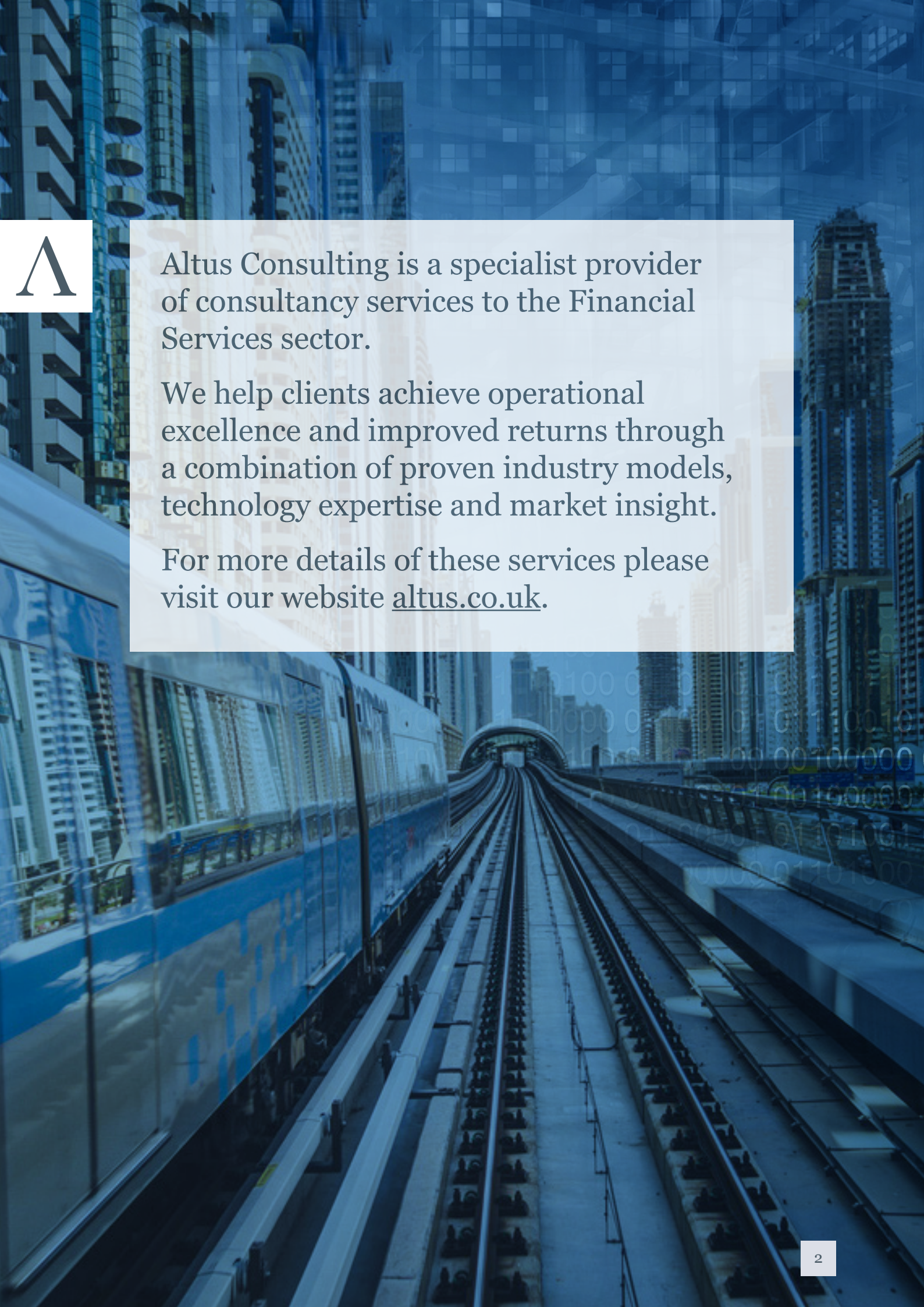
Service Disruption: Next Stop For Claims

Altus Consulting

People | Passion | Partnership



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We help clients achieve operational excellence and improved returns through a combination of proven industry models, technology expertise and market insight.

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Foreword:

Mark McDonald, Altus Consulting

Insurance has always had something of a love/hate relationship with the most important aspect of what it does – the claims function. It is the moment of truth for customer and insurer alike. The customer has put their faith and trust in the insurer to pay their claim should the worst happen, and the insurer undertakes its contract to honour that trust. Put simply, it's the core purpose of the insurance product.

However, the reality is that many insurers are still trapped in a mindset that sees claims as a cost, a cost that must be controlled to protect profit.

In a world where service expectations are high and trust in insurance is low, the insurance sector has worked its way into an unenviable corner – the very reason people buy the product is seen as a real and continuous threat to the health of the balance sheet. When an organisation looks at the moment its true value is recognised as a cost that must be managed, something has gone fundamentally wrong with the claims process and the thinking around it.

Many insurers in the UK are awake to this problem and are tackling it head on, putting all their efforts (and their hopes) into a 'digital transformation' of the claims function to improve efficiency and the customer experience. Everything from advanced analytics and blockchain to chatbots and dedicated apps are being used in an effort to modernise the claims process, create greater efficiency and deliver more customer satisfaction.

While some are building bespoke, in-house systems to deliver this, most are putting their faith in the world of technology, applying it in a discreet, specific way, tackling individual process issues without considering the need for a wider, cohesive and strategic approach to the claims management function. What has largely happened to date is a slight modernisation of some parts of the claims process that has generated so much customer distrust to date.

So while many speak of transformation, few are actually undertaking a genuine one. A true transformation requires not just a change in the kind of tools being used to power the process, but a complete change in how insurers approach the single most important aspect of what they do, honouring the promise to pay.

The need for such a fundamental change in claims is gathering momentum across the market but most insurers are still looking to effect this change from a purely digital perspective. The temptation to do so is understandable but to rely entirely upon technology to create the necessary change is a mistake.

While technology undoubtedly has a crucial role to play in transforming claims, it isn't the only tool available. Humans will always have the central role to play in the claims process as they bring critical thinking, intellectual and moral challenges and a crucial empathy to play in the process that machines will never be able to match.

Before any consideration is given to technology, insurers must start from the ground up and map out the process they want - from a satisfied customer right the way back to the notification of their loss. It is only by taking an engineering approach to the claims process that insurers can hope to make the most of the genuinely exciting technology that is available to them today.

And it is only by taking that methodical, ground-up approach that insurers can start to deliver the kind of consistent, efficient and service-driven claims experience they know the customers of today and tomorrow will demand.

All aboard!
The current state of claims

Chapter Summary

- Claims functions needs to adapt to rapidly changing expectations from customers and a renewed focus from the regulator, whilst also navigating the impact that inflationary cost pressures are having on profitability.
- Insurers embarking on claims transformation are broadly restricted by their existing technology stacks.
- Successful transformation can only be achieved by looking at the bigger picture, with the target operating model (people, process and technology) being central to this, rather than focusing purely on new software solutions.
- There are emerging technology solutions that provide real enablers to change, and an understanding of these and how they can be applied will be a key part of any operating model design.

No matter how innovative or complex the insurance landscape becomes, one thing will remain unchanged – the promise to pay if something goes wrong always has been, and always will be, the core purpose of the insurance product.

While that truth remains unchanged, little else in the wider insurance landscape has. Across the industry, from reinsurers to company markets and from brokers to loss adjusters, the management of claims has reached an inflection point in recent years. Increased regulatory scrutiny and changing customer expectations are driving the need to make the claims experience central to insurer propositions, whilst the financial impact of rising claims costs and the burden of legacy technology conspire to limit their ability to implement transformational change in this area.

Customer expectations

For today's customer, fulfilling the basic promise to pay is no longer enough. The way in which a claim is received, managed and settled is of increasing importance, and, in line with other aspects of their lives, customers are placing greater emphasis on having some degree of influence and control over the claims process.

According to research by sprout.ai, 21% of customers expect a claim to be settled within hours and 100% of 18-24 year olds expect their claim to be settled within one week[1]. Technological advances in the last decade mean that smartphones are now near-ubiquitous, there is an expectation of instant responses, and for transactions to be completed through a simple interface online.

Service expectations in insurance are no different to any other brand customers engage with, and the industry must respond if it hopes to remain relevant in the long term.

Claims inflation

Claims inflation, triggered by the pandemic and compounded by the war in Ukraine, is hitting every insurer hard with the knock-on effect to customers of sharp increases in premiums, particularly in the motor market.

According to the Association of British Insurers (ABI), in the 12 months up to Q1 2023, the cost of vehicle repairs increased by 33% to £1.5bn, labour costs were up 40% and the cost of replacement car parts had increased by up to 21%[2].

These costs are real, sustained and infecting every part of the market and they must be managed creatively to reduce pressure on pricing and, subsequently, customers.

> 21% of customers expect a claim to be settled within hours, 100% of 18-24 year olds expect their claim to be settled within one week.

[1] "Responding to rising customer expectations in insurance"

[2] https://www.abi.org.uk/news/news-articles/2023/8/sustained-cost-pressures-on-insurers-push-the-average-price-of-motor-insurance-to-a-record-high/

All aboard!
The current state of claims (cont.)

A rejuvenated regulator

A claims process that meets or beats the expectations of today's customers is also a key opportunity to retain customers, but the regulator's guidance around the delivery of 'good' outcomes rather than simply 'fair' ones, adds another dimension.

Recent interventions from the Financial Conduct Authority (FCA) have started to give the market a view of the regulator's latest thinking on what good looks like, as the Consumer Duty is introduced, Insurance Conduct of Business (ICOBS) rules are updated, and public warnings are issued by the FCA[3] about negative behaviours in the management of claims.

It has been apparent for a number of years that the customer claims experience does not meet the standards set by other sectors or the expectations of the regulator and this inability to meet customer and regulatory expectations poses financial as well as reputational risks.

According to one study, 31% of claimants were unsatisfied with the handling of their home or motor claim with 30% of those reporting they had switched insurers in response with a further 40% considering doing the same[4].

Legacy technology

The struggle with legacy technology is not unique to insurance but the impact of operating on multiple, outdated platforms is acting as a particular drag in this sector, most notably in claims.

While most insurers are embarking upon a digital transformation of their claims proposition in some form or another, the reality is that they can only go as far and as fast as their existing platforms permit. Research by Duck Creek Technologies found that many insurers spend up to 80% of their IT budget on maintaining these outdated systems[5], strangling the opportunity for real, wholesale change.

A new approach to an old problem

In simple terms, the claims handling capabilities of insurers have not evolved as quickly as the world around them, largely due to the broad spectrum of complexity across claims, and the fractured nature of how claims are managed both in-house and externally.

Taking a step back, the various external factors, in conjunction with emerging technologies and models for sustainability, should be seen as a real opportunity for those operating in the insurance industry.

What is required is a complete rethink of how claims are approached to focus less on insurer efficiency and much more on customer experience, but the delivery of this requires not just a revolution in technology but a revolution in mindset.

Those insurers seeking to make real and lasting change to their claims experience, should consider the following questions:

- Do we have an optimised target operating model for claims handling?
- Have we fully addressed the key touchpoints that deliver certainty in claims resolution?
- Is the structure of our supply chain truly delivering for our business and our customers?
- Have we fully embraced the technology that can help deliver the right outcomes?

These are the core questions this whitepaper will seek to answer through the prism of well-established Altus Consulting industry models, developed and maintained by our insurance industry subject matter experts.

> "To deliver real transformation for claims, there needs to be clarity on the current overall state and the target operating model, before embarking on a programme of change. For this to be successful, the claims function and other interdependent parts of the business need to be brought fully on board, and full transparency of the transition states as an insurer implements a new model will help to ensure this is a smooth journey."
>
> **Patrick Hayward,**
> Altus Consulting

[3] https://www.fca.org.uk/news/press-releases/fca-warns-insurers-about-support-provided-struggling-customers

[4] https://newsroom.accenture.com/news/poor-claims-experiences-could-put-up-to-170b-of-global-insurance-premiums-at-risk-by-2027-according-to-new-accenture-research.htm

[5] https://www.duckcreek.com/blog/blog-insurance-industry-challenges/

Altus Consulting Business Models

Our approach takes an engineer's view of an insurance company, breaking it down into its logical building blocks or capabilities and understanding the data flows in and out of the organisation.

Alongside our reference capability models we have developed our own view of end-to-end processes and we use a combination of these models to describe existing and future state operating models, re-designing processes to drive transformation for our clients.

These models are used to anchor some of our thoughts, and to provide a reference point throughout this paper.

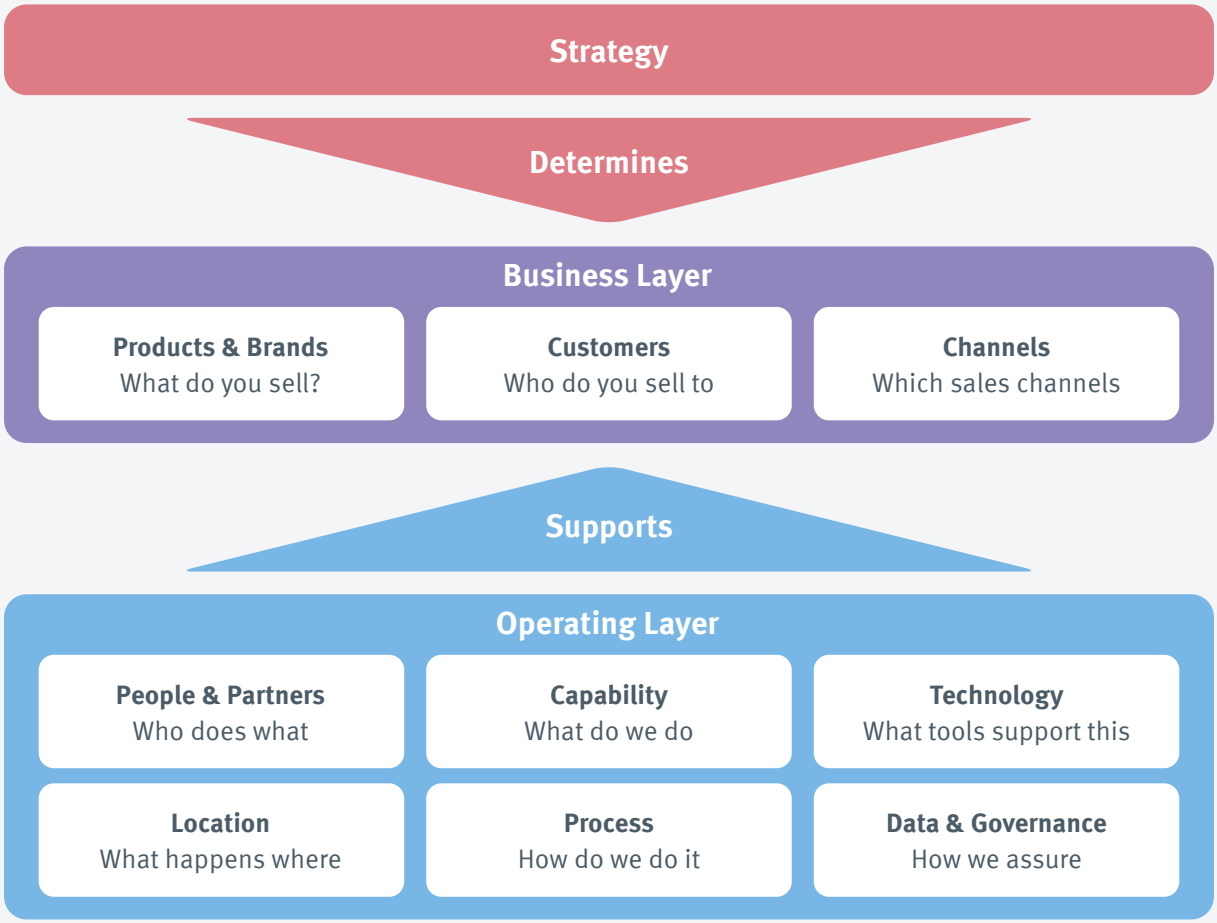


Figure 1: Altus Consulting Operating Model Framework

Your journey planner for good claims management

Chapter Summary

- The insurance industry, particularly with the influence of price comparison websites, generally markets and competes on price, rather than service.
- There is still a perception that insurers will look for ways to not pay a claim, due to a lack of trust in the industry.
- There is no one-size-fits-all approach to claims, but there will be common elements that are key to a strong claims service for the customer. They can be broken down in different ways, and in this paper we consider the following factors: Understanding of liability; Communication; Fairness; Prompt Settlement; Management of Expectations and Empathy.
- Claims functions operate in an evolving legal and regulatory environment. In the last two decades, we have seen the introduction of FCA's Treating Customers Fairly (TCF), statutes aimed at bringing insurance law up to date for consumers, and a regulatory approach to consumer outcomes which is culminating in the introduction of the Consumer Duty.
- Claims can be a differentiator for insurers, providing the opportunity to exceed customer expectations and increase customer retention.
- In this section, we also introduce a high-level view of the claims process which provides the structure behind our approach, guiding the development of a target operating model later in the paper.

What does it mean to manage a claim fairly and in a way that delivers good outcomes for customers? For most, the fulfilment of a claim simply means the insurer has delivered on the promise they made when the product was bought. It is the crystallisation of the protection the customer has paid for, the end result of the trust they have placed in their insurer to put them back in the position they were before the claim.

Delivering on your promise

Unfortunately, that crucial trust is low in insurance with one survey showing that only 21% of respondents considered their insurer trustworthy, despite the fact that, for example, UK motor insurers are paying around £8bn to £10bn in claims every year[6].

If insurers are paying out on nearly 100% of claims made, why does the perception that insurers will fight every claim persist? The answer, lies in the experience customers have of making that claim, paid out or not.

It is true to say that customers may not always think about this promise to pay at the point of purchase but that is largely down to the fact they have been 'trained' by decades of price-sensitive marketing from insurers and price comparison websites to place the greatest emphasis on the cost of the policy.

This has long been seen as a misleading approach to evidencing the value of insurance particularly when, in such a complex area of insurance, there is no such thing as a one size fits all approach - for products, for customers, for handlers and indeed, for insurers.

However, to lean on the inherent complexity of insurance to explain the lack of consistency and service delivered in claims across the market would be to duck the issue.

There are of course commonalities across the industry, particularly within specific lines of business. For example, basic levels of service will be demanded by a combination of regulation, legal precedent and the intervention of industry bodies, such as, the Financial Ombudsman Service (FOS), the Association of British Insurers (ABI), Chartered Insurance Institute (CII) and the Forum of Insurance Lawyers (FOIL), from which best practice often emerges.

However this best practice manifests itself, it remains the basics of good claims management. What it can't and won't do is advise insurers of their claims philosophy or the values they hold that inform claims decisions. But it is these two elements, properly understood and applied across the organisation, that will allow an individual insurer to make their claims service a genuine point of differentiation and to act as the marketing tool it should always have been.

[6] https://www.abi.org.uk/news/news-articles/2023/6/keeping-motorists-mobile---motor-insurers-payouts-up-14-over-the-last-year/

The key elements of a strong claims service

Figure 2: Outcomes-based view of good claims management

Your journey planner for good claims management (cont.)

The Legal and Regulatory Environment

Claims management doesn't operate in a vacuum, and over the last two decades, the sector has been subject to a range of legal and regulatory changes relating directly to claims. Some developments, such as the introduction of the Treating Customers Fairly principle, stating that customers should be confident they will be treated fairly by their insurer, led to a significant amount of introspection and recognition of the need to change by major players in the market.

This was followed by the Consumer Insurance (Disclosure and Representations) Act 2012 which formalised the approach that most insurers were taking, namely that they could not simply refuse to pay out on any element of a claim if a customer failed to disclose all material facts when taking out the policy.

The Insurance Act 2015 extended this approach to commercial insurance (to a degree) and introduced the concept of 'damages for late payment', under which an insurer could be contractually liable for losses that result from an unreasonable delay to the settlement of a claim.

More recently, we have seen a renewed focus from the FCA on claims outcomes, initially looking at add-on products in 2018, and then again as part of the Vulnerable Customer requirements introduced in 2019. The pandemic, which severely impacted most sectors, exposed the frailties in the management of claims, introducing an element of vulnerability for a significant proportion of customers, as many people entered into or faced financial difficulty.

FCA Principle 12:

"A firm must act to deliver good outcomes for retail customers."

All of which brings us to the present day and the introduction of the Consumer Duty, under Principle 12 of the FCA Principles for Business Handbook. This applies to the whole insurance value chain, but it is clear that a new requirement for 'good outcomes' for consumers represents a likely shift from 'fair outcomes', which could result in significant regulatory scrutiny for the management of claims in personal lines.

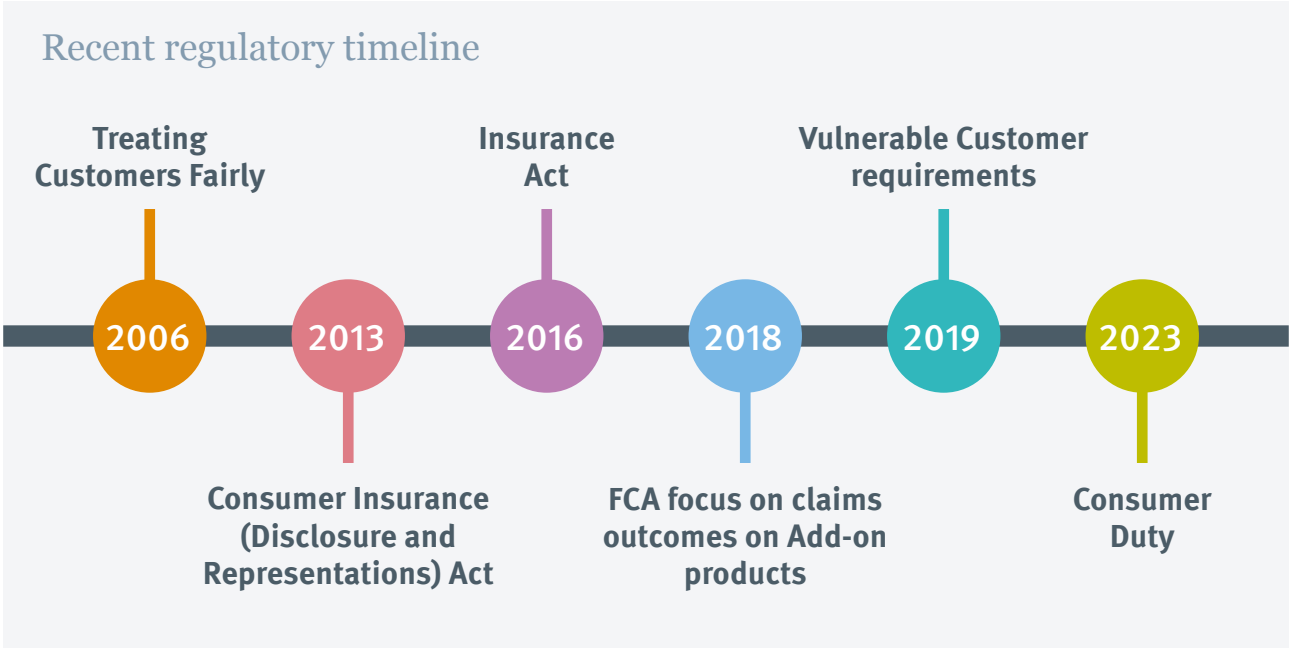


Figure 3: Key recent legal and regulatory developments

Claims as a differentiator

All of this regulatory change has to be applied to any claims service but again, these are basic expectations and will do nothing to differentiate one service from another. Insurers must go much further than regulatory stipulations if they wish to win the trust and favour of the public.

Through its annual research and analysis on public trust, the CII has identified a change in what consumers feel is most important to them in selecting an insurance product. Over the last few years, the emphasis has moved more to the speed of settlement of claim, and perhaps more interestingly, towards having greater 'control' over the claims process.

This indicates that rather than a reluctant willingness to engage, customers have an active desire to influence and manage the claims process themselves through self-serve mechanisms.

> "We have seen a shift in consumer priorities, from it just being about the importance of having insurance, and ease of doing business, to a real focus on claims performance, speed and method of settlement, control over the claim and the need to be treated with respect, rather than as a potential fraudster."
>
> **Matt Connell,**
> Director of Policy and Public Affairs, CII

The appetite for greater transparency is clear but the challenge facing insurers is articulating the full claims proposition to prospective customers in a way that makes sense. A significant amount of regulatory information must be communicated which, while important, can obscure the value that an individual insurer provides. It is worth remembering, however, that these regulations were introduced because the FCA felt the sector wouldn't address the clear issues at play 'unaided'.

However, when it comes to retention, communicating the value of a claims service is arguably most straightforward when the customer incurs a loss and seeks indemnification from the insurer. This provides a real opportunity for the insurer to showcase the quality of its claims management, to build a genuine connection and, hopefully, long term relationship with their customer.

Those insurers that are able to improve efficiency through reduced claims settlement periods, increased use of automation and better cost control for third party claims, will secure a direct benefit in being able to pass these savings to consumers, improving their growth opportunities. More than that, the experience will be far more in line with the customer's engagement with other sectors.

Your journey planner for good claims management (cont.)

Claims value chain

By taking a methodical, architecture-led approach to visualising an organisation, Altus Consulting has built its understanding of claims processes at a logical level, based on the underlying flows of data between an insurer and the external entities it interacts with.

The resulting view below covers high level claims processes and the sub-processes involved in claims management, from end to end.

Figure 4: Claims value chain

The process view

If delivering a truly different claims service was a simple task, everyone would have done it by now. But the reality is that marketing an insurer through its claims service requires the application of new thinking and a new approach to what has been a long-standing problem.

Taking the process view as the starting point for the high-level model, acknowledging that terminologies and views around process will differ across the industry, we can use this as the reference point for assessing elements within claims and where have started to see some real innovation, which we'll show you later in the final chapter.

This enables us to capture a systematic view of the different parties involved in a claim and how they interact. Figure 5 below provides an outline of the potential parties involved in a Home or Motor insurance claim, together with context around their interactions and interests.

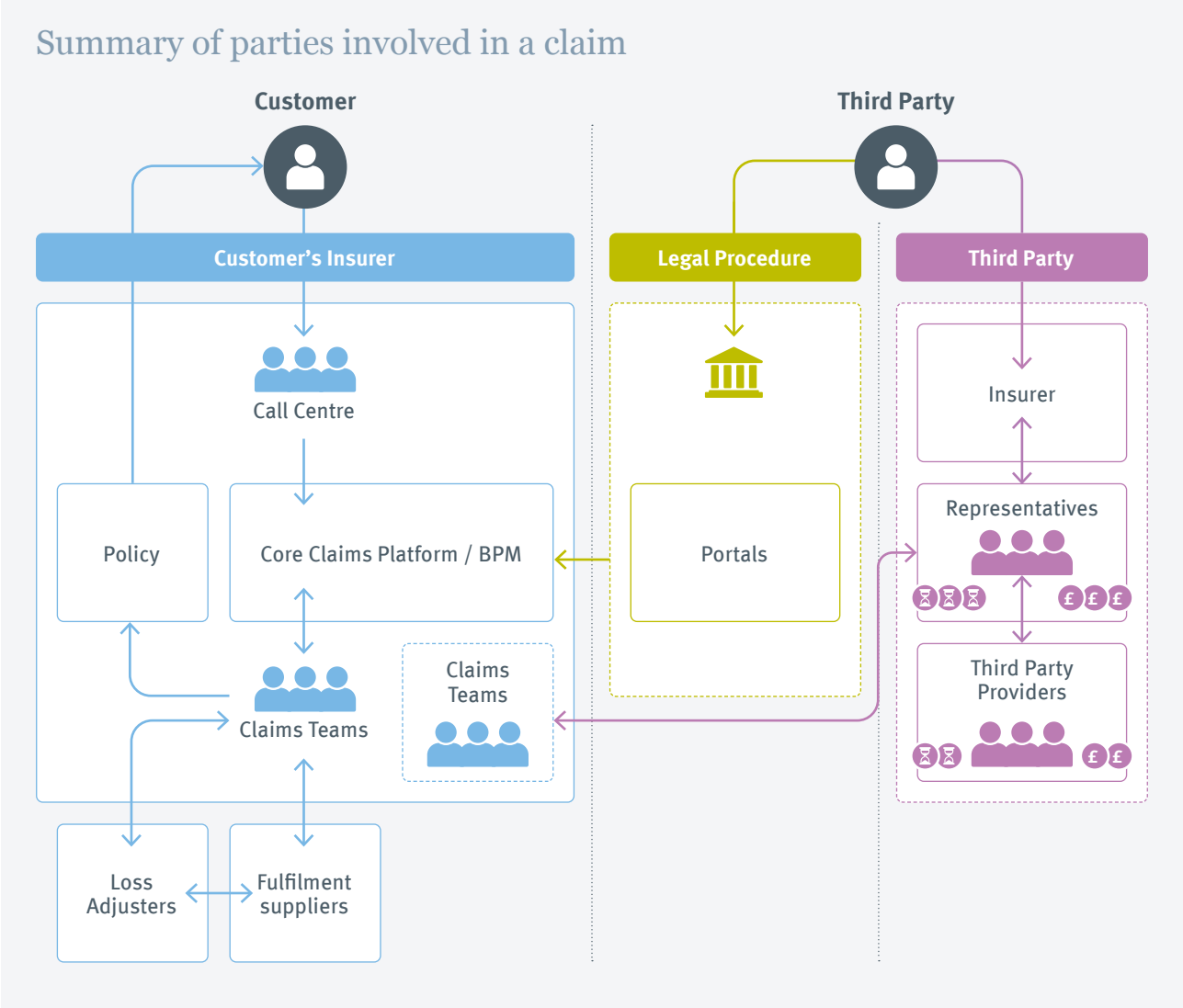


Figure 5: Diagram depicting the parties and interactions during a typical claim

Lifting the barriers to transformation

Chapter Summary

- One of the biggest issues facing insurers is claims inflation and the impact it is having on profitability for home and motor insurance.
- There is pressure on insurers to find new efficiencies, so that they can remain competitive in an environment where premiums are going up.
- At the same time, insurers are having to adjust to the new Consumer Duty regulations, introduced this year by the FCA, with claims being a key area of focus for the regulator.
- Insurers embarking on transformation programmes will need to ensure they really understand why delays and friction in the claims process are occurring, that they are looking at the whole value chain including suppliers, and that any technology changes are in fact making the process simpler.
- Legacy technology continues to be a significant challenge and barrier to change, but we have started to see the emergence and maturity of solutions that bridge the gap between the core platform and the customer experience the industry is working towards.
- The application of artificial intelligence is firmly on the agenda for boardroom discussions, with clear challenges in how this technology could and should be adopted, but also significant opportunities that are likely to take shape.
- Conversely, fraud remains an ever-present risk, and increased use of self-serve technology and AI can both counter and feed into the capabilities of fraudsters. Fraud management therefore needs to remain central to the transformation strategy.

Innovating while facing into claims inflation

Arguably the most pressing issue for insurers at this point in time is how to respond to the prolonged period of claims inflation we have seen in recent years. The table below sets out the combined operating ratios (COR) for motor and home insurers in recent years, alongside the key causes for the 2022 increase.

Line of business	2020 COR	2021 COR	2022 COR	2023 COR (predicted)	Headline reasons for 2022/23 increase
Motor	104%	93%	109.5%	108.5%	• Rising repair costs • Energy inflation adding to the cost of each repair • Parts and material costs • Second hand car values • Increasing labour costs • Prolonged vehicle rentals, due to increased time taken to repair
Home	110.5%	103%	116%	109%	• Shortages in labour, fuelling increasing labour costs • Increased costs of materials • Delays in sourcing materials • Increased costs for alternative accommodation due to delays

Figure 6: The impact of claims inflation on underwriting profitability. *Sources: Insurance Times, DataLab, EY*

Claims inflation has a direct and immediate impact on the bottom line and the simplest and most obvious way out of this is to increase prices, often triggering a hard market. While this may solve an insurer's short term profitability concerns, the problem is merely shifted towards the customer which starts to challenge the regulator's demand for good outcomes.

Insurers must act but they must do so by striking a fine balance between protecting their profitability and meeting the rapidly changing needs of today's customer, while managing the internal challenge of competing change activities, where budgets inevitably tighten.

This is no easy task as many of the factors outlined above are beyond the control of the claims manager. Nevertheless, there is an imperative for insurers to review existing claims operating models, including areas of indemnity spend which can be sharpened, such as fraud management, to reduce the overall cost of claims for the benefit of the customer.

However they choose to manage it, insurers are struggling to balance profitability with their customers' ability to absorb sharp price increases at a time when the cost of living crisis continues to bite at people's finances from almost every conceivable angle.

While insurers are not in control of the cause of this crisis, they are in control of their response to it. Price increases may solve a temporary problem, but all the signs indicate that much of the inflation we have witnessed over the last 18 months is now firmly embedded into the economy.

Claims costs are unlikely to decrease markedly in the medium term, placing the onus upon insurers to find better, more efficient and longer term solutions to a recurring problem. Technology of course plays a key role in this future but wholesale change across the entire claims operating model, more than anything else, will make the real difference for customer and insurer alike.

Getting on board with the Consumer Duty

As insurers scramble to meet changing customer demand, the regulator has been busy issuing guidance in an effort to drive better customer outcomes. As outlined in the previous chapter, the FCA has introduced various new regulations over the last decade or so with its latest, the Consumer Duty, billed by the regulator as a 'paradigm shift' in its expectations of insurers operating in retail markets.

However, our DigitalBar research[7] has shown that much of the digital investment and innovation in insurance to date has been focused on the distribution and sales side of the coin with claims being something of an afterthought for many. But the regulator's focus is clear – innovation and digitisation in the interests of efficiency and customer experience are to be encouraged, but this must be applied across the board, particularly when delivering on that crucial promise to pay.

To stay onside with the regulator's new demands, insurers need to look at their existing claims processes and consider where there is potential harm to customers, answering the questions below:

- Where are delays in claims processing occurring, what is their impact and why are they occurring?
- Are the digital developments being undertaken creating more, rather than less, confusion and complexity for customers?
- Are external suppliers and partners aligned with the claims philosophy and processes to ensure that every customer touchpoint meets the regulator's expectations?

> "As with much regulation, the language is designed to be interpreted and tailored by individual firms but in general terms, the regulator expects insurers to deliver a claims experience that is of the same standard and as easy to navigate and understand as the process for buying a policy is."
>
> **Kirsty Priddle,**
> Altus Consulting

The impact of inflation on the industry

One analysis of the motor market predicts that premiums will increase by 16%[8] (an average of £74 per policy) in 2023 and by a further 11% (£59 per policy) in the following year. The motor warranty market is also showing the impact of claims inflation with analysis by Intelligent Motoring[9] showing that the average cost of warranty claims had risen by 37% between July and December 2022 on the back of rocketing repair costs.

It's not all doom and gloom though with some insurers seemingly able to work their way through it. Admiral Insurance boasted a 4% increase in profits[10] at the halfway point of 2023 despite losing 380,000 customers on the back of price increases of up to 20%.

Elsewhere, Aviva grew its share of the general insurance market with more moderate price increases, with analysis suggesting that Aviva's quick pricing response to claims inflation has left them in a more stable position than some of its peers, but a favourable investment environment may have had a more telling impact[11].

[7] www.digital-bar.co.uk
[8] https://www.ey.com/en_uk/news/2023/06/ey-uk-motor-insurance-results-analysis
[9] https://www.intelligentmotoring.com/press/3Qzvh6ID37rgx8NztKhzIa
[10] https://www.bbc.co.uk/news/business-66521490
[11] https://www.insuranceage.co.uk/insurer/7953539/successful-together-aviva-ukgi-boss-winslow-vows-broker-support-amid-solid-2023-results

Lifting the barriers to transformation (cont.)

Paying lip service to claims management issues is unlikely to satisfy the regulator. In July 2023, the FCA ordered Direct Line, the UK's second largest private motor insurer, to review five years' worth of total loss claims following a review into how the market managed these settlements[12]. The regulator, it seems, has located its teeth and is keen to use them.

The good news is that recent developments such as the introduction of rules around the expected treatment of vulnerable customers and the management of customers in financial difficulty (now part of ICOBS), should, in theory, mean that insurers are already operating in the way the FCA expects.

> "The biggest challenge in meeting the Consumer Duty requirements will be around supply chain - metrics will need to be truly outcome focused, and aligned with both insurer and its service providers."
>
> **Jeremy Trott,**
> Claims Director, Ecclesiastical

However, in what is often a complex and potentially lengthy process, with different approaches and philosophies driving different customer experiences across the industry, it is likely that the regulator's view of what amounts to 'good customer outcomes' will evolve with time.

The key point insurers should be focused on is that the Consumer Duty is not a standard regulatory exercise. This is no "one and done" operation as the FCA is as concerned with *how* insurers do something as they are with *what* they do.

For many insurers, this will require a complete rethink of how they approach and manage claims and while many will understandably turn to technology for the answers, the real and lasting solution lies in understanding the processes used to create better customer outcomes and using technology as an enabler.

The limits of legacy tech.

Regulation is not the only pressing issue that insurers have to deal with. Any insurer that has been operating for at least the last 10-20 years, will be burdened with some degree of legacy technology. Awareness of the need to modify the tech landscape in claims is high with most insurers already embarking upon a 'digital transformation' of some kind or another.

While the language being used suggests a complete overhaul of how claims are managed, the reality is that most carriers are tinkering at the edges, focusing on the very front end by automating first notification of loss (FNOL), for example.

This has less to do with a lack of ambition and more to do with the restrictions of legacy systems that most are fighting with. The common approach across the industry is to develop a core claims platform as the system of record for claims and integrating it with the policy administration system and other key systems. Typically insurers partner with a third party technology provider to facilitate this while others have taken the plunge to build their own proprietary system.

Whatever approach has been taken, due to the core record-keeping requirements and basic needs for business process management, these systems will have been built to fit with an insurer's existing operating model and, as a result, have limited capabilities to support digital claims processes.

This starts to explain why most of the digital innovation seen to date in claims seldom gets beyond the foothills of what true digital transformation can deliver. Introducing new changes to the IT estate is undoubtedly a challenging undertaking, due to existing complexity, resilience, and potential risks around further change and few CEOs or CIOs wants to be the one who uses their tenure to focus on the wholesale digital transformation of the business - the lasting benefits will likely not be seen for years to come, long after the individual who drove the change has moved on.

The reality is that most of these systems will either need to be upgraded or replaced at some stage, but rather than seeing this as a burden to bear, it actually presents a rare opportunity to re-think the whole claims process and what it is the company wants its underpinning technology estate to do for the business and its customers.

[12] https://www.theguardian.com/money/2023/jul/01/direct-linecar-claims-underpayments-write-offs

> "There are broadly two approaches to digital transformation - you go greenfield with an adaptive core platform to deploy new brands, products, and services faster, and be willing to try, fail and learn fast, or you try and connect best-of-breed solutions to a legacy platform, but suffer slower innovation cycles and falling behind."
>
> **Mike Daly,**
> Growth & Development Executive, RightIndem

There is no denying, however, that this is a large-scale change, and with that comes a tendency to take the easier route by basing the requirements on existing functionality, rather than replacing and migrating across. This may answer the immediate questions of today but does little to take the business forward.

Any insurer hoping to make their claims experience a point of differentiation, needs to be thinking about how they can rationalise their estates and develop flexible models that enable them to introduce changes in functionality without major upgrades in the future.

The impact of AI

In the dash for digital transformation, many are looking to artificial intelligence (AI) to turbo boost their capabilities, automating lengthy administrative processes and increasing the ability for customers to self-serve and manage their claims.

But despite the acres of column inches dedicated to the use of AI in insurance, most insurers (and indeed financial services firms) have struggled to get a real handle on their own data, the vital raw ingredient of any AI system. This is due to the volumes of unstructured and often incomplete data and the complexity of their IT estates, as well as a lack of clear data management principles and governance in action.

The prospects of what AI can deliver are certainly encouraging and exciting, particularly the incorporation, where appropriate, of generative AI such as ChatGPT. There are risks around accuracy of responses, the potential for bias and data privacy, but the technology has considerable potential to transform customer-facing services, and whilst we are still at the early stages, this technology should not be ignored.

Before any insurer dives into the world of generative AI, they need to consider the ethical implications and inherent risks of using this type of technology:

- Are the outputs sufficiently accurate?
- Does it carry in-built biases?
- Does it limit the application of creative, human thought?

Decisions on AI must be made with a full understanding of risks and benefits as well as a technical understanding of how and where it could be applied to secure the greatest benefits for customers and, ultimately the business.

Fighting fraud in the future

Digital transformation in claims is not just limited to insurers, the world of insurance fraud is increasingly powered by the same digital tools and techniques insurers have at their disposal. Indeed, the introduction of self- serve process could well create new opportunities for fraudsters to exploit, and so fraud controls also need to be redesigned.

The industry has made great strides over the last 20 years in combatting fraud, coming together to share data and tactics to ensure that the actions of the criminal minority don't impact the experience of the honest majority.

As laudable as these efforts are, the pace of change in the world of fraud is as fast as anywhere else in the sector with insurers challenged with limited budgets and resources. Therefore, when insurers are considering transformation in the claims arena, it is essential that anti-fraud processes, technology and measures are baked into any digital or operational change.

A piecemeal approach to transformation, looking at one discreet area at a time, will ultimately lead to a piecemeal experience for customers and a fractured approach to identifying and tackling fraud. A longer term, strategic process-led view of the whole claims operation, and its transformation, is essential to ensure the security of the business, reducing leakage and ensuring that the experience of the honest majority is kept at the forefront of priorities.

> "Insurers cannot under-estimate the capabilities available to fraudsters, who are often one or more steps ahead in their use of emerging technology. Consequently, optimised fraud management processes and cutting edge technology should be central to a future claims operating model."
>
> **Mark McDonald,**
> Altus Consulting

Are we on track?

Chapter Summary

- When it comes to digital transformation, claims management is starting to catch up with the services provided for purchase and policy administration.
- The focus has been largely on developing an electronic first notification of loss (FNOL or eNOL) process.
- Whilst the "Insurtech" sector has been a hotbed of innovation over the last decade, it is more recently that we have started to see significant investment in claims-focused solutions and for a number of them to reach a level of maturity.
- With the availability of improved tools for data analytics and decision making, it is now possible for insurers to start digitising the end-to-end claims process.
- Insurers need to consider the whole value chain, starting from the proposition, through to the overall claims service and operating model, rather than tinkering with incremental changes (which are important, but should form part of continuous improvement).
- There is a risk to insurers that take a wait and see approach, that they find themselves behind the curve and as a result struggle to compete with those that developed more efficient operating models for claims.

Claims has historically been treated as a 'back office' function when it comes to transformation strategies and has, as a consequence, not received the attention it deserves. But there has in recent years been an emerging focus from the industry on bringing the transformation train to claims.

Varying levels of transformation across the sector

What claims transformation looks like varies considerably across the industry, with some insurers focusing on tactical cost efficiencies which can be gained through automating the non-customer facing activities while others are targeting the extended roll-out of self-service capabilities beyond FNOL.

One of the key drivers of change in this space has been the maturing insurtech landscape, which we look at in more depth from a technical perspective in Chapter 6. Historically, the focus has been on policy administration and distribution but the rush to develop new technology solutions to insurer problems has led to pockets of real innovation in claims emerging.

While technology vendors operating in the claims space have consistently represented a reasonable segment of the insurtech market, the majority of investment has been focused on those solutions in the sales and distribution area. Consequently, innovative claims solutions have been fairly low down the pecking order when it comes to external investment.

While this can't be viewed as the only metric of a successful start-up, it does correlate with the broader insurance industry view that when it comes to transformation, wholesale changes to claims processes, which as we all know are the most important moment in the insurance value chain, become more often than not, an afterthought.

Process thinking vs system thinking

Long term underinvestment in claims doesn't just have a direct impact on customers - it limits an insurer's ability to effect real, lasting change. Historically, change in claims has been incremental with the process broken down to its low-level component parts and opportunities to improve or digitise processes (and the business cases for them) also taking place at this level.

Of course, this process does lead to change – we see that happening across the market – and it does so in a way that doesn't break the bank. But any developments are necessarily limited in scope and, as a result, seldom result in true transformation.

If insurers can take a step back and pause among the constant activity in claims, they can ask themselves a crucial strategic question - what is it that the claims function, and the wider business, is trying to deliver?

Whatever answer they land upon, the claims proposition has to be a key element of the wider strategy and play a core role in any emerging propositions, such as parametric insurance (near-instant settlement triggered by an event), extensions to the indemnity principle, embedded insurance products and the avoidance of losses altogether.

If there are ambitions to design, improve and launch products that address real gaps in protection, a modern claims model, with data, insights and an understanding of customer needs at its heart, will play a crucial role in delivering this.

> "We may see the personal lines market start to fragment, with some sticking to the current model, those that recognise the need to adapt to meet changing customer expectations, and the emergence of new, digital first providers providing a genuine challenge to the incumbent players."
>
> **Jon Cawley,**
> Head of Claims Operations, NHS Resolution

> "The shape of tomorrow's market has yet to be drawn but those that take a strategic, all-encompassing approach to technology, will likely be the ones to emerge as the future market leaders."
>
> **Mark McDonald,**
> Altus Consulting

Late mover disadvantage

With the rising service expectations demanded by customers, the imperative for insurers to move to a claims model that is focused primarily on customer experience increases. As we will see in the next chapter, examples of claims transformation are emerging which will have a positive material impact on customer experience and operational efficiency in the long term.

However, as progress is made, the host of external and internal pressures bearing down on insurers could lead to some becoming more risk averse, restricting their progress or reducing the scope of planned changes in favour of securing short term benefits.

This instinct for conservatism within the industry is one of the key blockers to true transformation in claims. The danger is that such decision making will create a twin-track industry with the difference between those who are investing in transforming claims and those who are not, becoming clearer as the years progress and the financial results published.

For those who are reluctant to make wholesale changes to their claims process, it will become harder to close the gap. Those who are reaping the benefits of improved retention and expense ratios with the cost savings passed back through to premiums, will secure a distinct competitive advantage and emerge as the clear market leaders.

Engineering works – progress update

Chapter Summary

- Whilst real transformation in claims has been slow to take shape, we are now starting to see examples of major personal lines insurers taking a lead on claims innovation.
- esure has replaced its core platform with a modern, flexible solution that has enabled full-scale transformation across its claims function, with various third-party vendors integrating with the new platform.
- Zurich has integrated multiple technology solutions with its core platform to delivery AI-supported claims management across property and motor claims.
- Ageas has implemented AI image analysis in motor claims, enabling the automation and acceleration of the steps involved in assessing vehicle damage, estimating repair costs and making decisions as to whether a car should be repaired or replaced.
- Leading an industry-wide initiative, Flood Re has persuaded insurers to collaborate and go beyond the principle of indemnity under its "Build Back Better" scheme, under which home insurers will pay for the completion of flood resilience improvements in addition to repairing the property after a flood.

Despite the challenges identified in previous chapters, there are examples of insurers demonstrating a real focus on improving the claims process, and moving towards a model which more and more customers are going to expect in the near-term future.

Pockets of excellence

These range from an emphasis on an intuitive self-serve process, through to specific solutions which support accurate and immediate assessments of claims, and on towards a model which enables straight through processing for low cost, low complexity claims.

What these developments demonstrate is that while there are different areas and levels of focus in each example, there is a genuine sense that insurers are moving towards a more optimised model for claims management, or at the very least, exploring the opportunities available.

esure

As highlighted earlier, one of the main drags on transformation is the fact that many insurers still operate on legacy platforms. esure, one of the largest private motor insurers in the UK, partnered with EIS, a cloud platform provider, to migrate its policy and claims systems to a new core platform.

esure has taken the opportunity of this digital overhaul to undertake a full transformation of it's claims processes and is building what it describes as a highly configurable platform with strong integration capabilities, supporting further digital development.

While EIS is the core platform, esure has engaged with a range of technology suppliers to a deliver a full self-serve and digitised claims process which has resulted in between 30-50% of customers using their eFNOL process – a headline number that will clearly be having a positive impact on the underlying operating costs.

However, it is crucial to understand that while technology was an enabler in this transformation, the business will also have needed to undergo significant changes in the operating model, how people work and the knowledge management in the business to ensure the full benefits of the technology are realised.

Zurich

Zurich has been through an extensive period of claims transformation, starting with an upgrade to its core platform, which provided the integration capabilities for its wider roadmap. A key part of this transformation has been the implementation of Sprout.ai, a solution which utilises AI to automate or augment the claims handling process.

Zurich ran a pilot with Sprout in early 2021, targeting property claims, using AI decisions based on the machine learning outputs of 20,000 historical claims. Through this pilot, Zurich was able to identify some significant benefits early on, including:

- A reduction in property claims handling times to below 24 hours
- Achievement of 98% accuracy in claims handling recommendations even though decisions were ultimately made by a human handler
- For claims that were within scope of the pilot, Zurich was able to settle 50% through an automated, straight-through process
- The success of this pilot has led to the approach being rolled out to non-property claims

As we have argued, a true transformation requires more than the application of one tool to one part of the process. Beyond the engagement with Sprout, Zurich has established further partnerships, implementing tools including AIS's BAIL solution, enabling faster decision making through the of AI analysis on motor liability scenarios, increased the use of drones to assess property damage, and developed a strong multi-channel approach which includes text and social media communication, webchat and chatbot capabilities. To do this, however, Zurich has had to engage with a number of partners, building an ecosystem where they are all playing their part in bringing a wider strategy to life.

Looking beyond the technological innovation, Zurich has also focused heavily on the use of green parts as part of the motor supply chain , supporting its sustainability objectives while also mitigating some of the existing challenges around the availability of parts[13].

Ageas

There has been a huge amount of debate about where, how and why AI should be used in insurance, but Ageas has been a relatively early adopter of AI image analysis[14], using it to streamline its motor damage claims process.

The tool, which started trials in 2019 and went fully live in 2020, identifies which parts of the vehicle have been affected and to what extent, generating a full estimate including recommended repair, paint, and blend operations, as well as costs and labour hours.

Ageas has stated that the use of AI has:

- Significantly accelerated claims resolution times, with each stage of the process accelerated
- Reduced the number of interactions necessary to collect data from the customer
- Created a process that gives the customer a greater sense of control over their claim

All of which will have significantly reduced the cost of operating their claims process, but tellingly, when the introduction of the tool was announced, the stated motivation for its implementation was to improve the customer experience rather than to reduce costs.

[13] https://www.zurich.co.uk/news-and-insight/zurich-slashes-property-claims-resolution-times-with-industry-first-ai-solution
[14] https://tractable.ai/en/resources/ageas-is-first-uk-insurer-to-use-ai-to-create-end-to-end-car-damage-assessments-and-estimates

Engineering works – progress update (cont.)

FloodRe - "Build Back Better"

While the smart use of technology usually grabs the headlines, not every innovation is dependent upon it to create change.

A recent collaboration between Flood Re (a not-for-profit, levy-backed reinsurer of flood damage in the UK) and the wider industry called Build Back Better[15], has shown that a shift in mindset and approach can have just as significant an impact as any AI tool. This is a fundamental change to how insurers handle a claim, as the principle of indemnity is to put the policyholder back in the position they were before the flood, rather than make improvements to mitigate against a future loss.

A significant number of the country's insurers have joined the initiative, agreeing to pay additional costs of up to £10,000 to implement flood resilient property improvements as part of their property repairs following a flood claim.

These improvements are relatively simple things like raising the level of electrical wall sockets, installing non-return valves and flood-resistant doors and using alternatives to wooden flooring, such as concrete and porcelain tiles.

The real innovation here is in the industry's ability to ignore established practices by looking beyond its annual renewal cycle and taking a collaborative approach to reducing the perennial problem of how to protect thousands of UK properties at severe and repeated risk of flood.

It is a good example of insurers adapting their propositions and their approach to act at the claim stage to improve the resilience of the customer's property while simultaneously reducing the flood exposure across the country, one claim at a time.

More than that, this approach supports the objective of Flood Re fully transferring the flood risk back to the market by 2039 through securing a real and practical reduction in the underlying flood risk.

"By definition, it's madness to reinstate flood damaged property with the same vulnerabilities as before. This initiative supports best practice and reduces the impact of subsequent events for homeowners."

Andy Bord,
CEO, Flood Re

"This collaboration to improve the underlying risk for everyone could be extended more broadly by taking a global view of risk, rather than an individual one, and introducing measures to improve the sustainability and carbon footprint of properties to mitigate the growth in climate related risks."

Mark McDonald,
Altus Consulting

[15] https://www.floodre.co.uk/buildbackbetter/

Upgrading the line and service improvement

Chapter Summary

- Altus Consulting tracks over 100 claims technology solution providers in its knowledge base.
- The early stages of the claims lifecycle has seen the greatest share of technology innovation, reflecting the industry's early focus on delivering digital loss notification and data upload capabilities.
- In this chapter we have highlighted 8 claims technology solutions that are providing innovation into the industry at various stages in the value chain.

Over the last decade, there has been a proliferation of technological innovation in the insurance sector, with countless new software solutions emerging.

In the early iterations of 'insurtech', the solutions coming to market were broadly driven by opportunities to enable the creation and speedy launch of new products, and to improve distribution and growth for insurers, but with limited focus on claims.

This has changed in the last five or so years, and we are starting to see some of the claims-focussed solutions reach a level of maturity. This is, however, still a revolution in its infancy. There is some way to go for the latest offerings to deliver widescale transformation in claims, particularly when looking at claims with elements of complexity and third-party suppliers involved.

In this section, we set out the high-level output of our review of over 100 claims-focused technology vendors, and identify some examples of innovation which we believe will help pave the way for new, optimised operating models in claims.

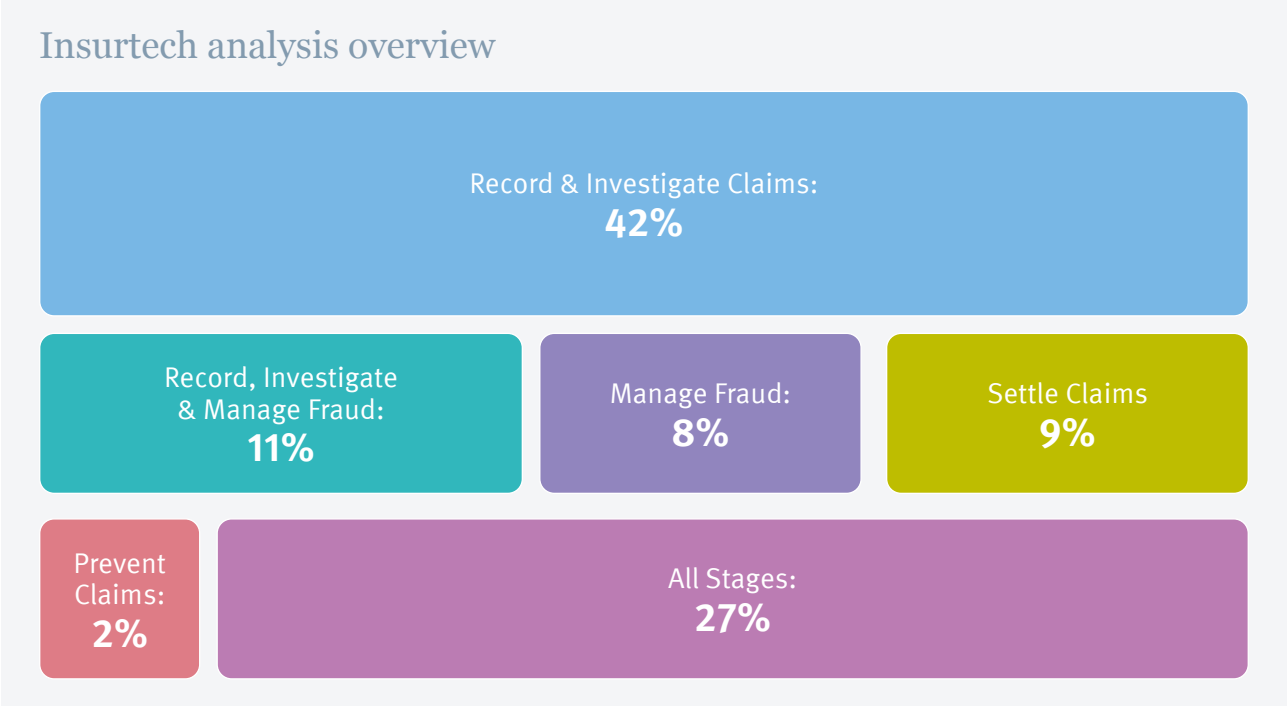


Figure 7: Insurtech analysis overview

Upgrading the line and service improvement (cont.)

Claim Technology

What does it do? Claim Technology provide an API Marketplace that enables insurers to use cloud-based apps and services as a wrapper on top of their legacy systems. Provides a combination of proprietary and third-party digital self-service capabilities including a customer/supplier portal.

Impact: By starting with a focus on the problem areas for claims, Claim Technology has developed an integration solution, supported by a comprehensive tech marketplace, that is well place to support a range of transformation strategies through its ecosystem of innovative solutions.

Prevention | **Notification** | **Investigation** | **Claim Settlement** | Fraud

FRISS

What does it do? An AI solution carrying out analysis of claims data to provide a fraud risk score for all customers making a claim, with detailed rationale and recommended next steps. Network analysis at the point of query, ensuring fraud risk and highlighted issues reflect the real-time position.

Impact: As insurers move towards greater use of self-serve, with reduced active involvement from claims handlers, this increases the scope for organised and opportunistic fraudsters to try to game the system.

FRISS's suite of solutions bring fraud controls that are robust and up-to-date, identifying new behaviours through large-scale pattern analysis that this possible using AI. For the customer, less false positives means a faster claims process.

Prevention | Notification | Investigation | Claim Settlement | **Fraud**

Ondo Leakbot

What does it do? Device and system that provides early detection of water leaks and notification via a mobile app with the aim of reducing escape of water claims, and minimising the impact of them.

Impact: Whilst the Leakbot (and similar) technology has been around for some time, increased take-up and affordability should make it a more attractive proposition to insurers and home-owners.

The benefits of this are reduced claims frequency and severity for water damage, alongside removal of the stress this causes to customers, and a positive environmental impact in reducing water waste.

Prevention | Notification | Investigation | Claim Settlement | Fraud

RightIndem

What does it do? RightIndem have designed a solution has to make the FNOL process as straightforward as possible for customers. Claims can be raised through the customer's chosen channel, including conversational UI, and the platform has been integrated with a range of third-party solutions to enable straight through processing (STP).

Impact: The solution has been developed to capture and contextualise a wide range of claims data from the point of loss notification. This approach supports the accurate classification of claims and therefore the assignment to the right claims-handlers, suppliers, or to an automated settlement route.

Prevention | **Notification** | **Investigation** | Claim Settlement | Fraud

SHIFT

What does it do? Modular solutions covering: fraud detection and risk assessment, AI-supported loss notification and data capture, automated document analysis and decision engine, and recovery opportunity identification.

Impact: SHIFT's solutions are maturing, with multiple major insurers globally and the UK's Insurance Fraud Bureau (IFB) as clients. Its application of AI and machine learning to large insurer and external datasets has applicability to the wider claims value chain, and can be an enabler for claims automation and augmentation.

Sprout.AI

What does it do? Sprout utilises AI analytics capabilities to interpret and understand unstructured data submitted by a customer, and large language models (LLM) to interrogate data and provide a human-like response. It can be used to guide handlers on next steps or to deliver fully automated claims.

Impact: Similar in terms of impact to SHIFT, this solution removes much of the heavy lifting involved in analysis and categorising of claims, assessing coverage, estimating loss and determining settlement decisions.

Tractable

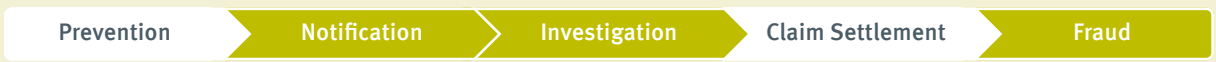
What does it do? The Tractable solution applies AI visual analysis to provide accurate assessments of vehicle and property damage, and to support automated estimates for repair.

Impact: Whilst the biggest strides have been made in motor, there is significant potential to reduce labour-intensive damage assessment activity across product lines. For motor, Tractable has made a significant impact with its clients, as identified in the Ageas case study in Chapter 5.

Verisk suite

What does it do? Verisk has developed a range of solutions, in part through its acquisitive strategy. These include a customer portal (ClaimXperience), AI vehicle damage analysis (IVI), quantum assessment tools (Xactimate, COA), liability scenario modelling (BAIL) and fraud analytics (FraudStar).

Impact: Through a combination of its more cutting-edge solutions and experience of delivering software at scale in the UK, Verisk has the capacity to support insurers transformative strategies for claims with its range of solutions.



Driverless claims or AI augmentation?

Chapter Summary

- Automation and Artificial Intelligence (AI) do not mean the same thing. Automation involves the replacement of a manual task with robotic process, whereas AI ranges from targeted analytics tools built with machine learning capabilities (narrow AI) through to the as-yet unachieved creation of human-like intelligence (general AI).
- The emergence of generative AI, which utilises stochastic models to combined disparate information and provide human-like responses, has over the last year invoked significant hype and a rush to find applications across sectors.
- Generative AI has powerful natural language processing (NLP) capabilities, which could revolutionise how insurers manage some of their customer interactions, but this will require robust management of the underlying data and clear data governance for any application with customer data.
- Insurers can apply narrow AI solutions (third party or proprietary) to improve the accuracy and efficiency of analytical tasks involved in the claims process.
- Ultimately, the application of narrow AI solutions can be used to fully automate the claims process, where there is an appetite to do so.
- Generative AI carries different risks, but the opportunities to innovate are much wider. As confidence and understanding in this technology develops, insurers can start to think beyond the process view of the world and look at how AI could enhance their approach to claims strategy and management at all levels.

In recent years, and particularly in the last 12 months, there has been an explosion of interest in AI. Where once it was the preserve of futuristic storytelling, its current and potential benefits are now being discussed seriously in a range of academic studies, in news articles and across social media channels.

The emergence of generative AI and large language models (LLM) have made many commentators and board rooms sit up and take notice. The emergence of generative AI and large language models (LLM) have made many commentators and board rooms sit up and take notice. Currently, when discussing "Generative AI" we are referring to a "stochastic parrot", i.e. a tool which uses combined, disparate information to provide sophisticated responses in text, images, video and audio formats. AI has moved from the realms of science fiction into our everyday experiences and businesses of all shapes and sizes are rushing to understand how to harness its emerging but undeniable potential.

In the insurance sector, the ability of generative AI to respond quickly to queries with detailed, human-like answers in tandem with its powerful capabilities to ingest and 'understand' data, could enable insurers to develop new ways of solving problems internally and generating actionable, near-instant answers for customers.

However, as the various debates about AI indicate, there are real risks in applying this technology, even within a narrow scope. The answers it finds are not always right, and there is a tendency to 'hallucinate' parts of a response – in other words, it is not clear where the information it has delivered came from. This is due to bad data and while the insurance sector has oceans of data, much of it is fragmented, incomplete and inaccessible across the various legacy IT platforms being used.

Fundamentally, the application of AI is only as good as the data it is using, and the quality of data currently is unlikely to be at the necessary level to support LLM-led processing, beyond understanding the basic query, a task this technology admittedly does exceptionally well.

Existing, under-utilised AI capabilities.

While much of the discussion on AI is located firmly in the future, there are existing AI capabilities that can be utilised to create a marked and immediate improvement to a customer's claims experience.

The areas where insurers have delivered the greatest innovation is in using tools derived from the narrow AI space. Much of the functionality these tools provide to insurers are built on increasingly intuitive cloud-based services provided by the likes of Amazon Web Services, Google Cloud Platform and Microsoft Azure, and are therefore relatively easy to access and implement.

By becoming specialists in the application of these more targeted AI components, some of the claims technology providers identified in the previous chapter, and others like them, have developed propositions that can really enhance an insurer's approach to a claim, particularly when it comes to analysis and decision making. The key is to view these providers (and the technology they supply) with a collaborative, creative mindset and look at how the capabilities they provide could be the enablers for a re-engineered claims model.

As highlighted above, the key dependency for all of these solutions, and the application of AI more broadly, is the quality of the data it uses. This will include the insurer's own data but is also likely to incorporate external sources as part of 'data enrichment' processes. In simple terms, this removes the need to ask the customer or another party a host of questions as the information has already been gathered by the tech from other sources.

While this level of AI has resulted in meaningful change to some parts of some claims processes, to move beyond this 'isolationist' approach towards a more global digital strategy, there must be a plan to implement a robust, secure approach to data management and governance.

An updated approach to data management will need to be backwards-looking, to impose new structures on historical data (upon which any AI tool will be heavily reliant), whilst at the same time aligning it to improved processes and systems for effective data capture and processing.

The emergence of Generative AI.

While AI is used as a catch-all term, not all intelligence is created equal. It can be broken down into the following categories:

- **Automation** – while still relatively new, these tools will more often than not have a minimal or no use of AI. For insurers, it usually refers to the use of robotic process automation (RPA) to replace a human-managed task with a computer 'bot' process. The time and cost benefits of automation are well established as it strips out manual, repetitive tasks but customers are unlikely to see significant improvements beyond quicker response times.
- **Narrow AI** – this refers to the use of AI-powered tools in specific tasks that form part of a wider process. This includes the use of natural language processing, sentiment analysis and computer vision analysis. As we have seen in the last two chapters, most of the AI solutions and initiatives that are being deployed or marketed to the insurance industry fall into this category.
- **General AI** – while not yet a reality, this type of AI refers to a universal model with human-like intelligence. Whilst this does not yet exist, the recent advances linked to ChatGPT, Google Bard et al indicate a leap forward, and partial progress from narrow to general AI.

Driverless claims or AI augmentation? (cont.)

Ways in which we expect AI to transform the future operating model for claims.

Predictions of how AI will influence our lives in the future range from the everyday (powering chatbots) to the apocalyptic (the extinction of humanity). But the reality is the application of AI in the claims process is likely to be a much more mundane, but no less disruptive, affair.

At its most advanced, AI could be used to fully automate customer interactions in lower level, 'simple' claims – everything from notifying the loss and applying policy conditions to quantifying the losses and triggering the settlement of the claim.

With the work controlled and administered through an AI-powered 'decision engine', this could all take place with a single conversation between insured and the insurer and although it is likely to be limited to straightforward claims, this kind of process starts to deliver on those customer service demands.

While AI promises to carve out a role across the claims landscape, for more complex claims and for cases which really require human interaction and empathy with the customer, there will always be a need for the human touch.

But beyond automating processes, AI can also be an enabler for new propositions, such as those which incorporate IoT devices like telematics and smart home apps, with the insurer becoming the proactive partner when engaging with customers following a loss.

As understanding of this technology improves, we may see increased insurer engagement with the technology vendors that are already operating in the 'narrow AI' space, or alternatively trying to build solutions themselves. Similarly, the larger scale claims and policy admin platform vendors that have typically stuck to the same broad structures and functionality, may find themselves needing to incorporate AI into their planning and their systems as well as looking at how AI tools could and probably should become part of their core propositions.

Some may be looking at this in a similar way to the last wave of robotic process automation when the focus was on how to automate processes across operations, with the goal of reducing costs. While this is an understandable motivation, it ignores the bigger prize up for grabs – transforming the claims experience to generate trust and loyalty from the customer base.

This suggests a general lack of innovation, but this isn't surprising given how new this technology is. There is a risk, however, that we are missing the point with artificial intelligence and its potential to transform.

> "It will not be the solution to every problem, but perhaps AI can be applied to help insurers understand the problems they haven't yet discovered, read trends before the human claims handler has started their analysis, and act as another intelligent deputy to the claims manager or claims director that wants to be on the front foot with the strategic management of the claims function. "
>
> **Sarah Bateman,**
> Head of Data and AI, Altus Consulting.

If a generative AI solution could be applied to data across an insurer's systems, its MI sources, and gather intelligence from the outside world, it could be given a wider remit to analyse, problem-solve, and create proposals based on the organisation's strategic aims and objectives. This may well sit further down the roadmap, but moving from a narrow to a more general application of AI could be the game-changer for an insurer and its customers.

On the branch line – the TPA perspective

Chapter Summary

- The current model for many insurers involves the delegation of claims management to third party administrators (TPAs).
- As insurers look to innovate, TPAs may end up in a position where they are competing with the in-sourcing of claims.
- TPAs will need to keep pace with innovation to ensure they are providing a service which meets their insurer clients' visions of claims management.
- Both large-scale and emerging TPAs have started to develop their own technology propositions, either as part of their core services or as more modular software services alongside outsourced claims management.
- To become the long-term transformation partners for insurers, TPAs therefore need to be focussing on innovations in the claims sector, and develop propositions that are flexible and modular to meet the needs of their insurer clients.

Delivering true transformation would be a lot easier if insurers controlled every aspect of the claims service. But of course, they don't. The claims handling process is fragmented with most insurers using a combination of third party administrators (TPAs), brokers, loss adjusters and technology vendors to help facilitate the delivery of their customer promise.

Innovation in the TPA / Loss Adjuster sector.

Some insurers do manage their claims entirely in-house, but this is the exception rather than the rule. The vast majority outsource various aspects of their claims service, be that engaging a third-party administrator (TPA) or loss adjuster to manage claims for niche products and add-ons, or outsourcing the management of claims for entire lines of business.

In recent years, there has been a trend towards broker-focused insurers encouraging greater engagement from intermediaries, while the larger loss adjusters and defendant law firms will also act as TPAs for a range of claim types.

The motivations for outsourcing the most important service element in insurance range from a desire for scalability in a growing business and entry into a new market to the most common motivation for outsourcing, cost saving. Whatever the motivation, these partners will play a crucial role in whether or not an insurer can secure real and lasting transformation in their business. Third parties managing claims on behalf of insurers will need to adapt at the same pace and in the same direction as their multiple clients, which is no easy task, but there are some clear examples of innovation in the sector, with some of the major loss adjuster and TPA firms are starting to offer their own technology solutions.

Davies, for example, provides a digital portal and claims tracking tool, remote adjusting services as well as the use of speech analytics and AI to identify fraud or potentially vulnerable customers. This is just one example, but the emerging solutions are inextricably tied to the claims service and demonstrate a capability to align with an insurer's strategic ambitions.

Looking beyond the major TPAs, there are models emerging which combine outsourced claims services with new software propositions, such as Coplus with its Cobalt solution and Claims Consortium Group and its Synergy platform delivering process management, claims tracking and weather data integration as part of its services.

On the branch line – the TPA perspective (cont.)

There are also new models starting to emerge in the world of loss assessors. Typically operating in property claims, these are third parties that act for a policyholder in assessing and negotiating a claim with their own insurance company.

Extending this approach to motor claims, The AA launched the Accident Assist proposition in 2021 – under their breakdown cover. AA customers can seek support from the AA to manage interactions with their motor insurer, should they need to make a claim following an accident. This does enable the AA to bring vehicle repair activities into its own repair network, and this model potentially brings its own cost challenges for insurers who are losing some control of the process.

The question insurers and TPAs need to ask is, why would customers prefer to be represented by a third party when navigating the motor claims process, and what can be done to improve the customer's trust that engaging directly will be easy and will achieve the best result?

Can TPAs become transformation partners for insurers?

Historically, the main benefit and motivation for using TPAs has been to deliver cost savings, but insurers who continue to view their claims partners in this narrow fashion are ignoring the strategic benefits that can be secured when real integration happens with TPAs.

As we have seen, TPAs are starting to digitise and modernise their services in line with their insurer partners and this has to be encouraged. But this alignment must go beyond digital – all parties must be aligned with the claims philosophy the insurer is pursuing, as outlined in chapter 2.

True and lasting transformation in claims is dependent upon TPAs having the ability to align their operations with their insurer partners while adopting the same culture of improvement. This requires a degree of integration between the parties, a critical eye on what the key measures of success should be, and surfacing management information transparently.

At first glance, this may seem like a significant and tricky leap for insurers to make but the level of integration required with TPAs is no different to that already secured with the various software houses that serve the sector.

And as with the application of IT, each insurer will have its own ambitions and requirements when it comes to designing and delivering a new claims process, placing a responsibility on TPAs to create solutions that have the flexibility to fit in with multiple individual insurer requirements.

No two insurers manage their claims in the same way, so a one size fits all approach to supporting claims won't work. TPAs therefore need to continue on their journey of becoming part human service, part technology provider and develop from that, propositions which are truly modular.

> "A key challenge for insurers outsourcing claims to TPAs, is that they are reliant on the TPA's digital roadmap, and are therefore less well positioned to transform existing claims processes."
>
> **Michael Lewis,**
> CEO, Claim Technology

Reaching our destination – defining the model

Chapter Summary

- When embarking on a claims transformation programme, insurers must first ensure there is a detailed understanding of the current state and the target operating model, defined in accordance with corporate objectives, alongside clarity of vision and a sustained focus on delivery.
- Target operating model (TOM) design is about more than just IT, as it encompasses factors relating to people, process and technology.
- In this section, we include a diagram of a high-level operating model for claims, and highlight key areas of change which can enable optimisation of customer service and internal operations.
- The supply chain is fundamental to the fulfilment of claims. By designing an architecture which brings suppliers close to the mechanics of the insurer, communication, control and transparency can be improved for all parties, in particular the customer.
- The customer experience, from the point of quote through to claim notification, claim settlement and renewal is absolutely key. Maintaining a focus on both the high level process and the individual interactions between customer and insurer, will enable the insurer to design a new model which delivers a better service to its customers benefiting from the improved efficiencies (and customer retention) that follow from these changes.

When it comes to claims transformation, there are two crucial steps to be taken before any of the building work can start – a common understanding of the current state of claims management from end-to-end, and an agreement of the business objectives.

Key considerations for a new model – Process, People and Technology

The first priority is to make sure there is a common understanding and documented view of the current state of the claims process for all parts of the function that are in scope. This stage isn't about what the claims process should look like - simply what does it look like today.

In tandem, it is necessary to agree upon the rationale for change and the key objectives. It is critical that customer outcomes are at the forefront of the new vision, to reduce the risk that changes with a real customer benefit are delayed or de-scoped due to competing priorities. Change is difficult, particularly in a technically complex area like claims, and requires a clear vision, commitment, and focused effort to deliver.

As outlined above, one of the key errors made in the past is to assume that technology will provide the answers to the problems and ambitions identified. In our experience, technology is rarely the whole solution.

It is important to look at the process 'as is', at both a low level, with a full understanding of all touchpoints and their cumulative impact, and at the highest possible level, the start- and the end-point between the customer and the insurer for an end-to-end claim. This allows the insurer to understand how to design the claims processes that underpin the Target Operating Model (TOM), utilising the right combination of its existing tools, new product offerings and innovative technology, including AI solutions where there is a clear benefit. Once the internal capabilities of the TOM are better understood, insurers can make clear-headed decisions on the extent to which claims are managed in-house or with support from third party administrators (TPAs).

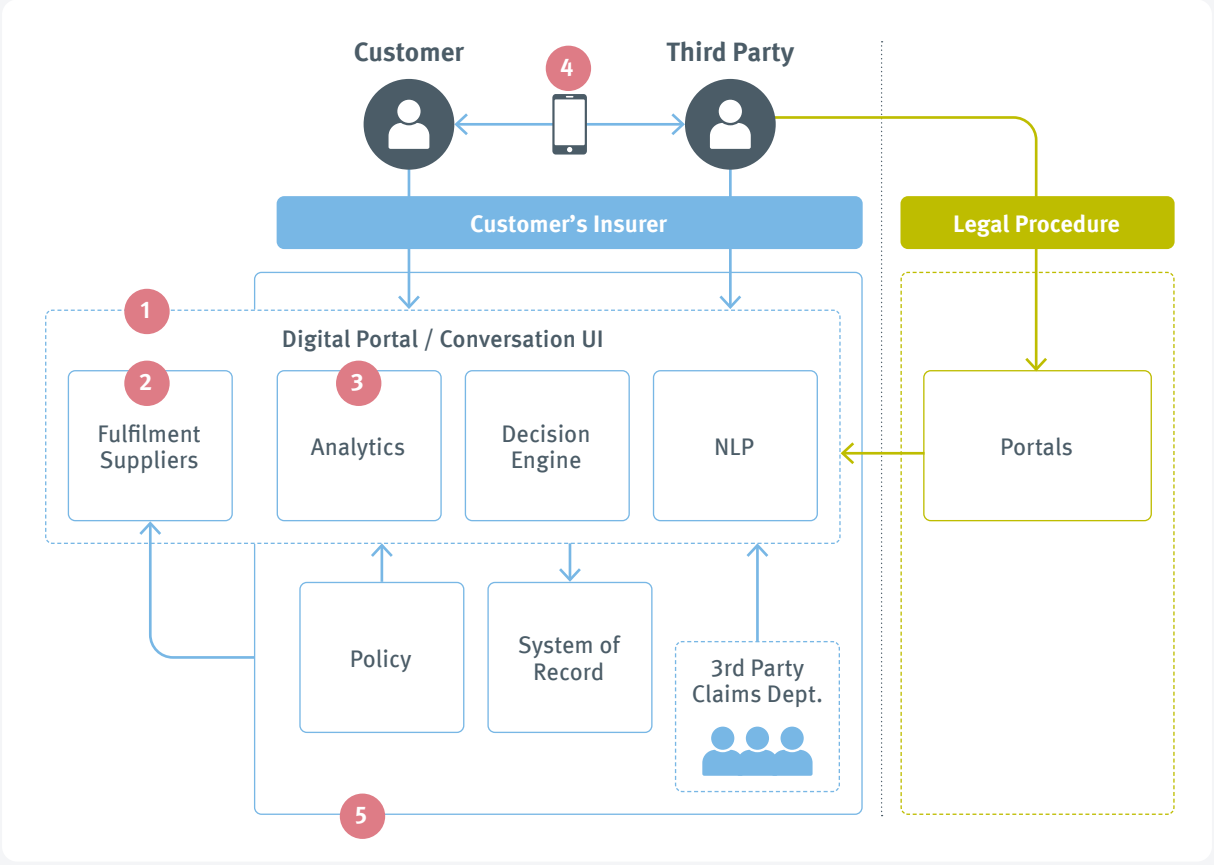
Ultimately, the future state needs to be underpinned by both strong technical knowledge to ensure claims are managed correctly and an MI and oversight model that enables the insurer to continuously improve and adapt to changes in the external environment. These may be supported by solutions with AI elements, but they will ultimately need human experts to assess and make the right decisions.

Collapsing the touchpoints

Claims processes are often quite convoluted, with multiple parties involved within the insurer and across third party suppliers, and multiple touchpoints between each of these and the customer.

This can lead to customer friction, increased effort by customers to reach a conclusion, inefficiency and challenges in maintaining full visibility and control of claims management.

There will not be a one-size-fits-all approach to claims, even within a single product line, but there are key elements which will shape an optimised model.



1 DIGITAL LAYER

Pending a significant change in approach from the main claims platform providers, there is a strong case for developing a "digital" layer which sits above this.

Benefits: enable self-serve processes for customers, with full visibility and transparency of the claim; bring systems and parties outside core platform into the insurer's environment.

2 SUPPLIER INTEGRATION

Bringing suppliers into closer alignment with insurer systems will make it easier to oversee and manage claims that have supplier elements in real time, rather than after the event.

Benefits: Enable capacity / expertise based supplier allocation; empower customer to engage supplier through insurer system; removal of friction / layers of authority.

3 ANALYTICS

To be able to both assimilate data in various structured and unstructured formats into this system, and to communicate / convey data back to multiple parties, a strong emphasis on data analytics is needed, utilising third party or proprietary solutions. Similarly, NLP is a use case for large language models (LLMs) which fits into this structure, by enabling interactions with customers and suppliers that appear human.

Benefits: More efficient operating model; faster, more accurate customer responses; removal of repetitive, manual activity; improved identification of outliers (fraud, customer vulnerability).

4 EFFECTIVE THIRD PARTY INTERVENTION (TPI)

3rd party captured early and brought into insurer claims ecosystem (primarily in motor). Where successful, this removes the involvement (beyond TP notification) of the 3rd party insurer and the potential for inflation through credit hire and credit repair.

Benefits: Reduced cost and delays associated with credit hire, repair and injury claims; crucially, an opportunity to make a positive impact on the third-party claimant (a potential future customer and advocate in a dynamic, competitive environment).

5 OPERATING MODEL

There needs to be a strong coherence to this operating model, incorporating systems, process and people, to avoid replicating the existing issues around multiple, interlinked systems which can become out of date.

Figure 8: Key considerations for an optimised claims model

A new approach to the claims supply chain.

Claims suppliers play a key role in the insurer's fulfilment of the promise to put the customer back in the position they were in before the loss. Their service is as important as that of the insurer, but this supply chain is often complex, with multiple preferred suppliers recruited to provide replacement items, provide repair services or to oversee and manage this activity.

Loss adjusters play a key role in property claims, providing the expertise to assess damage, the scale and the likely works needed to reinstate a property and as discussed in the previous chapter, they will often manage claims above a certain threshold under delegated authority. Similarly, there may be third party suppliers who are responsible for the project management side of construction, with either the insurer or the loss adjuster engaged to approve works.

This approach is likely to work for a proportion of claims, but the question insurers need to ask themselves is whether the overall model is optimised, both for the customer and from an efficiency and profitability perspective.

Can the structure be flattened, such that the end-contractors engaged to carry out the repairs can obtain approval through an insurer-managed mechanism? This may require different contractors, and potentially additional in-house expertise, but it would also be a route to removing potential areas of friction.

For insurers who choose to make self-serve central to a new model, opening up the insurer platform to all suppliers will help to provide the customer with a greater sense of control in the process. For example, they could see and potentially decide when works are scheduled to take place, by whom and when they are expected to finish.

This approach not only removes friction by reducing the number of update requests from customers, suppliers and the insurer, it gives the claims function a new level of visibility, allowing each party to proactively step in, when necessary, to ensure the claim is managed and delivered in the optimal way for the customer.

Perhaps more than technology and process, this vision of claims requires insurers to take a significant step outside of their comfort zone, allowing suppliers and customers alike, to access the deepest recesses of the claims process. But if they can do that in a way that works for all parties, significant rewards are there for the taking.

> "When you look at the current model for home claims, there are some fundamental challenges. Builders really need to be integrated into insurers' processes, because delays in communication and payments can leader to disaffected suppliers and ultimately more friction and stress for customers."
>
> Head of home claims, personal lines insurer

Reaching our destination – defining the model (cont.)

Make the customer the focal point

Whatever this new model looks like and regardless of what changes are necessary for its delivery, it is vital that the customer experience plays a starring role. The loss and accompanying claim is a customer problem, not an insurer one, and the onus is upon the insurer to provide the solution in a way that best meets the customer's needs.

It is not controversial to say that insurers have largely, to date, seen claims as a problem to be managed, specifically in terms of the loss ratios and profitability of their businesses. But for any insurer that wishes to continue to compete in the modern insurance market, the mindset has to shift towards seeing the management and payment of claims as the most important aspect of the relationship under the policy.

To design such a model effectively, insurers have to look at the claims process from the customer's perspective and understand how the customer really wants to interact with their insurer at all points throughout the claim, for different types of claims and when the process, for whatever reason, doesn't follow the predicted path.

By giving more control to the customer through self-serve claims management, insurers can finally deliver real transparency at each stage of the claim and proactively manage expectations throughout. While technology plays the key role in delivering this outcome, it cannot operate effectively in isolation. Technology must be the enabler, supporting and supported by well-designed, human-driven and led processes.

Ultimately, the insurer needs to introduce measures that have the dual benefits of improving the customer experience and improving the overall operational efficiency of the claims function. Taking this a step further, in a truly customer-centric claims model, insurers should be giving their customers (and third-party claimants) reasons to continue to do business with them, whilst also generating savings which can be used to invest further in the service, making their approach to claims a genuinely attractive proposition for new customers. It is first and last about service and customer experience.

Destination for Claims

This may feel like a very different approach to the claims process, one that may seem like a utopia rather than a reality, but insurers are starting to make these changes, moving in the direction of a more optimised model, some at a greater pace than others.

> "It is those that move now, with the right customer focus, that will be able to satisfy the expectations of increasingly tech-savvy customers, whilst growing and maintaining a customer base that ensures the sustainability of the business."
>
> **Patrick Hayward,**
> Altus Consulting

Contributors

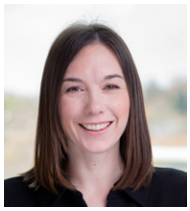
Author:

Patrick Hayward
Senior Consultant
patrick.hayward@altus.co.uk

Altus Consulting would like to thank our external contributors who supported our extensive research and helped to shape this whitepaper.

Contributors:

Mark McDonald
Personal Lines Insurance Director
mark.mcdonald@altus.co.uk



Kirsty Priddle
Consultant
kirsty.priddle@altus.co.uk

Sarah Bateman
Head of Data & AI, Principal Consultant
sarah.bateman@altus.co.uk

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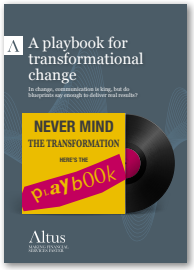
LLOYD'S OF LONDON



A playbook for transformational change

This whitepaper sets out the need for Lloyd's of London to create playbooks' for transformational change if it is to survive and thrive amidst growing challenges and competition.

WHIPLASH REFORM

Whiplash Reform: Operational Impact for Insurers (2021)

"Whiplash Reform: Operational Impact for insurers" provides an in depth study looking into the broader impacts of the Civil Liability Act 2018 (CLA) that came into force on 31 May 2021.

INSURTECH

The InsurTech Journey... are we there yet?

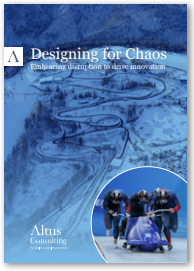
'The InsurTech journey' reviews the range of emergent trends in the insurance industry and predicts what the direction of travel means for the future.

CHANGE STRATEGY

Navigating the Sea of Change

Embarking on any change journey can be a daunting prospect. In this Whitepaper, we provide practical insights for organisations facing the mounting pressure of delivering ambitious and complex change programmes in today's dynamic business environment.

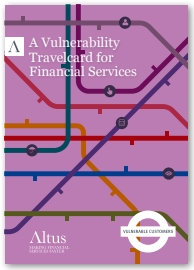
DIGITAL TRANSFORMATION



Designing for Chaos: Embracing disruption to drive innovation

We explore synergies between the approach of the GB Bobsleigh team and that of delivering transformational change within the FS industry; including chaos planning; a relentless focus on data and a determination to deliver the best outcome possible.

VULNERABLE CUSTOMERS



A Vulnerability Travelcard for Financial Services Industry

"A Vulnerability Travelcard for Financial Services" represents some of the most interesting facts and insights from industry experts discussed during our Vulnerable Customers Webinar Series, hosted in 2020.

Bath Quays South
1 Foundry Lane
Bath BA2 3GZ

+44 (0)1225 438 000
altus.co.uk

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