Cutting the cost of insurance claims

Taking control of the process
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About the authors
Gaining control over claims can reduce an insurer’s costs significantly, yet often comes at a price. Any attempt to introduce more competition, such as bidding auctions, is likely to meet with resistance from service providers accustomed to calling the shots. Some insurance companies have even chosen to take complete charge by managing the end-to-end process in-house, but this strategy requires a big investment and brings added complexity. Taking a more enlightened approach, insurers should try to align their commercial practices with those of repairers or other providers. In addition to giving suppliers more assurance of future work — such as preferred supplier lists — they should come up with creative ways to reward good cost performance. Some may even want to enter into closer partnerships to tackle specialized types of claims.

Many insurance companies are not making the most of the vast amount of information at their disposal. Benchmarking and other forms of analysis can provide greater understanding of the true drivers of costs, enabling firms to compare the costs of different providers or predict the risk of a large payout for a claim. Insurers are also failing to exploit the talent at their disposal, viewing the claims department simply as a back-office, transaction-based function. By gaining a better understanding of the risks and costs of claims, and prioritizing accordingly, claims professionals will be free to take on a more strategic role, focusing on higher-value work. Such a step forward may require further investment in systems support, but should help insurance companies achieve the control they seek.
Claims are the heartbeat of insurance

A claim is the defining moment in the relationship between an insurer and its customer. It’s the chance to show that the years spent paying premiums were worth the expense. If a claim is handled well, retention rates may rise. If handled poorly, the insurer may not only lose the customer, but also damage its wider reputation.

Commercially, claims represent by far the largest single cost to insurers; up to 80 percent of all premiums are spent on claims’ payment and associated handling charges. By keeping these costs under control, an insurance company can price competitively without sacrificing margins.

However, there’s a delicate balance between reducing expense and giving customers a positive claims experience. Seeking multiple supplier quotes may get you a better price, but can also be very time consuming, especially if the claimants themselves have to chase and approve the estimates, leading to a negative customer experience. At the other extreme, without sufficient controls on liability and claims costs, insurers can pay too much to service providers, or even unknowingly make payments for fraudulent claims.

The often adversarial relationship between suppliers and insurers can also hinder efficiency, because those carrying out repairs or other services have no real incentive to cut their costs.

With its knowledge and experience, the claims handling team has the potential to make a big contribution to improving performance. Unfortunately, this area has traditionally been seen as a low-status, back-office function focused purely on transactions. This perception is slowly changing, as insurers recognize the value in taking greater control of the whole claims process and using sophisticated, risk-based decision-making techniques.
**Five issues for insurers**

To keep both service providers and customers happy, and to return healthy profits, insurers need to address five key issues: (1) taking greater control of the claims process; (2) understanding your customer; (3) choosing the right claims model for your business; (4) developing a mutually beneficial relationship with service providers; and (5) gaining an information advantage.

1. **Taking greater control of the claims process**

Many service providers are small businesses, so insurers have to deal with a large number to achieve geographic coverage. Yet even the biggest insurance companies have surprisingly little buying power, despite the fact that entire industries are dependent upon them. Strategy& industry analysis reveals that up to 80 percent of a typical motor repairer’s revenue comes from insurance claims.

For a typical motor claim, paint and parts account for around half of the total expense, and these are sourced by thousands of small businesses at significantly higher costs than could be negotiated by a single large insurer. Although each repairer alone has limited power, as a group they can quickly identify weak spots in the insurer model. With no direct contractual commitment to insurers, the large paint and parts suppliers can effectively pass on price increases unchallenged.

Claims costs can also rise when individual customers are allowed to deal directly with the service provider, with no pressure to go for the best deal.

Insurers need to gain more control of the claims process where possible by dealing directly with customers, service providers, and suppliers. By establishing an ongoing relationship with regular suppliers, they can start to exploit their scale to bring down costs and improve quality. Studies show that controlling the service provider can save as much as 30 percent.
In another example from the motor industry, increasing control over the claim can reduce repair costs because it enables the insurer to use known and reliable repairers. For example, if an insurer has higher control over the flow of repairs in a region, costs go down (see Exhibit 1, next page).

There are two main ways to gain control of a claim:

*Strictly using a preferred supplier network.* It’s not uncommon for insurers to have a formal customer claim procedure with a defined list of suppliers or service providers. However, it may not always be commercially acceptable or competitive to control claims so rigidly, and in some countries this practice is illegal.

*Encouraging the claimant to surrender control by providing good service.* Plenty of customers do not want the hassle of chasing down multiple quotes from motor repairers or builders and are happy to leave this task to their insurance company. Automotive insurers in particular have recognized this and emphasize convenience as a core part of their value proposition, offering valet services or taxi fares to and from the drop-off point, as well as a guaranteed repair time.

One company found that a new claims call center script in which agents told customers, “It’s easy; just drop the car off and we’ll take care of it” resulted in a 10 to 15 percent increase in the insurer’s ability to control who made the repairs.

However, such extra control often comes at a cost, namely, increased servicing expenses and investments in systems and service infrastructure. As part of its own “drop and go” model, U.S. insurer the Progressive Corporation has invested heavily in drop-off locations, to ensure that no customer has to travel too far to access repairs.

Other benefits to insurers include offering the complimentary use of a loaner vehicle while the car is being repaired. The expense of providing such a service is typically far less than the extra margins gained from controlling repair costs.

### 2. Understanding your customer

The claims experience is a critical “moment of truth” for customers. Insurers that realize its importance are increasingly focusing on customer-centric approaches to claims fulfillment.

To understand customers’ needs, an insurer should first consider the distribution model in its sector. This will in turn influence the extent to which it can gain control over the claims process.
Exhibit 1
Repairer costs for similar vehicles by region

Cost index

Claims controlled by insurer (%)

Source: Major Australian insurer
Direct insurers naturally have a closer relationship with the customer, making it easier to take control. Where intermediaries are involved, attention shifts from the end-user to the broker or agent. Many insurance companies have gained competitive advantage by giving intermediaries a positive claims experience, increasing sales and loyalty.

Brokers can become upset when insurance companies bypass them and try to deal directly with the customer. They feel that they “own” the relationship and see such involvement as compromising their role as trusted advisors. Brokers therefore tend to prefer a low-touch model in which claims are settled immediately.

Irrespective of the distribution model, where customers have an emotional connection to the subject of the claim, such as jewelry, art, or furniture, they are less likely to surrender control of the repair or replacement to the insurer. And for commodity products such as computers, customers often rely on local suppliers for support and after-sales service, and may resist centralized, low-cost procurement models.

In other cases, the “customer” for your claims model may be an injured worker or an individual injured in a car accident. In this case, insurers have to balance the needs of several parties: the employer or customer of an accident insurance policy, the person injured, and perhaps the intermediary as well.

3. Choosing the right claims model for your business

In seeking more control over the claims process, insurers have to weigh the costs and risks of various models against the potential benefits (see Exhibit 2, next page). These models include:

**Immediate claims settlement.** By instantly reimbursing or paying cash for a claim, an insurer can offer good, quick service. Insurance companies tend to go for such an approach when they lack the scale or geographic coverage to manage service providers, or when legal regulations dictate it. This approach, however, gives them little control over the claim and no relationship with the repairer or other providers.

Although brokers like the convenience of fast settlements, they carry a risk for both the insurer and the customer. The insurer is more susceptible to fraud or overpayment, and the customer may end up with funds insufficient to cover his or her bills.

Consequently, many insurers limit their payments, either through an “agreed amount” policy or through caps on both the number and cost...
# Exhibit 2
Alternative claims models

<table>
<thead>
<tr>
<th>How it works</th>
<th>Immediate claims settlement</th>
<th>Preferred supplier network</th>
<th>Competitive bidding/reverse auction</th>
<th>In-house service center</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>– Appraiser visits site and writes a cheque for estimated repairs (before quotes are obtained)</td>
<td>– Insurer authorises acceptable repairers</td>
<td>– Customer drives to a central site. Repairers bid for work</td>
<td>– Insurer works to provide solution, usually in tandem with partners</td>
</tr>
<tr>
<td></td>
<td>– Customers can select from a network of preferred repairers</td>
<td>– May have video assessment</td>
<td>– Alternatively, direct work to benchmarked low-cost repairers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Desired impact on economics</th>
<th>Immediate claims settlement</th>
<th>Preferred supplier network</th>
<th>Competitive bidding/reverse auction</th>
<th>In-house service center</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Eliminate fraudulent/inflated claims</td>
<td>– Reduce fraud</td>
<td>– Create more competition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Smooth flow of work to repairer, reducing overhead</td>
<td>– Price on marginal cost</td>
<td>– Incentivise “Darwinism”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>– Create price transparency</td>
<td></td>
<td></td>
<td></td>
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</tbody>
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<table>
<thead>
<tr>
<th>Impact on customer service</th>
<th>Immediate claims settlement</th>
<th>Preferred supplier network</th>
<th>Competitive bidding/reverse auction</th>
<th>In-house service center</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Immediate funding of repair</td>
<td>– Risk of “underpayment”</td>
<td>– Fair degree of choice, but must select within preferred network</td>
<td>– No input into selection of repairer</td>
<td>– No choice of repairers</td>
</tr>
<tr>
<td>– Fairness</td>
<td>– No assessment</td>
<td></td>
<td>– Guaranteed service quality</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Implications for insurers</th>
<th>Immediate claims settlement</th>
<th>Preferred supplier network</th>
<th>Competitive bidding/reverse auction</th>
<th>In-house service center</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Increased assessment</td>
<td>– Decreased claims processing</td>
<td>– More focused assessment model</td>
<td>– No assessment</td>
<td>– No assessment</td>
</tr>
<tr>
<td>– No assessment</td>
<td></td>
<td></td>
<td>– Reduced claims processing</td>
<td></td>
</tr>
</tbody>
</table>

**Insurer requires increasing control of the repair decision**

Source: Strategy&
of services (as is common in private health insurance). They also use assessors and brokers to assess the legitimacy of and appropriate amount for each claim.

**Preferred supplier network (PSN).** By using a consistent group of repairers for each region, insurers gain consistent quality, while providers get a regular flow of business. Either work is directly allocated to repairers from assessment centers, or the customer is directed to the closest repairer through a call center or website.

The PSN can create a close working relationship between insurer and provider, reducing administration and claims costs. To gain more control over costs, suitable rates and servicing times are agreed upon, with the insurance company employing qualified assessors (such as tradespeople and medical professionals) to review and authorize all work.

**Competitive bidding/reverse auction.** In the competitive bidding model, the insurer aims for greater control, often restricting bidding to a known group of preferred suppliers. A motor repair auction can even be held at an assessment center, where repairers can inspect a number of damaged vehicles before quoting.

There have been instances in which repairers have colluded to artificially increase costs and spread work evenly among themselves. As a counter to this practice, some insurers have introduced online auctions, bringing in a greater number of bidders.

Not surprisingly, providers tend to be less than enthusiastic about bidding, and there have been incidents of boycotts and other kinds of activism that have damaged the insurer’s brand.

**In-house service center.** By taking on claims service provision, insurance companies can raise the level of control by becoming repairers in their own right, which gives them direct access to suppliers. However, with control comes complexity, as they now have to manage parts and paint supplies and ensure that the center is highly utilized.

Insurers need to think carefully before selecting a particular claims model. Taking full control of the claims process may not suit all insurers. Those with low market share often can’t justify the expense of setting up an infrastructure. They may opt instead for a tiered approach, with service centers in those areas where they have significant business, and preferred supplier networks elsewhere — particularly in less populated regions.
Any attempts by insurance companies to gain control tend to lose impact over time (see Exhibit 3, next page). This is because service providers are continually looking for weaknesses in the process, using tactics such as collusion. Although each repairer may have limited power as an individual, as a group they can exert considerable influence. Consequently, insurers also need to continually change and adapt to maintain good cost performance.

4. Developing a mutually beneficial relationship with service providers

Service providers have little incentive to reduce the cost of a claim, which to them is revenue. To insurers, in contrast, it’s the main expense. A traditional way for insurers to create more value for providers is to assure them of a predictable level of work. This gives the relationship more stability and helps providers negotiate better prices for parts and materials.

However, it can be dangerous for providers to rely too heavily on a single insurance company. When a major insurance player launched a new Web-based auction system, it was met by an aggressive, coordinated press campaign from its repairers, which were unhappy that their reliable revenue streams were under threat. As a group, they chose to boycott the insurer’s services, which along with the negative media publicity so damaged the brand that it eventually withdrew the auction scheme.

To avoid such problems, many repairers limit the volume of work sourced from individual insurers, thus ensuring diversity of supply. They tend to differentiate between regular “base-load” work and ad hoc “capacity-filling” jobs, with the latter regarded as a welcome bonus. They may even join multiple preferred repairer groups to remain independent.

In the example above, the auction system was actually successful in certain regions where the insurer’s market share was low. This was because most providers received only a small proportion of their business from the insurer, so felt less threatened, and they could also take advantage of pricing at marginal costs when they had capacity, without risking their baseload costs.

Creating true “win-win” situations. Smart insurance companies are now looking beyond existing models to try to change the service provider’s mind-set and behavior. A number of preferred supplier schemes reward good cost performance with larger allocations of work, better payment terms, and less scrutiny.
Exhibit 3
Impact of competitive quoting on claims cost

Index of costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Index</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 0</td>
<td>100</td>
</tr>
<tr>
<td>Year 1</td>
<td>82</td>
</tr>
<tr>
<td>Year 2</td>
<td>88</td>
</tr>
<tr>
<td>Year 3</td>
<td>93</td>
</tr>
<tr>
<td>Year 4</td>
<td>95</td>
</tr>
</tbody>
</table>

Source: Major Australian insurer; Strategy& client work
When parts or materials form a large component of total claims costs, there is an opportunity to change the game. Markups on materials typically amount to 20 to 30 percent of an auto repairer’s total profitability; historically, repairers have had no real incentive to go for the cheapest option.

However, if the repairer is able to realize a greater margin while spending less overall, both parties can benefit. If the insurer offers a fixed rate (say, 75 percent of the OEM [original equipment manufacturer] cost) for a part, the repairer is motivated to seek cheaper supplies, knowing that the lower the price, the greater the markup. These schemes have achieved savings of as much as 5 percent on parts at some companies.

An unfortunate occasional consequence of such practices is a rise in car theft, as demand for lower-cost parts rises.

Looking beyond short-term cost reduction. An insurer of bodily injury has found a way to reduce the total cost of a claim. By actually paying a higher rate to its best medical service providers, the insurer encourages better care, which in turn leads to faster recovery and less time spent in hospitals or with treatment providers.

Early intervention can also significantly reduce patients’ recovery time, so some bodily injury insurers pay for up-front medical treatment even before liability is established. Although an insurer may end up funding some cases in which it is not liable, overall costs of treatment come down considerably — as do the follow-on costs of loss of earnings and compensation.

Another option is to encourage specialisation among service providers. Many motor vehicle repairers are generalists, and they effectively subsidize the cost of complex jobs by raising prices for simpler repairs. Large insurers in some countries have countered this by setting up a network of partners specializing in small repairs and directing damaged vehicles to these firms. The work is done more quickly, and at around 20 to 30 percent lower cost than in traditional workshops. These specialized repairers benefit from being on a preferred list and realizing the higher margins associated with such work.

In most property claims, the insurer deals directly with the customer to arrange replacement of the damaged goods. It’s relatively straightforward to negotiate volume discounts on popular items such as televisions, cameras, and computers. However, it’s harder to exploit scale for building materials or motor parts, because thousands of individual repairers source parts from a few large parts suppliers. One way around this problem is for the insurer to form buyer groups.
of preferred suppliers. These are likely to be effective only if the sourcing benefits outweigh any additional administration costs — which can be a particular challenge in smaller markets. Insurers should also make sure that repairers have a financial incentive to belong to a buyer group, by passing on some of the cost savings.

Finally, it’s not always all about costs. For some insurers, being able to access suppliers on a “first call” basis with guaranteed turnaround times can be a great part of the customer value proposition. For example, the ability to repair someone’s property after a catastrophe can result in enduring customer loyalty, great advocacy, and enhancement of the broader reputation of the insurance company.

5. Gaining an information advantage

Many insurance companies are not accurately assessing their claims management performance. The use of “average claims cost” is widespread, but it often disguises important trends. For example, an increase in motor repair costs may be driven by a rise in imported prestige cars, an increase in the severity of accidents, or a period of bad weather.

The key is to classify claims in appropriate categories, enabling easier comparisons. This is already common practice in some areas, such as diseases and bodily injuries. The International Classification of Diseases (ICD) describes both the severity of the injury and its bodily location, helping actuaries estimate the expected cost of treatment. Other classifications cover the average recovery time for an injury and how quickly a patient can return to work. For a lower back injury, for example, a sedentary office worker would be back in just three days, whereas a firefighter would require 28 days. With claims properly coded, insurers have a benchmark treatment cost for different types of injury and can quickly spot cases in which these expenses are too high.

The motor industry has no standard coding, although at least one major company has developed its own simple system for working out the estimated duration and cost of repairs. Damage is rated by type and severity across 12 locations on the vehicle, from light panel dents or scratches through mechanical or heavy structural damage.

When comparing the average cost for different types of repair, a heavy structural job is almost four times more expensive than light panel beating (see Exhibit 4, next page).

Classification also lets auto insurance companies compare the performance of various repairers across each category of work.
Exhibit 4
Repair cost ranges by damage classification

Late-model passenger vehicle, same make and model

Source: Major Australian insurer
Once the damage on a car is assessed, it can be passed to a provider with the best track record for that type of repair. And, as mentioned earlier, insurers could choose to build up a pool of repairers for specific categories such as light panel work, which would help bring down costs.

It is almost impossible to achieve a standard classification for a building claim, due to the wide range of construction methods and materials, varying age and conditions of properties, and multiple causes of damage, such as fire, water, and subsidence.

What’s more, assessors and builders rarely visit buildings to assess damage, owing to the high cost and inconvenience of travel. Consequently, insurers often end up paying too much for home property claims — even when they use competitive tendering — because of a lack of understanding of the main costs.

One way to overcome this weakness is to build a formal scope of work that includes all the information a repairer needs to make an informed judgment on the repair costs. These include location, site access, slope, and, for major work, planning permission. And where there is significant damage or a likelihood of fraud, an assessor should visit the site at the insurer’s expense.

A scope of work statement gives all builders the same information, which should encourage more accurate, competitive tendering. To achieve maximum participation in the bidding process, insurers should endeavor to reach all potential bidders via mobile technology, given that builders are on site most of the time. The growth in smartphones will help in providing access to Web-based tenders from any location.
Creating a 21st-century claims model

To reap the benefits of greater control, insurers will have to rethink the whole role of the claims department, which has traditionally been considered a relatively low skill area focusing on (often manual) transactions. Until the function is seen as a core part of the customer experience that can bring real value to the business, insurers will continue to view it as a back-office function.

In building a 21st-century claims model, insurance companies have to consider the supporting business processes. These provide the all-important data that enables claims professionals to make effective decisions.

Setting expectations through benchmarking

Assessors have historically handled quality assurance, testing that the insurer is liable for the claim and that the claims cost is appropriate. However, assessor performance is only as good as each individual’s experience and capabilities.

By defining a benchmark or a scope of work, companies have a powerful tool for setting expectations for internal claims staff, as well as external providers such as repairers. An effective benchmark should be objective, easy to communicate, and credible.

Some benchmarks exist already. For bodily injury claims, there are off-the-shelf commercial products that have been reviewed by statisticians and medical professionals. The motor industry lacks such a classification system, although, as noted above, some individual firms have made attempts at creating them.

Introducing a benchmark into the claims process can be challenging because assessors and repairers may feel it’s inaccurate, especially if their quotes are significantly higher than the benchmark.
Benchmarking also represents a new business process, the introduction of which can have a major impact on existing work practices and supporting systems. To make the most effective use of benchmarks, insurers need to record data systematically and make it simple to access. This usually requires (potentially costly) systems changes.

**Mining data to identify risky claims before they become expensive**

Claims assessors tend to judge claims based on experience, and have learned when they’re dealing with a high-risk claim. For example, a 55-year-old male with a lower back injury and a previous insurance claim is likely to be an above-average risk. Similarly, in motor and home claims, certain builders or repairers have a reputation for high cost or poor quality. Likewise, specific plaintiff lawyers are known for their aggressive approach to settlements.

However, there are many less-obvious risk factors that may remain undetected. By identifying these clusters of data, claims professionals can focus on high-risk claims before they become high-cost claims.

One workers’ compensation insurer wanted to know why a large number of claims were running well beyond the accepted maximum duration. Through intelligent data mining of those claims, the firm was able to predict which new claims had the potential to last longer, and put more resources into dealing with those. It also simplified the process for handling low-risk claims. These changes brought down administrative costs and reduced the average length of payout.

**Segmenting claims to cut costs**

The case above shows that not all claims justify the same investment in time and effort from claims staff. Too much time spent on low-cost or low-risk claims will push up the handling expense. Equally, there may be too little focus on high-risk and high-cost claims, resulting in unnecessarily large claims payments.

Adopting a “triage” approach (see Exhibit 5, next page), similar to that used in medical care, enables insurers to segment incoming claims and treat each group with the appropriate resources, putting their best case managers on those with the highest predicted cost or risk. Simple claims — such as car windscreen replacements — can go through a “fast track” process, where they are handled with a minimum of fuss by relatively junior staff.
Exhibit 5
Conceptual claims risk segmentation

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
<th>Source of value</th>
<th>Potential model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core insurance claims model</td>
<td>Mainstream of claims management activity</td>
<td>Isolate sources of risk</td>
<td>Supplier network</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Bidding</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Repair centre</td>
</tr>
<tr>
<td>Specialist team</td>
<td>Skilled internal team working with network of external specialists</td>
<td>Caseload management</td>
<td>Referral to specialist providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Effective use of external resources</td>
<td>In-house management</td>
</tr>
<tr>
<td>Streamlined procurement model</td>
<td>Straightforward cases, e.g., glass damage</td>
<td>Effective usage of supplier network</td>
<td>Supplier networks</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Immediate claims settlement</td>
</tr>
<tr>
<td>Pay and forget</td>
<td>Balance complexity and risk vs. cost</td>
<td>Minimal complexity process</td>
<td>“Fast-track” claims processing</td>
</tr>
<tr>
<td></td>
<td>Risk that administration cost will exceed value of claim</td>
<td>Limits on the level of claims intervention on low-value cases</td>
<td>Immediate claims settlement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Potential time wasters</td>
<td>Balance complexity and risk vs. cost</td>
<td>Minimal complexity process</td>
<td>“Fast-track” claims processing</td>
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<tr>
<td></td>
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<td>Immediate claims settlement</td>
</tr>
</tbody>
</table>

Source: Strategy&
Each of the segments would be treated differently. Claims that are neither high nor low risk can be processed according to the insurer’s particular model (high, medium, or low control).

**Using claims data to create more efficient pricing**

Many insurers have insufficient integration among their underwriting, actuarial, and claims departments. This means that valuable claims data is often not aligned with actuarial information, reducing its effectiveness. Closing the loop between actual claims experience, risk prediction, and pricing could lead to more accurate policy prices that better reflect the risk of that particular customer.

**Making the most of information**

By feeding appropriate information to claims staff, service providers, and suppliers, insurers can drive more effective decision making.

The data provided should reflect the particular business model being used. For example, some insurers will want to know the proportion of claims in which they have achieved their desired levels of control. For a motor insurance company, this may mean understanding the percentage of claims that have gone outside its recommended repairer network. If this figure is high, the company could take appropriate measures, such as adopting a preferred supplier list.

Where benchmarking or risk segmentation is used, reporting should show the trends for key claims segments, to identify good or bad performance. Feedback and monitoring should be able to show performance at various levels:

- **Geographic or organizational:** by state, region, center, or claims manager
- **Supplier:** by repairer or repair site
- **Insured property:** by make, model, type, and age of vehicle
- **Product:** by policy type

Giving additional insights, multi-dimensional analysis can enable claims professionals to compare costs among different types of supplier across regions, among different sizes of provider, and so on.
**Focusing on high-value activities**

To get the most out of practices such as benchmarking and risk segmentation, frontline claims staff should have easy access to data. Although many new initiatives can be implemented within existing systems, the real value-adding changes may require further investment in data storage and analytical capability.

Despite its potential cost, process automation can substantially enhance decision making and increase efficiency *(see Exhibit 6, next page)*. By automating low-value activities, companies free up staff to focus on work that can cut costs and increase levels of control.
Exhibit 6
Workflow opportunities

**Transactional task automation workflow opportunities**

- Streamline processes to reduce handoffs
- Ensure data is entered into the system to streamline processes that come later
- Allocate simple open/pay/close claims to fast-track claims processing

- Streamline process by auto-populating/providing data and treatment plans
- Improve knowledge and expectations in use of benchmarks

- Streamline operations with a “no touch” model for preapproved costs

**Value adding workflow opportunities**

- Streamline case management process by allowing segmentation of risks
- Identify claims with a high risk
- Assign case based on risk
- Optimise the utilisation of central fast-track teams (centralisation)

- Streamline process by providing data for automatic payment process
- Improve estimation through provision of average costs
- Improve underwriting by explicit linkage to claims experience

- Improve prioritisation of activities
- Improve efficiency through increased automation
- Define escalation points based on case progression rather than standard times
- Improve focus on high-risk/poorly performing cases
- Create centers of excellence in specific skills

Source: Strategy&
Staying in the driver’s seat

Investing in greater control over claims can be an expensive business, and may meet considerable resistance from service providers anxious to preserve their margins. The alternative for insurers is to remain at the mercy of repairers, builders, and clinicians who have no real incentive to seek low-priced supplies, and who provide little transparency in costs.

The use of more aggressive approaches such as auctions can lower costs dramatically, but may also upset service providers and can even lead to boycotts. A preferred supplier list may be received more favorably, however, because it gives repairers and builders more assurance over work volumes.

To maintain a win-win relationship with service providers and intermediaries, insurers need to understand and work with these partners’ business models, and reward good performance. This may take the form of additional work and higher agreed-upon margins. A further approach is to create groups of providers specialized in a narrow range of activities, increasing efficiency and lowering costs.

In taking control of the customer experience, insurance companies should consider the claims model that’s appropriate to their market position. Moving from a position of low to high control is costly and adds to complexity, so may work only for those with a large market share.

The industry is awash with data, but it isn’t always used to best effect. A more systematic use of benchmarking can help insurers spot good and bad cost performance and react accordingly. And data-mining techniques can help predict the risks and costs of new claims, enabling the insurer to segment high and low risk exposures, devoting more resources to the former.

To make these gains, the claims function needs to step out of the shadows of the back office, to be viewed as an important strategic activity with the capacity to add real value to the business. Claims are the heartbeat of an insurance business and can deliver huge value both in reducing costs, which can be passed to customers in lower premium prices, and in being the “moment of truth” in the customer value proposition and experience.
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