INDUSTRY HEADWINDS BRING RENEWED FOCUS ON CLAIMS MANAGEMENT

The sustained low investment yield environment has forced most insurers to focus their efforts on improving the combined ratio. Historically, investments contributed to 90% of industry profits and as a rule of thumb, most industry professionals targeted a combined ratio of 100 pts. Executives now realize that they need to achieve an overall combined ratio closer to 95 pts to match past returns. In recent times, most companies have launched one or more of three types of initiatives: standard cost cutting programs, improvement in risk selection/adoption of technical pricing, and better claims management. Of these, claims optimization offers the biggest bang for the buck – on average, a 1% improvement in claims costs results in a 10% net income benefit. Additionally, insurers are seeing diminishing returns from cost reduction efforts and find it difficult to adhere to technical pricing in a soft market.

We observe that many claims optimization efforts often fall short of achieving their anticipated benefits. In our view, these failures often stem from an overly narrow focus on the processes and systems for claims management; the people side of the equation is frequently an afterthought. All too often, claims management initiatives do not deliver sustained results because they often do not filter down to the adjusters and the culture in which they operate. What results is a lack of employee engagement and ownership in changes that are pushed through.

1 All figures derived from Oliver Wyman analysis.
Over the last four decades, the claims function at various insurers has gone through multiple “transformation” efforts. While, the specific objectives vary, the general direction has been towards industrialization of claims, i.e., moving away from the historically “artisan” model based on local customization and experience-based decision-making of individual adjusters, and towards a streamlined model with heavy reliance on standardized processes and tools. Broadly, the underlying themes in most claims improvement efforts can be segmented into either workflow or structured adjustments, as seen in Exhibit 1.

While most insurers have obtained positive benefits from these efforts, the impact on the combined ratio has been quite varied, with only a few organizations realizing the full potential. We believe that achieving more substantive and sustainable results requires a more nuanced approach. Insurers continue to face challenges in obtaining buy-in from the organization to adapt to an industrialized approach. They often lack a strategic and systematic approach to developing the talent pool that is required to create a high-performing claims function. The gains required to offset the industry headwinds described earlier require a greater focus on empowering and developing claims professionals, whose collective actions shape important customer perceptions and drive bottom-line results.
We observe a range of claims management practices in our work for insurers globally. The common denominator among insurers with strong claims management capabilities is that they strike the right balance between the “hardware”, such as workflows and systems, and the “software”, the people and culture. That is, they use technology, claims workflow processes, and the formal reporting structure to support rather than replace the expert judgment of their claims professionals.

Bringing all of these elements into alignment requires an integrated perspective on the claims function. Our recommended approach is to think of the claims function as a system, consisting of interrelated strategic, technical, and social subsystems (see Exhibit 2).

**Exhibit 2: A Blueprint for Claims Management**

1. **Strategy**
   - Claims priorities aligned with overall company vision and business goals
   - Clear claims management philosophy
   - Effective tradeoffs between competing opportunities achieved

2. **Workflow**
   - Identification and triage of claims based on complexity, cost and predictive analytics
   - Rapid and effective processing of low-complexity claims
   - Strategic resolution of high-complexity claims

3. **Structure**
   - Adjusters authorized to make decisions on complex claims
   - Integrated platforms and data
   - Clear outcome/process metrics

4. **People**
   - Trained adjusters, exercising business judgment
   - Leaders who engage frontline staff in problem solving and change

5. **Culture**
   - Outcome-focused
   - Empathic
   - Proactive mindset, personal initiative
   - Collaborative across functions/geographies

**Output**
- Improved outcomes and customer service
- Reduced claims leakage
- Reduced litigation and fraud
- Lower turnover

Source: Oliver Wyman
The claims function is composed of four essential components: workflow, structure, people, and culture:

- **Workflow** refers to the inherent processes that need to be carried out by the claims function
- **Structure** consists of the formal organization, systems, and metrics that help leaders and individuals perform required tasks
- **People** includes the characteristics and capabilities of the individuals within the claims function
- **Culture** includes behavioral norms, patterns of influence, and communications.

Ultimately, the purpose of the claims function is to deliver on the claims management strategy. However, the degree of alignment between each component will determine the claims function’s ability to effectively meet its objectives. While it sounds simple, maintaining the “fit” between these four components is incredibly difficult.

Typically, claims functions are overly preoccupied with the workflows and the formal organizational structure. This focus is the primary cause of failure of claims transformation projects. Improving claims functions requires a more holistic approach that addresses culture and people, as well as the workflows and systems. Overall, adjusters must be able to think strategically about how to best resolve claims, relate to claimants, and take appropriate, outcome-oriented decisions. This necessity requires a change in perspective from leadership in how they view culture, talent and organizational structure as essential elements in any change plan.
A BLUEPRINT FOR CLAIMS MANAGEMENT

1. STRATEGY – PHILOSOPHY AND PRIORITIES

Clearly, the right blueprint begins with a well-defined claims management strategy and philosophy that is aligned with the overall corporate vision and business goals.

For most insurers, claims strategy starts with the principle that effective claims management is about identifying and resolving claims in a way that delivers quality customer service and manages costs. There are three basic components to this claims philosophy:

1. Adjudicating claims and paying the fair amount
2. Getting to resolution in a fast, cost-effective manner while tending to customer needs
3. Performing analysis required to send the right signals back to the rest of the organization (marketing, actuarial, underwriting, loss control, and premium audit) to help guide and refine the overall company strategy

At the same time, there is a balance between competing priorities that must be clearly communicated throughout the claims function. At its heart, strategy is about making choices. While there may be dozens of urgent projects in the pipeline, it is essential that the strategy provide focus to these efforts. The strategy governs the time and resource decisions for leaders, managers, and staff and it must clearly define what those priorities are and enable effective tradeoffs between competing demands. Without that discipline, even a well-engineered organizational system will buckle under the weight of too many projects and unrealistic expectations.

2. WORKFLOW – TRIAGE AND RESOLUTION

Claims functions must optimize the tradeoffs between loss payouts, loss adjustment expenses, and customer satisfaction. Managing these tradeoffs requires appropriate decisioning, informed by the right data and accurate predictive capabilities.

Most insurers segment claims based on expected severity and complexity. This approach allows them to settle a larger portion of their claims closer to the optimal settlement outcome. However, many insurers still lack a thorough understanding of their quantitative performance against best possible service, speed and settlement. This necessitates continued investment in an adaptive triage process using predictive analytics to fine-tune claims segmentation.
However, model-based triage is only the first step. The organizational system needs to be structured to support different claims handling processes and the funnelling of cases to individuals with appropriate skill levels. Ideally, low severity-complexity claims should be quickly identified, segmented and addressed using standard procedures and rapid processing. More complex claims should be directed towards adjusters with the appropriate skills and experience. High severity-complexity claims that can be influenced and managed through skilled intervention should be directed into a highly skilled group of specialist adjusters for detailed review and strategic decisioning. This kind of optimal segmentation and resourcing requires more than triage algorithms and a few workflow diagrams; to successfully execute these processes, the claims function must also place the appropriate amount of decision authority into the right hands at the right time.

3. STRUCTURE – ENABLEMENT AND METRICS

While they aren’t magic bullets by themselves, changes to the structure of an organization might also be necessary to support the overall direction of the claims function. This may involve making adjustments to elements such as the reporting structure, decision-making rights, settlement authorities, systems, and performance metrics and targets.

In a typical claims function, the top 10% of claims make up the lion’s share of incurred losses (see Exhibit 3). The consistency and business judgment of claims adjusters working on high-risk claims are major factors in insurers’ ultimate results. Formal reporting lines and authorities need to be structured so that decisions are directed into the hands of those adjusters best able to make the critical calls these claims require, while oversight is retained. Maintaining this balance of adjuster independence and appropriate governance needs an in-depth look at the critical decisions that are being made on high-risk claims and structuring the approval process accordingly.
Integrated, end-to-end platforms are a key step in minimizing claims leakage and improving customer service and speed.

In order to get the right information into the hands of those making these decisions, systems need to be streamlined; having multiple systems often means that people must look high and low for the right information. Integrated, end-to-end platforms that allow rules-based decision-making supported by historical data and predictive tools are a key step in minimizing claims leakage and improving customer service and speed.

Metrics and targets should be developed as another key organizational lever, starting with overall claims management goals followed by their translation into performance metrics for claims executives, supervisors and line adjusters. By engaging front line managers and some staff in this process, these metrics become a yardstick of success and improvement that have real meaning for the people doing the work and drive consistency throughout the organization.

Implementation of such quantitative targets can often be a challenge. Concerned by the possibility of lawsuits, insurers have struggled to legitimately tie adjuster compensation to overall claims outcomes. The ultimate destination is likely a clear linkage between financial incentives and quantifiable claims leakage (both under and over payment on claims). In the meantime, we have seen insurers successfully apply non-monetary incentive mechanisms such as token rewards, recognition from senior leaders, and celebrating “the stories” that exemplify the right choices.
The workflows and structures are often where claims management improvement efforts start and finish for many insurers. When change is necessary, many leaders automatically reach for the organizational chart, move the boxes and lines of the formal reporting structure around, and perhaps assess process efficiency and workflows or invest in new systems. There is often a feeling of satisfaction among leadership once these changes are implemented, but a few months later, many may wonder why little has changed at the front lines. Results may improve for a period of time, but then regress once the next change or metric takes away the focus. This can be frustrating to leaders. With so much investment in process efficiency, tools, and organizational structure, why aren’t changes resulting in consistent improvements?

In order to cement the effects of these initiatives and deliver sustained results, process and formal organizational improvements are not sufficient on their own – the people and the culture also need to be engaged and aligned with the strategy.

4. PEOPLE – THE PROBLEM SOLVERS

People drive best-in-class claims management. The actions and judgments of individual adjusters impact the outcomes for customers and the company.

Unfortunately, the insurance industry has had significant challenges in recent years in attracting the right talent into claims organizations. Most insurers rely on the same dwindling pool of experienced adjusters, trying to retain or poach these individuals from other organizations. Some of the difficulty in attracting new talent may come from the perception that claims management requires checking one’s independent thinking at the door – deferring to dogmatic processes without much ability to exercise intelligent or decision-making. We see this notion reflected in popular culture: in Double Indemnity, a 1944 film noir directed by Billy Wilder, Edward G. Robinson portrays a claims adjuster who tenaciously pursues the facts surrounding a suspicious insurance claim. By contrast, the 2004 animated comedy The Incredibles uses Bob Parr’s humdrum life as a claims adjuster as the antithesis of his earlier exploits as a superhero.

In reality, career claims adjusters often see their craft as an art, involving creative problem solving and fast decision-making. Adjusting is a constant balancing act that has real impact on real people, every day. For complex cases, there is no company manual or process diagram that can point the adjuster to the right
Developing people who appreciate the real art of adjusting requires the right recruiting messaging and selection process, quality training and reinforcement, and clear development paths that reward the contributions of individuals.

choice – this is where business judgment based on insights gathered from thousands of cases drives the best decisions. The general trend of lower frequency and rising severity coupled with the challenging tort and medical environment only increases the need for these skilled adjusters.

Unlike changes in processes or systems, which may be one time, developing and training a skilled claims staff requires sustained focus and investment from leadership. It can be difficult to maintain this focus, especially under staffing pressures that may force managers to place less-than-ideal candidates in positions where their decisions impact customers.

In one real-life example, an insurance company was reviewing its homeowners’ book and was surprised by the loss ratios it was seeing, which were much higher than in past years. The losses were traced back to a new group of adjusters, who, recently out of school, were all renters and had little idea of the issues facing actual homeowners. They were following procedure and checking the boxes, but they fundamentally didn’t understand the right questions to ask, leading to critical gaps in initial claims assessments. Results only improved once the company moved more experienced adjusters into the staffing pool with the right backgrounds and skills to relate to their clientele.

Developing people who understand and appreciate the real art of adjusting is critical to effective claims management. It requires the right recruiting messaging and selection process, quality training and regular reinforcement, and clear development paths that reward and celebrate the contributions of individuals.

In turn, retaining these skilled adjusters requires developing leaders who support, motivate, and engage their staff. As the organization becomes more sophisticated at identifying general claims issues and managing them using a systematic approach, managers will increasingly spend their time addressing new problems and more complex issues that may not have had sufficient attention in the past. They will need to call upon the expertise and experience of the front line adjusters in recognizing these issues, bringing them to the fore, and coming up with solutions. For some organizations that currently run in a command-and-control environment, this may be a new set of expectations and behaviors. Managers who have been successful in the past may not have the skills or desire to engage people in the change. Ultimately, the right culture is critical in driving these behaviors and in motivating managers to think about engagement in a different way.
5. CULTURE – DOING THE RIGHT THING

The claims management culture needs to motivate and drive the right attitudes and behaviors for the individuals in the organization, from top leadership to the newest staff member. When people say they are doing “the right thing,” how do they know what that is? In each environment, the answer may be very different; an employee in one claims department may say the best action is to “wait and see,” while the same employee in the same situation at another organization would say “we have to escalate and get it resolved now.”

One example of “doing the right thing” was recently raised at a company meeting of adjusters as a case exemplifying the ideal culture of that company. There had been a workers’ compensation case involving an accidental death. It was a complex matter, one that would typically have taken a few months to resolve. The widow of the insured was in difficult circumstances and desperately needed some financial relief for her family. She contacted the adjuster, hoping to get help.

This was a major decision point for the adjuster. While some might have said “there is nothing we can do—it’s too complex and you’ll have to wait until we sort it all out in our processes,” this adjuster wanted to do more. She listened, had empathy for the problems the widow was facing, and acted—assembling a team of attorneys, managers, and investigators to complete the discovery and make a decision quickly. Within two weeks, the widow had the check she was entitled to and could move on to helping her family through their grief with a little peace of mind and security.

Some claims functions find themselves locked in a reactive mindset, allowing complex issues to sit until they reach a critical point or gather until the system is overburdened. All too often, issues sit in organizational silos, passively waiting for a request from another part of the organization before decisions can move forward. The culture set by the top leadership is what drives this behavior. Ideally, the culture of an effective claims management organization values and has empathy towards the customer who is impacted by its decisions, rewards personal initiative from its people, and has a collaborative mindset in accomplishing its goals where there is joint responsibility for outcomes. All of these qualities support and motivate high-performance behavior, motivating skilled adjusters to act and reach out when more information or context is required to get a better result.
CONCLUSION

The challenge of balancing the components of the organization lies in the need to achieve flexibility and autonomy of decision-making at the claims frontline while maintaining discipline and focus on fair outcomes and costs.

What differentiates successful companies is that they recognize the inherent interdependence of each element in claims management—the capacity for each part to strengthen and sustain the others. They engage the leaders and front line employees in driving real change, explicitly adhering to the organizational structure.

A focus on any one system component in isolation is unlikely to yield dramatic, long-term results. However, weaving them together across the claims function, rather than treating them as sporadic initiatives, should lead to sustainable improvements.

ASSESSING YOUR ORGANIZATION – DIAGNOSTIC QUESTIONS

Insurers should assess the degree to which their claims functions are aligned with their overall corporate strategy. To start this assessment, we suggest conducting a short diagnostic exercise across the key components:

STRATEGY
• Is your claims management strategy and underlying philosophy defined and aligned with your company strategy? Are the priorities and tradeoffs clear?
• Has the strategy been communicated to leaders, management, and the front line staff?

WORKFLOW
• What are the key segments of work for your business?
• Do you effectively segment claims by complexity and route those claims appropriately in the organization?

STRUCTURE
• Are decisions being made with people at the right level and with the right authority? Are the right people empowered to make critical decisions for high risk cases?
• How do you track and measure performance? Are metrics consistent with the strategy and performance and reward systems?
• Do you have the right tools and systems to support the critical work and decision-making processes for your business?

PEOPLE
• Do you have the right skills and capabilities in leadership to support your strategy?
• Where are there talent and capability gaps?
• Are your front line staff engaged in raising issues and solutions?

CULTURE
• How would people describe the culture and subcultures of your organization?
• Does the culture of your organization support your strategy? Is it aligned with the work people are doing in claims?

This diagnostic offers a starting point for a company looking for sustained performance improvements. However, identifying the areas where the “fit” will need to be adjusted is just the beginning. An organization needs to implement changes in a coordinated and consistent way to realize their full value.
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