SHIFT

The New Stakes for Claims: How AI-based Decision Automation and Optimization is Powering a Customer Experience Revolution

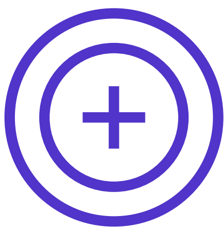
Éric Sibony

Chief Scientist and Co-founder, Shift Technology

www.shift-technology.com

The New Stakes for Claims

The insurance industry finds itself in a unique position when it comes to competition, differentiation and the insurer's relationship with the insured. Being a highly regulated industry, premium rates are often set by government agencies, limiting the ability to compete on price. And while many carriers do introduce new products and services, these frequently resemble variations on a theme as opposed to something radically different than before. Unlike most other business to consumer relationships, after buying their coverage, policyholders rarely interact with their carrier. That is until something bad happens. Taken together, these factors mean insurers must focus on delivering an exceptional customer experience to keep their policyholders happy, loyal, and willing to recommend the carrier to friends and family.



Because of this, insurers have long focused on the point of sale to establish a positive rapport with their customer. Making it easy to establish a policy, offering the right coverage for their needs, and providing the best rates possible was the accepted means to make most customers feel positive about their choice of provider. The advent of the "on demand economy" began to radically change things for insurers. Customers who could now buy almost anything with a simple click of the mouse or the swipe of a finger on their mobile screen were left wondering why buying insurance could not be that easy. As a result, and now facing new competition from "digital native" insurers, the incumbents focused on creating their own version of customer-self-service for insurance. Today, buying insurance is as easy as ordering dinner. The revolution has clearly begun.

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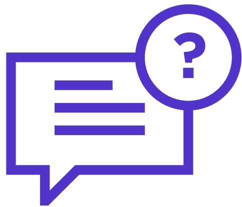

Yet, revolutionizing how customers obtain and/or renew their coverage simply is not enough. In this scenario, we are assuming that a policyholder is only interacting with their carrier once, or maybe twice during the lifecycle of their policy. And while that would be good news for both the insured and the insurer – no need for contact likely means there has been no need to file a claim – we all know the reality. Keeping a customer happy when things are going well is one thing. Keeping customers happy (or at least minimizing their frustrations) when they have wrecked their car, flooded their bathroom, or had a tree fall on their roof is an entirely different story. Why is delivering an exceptional customer experience during the claims process such a difficult accomplishment to achieve?

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To answer that question, we first need to truly understand the claims process. What many, even some industry insiders, perceive to be a singular, linear progression, is significantly more complicated. The final outcome of any claim – to pay or not to pay, and how much to pay – is based on a complicated series of micro decisions that begins with "does the claimant have a policy and does the policy cover the claim?" While the answer to those initial question may seem easy to answer on the surface, in today's environment of phone calls, emails, portals and even apps, getting to, "yes you have a policy and yes the damage you're reporting appears to be covered," might involve more back-and-forth than anyone would expect.

And that is only the beginning. Claims professionals need to determine if the policyholder has provided all the required documentation to support the claim. They need to evaluate if the claim is suspicious, and if so, does it warrant further investigation by the SIU. Even if everything is legitimate, an adjuster must determine the extent of damage, if a deductible must be applied, or should a third-party be held responsible for some, or all, of the payout. The decision chain is long, complex, and frequently cumbersome. Both insurers and the insured are looking for something new from the claims process.

Let us first explore the policyholder's perspective on what a positive claims experience might look like. We have already addressed the simple fact that customers are used to using technology to instantly order dinner, a new pair of shoes, the latest best-seller, or even a car. Responding to customer demand, and a new understanding of what was possible, it was a natural next step to make going online to buy an insurance policy for that new car a possibility. But why stop there? Why can't filing a claim be as fast and easy as buying the policy itself? Today, the typical actions required to file a claim may feel something like this: Make a phone call; wait on hold; speak to an agent; get put on hold; get put on hold again; be transferred (perhaps multiple times); repeat basic information or answer security questions multiple times; follow up via more phone calls and/or emails; wait patiently; get paid. Unfortunately, even when the outcome is positive for the policyholder, they are often left with the sense of "shouldn't this be faster and easier?"

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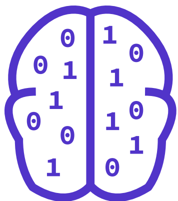

Although the frustration experienced by claimants is, by itself, a worthy reason to re-examine the fundamental claims process, we must remember also that this operational area is core to every insurers' business. It is the largest cost center in the insurance industry and those costs are divided between the actual claim settlement and the costs to the insurer of arriving at that settlement. In the case of large P&C insurers, those processing millions of claims per year, the cost of claims processing is massive. And in these large organizations, hundreds or thousands of claims handlers, adjusters, and/or investigators are all involved in settling policyholder claims. The combination of human resources required to examine submitted claims data and the time and inefficiency inherent in the handoffs between these internal resources to settle a claim make it very clear that the longer a claim takes to make its way through the insurer, the greater the cost the insurer is incurring to settle the claim. And as we have explored before, the more the upset the customer becomes. Thus, improving the claims process is a critical business requirement.

The next natural question then is, "how does the insurance industry accomplish this?" The good news on that front is that there are technologies already available in the market that can address both aspects of improving the claims process: the customer experience issue and the operational efficiency issue. Already proven as an effective way to identify suspicious behavior in the claims, underwriting and application process, when applied properly, Artificial Intelligence (AI) can empower insurers to not only deliver an exceptional customer experience, but also do so with increased operational efficiency and reduced costs. What we are talking about is using AI to support claims decisioning, either to support a seamless customer self-service journey or an "augmented" claims handler experience.

A customer self-service journey powered by AI is ideal for a variety of reasons. As we described earlier, the claims process is driven by hundreds of individual decisions from the time the initial claim is made to its settlement. Traditionally, those decisions are being made by humans. Even for what might be considered simple claims, the time and effort to make those decisions can be daunting. With AI, we now have the computer making those decisions based on data and past experience. It makes several evaluations at each stage of the claims process and determines the most appropriate next steps – beginning with does it appear that the claim may be fraudulent. When it determines the claim has no fraud risk, the AI continues to evaluate the claim and make decisions about next steps in the claim handling process. If at any point the AI determines that the claim is best handed off to a human claims handler – even if that reason is the AI does not know what to do next – the automation ends, and a human takes over. The benefit to insurers here is that the customers can interact with their insurer in the same way they engage with ride-shares, online retailers, and other digital businesses, boosting the customer experience.

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Insurers can also elect to deploy AI and decision science to provide employees with what can be called an "augmented" claims handling experience. In this scenario, the AI is used to help claims handlers make better and faster decisions. The focus with augmented claim handling is to improve the customer experience, and the insurance company's claim outcomes, for those customers who still wish to experience a more traditional claims process. This idea is receiving interest by the industry in the face of staggering internal knowledge loss as their most experienced claim handlers retire, and the ongoing challenges of recruiting new and inexperienced talent to the insurance industry.

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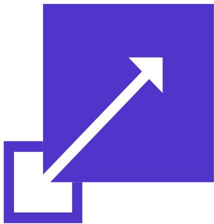

Some may ask, "why AI? Can't I do this using business rules and existing technology?" The reason AI is ideally suited to addressing these challenges – instead of, for example, a solution based on business rules – is that even relatively "simple" claims can involve incredible amounts of structured and unstructured data that must be analyzed and evaluated to arrive at the optimal outcome for the policyholder and the insurance company. There are documents and photos to analyze and there can be multiple parties involved. The complexities and unique attributes of each claim are what have traditionally required so much claim handler involvement, and what prevents a solution based on business rules or basic models from being effective at scale. And that's where AI really succeeds, because it can be trained to make decisions as accurately as an expert would, but to do so at virtually unlimited scale.

In all discussions related to the use of AI to drive transformation in the insurance industry, it is critical to remember that this is not about advocating for the replacement of people. AI is a tool. It augments insurers' teams. And if the AI is good enough to fully automate a percentage of claims, and if the AI is good enough to raise issues to the expert claims professionals when it can't decide with 99 percent confidence, insurers can allocate human resources to other areas where their skills are most valuable to the business.

We are poised for a customer experience revolution in the insurance industry. Insurers are approaching a point where an increasing number of claims can be accurately settled by an AI solution, and where AI can be used to make claims professionals more efficient, accurate, and focused on the claims where they are most needed. It is an exciting future when AI can support operational efficiency, help better leverage the skills and talents of each employee, and perhaps most importantly, drive better outcomes for the policyholder.

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About Shift Technology

Éric Sibony is Co-Founder and Chief Science Officer of Shift Technology, a provider of AI-native fraud detection and claims automation solutions for the global insurance industry. Since the establishment of the company, Éric has supervised the design of the solution and its evolution, as well as the R&D on the algorithms that it uses. He holds a PhD in machine learning.

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About Shift Technology
Shift Technology delivers the only AI-native fraud detection and claims automation solutions built specifically for the global insurance industry. Our SaaS solutions identify individual and network fraud with double the accuracy of competing offerings, and provide contextual guidance to help insurers achieve faster, more accurate claim resolutions. Shift has analyzed billions of claims to date, and is the Frost & Sullivan 2020 Best Practices Award Winner for Global Claims Solutions for the Insurance Industry.

Learn more at www.shift-technology.com