Deloitte.

Driving operational excellence in claims management

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Foreward

Dear Colleague,

As Property & Casualty (P&C) insurers continue to confront a soft market and an uncertain economic outlook, claims management is certain to have a central place in their strategies. The cost of claims pay-outs and expenses is the largest spending category for a P&C insurer, often times accounting for up to 80 percent of premium revenues. Companies that can achieve excellence in claims management can secure a competitive advantage by increasing operational efficiency, as well as provide better service to their customers and agents.

Based on Deloitte's work with a wide array of P&C insurers, we are pleased to provide you this report of specific areas of opportunity for insurers to upgrade their claims management capabilities. We describe how advanced analytics can offer insurers the ability to leverage claims data to increase efficiency, improve the allocation of resources, and reduce claim cycles. We also provide an overview of how insurers can reduce losses from both hard and soft fraud by employing the latest fraud detection tools. Another topic we address is how a more strategic approach to technology investment can employ a cost-benefit analysis to underpin these and other initiatives to increase operational efficiency.

As insurers increasingly rely on outside suppliers of claim professional services, having an effective supplier management strategy has become more important than ever before. And when it comes to outside suppliers, the cost of legal representation is large and has proven difficult to manage. This report will update you on the opportunity for insurers to improve their selection of legal firms and the associated costs by employing a more disciplined, performance-based approach.

We hope that this report provides you with a number of useful and innovative ideas. Most importantly, to the extent that it sparks a lively dialogue inside your organization, we would welcome the opportunity to hear your thoughts on these and other initiatives to enhance claims management.

Sincerely,

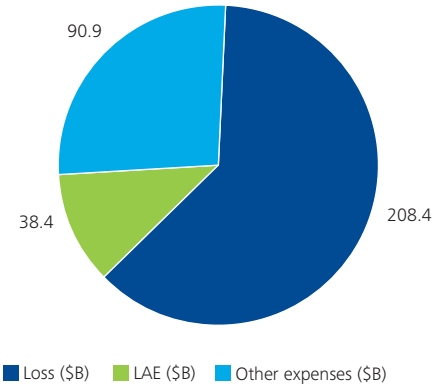
Rebecca C. Amoroso
Vice Chairman
U.S. Insurance Industry Leader
Deloitte LLP

Executive summary

P&C insurers face a myriad of challenges, including dwindling pricing power, erratic investment yields, and recent heightened catastrophe activity. Despite very strong top-line performance over the prior year, 2010 was the second consecutive year in which the industry suffered underwriting losses in the first half of the year. Overcapacity for traditional products and services, coupled with weak demand, are expected to continue to push down rates.

Since claims are the single largest spend for a P&C insurance company, investing in operational improvements in claims management is one of the most effective strategies to drive profitable growth. Typically, up to 80 percent of each earned premium dollar is "claimed by claims" as pay-out and related expenses. Insurers that can reduce their claims costs by just one percentage point will likely achieve substantial savings. (See Figure 1.)

Figure 1. P&C industry cost summary - 3Q2010



Total cost base (Loss + LAE + Op Exp.) = $337.7B
NWP = $325.4B, NEP = $316.6B
Loss Ratio = 77.9%, LAE Ratio = 12.1%

Source: Highline P&C Aggregate quarterly data and Deloitte analysis

But claims management is highly challenging, with multiple processes and platforms. Complex, duplicative functions are performed, often with outdated technology. The answer to these challenges is a top-down commitment to operational excellence, which can provide a competitive advantage in a soft market. To help achieve this objective, insurers should leverage data to provide actionable information about what drives loss and expense, and then put in place the business processes and supporting infrastructure needed to take advantage of these insights. The goal is to align the "right claim with the right resource at the right time."

The outcome is not just significant cost reductions, but also high-quality customer service and streamlined processes. An effective operational excellence strategy can lead to the following measurable results:

- More stable and predictable loss costs
- More efficient and predictable operating expenses
- Improved loss and expense costs
- Higher overall claim service ratings
- Higher policyholder retention
- Improved employee productivity
- More reserve stability
- Improved regulatory compliance

To enhance operational excellence in claims, the following are some of the key areas in which P&C insurers should take action:

- **Leveraging advanced analytics** – Using data acquired at First Notice of Loss (FNOL) to effectively forecast outcomes for individual claimants and to segment claims can transform claim management by improving the allocation of claim resources, increasing efficiency, improving the estimates of claim severity, and reducing claim cycles.
- **Supplier management** – As insurers rely more heavily on third-party suppliers, a supplier management strategy can not only contain costs, but can also enhance the customer and agent experience.

- **Legal cost management** – A performance-based approach uses data-driven analysis to develop a streamlined, reusable process for firm selection, case governance, and traditional cost management. This can be combined with predictive modeling for litigation management to create a disciplined process that assigns cases to the most appropriate resources for optimal resolution, reducing the total cost of the claim.
- **Technology enablement** – Developing an overarching approach to how and where to invest in new capabilities can improve efficiency and ensure that the technology infrastructure effectively supports the firm's initiatives to enhance operations.
- **Fraud detection** – Insurers that adopt advanced fraud detection tools and techniques that immediately identify claims with a high propensity for fraud can reduce losses and gain a reputation in the industry of being hard on fraud.

While these five areas are by no means intended to be an exhaustive list, they do provide sound direction and insight based on Deloitte's experience and P&C claims marketplace presence. We continuously explore other areas of opportunity and enablement and will share more on these topics and trends in the future.

P&C carriers today are competing in a difficult market environment against the backdrop of an uncertain economic outlook. Those that can upgrade their operational capabilities by addressing these areas will not only increase efficiency and reduce costs, they will also improve the experience of both their customers and agents. By driving operational excellence, insurers can gain a distinct competitive advantage that drives long-term, profitable growth and increased returns.

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Leveraging advanced analytics: Quickly identifying the most complex claims

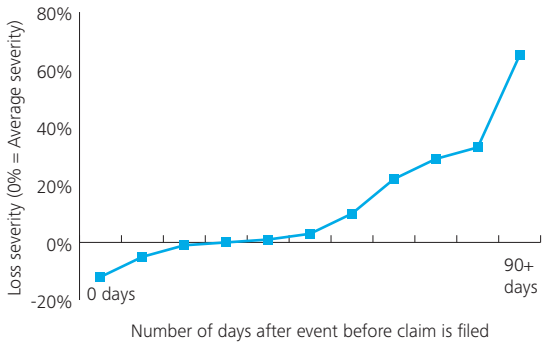
Since 20 percent of claims typically drive an estimated 80 percent of losses and expenses, it is critical for insurers to quickly identify which claims are likely to prove most complex. Predictive modeling can help provide this insight by applying data mining techniques and statistical algorithms to effectively forecast outcomes for individual claimants. These analytical tools analyze a wide variety of characteristics to detect patterns that had formerly gone undetected, providing insurers the insight they need at FNOL to improve the claims management process from assignment to resolution. For insurers, predictive modeling can result in increased efficiency, more equitable outcomes for all parties, and significant cost savings. In Deloitte's experience, using predictive modeling for claims can result in:

- 4 – 8 percent reduction in annual loss and expense
- 3 – 7 percent improvement in nurse-managed claims
- 5 – 10 percent improvement in claims managed by a fraud investigator
- 20 – 25 percent redeployment of supervisory resources

Over the past decade, insurance carriers have effectively deployed predictive modeling applications in pricing and underwriting. However, developing these applications for claims, which many believe is more complex, is beginning to gain traction in the industry. Claims predictive models are now being applied successfully to multiple lines of business, including workers' compensation, personal and commercial auto bodily injury, general liability bodily injury, and disability. A 2010 Towers Watson survey of claims officers found that most believe claim severity, fraud, and litigation are on the rise, and more than three-quarters said they will be investing in claims analytics over the next 24 months.[1]

Predictive modeling combines internal claim characteristics and external third-party data to calculate a score that allows claims to be segmented at FNOL. Several hundred variables are tested to identify the 50 to 100 with the greatest predictive power. For example, the amount of time that passes before a claim is filed ("lag") strongly predicts how severe the loss will be. Claims filed immediately after an event tend to result in below-average losses, while claims filed weeks later are likely to have much greater severity. (See Figure 2.)

Figure 2. Impact of lag in filing claim on loss severity



Source: Deloitte Consulting LLP analysis of more than 25,000 closed claims during an eight-year period, 1998-2006.

While individual variables can be used to predict the potential loss, the real power of predictive modeling comes from combining numerous variables to identify patterns that couldn't be recognized without the aid of these statistical tools. Predictive models become "eye glasses for the mind," allowing claims professionals to leverage numerous variables, optimally weighted, in their decision-making process.

The results are summarized in a model score, which allows claims to be segmented based on their performance relative to the average of the overall book. For example, one insurer using predictive modeling for lost time due to back strain was able to identify at FNOL the "worst" 10 percent of claims. These claims eventually resulted in losses that were twice as large as the average loss. In contrast, claims placed in the "best" 10 percent segment resulted in losses that were 50 percent below average. (See Figure 3.) Claims placed in the worst segment can be assigned to the most experienced personnel and given the appropriate attention and oversight required. The best claims can be routed to a service center or entry-level worker, decreasing operational costs and freeing up resources for the most complicated claims.

[1] The Economic Landscape and Operational Performance Metrics Bulletin 2010, Towers, Perrin Watson

The most common types of predictive modelling applications for claims are:

Severity model – targets core claim management process, predicting the overall severity of a claim.

Targeted fraud model – focuses on early identification of fraud so that claims can be quickly referred to an investigator or Special Investigation Unit (SIU).[2]

Subrogation model – identifies claims that have the potential to be turned over to another insurer, improving the timeliness and quality of subrogation referrals.

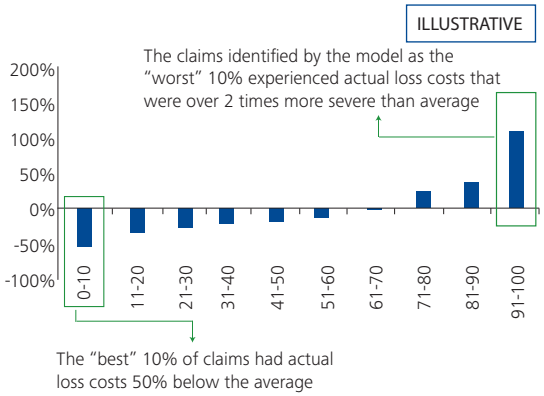
Litigation propensity model – targets the likelihood that a claimant will litigate a particular claim and assists in case assignment and claim settlement strategies.

Litigation management model – once a claim is litigated, it assists in development of litigation management strategies.[3]

Medical management model – focuses early intervention on high severity claims being driven by medical complexity. A medical management model allows insurers to use characteristics other than just injury diagnosis for referral criteria, to promptly assign nurses to high-need cases, and to detect adverse patterns in treatments.

Predictive analytics has the potential to become even more powerful over time as data integrity improves and the quantity of internally and externally captured data increases. To be fully effective, however, the use of predictive models must be driven from the top and become part of an organization's claims culture. Given the appropriate support, predictive modeling can transform the allocation of claim resources, enabling more efficient claim management, improved severity estimation, and shorter claim cycles. Early adopters often expect not just to improve outcomes, but also to gain market share and improve client satisfaction. The adoption of predictive modeling may ultimately benefit society as a whole by ensuring that injured Americans receive timely and appropriate resolution of their claims.

Figure 3. Claim severity projections



Source: Deloitte Consulting LLP

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[2] New techniques to combat fraud are discussed in "Fraud detection."

[3] Litigation costs are discussed in "Legal cost management."

Supplier management: Reducing the costs of third-party suppliers

With carriers focused on developing strategies to achieve sustainable cost reduction over the long term, improving management of spending on third-party suppliers for claims is essential. Deloitte estimates that as much as 40 to 50 percent of losses stem from payments to suppliers of goods and services. This spend is growing as insurers rely more heavily on outsourcing due to increased specialization and technology-based delivery models. There is an enormous opportunity to manage these costs more effectively and drive value to the organization through the development and implementation of a claims supplier management strategy.

Many insurers have begun to develop enterprise-wide supplier strategies, investing in the procurement and sourcing functions, but the claims arena has typically lagged the rest of the organization due to a myriad of challenges. First, the market for suppliers in claims is extremely diverse, complex, and far more fragmented than for other company-wide spend categories. Further, ultimate control and buying decisions reside with the insured, which requires a different approach than most spend management strategies. The suppliers are also embedded deeply into many of the core processes—which can blur the line between supplier and process management.

Operational challenges are even more daunting, with many insurers failing to apply the basic tenets of supplier management, strategic sourcing, and supplier partnering. These disciplines are typically not part of a claims professional's expertise. In addition, procurement and sourcing departments often suffer from insufficient scale, tools, and capabilities. One of the biggest operational challenges is a lack of analytical insight, most insurers are simply unaware of what their suppliers are costing them.

These challenges can result in:

- Limited visibility, control, and tracking of supplier spending
- Inconsistent supplier performance
- Lack of knowledge of suppliers, resulting in increased risk

So while claims supplier management remains a challenge for many insurers, the sheer size of the spend demands concerted attention and a thoughtful strategy. The scale of auto repair programs is well known, but large cost savings can also be realized in areas such as counsel, adjusters, remediation firms, salvage, and case managers. Many of these suppliers are small, independent firms, while others are large firms that deal directly with both agents and policyholders.

Improving these vitally important relationships represents a tremendous cost-savings opportunity. The following components are essential to a successful claims supplier management strategy:

- **Executive commitment** is the most critical element. Companies need to establish collaborative goals and financial targets while ensuring accountability.
- **Analytical rigor** requires creating and analyzing a spend baseline based on historical purchasing data, including the identification of spend outliers, as well as understanding demand drivers and usage trends. Obtaining data can be difficult and often requires partnering across the firm's business units and even with the suppliers themselves.
- **Category expertise** entails leveraging internal and external category experts, engaging high-caliber, collaborative staff, and using category managers to monitor marketplace trends.
- **A cross-functional**, collaborative team builds a sense of partnership among claims, sourcing, procurement, legal, and information technology departments—and is essential to driving maximum value.
- **Active**, ongoing spend management rooted in disciplined, objective measurement and tracking enables the insurer to not only drive value at the onset of the relationship, but enables a sustained value creation mechanism.

An effective claims supplier management strategy will not simply contain costs. It can enhance customer service as well, since many suppliers directly engage with the policyholders and play a key role in the overall claims process. Direct repair programs, for example, not only offer discounts to carriers, but improve service to policyholders. A well-managed program provides policyholders with the convenience of a "one-stop shop" with a prequalified service provider. The known quality of the repair network allows the carrier to frequently provide an extended or lifetime guarantee on the workmanship, an additional customer satisfier. Creating value for both the carrier and the insured solidifies their relationship. This strategy can also help optimize service delivery by effectively balancing the workloads of outside counsel and independent adjusters.

In Deloitte's experience, deploying an effective claim supplier management strategy can yield savings as high as 30 percent in certain spend categories. Management benefits from the sense of collaboration and an enhanced ability to balance internal workload, control costs, and drive efficiency. However, one of the most exciting benefits of achieving optimal supplier management is the enhanced experience that an organization will deliver for customers and agents. If done right, supplier management can be a win-win for all involved.

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Legal cost management: A disciplined approach to managing litigation costs

Any serious effort to drive efficiencies must focus on reducing the spend on litigation, which is the single largest cost for P&C insurers beyond claim payments. Based on Deloitte's experience, the amount of annual spending typically ranges from $25 million to more than a billion dollars, depending on the size and nature of the insurer's book of business. Unless an organization is willing to transform its processes, these costs can continue to grow and adversely affect its bottom line.

Litigation costs have proven to be among the most challenging spending categories for an insurer to manage, given the difficulty in striking the right balance between efficiency and effectiveness. No insurer wants to reduce the expenditure on legal representation if the end result is larger claim payouts. Indeed, any meaningful solution must focus on reducing the total cost of the claim—both expenses and loss payments. Traditional cost-reduction approaches, such as demanding firms to cut hourly rates, have often proved counterproductive due to complexities that include a large, fragmented portfolio of legal firms and a lack of meaningful quantitative and qualitative data.

Today, advanced analytics has led to breakthrough approaches that can help insurers place the right case with the right law firm at the right price. Performance-based cost management, combined with applying predictive modeling to litigation management, can help to significantly reduce the total cost of claims, while at the same time improving the cost-effectiveness and quality of legal representation.

Performance-based cost management

E-billing systems and claims system data capture provide insurers with new opportunities to analyze a wealth of litigation-related information to identify opportunities for reducing costs and improving outcomes. In Deloitte's experience, a performance-based cost management approach can reduce litigation costs from single digits to more than 20%, resulting in recurring savings that can reach hundreds of millions of dollars per year at the largest companies.

A performance-based approach uses data-driven analyses to develop a streamlined, reusable process for the three primary areas of litigation management: firm selection, case governance, and traditional cost management. (See Figure 4.) The first step is creating a measurement process to evaluate the aggregate performance of defense counsel. Firm-level balanced scorecards and dashboards use both quantitative and qualitative measures to assess the efficiency and effectiveness of law firms. For example, assessing scorecard data on cost and quality can enable case referrals to be redirected from higher-cost to lower-cost firms of equal or superior quality.

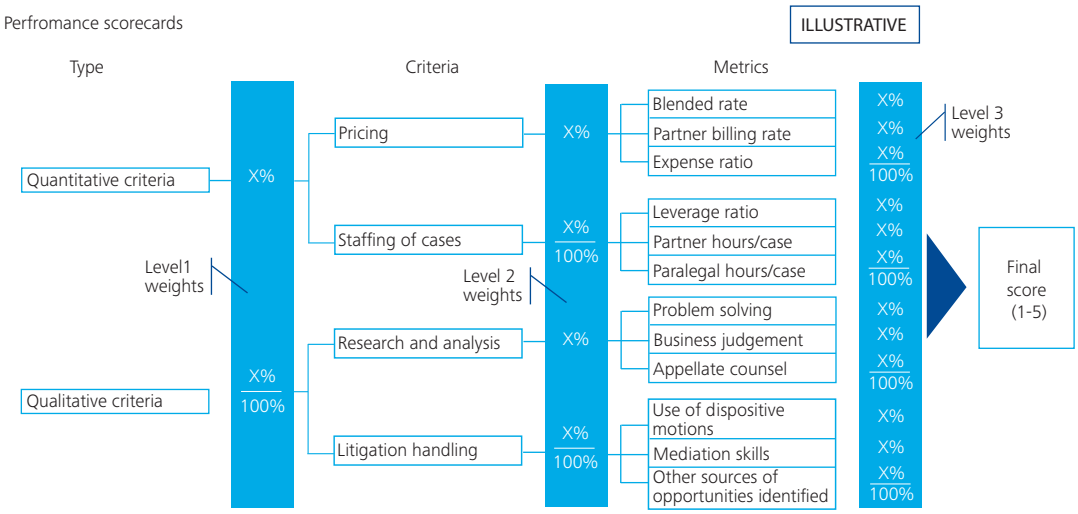
After a law firm is selected, a robust governance framework can maximize the value received from defense counsel. Creating upfront agreements on the scope of services and budgets, followed by aggressively managing staff levels, tracking milestones, and reviewing bills allows for the creation of standard metrics to compare performance across firms. The effective use of workforce management and e-billing tools are critical to the success of this approach.

The insights gained through an analytic-based evaluation of counsel during selection and case governance enable an insurer to identify and prioritize a broad set of opportunities for cost reduction and quality improvement. These can include initiatives, such as:

- Bringing more cases in-house
- Shifting referrals to the most effective and efficient firms
- Leveraging volume to standardize rates
- Transferring lower-level work, such as research, to administrative staff or more junior attorneys
- Shifting volume to lower-cost firms
- Conducting regular, fact-based performance improvement discussions with counsel
- Requesting preferred or fixed fees for recurring legal defense activities or cases
- Enhancing attorney productivity by evaluating file loads and identifying opportunities to increase the number of files handled by counsel

This approach provides a foundational framework for a cycle of continual improvement. Insurers can create a performance scorecard that evaluates each defense firm both quantitatively and qualitatively on a regular basis to identify and remedy performance issues, and to direct cases to the top-performing firms.

Figure 4. Counsel performance measurement



Predictive modeling for litigation management

In litigation management, predictive modeling can be used to identify which claims are in the critical 20 percent that drive the bulk of litigation costs. One insurer was able to use these tools in its litigation complexity model to predict which claims would result in legal costs three times greater than claims placed in another segment.

Predictive modeling and performance-based cost management are highly complementary. Both approaches use advanced analytics to assign cases to the most appropriate claims resources and defense firms for optimal resolution. The result? In general, case outcomes are improved, which not only reduces legal costs, but also the total cost of the claim. Insurers that adopt these leading practices in litigation management will likely find that they have gained mastery over a key component of their bottom line.

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Technology enablement: Developing a technology investment strategy

Improving operational efficiency and customer satisfaction in claims depends heavily on an effective technology infrastructure. Recent trends in leveraging technology affect the entire claim value chain, including core claim, technical, and support processes. Some of the leading trends and technological developments with the greatest impact on claim processes include:

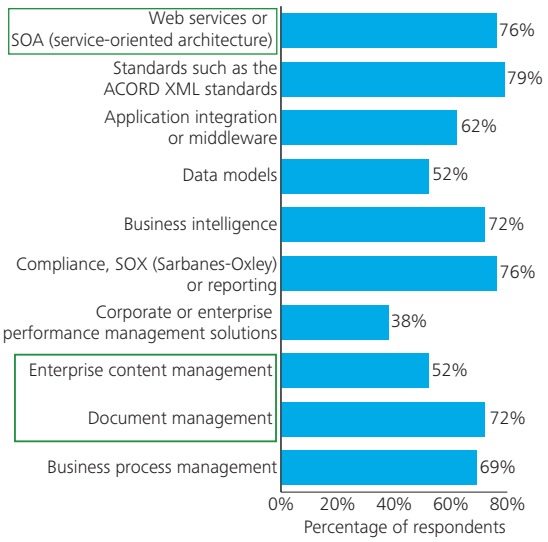
- Improved core legacy claims management system (CMS)
- Advanced data analytics and performance management
- Full channel enablement and claims self-service
- Business claims process automation

In Deloitte's experience, technology enablement, if employed with proper training to leverage new capabilities, can reduce claims adjusting expenses and increase productivity levels by as much as 20 to 25 percent. In addition to greater efficiencies, technology enablement can also allow carriers to realize better outcomes by focusing on the work that matters, with some insurers achieving up to a four- to six-point reduction in loss ratio.

Although the benefits can be substantial, there are a number of potential technology investments areas for insurers to choose from. (See Figure 5.) Insurers must strategically consider where to invest their limited resources and funds in order to achieve the highest impact on their organization from efficiency and service differentiation perspective. In making these investment decisions, Deloitte suggests insurers consider the following guiding principles:

- **Although a critical foundation, a core CMS cannot address all needs.**
  A CMS is the cornerstone for the efficient capture of data, effective analytics, automation of key processes, and channel enablement. But an upgraded system doesn't need to supply every desired function. Rather, it is more important to invest in a core system that is built on and supports open architectures, which can then be integrated with specific tools and enhancements to provide functionality in specific areas. The core system should allow an organization to extend its capabilities as new technologies and tools become available.

Figure 5. Investment in enterprise improvements



Source: Gartner, March 2010.

For example, one of the world's largest P&C carriers is constructing a core system with business process management and rules engine capabilities, and 'bolting on' and integrating additional functional capabilities, such as document and business partner management capabilities via open architecture.

- **Make use of enabling tools.**
  Integrating leading-edge tools, such as rules engines, scoring engines, process management, and middleware has allowed carriers to make tremendous strides in improving operations. These tools have helped insurers in implementing such areas as straight-through processing, automation, and self-service capabilities. As these tools have evolved, it has become easier to integrate best-of-breed tools with the existing enterprise infrastructure. To take advantage of these capabilities, however, it is essential that the enterprise infrastructure is kept up to date or, at minimum, that older infrastructures are adequately enhanced to integrate with these tools.

- **The goal is usable information, not just data**. While claims organizations have always used industry measures and metrics, they are just beginning to understand how much data they can leverage, both internally and from external sources. From gaining insights into existing claims and better understanding operational metrics, to more efficiently producing and understanding regulatory reporting data, claims organizations need to take advantage of data that already exists and also new sources of data not familiar to them. New techniques and tools make this possible even with existing legacy and multiple systems.

  For example, one major insurer recently created a core claims data warehouse where 70 to 80 percent of data has been consolidated from previously disparate systems, greatly improving efficiency, enhancing data quality, and gaining greater ability to gain insights from their data.

These principles can help guide insurers as they consider the range of potential technology investments available. To reiterate, combined with proper management and training to provide new capabilities to its users, these investments can help an insurer to increase operational efficiency while at the same time supporting analytics and enhanced service. A strategic, holistic approach to technology enablement offers a compelling cost-benefit analysis for investment and lays the essential foundation for all initiatives to drive operational excellence.

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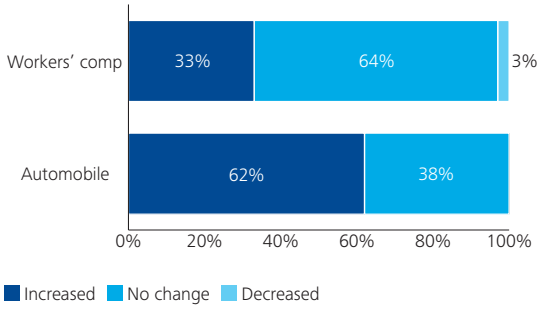
Fraud detection: New tools to combat insurance fraud

Imagine if an insurer could identify claims with a propensity for soft or hard fraud as soon as the day they were reported and immediately take effective action. Suppose they could close some of these claims within a few days with no payments as claimants realized the company was simply "too hard to fool" and withdrew their claims. While these capabilities were once the stuff of imagination, new advanced techniques have now made them a reality.

The number of potentially fraudulent claims has been on the rise. A 2010 survey of 50 claims officers found that 62 percent reported that they had recently seen an increase in exaggerated or potentially fraudulent auto claims. (See Figure 6.) For many years, insurers have used basic fraud tools to help them identify potentially fraudulent claims, but recently much more sophisticated tools have been developed and are already starting to have a successful impact on reducing the cost of fraudulent claims. These sophisticated tools include advances in data mining, better implementation of rules engines, and predictive modeling. Insurers that employ such advanced tools are able to more accurately identify claims with the highest propensity for fraud as early as the FNOL by utilizing tens or even hundreds of pieces of data to predict the propensity for fraud of each claim or claimant. This includes data from a variety of external sources that were not previously available to the claim adjuster.

But having the right tools is just the first step. The success of any fraud tool depends on its successful implementation in the business. Claims flagged as having a high potential for fraud can immediately be referred to a fraud investigator or SIU. The output from these advanced tools helps an investigator develop an effective action plan. They can provide claim adjusters and other claim professionals with more than a basic indicator of the propensity for fraud. In addition, they can provide information on the degree of potential fraud and detailed reasons explaining why a claim has a propensity for fraud, as well as a summary of data relevant to the potential fraud that can be used to develop an action plan.

Figure 6. Change in exaggerated or potentially fraudulent claim



Source: The Economic Landscape and Operational Performance Metrics Bulletin 2010, Towers Watson.

Traditional investigation activities are typically used, such as face-to-face interviews, home visits, coworker interviews, scene pictures, recorded statements, and the use of private investigators. But since these tools make available a much broader set of information early in the claim life, rather than waiting for 30 to 60, days the investigator can conduct a targeted investigation within the first week, before liability has been accepted, hours have been spent examining and adjusting the claim, and initial payments have been made.

One insurer that recently introduced an advanced fraud tool began to see results within the first two weeks. The presence of a numerical indicator of potential fraud, as well as having a summary of the most important facts of the claim from both internal and external sources, immediately led to a more targeted approach to fraud referrals. Armed with that information, fraud investigators were able to develop appropriate action plans and begin their investigations within days after the claim was reported, rather than weeks or months. In many cases, the quick action of the investigators led claimants to withdraw their claims. In other cases, early on-site visits provided the investigators with the necessary evidence of fraud to deny claims. All these improvements resulted in a projected

reduction in loss costs of almost 10 percent in claims involving potential fraud, and the company was able to slash the average length of time for fraud referral from six to nine months to just 10 to15 days.

Deloitte believes that organizations that invest the time and effort to ensure a successful implementation can achieve an additional 5 to 10 percent of savings on claims involving potential fraud. The key elements of a successful implementation include the following:

- Evaluate existing processes and clearly define the impact of proposed changes to those processes.
- Analyze the output of fraud detection tools to develop detailed, customized rules to automatically refer certain claims to the fraud unit or to require specific actions.
- Develop clear training and communication strategies.
- Involve end users throughout the process to ensure the output from the tools can be effectively utilized.

Committing the time and effort to consider how a fraud tool should be implemented will increase the chances of successfully flagging fraudulent claims and reducing loss costs. Once an insurer becomes known for effectively addressing fraud, its reputation alone can reduce the incidence of dishonest claims, particularly in lines of business like workers' compensation where claimants interact with other potential claimants on a regular basis. Claimants will conclude they are simply "too hard to fool."

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