WORLD INSURANCE REPORT 2011

Excerpt from the World Insurance Report 2011:
Insurers Need to Transform Claims to Meet their Brand Promise to Customers while Driving Results

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Insurers Need to Transform Claims to Meet Their Brand Promise to Customers While Driving Results

CHAPTER 3

HIGHLIGHTS

Operating conditions remain tough for insurers around the globe. Balance sheets are looking better than they did in 2008, but the post-crisis landscape features new financial constraints, increased competition, more stringent regulation, and a new breed of customer preferences. At most insurers, reserve redundancies are depleted, and the days of relying on investment income to supplement earnings are over.

Life insurers must find a way to generate results in a capital-constrained, low-interest-rate environment, while catering to customers who want capital protection and guaranteed returns. Non-life insurers face a world in which claims frequency and severity are rising, at the same time that gross written premiums are falling and customers are shopping around for coverage on price.

For non-life insurers, the challenge is especially acute as their success so often boils down to one issue: the customer's experience around claims. In fact, our research shows a less-than-satisfactory claims experience prompts one in five customers to switch insurance providers, so it is an area no non-life insurer can ignore.

Non-life insurers also need to capture operational efficiencies in claims, where costs are rising fast. The claims ratio in the studied countries increased at a greater rate (4.6%) than the expense ratio (0.3%) during 2006-09. Non-life insurers also, on average, pay out 61 cents of every dollar earned in premiums on claims, and spend another 13 cents on claims-related expenses.

As it stands, however, myriad inefficiencies are driving up claims costs and adversely affecting customers' claims experiences. To grab market share from competitors, and deliver on a value-added brand promise, non-life insurers will clearly need to focus on enhancing efficiency and effectiveness in claims. But to do so, most will need to move toward a more reliable, integrated claims system to deliver high-tech, high-touch service in the customer's hour of need, and to support everyday activities.

"Our reputation is really how we handle claims," says an executive at one leading global insurer. "And the better we make the claims department with technology, the better and more sustainable that reputation is."

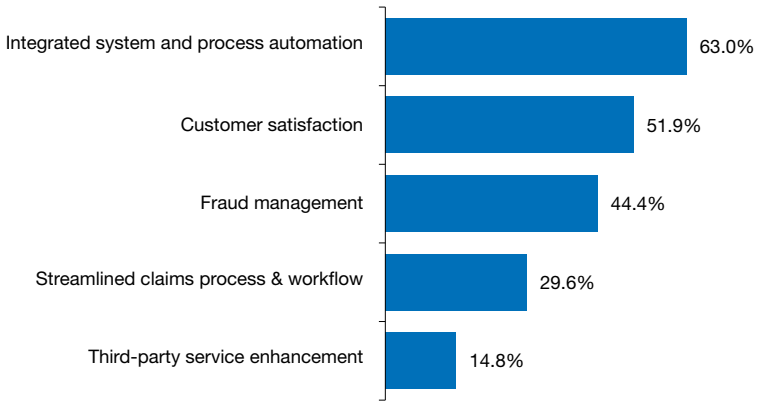
FIVE MARKET FACTORS ARE ACCELERATING THE NEED FOR INSURERS TO TRANSFORM CLAIMS PROCESSING

Inefficiencies—stemming from environmental, technical and organizational factors—are all driving the imperative to transform claims processing. Some issues are newly emerging, but many are long-standing and getting worse. Arguably most pressing are the following:

- **The changing external environment.** There has been a global increase in litigation, in part because of weak economic conditions. For example, D&O (Directors and Officers) insurance has expanded since the financial crisis, as companies have faced more suits from disaffected investors. Demand for liability coverage, and payouts on that coverage, have both risen. Increased regulation is also increasing costs for the industry as a whole (e.g., by requiring more capital to be set aside as per Europe's Solvency II regulatory framework) and for specific lines of coverage (e.g., changes to health-coverage mandates). Claims costs have also been directly affected by the rising number of weather-related catastrophic losses in a number of countries.
- **Aging technology is contributing to process inefficiencies.** Many insurers continue to run multiple disparate legacy platforms. This impedes integration with both internal and third-party systems, increasing claims settlement times and costs, and creating customer dissatisfaction.
- **Increasing complexity in claims processing.** In part because of aging technology, processing requires multiple hand-offs, and duplication and redundancy are rife. As a result, people resources are poorly mapped to processes, and claims adjustors spend more time administering claims than adjudicating them. These process complexities inflate loss-adjusted expenses. Moreover, growing regulatory pressure to improve transparency in pricing and ever-increasing policy features and coverage are adding to process complexity.
- **Contingent liability risks are growing.** Fraudulent claims remain a major and growing challenge for insurers, accounting for 10%-15% of insurers' loss ratios today. Missed opportunities for salvage, subrogation and third-party recovery are wasting profits, and vendor management is sub-optimal, creating expense, delaying service and extending cycle times. Reserves are often poorly aligned with obligations. All of these issues stem at least in part from the lack of integrated claims data. In some cases, data is unavailable; in others, there are gaps in reporting and analytics around the data. Either way, the deficiencies create unwanted risks and costs for insurers.
- **Lack of customer centricity.** All of these factors combine to undermine insurers' reputations, which live or die by their ability to process claims efficiently and effectively. A bad claims experience drives clients to competitors, a dynamic that is especially costly for insurers given that it costs seven times as much to acquire a new customer as it does to serve an existing one.

Clearly, then, there is ample reason for insurers to see value in transforming claims processing. And in fact, our research shows insurers already recognize claims transformation could be instrumental in overcoming pain points in existing operations—specifically customer service, fraud, and inefficiencies in the claims process (see Figure 3.1).

Figure 3.1 Most Important Reasons Insurers See for Investing in Claims Process Improvement



Source: Capgemini analysis, 2010, Executive interviews and survey results

However, insurers still need to identify how claims transformation will drive their business, and which specific actions and investments will generate value.

By Investing in Claims Processing, Insurers Can Derive Tangible Value in Four Key Areas
Our analysis shows investing in claims transformation delivers benefits in four key areas:

1 **Efficiency and effectiveness in claims adjustment/processing.** Individual activities within the claims process can certainly be optimized to improve efficiency and reduce claims cycle times. But systems integration—with third parties and other internal systems—can also pay dividends through synergies in products, distribution, procurement, and other activities.
2 **Risk management to reduce the impact of contingent liabilities on indemnity costs.** Managing the indemnity portion of overall claims costs is critical to delivering sustained profitable growth. Fraud costs are already onerous and rising, but other liabilities also need to be monitored and managed more tightly, including litigation, reserves, and vendors. Insurers also need to be proactive in maximizing salvage, subrogation and other recovery opportunities.
3 **Customer retention.** More effective claims processes, consistent service standards and prompt and equitable claims settlements will all help satisfy customers and keep them loyal.
4 **Customer acquisition.** More effective risk underwriting will help insurers to price risk competitively, based on experience. This will help to attract customers (as rates will be competitive), but will also help insurers to ensure customer acquisition strategies are profitable. Moreover, positive word-of-mouth from satisfied customers boosts the opportunity to acquire new customers.

Importantly, these areas are all key to business results but each drives performance differently: Improvements in efficiency/effectiveness of claims adjustment/processing will directly benefit the bottom line, as will risk management. These improvements, in turn, enable customer strategies that fuel the top line.

A practical example of the value of claims transformation is the case of one major U.S. insurance carrier. The insurer, among the top 5 in the U.S., defined a transformation vision for its claims organization, aiming to enhance customer experience and increase operational efficiencies in order to gain strategic advantage over competitors. The effective implementation of its claims-transformation strategy ensured the following tangible impact: measurable benefits totaling more than $75 million, increased customer satisfaction, and higher retention rates (up 4% for all auto policy holders and 2% for homeowner policyholders).

Business Information Management and Analytics Are Critical to Operational and Strategic Effectiveness
Notably, business information management and analytics will be integral to achieving fundamental improvements in the four key areas.

At the very least, insurance adjustors need quick and easy access to accurate claims information to help them operate more efficiently and focus their time and expertise on adjudicating claims, containing loss adjustment expenditures, and driving effectiveness.

On the next level, insurers need high-quality claims intelligence to capture decision-driven efficiencies by leveraging volume market data to make underwriting and risk decisions, optimize indemnity expenses, and adapt quickly to changing markets conditions.

Ultimately, though, the greatest potential value from claims data can be found at the enterprise level. For instance, insurers can leverage high-quality claims data as an enterprise asset to explore synergies among internal operations (policy administration, product development, front office, and so on) and with third parties. They can also use predictive analytics to improve key activities such as risk management and compliance.

However, while many insurers intrinsically understand the value of comprehensive claims data, few are yet working on the more sophisticated uses of that data. And even if they are formulating data strategies, they still need to identify specific actions they can use to capture benefits in the four key areas that will drive bottom-line and top-line improvements—and determine what kind of data strategies are needed to back up those actions.

STABILIZING CLAIMS PLATFORMS, MANAGING FRAUD, AND LEVERAGING CLAIMS DATA EMERGE AS FOCAL POINTS FOR CLAIMS TRANSFORMATION

In identifying value-creating claims-management actions, insurers need to consider both the operational challenges they face and the benefits they hope to capture. Our research identified three actions that would address operational pain points and drive value for insurers in one or more of the four key areas of adjustment/process efficiency and effectiveness, risk management, customer acquisition, and customer retention.

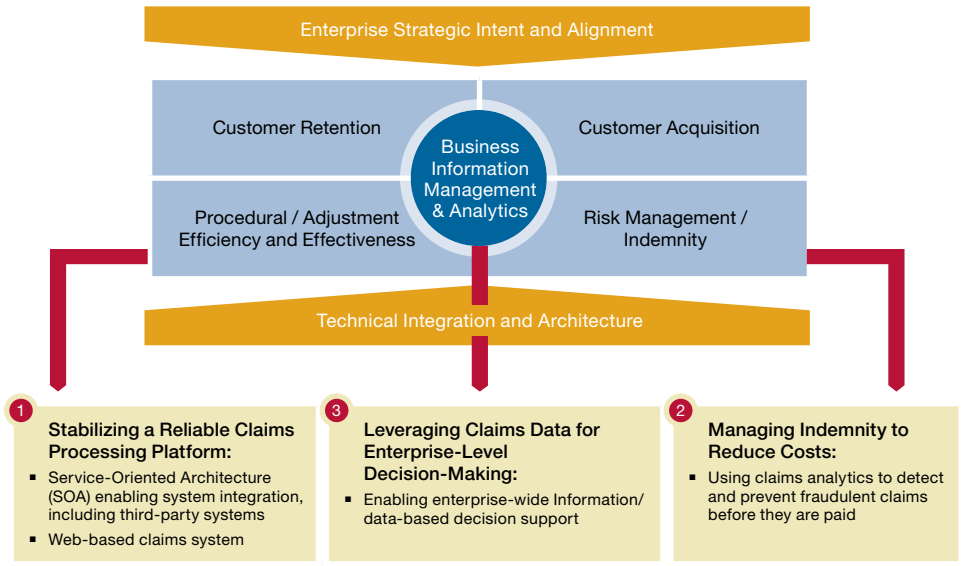
These three actions—or 'focal points' for claims transformation—are:

1. **Implement/Stabilize a reliable claims processing platform** that leverages technology to enable integrated claims processing, enhance process efficiency and cost effectiveness, reduce cycle times, and allow insurers to measure performance of their claims processes.
2. **Optimize fraud management to reduce costs (and ultimately improve combined ratios)** by making sure fraud is detected quickly and effectively, without undermining customer satisfaction or unduly raising litigation costs or creating net new costs.
3. **Leverage the full value of claims data management** by making sure the right data is captured and used to support business decision-making and deliver benefits in terms of profitability, efficiency, strategic planning, and regulatory compliance.

As illustrated in Figure 3.2, these three focal points are inextricably tied to the bottom-line drivers (efficiency and risk management) and business information strategies that will ultimately impact the top line (through customer retention and acquisition).

Notably, while investment will no doubt be required to reinforce these focal points, many non-life insurers consider claims management to be a differentiator, so they see such spending—on IT in particular—as necessary to increase their flexibility and meet customer needs and demands.

Figure 3.2 Focal Areas for Claims Transformation



Source: Capgemini analysis, 2010

IMPLEMENTING/STABILIZING A RELIABLE CLAIMS PROCESSING PLATFORM

A reliable claims-processing platform leverages technology to enhance process efficiency and reduce cycle times. In fact, the modern claims-system platform is most likely to rely on service-oriented architecture (SOA), which—by design—can integrate a flexible suite of loosely coupled applications across multiple business domains. In the case of insurance, SOA can help to deliver business flexibility, facilitate straight-through processing (STP), and support control and monitoring functions. This can streamline and improve claims processing by reducing manual hand-offs of paperwork and minimizing processing delays. It also allows data to be integrated efficiently and accurately into policy administration and underwriting support systems.

By closing process gaps, insurers should be able to reduce existing loss-adjustment expenses and drive continued improvements by conducting end-to-end monitoring of the claims process cycle, capturing key business and technical performance indicators, and establishing performance reviews and targets.

Insurers Need Solutions to Trump Today's Disparate Systems

Today, the majority of non-life insurers still rely on multiple and disparate legacy systems for claims processing. Insurers acknowledge these systems lack the flexibility to meet changing needs, are expensive to maintain, and eat up a significant portion of IT budgets. In short, these systems present a significant obstacle for insurers seeking to pursue top-line and bottom-line improvements in claims performance. For example, multiple systems not only create a barrier to efficient claims turnaround times (undermining customer retention and acquisition goals), they increase operational inefficiencies and process complexity (increasing costs and reducing customer and employee satisfaction).

The need for a better solution is urgent and widespread. After all, many insurers are still using multiple claims systems even for motor claims, which are relatively simple and straight-forward. Many insurers are moving—or seeking to move—toward a single integrated claims system in which their requirements can be centralized. An integrated system can lead to simpler and faster processes, which can reduce costs and improve customer satisfaction.

Moreover, a system based on emerging technologies like SOA can leverage configurable features to accelerate claims handling, and give both insurers and customers access to more, and more current, information on the status of claims throughout the process. SOA-based systems can also facilitate business integration, for example across products lines.

SOA Can Improve the Flexibility of Claims Systems by Facilitating Smooth Service Communication between Domains

Indeed, the real value of the SOA approach lies in its ability to reduce the inherent complexity of disparate legacy systems and provide flexibility in the claims processing system.

SOA can, for example, reorganize complex legacy systems into a collection of functional business applications in which each business application is the single point of access for information relevant to a given business function.

As a result, the insurance eco-system is integrated in such a way that insurers can make the claims process more efficient, and monitor and measure the effectiveness of claims performance on an ongoing basis (see Figure 3.3 on page 33).

Consider the benefits to insurers of establishing an SOA-based, integrated Web claims system:

- **Shorter claims-processing cycle times** due to application integration, remediation of gross system inefficiencies, and consolidation of multiple claims systems.
- **More accurate and efficient transfer of claims data** to insurers' management information systems, actuarial data bases, policy administration and underwriting decision-support systems, general ledger/treasury systems, etc.
- **Lower claims-handling costs** as process gaps are eliminated and analytics capabilities improve the management of loss adjustments and claims leakages.
- **Seamless integration with third-party vendors,** automating business interactions and transactions with external systems. Supply-chain automation helps insurers to reduce costs and increase revenues, because there are fewer hand-offs and claims are settled faster.
- **Greater customer satisfaction,** with systems providing transparency into claims processes, and access to delivering more accurate data, accelerating claims settlements.

STP Is Critical to Improving Claims Efficiency and Effectiveness

STP is especially important in streamlining processes and accelerating claims settlement. Straight-forward claims, such as windshield damage or towing, can be settled within minutes of receiving a claim (see Figure 3.4). And even for more complex claims, the process is streamlined by reducing the number of hand-offs and unnecessary process delays.

These enhancements not only speed settlements, they reduce operating costs and help insurers make headway in optimizing numerous aspects of claims operations.

For instance, STP enables insurers to standardize internal processes and establish real-time integration with third-party vendor systems. It also frees up adjustor time so more experienced adjustors can concentrate on more complex claims. And it makes audits easier by increasing process transparency.

STP can also help with compliance, because processes become more efficient, enabling insurers to meet regulatory standards on claims cycle times and accuracy more easily. STP also supports compliance-driven demands for claims-information transparency, consistency and traceability.

Critically, integrated systems featuring STP also improve customer experience. For example, they allow insurers to provide self-service options to customers, who can lodge claims, monitor their progress, and get notification of settlements and payouts—all online or by mobile phone.

These self-service features tend to improve customer satisfaction because claims are resolved quickly and accurately, and customers have access to real-time information on claims progress.

Moreover, in improving the accuracy of claims processing, these service enhancements help insurers to expand their processing capacity, optimize resource utilization and lower processing costs.

To illustrate, a government organization in the U.K. wanted to improve the end-to-end claims experience for claimants. It adopted STP claims to try and increase flexibility, reduce costs, and enhance risk management. The initiative ultimately achieved STP rates of 30% or more on some schemes, and enabled the insurer to reuse 100% of some system elements between schemes. The approach delivered other benefits too, including better access to customer information, improved fraud detection, significant cost savings, and a more flexible and scalable process that is better able to respond to changing market conditions.

INSURERS NEED TO MANAGE THE RISING BURDEN OF CONTINGENT LIABILITIES

While much attention is paid to the cost of paying and administering claims, there is also a significant need for insurers to tackle contingent liabilities. For example:

- **Fraudulent claims** remain a major and growing challenge for insurers, accounting for 10%-15% of the non-life insurance industry's incurred losses and loss-adjusted expenses every year.
- Missed opportunities for **recovery management** (salvage, subrogation and third-party recovery) tangibly undermine insurers' profitability.
- Only 15% to 20% of the top global non-life insurers have **claims litigation management systems**, even though non-life insurers globally spend more than $20 billion a year on defense and claims cost containment.
- **Vendor management** is sub-optimal, because few insurers can communicate real-time with vendors, and the lack of systems integration slows cycle times and delays service.
- Lax **management of loss reserves** creates mismatches between insurers' reserves and their future obligations.

Fraud, however, is arguably the liability insurers most need to tackle. Research shows, for example, that undetected fraud in general insurance claims cost U.K. insurers nearly £1.9 billion ($3.0 billion) in 2008[1]. In the U.S., fraud strips nearly $30 billion from the non-life insurance industry each year[2], with false slip-and-fall injury claims and related costs amounting to nearly $2 billion a year[3], and fraud in personal auto claims alone adding $4.8 billion to $6.8 billion in excess payments to injury claims.

Since losses to fraud weaken an insurer's financial position, as well as undermining their ability to offer competitive rates and underwrite profitable business, initiatives to reduce fraud costs could create significant opportunities for insurers to reduce their indemnity costs and improve combined ratios.

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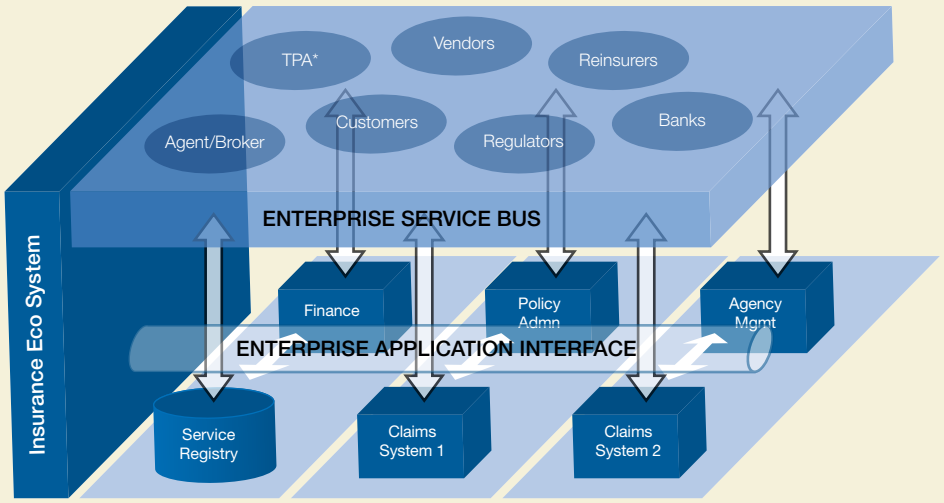
[1] Research Brief, Association of British Insurers, July 2009

[2] Insurance Information Institute

[3] National Floor Safety Institute and Insurance Research Council

Figure 3.3 SOA-Based Approach Facilitates Smooth Communication Between Domains



* TPA = Third-party Administrators
Source: Capgemini analysis, 2010

Figure 3.4 Accelerated Settlement of Simple Claims with STP

FNOL* through Web Application	**Assignment** Automatically to a Processor	**Business Rules Engine** Business Rule 1 Business Rule 2	**Negotiate/ Initiate Servicing**	**Claims Payment**
▪ Web application that allows a customer to enter loss information, upload photos, receipts, police reports, and other required proofs	▪ Enters data into claims system ▪ Enters approved bill information into payment systems	▪ Forward simple claims (e.g., replacing windshield, processing a towing bill) via straight-through processing (STP)	▪ Uploaded bills can be automatically adjudicated, reviewed, authorized, and immediately paid	▪ Payment is issued within minutes of receiving the claim

* FNOL = First Notice of Loss
Source: Capgemini analysis, 2010

Predictive Modeling and Analytics Can Boost the Effectiveness of Anti-Fraud Efforts

Fraud is widespread today largely because insurers don't have the claims data they need to identify fraud promptly, effectively, and cheaply.

Quite simply, the challenge is to ensure that the cost of detecting fraud is less than the leakage saved, and while insurance companies generally have a formal fraud-fighting strategy in place, their approach to detecting and preventing fraudulent claims is far from optimal.

Admittedly, insurers face many challenges in detecting fraud, including excessive costs for investigations, high litigation costs (which may make it cheaper to pay a potentially false claim than investigate it), and fears that investigation-related delays in claim payouts will displease customers.

A fraud detection and prevention strategy that uses predictive modeling and analytics tools and technology, and extends across all claims-related activities, can greatly increase the effectiveness of the fraud-fighting effort.

For instance, insurers can make sure their own recruitment processes are thorough and comprehensive to minimize the chance of fraudulent activity among adjustors. By combining these initiatives with the use of predictive analytics and advanced visualization and investigation tools to monitor transactions, insurers will also be in a better position to identify crime rings that perpetrate a given fraud repeatedly. Internally, specific values can be written into processes to, for example, send a 'red flag' alert to an individual adjustor as soon as certain predictions arise and suggest a fraud may be underway.

It is even possible to detect and prevent fraudulent claims before they are paid, using a combination of business rules, social networking analysis and predictive modeling techniques. Among the techniques already being used (see Figure 3.5):

- Rules-based systems test each transaction against a predefined set of business rules to detect known types of fraud based on specific patterns of activity.
- With exception reporting, key indicators associated with tasks are base-lined, and triggers are set. When a threshold for a particular measure is exceeded, the event is reported.
- Many insurers have turned to predictive modeling to detect complex patterns by using data-mining tools, and building programs that produce fraud-tendency scores.
- Social networking analysis is an effective tool to identify fraud activities by establishing relationships between entities in claims.

LEVERAGING THE FULL VALUE OF CLAIMS-DATA MANAGEMENT

For an insurer, the ideal business information system makes efficient use of enterprise-wide data to support business decisions. That includes data from sales, general ledger, policies, consumers, reinsurance, claims distribution, products, legacy and other data, but the critical piece is claims data. Capturing and analyzing claims data, and making claims-related data and intelligence available to other systems, is vital for improving risk underwriting and supporting enterprise-level decision-making.

In short, the effective sharing of good claims data enables senior management to make information-based strategic and tactical decisions, resulting in improved efficiency and effectiveness, better regulatory reporting and compliance, more astute strategic planning and, ultimately, improved profits.

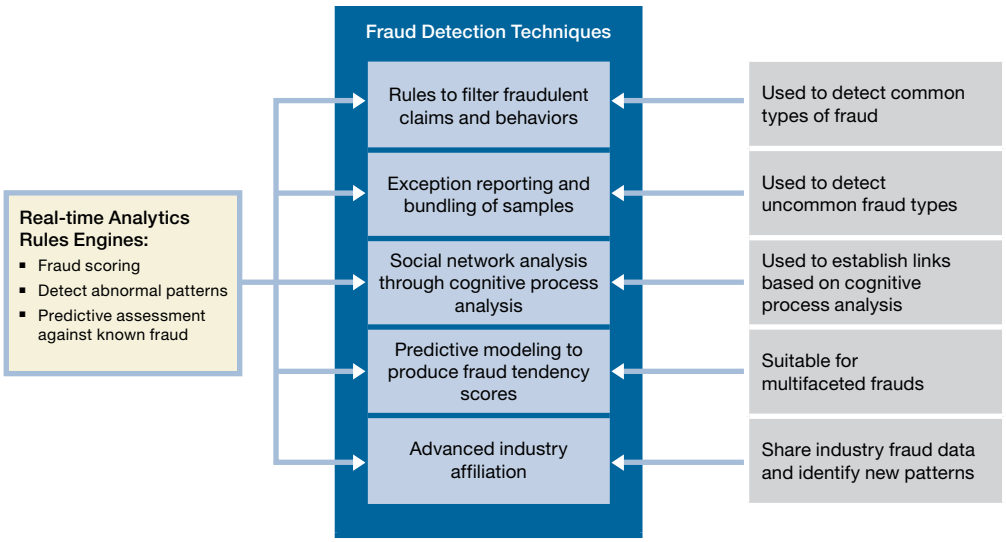
Data Sharing Can Improve Efficiency and Effectiveness, Compliance, Strategic Planning and Profits

An effective claims data management system will efficiently store and manage the appropriate claims-related data, using standardized data dictionaries, data field code tables/descriptions, and data file layout formats. This facilitates easy sharing of claims data throughout the organization (including call centers) and with third-parties. It also enables information-based strategic planning as management can get specific data on existing claims-management performance, and discern the potential impact of a given strategic decision.

Insurers can also use the data-management system to make sure they have all the data required for regulatory reporting and to meet other compliance imperatives.

Ultimately, then, effective data-sharing provides management with a more comprehensive understanding of business risks and performance trends, so drives more informed business decisions–potentially resulting in improved profits.

Figure 3.5 Claims Analytics: A Combination of Analytical Techniques to Detect Fraud



Source: Capgemini analysis, 2010

In fact, data-sharing can help on both a strategic and tactical level to boost profitability by driving operational efficiency and cost containment in numerous ways. Importantly, for instance, insurers can use data-management systems to help benchmark best practices, particularly in identifying potential fraud situations, managing vendor relationships and costs, containing the costs of litigation and recovery management, and structuring operations (e.g., incentive compensation).

These systems also help management to benchmark standards that can provide potential cost benefits, as well as actually helping to contain costs by reducing multiple points of data translation—which eliminates the costly manual input of a claim adjustor's data and improves data quality.

CONCLUSION

In an intensely competitive insurance market, differentiation through innovative claims-management practices is going to be the most important and effective way to maintain market share and profitability.

Especially by leveraging business intelligence and analytics, insurers can transform claims adjustment/processing efficiency and effectiveness and risk/indemnity management. This will pay dividends both operationally and strategically by generating cost savings and unlocking value in the cash-handling side of the business, as well as by improving enterprise business decisions and driving customer retention and acquisition.

Ultimately, then, claims transformation not only improves everyday efficiency and effectiveness, it enables insurers to deliver on their brand promise, and enhance brand value for the long term. Without it, insurers will be challenged to differentiate themselves and maintain and evolve their market position.

We would like to extend a special thanks to all of the Insurance companies and individuals who participated in our Insurance Executive Interviews and Surveys.

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