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WHAT YOU NEED TO KNOW
NON-LIFE INSURANCE

Global Trends in Non-Life Insurance: Claims

Key claims trends and the implications for the non-life insurance industry

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1 Highlights

As the economy has improved across most of the world, the global non-life insurance industry has participated in the recovery with written premium growing 4.4% in 2010. This was especially true in Asia where written premiums grew by 16.8% the same year. The growth trend is likely to continue in 2011, although the underwriting margins continue to be under pressure due to the impact of catastrophic and other major claims across the world, such as the devastating earthquakes in Japan and New Zealand. In addition, the uncertainty over economic issues lingers on, and could also affect the future growth of the industry.

The non-life insurance industry is witnessing shifting trends across the front office, policy administration, and claims—the three core functions of the insurance value chain. This paper identifies key emerging trends in the claims function of non-life insurance firms.

The claims process is the defining moment in a non-life insurance customer relationship. To retain and grow market share and improve customer acquisition and retention rates, insurers are focused on enhancing customers' claims experience. In a highly competitive insurance market, differentiation through new and more effective claims management practices is one of the most important and effective ways to maintain market share and profitability.

In particular, insurers can transform the claims processing by leveraging modern claims systems that are integrated with robust business intelligence, document and content management systems. This will enhance claims processing efficiency and effectiveness. It can benefit the insurers both operationally and strategically by enabling them to reduce claims costs to improve their combined ratio, improve claims processing efficiency, and drive customer retention and acquisition.

Smartphones offer a new opportunity for insurers to improve customers' experience and reduce claims costs by offering convenient self-service tools.

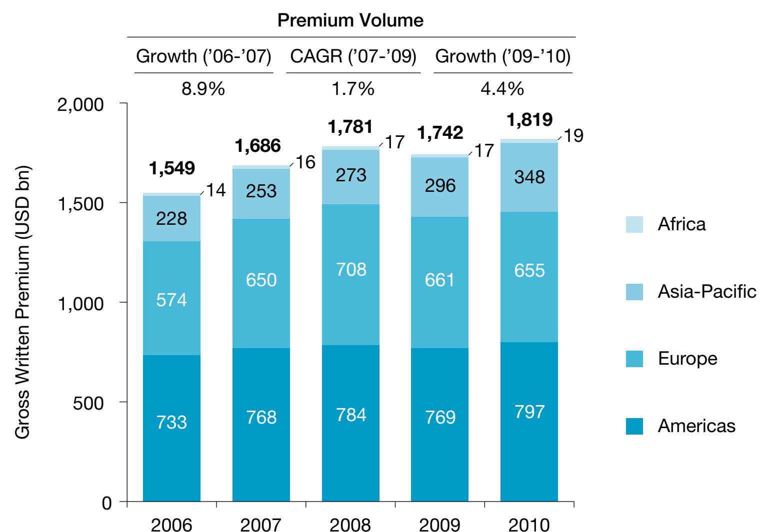
2 Introduction

2.1. Global Non-Life Insurance Performance

The global insurance industry witnessed a positive growth of 2.7% of premium volumes during 2010[1] in real terms, after experiencing a decline during both 2008 and 2009—the worst years of the financial crisis. The return to growth in 2010 was largely a result of the increased demand for insurance due to initial economic recovery across the globe. Looking to 2011 and 2012, the insurance industry is expected to witness a further growth in volumes, though the uncertain outlook for further economic recovery will be a key determinant.

After posting a decline in 2009, global non-life insurance premiums grew by 4.4% in nominal terms (2.1% in real terms) to reach $1.8 trillion in 2010. This increase was mainly driven by the robust economic rebound in Asian countries which helped to boost premium growth in emerging Asian markets and the newly industrialized countries[2] in Asia.

Exhibit 1: Global Non-Life Insurance Premiums (in USD bn), 2006-2010



Source: Sigma Reports 2007-11, Swiss Re

Fuelled by the economic recovery, non-life premiums for the Asian region grew by 17.4% in 2010. The increase was primarily boosted by a 33.0% and 27.7% rise in non-life premiums in the emerging markets of China and India respectively in 2010. The newly industrialized Asian countries, particularly South Korea (24.3%) and Singapore (18.5%), also witnessed a robust growth in premiums.

[1] Sigma Reports 2007-11, Swiss Re
[2] Newly industrialized countries in Asia include Hong Kong, Singapore, South Korea, Taiwan

However, almost flat premiums growth of 2.4% in the mature insurance markets continued to drag down the growth in the global premiums. The continued softening of premium rates as well as intense price competition and a slowdown in non-life insurance demand in the U.S. and Western Europe hampered non-life premiums growth in these markets.

Nonetheless, non-life premiums growth in emerging markets is expected to remain strong. Although the premiums growth in mature markets is forecasted to improve, the improvement is likely to be restricted by continued rate declines in commercial lines of business and ongoing economic concerns.

While the actual cost of the devastating earthquakes in Japan and New Zealand in the first quarter of 2011 remained unclear for insurers, the size of the property damage and expected rise in insured loss indicates that the underwriting result for non-life insurers may deteriorate in 2011.

2.2. Insurance Value Chain

Insurance firms' operations can be broadly divided into three core elements that represent the insurance value chain:

- Front Office
- Policy Administration
- Claims Processing and Payout

Along with these three core elements, a range of support functions are also required to ensure smooth operations of insurance firms, such as finance and accounting, human resources, legal, infrastructure, and asset management.

This paper focuses on the claims function of the insurance value chain for non-life insurers. It identifies the key trends in the claims function and their potential implications.

3 Emerging Trends in Non-Life Insurance: Claims

Claims are the defining moment in the customer relationship for non-life insurance firms, with a firm's success often defined by one factor: the customer's experience around claims. For non-life insurers several inefficiencies—including aging technology, increasing process complexity, and a rising number of fraudulent claims—are driving up claims costs and adversely affecting customers' claims experience.

To reduce the cost of claims and deliver on a value-added brand promise to customers, non-life insurers are focusing on enhancing efficiency and effectiveness in their claims function. To achieve their goal of higher levels of operational efficiency and better process effectiveness, non-life insurers are seeking to implement modern claims system or enhance their existing claims systems, leverage advanced fraud detection technologies, and innovate around self-service and straight through processing.

These technological and operational factors have led to the emergence of the following key trends within the claims function for non-life insurers[3]:

- Implementation of a modern claims processing platform or enhancements/ upgrades to existing claims processing platforms
- Use of advanced analytics tools to track and reduce fraudulent claims
- Increased use of claims document and content management tools
- Adoption of mobile solutions for claims management
- Leverage straight-through processing (STP) to streamline claims processing in some select lines of business

[3] Trends shown are not necessarily comprehensive, but have been highlighted due to their relevance and potential impact on the industry

4 Trend 1: Implementation of an Integrated Claims Processing Platform

An integrated claims processing system can lead to simpler and faster claims processing, which can reduce costs and improve customer satisfaction.

4.1. Background and Key Drivers

Many insurers are still using multiple legacy systems to process claims. Unfortunately, these disparate legacy systems lack the flexibility to meet the changing needs of the industry and suffer from high maintenance costs, which consumes a significant portion of insurer's IT budget.

Some of the problems of multiple disparate claims systems include erosion of profits and decline in customer satisfaction levels. Moreover, multiple systems act as a hindrance to efficient claims turnaround times, resulting in a decline in customer retention and acquisition.

An integrated claims system will help non-life insurers achieve the goals of improved operational efficiency, reduced claims management costs, and enhanced customer claims experience. Implementing a single integrated claims system can help an insurer:

- Minimize the built-in complexity of disparate legacy systems and improve the flexibility of the claims processing system.
- Reduce claims settlement time and costs, and ultimately enhance the customer experience.
- Integrate systems with third parties and other internal systems.

4.2. Analysis

An integrated claims processing platform helps insurers enhance process efficiency and reduce claims processing time. The modern integrated claims platform usually leverages service-oriented architecture (SOA)[4] to enhance business flexibility, enable straight-through processing, and support control and monitoring functions. Additionally, an integrated system can reduce the number of hand-offs, manual paperwork, and process delays by streamlining the claims settlement process.

New emerging technologies, such as SOA, allow for much faster and efficient online claims filing. An integrated claims system based on service-oriented architecture with configurable features can support integration across product lines. By centralizing their requirements into a single integrated claims system, insurers can minimize the built-in complexity of disparate legacy systems and improve the flexibility of the claims processing system.

Many non-life insurers are looking to enhance and upgrade existing claims systems to increase efficiencies, minimize the built-in complexity of legacy systems, and reduce claims settlement time and costs.

[4] A service-oriented architecture (SOA) provides, by design, a flexible suite of loosely coupled applications that can be integrated across multiple business domains

4.3. Implications

Implementation of an integrated claims system or upgrading the existing claims systems are key priorities for non-life insurers, driven by the need to enhance process efficiency and cost effectiveness, as well as reduce cycle times to drive an improved customer experience. Other benefits of a modern integrated claims-system include:

- Claims data can be leveraged efficiently by insurers' management information systems and underwriting decision support systems.
- Business interactions and transactions can be automated with external systems, such as third-party administrators, salvage vendors, or loss adjustors.
- Claims handling costs can be reduced through efficient management of claims costs and claims leakages expenses.
- Improved customer satisfaction and higher customer retention levels can be achieved by to implementation of straight-through processing and self-service.

4.4. Leading Practices and Innovation

One of the top personal and commercial insurance groups in the U.K. implemented a single integrated claims solution to reduce their claims adjustment expenses and improving process and operational efficiency. The group's multiple disparate claims systems were the primary area of concern. The insurer wanted to implement a new integrated claim management solution to improve the efficiency of its claims function and reduce its overall claims costs.

Under a three year claims transformation program, the insurer implemented a leading integrated claim solution as the single claims handling system across the U.K. operations, and an offshore claim processing center was established for claim notification and recovery processing. The new claims operating model helped the insurance group reduce its claims costs by more than £100 million in one year. The insurer's U.K. claims function now processes claims through a single integrated system.

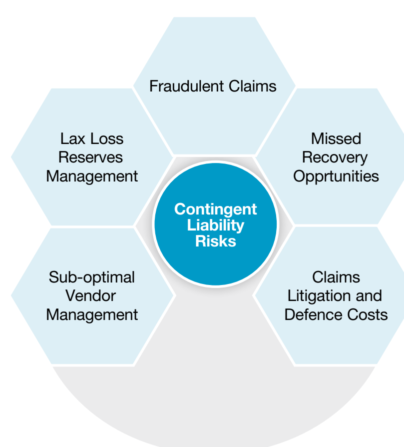
5 Trend 2: Use of Advanced Analytics Tools to Reduce Fraudulent Claims

5.1. Background and Key Drivers

While most insurers are focusing on strategies to control rising claims administration costs, there is also a growing need to manage the escalating costs related to contingent liability risks:

- Fraudulent claims account for 10%-15% of the non-life insurance industry's incurred losses and loss-adjusted expenses every year[5].
- Missed recovery opportunities, including salvage, subrogation, and third-party recovery, have considerable impact on insurers' profitability.
- Although non-life insurers, globally, spend more than $20 billion a year on defense and claims cost containment, only 15 to 20% have proper claims litigation management systems[6].
- Vendor management can be inefficient due to lack of system integration and real-time estimation of service cost and completion time.

Exhibit 2: Contingent Liability Risks for Non-Life Insurers



Source: *World Insurance Report 2011*, Capgemini and Efma

Although all the contingent liability risks are a growing challenge for non-life insurers, fraud is the most urgent challenge that needs to be tackled to reduce their overall claims cost.

Fraudulent claims cost U.K. general insurers nearly £1.9 billion ($3.0 billion) in 2008[6]. In the U.S., fraudulent claims cost nearly $30 billion each year[7], with false slip-and-fall injury claims and related costs amounting to nearly $2 billion a year[8].

[5] *World Insurance Report 2011*, Capgemini and Efma
[6] Research Brief, Association of British Insurers, July 2009
[7] Insurance Information Institute
[8] National Floor Safety Institute and Insurance Research Council

5.2. Analysis

Non-life insurers face a number of challenges in detecting fraud, including excessive costs for investigations, high litigation costs, and decline in customer satisfaction due to delays in claims settlements caused by investigations. These issues can make it cheaper for insurers to pay a fraudulent claim than investigate it.

While many non-life insurers have a formal procedure in place to detect fraudulent claims, an approach that is missing a fraud management system can be less effective. Fraud management systems that leverage advanced analytics tools including predictive modeling and extend across all claims-related activities can greatly impact both the cost and success of fighting fraud.

Some insurers are using a combination of advanced analytics tools to detect and prevent fraudulent claims which include:

- Rules-based systems that test each claims notification against a set of predefined business rules to detect fraud patterns that are known to the company.
- Exception reporting that highlights when a threshold for a particular measure is exceeded.
- Predictive modeling that helps insurance companies detect complex fraud patterns by using data-mining tools and programs that produce fraud-tendency scores.
- Social networking analysis that identifies fraud activities by establishing relationships between entities in claims.

5.3. Implications

Fraud has become a big challenge for the industry largely because most insurers do not have the claims data they need to identify fraud promptly, effectively, and inexpensively. Non-life insurers need fraud detection strategies where the expenses incurred to detect and prevent fraud are less than the costs of paying the claims.

By implementing a real-time analytical engine that calculates the propensity for fraud at each stage of the claims cycle right from first notice of loss to claim settlement, insurers can increase the effectiveness of combating fraud. With claims being the make-or-break touch point for the customer experience, firms have to ensure they adopt a comprehensive approach to manage contingent liability risk, especially fraud, to reduce costs.

5.4. Leading Practices and Innovation

One of the top property and casualty insurers and a major writer of non-standard automobile insurance in the U.S. implemented predictive analytics software to enhance and speed up their claims fraud detection and management.

The insurer wanted an efficient and accurate model that could enable the firm to generate a fraud propensity score for each claim. The insurer's existing fraud detection model was elementary and required too much manual intervention. The insurer introduced predictive claims tools to leverage advanced analytics for fraud detection. The predictive analytics tools helped the firm optimize its workflows to promptly settle unsuspicious claims and efficiently detect and investigate suspicious claims.

The predictive analytics tools led to an increase in recoveries and a reduction in the time required for detecting, investigating, and successfully pursuing suspicious claims.

6 Trend 3: Increased Use of Claims Document and Content Management Tools

6.1. Background and Key Drivers

An ideal business information system makes efficient use of data from various enterprise-wide systems, including sales, general ledger, policies, consumers, claims, distribution, products, and other data management systems. Claims data is the most critical for a non-life insurance firm. Capturing and analyzing claims data and making claims-related data and intelligence available to other systems is vital to improve risk underwriting and support enterprise-level decision-making.

Lack of integrated claims data creates unwanted risks and costs for insurers, such as payments of fraudulent claims as well as missed opportunities for salvage, subrogation, and third-party recovery. Moreover, inadequate and delayed sharing of claims data also results in mispricing of risks as well as adverse risk selection.

The effective sharing of claims data helps an insurance company's top management make strategic and tactical decisions based on accurate and well-analyzed information. These decisions are likely to result in improved efficiency and effectiveness, better regulatory reporting and compliance, more astute strategic planning and, ultimately, improved profits.

There are three key factors driving the need for non-life insurers to invest in claims-data management tools:

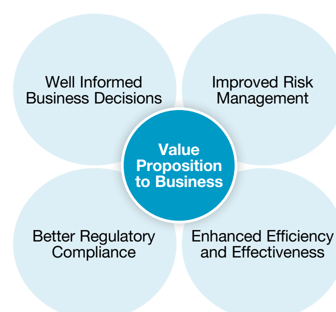
- Availability of accurate and reliable claims data is likely to improve the efficiency of claims adjusters by allowing them to focus their time on adjudicating claims and controlling claims adjustment costs.
- Insurers need high-quality claims intelligence to make efficient underwriting decisions, control over-all claims expenses, and adapt to a changing operating environment.
- An efficient claims data management system helps in better pricing of risk and reduces the chance of adverse selection of risk by sharing claims experience data with the underwriting system.

6.2. Analysis

An effective claims document and content management tool efficiently stores and manages the appropriate claims-related data using standardized data dictionaries, data field code tables/descriptions, and data file layout formats. This facilitates sharing of claims data throughout the organization including call centers and third parties. It also enables information-based strategic planning. Management can obtain specific data on existing claims-management performance, and discern the potential impact of a given strategic decision.

Insurers can also use document and content management tools to make sure all data elements required for regulatory reporting are captured and reports are produced in the proper format as required by regulatory reporting standards. Ultimately, effective data sharing provides management with a more comprehensive understanding of business risks and performance trends, and helps drive well-informed business decisions which can potentially result in improved profits.

Exhibit 3: Claims Document and Content Management Tools: Value Proposition to Business



Source: *World Insurance Report 2011*, Capgemini and Efma

An efficient claims document and content management tool is critical for insurers to improve their operational efficiency, contain costs, and benchmark their own claims data with industry data. These systems also help management benchmark the standards that can provide potential cost benefits, as well as 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.

6.3. Implications

Capturing and analyzing claims data and making that information available to other systems is vital to improve risk underwriting and to support enterprise-level decision making. The greatest potential value from claims data can be found at the enterprise level. Insurers can potentially leverage high-quality claims data as an enterprise asset to explore synergies among internal operations, such as policy administration, product development, and front office and with external vendors. Insurers can also use predictive analytics to improve key activities such as risk management and compliance.

Insurance companies need to make sure that claims data management systems efficiently store and manage the claims related data and facilitate easy and enhanced sharing of claims data throughout the organization and externally.

6.4. Leading Practices and Innovation

One of the largest Swiss health insurers implemented a new claims data management system to reduce claims cost and meet the new detailed reporting requirements introduced by the Swiss government. The insurance company's existing claims data management system was inflexible, did not support new applications, and offered limited possibilities for decentralized claims data analysis. The insurer wanted to replace this aging system.

The insurer defined its data and business intelligence requirements, including data model, data warehouse architecture, and data migration approach, and selected a new robust data management system. During the implementation, the insurer integrated a two-terabyte database with its core data source system and existing applications, along with reference data from government and national health department sources.

The new system provided a customized interface that allowed easy access to department-specific product lists. It also generated daily reports versus the previous weekly or monthly report cycle with better quality and consistency. It helped the firm reduce its claims costs by more than $10 million a year.

7 Trend 4: Adoption of Mobile Solutions for Claims Management

7.1. Background and Key Drivers

Mobile and wireless technology is emerging as an inevitable solution for insurers. Mobile solutions help firms keep pace with customers' strong demand for real-time business processes. In the near term, most young consumers are likely to have access to advanced mobile devices and expect insurers to offer services through smart applications.

Many factors stemming from environmental, technical, and organizational changes are driving the imperative to adopt mobile solutions for claims management. However, five highly pressing factors are accelerating this need:

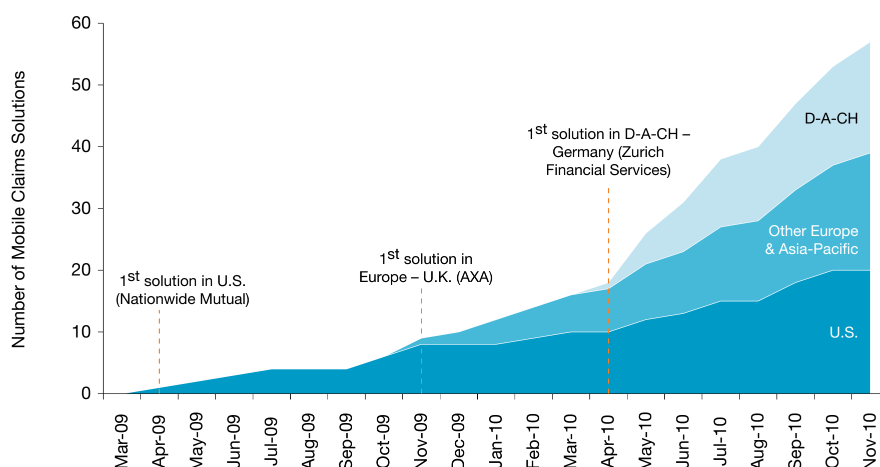
- **Fast growing channel** – Mobile application sales are expected to grow rapidly at a compounded annual growth rate of 73% for smartphones and 93% for tablets during 2010-15[9].
- **Changing customer preference** – A growing number of insurance customers are using their mobile phones to engage with insurers. 23% of younger insurance customers in the U.S. had smartphones in 2009, and this trend is expected grow significantly going forward[10].
- **Competitive edge** – To gain advantage in an intensely competitive industry, leading non-life insurers have already launched or are aggressively developing mobile solutions.
- **Increasing process complexity** – The claims function often involves multiple handoffs, duplicated work, and an overlay of business compliance processes that make the claims settlement process cumbersome and lead to decreased client satisfaction and increased attrition risk. Mobile and wireless technologies can facilitate faster communication and exchange of claims data and information.
- **Rising claims cost** – For every dollar collected in premiums, insurers, on average, spend 61 cents on claims pay-out and 13 cents on claim expenses. The claims cost has increased 4.6 percentage points from 2006 to 2009[11].

7.2. Analysis

Technology-enabled mobile solutions offer insurers an opportunity to gain a competitive edge by turning a customer's unpleasant and stressful claims situation into a positive service experience. Companies that use mobile solutions to successfully transform the customers' claims experience are likely to gain a competitive edge in the non-life insurance industry. Worldwide, 57 insurers had already introduced mobile claims solutions by November 2010 with U.S. and European insurers leading the trend. Asian insurers are still in the initial |stages of adoption.

[9] *Mobile App Internet Recasts The Software And Services Landscape*, Forrester Research, Inc, March 2011
[10] *Technographics Benchmark Survey 2010*, Forrester Research
[11] *World Insurance Report 2011*, Capgemini and Efma

Exhibit 4: Mobile Claims Solutions Adoption Trends – by Region 2010[12]



Source: *Mobile Claims Management: Smartphone Apps in Motor Insurance*, I-Lab, March 2011

The trend started in the U.S. when insurer Nationwide launched the first mobile claims solutions in April 2009. Nationwide launched a free downloadable application for the iPhone to help customers file a claim and offer self-service on the road. By November 2010, nine out of the 10[13] largest U.S. auto insurers were offering corresponding solutions.

By the end of 2009, the trend reached Europe with AXA becoming the first European insurer to launch an iPhone claims application. While most insurers still offer mobile solutions in just one country, a few insurers successively released solutions in several countries. For example, Zurich Financial offers mobile claims solutions in Switzerland, Germany, the U.K., Turkey, and the U.S. AXA offers mobile claims solutions in the U.K., Germany, France, Luxembourg, and Switzerland.

In early 2011, Tata AIG became the first Indian insurer to provide a round-the-clock toll-free helpline number and SMS facility for notification of claims in the Asia-Pacific region. In April 2011, AIU Insurance introduced iPad and iPhone applications in Japan to facilitate claims adjustments and expedite claims payments. AXA planned to launch a mobile claims application for the Android in Singapore in late 2011. As mobile technology improves and mobile handheld devices become less expensive, this adoption trend is likely to gain further momentum.

[12] D-A-CH represent the German speaking countries; where 'D" – Germany, 'A' – Austria, and 'CH' – Switzerland
[13] *Mobile Claims Management: Smartphone Apps in Motor Insurance*, I-Lab, March 2011

7.3. Implications

Insurers can offer convenient claims service through mobile claims self-service solutions while reducing the servicing cost. Self-service functionality helps insurers expand their processing capacity, optimize resource utilization, and lower processing costs. Although insurers can improve customer satisfaction through mobile claims self-service applications, integrating mobile solutions with enterprise claims management systems is critical to successfully leverage the full potential of mobile claims solutions.

Dedicated integration architecture is vital to reap the benefits of mobile claims solutions in terms of process efficiency, data accuracy, and business partner integration. A smartphone can be used to submit a loss report to the claims management enterprise system via integration architecture. The integration architecture can facilitate enriching the loss report with supplementary information like pictures of the accident scene or data about the other party.

Therefore, while implementing mobile claims solutions, insurers should also focus on developing a dedicated integration architecture that connects the mobile claims solution with the enterprise claims management systems.

7.4. Leading Practices and Innovation

One of the largest personal property and casualty insurance providers in the U.S. introduced a mobile solution to offer customers convenient claims self-service at the accident site. The company was looking for a modern solution to demonstrate its brand promise by being the first to market with a very innovative customer experience. The insurer wanted to develop a range of useful smartphone self-service tools to reduce the number of calls to customer service and claims processing centers.

The insurer launched a customer survey in 2007 asking customers what features they would like for their smartphones, and continuously evaluated mobile concepts based on customer feedback for two years. In 2009, they became first non-life insurer to develop custom mobile web technologies for an iPhone application.

After the launch of its smartphone self-service tools in 2009, the firm experienced 60,000 downloads in the first 60 days of rollout. In the first few weeks, 20 claims were submitted via the iPhone application.

The firm is also leveraging its mobile self-service solution for lead generation, as the insurer captures customer information, scans the customer database to identify the customer, and assigns the mobile transaction as a sales lead.

8 Trend 5: Leverage of Straight-Through-Processing to Streamline Claims Processing

8.1. Background and Key Drivers

Many insurers still require multiple hand-offs and duplication of work even for auto claims which are relatively simple and straightforward. These issues result in delayed claims settlement, higher claims processing costs, and greater customer dissatisfaction. In the absence of straight-through processing (STP) and self-service facilities, customers are likely to interact with multiple representatives of their insurance company during claims processing.

Most policyholders prefer to interact with only one representative of their insurance company during the claims process, and those who need to interact with three or more representatives are likely to be four to five times more dissatisfied[14].

The following factors are accelerating the need for non-life insurers to leverage STP to improve claims efficiency and effectiveness:

- Claims services are effectively the moment of truth. One out of every five customers switches insurers after experiencing a less-than-satisfactory claims process .
- It costs insurers five to seven times more to bring on new policyholders than to retain existing ones[15].
- The average time and effort of claims handlers consumed to process simple claims like windshield damage is significantly high and exerts considerable pressure on the underwriting margins.

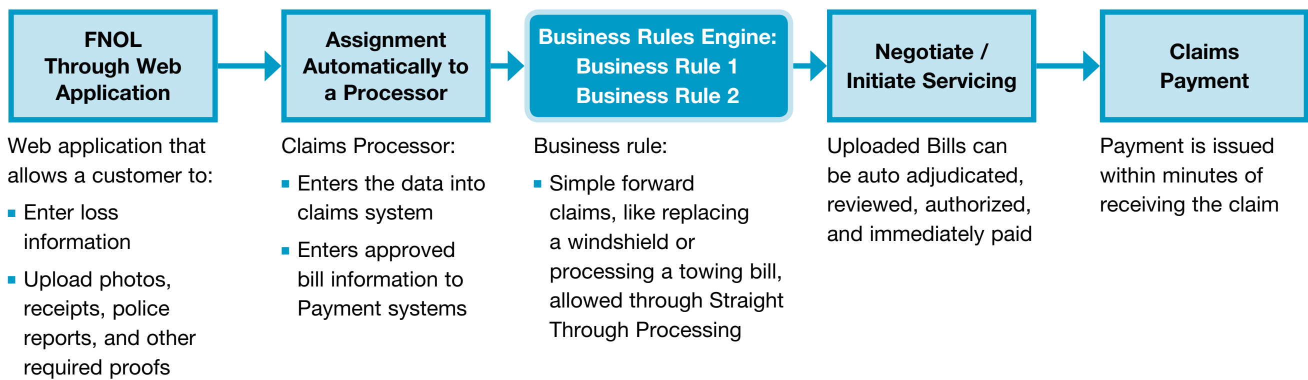
8.2. Analysis

Straight-through processing streamlines the process to enable insurance companies to easily settle simple claims like windshield replacement or ambulance bills within minutes. For more complex claims, STP streamlines the process by reducing the number of hand-offs and unnecessary process delays. It not only reduces claims settlement time, STP also helps insurers reduce their claims processing costs by allowing them to streamline and simplify.

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

[14] Inputs from Capgemini industry experts
[15] *World Insurance Report 2011,* Capgemini and Efma

Exhibit 5: Accelerated Settlement of Simple Claims with Straight Through Processing



Source: *World Insurance Report 2011*, Capgemini and Efma

Straight-through processing can also help with compliance, allowing insurers to more easily meet regulatory standards on claims cycle times and accuracy. STP also supports compliance-driven demands for claims information transparency, consistency, and traceability. The self-service features are likely to enhance the customer experience as claims can be resolved quickly and accurately, and customers have access to real-time information on claims progress.

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

8.3. Implications

By leveraging STP, insurers can settle simple and straightforward claims within just a few hours of first notification of loss, while also reducing servicing cost. Insurers seeking to derive efficiency gains from STP should examine the internal and external processes around first notification of loss, case assignment, and bills approval, focusing on those processes that are the most manual, resource intensive, and costly.

Increasing the ease and speed with which insurers can acquire and serve customers is the real advantage of STP. It also allows insurers to achieve huge efficiency gains by realigning adjusters, loss report takers, and valuable management resources from process-related tasks to value-added functions.

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WHAT YOU NEED TO KNOW
NON-LIFE INSURANCE

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