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Financial Services

POINT OF VIEW

# HANDLE WITH CARE

## A DIAGNOSIS OF THE CHALLENGES IN CORPORATE CLAIMS MANAGEMENT


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The manufacturing industry has recently been triumphant as it shows off the "3D printer", a flexible, new tool that is claimed to herald a transition from uniform mass production to mass customisation, where volumes remain high but products are bespoke. This modern invention means high-volume products can be tailored to each customer's circumstances, demands and wallet without the need for expensive downtime and re-tooling. Insurers, however, may be less than impressed with this supposed breakthrough. Corporate and industrial insurance claims functions have been dealing with a high-volume, high-variance workflow for years now, with claims services needing to cover everything from a crate of missing goods to a multi-million dollar pollution lawsuit.

The theory of efficient and effective claims processing in such a high-variance environment is well-accepted. In short, the key is effective triage and segmentation: that is, separating claims early in the process into relatively homogenous pools for processing by the appropriate specialist handler group. If properly managed, such a process can create a virtuous (and profitable) circle of:

- Greater efficiency in volumes of claims handled and their settlement speed
- Greater consistency, accuracy and fairness in the payouts awarded
- Tighter control of both indemnity costs (for the highest-complexity and largest-exposure cases) and overhead costs (for the simplest and highest-frequency cases)
- Improved customer satisfaction.

In high-volume retail, insurers can draw on statistical techniques for claims segmentation, implemented as soon as the first notification of loss is received. However, in corporate claims, the practice is considerably harder than the theory. Even the more common corporate claims types are typically larger, less frequent and more complex than retail claims. And, the downside risk of getting the claim approach wrong (for example, by not using the appropriately skilled adjuster in time, or from mishandling the legal approach) can be significantly more severe.

Attempts to implement effective claims distribution and segmentation processes in the corporate insurance world often fall short. The typical mistake in such an exercise is in poorly designing the triage process. For example, it is all too common to use easily measurable headline figures (like raw claim size or risk and indemnity type) as the main segmentation variable, when instead the true underlying sorting variable should be potential claim complexity. To be successful, segmentation must focus on the early warning signals of complexity rather than proxies such as notified claim size.

However, triage is not the only area for concern. Serious failures can also develop in the associated process and organisation design, for example, in failing to establish truly differentiated processes and handler groups for the segmented claims pools. Beyond design, the implementation of a change process requiring front line handlers to adhere rigidly to a new and complex claim distribution process can lead to failure. All too often, frontline claims handlers either misunderstand – or in extreme cases even choose to subvert – the new approach if they do not believe in its expected benefits.

A successful corporate insurance claims distribution approach needs to include:

- Clear definition of the desired outcomes and hence claims handling approach for different segments: a "Claims Appetite"
- A technical segmentation process to split claims into pools of relatively homogenous complexity...
- ...supported by a clearly designed organisational and process set-up, with clear links to handler incentives and career and skills development paths
- Dedicated change efforts to ensure the design is adopted within the organisation in practice, not just in theory.

## CLEAR DEFINITIONS OF THE END GOAL – CLAIMS APPETITE

Insurers need to balance the financial impact of claims handling with the claimants' experience of the insurer's brand and service, but are rarely systematic in defining how to make such trade-offs. As a result day-to-day handling decisions on are more often based on the interpretation of the individual claims handler than they are management's intentions. Worse, the right balance between cost and service can vary by claim or product type: a difficult bodily injury claim might need more emphasis on service, but for a claim where only property has been damaged, efficiency may be a greater priority for insurer and customer alike. Aspirational group-level statements such as "excellence in customer service" do not provide sufficiently granular guidance as to the "right" behaviour in each category of claim.

We believe that best practice insurers need to adopt a more systematic approach to defining how the cost-service balance is achieved. This starts by defining a clear strategic "claims appetite" in as structured and professional a way as they define their risk appetite and demands a more detailed consideration of the daily trade-offs within Claims Management than the overall group strategy usually provides.

If properly done, a systematic consideration of the balance between objectives for each product, claim type and handling type can generate a much more precise and practical articulation of the objectives for claim handling. This will then provide principles that are aligned with group strategy but can also can be cascaded down into detailed operational guidelines about how to make trade-offs in practice.

# SEGMENTING CLAIMS INTO HOMOGENEOUS POOLS

As stated, the claim triage and allocation process is critical but often underperforming due to errors in design. The allocation can be arbitrary (or based on the "cab rank" principle of claims being allocated to the first person to pick up the phone) or even counterproductive (when handlers have incentives to retain claims in a geographic or product silo even when they are unsuited to handle them).

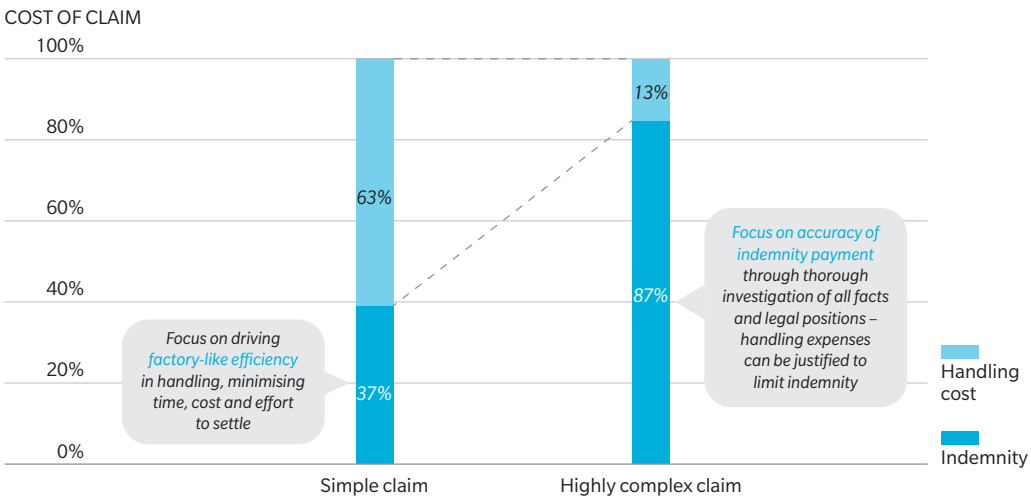
Needless to say, this can lead to numerous problems and inefficiencies, for example:

- Claims are not matched to the right skill set
- Handovers are informal, with claims "falling between the gaps"
- Workloads are unmonitored and unsmoothed, leading to bottlenecks
- Management information is plentiful, but rarely insightful or actionable.

An effective distribution mechanism to create homogeneous and discrete flows of work needs to rely on an assessment of claims complexity that would ideally produce:

1. A high-volume flow of small and simple claims where handling cost can be optimised through a standardised mass production environment
2. A more irregular flow of complex and unique claims with big indemnity risks that need to be handled in bespoke project environments by seasoned handlers able to work with a wide variety of technical, commercial and legal inputs.

EXHIBIT 1: ILLUSTRATIVE COST MAKEUP BY CLAIM COMPLEXITY, COMMERCIAL CLAIMS




**Source:** Oliver Wyman analysis

However, creating the triage framework in low-volume corporate claims is a harder exercise than in retail, where statistical techniques can be applied. For corporate claims typically an expert-based approach is needed that:

- Utilises internal experts to review sets of carefully-selected historical claims
- Categorises claims' expected complexity ex-ante at FNOL and eventual complexity ex-post
- Uses scarce data to suggest possible traits or warning signals of complexity per category
- Conducts an expert review to refine these suggestions into a robust framework of rules that can be used to categorise incoming claims
- Considers the warning signals of developing complexity post-notification.

## CLEARLY DESIGNED PROCESS AND ORGANISATIONAL SETUP

But, a triage formula alone is not enough – there are always difficult process, organisational and systems trade-offs to resolve. For example, in a global business line, claims functions need to be sufficiently international to ensure continuity in key client relationships - but at the same time need to retain local responsiveness.

A design process therefore needs to manage a variety of issues:

- On a global level, evaluating the minimum efficient scale of dedicated local expertise to ensure that scale benefits in processes or shared services are not missed.
- At a more detailed level, structuring handler teams and hierarchies such that organisational efficiency is realised while also maintaint a clear split of responsibility for different claims types and complexities.
- Allowing a controlled degree of flexibility by not simply matching complexity and experience (if an inexperienced handler only gets simple cases, they will never develop).
- Not only defining the initial claim allocation but also how best to handle each resulting claims pool.
- Accommodating the fact that the initial complexity assessment is only an estimate: the process needs to allow for periodically re-assessing claim complexity and reassigning responsibility as needed.

## DEDICATED CHANGE EFFORTS

Implementing changes to a corporate claims process is rarely straightforward. In our experience problems include:

- Handlers seeing the high-volume "factory" to process simple claims as de-skilling
- Handers becoming territorial about client ownership when moving from a more systematic claims distribution mechanism
- Handlers resenting the intrusion of more active management and monitoring into their day-to-day processes.

To manage this, and to ensure buy-in to the new system, management therefore need to keep up an active change dialogue throughout the process.

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## BRINGING IT TOGETHER: THE ROUTE TO EFFECTIVE CLAIMS DISTRIBUTION

In summary, a well designed claims distribution process has clear benefits for corporate insurers – but is sufficiently difficult to achieve that it makes careful design paramount. We believe successful implementation requires insurers to focus on four key challenges:

1. Ensuring the objectives for the overall function are clearly defined and translated into claim-handling goals with a similar rigour to that seen in the setting of risk appetite
2. Defining a mechanism that splits a heterogeneous flow of claims into pools with homogeneous characteristics that can be handled similarly
3. Conducting a thorough assessment of the ability of the organisation and processes to cope with these new pools in an efficient and effective manner, redesigning them where necessary
4. Running a change programme to realise the new process and organisation design while maintaining engagement with handlers.

Getting this right will allow insurers to achieve the equivalent of "mass customisation" in corporate claims – bringing higher efficiency, greater consistency and fairness, tighter cost control and improved customer satisfaction.

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