Fantastic claims

When a customer files a property and casualty claim, it's a moment of truth. How an insurer handles the claim can make or break its business.

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When it comes to property and casualty (P&C) insurance, proficiency in handling claims has become a signal ingredient of success. Roughly 75% of revenues from premiums flow through the claims function as expenses or indemnity payouts, so even a marginal improvement can affect the bottom line. Claims handling also stands as a moment of truth that can turn customers into stalwart promoters or detractors of the carrier, depending on how they perceive the experience.

Superior claims management thus offers a means of competitive differentiation, whether that's through faster payout, easier filing through digital channels or higher-quality interactions between customers and claims representatives. Very few carriers excel on every dimension of the claims process (*see Figure 1*), but those making the most headway have focused on four areas that form the basis for claims excellence:

- Earning customers' loyalty
- Upgrading to smarter digital technologies
- Tuning the adjustment process for efficiency and accuracy of payouts
- Selectively using specialists

Strong execution in each of these four areas accelerates profitable growth through greater customer retention, lower expenses and lower indemnity spending.

The customer connection: It's not just a transaction anymore

Some carriers steeped in an actuarial culture remain skeptical that the customer's experience matters as much as pricing or risk modeling. Yet customer loyalty does translate into better economics for the business. Bain & Company has consistently found that customers who become promoters stay longer, recommend the company to friends and family and usually cost less to serve. One major P&C insurer in the US, for example, found that a promoter's lifetime value is worth, on average, about five times that of a detractor.

Figure 1: Few carriers have achieved leading performance on all claims outcomes

US carriers, personal lines

Carrier	Loss ratio (2008–2012average)	Loss-adjusted expense ratio (2008–2012 average)	% growth in net premiums (2008–2012 average)	2012 NPS
State Farm	70.3	11.9	2.5	32
Allstate	61.5	10.6	0.0	16
Liberty Mutual	61.5	19.8	7.5	12
Travelers	61.1	22.7	2.0	8
AIG	61.3		-15.2	-43
Geico	66.7	9.2	7.6	23
Nationwide	64.3	12.1	-1.6	19
Progressive	61.9	10.5	5.4	15
Farmers	60.3	11.5	-2.2	5
USAA	71.1	8.8	8.2	77
Hartford	65.7	19.8	-2.0	27
Chubb	57.8		-0.5	27
American Family	66.2	10.8	-0.8	22
Zurich	58.7		2.6	-34

Underperforming | In line | Outperforming | Not meaningful

Note: P&C carriers listed in descending order of 2012 net premiums earned. Underwriting ratios (commissions, salaries and benefits, taxes, licenses and fees) omitted
Sources: SNL; Bain & Company 2012 NPS Auto Insurance Customer survey

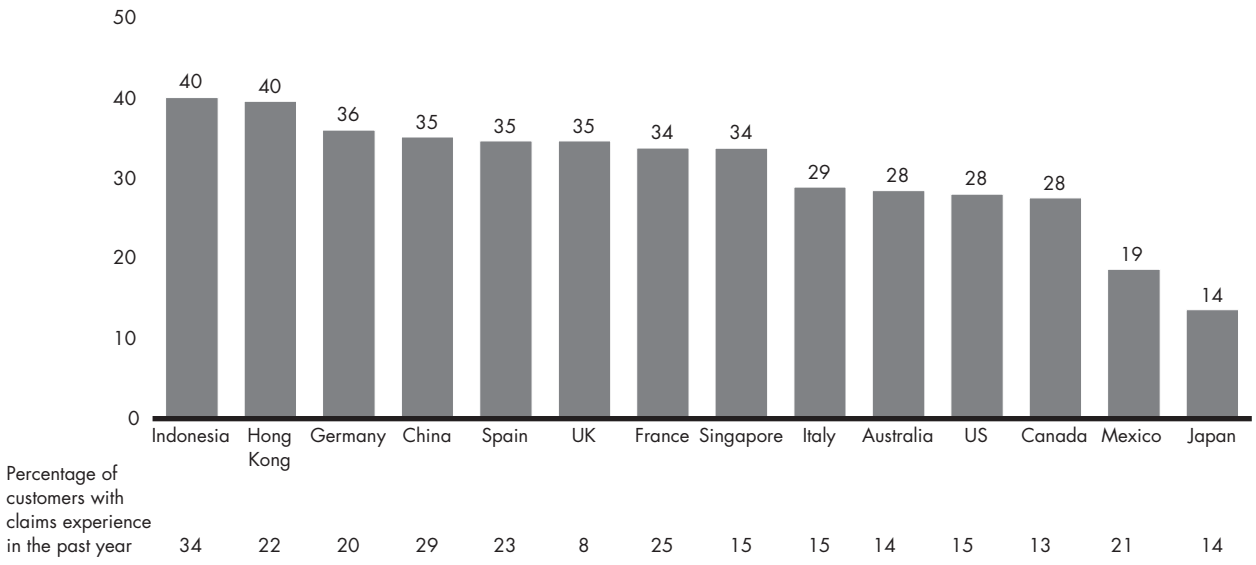
Carriers that forge stronger ties with customers and become more trusted and valued will be better positioned to counter the "price only" proposition for new customers and to cross-sell to existing customers.

Consider how claims management in particular can create better economics by raising customer loyalty. Bain recently surveyed 140,000 insurance customers in 14 countries on what Net Promoter Score℠ (NPS®)—the best metric of customer loyalty—they gave their insurers. Customers who had a good claims experience gave an NPS that ranged from 14 to 40 percentage points higher than all other customers (*see Figure 2*). Conversely, a poor claims experience can upset a customer to the point of defecting to a competitor.

Carriers that forge stronger ties with customers and become more trusted and valued will be better positioned to counter the "price only" proposition for new customers and to cross-sell to existing customers. One carrier in Brazil, for example, developed a network of integrated auto claims drop-off centers across the country. Claim adjusters conduct damage appraisals on site, and approved garages nearby handle repairs. The insurer realizes net repair costs that are significantly lower than those of comparable claims appraised directly at garages, while customers benefit from the convenience as well as a discount in deductibles to use these centers. In fact, customers who use the auto centers give the company a higher NPS than other customers who file comparable claims.

Presenting attractive self-service options provides another route to improving the customer experience and, often, to reducing expenses in the bargain. Allstate and other carriers have started to allow customers in minor traffic accidents to use their smartphones to photograph the damage and upload the images using an app. In some

Figure 2: Claims handling has a major effect on customer loyalty



Note: "Other customers" include those with no claims experience, those dissatisfied with claims handling or those neither satisfied nor dissatisfied with claims handling
Source: Bain/Research Now/SSI Global Insurance Customer-Centricity survey, 2013–2014

cases, carriers can settle the claim on the spot and make a direct deposit to the customer's bank account. And as in-vehicle telematics catches on, carriers will be able to lay the black-box data over the customer's own report, for a more accurate picture of what happened.

Self-service puts the customer in control, but the mechanics must work well, if not flawlessly, in order to delight the customer rather than impose a burden at a stressful moment.

Initiatives like these succeed when they directly address customers' most pressing needs, gleaned from the customers themselves. Insurance companies that sustain high levels of loyalty regularly solicit customer feedback to understand what they are doing right and wrong. They loop the feedback quickly to frontline employees and their managers, who uncover the root causes of both problems and areas of distinction, then take targeted actions to improve customers' experience.

Information technology: Look outside for flexible systems and innovation

Many carriers are weighed down by legacy information systems as old as the 1970s and cobbled together from acquisitions. But the work of claims units has outgrown what these legacy systems can handle. Claims information architecture has become quite complex, integrating information from mobile phones, mail, fax, email, call centers, and batch and online systems. And claims units want to supplement their intuition and classic investigative methods with data analytics, in order to make better decisions.

Carriers thus have been investing in new information technology (IT), including a shift to external modular solutions provided by Guidewire and other firms *(see Figure 3)*. The challenge will be to reap value from these tech investments, by moving beyond process efficiency to using IT in ways that reinforce close connections with customers and inform better decision making. Carriers can take advantage of the surge in digital innovation.

Figure 3: Moving to more effective deployment of information technology

	From a siloed, insular system	→	To an integrated, flexible system
Customer	Mostly analog		Digitally fluent
Technology and data	Digitizes entrenched norms		Redefines expectations
Claims process	Linear, process-driven		Automated, networked, parallel
Claims segmentation	Adjuster-based		Algorithm-based
Role of adjuster	Process oversight		Data and management expertise
Pace of change	Long and sequential		Fast and iterative

Source: Bain & Company

Here's a taste of the options now available:

- Mattersight software listens to claims interviews for various carriers in order to discern whether the claimant is being truthful.
- State Farm uses an online auto parts exchange called Parts Trader to more efficiently source parts for repair work.
- EagleView relies on satellite imagery to identify pre-existing conditions and estimate storm damage to roofs, eliminating the need in most cases for an adjuster to visit the property.
- Enservio software estimates the value of contents in a home based on demographic and other information. If a house is destroyed, a carrier using the software can make a payout three times faster than processing a traditional bank check and sharply reduce time-consuming negotiations.

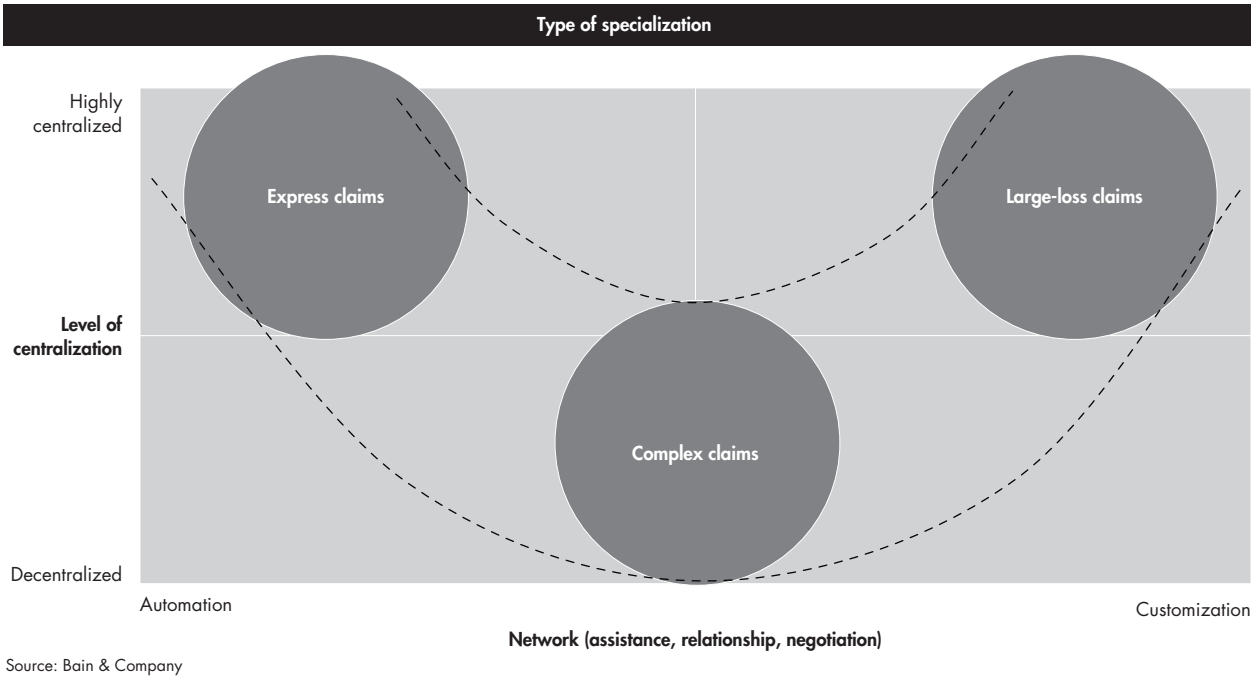
These and other innovations give adjusters new tools to determine payouts, but it's also essential that carriers adapt their processes so adjusters can use the data to make better decisions.

A well-tuned adjustment process: Aligning everyone's incentives

With so much value at stake in the claims process, it's worth a renewed push to ensure that carriers make the right payout through a more efficient process, in ways consistent with a positive customer experience. Payouts comprise roughly 80% of the claims costs, with the remaining 20% being the loss-adjusted expenses incurred in settling the claim.

At some carriers, we estimate that they overpay, on average, by 10% to 12%, in large part because they skimp on adjustment resources or rely too heavily on independent adjusters. A review of independent field adjusters showed that one carrier's estimated promise

Figure 4: Thoughtful segmentation up front can reduce total claims costs



Source: Bain & Company

of a payout, based on a desk review of the claim, was 10% more than what was actually owed and sent to the customer as a fair payment. Naturally, receiving a smaller payment than expected negatively affected the customer's perceptions of the company.

To improve the process, therefore, leading carriers are investing in capabilities for smarter claims segmentation up front (*see Figure 4*). It's no longer effective for each adjuster to get a mix of simple and complex claims. Instead, many insurers have their most experienced adjusters handle the most complex and large-loss claims, with some of these adjusters specializing in certain types of claims. The simpler claims can be handled by less experienced, lower-cost staff and auto-adjudication software.

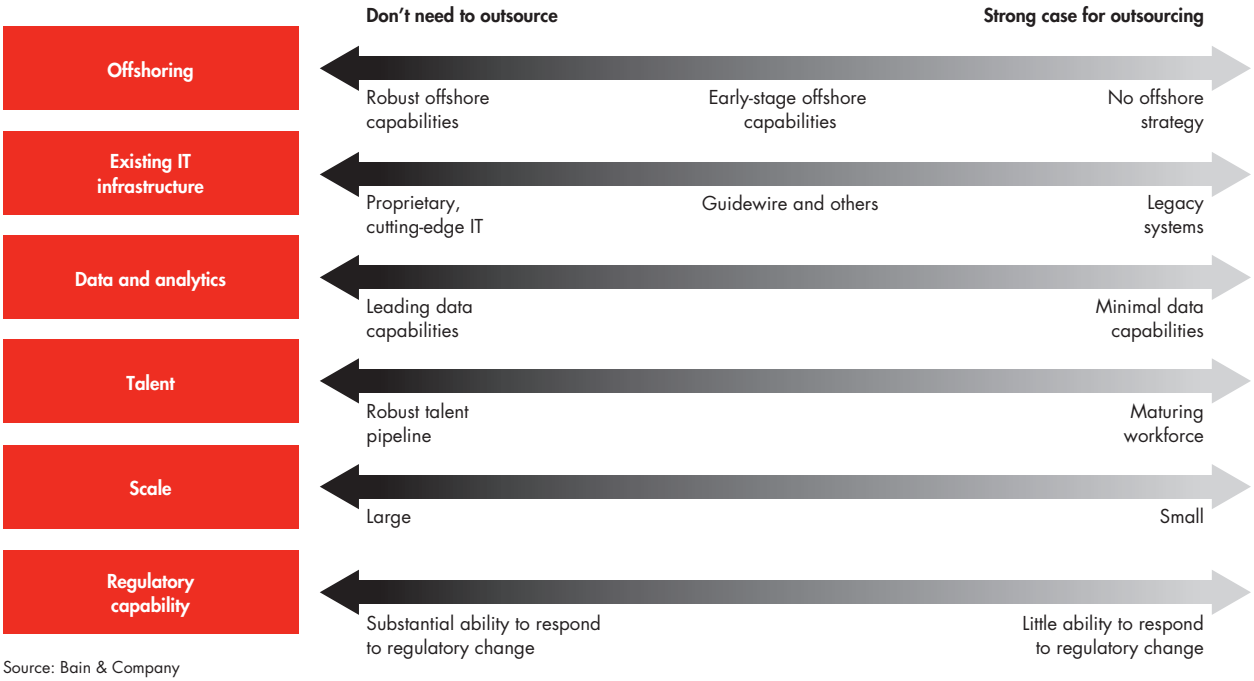
Leading companies such as Chubb go a step further, deploying sophisticated models for faster, more accurate triaging and routing of claims. This allows Chubb to deliver exceptional claims service and payout at the appropriate amount, not a penny more or less. As a result, for its personal and commercial lines, Chubb has the lowest loss ratio of the largest carriers, relatively high customer loyalty scores for its markets and stable premiums in a turbulent environment.

With smarter segmentation in mind, some carriers find it increasingly attractive to outsource the straightforward majority of claims, while keeping more complex and high-value claims in-house (*see Figure 5*). XL, for instance, uses a network of several providers and just a handful of employees to oversee its claims. Third-party administrator WNS, based in India, handles claims for insurers and, by working under a contract based on outcomes, also shares the risk.

Outsourcing offers several benefits:

- Access to global talent, combined with cost savings through labor arbitrage.

Figure 5: Assessing the potential value of outsourcing



Source: Bain & Company

- Higher productivity by leveraging best-in-class practices and large-scale IT investments.
- More flexibility through a variable cost model.
- A better experience for commercial customers through more tailored updates, reporting and handling. Third-party administrators tend to have more flexible systems than insurers' own core systems.

Specialist expertise, whether in-house or external, is proving valuable in three areas: litigation management, fraud detection and medical management.

As an alternative, a number of carriers have opened their own offshore facilities in low-cost locations. AIG, which operates in more than 90 countries, has been consolidating its claims processing into a smaller set of shared-service centers in low-cost locations. And QBE of Australia has opened an offshore facility in the Philippines, where it found high-caliber, low-cost talent to support its worldwide operations.

Regardless of who handles the claim, carriers need to choose and manage vendors and service providers, such as car repair shops and medical doctors, with greater care. It's critical to develop a trusted panel of preferred providers that adhere to contracts based on performance and have distinct service levels and fee arrangements to ensure consistent, high-caliber service on behalf of carriers and customers.

Specialists on call: Knotty claims untangled

For a typical large carrier, complex claims represent only 5% of cases but 70% of payouts. In response, more carriers have been using expert specialists, either by building specialized claims units or enlisting outside firms.

Santam, a South African multiline insurer, captures key risk indicators when claims are made and triages them into five categories. It settles immediate claims with no further assessment. Merit claims with a high fraud risk go to specialists. Other categories may require a visit by a Santam operative. Through triage and greater reliance on specialists, Santam has speeded up its claims processing by 90% for low-risk claims, reduced fraud with its attendant costs and further cut costs through a faster process and fewer visits.

Specialist expertise, whether in-house or external, is proving particularly valuable in three areas:

Litigation management. Forward-thinking carriers have been working to actively prevent litigation. They've also upgraded their in-house counsel and winnowed their external panel to a smaller number of law firms with greater attention to aligning incentives and focusing on outcomes rather than billable hours.

Some carriers in the UK, Europe and Australia, for instance, now pay a fixed amount per case and target an annual level of indemnity. This benefits the law firm as well, because it is assured of business and avoids having to track hourly billing. One global multiline insurer pruned its panel from 200 to 75 law firms, renegotiated their contracts and created clear guidelines for which types of claims would go to which firms. Loss leakage went from 15% to 6% in two years and loss-adjusted expenses declined by 3 percentage points, while the insurer also achieved lower indemnity settlement costs and lower legal fees.

Fraud detection. Among the people disposed to committing fraud, there is perfect information on the street; they know the vigilant and complacent carriers, and tend to target the latter. So it's important for carriers to aggressively pursue the bad guys through tactics including innovative use of data sources and software that spots patterns of suspicious behavior. Word will reach the street.

One tactic involves automating guidelines to help identify fraud. Claims made on a particular day of the week or by a policyholder who just signed on with a carrier or moved

three times in the past year will raise a red flag. Software houses now offer databases that list middlemen such as auto-body shops known to have problematic histories.

Claims investigators have also rooted out fraud by looking through social media sites, such as Angie's List and Facebook, where claimants sometimes advertise services or post photographs at odds with their alleged claims.

CNA, a US commercial lines carrier, has tackled the problem through a special fraud unit comprised of two dozen employees with military and law enforcement backgrounds. The company worked with SAS to build a predictive model that identifies connections among multiple claims, such as a doctor consistently charging the maximum billable hours. Within a year of implementing the model, CNA had recovered or prevented fraudulent claims totaling more than $2 million.

Predictive modeling also underlies a new approach taken by the Brazilian insurer mentioned earlier, which was looking to reduce fraud in auto collision and theft claims. This insurer tested hundreds of variables from policies, claim notifications, credit scores and other sources, and identified the ones that help explain fraud. This modeling has allowed the carrier to identify twice as many suspected fraud cases as previously and reduced the start time for investigations by about half.

Medical management. Carriers have found value in developing a strong network of healthcare providers that will ensure the right treatment through outcome-based reimbursement, at reasonable rates. Their double check of medical necessity can substantially lower costs.

Effective networks emphasize accurate procedure coding and associated bill review. They use nurses and telephone interactions whenever appropriate to manage cases. And for workers' compensation, it's critical to steer policyholders to providers that not only ensure the right medical treatment but also expedite return to any form of light-duty work, which limits indemnity. Active intervention along these lines can lead to a roughly 3% reduction in medical payouts.

Organizing for claims excellence

Many of the recent shifts in claims management, including innovative digital analytics, more auto-adjudication and greater standardization through "rules-driven" processes, have major implications for carriers.

Technology has been moving much of the work out of the field and into the machine. That allows carriers to centralize their claims staff and build economies of scale. Claims organizations also become more connected with other internal functions and external partners as data flows more freely through the enterprise. The physical footprint, staffing and supervisory model, and workflow all must be redesigned as a result.

Offshoring or outsourcing has become a more viable alternative for parts of the claims process, such as first notice of loss, so insurers will have to manage that transition as well.

The bulge of aging employees means valuable knowledge will soon walk out the door. Insurers should find ways to codify that collective experience for the benefit of junior adjusters.

For example, carriers that pursue outsourcing aggressively will simply need fewer adjusters. For those adjusters who do remain in-house, we expect a dual-path model to become the most sustainable path to organizing for superior claims management (*see Figure 6*). Lower-level adjusters will handle most claims, and for this group, carriers will emphasize throughput and efficiency, as directed by experienced supervisors. Some of those adjusters, along with outside hires, will then be trained and developed to take on more complex or large-loss claims, and perhaps move into specialty lines.

Figure 6: Define who will do the work and build the requisite capabilities

Source: Bain & Company

Planning for the future pipeline of adjusters and managers poses a challenge for carriers accustomed to long tenures for adjusters and supervisory promotions based on seniority rather than demonstrated management skills. Success in building a claims organization for the future will no doubt involve some dismissals and a fair amount of recruiting and retraining, as companies such as Sedgwick have already begun.

In addition, the bulge of aging claims employees nearing retirement means that valuable knowledge will be walking out the door. Finding ways to capture and codify their experience so that junior adjusters can learn more quickly will contribute to successful claims management in the future.

Fuel for future growth

The P&C industry has grown intensely competitive. At the start of 2000, of the 20 companies with the greatest market capitalization, 12 did not make the list 12 years later. The quality of claims management will play a key role over the next 12 years.

Carriers that aim to fuel long-term growth and sustainable profits, regardless of their strategies or target segments, will take a more systematic and customer-centered approach to claims management. They will look hard at the value of owned vs. outsourced resources. And they will embrace digital technologies not just for efficiency, but also to improve risk management and customer loyalty—and, ultimately, to enhance their economics.

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