THE ANALOG TO

DIGITAL TRANSFORMATION

OF PROPERTY CLAIMS HANDLING

HOMEE

INTRODUCTION

Claims handling is the art of paying exactly what is owed to indemnify the policyholder experiencing a loss. While many adjusters would agree with calling claims handling an art, researchers are beginning to turn to science to refine the process further than ever before.

By utilizing **digital tools**, the average adjuster can make **smarter claims decisions** to **maximize efficiency** and customer satisfaction. That said, these digital tools shouldn't be used to recreate manual processes, as they so often are. Instead, these claims handling tools should take some burden away from claims staff by using good data to make decisions that a subjective adjuster may not have made.

Some may oppose this notion as too radical. This paper will serve as an exploration into this growing debate: **do data-driven solutions outweigh human experiences?**

HOMEE

CLAIMS HANDLING AND EXPERIENTIAL BIAS

How Claims Leaders are Made

Experiential bias is something we've all encountered, even if we never placed a name to the phenomenon in our own lives. Experiential bias is when a person's previous experiences impede or at least alter their ability to make judgements in the present. We have several adages that actively encourage experiential bias, such as "if it isn't broke don't fix it", or "this is how it's always been done". While these expressions are catchy and memorable, they're poor ways to make decisions which result in millions of dollars in lost productivity. Yet all too often adjusters hear these expressions from the very people who are meant to guide them towards more sound decision making: their leadership.

Claims leadership, from supervisor to VP, is often comprised of adjusters who have since shown a capacity for guiding peers and were thus elevated to a position of authority. While we must always respect the experience of those who came before, we also need to understand how this background lends itself to leaders relying on their past experiences all too easily.

HOMEE

If insurance companies are designed to make their policyholders whole, and often gauge their success as an organization by measuring customer satisfaction (typically in the form of NPS ratings), then once customer satisfaction begins to drop, the carrier needs to re-evaluate its processes.

Whether a sluggish escalation process delays repair completion, or erroneous initial estimates lead to large supplements and further handling delays, claims leaders should always be ready to reevaluate their existing processes to improve the policyholder experience.

Being able to identify when reevaluation is needed is the first step to build a better policy holder experience, but doing the hard work to begin implementing changes within the organization is the sticking point leaders often struggle with. It can be a daunting task to make alterations to claims handling processes while watching adjusters struggle in their current conditions. Changes to processes can be time-consuming and require additional effort on all levels to implement. However, the return on investment when a positive change is implemented is nearly always worth the effort to forging that change.

Suppose that, in the past, subrogation claims were a large factor for claims severity for a particular carrier. In response, the claims department began implementing more comprehensive review processes for subrogation demands to reduce inflated claims spend.

The process is labor-intensive for adjusters, and increases cycle time, but severity decreases as a result. Some claims leaders might see this as a necessary part of their claims handling process and make no further effort to mitigate the negative side effects of their solution. Meanwhile, in the modern environment, **65% of subrogation claims are automated**. Implementing an automated solution to handle subrogation files may be the best solution in this scenario, but some claims leaders might be opposed to trying based on previous experiences. If they were trained to view subrogation claims as a labor-intensive form of adjusting, they might oppose automation on principle without properly reviewing the data that contradicts their opinion.

Though many leaders may choose to rely on their own experience, some may yet decide that they wish to adopt new ideas to see if they'd fit their current situation. People who are willing to take on the work that comes with change to achieve the greatest outcome are often said to have a Transformation Mindset.

HOMEE

CULTIVATING A TRANSFORMATION MINDSET

Regarding change, a leader can have one of two mindsets: a transformation mindset, or a fixed mindset.

TRANSFORMATION

Transformation mindset leaders embrace change. They understand that industries are ever-changing, and that adapting to these changes, rather than resisting them, bring about better business decisions and processes in whatever new environment emerges next. Leaders with transformation mindsets often even seek out change unprompted, aware that innovating before it is necessary can lead to a proactive business strategy. It's these leaders that adopt technology solutions early, attaining higher prioritization with vendors for getting in before the rush of late adopters.

FIXED

Fixed mindset leaders are the antithesis of those with transformation mindsets: they often have a reactive approach to business strategy and do everything in their power to minimize the amount of change within the organization. They're eager to tout budget constraints when discussing new solutions, but often find funds for initiatives they're more comfortable with. These leaders often operate unchecked, due to the HiPPO phenomenon.

HOMEE

HiPPO is an acronym referring to the "**highest paid person's opinion**". This phenomenon highlights the very real state of corporate culture: stakeholders who are meant to be instrumental in guiding the discussion on new initiatives (claims handlers, vendor managers, etc.) end up defaulting to whatever the highest-ranking executive wants. Essentially, it's difficult to make a HiPPO budge once they've set their mind on something; if they've deemed that a solution is too costly, or too time-consuming to integrate, they'll dig in their heels and oppose it every step of the way. This can be a costly hurdle to overcome when the organization is in dire need of change. Stakeholders may even hide the detrimental effects the HiPPO's decisions have had on the business just to remain in their leader's good graces.

This is not to say that those with fixed mindsets are always poor leaders. Indeed, sometimes fixed mindset leaders are one good experience away from understanding the benefits of being more flexible. Other times, leaders are forced to adopt a fixed mindset because success for their department is so rigidly defined there's no room for change.

So, as business leaders, how do you set proper goals and KPIs to measure success that will in turn create strong leaders as they strive to achieve these goals?

HOMEE

DEFINING SUCCESS IN THE CLAIMS ENVIRONMENT

What metrics does your organization use to measure success? Common claims KPIs include cycle time and time to first contact.

Above all, the metrics you chose to track should be chosen for objective business purposes, rather than an assumption that the chosen metrics are sufficient. What was relevant to measure last year may be irrelevant as a metric this year. Leaders need to evaluate and reevaluate the measurements they're taking to ensure they're still relevant to the business' goals as well as the current market.

A prime example of this need is the debate about savings within the claims world: should you try to cut down on severity, or expenses?

Some claims handlers attempt to cut costs by attempting to reduce severity. There is merit to doing this, such as when SIU units combat cases of fraud or overinflation of damages. No one would argue that this is a necessary aspect of claims spend mitigation, however it is a losing battle to attempt to reduce severity in the case of legitimate claims with policyholders that need to be indemnified. In these instances, severity is not the best metric to measure claims handling success. Instead, in the case of many claims, it can be more effective to instead combat the spend on expenses.

HOMEE

For the purposes of this paper, when discussing expenses, we will be referring to Allocated Loss Adjustment Expenses (ALAE), or the expenses that come directly from the claims handling process. ALAE rises in a **variety of circumstances**, but can often be tied directly to the current state of the insurance industry and the macro environment in general. As it becomes more expensive to hire independent adjusters (IAs) and other claims professionals to assist in regular handling, it stands to reason that there is room to reduce the amount of ALAE spend if an insurance company has the correct staff and procedures in place.

That said, the refusal to evaluate process quality or integrate automated solutions can lead to fixed mindset leaders spending more money on expenses to compensate for legacy processes.

Because experiential bias can sometimes prevent even the best claims leaders from making objective decisions about handling processes, the insurance market is moving towards data-driven decision making.

Decisions driven by the objective performance of the business will have a greater impact than decisions made from previous experience, as we will illustrate in the following section.

HOMEE

A CASE STUDY OF THE DEATH OF TRADITIONAL TRIAGE

One of the cornerstones of claims handling is the concept of Triage, which refers to using pre-determined criteria to route the work to an appropriately skilled adjudicator. Triage is firmly engrained within claims culture. These criteria typically centers around: severity, fraud identification, public adjuster/attorney representation, and cause of loss.

Most organizations use lower-skilled staff to receive the first notice of loss (FNOL). These unlicensed, entry-level, or administrative-type professionals are tasked with making assessments based on traditional criteria. This historical approach usually assigns the work to the lowest skilled staff capable of handling the claim type. As the life cycle of the claim develops, it is often discovered that mis-assessment requires reassignment to higher-skilled staff.

HOMEE

For example the classification of the claim as lower-loss, mid-loss, and large-loss. The challenge with this methodology is that criteria are typically defined by the dollar value of the repair or estimate. Thus, a mid-loss claim might be repair costs between $35,000 and $100,000. The simplicity of this criterion is its binary nature. However, this information comes late in the life cycle and causes delays and hand-offs as the claim is routed to another higher-skilled adjuster to conclude.

Software companies selling an automated industry triage, are offering the mechanization of this analog approach to Triage. Using the same logic, the system can route the claim to the new adjuster based on data input by FNOL staff. However, if we challenge this experiential bias and begin to reimagine who does the work, what work they do, and how to match the work to the proper staff, perhaps we can optimize workflows and use of digitization.

In our case study, the carrier challenged the following assumptions:

- ✓ **Who is best at taking the FNOL report?**
- ✓ **What attributes of a claim, typically known at FNOL, can reasonably predict the complexity of the claim at full development?**
- ✓ **Which staff are best skilled to handle which profile of fully developed claims?**

The first assumption challenged was having non-adjusters taking FNOL instead of adjusters. The organization moved FNOL to their desk, adjusting staff. This change allowed licensed adjusters to assess the claims and start the investigation. The organizational data process team reviewed the historical claims by several attributes and identified many deemed predictive. The data team developed an algorithm, and the programmed work distribution system identified which staff type would be the best match for the claim by these data attributes.

Examples include causes of loss, fire claims versus theft claims, policy attributes, number of rooms, and roof breach. The final assumption challenged was the skill set needed by staff to handle the fully developed files. Training was provided to adopt a file ownership model. This retraining allowed claims to be matched to the professionals with the best skills to adjudicate and manage that work.

The revised model improved all key metrics. In 60% of the cases, the adjuster who took the FNOL kept that claim, requiring no hand-offs.

The algorithm of assignments led to a 90% accuracy rate, leading to a reduction of workflow-related reassignments. In this new model, expenses dropped due to efficiency gains at FNOL, cycle times dropped, quality improved, and NPS increased almost 10 points within a month.

HOMEE

A CASE STUDY ON CLAIMS IMPACT ON RENEWAL UNDERWRITING

When a policy renews, claims behavior during the prior policy periods usually impacts eligibility and pricing. Historically, base rates are grounded in actual loss experience by approved variables.

Emerging pricing methodologies expand the opportunity for insurance companies to rate not only by coverages but also by peril. Accurate by-peril pricing depends on the accuracy of the data fields within the digital claim file. The fields added to claims software systems were developed using old checklists with financial data stored within the supporting payment systems. This analog approach failed to leverage the capabilities of digitization to improve the pricing, underwriting, and claims adjudication process.

Process architects met with actuarial, underwriting, and modeling leaders within organizations to capture the needs and wants of their respective teams as it pertains to claims data. These requirements were included in building a work distribution algorithm. This holistic approach combined the need for specific data to properly route a claim with the data required to support the other teams.

HOMEE

For example, the parsing of fire losses required the FNOL agent to identify the *type* of fire. The choices are constrained by a list of values that include options such as cooking fire, electrical fire, or wildfire/grass fire. This approach led to more accurate coding and more accurate data consumed by others within the organization.

Currently under development is the transfer of property attributes captured at underwriting being accessed and transferred to the claims estimating program. This data provides many measurements, photos, construction components, and materials on the insured property. The hypothesis is that this information could focus any future investigation on coverage.

CONCLUSION

As illustrated in the case studies above, it is clear that we are entering a new digital era of claims handling. Despite the insurance industry moving in this direction, some claims leaders are resistant to new ideas and experiments in their processes based on an experiential bias. While experience is an important factor in leadership, carriers should seek to cultivate transformation mindsets within their leaders to encourage less biased decision-making.

Moreover, these organizations should routinely reevaluate their goals and metrics to ensure that the old methods built off experience have not been outpaced by the market. We have seen examples of the success of data-based decision making from our co-author, **Dr. Theresa Young**, when it comes to the topics of triage and renewal underwriting. As outlined above, claims leaders need to put their biases aside and start using data to make better decisions around their claims handling process to secure their organization's place in the modern insurance market.

HOMEE

REFERENCES

CSAA Insurance Group. The Death of Traditional Triage & Claims Impact on Renewal Underwriting. Unpublished internal documents.

Jankel. (2021). The Transformation Mindset. Duke. https://www.dukece.com/insights/the-transformation-mindset/#:~:text=The%20transformation%20mindset%20takes%20the,-%20and%20ruthlessly-changing%20world.

Marr. (2017). Data-Driven Decision Making: Beware Of the HIPPO Effect!. Forbes. https://www.forbes.com/sites/bernardmarr/2017/10/26/data-driven-decision-making-beware-of-the-hippo-effect/?sh=29fa65780f9f

Nickerson et al. (1991). Casualty Loss Reserve Seminar 2B: Loss Adjustment Expense Reserves. Casualty Actuarial Society. https://www.casact.org/sites/default/files/old/clrstrans_1991_55.pdf

Savage. (2019). Data-Driven Claims Solutions and Mobility Claims. Verisk. https://www.verisk.com/insurance/campaigns/data-driven-claims-solutions-and-mobility-claims/

HOMEE