting the right claims to the right handler at the right time, this carrier also improved claims handler retention.

Another leading insurance carrier was able to predict which claimants would be most likely to sue. Litigation costs constitute to be the greatest expense associated with general liability claims. Early indicators of potential legal action can help insurers better manage and reduce the associated costs. By flagging claims likely to wind up in court early in the adjudication process, the company was more likely either to prevent the legal action or settle more quickly, as well as more accurately reserve the cash required for legal expenses. The analysis also helped the insurer better understand the factors that result in legal action on a claim.

Similarly, another U.S.-based property and casualty insurer (which had one-third of its claims in litigation at any given point in time) wanted to rationalize its massive investment in attorney time. Using data related

to claims characteristics, legal expense drivers, and attorney skills, the company built a model that could predict whether a claim could be handled best by staff attorneys or more-expensive external counsel. This insurer was able to compare the effectiveness of internal legal staff to external counsel in terms of payments and litigation duration to most effectively manage litigation costs. Using key data about claim characteristics, legal-expense drivers and attorney skills and expertise, the model predicted the best option for reining in legal costs without compromising (and, in some cases, actually improving) outcomes. And this more effective allocation of counsel led to faster and less-expensive claim resolutions. Ultimately, the carrier realized annual savings more than \$100 million in legal expenses.

The cost of auto personal injury protection coverage in no-fault U.S. states has been skyrocketing due to increased medical costs, excessive treatment, fraud, and significant litigation. One U.S.-based auto insurance company analyzed medical billing, claims, legal



and policy information to improve the handling of these claims and identify suspicious cases early in the process. The insurer was able to predict how such claims would progress over their lifetimes, thereby helping claims adjusters flag and handle suspicious cases. The company was also able to provide underwriting and product teams with intelligence about how specific attributes affected the total costs of these claims in order to better align pricing with risk. By analyzing unstructured data in adjuster notes, the carrier identified several factors (number of household relatives, age, gender, pre-existing medical conditions and occupation) that could affect risk. Now the insurer is considering collecting that information in a structured, digital format to determine future product pricing.

In many cases, the insight of medical professionals may be helpful during claims adjustment. Exactly how beneficial it was used to be anyone's guess. One leading property and casualty insurer wanted to measure the impact of assigning a nurse to its potentially severe no-fault, firstparty auto claims. The company created a model to predict the impact of

nurse involvement on medical payouts, arbitration and litigation, and more accurate cash reserving. They discovered that in cases with certain attributes nurse involvement led those involved in the claim to return to work sooner, thus lowering payouts. Another U.S.-based property and casualty carrier developed an early warning system to predict claimants in no-fault states like New York and New Jersey likely to use costly ambulatory surgical centers for treatment. By assigning a nurse and case manager to those claims, the company was able to save \$2 million a year on medical coverage.

General liability insurance claims usually turn out in one of two ways—a huge payout or no payout at all. One insurer saw the majority of its general liability claims close without payment. However, the resolution of those claims took several years during which the

carrier was forced to set aside large reserves, negatively affecting working capital. To better manage the costs associated with these no-pay claims and better manage its cash reserves, the insurer built a model that would predict whether a claim was likely to close without pay. Today, the company is able to assign the appropriate level of claims handling to these no-pay cases and free up cash previously reserved for their payout.



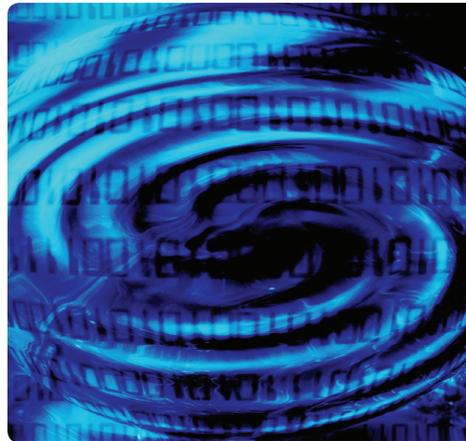


While there are instances of hard fraud (purely fabricated loss claims) in the property and casualty industry, the majority cases involve soft fraud. A claimant may exaggerate the details of an accident or file for additional injuries not experienced. Medical providers can pad their bills. Even adjusters can pad or invent claims.

Because fraud is dynamic, past fraud patterns are often ineffective in predicting future fraud. Insurers today are using machine-learning techniques capable of recognizing non-linear patterns in the most recent unstructured claims notes to predict fraud. Carriers can also take advantage of new sources of digital data they never had access to before, such as claimants' social media activity. If, for instance, the insured has filed a workers' compensation claim but is also posting photos of his latest ski trip on Facebook, that behavioral data can help inform the claims management process.

By identifying potential fraud more quickly, the insurer can route the suspect claim to an investigator before

expenses pile up or the claim is paid. For example, the early prescription of opiates, along with overlapping treatments by chiropractors, physical therapists and massage therapists, when combined with other claim attributes, may trigger a fraud referral. One leading U.S.-based property and casualty insurer used advanced analytics to identify potentially fraudulent auto and workers' compensation cases earlier in the claims



administration process. By flagging an additional 15% to 18% of questionable claims sooner — allowing for more targeted mitigation efforts — the company was able to save \$12 million to \$14 million a year. Leading carriers are creating fraud detection systems that continue to re-evaluate fraud potential every time

data is added or changed on the claim. Such ongoing reassessment outside of a regularly scheduled fraud rescoring process enables adjusters to view, prioritize and address claims to drive the best outcomes.

Digitization, analytics, globalization: the new competitive differentiators

In today's property and casualty insurance environment, the integration of automation and analytics into the claims adjudication process is no longer a luxury; it is a necessity. It will be one of the key drivers of sustainability in a highly competitive marketplace. But by forging partnership with global service providers who not only provide these new systems but the scarce talent to make the most of them, carriers can rework their outdated claims management processes.

The carriers on the cutting edge of such technology innovation will reap meaningful bottom- and top-line benefits. They will not simply cut costs but will improve the customer experience.



References

6. <http://www.pwc.com/us/en/insurance/publications/top-insuranceindustry-issues-2014.jhtml>



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