DATA & MACHINE LEARNING

Claims Optimization: is all fair in motor insurance payouts?

If you have ever bought something online, there is a high probability that you have been subject to price optimization, a process whereby companies cleverly use big data and analytics to determine how customers will respond to different prices through different channels to maximize operating profits. In short, prices are flexed based on a customer's propensity to buy.

In the insurance industry, price optimization is adopted with risk-rated pricing models used to calculate customer premiums on insurance products. It is also an approach that could be employed with the claims element of insurance policies, optimizing the financial settlements that are paid out when claims are made. When, how and with whom this is done throughout the claims lifecycle can, however, lead to questions of fairness.

In Ireland, there has been growing concern about how fraudulent claims and overly generous financial awards have impacted policy pricing and how that, in turn, has negatively affected private individuals and small businesses. A recent incident in Ireland involving a high-profile politician is a case in point. The individual made a substantial claim for an accident that involved falling off a swing in a hotel bar, but eventually, they withdrew the claim. At some point in the claim process, both the hotel and its insurance company would have decided to 'fight' the claim. This decision can be perceived as rational and practical, and in fact, inevitable. Indeed, it was probably a decision made by a human rather than a machine. However, what if it wasn't? Moreover, does it matter?

In this article, we look at when and how data and machine learning is used to optimize motor claims payments and discuss whether or not this is ethical in the fourth industrial revolution.

Motor Claims Lifecycle and Intervention Points

Although not always the case, an insurance company typically wishes to settle as early as possible to reduce cost. This cost reduction is threefold on:

- lower settlement costs;

- lower operational costs; and
- the release of reserves.

To achieve this, insurance companies have overall claim strategies (such as to settle as fast as possible) and sub-strategies relating to First Notification of Loss (FNOL), Claims Management and Claim Settlement.

FNOL is important in capturing the relevant characteristics of a claim and in ensuring it is appropriately routed within the claims department. Ambiguity at this point over liability (who is at fault), injury and/or fraud can open up areas for delays and financial loss.

Once these characteristics have been determined, the claim will go to the agreed claims handling process and third parties (such as solicitors, car hire companies, repair companies, and doctors) may or may not get involved. How these third parties are managed and what their strategy is can again open up additional areas for delays and financial loss.

Finally, and typically the costliest stage of a claim, we have negotiations, litigation, and settlement.

Whiplash and Opportunistic Fraud

There has been a lot of noise in the Oireachtas and Irish media recently concerning the number of motor cases insurance companies estimate to be fraudulent versus the handful reported to An Garda Siochana (typically 10k occurring versus 40 reported for one company).

Although the definition of fraud is broad, the public's first thought is often one of fake or bogus claims and/or criminal fraud rings. Opportunistic fraud (or exaggerated claims) is a much more prevalent problem and one that is sometimes not worth pursuing legally for an insurance company. Ultimately, an insurance company tries to reduce claim expenditure. Where historic data tells us it will be more financially viable to pay out early rather than fighting the case, they may decide to pay the claim. The longer-term ethical and financial question here is: will these types of decisions lead to a proliferation of exaggerated claims across the industry and ultimately drive up the cost of claims and impact customers through increased premiums?

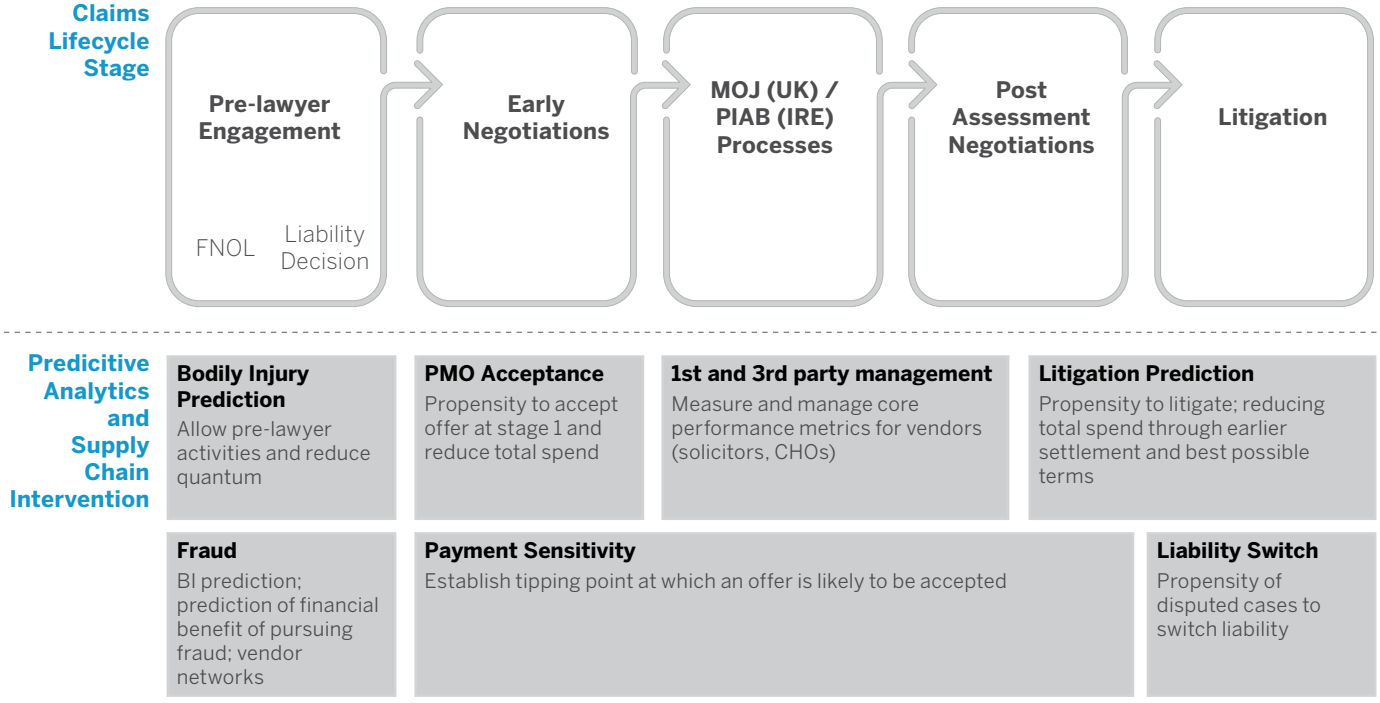
This notion is more feasible in the UK than in Ireland due to baseline injury costs. Victims of whiplash in Ireland were awarded an average of €20,000 per claim in 2018 - four and a half times higher than awards made in England and Wales for similar injuries in the same period. Considering that over 30% of third-party motor claims ultimately present with a bodily injury element (of which 70% assessed by the Personal Injuries Assessment Board (PIAB) were related to whiplash)[1] this figure is substantial.

Interestingly, less than 60% of third-party injury claims reported the injury element at FNOL, or even within the first week after notification. A large proportion of the remaining 40% are legitimate claims with delayed onset of symptoms; however, there is a consensus amongst the industry that a significant number are indeed exaggerated or fraudulent.

With this in mind, FTI Consulting has worked with insurance companies in the UK to run models that predict the likelihood of whether a late bodily injury would appear on a claim. Using these models as inputs, there have been many successful campaigns to deter potentially fraudulent bodily injury claims

1 https://www.irishtimes.com/news/crime-and-law/whiplash-victims-awarded-average-of-20-000-for-injuries-1.3686262

Figure 1: The Motor Claim Lifecycle and Potential Intervention Points



and reduce settlement cost through early intervention. These models and campaigns directly contribute to a 2% reduction in injury claims cost per year.

One tactic employed by most UK insurance companies to reduce settlement costs is via pre-medical offers, that is, early offers of £1,000 - £2,000 before the claimant has seen a doctor or engaged a solicitor. Here, the benefit for the claimant is that they get a guaranteed amount, there is no scrutiny over whether they are injured and, more importantly, they get the cash almost instantly. This could be perceived as encouraging fraud (and there are fraudulent cases within this cohort of claimants); however, it is a successful strategy in lowering the overall average payout and, therefore, the total claims cost output.

Yet the question still arises: is it ethical to pay a person £1,000 in cash now when it is potentially lowering their overall compensation? What if the person takes the money upfront because they are struggling financially? What if an analytical model could predict this? What if the case is fraudulent? What if a cold calling solicitor prompts the injury claim?

Third-Party Vendor Management

A common misunderstanding of opportunistic claims is that the claimant drives the fraud or the claimant is the person benefiting. In reality, a large proportion of costs in these claims ultimately end up with third parties – solicitors, car hire companies, garages and so forth.

There are apocryphal stories of repair garages referring customers to solicitors to get a payout for low-level whiplash claims. The theory is quite simple: a car arrives at the garage; the garage gives the customer details to the solicitor; the solicitor rings the customer and promises upwards of a thousand pounds for no work at all (the customer merely gives the solicitor permission to submit a claim on his/her behalf).

In this instance, data and analytics can point towards similar potential fraudulent behaviour in two ways:

1. Comparing solicitors and claims across claim settlement classification (e.g. solicitor A has a 60% pre-medical offer settlement compared to 30% for similar solicitors/ claims);
2. Using network analysis to uncover links between vendors and comparing those links to other vendors in the same segment. If Garage A is on 70% of Solicitor B's claims and all other solicitors have an even spread of garages on their claims then the discrepancy should be investigated.

The first case is true across the entire claims value chain; it will help us spot solicitors who are trying to settle claims quickly at a low value, as well as identifying solicitors who are deliberately trying to get cases to litigate. If you speak to claims handlers, you will often hear of the cat and mouse game that goes on between the insurance company and vendor. This type of behaviour is not only limited to being a settlement tactic; the goal is to eke out as much money as possible for every participant of the claim: claimant, solicitor, car hire company and garage.

Combating this behaviour using data, experienced claims handlers and decision support tools reduce the total claim pay out value and ultimately bring down the opportunistic claim cost. This is generally perceived to be ethically ok as it is viewed as being more efficient without directly lowering the claimants payout (although, it will indirectly lower them in a lot of cases).

Litigation and Liability Switch

When a claim goes towards litigation, the cost of the claim increases exponentially. This is why the Ministry of Justice portal (MOJ) and the Personal Injury Assessment Board (PIAB) exist in the UK and Ireland respectively. The aim is to reduce the additional costs of claims – i.e. the legal, insurance and operational costs – by putting guidelines and rules around the process and reward values. However, no system can anticipate and cater for all eventualities and every type of claim.

The worst possible outcome for a case going to court is a disputed liability case in which the first party accepts responsibility at the last minute ("on the steps of the courthouse").

If a company can predict the claims that are likely to litigate, they can manage them more closely and engage early and often with the claimant. Settling a claim six months earlier if it litigates saves six months of staff and legal fees. Of course, this is a balancing act, as showing that you do not want to litigate can weaken your negotiating stance.

When is it OK to minimize the pay-out value?

There is an underlying indemnity principle in insurance that the insured should be 'put back in the position they were in before the loss occurred.' Unfortunately, this is difficult to fully quantify from a settlement value perspective.

In a large proportion of 'minor non-injury crash' situations, general damage elements (such as inconvenience, time loss and stress) are not accounted for. What's more, people often don't know if they are insured against these risks. Introduce ambiguity and there will always be ways of taking advantage of this, on both sides. From claimants to repair garages, from loss adjustors to credit hire companies, from solicitors to insurance companies, everyone is trying to increase the value they can get. No claimant, for example, refuses a settlement for being too high and, likewise, an insurance company will always try to reduce their outgoing costs. The question of whether this is 'right' or 'wrong' arises primarily from ambiguity and lack of clarity.

Claims optimization is by its very definition about reducing claims cost. It uses details related to claimant, vendor and event characteristics to determine the settlement value as opposed to basing it purely on loss. However, it is unrealistic to think that a claim can be settled solely on loss. Loss tends to be a subjective issue that, for the most part, cannot be quantified. If it were, then claims optimization would be unethical but, unfortunately, without clear legislation, and with room for opportunism existing on both sides, claims optimization has both positives and negatives. However, if it can be used to reduce opportunistic fraud and, in turn, reduce premiums, then for the moment, I believe the positives outweigh the negatives.

For more information on how you can crack down on fraudulent claims using data and analytics, please contact Aran Brady or Johnny Enright.

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