Rethinking Claims

Achieving High Performance in the Insurance Industry Through Claims Transformation

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Introduction

Within the global insurance industry, there is widespread recognition that the claims function occupies a unique place in determining an insurance company's competitiveness. On the one hand, claims represent a significant portion of the insurer's balance sheet, consuming nearly 80 percent of the premium in the form of claims payments or processing costs. On the other hand, claims service is where the insurance company is put to the test in terms of its ability to delight or disappoint the customer.

Combine these demands with more rigorous regulatory regimes, more litigious legal environments and globally sourced competitors that are continually raising the bar on efficiency and service, and it is no wonder most insurers today find themselves in a precarious position, teetering on the edge of success and failure.

Accenture's ongoing, systematic study of insurance claims performance—dating back to the 1990s—has shown a mixed bag of successes and clear signs that the industry overall continues to struggle to achieve durable performance improvements. Nearly 10 years of research—compiled across more than 50,000 claims reviews, 4,000 interviews with claims professionals, and across companies operating in more than 10 countries—has confirmed that there is significant room for insurers to transform the claims function.

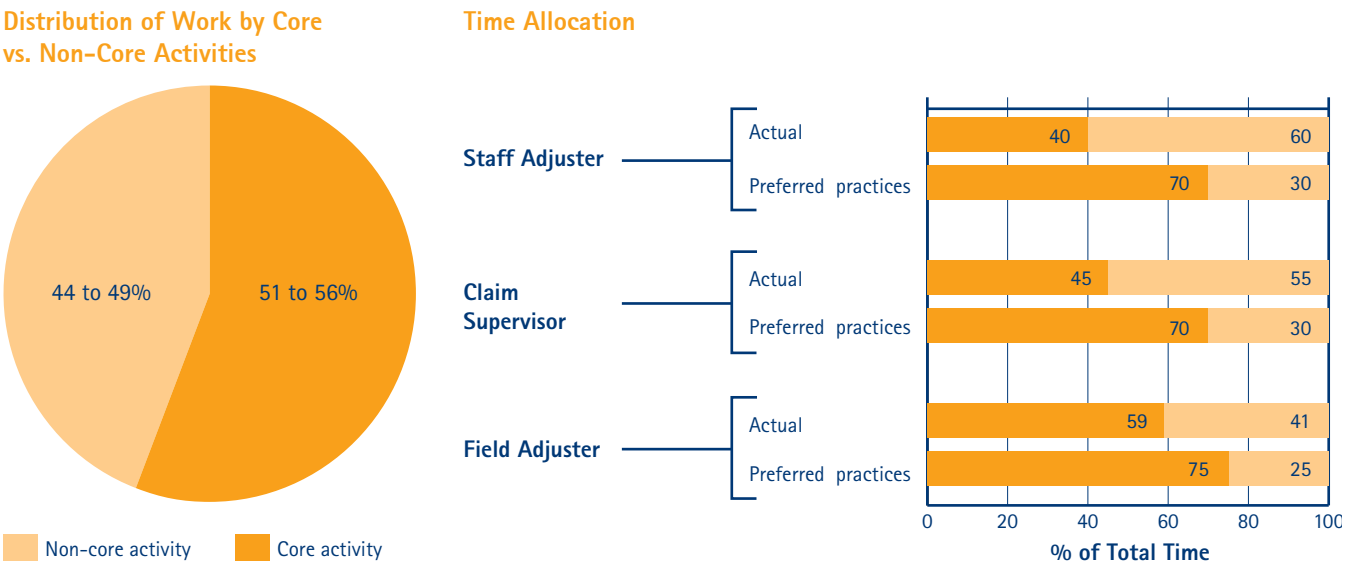
Claims professionals still spend nearly half their day on activities that do not impact the outcome of the claim (see Figure 1). And claims outcomes overall remain mixed, with varying degrees of consistent top level performance (see Figure 2).

The sheer persistence of this opportunity points not to an industry unable to take corrective action—but to a more fundamental need to rethink the problem at hand. Companies that wish to thrive and build durable competitive advantage through their claims performance need to embrace a holistic vision of a newly configured claims operation rather than isolated, occasional improvement initiatives. They cannot solve today's problems through an evolution of yesterday's solutions. It is time to recognize that breakdowns in the claims function can no longer be addressed through piecemeal, quick-hit strategies. In fact, we believe that now is the time to bring a new "playbook" for success.

The good news is that there is clear evidence that such transformational approaches can bring vast long- and short-term benefits for insurance companies, policyholders and investors alike. These benefits include greater internal efficiencies, lower operating costs, increased customer satisfaction and loyalty, and higher profitability.

In this paper, we will explore some of the issues that have created the current crisis in the claims function, and offer our playbook for helping this critical function enable high performance for the organization as a whole. Moreover, Accenture will also demonstrate that the benefits of claims transformation are well worth the costs.

Figure 1. Claims efficiency



Source: Accenture analysis

Figure 2. Claims effectiveness

Class	Type of claim	Loss Economic Opportunity: Below average	Average	Above average
Personal and Commercial Auto	Comprehensive	>12%	8-12%	<6%
	Liability: property damage	>12%	8-12%	<5%
	Liability: bodily damage	>14%	10-14%	<7%
Personal Property	Contents	>12%	8-12%	<3%
	Structure/building	>10%	6-10%	<3%
Commercial Property	Contents	>12%	8-12%	<3%
	Structure/building	>10%	6-10%	<3%
	Inland/ ocean marine	>13%	9-13%	<3%
Commercial Liability	General liability	>12%	8-12%	<5%
	Professional liability	>10%	6-10%	<3%
Private Liability		>18%	14-18%	<7%
Accident/disability		>8%	4-8%	<3%
Workers' compensation		>16%	12-16%	<7%

Loss Economic Opportunity (LEO) is defined as the savings potential associated with achieving consistency in claims handling, in accordance with good market conduct and consistency of application of company procedures.

LEO is derived through a comprehensive fact-based review of claims cases using Accenture's patented Claims Data Analysis methodology.

The Claims Reality Check: The Game Has Changed

"The more things change, the more they stay the same."

This adage is applied in many areas, including insurance claims. People who believe it are clinging to the false hope that yesterday's strategies and tactics are up to the challenge of today's competitive environment. In fact, we believe today's claims executives must face a reality check. Insurers that wish to achieve high performance through their claims processes face three major challenges —two external and one internal.

Reality Check #1: Customer Expectations Have Changed, and Demands Will Only Increase Over Time

It goes without saying that making a claim is a critical moment for the customer. Confronted with a loss, sometimes in a situation that is emotionally charged, and always searching for answers, the customer is looking for help through what can be a difficult process. This lack of comfort with a perceived "insurance service black box" is nothing new. In fact, a number of Accenture research studies indicate that insurance companies have a long way to go in meeting and exceeding customer expectations in claims service. What is new, however, is how companies outside of insurance have answered this challenge and, in turn, are raising the bar for insurance companies to meet service expectations.

Pick any household name among today's consumer giants—Gap, Apple, Starbucks, Nordstrom, FedEx. What makes these companies—otherwise a world apart from the insurance industry—relevant when thinking about claims service in particular? First and foremost, when interacting with any of these companies, it is the customer who makes the choice of how to engage, not the company.

Apple, for example, has arguably one of the most robust online channels available, offering everything from song downloads and notebook purchases to "how-to" videos for using the latest Apple merchandise. That being said, a consumer can still walk into an Apple store and get the same seamless buying experience as in the online world. The products, service philosophy and approach are the same, and the Apple culture permeates the total experience.

Meeting Customer Service Expectations

Claims service expectations are evolving, and today's insurance customers are simply demanding more from their carriers:

- Seventy-five percent of policyholders would prefer to speak to only one representative of their insurance company during the claim process.
- Those who spoke with three or more representatives were five times as likely to be dissatisfied.
- Nearly one in five said their claim experience would keep them from referring their insurance company to their friends.
- Negative claims experience ratings were highest for claims that took more than 20 days to be resolved (40 percent compared with 20 percent overall).
- Eighty percent of respondents said they would file claims online if it would expedite the process.

Source: Accenture 2005

This recognition of what makes Apple desirable to consumers and the explicit strategy of being able to meet those demands across multiple channels is part of Apple's continued success.

A similar approach holds true for FedEx. Consumers have come to expect a level of certainty, predictability and convenience in shipping and tracking their package—done either at a FedEx retail location, online or by phone. In the FedEx value chain, there are no surprises in the ability to meet customer expectations. The process is laid bare for all to see (and track) in real time, one stop to the next, until the package reaches its destination.

The average consumer interacts with a company like FedEx far more often than their insurance company—and almost invariably receives superior customer service. Over time, this raises service expectations to a level that is even greater for products and services that consumers consider to be expensive. As a result, insurance customers—who tend to think of insurance as a costly product of limited utility until a time of crisis—tend to bring intense service demands to their carriers based on their experiences elsewhere.

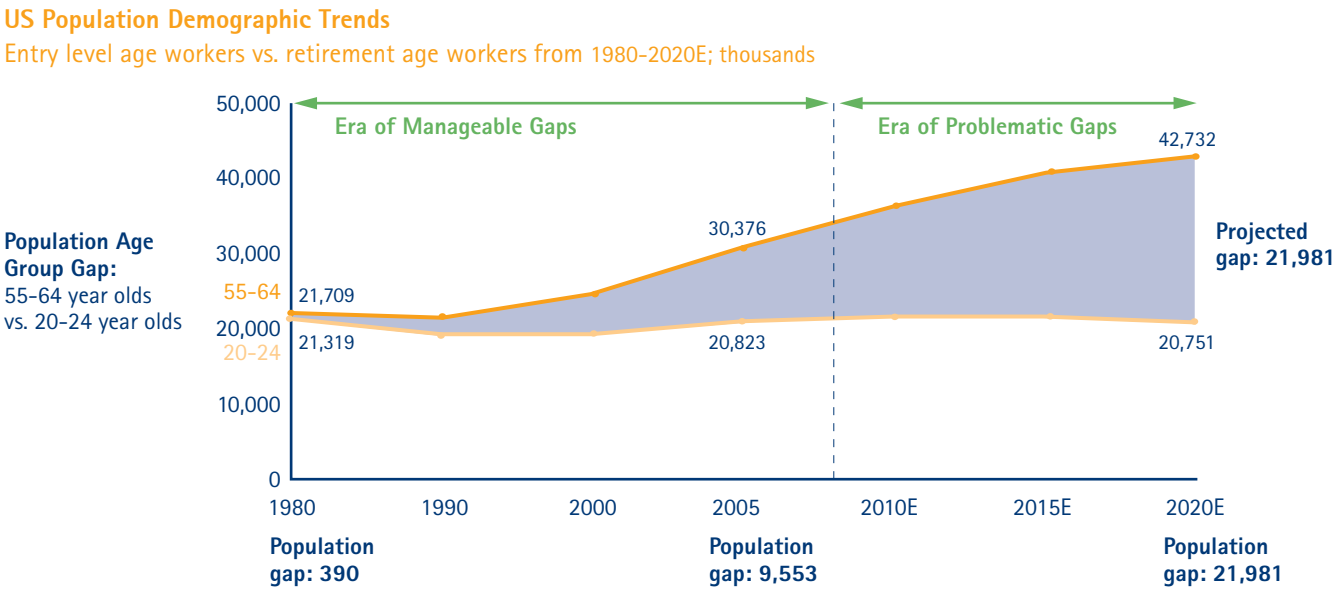
And that superior customer experience matters: companies that enjoy strong customer loyalty also have higher margins and revenue growth—and thus higher shareholder value. According to Accenture's High Performance Business research on customer relationship management, customer loyalty accounts for 38 percent of margin, 40 percent of revenue growth and 38 percent of shareholder value.

So the reality check on customer service is simple: service levels are no longer dictated solely by the insurance company. Customers increasingly set their expectations based upon their experiences with other industries. And more and more, the insurer is being held accountable to meet those expectations.

Reality Check #2: The Workforce Is Undergoing Seismic Shifts

In many respects, an insurance claim is the most human connection between the policyholder and insurer. Having suffered a loss, the policyholder is likely to feel vulnerable and exposed. Consequently, both the efficiency and consideration demonstrated by the claims professional will have a significant effect on customer satisfaction. The claims professional, therefore, occupies the most important stage of the insurance value chain, becoming the face of the insurance company itself.

Figure 3. A new workforce profile



Sources: US Census Bureau; Accenture analysis

Given its importance, the role of the claims professional requires a high level of general competence and the personal qualities that distinguish talented employees as valuable representatives of their company.

That is not a new standard for insurance claims, of course. What is new is the confluence of events and demographics that have created what might be called a "talent time bomb" with regard to staffing in general and the role of claims professionals. In order to defuse that bomb, carriers will need to reinvent the role of the claims professional to simultaneously attract new talent and deliver new value to the organization.

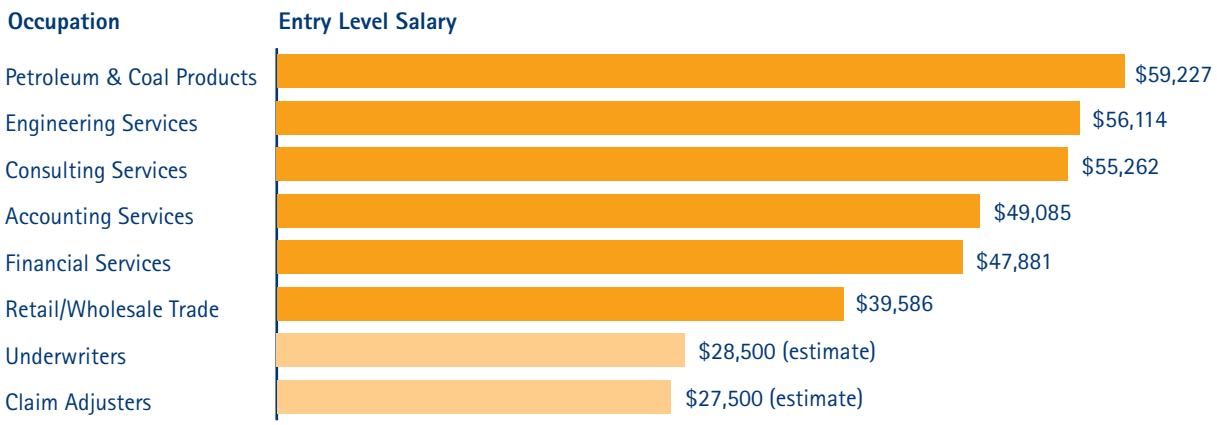
The human challenge for claims operations can be summed up in a simple phrase popular among today's global demographics experts: The future belongs to those who show up. But insurers globally are finding it increasingly difficult to get qualified professionals to join their claims organizations—or "show up"—for two mutually reinforcing reasons.

First, the population is top-heavy with baby boomers, who because of their numbers and their ages are very heavily represented in the professional classes. Approximately 40 percent of that group will reach retirement age within the next decade. Consider the United States, for example. Since 1980, demographers have observed a gap between American retirement age workers (55- to 64-year-olds) and entry-level workers (20- to 24-year-olds) that is rapidly widening. Starting from a baseline of 390,000 workers in 1980, the gap is expected to expand to nearly 22 million by 2020 (see Figure 3).

In the insurance industry, the net effect will be experienced workers leaving much faster than they can be replaced. The industry will simply be unable to fill professional roles at previous rates.

Second, and making matters worse, the insurance industry is struggling to effectively recruit from this dwindling pool of prospects—in no small measure because entry-level claims salaries are considerably lower than the salaries for most other professional positions (see Figure 4). The hard truth is that working for an insurance company is no longer among the most attractive options available to aspiring young professionals.

Figure 4. Top employers/job functions for 2007–08 new college graduates



Sources: National Association of Colleges and Employers' Winter 2008 Salary Survey; U.S. Bureau of Labor Statistics, 2007; Accenture analysis

A Transatlantic View of Claims Performance

Accenture's research of global claims practice suggests that there are valuable opportunities for insurers to benefit from the innovation and experience of their peers in other geographies.

For example, Accenture's 2007 Global Claims Study of insurers on their measurement of claims performance revealed that almost one-half (45 percent) of North American insurers differentiate performance measurement by claim segments and profiles within a specific line of business—compared with only slightly more than one-quarter (27 percent) of European insurers.

As well as having a greater level of granularity of measurement, we find that a greater proportion of US insurers have established balanced measurement regimes that include financial, operational and customer service measurements rather than focusing more on pure productivity measures such as closure rate. Applying a more holistic set of performance measures is critical in driving a balanced claims outcome, in terms of indemnity cost, expenses and service.

While the European industry may have room for improvement in claims measurement, it has experience in other areas that could be of value to North American insurers. For example, the level of sophistication in the structure and management of property supply chains operated by leading insurers in the Scandinavian and UK markets is very high. A wide range of property commodity/service categories are supported through managed supply chain, and there is extensive integration between insurer, supplier, field adjuster and claimant.

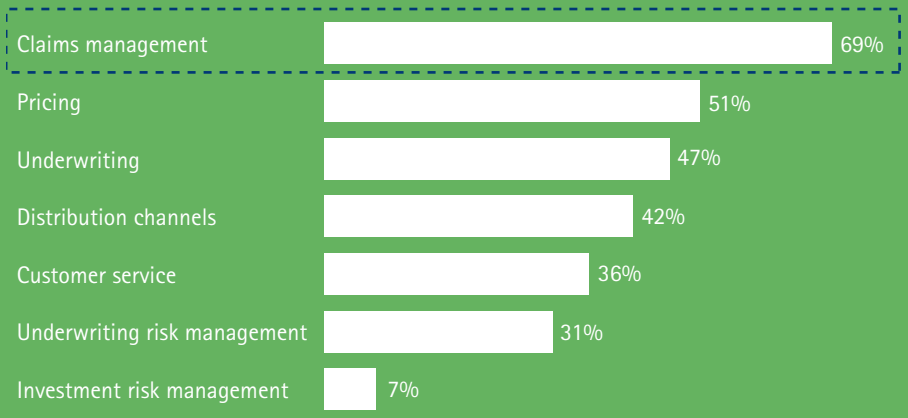
There are also exciting new business models emerging. Three Accenture clients in the United Kingdom have come together to channel their demand through a single shared supply chain, enabling them to share sophisticated infrastructure, pool their buying power and achieve advantageous business terms.

The diversity of claims practices across Europe and North America offers a valuable source of inspiration to claims executives who are seeking to maximize the efficiency and effectiveness of their operations.

Meeting Shareholder Expectations

The critical role of claims infrastructure has hardly gone unnoticed by the industry and investors. Accenture recently surveyed 108 insurance equity analysts around the globe and found that the IT investment area they currently value most among P&C insurance carriers is claims management technology.

Most Favored IT Investment Areas Among Global P&C Equity Analysts



Source: Accenture/Institutional Investor Market Research Group, December 2007

Reality Check #3: Infrastructure Can No Longer Be Ignored

The health of the claims operation rests heavily on its information technology infrastructure—the processes, applications, customer and policy databases, and all the electronic channels through which that operation is accessed. That infrastructure can enable step-changes in performance by doing a better job of breaking down and sharing work tasks, through analytics and the capture of detailed data. Being behind the curve in this area can bring information "blackouts" between parties, inflexible processing rules and a lack of agility to meet changing demands. Accenture's 2007 Global Claims Study indicates that there is more work ahead of the industry than behind in order to address this issue. A recent Accenture survey of more than 100 global insurers found:

- Less than one-half (49 percent) of insurers have integrated claims processing systems with first notice of loss systems.
- One-quarter (25 percent) say they are still using claims systems that are mainly manual and paper based.

These statistics demonstrate a fundamental weakness in claims infrastructure, where vast amounts of valuable information end up in static paper files and little is available within transactional systems. As a result, only a small amount of information is being used in narrow ways—lending little predictability and even less transparency to the various parties involved in the process—not least from the point of view of the end customer.

A New Playbook: The Road to High Performance

Breaking from the pack is not a question of tactical steps, but a thoughtful orchestration of key elements that leads to true claims transformation.

Based on our ground-breaking research and experience with hundreds of insurance companies worldwide, Accenture recommends the following actions for insurers to drive high performance for their businesses through claims operations:

Action #1: Tackle the Whole, Not the Pieces

Insurers simply cannot achieve high performance by pursuing isolated, quick-hit systems and process improvements at the periphery of their claims operations. Instead, they must take a holistic view of claims personnel, processes and technologies, rooted in enterprise data management and executed across the operation. Insurers must adopt well-defined processes supported by meaningful metrics and enabled by effective tools and technologies.

Insurers that embrace this new vision will achieve gains that exceed the benefits of even the most successful piecemeal solutions. And, most importantly, they will create a unified foundation for continuous improvement.

Insurers may be tempted to simply try to do a better job responding in the same ways they have in the past. For example, they may address today's talent crisis as a mere recruitment issue. But that would be a mistake. Insurers must rethink the claims operation from top to bottom, including the essential role of the claims professional itself. That role must be adapted to reflect the broad systemic changes required of the overall claims operation. It must work in harmony with the value advantages of superior access and the management and segmentation of information. And it must capitalize on a more open and extended organizational structure.

In short, the claims function must become an integral component of a growth- and future-oriented business model. Clearly, insurers must think differently about how they will construct, enable and manage the claims operation of the future. But more importantly, their basic vision for the claims function must undergo a metamorphosis.

Action #2: Reinvent the Role of the Claims Professional

In most insurance companies today, the claims professional performs a job that is 80 percent clerical and 20 percent professional. To attract "new blood" that brings competitive advantage, that ratio will need to be reversed.

The claims professional of the future will be at the center of a service offering channeled through the customers' preferred means of interaction and powered by real-time access to relevant data and information. A truly motivated claims professional, equipped with the most effective set of tools and supported closely by strong back-office capabilities, will bring claims to a more rapid and satisfactory resolution for both the policyholder and the insurer.

The claims professional of the future must also be less focused on processing and more oriented on decision making. The claims professional's focus must shift from the administrative to the advisory, from the rote clerical processing that is amenable to automation to the skilled technical, medical, legal and liability problem solving that makes the claims profession interesting to talented candidates and more valuable to their employers.

Quality candidates seek a job that is both meaningful and reasonably rewarding, both in terms of compensation and in the opportunity for career development and professional growth. The insurer needs to cultivate those aspects of its culture that deliver those desired qualities in a manner consistent with the objectives of the business.

Insurers should leverage the advantages they hold over other industries that may be perceived as more dynamic, but also more exclusively profit driven and even less socially responsible. The role of the claims professional itself potentially has more appeal as a "helping profession" with even a measure of heroism. It is a role where dedicated professionals address the needs of people who have suffered some loss and need urgent help, often delivered in challenging physical circumstances. Insurers can reshape the claims profession by appealing to a rising generation that values socially responsible organizations that have integrity, global relevance and local impact built into their cultural DNA.

Insurance organizations need to explain to their recruitment pool how they meet those standards and show their company's relevance to the world view shared by much of the younger generation. In addition, they must do so through that generation's favored communication channels, including the emerging world of social networking.

More importantly, insurers need to "walk the walk" by integrating the world of instant communications—and even social networking—into their claims process, and thus into the operational character of the claims professional. It is unrealistic to expect a generation used to communicating through instant messaging, the iPhone, YouTube, MySpace and Second Life to enter an insurance environment where the technology is dominated by green screens and disjointed, sluggish communications. Today's prospective hire is easily able to go to a website and plan travel, complete with detailed instructions and satellite imagery. They will not be impressed by a claims system that does not even allow them to find their customers by their last names.

The aspiring professional is much more likely to be impressed by a job in which he or she is dedicated to value-added tasks, with an emphasis on problem solving and decision making, and then is given the tools to execute those tasks and communicate their status in real-time.

Providing this type of working environment may be a daunting prospect for many insurers, but its necessity and value should be clear. A claims environment characterized by speed and transparency, one that incorporates real-time communications and allows the insurer to quickly keep its fundamental promises to its policyholders—from writing checks to facilitating third-party services—is an environment that fosters customer satisfaction and operational efficiency. It also provides the necessary tools to attract future talent and defuse the so-called talent time bomb.

Action #3: Foster a Next-Generation, Outcome-Focused Culture

Changes in the claims operating model and the roles of who processes what will require a new set of metrics to ensure that performance objectives are aligned. In essence, today's common claims metrics focusing primarily on "inventory" such as file counts, closure rates and average pendings are becoming increasingly less relevant in a world where a claim may be touched by a number of people, each with a specific responsibility and contribution to the ultimate outcome.

These traditional measures will need to give way to a balanced scorecard of measures that are reflective of each individual's impact on the claims outcome. Accenture envisions a set of primary and secondary indicators that first recognize the result of a given person's immediate work (primary) and the effect of that work downstream (secondary). For example, consider a model in which the handling of auto material damage claims is distributed across a team where one person has responsibility for timely scheduling of repairs and another has responsibility for managing rental car duration. Both would have a specific primary metric—either the average time for scheduling a repair or the average number of days the policyholder should have a rental car. These metrics would be tracked and measured. In addition to these metrics, each person would have a secondary measure more reflective of

How Japanese Carriers Can Inspire Loyalty through Claims Excellence

In many ways, the claims function is the ultimate "face" of the insurance carrier and indeed of the insurance industry itself. The efficient and accurate processing of benefits is a factor that can literally make or break the basic customer relationship—both individually and at large.

While the importance of an exceptional customer claims experience transcends geographic location, the Japanese market recently underwent intense regulatory demands to improve the industry's claims function. In 2007, Japan's Financial Services Agency (FSA) required insurers to investigate one million cases of nonpayment. This widely publicized event has had a detrimental impact on the confidence of Japanese consumers regarding insurers—and one that is only now starting to be repaired.

In large measure, these problems can be traced to the current technology environment of siloed, mainframe-based legacy claims systems. The absence of modern IT and integrated systems has contributed to a lack of transparency and hampered the smooth governance of claims processing. Although perhaps somewhat more pronounced there, that challenge is not limited to Japan. Accenture's 2007 Global Claims Study revealed that 72 percent of North American and European insurers' claims systems are disconnected from their policy administration and central customer databases.

To improve the claims function and restore Japanese customer confidence, some of the leading insurers in Japan are learning from the global lessons of their overseas counterparts and tackling the problem by modernizing their claims platforms to allow for seamless information flow between other core functions, such as policy administration. Leading insurers are embracing business intelligence, information analytics and business process outsourcing to break away from their competition and win over their customers.

The recent experience in Japan demonstrates how pivotal the claims function is in driving customer satisfaction. The measures being taken by the leaders will result in faster, more efficient resolution of claims and easy-to-understand claims reporting—and are ensuring that all of a customer's policies held with the insurer are considered during eligibility reviews. By striving to create a single, efficient, unified "face" to their customers who file claims, they can move more quickly down the road to becoming high-performance businesses by restoring customer loyalty, easing regulatory scrutiny and increasing revenues and top-line growth.

the overall team's work, for example, total cycle time. When determining individual performance, the primary indicators are given more weight in the analysis. That being said, the secondary metrics cannot be ignored as they are used to reinforce the potential knock on effect (positive or negative) of the primary indicator.

This is not necessarily an easy process. It requires a holistic look at individual roles and responsibilities, the metrics that would govern success for those roles, and the relationship between those roles and the entire outcome that is being measured. It is critical to take a broader view and ensure a true cascading of measures to avoid any "crossed signals" when providing employees with incentives for the right behavior.

Action #4: Create a Data-Driven Claims Life Cycle

The ideals of speed, efficiency and transparency in the claims process depend upon the insurer's ability to capitalize on rich claims information, make it readily available to internal and external consumers, and leverage it for continuous improvement. Next to the new business and underwriting process, the claims transaction is where insurers learn the most about their individual policyholders and, in the aggregate, about their businesses. This wealth of information constitutes a tremendous opportunity for insurers to not only improve the efficiency and effectiveness of the claims process itself, but also to power better underwriting, pricing, risk selection and reserving.

However, for most insurers today this remains an opportunity rather than a reality. What is missing in the claims life cycle—due in part to the limits of legacy claims systems—is predictability of processes and outcomes. Aging systems are simply incapable of classifying and recording the wide range of data attributes that any given claim presents. Having evolved from financial systems focused on payment processing and reserving, and lacking integration with core insurance applications, these systems help to perpetuate a manually intensive claims life cycle in which vast quantities of useful data are swallowed up, never to reemerge in any beneficial form.

As a pattern for potential success, insurers should look to the parallel case of the application of microsegmentation in underwriting. This approach, which became popular in the late 1990s and early 2000s, made it possible to identify pockets of profitability by writing unique products to cover highly specialized risks. Through the use of this technology-based approach, insurers have been able to generate significant profit from previously underappreciated risks.

Claims organizations can take a similar approach that breaks down the existing claims portfolio on the basis of highly detailed data. This approach to claims information management requires a highly granular breakdown of data throughout the entire claims cycle rather than simply at notification of loss and at payment of the claim. And it requires capturing attributes of all parties to the claim at all stages, as well as all the business processes enacted, and all the specific activities and their associated components.

Once this data-driven claims life cycle is fully embraced, an insurer can begin to reassemble the data to draw relationships between like claims and like outcomes. In other words, by properly segmenting and examining data, an insurer can begin to identify claims segments that follow the same who, what, when, where and how of claims processing. With that accomplished, the insurer can correlate highly differentiated actions to outcomes, introducing a novel degree of predictability and transparency to the process.

In addition, this data driven life cycle feeds the insurer's capability to make smarter retention decisions by testing the assumptions set by original underwriting guidelines. This is one of many inestimable benefits of the high-quality feedback that detailed claims information provides. Finely segmented claims information, appropriately analyzed and catalogued, can be leveraged to provide decision support for claims professionals applying reserves—the importance of which will increase in proportion to the scarcity of experienced claims staff. It also provides a stream of vastly more detailed and more accurate information for purposes of audit and compliance, and for product development and marketing.

Action #5: Extend the Enterprise Beyond the "Four Walls"

To date, insurance claims organizations have traditionally gravitated toward one of two organizing principles, resulting in approaches that could be characterized as either the "scale" or the "skill" model.

The "scale" model is characterized by a top-down approach, whereby success is driven by a cadre of capable executives managing in command-and-control fashion. This model works well when sufficient numbers of staff are performing similar tasks, but it tends to be idiosyncratic and resistant to change. Because of the model's hierarchical nature, new directives take time to flow throughout the organization. And because it is driven by strong managers, it elevates

personal influence over methodology, making it difficult to repeat successful processes across the enterprise.

The "skill" model functions through down-the-line excellence where star performers are placed throughout the organization. This model depends on acquiring and retaining highly skilled individuals, and tends to drive specialization among carriers corresponding to the skills a given carrier tends to emphasize. While this model is superficially more flexible than the "scale" approach, it is actually more fragile because knowledge tends to be personal rather than institutional, because individual knowledge tends to be of ephemeral value in a shifting market and because star performers are often recruited by competitors.

Both of these models have had their place in the past but neither offer the adaptability that today's business environment requires. Rather, this new environment requires insurers to reinvent their claims organizations with the characteristics of an "extended enterprise" centered on a clear understanding of the lines between claims adjudication and claims processing.

Beginning by identifying and deconstructing the essential links in the supply chain, the extended enterprise is not dependent on remote authority from the top, as in the scale model, nor on the heroics and star qualities of individuals at key points throughout the enterprise, as in the skill model. Nor is it bound by the rigidities of either paradigm. The extended enterprise model focuses competence rather than spreading or diffusing it across tasks. In addition, it elevates results over procedures and is not restricted in physical space. It also focuses on skills and competencies required to execute the work at the right mix of skill and cost, regardless of physical location.

In significant measure, the extended enterprise is made possible—and eventually necessary—by advances in information technology. The extended enterprise's characteristic functional deconstruction and reassembly of tasks is supported by the emergence of service-oriented architecture technology, which enables disparate systems to communicate more effectively at lower cost and, more specifically, enables rapid reconfiguration of functionality to meet changing conditions. The spatial or geographical openness of the extended enterprise model is facilitated by the availability of broadband Internet capability.

This concept of the extended enterprise does not begin and end with the insurance company's own personnel, but should include the policyholder as well as key vendors with which the insurance company does business. It is no longer sufficient to provide a window into the process at which the customer will watch the progress. Now, in the extended enterprise model, the customer is actually in the process, transacting business, providing information and potentially making decisions as to how their claim should progress. The same can be said for vendors that are strategic to the insurance company. They should be seamlessly integrated into the process, through real-time information exchange and the ability to work on pieces of the overall claim.

Royal & SunAlliance Transforms to Achieve High Performance

Royal & SunAlliance is a leading multinational insurance group. In early 2003, a new Group CEO was appointed by the Board with one main goal, to make Royal & SunAlliance, a stronger, higher performing business, one that delivered to shareholders and one that customers and employees could again be proud. Following a comprehensive strategic review, he and his team drew up a demanding set of objectives aimed at turning the business around. These included strengthening the Group's capital position, building a new management team, embedding a performance culture, and transforming the operational performance of its ongoing business.

The operational transformation program has had two elements. The first has been to restructure and de-risk the ongoing portfolio by focusing on general insurance and by successfully exiting life and underperforming businesses. The second has been a demanding operational improvement program. Two key targets were publicly announced: to cut the expenses of the Group's ongoing businesses by UK £270 million and to achieve a combined operating ratio of 100 percent on average across the insurance cycle for the Group's ongoing business. Critical to the transformation program was a fundamental restructure of the UK claims business. The objective was to improve claims performance by implementing a new operating model to drive reductions in claims indemnity costs and claims expenses.

The new Group CEO brought in Accenture to team with Royal & SunAlliance as the partner to implement this fundamental restructure. This would exploit Accenture's industry insights, transformation expertise, software assets and outsourcing capabilities. The two companies structured a contract with a risk and reward payment arrangement based on the delivery of the program benefits, within budget and on schedule. Both organizations stand to gain by making progress over the course of a three-year plan to transform the insurer. The transformation program was comprehensive and included:

- Implementing a new operating model comprised of a Rapid Response Unit for claims notification and settlement of simple claims, and a segmented back-office for handling complex claims
- Establishing an offshore claims processing center for claim notification and recovery processing
- Implementing Accenture Claim Components Solution as the single claims handling system across the operations
- Implementing consistent organization, team and job structures and re-engineered business processes across the operations
- Establishing supply chain arrangements with suppliers to optimize UK£500 million in spend across motor, commercial property and indirect spend categories

The Claims transformation program began in October 2003. Within three years, the target operating model and supporting system were fully implemented.

Royal & SunAlliance's UK Claims operations now have a consistent organization and handle claims through a single system using a single set of best practice processes. Whether based in a Royal & SunAlliance office or in the field, the Claims employees in the UK now work as integrated, virtual teams instead of the previous silos dictated by geography and systems functionality. Workflow with key suppliers is seamless due to supply chain system integration.

The Claims program is a significant contributor to Royal & SunAlliance's transformation program and strategic plans. At the end of 2005, the Claims indemnity costs were reduced by more than UK£130 million per annum, and Claims expenses were reduced by more than UK£5 million per annum.

Conclusion

Insurance companies that continue to take the traditional route to claims improvement through localized technology, people and process initiatives may enjoy modest benefits. However, history has shown that improvements garnered through such quick hits inevitably erode over time.

The only way to ensure durable competitive advantage and high performance is to rethink the claims organization, embracing a new vision that is built on a foundation of human performance, information access and management, claims segmentation and organizational agility.

The prospect of reinventing the claims function may seem daunting given its critical role in determining profitability and the constantly evolving demands that are placed upon this function. But the rewards can far exceed the time and resources invested in transformation.

Breaking old cycles requires a thoughtful reexamination of the claims operating model, across all elements of people, process and technology. A claims operation characterized by world-class capabilities in these areas is much better equipped to help the organization compete and win over the long term.

In short, today's issues cannot be solved by yesterday's solutions. The new claims playbook is not an evolution of thought, but a revolutionary reexamination of the claims operation from top to bottom. The key is to put the claims professional and the customer at the center of this change, opening and extending the enterprise to allow fully transparent processing independent of location, and employing the right kind of technology and supporting organizational structures. A more holistic vision of claims operations will help insurance companies build more durable competitive advantages, both near-term and long-term, and will ultimately help them achieve high performance.

About the Author

Michael Costonis is the executive director of Accenture's Global Claims Practice. In addition to heading up Accenture's global claims services, he is responsible for the company's North American insurance management consulting practice.

He has been with Accenture since 1992, during which time he has worked with more than 50 leading insurance clients in 14 countries. He is particularly experienced in the property and casualty sector, and oversees Accenture's claims strategies, assets, capabilities and sales development—in short, he is the key architect of the company's claims business.

Michael is a regular speaker at insurance conferences and a published author of numerous articles on insurance. His contributions to formulating the future of the claims function include his white paper "Unlocking the Value in Claims" and the Claims Capability Maturity Model—Accenture's point of view on what it will take for a claims organization to compete and win beyond the 21st Century.

About Accenture

Accenture is a global management consulting, technology services and outsourcing company. Combining unparalleled experience, comprehensive capabilities across all industries and business functions, and extensive research on the world's most successful companies, Accenture collaborates with clients to help them become high-performance businesses and governments. With more than 178,000 people in 49 countries, the company generated net revenues of US$19.7 billion for the fiscal year ended 31 August, 2007. Its home page is www.accenture.com.

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