

CAPCO

DIGITAL CLAIMS: THE SLEEPING GIANT



INTRODUCTION

The digital transformation of industries has accelerated exponentially over the last decade, with the emergence of new technologies driving change. The insurance industry is no exception. Innovations such as blockchain, AI and low-code/no-code platforms continue to play a central role in this ongoing disruption. Insurance companies now must choose whether

to remain working in a more traditional way or embrace a reevaluation and reengineering of their systems and processes.

Together with Instanda, in this paper we share how the landscape of claims is shifting and how new products built with no-code software are disrupting the industry today.

KEY CONSIDERATIONS FOR INSURANCE COMPANIES WHEN DELIVERING CLAIMS TO CUSTOMERS

There are several 'moments of truth' in delivering a claims service:

First notification of loss – it is vital that insurers capture claims details quickly and accurately to initiate the claims process. The use of digital front ends to enable 24/7 reporting is used widely across personal lines products and some commercial automotive products e.g., motor fleets (known as ENOL – Electronic Notification of Loss). As part of their claim's automation, one insurance company has introduced ZARA (Zurich Automated Response Agent) which is a claims chatbot, available 24/7, 365 days a year. It allows customers to digitally submit notifications for non-emergency claims by collecting required information using an instant messaging interface. ZARA mimics a human agent using customer feedback, empathy, and behavioral analysis. The use of such automated response agents provides a seamless and quick process for the first notification of loss for customers.

Responsive service – the use of everyday technology enabling images or copy documents to be uploaded to an insurer's claims portal is now well-established. In addition to being able to report a claim online, in some situations access to a claims handler is still essential. For small business customers being able to do this at a time that suits them, i.e., outside business hours is vital. Many insurers have integrated technology solutions into their claims management processes but will still enable access to a claim's handler.

Third parties – third party 'capture' involves obtaining rapid access to third parties to validate the circumstances of a claim. Where they are not at fault, it is in the insurer's interest to settle the loss themselves using their own arrangements to minimize outlay and claims leakage. It is estimated that costs can be saved by managing it in-house. Where the third party is at fault, insurers can seek to recover their outlay from the other party of their insurer using their right of subrogation.

Use of 'big' data – this can be utilized in several areas, including assisting in decision making, reserving and fraud detection. Machine learning technologies can also be employed to support decision making on simple claims avoiding the need for manual intervention. A well-known example of this is when an insurtech settled a claim for a lost coat in 3 seconds. In this time, the company's claims bot reviewed the claim, cross-referenced it against his policy, ran 18 anti-fraud algorithms, approved it, sent payment instructions to the bank for the transfer of \$729 (minus the excess) and informed the claimant.¹

Supplier networks – whether they are replacing goods, repairing vehicles, or refurbishing flooded buildings, a supplier must deliver to the insurer's agreed service standards and cost parameters whilst also epitomizing their brand and values. Procuring these services through selected panels of vendors (car repairers, jewelers, physiotherapists, etc.) ensures these requirements are met but also drives cost efficiencies through

bulk purchasing. Insurers therefore need to be skilled in the art of claims satisfaction but also supplier management.

Claims tracking – chasing progress on a claim either by the policyholder or their agent takes time and can often cause frustration. Creating digital claims tracking solution can be highly effective via an online portal or via SMS updates. One major UK insurer estimated that they reduced inbound call volumes to their claims centers by 20 percent by implementing these measures.

Claims cycle time – targets are often set around the expected time it will take to settle a claim. This is dependent on the claim type; with a bodily injury claim clearly taking significantly longer than the theft of a phone. These targets provide a potential win/win. The claim should be resolved in a timely manner for the client and the overall cost of administration should be lower. With recent innovations, cycle times have been reduced significantly. One U.S insurer estimated that over a 10-year period their average cycle times for commercial motor claims have reduced from 290 days to just 50.

Cycle times can be reduced using technology such as Tractable. This solution uses remote video assessment of a vehicle, which then via AI determines the degree of damage, parts and labor

costs and then produces an overall repair estimate within minutes instead of days.

Settlement – where items cannot be repaired or replaced, rapid settlement by BACS or other digital payment mechanisms, such as Amazon vouchers, can provide an effective way of reimbursing the claim and providing flexibility to the claimant. Often 'cash' payments are preferred by both the insurer and the claimant to simplify the claims process.

Several tech companies are innovating in this space, one such company provides omni-channel payment solutions to insurance companies, enabling them to provide frictionless digital and mobile payments to their customers. Its main offering is a cloud platform with configurable tools that enables insurers to digitize claims payments. It contains features such as an insurer dashboard, payee portal, payments hub and claim payment API.

Continual evolution of the claims process – by analyzing demand; using techniques such as 'systems thinking' and by looking at claims leakage the claims process can be optimized for the customer and the insurer. Value, non-value, and failure demands can be analyzed to optimize the customer journey and enhance the efficiency of the overall process.

WHAT 'GOOD' LOOKS LIKE TO A CUSTOMER

The claims process is a critical part of a customer's experience and interaction with their insurer. It can lead to the continuation of their existing relationship with the insurer, sometimes for years and often resulting in onward recommendations of the insurer's services amongst family and friends. However, if the claims experience is poor or lacking, it can also precipitate a swift move by the customer to another provider.

It is crucial, therefore, for insurers to make sure that their customers have the best experience possible, especially given the claims process may be their first direct interaction with their insurer.

We believe a 'good' customer experience of the claims process should encompass:

A customer-centric approach

It is vital that customers feel valued and that they feel that their needs are being met. This can be achieved with an easy-to-use platform to make the claims experience as user-friendly and hassle-free as possible.

Salesforce research reveals that 62 percent of customers share bad experiences with others, while a larger, 72 percent share positive experiences.² This suggests that the type of experience

that is provided to customers during the claims process has a huge effect on both customer retention as well as acquisition.

Transparency

The ability to track and monitor the status of a claim, including the facility to access and review key information related to that claim, is integral to ensuring the customer's expectations are being effectively managed. Insurance providers are beginning to integrate these metrics, tracking and monitoring, into their claims process as a way of providing a good claims experience to their customers.

Digitalization

As part of that focus on transparency, it is key the customer provided with opportunities to interact with the insurer through multiple channels (i.e. phone, email or app). This need for – and value of – an omnichannel experience was especially clear during the early months of the pandemic, where many firms had to completely close their offices and other facilities at very short notice and, with no viable back-up locations available, implemented working from home for all employees, which inevitably resulted in customer service backlogs. Moreover, most people nowadays will not recommend their insurer to friends and family if digital channels are not available – and will themselves consider changing insurers.

The good news for insurers is that artificial intelligence (AI) and machine learning (ML) can enhance the customer experience from first notice of loss (FNOL) all the way through to settlement. Specifically, solutions such as chatbots, fraud analytics and document management can provide an even better customer journey by increasing the accuracy of the process and the speed.

Such approaches can also benefit insurers from a brand equity perspective, by providing customers with the opportunity to share their satisfaction with an insurer's solutions and service levels through access to platforms like Trustpilot or by incorporating Net Promoter Score (NPS) into the customer experience.

Accountability

In a world where social media amplifies both positive and negative consumer sentiments, good customer experiences are ever more vital. Research has shown that individuals actively seek out and are influenced by reviews posted online and on social media by other customers about their claims experience. Clearly, this offers both a challenge and an opportunity for insurers. Since it is suggested that very satisfied customers are less likely to make fraudulent claims compared to unhappy customers – so there is also a potential upside in having to devote less time and money to investigating fraudulent claims.

THE CHALLENGES FACING INSURERS

Such is the pressure of customer expectations today that insurers must focus hard on balancing the need to deliver excellent service at all claims touchpoints with running an efficient operation that ensures they are delivering on their key metrics, particularly around profitability.

Typically, claims costs makes up approximately 80 percent of an insurer's gross written premium, so it is critical that the this spend is managed as effectively as possible. The challenges remain the same whether an insurer is handling low complexity, high-volume claims where automation is key, or large,

complex, long-tail incidents requiring a high degree of skill and judgement to resolve.

One of the key overall metrics for assessing efficiency is claims leakage. The International Risk Management Institute (IMRI) describes claims leakage as “dollars lost through claims management inefficiencies that ultimately result from failures in existing processes (manual and automated).³ In other words, the difference between what the size of the claims outlay versus what should have been spent resolving that claim.

The causes of claims leakage are many, but typically fall under a number of broad headings:

- **Process inefficiencies** – poor management or optimization of supplier networks
- **Poor decision-making** – arising from lack of training or poor guidance
- **Poor customer service** – poor customer service leading to complaints and reviews of decisions
- **Fraud** whether through exaggeration, manipulation, or fabrication of a claim incident
- **Incorrect /errant payments** – caused by poor processes or human error.

Let us explore some of these issues, and what actions insurers can take to mitigate them, in more detail.

i) Process inefficiencies: how they can be addressed

We have already discussed the need for a continual review of claims processes to optimize performance in this area, and this can be achieved via the adoption of methodologies such as Lean and Systems Thinking among others. Recognizing that claims processes are a living system means that the use of these approaches will be an ongoing commitment, and what are deemed as ‘valuable’ and ‘non-valuable’ process steps in the eyes of the customer will continually evolve.

One prime source of inefficiency is the management of an insurer’s supplier network. This can be an all-consuming challenge, depending on the breadth of cover provided and therefore the variety of the supplier arrangements needed. When delivering a quality service, it is also crucial that it is delivered in the most cost-efficient fashion. The management of a supplier network involving a multitude of transactions is ripe for streamlining and automation.

Blockchain is now being used by several insurers to simplify this area. Automating accounts reconciliation for processing supplier invoices has been implemented by a few insurers and



run as a proof of concept by the London Market Group. All have shown a significant reduction in the number of invoicing and reconciliation errors, reducing levels of rework and improving end-to-end delivery times.

ii) Customer service: enabling digital self-service

The rise of digital self-service impacts many aspects of our lives. Insurers have digitally enabled multiple elements of their claims processes, including FNOL (or ENOL), progress tracking and settlement. This benefits the customer by making the process more transparent and flexible – for instance, giving them the ability to report a claim 24/7 – while also delivering cost savings to the insurer.

Alongside the option of building in-house solutions, various technology companies can provide off-the-shelf solutions. One provides a white-label SaaS Electronic First Notification of Loss product technology and digital claims tracking, within which its main offering is Customer Managed Claims®. This enables customers to easily describe the details of an incident and add supporting photos and videos and to submit their claim online anytime. The claims information is instantly available to claims

handlers in a clear, ordered fashion, allowing the handler to determine the appropriate claim outcome. At the same time, customers can monitor the progress of the claim from various devices such as their phones and tablets.

iii) Fraud: detection and mitigation

One of the most significant but also most sensitive areas for any insurer is fraudulent claims. The Association of British Insurers (ABI) estimates that there were 107,000 fraudulent claims in the UK in 2019, amounting to £1.2 billion in total.⁴ In Europe the estimated cost of fraud runs at an estimated 13 billion euros per⁵ annum while in the US the FBI estimates annual fraud costs to be in the region of \$40 billion, or the equivalent of \$400 to \$700 per family.⁶ The scale of fraud is clearly colossal,

with the exaggeration of incidents, and hence claims, arguably considered socially acceptable by many.

Fraud detection may be considered something of a 'dark art', with insurers reluctant to share their strategies and methodologies. However, there are several vendors who are successfully delivering solutions to the market, such as shift technologies. Financial crime and specifically money laundering is another element of fraud, and again insurers need to ensure they have effective measures, such as machine learning detailed below, in place to prevent criminals benefitting from the proceeds of their crimes and being able to turn 'dirty' money into legitimate funds.

IMPACT OF TECHNOLOGY TRENDS

The shift towards digitalization in insurance has been significantly boosted by the boom in insurtechs, which are utilizing new technology trends and solutions to revolutionize some previously unchallenged attributes of insurance systems. Traditional insurance companies were dependent previously on systems that required expertise not only to build but also maintain. Factor in the amount of the build time for such systems, as well as implementation and the need to keep them updated, then such systems were particularly costly on a number of fronts.

Guidewire is one leading software company has secured a significant market share, with more than 400 insurers ranging in size currently running on its platform. Its Claim Centre offering, targeting the P&C industry, focuses on resolving claims faster and innovating claims management solutions through claims automation and AI. This innovative approach is reflected among other challengers who are constantly looking to improve the claims system through new approaches.

A current example of this is the adoption of low-code software by some insurance companies, which enables developers to design products with the minimum amount of handwritten code, speeding the path towards innovation. The caveat is

that users should have a working knowledge of code and its application to create products, while engineers are also required to create the initial code. (The speed and agility benefits inherent in low-code platforms also carry over to [no-code software](#), which allows mainline employees to play a part in digital transformation initiatives).

Development timeframes can be significantly reduced, from months to weeks or even days. This presents a truly exciting opportunity for longstanding insurance companies who would miss out on business and opportunities due to a backlog of internal IT requests. Established insurance and reinsurance brokers are now starting to utilize low-code software, with a focus on building solutions to aid data capture through the automation of processes such as sending policies to clients.⁷

Instanda, for example, provides a platform which enables you to implement your transformation without writing a single line of code. The emergence of no-code software has allowed for radical change to take place when it comes to delivery and agility of products. No-code software allows the client team to create a product without having specialized developers or any prior programming knowledge. Instead, you can select the components and functionalities you wish to have from a

library. As a result of this, several key steps are bypassed such as environment set up and code upgrade processes (both of which are particularly timely and costly for insurers). Everything that a user requires to construct a new product is already available in the platform. Insurers that incorporate the no-code solution are now able to deliver solutions in days or weeks rather than months.

An exciting additional benefit to the shift towards no-code is the larger choice available due to the ability to select from a product library and customize as much as you wish. Some even go so far to say that no-code is now 'leading the way of product innovation' and that the industry itself is also 'being redefined' as a by-product of the shift.⁸ In addition, the cost of the previous methods – due not only the length of development – but also the workloads of the teams involved have been greatly reduced.

Technology trends, such as machine learning and AI are being used to improve the customer experience through digital claims handling capability and a reduction in fraud and forms of leakage, as we will now explore.

Very significant improvements are being made to outdated processes – for example, **straight-through processing** of claims via enhanced rules engines. For simple claims, this allows the insured to claim for their loss in a quick and painless way, and for claims handlers to focus on the more technical elements of the claims. By having straight through processing for customers who raise their claims via the digital portal, it reduces the workload of an individual claims handler, enabling them to focus on providing a better customer experience for more complex cases. This shift in focus allows for not only a better customer experience but also a reduction in potential claim leakage, as the claims handler is able to spot irregularities.

Machine learning is used to reduce other forms of leakage by identifying losses which could become large if not handled well in the first instance. Machine learning can also be used to identify other forms of leakage which a claims handler might not have noticed. Another example is its use in reducing both fraud and forms of leakage. Firstly, several technologies are available to help reduce claims fraud, one of the biggest expenses to insurers. Via machine learning, claims handlers can be prompted to look at specific elements of the claim they

might not have previously considered as fraud indicators, while technology such as Detica NetReveal can help identify fraud rings by drawing upon data from several insurers.

In addition, digital claims handling capabilities provide an option for raising claims without making a phone call, where this was previously the preferred method. This is an addition to the multi-channel capabilities sought by customers and enables them to keep track of their claims progress in a quick and easy way.

Technologies such as AI and machine learning are being utilized at this point to assess loss. These assessments can be carried out in certain cases at any time of the day, as they do not require loss adjustors to be present – this allowing more cases can be assessed in a 24-hour period than previously.

Finally, one of the least appreciated benefits of these technologies is providing internal staff with a platform that makes their workday better, creating a better user experience for claims handlers themselves. Easier to use technology, offering sufficient flexibility to assist them while not restricting how they do their jobs, will help protect claims handlers' wellbeing, enabling them to provide better customer experience.

In summary, it is clear technology trends have a huge role to play in the modernization and improvements to the claims process and function, both for insurers and customers. A claims platform should look to meet the following criteria:

- Be capable of providing a digital experience for the customers and claims handlers.
- Enable a flexible workflow to enable each insurer to design a process which provides their customers with the best possible experience.
- Easy integration capability to enable insurers to utilize the wide claims ecosystems available
 - To use the AI and ML to improve the customer experience and reduce leakage
 - To pass data with various suppliers within the claims value chain.



CONCLUSION

The technology to bring claims into the digital age is already here, and some insurance providers are already reaping the benefits. Software is not only helping firms to get products to market faster, but it is also positively impacting the customer experience at all stages. Whereas in the past there were significant cost barriers to entry with digitalization, both low-code and no-code options are providing companies with a

viable and flexible alternative that is also helping them to focus on driving the business forward without as much pressure on resource and disruption to processes.

Contact us to find out how we are working with the industry to innovate their business processes and revolutionize the customer experience.

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ABOUT CAPCO

Capco, a Wipro company, is a global technology and management consultancy specializing in driving digital transformation in the financial services industry. With a growing client portfolio comprising of over 100 global organizations, Capco operates at the intersection of business and technology by combining innovative thinking with unrivalled industry knowledge to deliver end-to-end data-driven solutions and fast-track digital initiatives for banking and payments, capital markets, wealth and asset management, insurance, and the energy sector. Capco's cutting-edge ingenuity is brought to life through its Innovation Labs and award-winning Be Yourself At Work culture and diverse talent.

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