REINVENTING INSURANCE CLAIMS PROCESSING WITH DATA DIGITIZATION

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INTRODUCTION

Today, the insurance industry is witnessing new and quickly-evolving consumer expectations and behaviors. This caused a fundamental shift in how insurance companies serve customers – especially at this point in time when without access to either offices or staff, the pandemic accelerated the awareness and motivation of many insurers to achieve digital transformation.

Enterprises whose operational processes are still predominantly based on painstaking, manual assessments and filing of incoming documents – dare we say paper? – are finding themselves substantially penalized. More than that, however, the global crisis has taught us, once and for all, that digitization is the name of the game – not just for success, but also for survival.

It's a significant moment for the insurance industry, which risks lagging in what McKinsey calls its "digital maturity." Many experts within the industry turn toward Intelligent Automation to streamline the claims process and overcome the struggles posed by manually-entered information.

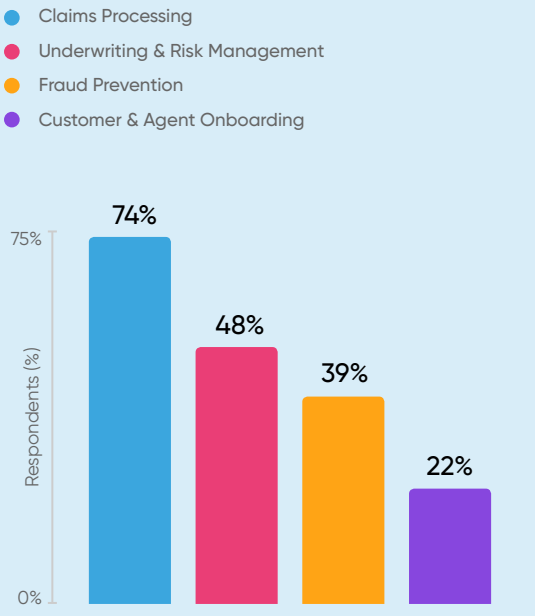
To seize this opportunity, insurance leaders need to spearhead a 'do-not-delay' mindset transforming claims operations to enhance customer experience and significantly improve internal operational processes.

BETH HAMPTON
Digital Editor, Shared Services and Outsourcing Network (SSON)

"Digitization is revolutionizing the insurance industry by significantly transforming the customer experience by bringing in superior experience and services at much lower cost."

SURAJ WALIA
Business Leader – Global Shared Services, MetLife

Which aspects of the insurance chain are you seeing the most adoption with Intelligent Automation?



SOURCE: Mantra Labs Global

THE ISSUE AT HAND – UNSTRUCTURED DATA

Claims processing relies heavily on short turnaround times, investigation accuracy and calculative evaluation to meet customer expectation and drive credibility. Customer satisfaction is achieved by minimizing disruption and maintaining high efficiency.

However, along the claims processing value chain there are several challenges:

- Multiple communication channels for FNOL (First Notice of Loss)
- Lengthy processing after FNOL
- Increase in litigation and legal expenses
- Increase in fraudulent claims
- Exponential increase in settlement cost
- Pressure on premiums drives the need to drive down claims related expenses
- Traditional insurers challenged by digital natives
- Up to 80% of customer complaints come from poor claims experience

Claims processing requires gathering a vast amount of information from several sources, creating exhaustive quantities of data. Current claims systems may lack functionality and flexibility resulting in excessive levels of manual processing. This inhibits efficiency and flexibility, which slows down response time and negatively affects the customer experience.

The good news for insurers is that Intelligent Automation digitally transforms claims processing by ingesting various data sources from 3rd parties. This enables more digitized information available for automating claims processing.

Automated claim processing is not new – many insurers have been processing high-volume, low-cost claims, with very little (if any) human intervention often targeted at the simplest type of claim with relatively low value. A quick-win expansion of this approach is to target similar claim types, or items that are part of a wider claim and lend themselves automation. Transformational claims steps have been taken but the unstructured data challenges remain.

UNSTRUCTURED DATA DOMINATES THE CLAIMS PROCESS

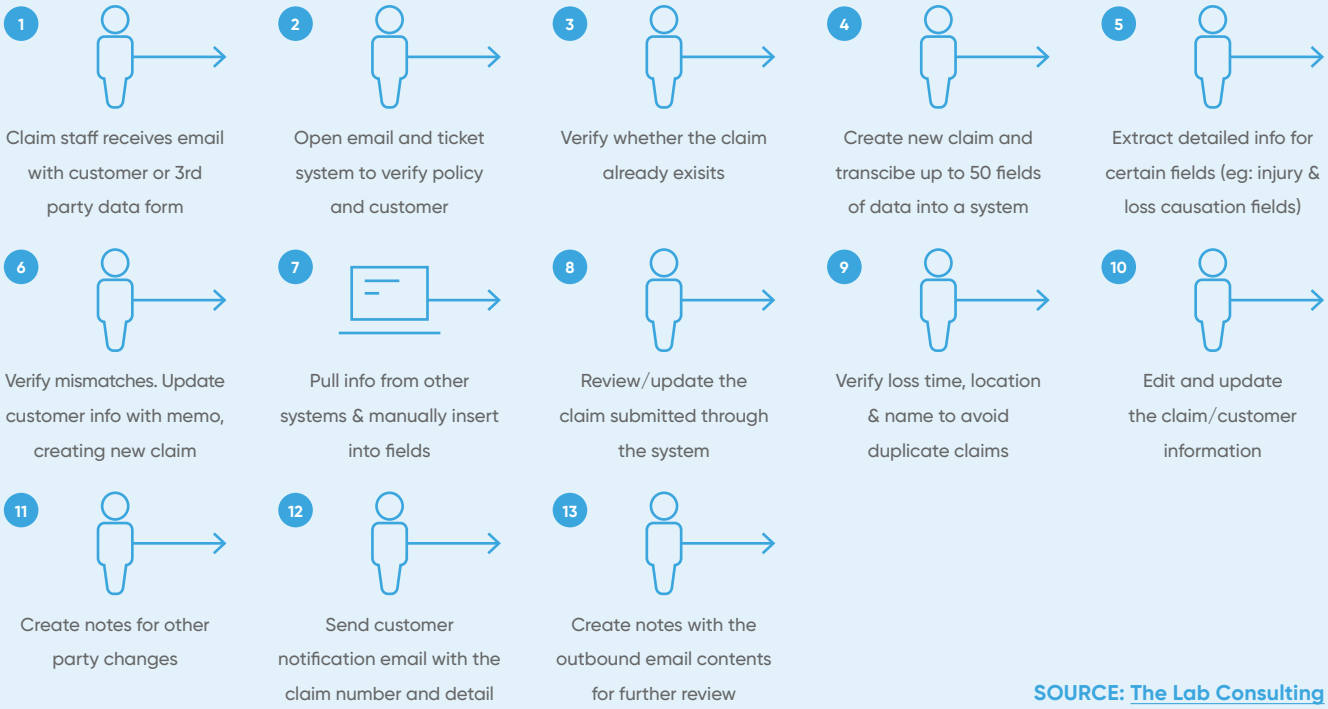
Whilst insurance companies want to automate claims processing, the challenge is digitizing data from variable and unstructured formats. In addition, the volume of information exchanged in the claims processed has increased exponentially to include photos, videos, emails, handwritten letters, court documentation etc. This information needs to be indexed, interpreted and entered into the claims system. Employees still sit in the back office and move data manually, requiring highly-paid claim processors to spend more than half of their days understanding and manually keying in customer-claim data, and moving that data into three or four different systems.

An example from within the US – a worker's compensation claim, the typical process involves an insurance adjuster talking to the customer about the claim. The adjuster takes detailed notes describing what happened and the resulting damage, along with routine details like name, social security number, and so forth.

These are free-form notes, with plenty of variation from one adjuster to the next. It includes a synopsis of every phone call, email and correspondence between the insured, adjuster and other parties involved. Additionally, an adjuster's file will include medical and lawyers' reports. In short, it's a significant amount of text – and nearly all of it unstructured.

From these documents, one of the team members extracts pertinent pieces of information and inputs them to a downstream claims processing system. Such data may include line of business, claim number, policy number, date and time of loss, location, coverage limits and more. For insurers, this job is labor-intensive and time-consuming, not to mention error-prone. And that, in turn, leads to delays, errors and an unhappy customer.

A New Loss Reporting Process Approximately 20 minutes per claim



SOURCE: The Lab Consulting

A HEAVY DOSE OF INTELLIGENCE FOR THE CLAIMS PROCESS

It's imperative, therefore, that insurance companies turn to automated claims processing tools that will ease this burden. Many insurance organizations find it's a too tall an order simply because the supporting documents include all that unstructured, free-form text. Tools that rely on rules and templates to identify relevant fields won't work because there's no way to create enough templates to cover every possible variation.

What's required is a tool that reads and understands the important information (data sets) that need to be fed into downstream systems. That's where Intelligent Automation (IA) comes into play.

Let's explore how IA transforms claims processing. In early 2020, Intelligent Insurer surveyed **300+** insurance executives (**60%** of whom were Vice President-level or above) to gather their perspective on the future of claims and where the key priorities lie.

The bottom line is the clear belief in IA's transformational power for claims processing. In fact, **94%** believe emerging technologies have the potential to transform claims, and **64%** believe claims is the area which has the greatest need for automation. The three technologies that will have the biggest impact on claims over the next **5 years** are advanced/predictive analytics **(68%)**, Artificial Intelligence (AI) & Machine Learning (ML) **(62%)** and automation/RPA **(40%)**.

To understand the key drivers for digitizing the claims process, improving the customer experience (CX) is the primary end-goal of technology deployment **(87%)**, with **62%** saying that improving CX is the top-priority long-term strategic challenge within their organization. It's unsurprising that the key factor insurance organizations look for when choosing a partner is the potential for **CX improvement (48%)**. This is closely followed by the **speed** factor **(41%)** - a key aspect of claims experience that customer expect **(90%)**.

To achieve this, one key area insurance organizations are focusing on in the digitalization process is data - having a system expertly capable of not just managing data, but actually **extracting** it from claims documents and over-piled paper trays is absolutely critical for leveraging the power of IA. Without automation, claims adjusters are tasked with reading through collected records and manually entering information into the system. A lengthy, inefficient use of company time and resources better allocated to other value-adding tasks.

A Heavy Dose Of Intelligence For The Claims Process

Almost two thirds say their key objective over the next 12 months is to obtain value from claims data, unlocking a whole new universe of insights and rivalling their most threatening competitors. Data quality and data management are two of the key obstacles to be overcome in achieving digital transformation within claims processing, with **52%** and **46%** of respondents (respectively) indicating these two factors to be just one peg lower than navigating legacy systems.

Overall, **58%** of respondents said they plan to invest in new technologies within the next 12 months and are actively seeking partnerships with providers who can help them overcome data management obstacles and realise their CX potential.

58% say touchless/virtual claims is the most promising use case for advanced automation

40% say fast-tracking claims is the most promising use for advanced analytics

59% believe reporting/FNOL is the part of the customer journey with the most potential for digitalization

62% of respondents say they see the biggest potential for efficiency gains in claims assessment

Intelligent Automation For Claims: In Practice

Automating FNOL Acknowledgements:
Once the wheels of the claims process have started to turn, claims triage takes the stage. Knowing where to route claims and how to allocate resources to manage those claims becomes a manual process - collecting photos, documentation, statements, and other evidence to build the file. But is allocating claims center resources the best use of time? Why not allow IA systems to handle claims triage? Better still, why not let customers interface directly with a chatbot-linked AI so they can submit their claim, supporting documentation, photos, and all relevant info in one place, it helps to ensure a more complete claims submission, and using AI for routing, the client can receive confirmation in real time saving FTE hours and hundreds of thousands of dollars per year.

Automate the Claims Closure Process:
Swift resolution of a claim is advantageous for both the insured and insurer. On the client side, they can get their damages recovered sooner. For the insurer, a speedier claim keeps costs down, which keeps premiums down. For example, on a total loss settlement, the client might not be satisfied with the decision and enter into negotiations with their insurer to find an alternate resolution. With this in mind, why not automate portions of the claims closure and free up even more resources and expense within your claims team? Proper data collection, analysis, and remuneration payments all factor in to shortening the claims cycle. In addition, managing policyholder expectations and informing them of the process during the claims cycle is critical to ensuring smooth closures.

THE DECISION TO AUTOMATE REQUIRES COMPLEX JUDGEMENT

The use of IA is well-recognized for its potential applications across the claims function. Yet all too often, 'IA claims projects' are not going beyond proof of concept. Why? As a generalization, it's because of two common faults in the way these projects are being set-up:

Firstly, innovation teams asking "what can we do with IA" rather than business teams starting with the problems they need to solve for customers, and then exploring what solutions and technology, could help to fix them. And secondly, reaching too far and too fast i.e. trying to transform too quickly, especially on newly emerging technologies, can backfire if the pace of business deployment is faster than both the staff and customer's willingness to adapt and adopt.

The beginning of any transformation always involves examining what's already in place, and it is often is the case that the antiquated technologies used by incumbent insurers is a key roadblock to claims process optimization. In fact, results from the Intelligent Insurer survey previously discussed showed legacy systems to be the biggest challenge when implementing new technologies (55%), and that 56% view navigation of legacy systems as their top-priority long-term strategic obstacle.

These systems have been built up over years (or even decades) and are siloed, leading to disconnected processes. Innovative digital technologies that offer speed and ease of use (both in the back office and with customer-facing systems) unfortunately don't integrate well with legacy infrastructure and applications.

Short of ripping and replacing legacy systems — or carrying out expensive and time-consuming custom integrations — the likely best option is to focus on process automation, which can manage and translate the flow of information between newer and older applications. This effectively provides a "digital wrapper" for legacy infrastructure, allowing insurers to take advantage of the benefits. Some carriers are concerned that automation might introduce more error and fraud risk into the claims process. They aren't fully confident that the technologies are mature enough to counterbalance these types of situations.

In achieving end-to-end automation in claims, the caveat is that certain aspects of the process or scenarios will require complex judgment, investigation or human involvement, such as the need to reassure a customer who needs support during a significant event like a flood on his or her property. This means that claims handlers will need to control and handle these critical elements.

However, if executed carefully, leveraging the data ecosystem to automate the claims process can overcome these concerns. For example, customers hate the time it takes to process a claim. Data prefill technologies can help minimize the number of information customers and claimants are required to provide. Still, with empathy being a top consumer concern, carriers need to find ways to integrate the human touch into automated processing.

> "Prioritization of key technology initiatives is instrumental in servicing customers and holds the key to maintain a long term competitive advantage in the insurance sector."
>
> **GIRISH NAYAK**
> Chief – Service Technology and Operations,
> ICICI Lombard General Insurance
> **SOURCE:** Analytics India Mag

CONNECTING SYSTEMS, DATA AND PEOPLE

The insurance industry is built on information and data. But when that data is generated and stored in disconnected systems, it's difficult to process a claim in a timely manner using automation to connect systems streamlines those workflows, improving efficiency, productivity and customer satisfaction.

While larger and more complex claims may require human intervention, the process can be made easier with automation to connect information. Regardless of the extent to which employees are part of the process, insurers must avoid creating a complex spaghetti structure between systems, processes, data and people by using automation (the spokes) to move data in and out to various systems as needed.

The vital underpinning is the standardization of processes and data that any RPA platform requires. Without that prerequisite, RPA will simply move bad-quality data from one source to another. Data and analytics can be incorporated into the claims process to improve accuracy and efficiency — factors that impact how customers feel about their claims experience. The bottom line: customers and insurers are open to a hybrid approach to automated claims that leverages digitized data, and automation is up to carriers to lead the journey to the future of connected claims.

> "Intelligent Automation (IA) tackles challenges across the claims lifecycle from connecting information to claims, extracting and transforming rich data, to assessing claims based on rules and historical data. IA integrates data seamlessly with business applications transforming customer experience and internal processes."

BEN PLATTS
Senior Director - Engineering, AntWorks

FUTURE-PROOFING THE CLAIMS PROCESS REQUIRES DATA DIGITIZATION

This surge in acceptance and reliance on RPA and artificial intelligence (AI)-driven technologies led to the development of the Intelligent Digital Workforce, AI-powered digital employees or bots, to augment the human workforce. These bots create near-limitless possibilities for organizations to streamline their business workflows while significantly reducing employee bandwidth constraints. Whether managing simple administrative tasks or a complex series of workflow functions, the Digital Workforce is adaptable and play a significant factor when increasing business output, eliminating errors, and reducing total operating expenses.

As technology advances, insurers search for new ways to leverage data, automation and digital innovation. Here are some trends that will alter the claims processing during this decade.

Electronic claims payments

Real-time electronic claim payments is a game changer for insurers. IA will facilitate faster payouts by enabling payments to be done through mails and texts. Customers are able to transfer the amount to their account with a few clicks.

Real-time FNOL online

Smartphones and apps rule our world, giving consumers access to anything with the click or a swipe. Intelligent FNOL apps are what insurers are creating today, enabling customers to report an accident. These apps have real time data integration and image recognition capabilities, helping in auto-populating the fields on the claims form. This reduces the effort on the consumer to answer numerous questions, increasing adoption of self service. Simplified, more accurate data collection and heightened customer satisfaction as the entire process now only requires a few clicks and pictures.

Address claims fraud

The siloed storage of information makes it difficult to connect the dots and detect fraudulent patterns of behavior. A top transformation goal for insurers should be development of an infrastructure that offers a secure, holistic view across all their information to detect patterns that may indicate fraudulent behavior.

Automation helps with case management and claims history, allowing insurers to look for patterns of insurance fraud (e.g. false claims, organized crime, and overvaluations), and providing opportunity to mitigate risk.

Claims: the most important customer touchpoint in the insurance journey

Customers expect claims to be handled with the same sort of self-service and multi-channel responsiveness they've become accustomed to in other industries (such as online shopping with Amazon, or transportation with Uber). It's the crux of the entire process. Get it right through fast, accurate appraisal and prompt reimbursement and you secure the customer relationship. Get it wrong and you've lost that customer (and anyone they talk with).

CASE STUDIES

Global Insurer Conquers Handwriting Data Digitization

A global insurer and financial services provider has over 8,000 employees and revenue over $530 million. Their mission is making decisions easier and lives better for their customers.

In their Long-Term Care division, this insurer manually handled bank authorization charge processing. The large volume of documents received needed to be manually processed and contained vast amount of unstructured data, including handwriting. Each of these documents required manual reading and entry into their downstream systems. In addition, presence of signatures were needed to be validated for processing.

The Solution:

After implementing AntWorks' Cognitive Machine Reading (CMR) solution:

1. Document quality improved with the pre-processing engine then classified using document indexing
2. Handwritten fields and checkboxes were dynamically extracted and signature presence were verified using advanced Deep Learning techniques
3. Exceptions handled using the innovative quality check screen, enabling CMR to learn with both assistive and adaptive Machine Learning
4. Clean data is fed directly into the downstream systems using API integrations

The Results:

Handwriting recognition reached **85-92% accuracy** enabling unstructured data to be processed. There was a **75% reduction in manual** work for tedious data extraction, and the insurer now experiences higher business productivity, faster turn-around time, increased accuracy and better workflow management.

Title Insurance Company Reduces Processing Time from 3 weeks to 3 days

For over 100 years, this Fortune 500 title insurance company facilitates and streamlines real estate transactions by providing comprehensive title insurance protection and professional settlement services. With over 18,000 employees, this company offers its products and services in more than 40 countries.

Title agents manually examined over 35 types of unstructured documents related to a property to evaluate the chain of title sanctity. The entire process was time-consuming and error prone. Business rules were complex and knowledge retention was poor, resulting in additional work for supervisors. As a result, there was high staff turnover, yielding substantial expenses to rehire and retrain employees. In addition, the client's existing OCR platform struggled with the variability of document formats which required constant intervention.

The Solution:

This insurer implemented Cognitive Machine Reading (CMR), a combination of AI, cognitive technology, Machine Learning and pattern recognition. CMR accelerates the title verification process by reading 35 unstructured document types and extracting 1,260 data points. Its pre-processing capability automatically enhances the readability of old property documents. Natural language models generate inferences and improves the ability to read and classify legal documents.

The Results:

After CMR was implemented, turn-around time for work processes decreased by **80% while ensuring 100% regulatory compliance.** The customer achieved a **200% increase in productivity**, 360-degree view of data points across all 35 documents, and automated inferences. CMR reduces the **processing time from 3 weeks to 3 days** for a single case leading to redeployment of resources within other functions, reducing operating cost and improved efficiency.

SUMMARY

Insurers continue to be challenged by quickly evolving customer needs and heightened competition. With the industry being highly dependent on the efficiency of back-office processes, insurers are adopting RPA and other IA tools to automate transactional, routine, rules-based operations so that employees can focus their efforts on more complex and strategic tasks.

Automation can not only transform the claims process - it can also prevent/reduce the losses that trigger the claims process, thus saving the customer the trouble of going through a "merry-go-round" while saving insurers operational costs.

The key task for claims leaders over the next few years will be in mastering the effective integration of the multiple technologies and analytical advancements that are available. This will deliver seamless automated claim processing and decision support for claims handlers in a way that improves the experience for customers, and realizes return on the investment for the business.

WE ARE ANTWORKS

We are fresh in our approach, and look beyond the obvious, Fearless in embracing change and exploring the most innovative solutions, and Fast in learning, adapting, and delivering solutions that enterprises need now.

AntWorks™ is a global, artificial intelligence (AI) and intelligent automation (IA) company that creates new possibilities with data through digitisation, automation, and enterprise intelligence. As the world's only integrated Intelligent Automation Platform (IAP) powered by fractal science principles and pattern recognition, ANTstein™ digitises every type of data for forward-thinking companies looking to achieve straight-through processing.

Led by Co-Founders: Asheesh Mehra, Group Chief Executive Officer and Govind Sandhu, Chief Operating Officer; and also, by Dr. Venkat, Chief Technology Officer; along with a Colony of more than 500 "Ants," together we continue to set the course for the future of AI within enterprises.

ABOUT THE SHARED SERVICES & OUTSOURCING NETWORK (SSON)

The Shared Services & Outsourcing Network (SSON) is the largest and most established community of shared services and outsourcing professionals in the world, with over 160,000 members.

Established in 1999, SSON recognized the revolution in support services as it was happening and realized that a forum was needed through which practitioners could connect with each other on a regional and global basis.

SSON is a one-stop shop for shared services professionals, offering industry-leading events, training, reports, surveys, interviews, white papers, videos, editorial, infographics, and more.