WORLD INSURANCE REPORT 2011

Capgemini
CONSULTING.TECHNOLOGY.OUTSOURCING

EFMA

TABLE OF CONTENTS

Preface

Capgemini is pleased to present the fourth edition of the *World Insurance Report (WIR)*. Insurance companies around the globe are re-focusing on their core operations. Some lost investment income during the crisis; others face changing customer preferences; most must tackle a newly stringent regulatory environment. The 2011 *World Insurance Report* explores some of the ways insurers can dissect their business to identify opportunities for making fundamental and lasting improvements in operations—improvements that will provide the underpinnings for long-term success.

We start by using an Efficiency Model to look at the current state of the non-life insurance markets in seven countries (France, Germany, India, Italy, the Netherlands, U.K. and U.S.), identify emerging efficiency trends in each market and potential lessons learned across markets.

We then look at business agility—the ability to identify, anticipate and respond to specific changes in operating conditions that directly impact an insurer's ability to achieve sustained performance. We use a proprietary Business Agility Maturity Model to analyze various insurers (life/non-life, stock, mutual, large, small) from around the globe, focusing on front office and claims-management activities. We explore the spectrum of performance in key sub-activities in the front office—activities that are relevant to life, health, and non-life businesses—and in the discrete value chain for claims management, which is clearly most relevant to non-life insurers.

Finally, we delve into the potential for improvement in claims management, which is so often the defining moment in the customer relationship for non-life insurers. Specifically, this WIR looks at the potential for insurers to improve customer retention and acquisition, process efficiency and effectiveness, and risk/indemnity management by transforming claims processing.

The report's findings draw on more than 50 interviews with senior executives from leading global insurers, covering 14 countries: Belgium, Canada, Denmark, France, Germany, India, Italy, the Netherlands, Norway, Spain, Sweden, Switzerland, the U.K., and U.S.

We are pleased to present you with this year's *World Insurance Report*, and hope you find real value in its insights.

Jean Lassignardie
Global Head of Sales and Marketing
Global Financial Services
Capgemini

Patrick Desmarès
Secretary General
European financial marketing association (Efma)

Efficiency Model Shows Insurers Have Ample Room to Reduce Operational Expenses and Acquisition Costs

CHAPTER 1

INTRODUCTION

Non-life insurance companies received a wake-up call during the recent financial crisis and realized they could not afford to depend heavily on investment income to sustain profits. As a result, many have begun to focus on improving efficiency, but the challenge is how to do so without impairing quality of service.

The potential for efficiencies varies by firm, since the specifics of business models differ by country, service segment, firm strategy, etc. However, there are a limited number of levers non-life insurance companies can pull, so by dissecting the role of these levers in their business, firms can potentially identify specific efficiency-focused actions that could drive business improvement.

Many firms acknowledge they need to reduce operational and acquisition costs to assure sustainable growth and profits. To explore insurers' options in more detail, we looked first at the current state of the non-life insurance segments in seven countries: France, Germany, India, Italy, the Netherlands, U.K. and U.S. These countries together account for approximately two-thirds of the global non-life insurance market. By applying a proprietary efficiency model to measure performance, we were able to identify emerging efficiency trends in each market, and reveal potential lessons learned.

Measuring Efficiency
Our efficiency model uses metrics that are consistent with industry-defined ratios for individual insurers, but it offers a better comparison for industry performance across regions. The model, valid only for non-life insurance companies, reflects the cost and financial-performance ratios of each country based on core and non-core insurance business. The efficiency ratios are calculated using various expense and profit metrics against gross written premiums (GWP).

Most notably in our model:

- **Underwriting ratio:** Like the 'combined ratio' industry benchmark, it measures the percentage of premiums an insurer pays out in claims and expenses. The lower the ratio the better, since a higher ratio means expenses are eroding more premium revenues. Notably, when insurers were earning steady and substantial investment income, they could remain profitable by offsetting weakness in underwriting ratios with investment gains. After losing investment income in the crisis, many insurers have refocused on the fundamentals that drive the underwriting ratio.
- **Claims ratio**—(total claims and benefits disbursed) / (GWP)—offers a proxy for underwriting efficiency. In general, a lower claims ratio produces higher returns.
- **Acquisition ratio**—(total commission and fees paid) / (GWP)—reflects the effectiveness with which distribution networks are being managed. While it is beneficial to financial results to keep the acquisition ratio low, these costs are inherently higher in some business models, so it may be more relevant for a firm to focus on the trends in its own acquisition ratios than to benchmark directly against other businesses or regions.
- **Operational ratio**—(total operating expenses) / (GWP)—helps to explain the maturity with which insurers are managing routine expenses. In general, the lower the operational ratio the better.
- **Investment ratio**—(net investment income + capital gains (losses)) / (GWP)—shows returns on insurers' investment portfolios. In general, the higher the investment ratio the better.
- **Profit margin**—(profit before tax) / (GWP)—measures profits from the overall insurance business. Notably, mutual insurance companies tend to have lower profit margins than proprietary insurers because there are no stockholders demanding annual returns, and because mutual insurers may choose, for example, to return earnings to policyholders in the form of lower premiums rather than dividends.

In all cases, ratios depend on a variety of external factors, including general economic conditions, government regulation, business type, consumer preferences, and so on. As a result, it is rarely relevant to compare ratios directly across regions. It is typically more germane to compare trends over time within regions, and perhaps within business types or insurance segments.

GENERAL FINDINGS FROM EFFICIENCY MODEL

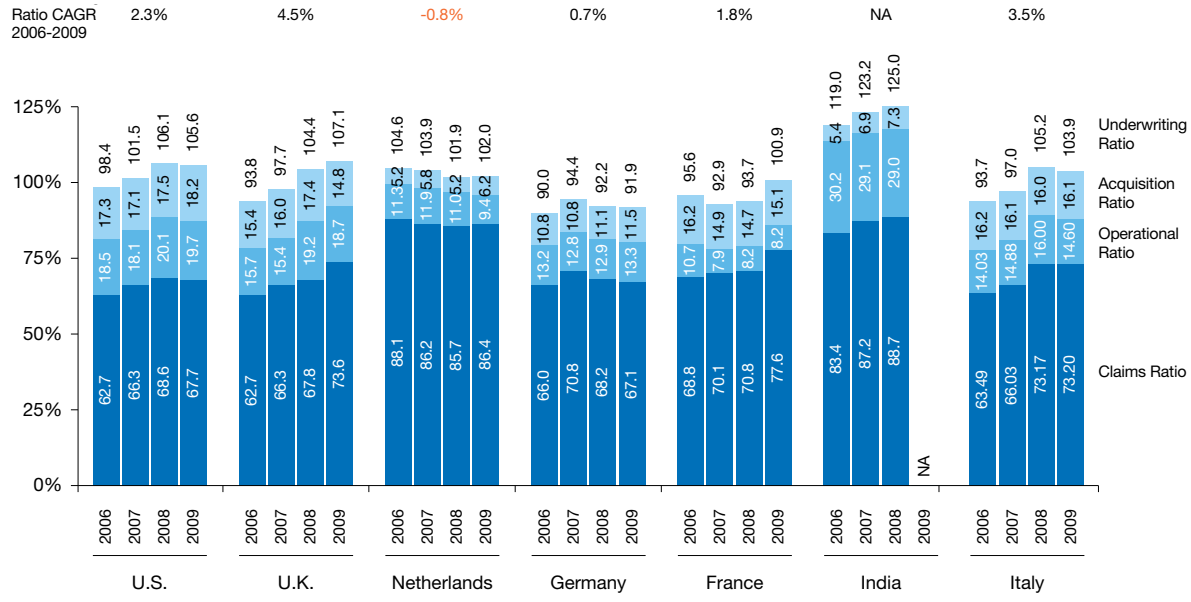
While each market is characterized by distinct conditions, some generally applicable findings did emerge from our efficiency analysis of insurance performance in 2006-2009. In particular:

- **Underwriting ratios generally rose between 2006 and 2009, indicating pressure on profitability.** In most countries, insurers were paying out a greater percentage of premiums in claims and expenses in 2009 than they had in 2006 (see Figure 1.1) for two key reasons: 1) non-life underwriting expenses increased slightly from 2006 to 2008, and 2) GWP dropped for most countries in 2008-09 due to the financial crisis. In the Netherlands, the ratio was lower in 2009 than in 2006, but mostly because the ratio had spiked higher in 2006 after the introduction of a new health insurance act (see country detail).
- **Claims ratios varied from year to year in most countries, largely because of natural catastrophes and variability in premiums written.** The claims ratio is highest in India and the Netherlands, where regulatory change has been a significant factor in recent years. A lack of historical data has also contributed directly to underwriting inefficiencies. The claims ratio has held mostly steady in France, largely because the frequency in claims declined, helping to offset the rise in claims costs.
- **Acquisition ratios tend to be lower among mutual insurance firms and firms that rely heavily on direct distribution.** The ratio is lowest in the Netherlands, where non-life insurers have been leveraging the Internet to bring down costs. The ratio is also low in India, but mostly because few insurers have invested in multiple channels to date. As they invest more, the ratio is likely to rise. Direct distribution is especially limited in Germany and Italy, but largely because consumers prefer to buy through agents, and not because there is a lack of technical know-how. French non-life insurers also operate mainly through intermediaries, inflating their acquisition ratios. The mature markets of the U.K. and U.S. have multiple distribution channels, increasing the overall cost of acquisition.

- **Firms have been trying to bring down operational ratios to keep costs in check.** France, for example, has the lowest operational ratio among the seven studied countries and has witnessed ongoing cost-saving initiatives by large insurers. This helped to reduce their operational ratios further in 2007. India has by far the highest operational ratio as firms have been investing heavily to scale up their operations. India could leverage lessons learned from France to optimize their operations going forward. German firms, which generally lack scale, have managed to maintain moderate operational ratios by outsourcing extensively. Italian non-life insurers rarely have propriety networks or significant exposure to direct channels, so their operational ratios are relatively low while acquisition ratios are quite high.

- **Investment ratios fell across the board during the crisis, but the sharpest losses were at large global firms, which generally had more exposure to toxic assets.** Large U.S. firms were hit especially hard, because dividend income and asset values dropped sharply. Investment ratios at Indian non-life insurers were far higher than most because regulators dictate that these insurers be heavily invested in domestic government securities. Those investments have offered above-average returns in recent years and kept India's insurers out of more volatile assets. In general, firms with a greater percentage of fixed-income bonds in their investment portfolios also performed better during the financial crisis.

Figure 1.1 Non-Life Insurance Expenses as a Percentage of GWP, by Country, 2006-2009



Note: (1) The ratios are valid only for non-life insurance. The ratios reflect non-life data as reported by the countries themselves, and hence include health insurance for France, India, Italy and the Netherlands, but not for Germany, U.K. or U.S. (2) At the time of analysis, no 2009 data was available for India, where the financial year ends March 31st. The Underwriting Ratio CAGR over 2006-08 for India was 7.1%.
Source: Capgemini analysis, 2010

- **Profit margins declined on crisis-related losses in 2008, but have been steadily improving with the recovery in financial markets—despite continued underwriting losses.** The non-life insurance segments in many countries remained profitable even in 2008 (see Figure 1.2), though returns were clearly lower than in prior years because of weak investment ratios. Profit margins have begun to recover, but insurers are still battling various profitability challenges. In India, for example, claims and acquisition ratios are rising, and in the Netherlands, regulation has pushed up underwriting ratios. Across the board, insurers are refocusing on core insurance operations to safeguard profitability.

MOST INSURERS FACE CLAIMS AND EXPENSE PRESSURES THOUGH COUNTRY SPECIFICS VARY

The efficiency modeling reveals the general pressure on non-life insurance companies to optimize their core capabilities, but each market has distinct operating conditions that affect the degree to which insurers can change the way they operate while pursuing sustainable growth. Here we offer some perspective on the non-life insurance segments in each of the seven countries we studied.

FRANCE

France is the third-largest insurance market in Europe. The P&C segment dominates French non-life insurance, generating 74.2% of the market's overall value in 2008.

- **The claims ratio rose in 2009, primarily because premiums declined and floods in Southern France increased claims.** In general, though, the claims ratio held quite steady between 2006 and 2008 at around 70%, because declining claims frequency offset increasing claims costs. In 2008, the positive effects of lower motor claims were wiped out by bodily-injury claims and health-related expenses.
- **French non-life insurance companies have excelled at reducing operational expenses, with two insurers among the ten most efficient in Europe.** Firms are investing in consolidated IT operations to improve efficiency even further and enhance customer experience. Global firms have lower operational ratios than local firms primarily due to economies of scale.
- **The common practice of selling through intermediaries has resulted in a comparatively high acquisition ratio of around 15%.** While most firms have diversified distribution networks and product-sales mechanisms, selling through intermediaries is more common. The Internet has not gained traction as a distribution channel, but continues to grow as a support channel.
- **A significant drop in investment income resulted in a drop of 1.7 percentage points in profit margins for French non-life insurers in 2008.** The investment ratio dropped to 6.6% in 2008 from 8.3% in 2007 amid the global financial crisis, but profitability shot up in 2009 with the recovery in capital markets and asset values. Nevertheless, French non-life insurers have increased their focus on core operations to reduce their dependence on investment income for profitability.

GERMANY

Germany is the second largest non-life insurance market in the world and the largest in Europe. In Germany, insurance is mandatory for everyone, helping the segment grow quickly. Most of the major non-life players are German, though a few pan-European giants also have a tangible presence. With more than 200 non-life insurers, the German market is highly fragmented.

- **The claims ratio was generally stable between 2006 and 2009, except for fluctuations in property and motor insurance claims after storm Emma and Hurricane Kryll.** The claims ratio for the top 20 insurers grew at an annualized rate of 0.6% in 2006-09, with the top 20 performing better (i.e., a smaller increase in the claims ratio) than the overall market during that period. Property and motor lines, which constituted around 60% of the market share in terms of premiums earned in 2009, were adversely affected by claims from natural disasters.
- **The non-life operating ratio was a moderate 13% in 2009.** Many large non-life insurers have taken significant steps to reduce administration costs and restructure their back offices in recent years. Despite unrest among labor unions, global non-life insurers have begun outsourcing their operational and administrative activities to low-cost centers, but economies of scale are still lacking at most German insurers.
- **The non-life industry is increasingly adopting direct sales channels, which are expected to reduce acquisition costs.** Germans still prefer to work through agents when buying policies, but the role of intermediaries is diminishing. Large firms with an established brand have started to focus on the use of alternate low-cost distribution networks, which are especially attractive to younger consumers.
- **German non-life investment income dropped only marginally during the crisis as insurers were heavily invested in low-yielding but safe registered bonds, debentures and loans.** However, this meant Germany's insurers were not positioned to gain from the recovery in world markets either, and their investment ratio dropped in 2009, reducing profitability. Profits were also squeezed

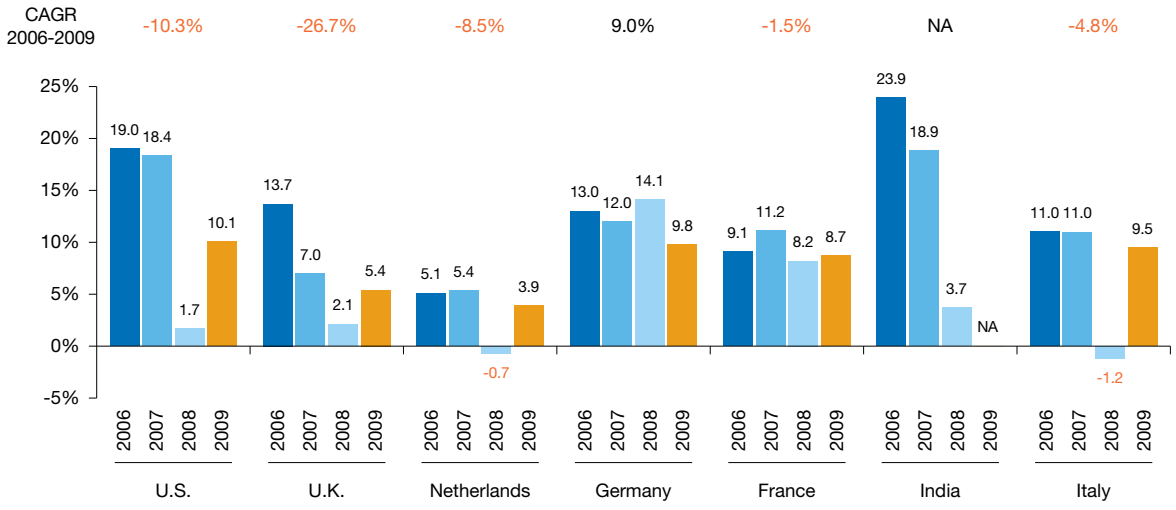
by rising underwriting ratios as disaster-related claims jumped. Nevertheless, despite these recent challenges—and the price wars, saturated demand and stiff competition that characterize the market—German non-life profit margins are among the highest among the studied countries.

INDIA

India's non-life insurance industry is in a nascent stage compared to the other studied countries. The market has opened up since deregulation in 2001, and 22 firms now sell non-life coverage, though the top four are public-sector firms. Insurance penetration is very low, except for compulsory third-party motor insurance. However, privately held insurers are increasingly looking to penetrate health insurance.

- **Claims ratios are high among Indian non-life insurers, especially government-owned insurers, due to less efficient underwriting practices.** Private-sector firms have significantly lower claims ratios than public-sector players.
- **Operational ratios are high, with new firms investing to build capabilities, and incumbents spending to expand and scale up operations.** Private-sector firms have higher operational ratios than public-sector players because of their smaller scale and more aggressive growth initiatives. Operational ratios are also lower for large firms than for smaller ones.
- **Commission and acquisition costs grew in 2008, fueled by motor insurance.** Acquisition costs have been increasing as firms expand their distribution networks. Commission expenses have also risen due to increasing competition in the non-life segment. Acquisition costs for public-sector players are about two times that of private sector players.
- **Strong returns on safe investments have helped Indian non-life insurers to offset underwriting losses.** India's non-life insurers are largely invested in government securities, which helped mitigate crisis-related losses and has guaranteed above-average returns in recent years. However, infrastructure-fund investments in 2006-08 did generate significant losses.
- **Profitability is high, mainly because competition is low and investment returns are high.** Despite some of the worst underwriting losses in the world, overall profitability is still above-average because of the high investment returns from government securities. However, increasing competition, continued underwriting losses and declining investment returns are starting to eat into the sector's profitability.

Figure 1.2 Non-Life Insurance Profit Before Tax as a Percentage of GWP, by Country, 2006-2009



Note: (1) The ratios are valid only for non-life insurance. The ratios reflect non-life data as reported by the countries themselves, and hence include health insurance for France, India, Italy and the Netherlands, but not for Germany, U.K. or U.S. (2) At the time of analysis, no 2009 data was available for India, where the financial year ends March 31st. The Profit Before Tax as a Percentage of GWP CAGR over 2006-08 for India was -60.7%.

Source: Capgemini analysis, 2010

ITALY

Italy is one of the largest non-life insurance markets in Europe, but market penetration is low, with individuals typically resorting to minimal and compulsory coverage. Apart from a few large international insurances companies, most insurers are Italian, and only a few of those players, such as Generali, have a strong presence globally.

- **The claims ratio for Italian non-life insurers rose sharply from 2006 to 2009, driven by declining premiums and increasing claims.** During that time, a series of regulatory reforms was introduced to lower the cost of compulsory insurance for Italian households. At the same time, premium income dropped while claims for property and motor physical damage rose, further increasing the claims ratio.
- **Italian non-life insurers rarely have propriety networks and have limited exposure to direct channels.** As a result, the operational ratio is slightly lower than in other countries while the acquisition ratio is a little higher. Low penetration of direct distribution channels, along with high bargaining power of agents, has inflated the acquisition ratio, though the ratio has decreased marginally with the increasing use of the Internet as a direct channel.
- **Despite conservative investment strategies, investment income fell significantly during the crisis.** Italians banks and insurers have traditionally had relatively low investment income ratios (of around 8%) as they are very conservative in their investment strategies. But with the Italian stock exchange index falling by almost 50% in 2008, insurers experienced a major drop in their investment ratios nevertheless.
- **Profitability started to recover in 2009 after being hit in 2008 by rising claims ratios, new government regulations, and the financial crisis.** Premium incomes declined in particular in 2007-2009 amid extensive motor and property physical damage and an increase in car thefts in 2008. Profitability started to recover in 2009 as better-performing capital markets helped to boost investment income.

NETHERLANDS

The Dutch non-life insurance industry saw a systemic shift in 2006 after the introduction of universal health coverage, which mandates that all residents acquire health insurance and requires health insurers to provide at least basic coverage to anyone who applies. (Coverage is funded by individual contributions and government subsidies.) The non-life market is fragmented: the market leader holds less than a 10% market share, though the top five insurance groups account for more than 70%.

- **The claims ratio, which surged after the Health Insurance Act of 2006, decreased marginally over 2006-09.** Still, the claims ratio is now among the highest in the world as the introduction of compulsory health insurance has led to a huge number of claims. Non-life insurers that do not provide health coverage have also witnessed increasing claims, but they continue to earn modest profits as claims ratios are lower than average.
- **Operational ratios dropped significantly in 2007-09 as productivity improved in the core business,** due to proactive efforts by insurers to increase efficiencies.
- **Intermediaries are still an important channel for selling non-life insurance, but Internet usage has been increasing in recent years.** Acquisition costs have risen, though, as non-life insurers have sought to build and scale up their capabilities to sell products online. There have been many new entrants in the market focusing solely on direct sales through the Internet.
- **Overall profitability recovered in 2009 after dropping sharply in 2008.** The underwriting ratio of non-life insurers decreased marginally over 2006-09 as companies became more mature (especially in the health segment). Local Dutch players have performed better than global players as the latter suffered more during the economic turmoil of 2008. Investment ratios marginally improved in 2009 with the global recovery in capital markets.

U.K.

The U.K. is the world's fourth-largest non-life insurance market. Premium volume dropped in 2008 due to the financial crisis, but the U.K. is still the second-largest European insurance market. The non-life market is saturated, with most households having some form of insurance. Unlike life insurance and pensions, non-life insurance has been mainly bought by individuals or households.

- **Claims have been predictable for most types of insurance, but property claims ratios have risen due to floods.** U.K. non-life insurers' claims ratios have held steady mostly due to accurate underwriting and a lack of catastrophic events. However, there was a significant increase in claims paid on property insurance in 2007 due to summer floods. Nevertheless, innovative underwriting processes have ensured a smooth claims ratio over the years.

- **Business consolidation and new investment to streamline administrative processes have contributed to a higher operational ratio.** Insurers are collaborating with banks and other networks, which has pushed up integration costs and increased the operational ratio. Ongoing price pressure is forcing insurers to streamline operational and administrative processes and achieve greater efficiency for the long run.
- **Distribution strategy has been undergoing radical change as insurers pursue more direct channels, such as the Internet, bancassurance and mobile applications.** Acquisition expenses have been stable as sales through direct channels have been trending upward. Unlike many of their European counterparts, U.K. consumers prefer to research insurance products themselves (especially property and motor products). Social networking sites are becoming commonly used to research and share information about insurance products, customer experience, and value for money.
- **Profitability dropped at most U.K. non-life insurers in 2007 and 2008 as investment income fell and acquisition and claims ratios rose.** The drop in net investment income was mostly due to capital losses realized as stocks plummeted amid the U.S. subprime crisis in 2008. Larger firms suffered most due to their greater exposure to global capital markets and U.S.-based assets. Profit margins started to rise again in 2009 as investment income recovered.

U.S.

The U.S. is the world's largest non-life insurance market. The majority of households have one or more types of insurance and the market is flooded with specialty and general insurance providers, which provide the bulk of products. Motor insurance is mandatory and accounts for the largest single segment of non-life coverage. Innovative products, mature distribution and global best practices across the insurance value chain are hallmarks of the U.S. non-life insurance industry. In terms of performance:

- **The claims ratio for U.S. non-life insurers deteriorated in 2008, primarily due to the increase in catastrophic losses and the drop in premiums written.** Global firms in the U.S. have a lower claims ratio than smaller, local non-life insurers, which tend to have less stringent underwriting guidelines. Larger firms also have a better mix of products, which helps to hedge losses.
- **Expense ratios (operational and acquisition ratios) rose in 2008, because written premiums declined, negating cuts in overheads.** The operational ratio for the U.S. non-life industry varied only marginally during 2006-09, though the ratio was smaller for large global firms.
- **U.S. firms have been pioneers in the use of novel distribution channels, such as the Internet and mobile technology, to gain and retain market share.** The U.S. is a saturated market so firms invest substantial amounts to gain more business and improve market share. However, the expenditures almost negate the benefits of implementing new technologies. As a result, with written premiums declining, the acquisition ratio rose further in 2006-09.
- **Insurers realized capital losses of $19.8 billion on investments in 2008.** However, the investment ratio improved vastly in 2009 as global capital markets rallied and economic conditions improved. Smaller firms typically have enjoyed better investment returns than larger firms.
- **Profit margins increased four-fold in 2009 as investment income rose and claims and operational ratios improved.** In 2008, insurers' returns and profitability tumbled as catastrophe losses, recession, and crisis in the financial system took a toll on underwriting and investment results, but profitability came roaring back in 2009.

CONCLUSION

The global financial and economic crisis has affected profitability in various ways at non-life insurance companies around the globe. Claims ratios in many countries have risen as the number of premiums written dropped and/or claims themselves increased in frequency and size (a trend that tends to worsen during economic downturns). More obvious still have been the declines in investment income.

By the second half of 2009, conditions had started to improve and many non-life insurers were starting to see profits trend back up. Nevertheless, the crisis provided insurers with a stark reminder that they cannot rely on investment income to deliver results, and they must refocus on the core drivers of operational excellence, especially the factors that drive underwriting ratios, to achieve sustained growth.

Business Agility Is Critical for Insurers Seeking to Thrive Long-Term

CHAPTER 2

HIGHLIGHTS

Insurers face tough operating conditions at present. The financial crisis has contributed to a drop in earned premiums, a rise in claims, and a loss of investment income. And shifts are under way in numerous other business factors—from regulation to customer preferences and technology. At the same time, customers are willing and able to research coverage and switch providers easily, and their expectations are high. Given these realities, insurers must be sure they can adapt to shifting conditions quickly and effectively if they are to solidify customer relationships and achieve sustained results.

This adaptability, or "business agility", necessarily takes different forms at different firms, but essentially refers to the ability of insurers to adapt ***rapidly and cost efficiently*** to significant changes in their business environment so as to gain competitive advantage. The specifics will depend on a firm's size, profile, goals, etc., but the overarching goal for insurers is to identify where agility—a quick and appropriate response to important environmental and business shifts—could help to drive sustained success.

So, how agile are insurers today? We employed a proprietary Business Agility Maturity Model to analyze a variety of insurers (life/non-life, stock, mutual, large, small) from around the globe.

The results show agility depends at least in part on an insurer's business line (pure non-life players, for example, are more likely to excel at claims agility), but more significantly, insurers that describe themselves as being in a dominant market position have achieved that success while being agile in only a few key areas.

In short, there is every reason to believe that business agility is an important attribute for insurers seeking to differentiate themselves and outmaneuver the competition, but insurers can be highly successful by targeting agility in just a few critical areas. The key for insurers is to understand those elements in the changing landscape that are pivotal for them, and decide when and how to increase their responsiveness.

THE BASIS FOR AGILITY MODELING

Our Business Agility Maturity Model gauges the degree to which insurers are agile (their "maturity" in terms of agility) in certain elements of the value chain.

We broke down the insurance value chain into four independent links: Product design, front office, policy administration/underwriting, and claims. We then evaluated the levers that influence each element of the value chain (see Figure 2.1).

For the 2011 WIR, we focused on the "Front Office" and "Claims" links in the value chain. Each is critical to customer relationships and results, and has numerous levers influencing performance—providing significant potential for improvement. Claims, however, is most relevant to non-life insurers, while front office activities are equally pertinent to life, health, and non-life businesses.

There are six levers of front office agility:

1. **Customer Needs Management.** How well insurers track the existing and potential needs of customers, and offer products accordingly.
2. **Distribution Channel Set-Up / Scale-Up.** How effectively front offices design and roll out new channels, how quickly they form alliances with other distributors, and how well they identify the right channel mix for target segments so as to maximize returns.
3. **Centralized Distribution-Related Support Functions.** How well insurers reduce redundancy and improve efficiency in support functions, such as licensing, compensation, and knowledge, content and lead management.
4. **Multi-Distribution Channel Optimization.** How efficiently insurers manage channels to ensure an integrated flow of communication, greater synchronization, and maximum customer satisfaction.
5. **Self-Service Processing Capability.** How well front office teams service policyholders' requests and process them in real time.
6. **Personalization of Services.** How well insurers industrialize and/or standardize front office operations while customizing services and relations offered to a single client (e.g., personal service through the direct channel).

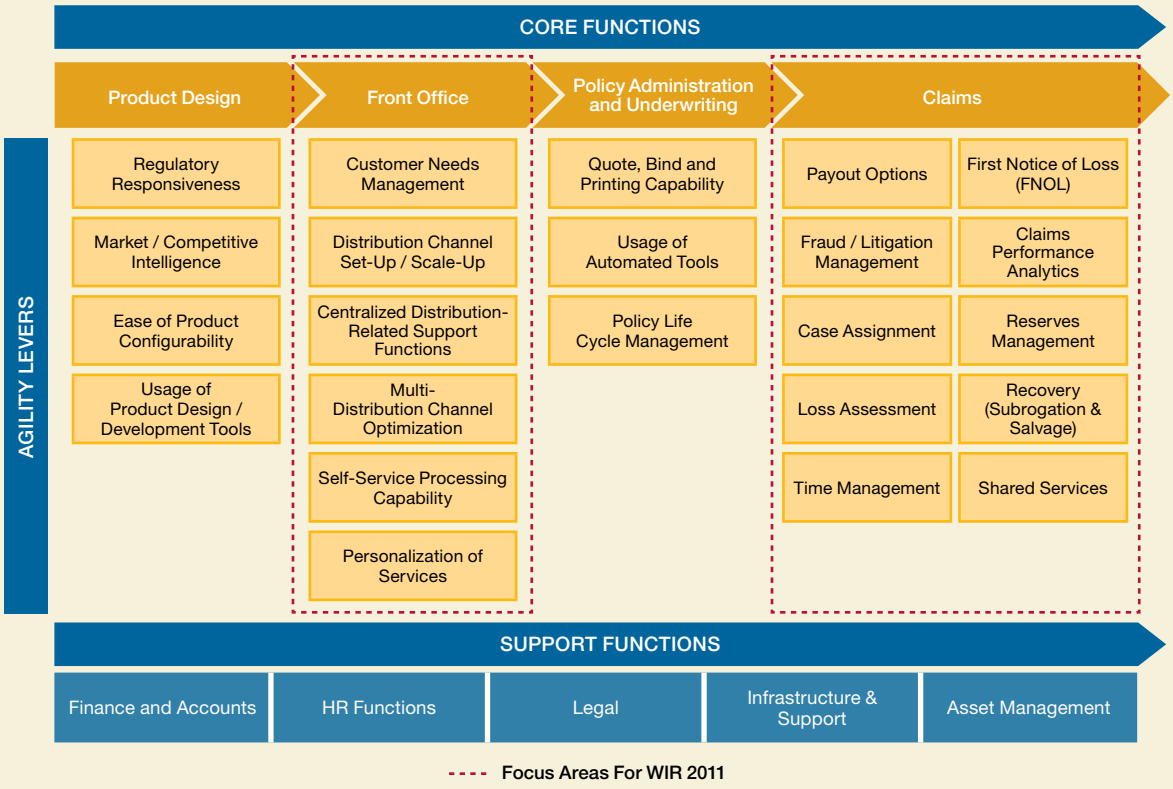
FRONT OFFICE AGILITY LEVERS ALL HAVE A DIRECT IMPACT ON CUSTOMER SATISFACTION

Agility in the front office improves speed-to-market, customer service and distribution capabilities, and therefore has enormous potential to enhance customer satisfaction and drive loyalty. For each lever in this segment of the value chain, we researched the current and planned actions of insurers and derived a business agility maturity 'score' for surveyed insurers. This enabled us to outline a spectrum of business agility for these levers (see Figure 2.2).

Here we illustrate some of the activities along the agility spectrum:

1. **Customer Needs Management.** Insurers are generally employing numerous tactics in this area, such as scoring customer value and agent value, segmenting customers, analyzing behavioral propensities, churn rates, etc. Challenges exist, however. Insurers have trouble, for example, migrating customer data to a single platform after a merger or acquisition.
2. **Distribution Channel Set-Up / Scale-Up.** In this area, insurers often have to deal with both long-standing and emerging customer preferences. For example, customers in some geographies resist the use of non-traditional channels (e.g., German customers balk at buying wedding insurance via the Internet or pet health insurance from veterinarians). Logistics are also a challenge, and product-launch cycles can vary enormously, depending on IT and piloting capabilities.
3. **Centralized Distribution-Related Support Functions.** Some insurers have fluid cross-network co-operation between the various available distribution channels, while some go so far as to centralize intelligence for all distribution channels. Insurers centralizing their front office support functions manage to reduce redundancy, have a better understanding of their customer base and can implement business decisions faster.
4. **Multi-Distribution Channel Optimization.** Very few insurers are effectively utilizing multi-distribution channels. In fact, for most insurers, at least 60% of existing customers continue to buy products from only one channel. Some insurers vary premiums by channel to account for the added value of the personalized and professional advice from brokers. Few insurers can complete all activities through all channels, however. For example, endorsements requiring a pricing change often cannot be issued via phone or the Internet.
5. **Self-Service Processing Capability.** Some insurers provide personalized entry services to high-end "affinity" group customers; some make a strategic choice not to provide self-service capabilities to intermediaries. Portfolio management services are among the self-service options more commonly provided to retail customers in life insurance.
6. **Personalization of Services.** Insurers providing personalization usually use two metrics: line of business and customer value. Some of the more technology-enabled insurers use a power dialer to enable telephone dialing direct from the CRM system according to the specific customer type.

Figure 2.1 Capgemini Insurance Business Agility Maturity Framework



Source: Capgemini analysis, 2010

Figure 2.2 Levels of Business Agility Maturity for Front Office Levers

		LEVELS OF MATURITY				
		Level 1	Level 2	Level 3	Level 4	Level 5
AGILITY LEVERS	Customer Needs Management	Customer database maintained product-wise	Single customer view	Single view along with easy retrieval	CRM system with BI applications used for up-selling / cross-selling	CRM-BI applications used for lead-generation/ referral analysis
	Distribution Channel Set-Up/ Scale-Up	Existing traditional channels can be scaled up for increase in volume of existing products	New products can be launched through traditional channels but time-to-market is protracted	New products can be launched quickly through traditional channels	New products can be launched quickly through non-traditional channels	New products can be launched and scaled-up quickly through non-traditional channels
	Centralized Distribution-Related Support Functions	Operational functions for each distribution network operate in silos	Some of the operational functions are centralized and shared across distribution networks	All the operational functions are centralized and shared across distribution networks	Shared operational functions as well as centralized intelligence-gathering process around customer, product, and pricing	Shared operational functions, centralized intelligence as well as cross-network cooperation to serve the customers better
	Multi-Distribution Channel Optimization	Fixed distribution channels allocated to individual product lines	Multi-distribution model with flexibility; minor rate variance	Multi-distribution model; no rate variance but varying capability to process endorsements across the channels	Multi-distribution model; no variance in rates and endorsements processing capability	Consistent customer experience across all the networks
	Self-Service Processing Capability	Self-service not available	Self-service available to intermediaries	Self-service available to intermediaries and B2B customers; individual customers can self-service non-financial MTAs	Self-service available to intermediaries and B2B customers; individual customers can self-service MTAs and renewals	All relations have full access to information directly related to them; individual customers can do financial transactions like unit-linked switches
	Personalization of Services	Exclusive focus on product standardization or no personalized service	Differentiation of the level of customer service by product	Differentiation of the level of service by product and channel	Introduction of personalized processes in non-traditional channels	Personal services and customized product offered thought the support of evolved CTI and quotation systems

Note: 1) Each level of maturity is incremental in improvement over the preceding one; 2) Centralized distribution-related support functions include IT, HR, operational finance, marketing, and commercial management; 3) MTA – Mid Term Amendments; CRM – Customer Relationship Management; B2B – Business to Business; BI – Business Intelligence; CTI – Computer-Telephony Integration

Source: Capgemini analysis, 2010

SCALE PARTLY DETERMINES WHICH FRONT OFFICE LEVERS ARE THE FOCUS FOR INSURERS

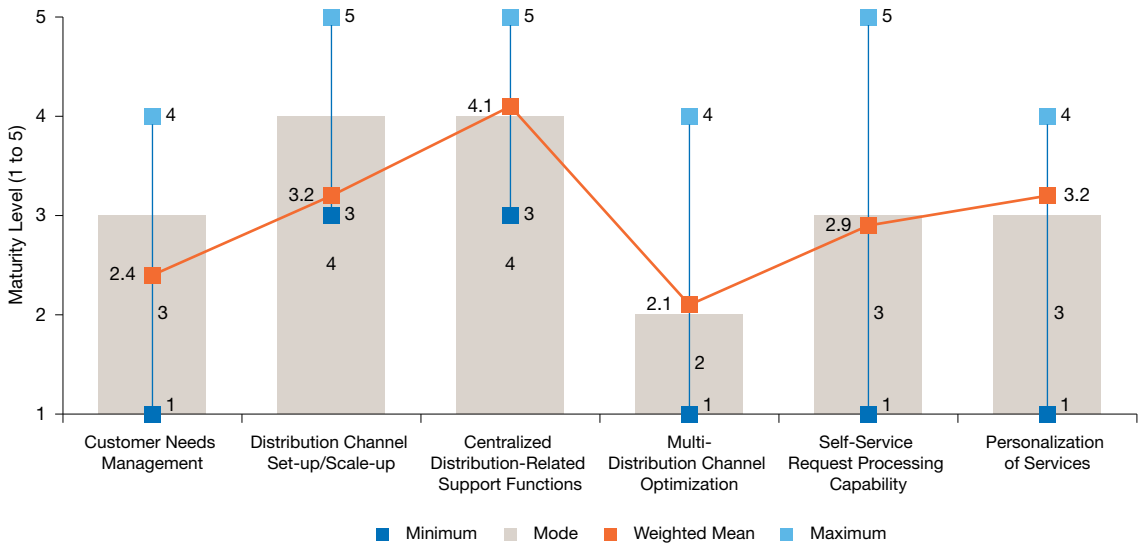
While the agility of individual firms varies enormously, some distinct aggregate patterns do emerge linking the scale of insurers to the maturity of their front office agility. Notably, larger insurers across all regions perform especially well on levers tied to scalability, including centralizing support functions and channel set-up/scale-up (see Figure 2.3). For example:

- Distribution channel set-up/scale-up is an area of maturity (level 4 or 5) for 73% of large insurers (GWP ≥ $1.0 billion in 2009). A few large firms can issue products through non-traditional channels in as little as a month. Setting up non-traditional channels and scaling up traditional ones are the most important improvement priorities, according to 60% of surveyed large-scale firms.
- 90% of extremely large firms (GWP ≥ $2.5 billion in 2009) have an area of strength in each of the following: distribution channel set-up/scale-up, centralized distribution-related support functions and multi-distribution channel optimization.
- Around 65% of large firms are agile (maturity level 4) in centralizing support functions. The scale of their operations gives these insurers the incentive to centralize support functions, and centralization has reduced operating costs by as much as 80% for some. Centralization of distribution-related support functions is one area in which the average maturity levels of the firms from different lines of business are roughly concurrent irrespective of their size.
- For most large insurers, however, synchronization between multiple channels and access points is still an issue, so few rank highly in agility on multi-distribution channel optimization overall.

Small and medium-sized insurers are more likely to be highly agile in levers that impact customer-service levels. For instance, 20% of small firms (GWP ≤ $500 million in 2009) are a maturity level 4 or more in customer needs management, personalization of services, and self-service processing capability. The fact that large firms are still struggling to provide appropriate levels of customer service, despite having larger CRM budgets than smaller firms, suggests there are inherent challenges with the scalability of their existing CRM applications.

And looking on a regional basis, North American life insurers are more agile in personalizing services, largely because they have invested heavily in business-intelligence-enabled customer relationship management (BI/CRM) applications. Some of them, can, for example, support computer-telephone integration (CTI), and some favor personalized services for high-value clients, though those services are not scalable at this point in time. Insurers from Western Europe have the highest agility level overall in front office activities and perform especially well in customer-satisfaction areas such as needs management and personalization of services (around 60% score 3 or above in these two areas). However, their score is average (2.9) in centralizing the support functions for distribution channels.

Figure 2.3 Weighted Mean, Minimum, Maximum and Mode Maturity Score Distribution of Large Insurers (GWP ≥ $1 billion) for Front Office



Note: GWP – Gross Written Premiums
Source: Capgemini analysis, 2010, Executive interviews and survey results

Corporate structure also helps to drive agility maturity in some areas versus others. In general, stock-structured insurers are more agile across front office levers than mutual firms, while mutual firms are more agile in personalizing services and customer needs management. This is because customer service is more likely to top the agenda for a mutual insurer (where policyholders are the owners) than scalability issues, which may be less relevant to a smaller-scale mutual firm.

CLAIMS MANAGEMENT, KEY TO CUSTOMER EXPERIENCE, IS RIPE FOR IMPROVEMENTS

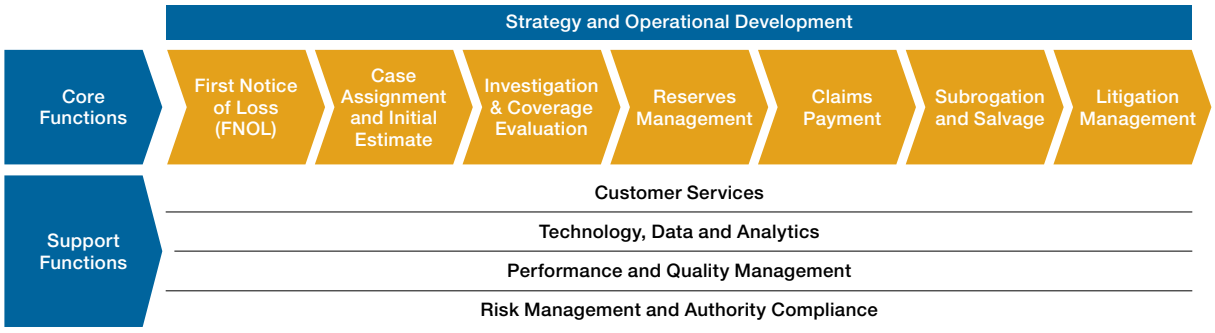
Efficient claims management is critical for achieving customer loyalty (and thus retention), and for increasing wallet share and generating positive word-of-mouth. Claims is therefore integral to driving performance and results, but claims management is also an opportunity to liaise with third-party service providers and minimize losses. Claims is unique in having its own workflow-driven value chain and this presents insurers (non-life in particular) with a wide scope for operational improvements.

In this section, we look at the agility of insurers along the claims value chain illustrated in Figure 2.4. However, this part of the analysis is focused more towards non-life insurance, where claims is a much more complex and effort-intensive process. But most elements of this value chain are broadly applicable toward life insurance claims processing as well.

Within and across the links of the claims-management value chain, we defined ten levers of agility:

1. **Payout Options.** How many payout options customers get when filing a claim, and how effective the options are.
2. **FNOL.** How sophisticated and efficient the process is for accepting First Notice of Loss filed by a customer.
3. **Fraud/Litigation Management.** How effectively insurers investigate fraud, contest claims and settle in case of legal complications.
4. **Claims Performance Analytics.** How sophisticated insurers are in investigating trends and patterns in past claims experience to re-price products, measure distribution channel performance and identify the most profitable customer segments.
5. **Case Assignment.** How sophisticated the procedures are for assigning claim cases and generating periodic updates.
6. **Claim Reserves Management.** How effectively insurers manage reserves for each claim.
7. **Loss Assessment.** How effectively and efficiently insurers quantify the loss under various claims.
8. **Recovery (Subrogation & Salvage).** How effectively insurers handle the subrogation and salvage process to ensure proper recovery.
9. **Time Management.** How well insurers employ appropriate and adequate tools to support the claims operations in fulfilling settlement deadlines efficiently and effectively.
10. **Shared Services.** The degree to which insurers are adopting lean and centralized structures dedicated to claims management and service to avoid duplication of activities and optimize the use of internal resources.

Figure 2.4 Claims-Management Value Chain



Source: Capgemini analysis, 2010

Again, for each lever, we scored the business agility maturity of participating insurers, and identified a spectrum of agility (see Figure 2.5).

Some of the activities we observed along the agility spectrum include the following:

1. **Payout Options.** P&C lines of business have the flexibility to provide more payout options than life insurers. Some insurers are offering replacement policies as a payout option as they try to develop product affinity or minimize the risk of leakage (claim inflation). However, replacement payouts are generally strictly regulated.
2. **FNOL.** Over time, FNOL has slowly moved from a paper-pen-application to IVR (Interactive Voice Response) filing to intimation through Smartphone. Supporting proofs (e.g., photos of car damage) are being sent directly from the site of an accident through Smartphone, for example. Insurers have traditionally been keen to leverage these advances in communication technology. Some use flagging on pre-determined parameters to catch fraud (e.g., claim repetition, recurring beneficiaries) but dynamic methods like voice-stress analysis and social network analysis are not yet being used. Claims are usually assigned to specific handlers, according to the line of business.
3. **Fraud/Litigation Management.** Fraud detection is mostly carried out through static flags, and only a few companies have well-established methods for communicating among the fraud detection team, litigation management team and collection agencies. For a mature organization, the fraud detection system and litigation management team share information through claim systems and I-Logs.
4. **Claims Performance Analytics.** Insurers that have enterprise data warehouses supporting claims analytics are at the mature stage, but most insurers are still struggling with the use of claims analytics data as a feedback loop to drive proper product positioning and channel selection.
5. **Case Assignment.** Some insurers use rules engines in claims systems to automatically route different types of claims to different adjustors based on their skill sets and workload.
6. **Claim Reserves Management.** Most insurers leverage historical claims patterns in preparing reserves for high-frequency and low-severity claims (e.g., motor). Preparing reserves for liability cases or catastrophe claims are the most difficult because claims numbers are inexact, as are forecasts of the corresponding obligations.
7. **Loss Assessment.** Initial estimations are usually done through rules engines/experience, but the final disbursement is usually verified through manual/semi-automated procedures. More mature insurers integrate loss-assessment systems with third parties (e.g., car-repair shops, doctors, Health Maintenance Organizations (HMOs)).
8. **Recovery (Subrogation & Salvage).** Some insurers have outsourced their subrogation and salvage activities. As insurers are adopting paperless systems, all the required documentation can be provided, shared and managed through integrated electronic exchange (e.g., claim numbers in e-mail subject lines and aligned bar codes on fax cover pages).
9. **Time Management.** Some insurers track cycle times and file-handling efficiency rates in audits. Many use automatic and scheduled-payment mechanisms for recurring payments. Some use activity-escalation mechanisms to track and address delays. (If a due date is missed, reminders are issued automatically through automated alerts to the adjustor and supervisor.)
10. **Shared Services.** For non-life insurers, professional services (e.g., auto experts, doctors, lawyers, engineers) are often outsourced, freeing up employees to focus on core activities and create, monitor, manage and maintain these networks.

Figure 2.5 Levels of Business Agility Maturity for Claims Levers

AGILITY LEVERS	LEVELS OF MATURITY				
	Level 1	Level 2	Level 3	Level 4	Level 5
Payout Options	Limited payout modes	Many payout modes with distinct modes reserved for individual lines of business	High flexibility to choose among the payout modes	Wide choices available (includes cashless modes and direct payout for simple claims) for claimant / beneficiary	Full integration with 3rd-party service providers; advisory services available for payout usage
First Notice of Loss (FNOL)	Single contact center for all customer queries	IVR-enabled FNOL acceptance	Multiple channel (email/ web/fax/call center, manual) FNOL intake	Rules-based, automated claims triage	Analytics-based fraud detection and flagging in FNOL
Fraud/ Litigation Management	Manual fraud detection and litigation management	Claims pattern study for fraud-detection; no dedicated team for recoveries	Analytics-driven fraud detection system; dedicated teams for recoveries, litigations	Fraud detection system integrated with collection agencies, internal and external litigation management team through industry communication standards	Use of system for both fraud detection and dynamic loss reserves management for each case filed
Claims Performance Analytics	Manual analysis of claims experience with respect to product lines	Analysis through standard reports in the claims management system	Customized reporting tool for claims analytics	Enterprise data warehouse supporting claims analytics	Feedback loop with BI application for pricing revisions, product positioning, channel selection, etc
Case Assignment	Manual assignment based on availability	Skills-based routing	Workflow routing based on load factor	Automated interface for routing cases from loss adjustors to 3rd-party vendors for settlement; appropriate rewards and incentive system to boost performance	Real-time system integration with 3rd-party vendors to check status; Web tools available for interaction and automatic invoice generation
Reserves Management	Experience-based manual reserving	Rules-based reserving with some touch-points automated	Automatic periodic update of reserves during claim life cycle	Reserves management enabled by modeling techniques	Real-time integration with General Ledger
Loss Assessment	Manual loss assessment	Document repositories available for accessing claim documents	Document and content management systems and workflow are integrated along with claims systems	Tools available for assessment of simple-to-medium complexity claims	Complete integration with vendor systems, workshops and other service providers
Recovery (Subrogation & Salvage)	Manual subrogation & salvage process	Limited automation of subrogation & salvage process	Complete workflow-based integration with subrogation, salvage and legal departments	Rules-based evaluation of recovery potential	Integration with analytics system
Time Management	Manual tracking of deadlines and complaints	Timer-setting integrated into the system at claims level	Automatic payment scheduling for the adjustor	Payment deadlines integrated in the workflow management system	Integration of payment deadlines with document management and inputs from vendor systems
Shared Services	Separate claims management procedures by company units/channels	Alignment of procedures among company units/ channels	Transversal claims organization function and process-reengineering	Introduction of a shared platform within the units/ channels, with dedicated resources	Industrialization of shared services procedures and outsourcing of no value-added activities

Note: Each level of maturity is incremental in improvement over the preceding one; IVR – Interactive Voice Response; BI – Business Intelligence
Source: Capgemini analysis, 2010

RECOVERY AND FRAUD/LITIGATION MANAGEMENT TOP THE LIST OF CLAIMS AGILITY CHALLENGES

All insurers say **recovery and fraud and litigation management** are the most problematic areas in the claims value chain. Notably, 85% of surveyed firms say these levers are driven heavily by external factors such as regulation and infrastructure (e.g., communication bandwidth), which makes it especially challenging to anticipate change and adapt quickly.

It is also difficult to develop an action plan for improving agility that is equally applicable to different business lines, regions, etc. Small firms, however, perform quite well in fraud and litigation management, largely because they operate in fewer lines of business or smaller geographies and have a simpler and more efficient process for fraud/litigation management.

Recovery management is a problem-area for around 70% of commercial lines insurers in the non-life line of business, and firms operating in personal lines suffer from excessive leakage and they are investing in leakage reduction.

As was the case with front office levers, **scale plays a role in claims agility**. Large firms (see Figure 2.6) are more likely than smaller firms to excel on FNOL (though FNOL agility is generally quite good at most firms and in most geographies). Large firms tend to have standard processes in place to handle FNOL and payout claims quickly, and are more likely to have automated internal work flows. However, large firms lack payout options for claims relative to the average. On aggregate, all insurance lines provide a variety of payout options, but 70% of large firms in a single line of business have only three options or less.

Large firms are also more likely to be adapting claims reserves management capabilities. For instance, they are more likely than smaller firms to have enough experience and historical data to manage reserves in an effective manner. Large firms are also more likely to use shared services arrangements as they can save far more than smaller firms in operational costs.

Adding in the regional perspective, around 70% of the large-scale insurers in Western Europe have integrated interfaces with third-party vendors and others to eliminate process inefficiencies. Most of the firms surveyed in that region had re-engineered their claims processes in the last two years. Overall, though, some insurers view geographic information systems and advanced estimation tools as discretionary spending, suggesting these tools are unlikely to gain traction in the near future. Within Western Europe, insurers from Italy and Spain perform particularly well in work-flow intensive areas such as case assignment.

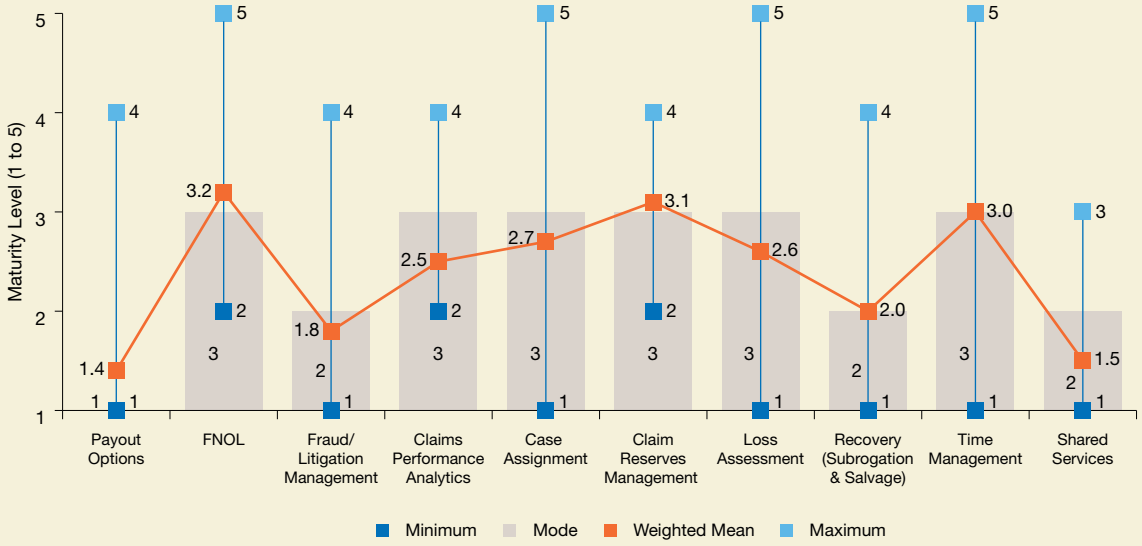
Corporate structure also seems to play a role in claims agility. For example, stock firms are more mature in their agility ratings than mutual firms on case assignment, claims performance analytics and fraud/litigation management, but mutual firms are more sophisticated in payout options, FNOL and recovery management.

AGILITY MATURITY VARIES NOTICEABLY BY LINE OF BUSINESS

The agility maturity of firms heavily depends on the lines of business in which the insurers operate (see Figure 2.7). For example, our research shows:

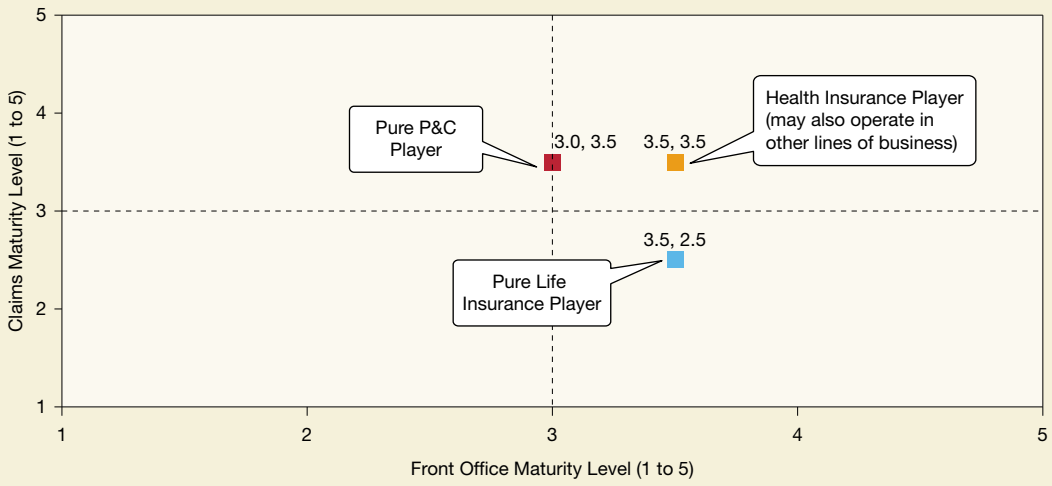
- **For pure P&C players, claims is an important focus in the value chain** (with a weighted mean score of 3.5 on a scale of 1 to 5). Traditional areas like FNOL, case assignment, and evaluation are also mature (3 and above) while areas like shared services and reserves management are in the early stages (weighted mean score at or below 2.5). Some insurers are planning to develop the capabilities required to access industry claims databases and public records to supplement their claims data. Last but not least, the majority of non-life firms feel that blending experience data with predictive data is the main challenge in loss assessment.
- Among firms **operating in the P&C and health lines of business, 90% score a 4 or more in their agility maturity on FNOL**. In other words, their FNOL processes and organization are dynamically designed to respond to the needs of customers in this area, and even to prompt anticipatory action (e.g., spotting fraud the moment a claim is filed). On front office levers, firms operating in health and/or P&C lines have high maturity scores in the channel set-up/scale-up capabilities.
- **Life Insurers are adapting well to address changing front office needs** (scoring 3.5 out of 5), while **health insurance players have developed comparatively high levels of maturity in both front office and claims activities**, largely because of the nature of their business.
- **Life insurers are more agile in most of their front office levers than their non-life counterparts.** Life insurance firms perform distinctly better in customer needs management and personalization of services (see Figure 2.8). Firms offering Universal Life (UL) or Variable Universal Life (VUL) (around 10% of the firms surveyed) provide options like fund transfers, switches, fund-rebalancing, etc., which makes the experience interactive. Firms offering VUL or UL also have a good maturity level in self-service request processing capabilities.

Figure 2.6 Weighted Mean, Minimum, Maximum and Mode Maturity Score Distribution of Large Non-Life Insurers (GWP ≥ $1 billion) for Claims



Note: GWP – Gross Written Premiums
Source: Capgemini analysis, 2010, Executive interviews and survey results

Figure 2.7 Weighted Mean Maturity Scores for Front Office and Claims, by Line of Business



Note: The maturity score of Life insurers' claims was determined by scoring those insurers on the levers that are applicable to their claims value chain
Source: Capgemini analysis, 2010, Executive interviews and survey results

AGILITY ALSO HAS A LINK TO BUSINESS STRATEGY

There are also links between business agility and business strategy. We asked insurers to classify their strategy in terms of access to products/services, and delivering on customer experience, price, product and services as one of the following:

1. "Dominating", i.e., customers not only prefer the insurer to the competition, they actively seek the insurer out. Generally these are insurers from which customers buy their first product, driven by excellent brand value, trust, long-standing reputation, etc.
2. "Differentiating", i.e., their brand is preferred over another. These are insurers whose products are preferred by customers in comparison to their peers due to pricing, service, etc. Normally brokers selling multi-company products prefer these insurers and hence recommend their products.
3. "Operating on a par", i.e., the insurer's offering is at the industry par and customers routinely and willingly opt for their brand.

The research shows insurers that *Dominate* do not perform well in all front office or claims levers. They generally do well in two or three levers and try to attain at least an average level of maturity in the rest.

Differentiating insurers generally focus on price, product and service, according to the survey results. They have achieved the third level of maturity in levers affecting the way they engage with their customers, while performing consistently well across all front office levers.

Those *Operating on a Par* seem to focus least on personalizing services and customer needs management.

Notably, strategy has little effect on the agility scores for centralizing support functions and channel optimization. For instance, managing the distribution network, building loyalty with agents, building out direct channels, and developing single-entry, multiple-carrier interfaces (SEMCIs) were listed as 'top of the mind' activities for 80% of P&C insurers across all the regions, showing these issues are important regardless of whether the insurer is dominating, differentiating or operating on par.

Case assignment, payout options and loss assessment are areas in which all types of firms are still lagging, with even dominant insurers achieving no more than a 3 maturity score. (Overall, 70% of P&C insurers surveyed, said case assignment is a complex element in the value chain.)

Another notable finding is that 55% of the non-life firms dominant in claims are investing in communication channels for real-time integration with third-party vendors, which facilitates loss assessment and claims management overall. Also, firms 'operating on a par' score only a 1 on agility on payout options, suggesting they need to diversify those options to improve the access/ease for customers. However, they also have low scores in other areas, including case assignment, time management and shared services.

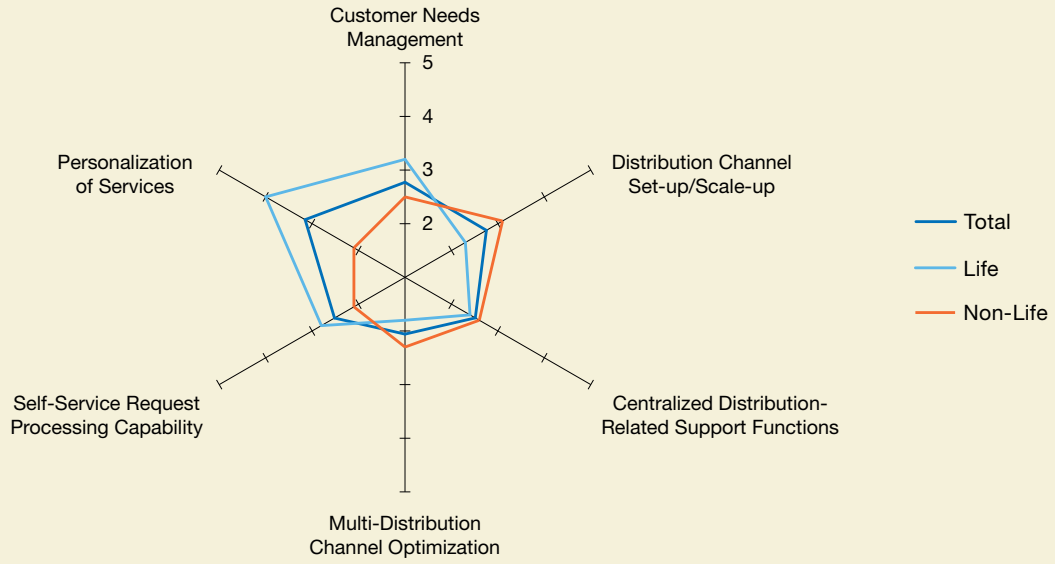
CONCLUSION

Business agility is the ability to identify, anticipate and respond to relevant changes in operating conditions—those changes that directly impact an insurer's ability to achieve sustained performance. Our research shows that by dissecting the insurance business into its numerous parts, insurers can identify specific areas in which improvement could drive success and long-term growth.

The greatest aggregate opportunities arguably lie around the drivers of business that have a direct (though not always visible) impact on the customer, but the specific areas on which insurers need and want to focus will vary by firm, depending on their line of business, scale, location, business strategy, corporate structure, etc.

Firms that are already head and shoulders above the competition are clearly progressing farther along the maturity spectrum in agility than others—but they also show that progression need not be universal to be successful. Rather, the key is for each insurer to select for improvement those business activities that are most likely to deliver long-term value and fuel sustained results.

Figure 2.8 Weighted Mean of the Maturity Scores of All Firms Interviewed for Front Office Levers, by Line of Business



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

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."

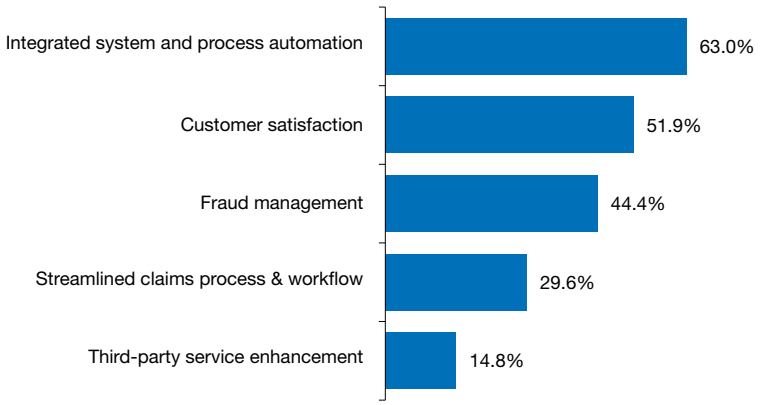
FIVE MARKET FACTORS ARE ACCELERATING THE NEED FOR INSURERS TO TRANSFORM CLAIMS PROCESSING

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.

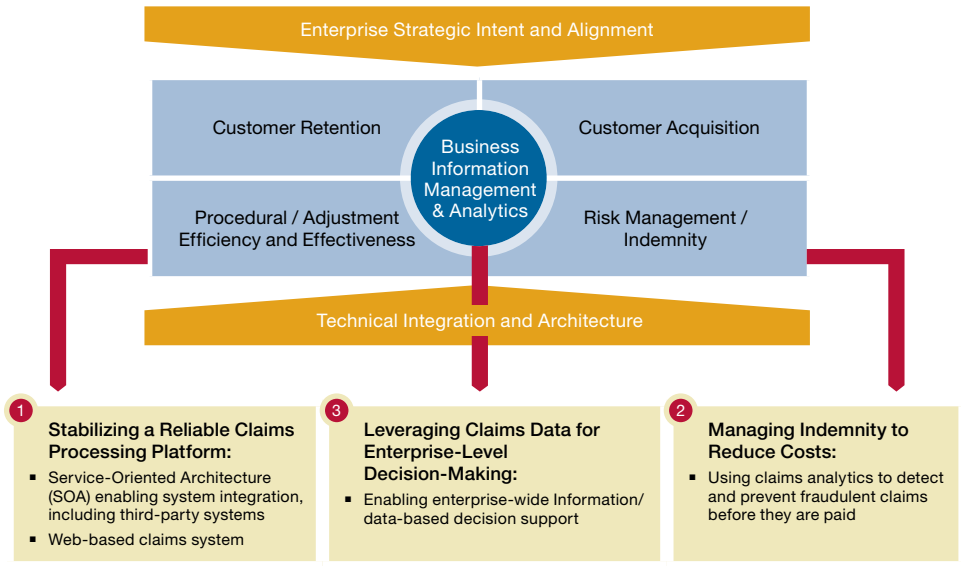
These three actions—or 'focal points' for claims transformation—are:

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.

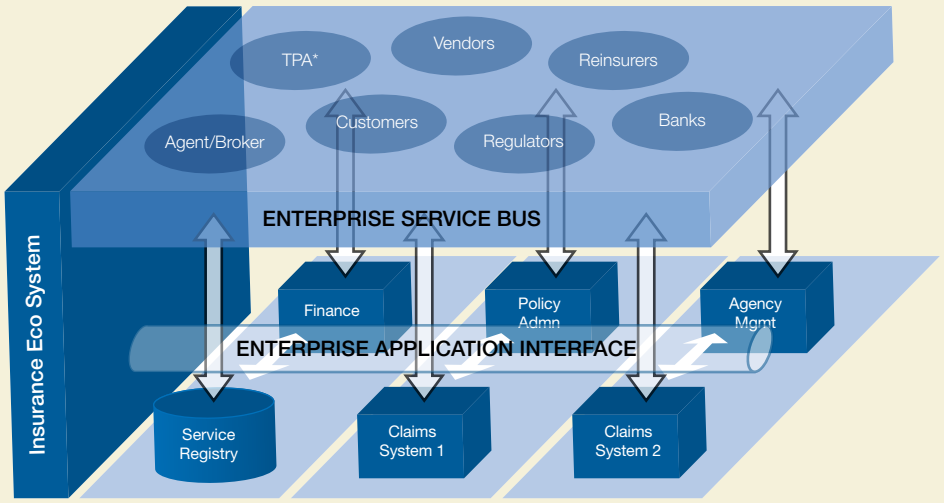
---

[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.

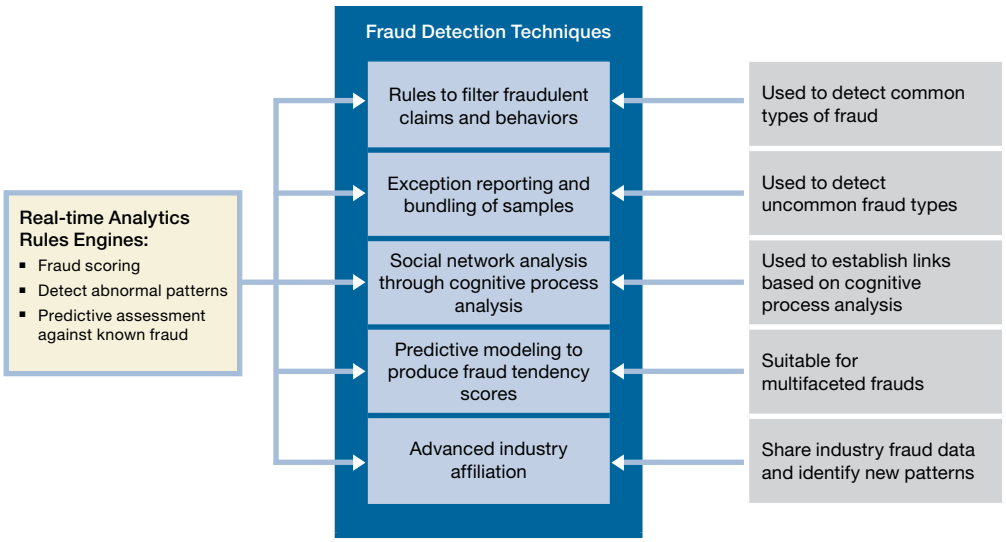
Data Sharing Can Improve Efficiency and Effectiveness, Compliance, Strategic Planning and Profits

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.

Methodology

SCOPE AND RESEARCH SOURCES

The 2011 *World Insurance Report* (WIR) covers both non-life (including health) and life segments (with a focus on non-life segments for some sections). This year's report draws on research insights from 14 countries (Belgium, Canada, Denmark, France, Germany, India, Italy, the Netherlands, Norway, Sweden, Spain, Switzerland, the U.K. and U.S.). The report is based on a comprehensive body of research that includes in-depth focus interviews (or extensive surveys) with 58 insurance executives. The sample of countries covers seven of the world's top 10 insurance markets in terms of premiums. Of all surveyed insurers, 42% sell both life and non-life insurance, 36% focus solely on life, and 22% are dedicated to non-life.

CAPGEMINI'S PROPRIETARY BUSINESS AGILITY MATURITY MODEL

To analyze the findings of the executive interviews, Capgemini's Business Agility Maturity Framework (see Figure 2.1 in Chapter 2) assesses the business agility maturity of insurers. The Model divides the insurance value chain into four components: Product Design, Front Office, Policy Administration and Underwriting, and Claims. The model defines multiple levers (parameters) for each of these value-chain components. Each of the levers has five maturity levels on which a firm can be placed based on their agility maturity. A weighted score was given to each response for a lever, based on the premiums of the company and premiums of the country in which the company is based, and a comprehensive regional and global score was derived to perform the analysis. The 2011 WIR is focused on business agility in Front Office and Claims.

EFFICIENCY RATIO ANALYSIS

We analyzed country-level financials for companies with a market share of more than 65% in that country. We obtained the country level breakdown of financials (Gross written premiums, Claims, Commission and Expenses, Operational Expenses, Investment Income, Profit before Tax) for the companies analyzed in each of the seven countries through extensive secondary research sources and local Capgemini insurance subject matter experts.

About Us

Capgemini, one of the world's foremost providers of consulting, technology and outsourcing services, enables its clients to transform and perform through technologies. Capgemini provides its clients with insights and capabilities that boost their freedom to achieve superior results through a unique way of working, the Collaborative Business Experience™. The Group relies on its global delivery model called Rightshore®, which aims to get the right balance of the best talent from multiple locations, working as one team to create and deliver the optimum solution for clients. Present in more than 35 countries, Capgemini reported 2009 global revenues of EUR 8.4 billion and employs over 100,000 people worldwide.

We bring deep industry experience, innovative service offerings and next generation global delivery to serve the financial services industry. With a network of 15,000 professionals serving over 900 clients worldwide, we move businesses forward with leading services and best practices in banking, insurance, capital markets and investments.

We leverage our Global Insurance Centre of Excellence to consistently deliver leading services for strategic value. Our global Centres of Excellence capture industry insights, best practices and the latest trends in techniques, tools and technology to continually upgrade solutions, help service new and existing clients, and provide visionary yet practical thought leadership.

For more information:
www.capgemini.com/financialservices

The European financial marketing association has been an unfailing observer of the numerous transformations that the retail financial services sector has experienced over the years and has demonstrated its ongoing commitment to providing a forum for professionals from the sector. Formed in 1971 by bankers and insurers to encourage their colleagues to share experiences, promote the best practices of their institution and collaborate through alliances and partnerships, today the non-profit association's members include over 80 per cent of Europe's largest retail financial institutions.

Through regular events, publications, and its comprehensive website, the association provides retail financial service professionals with answers to their questions about the main issues at stake in their business: multi-distribution strategies, customer approaches, product and service marketing, risk management or operational excellence, to name a few.

Efma is above all a dynamic association, providing a great opportunity for discussion and exchanges without any commercial constraints. For the past 40 years, the loyalty of its members as well as their permanent financial support are the best proof of its efficiency.

For more information:
www.efma.com

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.

The following companies are among the participants who agreed to be publicly named:

AEGON; Ageas Insurance Limited; ALKA Forsikring; Allianz Deutschland AG; Allianz SpA; AMF Pension; AXA France; Birla Sun Life Insurance; Chartis Insurance; Crédit Agricole Assicurazioni; Dexia Insurance Belgium; DnB NOR Skadeforsikring; Ergo nv/sa (BeNeLux); esure; Europ Assistance Italia; Federale Assurance/Verzekering; Folksam; Friends Provident; Generali Versicherungen; Genertel; Gjensidige; Grange Mutual Insurance; Grupo Liberty Seguros; Hannover Re Consulting Services; HDFC ERGO General Insurance; Helvetia AG Germany; If Skadeförsäkring; ING Life/Non-Life Belgium; L&T General Insurance; Länsförsäkringar; Main Street America Insurance; MAPFRE; Moderna Försäkringar; Nordea Life & Pension; PELAYO; Penn National Insurance; Quixa; Reliance General Insurance; SalusAnsvar; Sanitas Krankenversicherung; Santalucía; Skandia Insurance; SpareBank 1 Skadeforsikring; Storebrand Skadeforsikring; Schweizerische Mobiliar Versicherungsgesellschaft AG; The Towergate Partnership Ltd; Trygg Hansa; Visana Services AG; Württembergische & Wüstenrot AG; Zurich Canada; Zurich Financial Services.

We would also like to thank the following teams and individuals for helping to compile this report:

William Sullivan and Chirag Thakral for their overall leadership for this year's report; Anshul Agrawal, Soumya Chattopadhyay, Vikash Singh and Jackie Wiles for researching, compiling and writing the findings, as well as providing in-depth market analysis.

Capgemini Global Insurance network for providing their insights, industry expertise and overall guidance: Rengarajan Appan, Andreas Blom, Anis Chenchah, Carlalberto Crippa, Sree Rama Edara, Lars Ernsting, Pierre-Yves Glever, Raffaele Guerra, Imke Hahn, Jesper Halskov, Andrew Hood, Peter Kuijvenhoven, Andrew McQuade, John Mullen, Henning Munkvold, Doug Oldroyd, Venkatakrishnan Ramachandran, Dipak Sahoo, Lucia Gonzalez Sanchez, Edwin Steenvoorden, Virginia Martin Vallori, Christophe Vergne, Jan Verlinden, and Daniel Walther.

The World Report, Product Marketing and Corporate Communications Teams for producing, marketing and launching the report: Karen Schneider, Alison Coombe, Debbie Goulden, Jyoti Goyal, Marion Lecorbeiller, Martine Maître, Lisa Boughner, Matt Hebel, Sourav Mookherjee, Stacy Prassas, and Sunoj Vazhapilly.

The Efma Team for their collaborative sponsorship, marketing and continued support: Jean-Luc Méry and Céline Ristors.

For more information, please contact:

Capgemini
insurance@capgemini.com
Efma
wir@efma.com

For press inquiries, please contact:

Emma Hedges at ehedges@webershandwick.com
Lisa Boughner at lisa.boughner@capgemini.com