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Claims: the dawning of a new era?

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- Insurers and claims management companies will soon be regulated on equal conduct terms. This should trigger changes in how each engages with the other.
- The FCA's focus on claims and compensation could result in a re-examination of claims practices by insurers. If significant improvements can be made, might this make CMCs largely redundant?
- Fair claims decisions are difficult where conflicts of interest remain unresolved, yet people often shy away from tackling them. Claims directors need to show clear ethical leadership on this.
- Claims teams are experimenting with new ways to deliver fair decisions, but these need to be mainstreamed to prove lasting. Four components of a fair claims decision are examined.
- If consistent execution across delivery chains remains a challenge for claims teams, insurers need to put their supplier performance under a 'fairness spotlight'.
- The greater openness in claims being championed by some insurers is great, but could it also be the first step towards claims automation and the provision of 'de-risking services' through a profit-driven claims centre?
- New roles and responsibilities are being shaped for claims operations. For the future of claims to be bright, this needs to be done with fairness and trust in mind.

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CII Introduction: if there is one type of firm guaranteed to make insurers moan in frustration, even roar in anger, it is claims management companies. Soon they will share the same regulator as insurers, the Financial Conduct Authority. What might this regulatory switch mean for insurance claims? What might the regulator have on its radar when it comes to the wider changes underway in insurance claims? What will this mean for future relationships between insurers and claims management companies, and how should they adapt in response?

Introduction

With claims management companies now falling within its remit, will the FCA take another close look at insurance claims? Where might insurers cast a careful eye in preparation? And what affect might wider trends in insurance claims, such as increased outsourcing and greater openness, have on the FCA's thinking? More of the same, you may think, but how might warnings that they have been "far too passive" in the past influence the FCA's approach?

A switch of regulator does not often spur widespread change within a sector, but this one could be the exception, acting as a tipping point for all sorts of new initiatives that have been gaining momentum. In this Thinkpiece, I weigh up those ramifications and examine the two most pertinent ethical issues involved. I then examine the implications that increased outsourcing and greater openness could have for customer outcomes. And finally I look at the skills that insurers will need to build in their claims people to ensure that the integrity gained is then maintained.

Background

Claims management companies came into being largely as a result of the compensation available to the many hundreds of thousands of people that had been mis-sold payment protection insurance. With strong, often intrusive marketing, they began to dominate the market for obtaining compensation. It didn't take long for claims management companies (CMCs) to then apply their business model to other types of claims, most noticeably people seeking personal injury compensation from motor insurers. Their tactics became controversial, resulting in accusations of spurious and exaggerated claims being submitted.

The Claims Management Regulator sought to curb the worst firms and excesses of CMCs, but they sometimes struggled to contain the problem. It came to feel like everyone in the UK had at some point received a text message encouraging them to submit some sort of claim. Insurers started calling the UK the 'whiplash' capital of Europe, after the most popular type of injury claim. Something had to change and a review of regulatory options in 2015 set out the options.

A new regulator

Despite acknowledging that the level of PPI compensation had helped to raise UK economic growth, the Chancellor of the Exchequer took the decision in early 2016 to move the regulation of CMCs to the Financial Conduct Authority (FCA): 'one regulator to rule them all', to paraphrase JRR Tolkien.

It was not the first time that the FCA had been in such a situation. Only a few years earlier, it had taken on the regulation of many thousands of payday loan firms, another sector accused of controversial practices. Price and product controls soon followed, driving the more dubious payday loan firms out of business and putting others through some challenging restructuring.

Many of the accusations levelled at payday loan firms bear a remarkable similarity to those levelled at CMCs. So might the medicine - price and product controls - turn out to be the same? That's unlikely, given that payday loan firms manufacture their product, while CMCs provide a service. Yet there will undoubtedly be a market review conducted by the FCA, in which it will bang the table on practices to be banned and voice stern words on what good practice and bad practice look like. 'Seen it before', you may think, but be prepared for a surprise. That banging could be louder than before, those words sterner than before, given recent criticism from the UK Parliament's Public Accounts Committee that the FCA was being "far too passive" in tackling problems in the sector.

Cue 'much rejoicing' from insurers. Yet is that wise? They may wish for it to be the beginning of the end, but it feels more like the end of the beginning. After all, payday loan firms haven't gone away: they've just got smarter and more business like, serving a clear market in a more responsible way. And that will be at the back of the FCA's mind when it lays down its new rules for

CMCs: how they can serve a now established market in a more responsible way.

Changing the conversation

The claims management companies that will emerge out of this period of transition are going to be different from those that insurers have been complaining about for so long. They'll be more business-like in identifying their target markets, in marketing their services, in the way in which they engage with insurers in pursuit of their customers' claims. In which case, it would make sense for insurers to reshape the way that they in turn think about, and engage with, CMCs. Insurers should do this for two reasons.

First, when the 'bad CMCs' are swept away, then the ones left are more likely to have a substantive case to make against the insurer on their client's behalf.

Could those 'good CMCs' emerging out of the regulatory transition be seen as a form of antidote to the information asymmetry that claimants have felt exposed to in the past?

It's good then to see some insurers providing claimants with better explanations about how the decision on their claim has been made. In doing so, they will in effect be starting to nullify the very opportunities that CMCs have been exploiting.

And this leads to the second reason: the 'good CMCs' that emerge out of this regulatory transition will be viable businesses only to the extent that a market of disgruntled claimants exists in the first place.

So insurers should look carefully not only at how they communicate those claims decisions, but at how those claims decisions are being made in the first place. This can be done at the detailed level of processes and policies, but it also needs to be done at the higher level that can be summed up as 'how we listen to the voice of the customer'. This may seem like a somewhat nebulous concept, but it is in fact something that insurers have been urging upon themselves as a sector for some time now, in their pursuit of being 'customer centric' organisations .

Becoming customer centric

An insurer cannot be 'customer centric' if it does not listen to what the customers are saying about it. The trap that some insurers can fall into is assuming that they pretty much know what customers want, what is right for customers. Yet that can never really be the case with insurance: if you're making those sorts of judgements on behalf of your firm, then you're already too 'socialised' into the technical world of claims to be able to pick up that customer voice accurately.

This was highlighted for me when, in reviewing the performance metrics for a large claims operation, the one chosen 'on behalf of customers' turned out to only rank twenty second when the insurer actually listened to those claimants' views. The top two metrics (by far) had never been measured before. And in conducting and sharing that research, the insurer changed the claims conversation: from one of problems being encountered, to one of solutions being sought. Big tick to them.

So the challenge that insurers should put to their claims operations should be to take all that energy put into countering the 'bad CMCs' (because hopefully most of them will go away!) and transfer it into building new conversations with claimants, with the express (and entirely laudable) aim of cutting out the need for even 'good CMCs' to exist in the first place.

If more claimants understand that the decision on their claim is fair, then fewer claimants will turn to CMCs. And insurers can, today, take as a starting measure for this, the percentage of personal lines claimants who, even though their claim was successful, still felt like making a complaint. A FCA review of household and travel claimants found that this percentage stood at 15% in 2014: insurers should be reducing it to a single figure, even halving it, over the three years to 2017. Instead of turning to outsourcing as the best way to tackle concerns about the level of household claims expense, wouldn't it be better to achieve the same aims by reducing the cost of problems. Stop fighting fire with fire; turn off the fuel the fire is feeding on instead.

How might claims people go about this? What critical lines of thinking should they follow? The two that spring most readily to mind are conflicts of interest and fairness. Both have long been issues associated with insurance, and it is when claims are made that they can often be most in the spotlight.

And of course, insurers have responded to these two issues with policies, procedures and monitoring. Yet if those policies and procedures were working, why are more than a third of complaints about insurance

submitted to the Financial Ombudsman Bureau (FOS) upheld? If there is, as it appears, a disconnect somewhere, what should insurers pay attention to? Here are some thoughts.

Conflicts of Interest

Business people can sometimes shy away from conflicts of interest, sensing that they're bad news. Yet a conflict of interest lies at the very heart of insurance claims: the amount you pay out in claims influences the amount of profit the business makes. In other words, do claimants' interests come first or does the company's interests come first? The answer is hopefully an obvious one, but how do you then deliver that across a complex claims operation?

It's here you need to apply some ethical thinking techniques. For example, we can sometimes fall into a 'temporal trap', in which the shorter term consequences of a team's claims decisions (for example, "are we hitting our performance targets?") take precedence over the longer term consequences of those same decisions (for example, "how fair have those decisions been and what impact are they having on complaints and trust?"). Claims directors should be showing clear ethical leadership on mitigating that 'temporal trap'.

The ethics of conflicts of interest lie not in whether you're in one or not (for they are hard to avoid), but in how you handle them. And that is where the ethical culture in claims functions perhaps matters most. Does that culture signal permission to put claimants' interests first? Do systems work in support of such a culture? Do leaders talk more about honest claimants than they do about fraudulent claimants?

So in considering the impact that conflicts of interest could be having on the decisions being made by claims people, here are five steps you can take:

1. look for evidence of the risks from conflicts of interest having been mapped out and assessed, both internally and across the claims delivery chain. For the significant ones, what mitigation options have been prepared, and how clearly are they being monitored?
2. the mitigation options may look good on paper, but are they being used enough, or at all? Brokers have fallen into this trap (called the gross-net gap) in the past, so insurers should take heed. If you can't find evidence of those mitigation options being used, and having the desired effect, then stick a red flag on it.
3. check for how perceived conflicts of interest are being handled. They're not always included in a conflicts of interest review, yet claimants often sense them and judge claims decisions through their lens. Do perceptions matter? Ask anyone who works in sales, marketing, communications or public relations at your firm.
4. take a look at the performance metrics being used in claims departments and what moves them up and down. I've seen relatively indirect performance metrics having a stifling effect on the decisions that claims people were able to make.
5. take the same questions and ask them of your principle partners and suppliers. You may have delegated claims decisions to them, but you are still accountable for what they do.

Fairness

> *"For leaders today – both in business and regulation – the dominant theme of 21st century financial services is fast turning out to be a complicated question of fairness."*

Those were the words of the then-chief executive of the Financial Conduct Authority, back in 2013. Fairness can be both complicated and not complicated. It is straightforward enough in consumers' minds for them to rely on it when judging the trustworthiness of firms, yet for firms, putting it at the centre of how they make decisions has evidently been a challenge. If, after nine years of the regulator's 'Treating Customers Fairly' initiative, insurers are still trusted less than banks or estate agents, then clearly something is not adding up.

One problem could be the habit of insurers to view fairness through a somewhat partial lens. The emphasis seems always to be on the fairness of merit, which is perhaps not surprising, given how it sits at the heart of that key insurance principle, adverse selection. Yet if that 'voice of the customer' is to have any real meaning, then what that voice has to say about fairness needs to be taken on board as well. Is it time then for some new lessons to be learnt?

Adverse selection has taught the sector to emphasise one particular dimension of fairness, yet customers don't see (or experience) fairness in such singular terms. Insurance professionals need to be taught about

fairness in a more multi-dimensional way. 'Treating Customers Fairly' regulations need to say more about fairness in the process of individualised decision making. Everyone in a claims team should understand what the customer means by a fair decision.

It is good to see some claims teams experimenting with this: for example, the insurer who has a special team for assessing claims that don't fit neatly into workflow boxes. Yet should such a 'fairness team' really only be a temporary measure, used to learn more about the fairness of individual claims decisions so that lessons can then be seeded back into the wider function? If not, then the danger is of a claims culture split between 'them over there who do fairness' and the rest who do what 'the system tells us to do'. Fairness needs to permeate systems and not just be accommodated by special 'safety valve' teams dealing with 'problem' cases

What lessons can claims teams learn about fairness?

1. Learn about the different components of fairness:

If nothing else, it will give you a better understanding of what the customer is talking about when discussing the fairness of a claims decision. Here are four components to keep in mind:

- structural fairness: are there any constraints within the overall situation on the claimant gaining an equitable settlement for their loss? For example, access to technical information, conflicts of interest, the suitability of the policy originally sold to them, etc.
- assessment fairness: will the claim be processed correctly according to a policy wording that is clear and straightforward? For example, are claims staff properly training in the necessary skills, with adequate resources and authority?
- procedural fairness: will adequate and balanced enquiries be made of the claimant and their loss, and will the information obtained be acted upon in an open and honest way? Surveillance methods for example.
- outcome fairness: will the settlement being proposed reflect not just the letter of the policy, but the spirit of its intentions as well?

2. Learn how to weigh up the fairness of a particular decision:

One way to do this is by considering what decision you would make if you didn't know anything about the particular consequences of that decision for yourself. You have to weigh up whether you would personally be prepared to accept the consequences of your decision, not knowing how great or small those consequences might be. If you were prepared to accept those unknown consequences, then the decision can more easily be described as fair. (see the box for a worked-out example of this).

3. Learn how to weigh up the fairness of the options a decision presents:

Each option will have different impacts: the fairness of an option is based upon the extent to which it improves the expectations of the least advantaged people affected by that decision.

And bear in mind that a frequent source of pressure on making decisions that are fair are conflicts of interest. Be better at dealing with conflicts of interest and claims teams will find it easier to make decisions that are fair.

Weighing Up The Fairness of a Decision: Case Study

Using an example from the underwriting of flood insurance, you wouldn't know anything about

- where your own house was located, or its exposure to, or history of, flooding;
- whether you had sufficient financial resources to fall back on should you find cover for flood unavailable; and
- the insurance market, nor about the wider economic and political issues surrounding floor defences and the availability of insurance cover.

You would make your underwriting decision about flood insurance from behind what amounts to a veil of ignorance.

The consequences of that decision for you could fall anywhere on the scale between complete disaster and totally unaffected.

In taking that decision, you have to weigh up whether you would personally be prepared to accept the consequences of your decision, not knowing how great or small they might be. That is a measure of its fairness.

Time for a Relaunch?

Is it time then for the FCA to consider a relaunch of their 'Treating Customers Fairly' initiative?

People often say that the initiative has lost its way. If the FCA is responsive to the nudge given to them recently by the UK Parliament's Public Accounts Committee, they would be more specific in how they set out their expectations of firms around fairness, drawing on their experience of nine years of TCF related assessments.

It would for example be relatively simple to publish more up-to-date examples of what good practice and bad practice looks like when it comes to the fairness of claims decisions. This could extend beyond the insurer itself to how fairness is stipulated in the decision making processes set out in delegated authorities. After all, if the FCA publishes good and bad practices for CMCs, it would be relative straightforward for them to publish something similar for insurers and their agents.

A better CMC sector will result in a greater legitimacy to the claims it makes on insurers. This is in fact good news for insurers: they'll spend less time and cost fighting the spurious ones and more time weighing up, negotiating and learning from the valid ones. The challenge for insurers, as mentioned before, is to reach this point without being encumbered by the anger and challenge that can permeate existing relationships with CMCs.

There will of course be some CMCs who will try to operate around the outer edges of the regulatory boundary, targeting the insurance market in questionable ways, but that is for the FCA, insurers and regulated CMCs to tackle together.

Parliamentarians have also been putting pressure on the FCA to be more forward looking, to ensure that the claims practices being planned now deliver the right customer outcomes in one to two year's time. With claims operations being increasingly influenced by technological developments, that makes sense. Remember the old adage about 'technology and business' – think just as much about what's being shaped now, as about what's being implemented now.

The next part of this paper does just that – looks at two significant developments, one happening now and one being shaped now. Both raise questions about fairness and conflicts of interest, and both will have an important influence on customer outcomes over the next three years through how claims are handled.

Is consistent execution the flaw in supply chains?

Claims management companies are just one example of a broader trend in claims towards the involvement of more and more firms carrying out specific components of the overall claims experience. Just as CMCs manage the policyholder's interests in a claim, so accident management firms often manage the insurer's interest in a claim.

The proliferation of such firms has however produced longer supply chains, more complex boundaries and frequent handovers. Each such firm may bring to the claim its own particular skills and experience: added together, the claims journey begins to look pretty exceptional. However, appearance is not the same as experience, with the 'multitude of cooks' often leaving the claimant bewildered as to who is doing what and exasperated when their claim is handed over from one supplier to another.

For example, strange though it may seem, not all motor insurers handle their accident claims. The accident management firm who does it for them has one supplier who deals with repairs and another supplier who deals with write-offs. Engineers can be appointed by all of these three parties. Meanwhile the claimant rarely gets a straight answer to a question, for another firm in the supply chain has to be checked with first and the decision often referred up the chain. Delays become common, multiple people become involved and confusion can rein. What can look like efficiencies and enhancements on paper begin to feel like a disintegration of service in real life.

Insurers are now recognising this: "…consistent execution is a key challenge" said one leading claims director recently. Meanwhile 'fair outcomes' for the customer remain under pressure. How long for? Just as the FCA is expected to make short shrift of some CMC practices, might it become impatient with some of the knots that claims functions can tie themselves in?

Will we see that regulatory finger point to the 2015 thematic review into delegated authority, with its criticisms about the narrowness with which underwriting and claims authority was being delegated? Time perhaps then for claims directors to dust off that 'due diligence' manual and dig out that framework for what a 'treating customers fairly' culture looks like. At the back of everyone's mind should be the reminder in the Senior

Insurance Managers Regime that insurers may delegate their authority to supply partners, but they nevertheless remain accountable for the decisions taken under it and the outcomes so generated.

Fairness as part of the Due Diligence process for supply partners

- Explains what fairness is and why it is important;
- Shows who has responsibility for fairness as the claimant goes through the claims journey;
- Points to particular stages when fairness might be most under pressure and how the supply partner is to deal with this;
- Shows how fairness is being checked, monitored and reported during the course of the insurer/supplier partnership.

Will greater openness lead to claims automation?

A claims decision that is fair is also one that is clear and transparent. That's because fairness is not something that can really be determined by only one side to a situation. So, the more open a decision, the clearer its presentation, then the more likely it is that it will be seen as fair.

And insurers are recognising this, with the launch of initiatives to keep the claimant informed about the progress of their claim and about how its settlement has been arrived at. This is great, for while some things about insurance may be difficult to understand, there is always something that can be shared with the claimant.

It's easier to be transparent in this way with the more mainstream types of claims. And as by their nature, there can be quite a few of these, this form of initiative relies on a lot of data gathering and reporting. It may involve claims people in all sorts of number gathering and screen entries, but it's also a great way of building customer loyalty through engagement.

As all this data becomes organised into 'claims progress dashboards', the next step will see the introduction of options that allow claimants to state their preferences: about how repairs are carried out, about which items should be replaced, about how settlement is to be paid. This is just a short step from something that has been on the drawing board for a while: the self settled claim.

The self settled claim will allow claimants to report small, simple claims on a self service basis, uploading photos or receipts of items being claimed for and clicking on options and questions to allow settlement within minutes or hours, rather than days or weeks. It will feel a bit like the self service checkouts that now exist in many supermarkets.

The decision support software underpinning such developments will become progressively more sophisticated, allowing for greater levels of claims automation. And insurers will start to seize upon these moments of close engagement with their customers, looking for opportunities, as one leading data commentator put it recently, to go beyond indemnity and look for ways to make the policyholder feel safe. So the self service claims portal will come with menus of top-up extras, paid for by the policyholder of course, but timed to take advantage of the insurers' supply chain of contractors and the attention of claimants to 'get things sorted out'.

With all the risk attached to underwriting, and having tasted the potential for claims income from the likes of referral fees, some insurers will be tempted to extend their offering and build a more layered relationship with their customer. All for a fee of course. Indeed, some may be tempted to do so in the absence of an actual claim in the first place. After all, why wait for a claim to come along to leverage some value out of your supply chain: put it to work now.

This will fit with some insurers' strategies to move their relationship with customers beyond a purely risk based one, to incorporate more service elements that will build loyalty and engagement. And with so much data becoming available to insurers, this would support the ambition of many insurers to better predict the claims that could occur, by spotting variances that could produce a loss, by engaging with policyholders to have it put right, all wrapped round with the message of 'keeping policyholders safe'. Is this nirvana for insurers – turning claims into income opportunities, moving it from a cost centre to a profit centre?

A nirvana for insurers?

Does turning claims into income opportunities, moving it from a cost centre to a profit centre, sound a bit far fetched? Not really, if you think that we can now buy insurance for driverless cars, and of some insurers settling claims through a smart phone. Is there a dark side to this though? Perhaps, if insurers are connecting more than the obvious dots.

Consider this. Big data is allowing insurers to become more selective about what they're underwriting. In a diverse and competitive market, the result on paper will be a variety of niche players focussing in on particular types of insured. In reality however, markets tend to follow a herding instinct, the result of which will be an increasing number of people finding it difficult to obtain cover. As portfolios are de-risked of certain types of policyholder, insurers will seek to transform the relationship from a risk-based one to a service based one. For such policyholders, insurers will offer services to 'keep them safe', instead of products to 'indemnify me for a loss'. Both see risk as a business opportunity, but come at it from completely opposite directions.

Claims automation will be a significant component in this transformation of insurance, aligned as it is with the wider ambitions of many insurers to refashion their relationship with consumers. That alignment will however mean that claims directors need to understand the ethical issues being linked with that wider transformation, to ensure that steps forward are not overshadowed by steps back.

Preparing for the future

Over the next five years, the changes that will affect claims teams will create roles and responsibilities that were not envisaged five years ago. Those roles and responsibilities are starting to take shape now, so what can be done to ensure that they are shaped with trust and fairness in mind? Here are some suggestions:

- Provide training in key issues like fairness and conflicts of interest;
- Incorporate criteria for fairness and conflict mitigation into projects and systems;
- Encourage an open culture that allows questions around fairness to be raised;
- Bring a clear and defined 'voice of the customer' into claims management;
- Highlight examples of what a fair decision in a mainstream claim looks like;
- Highlight examples of what unfair decisions look like and how to resolve them;
- Give people practice in tackling tricky decisions in a fair way;
- Encourage some critical thinking about 'why we do what we do' in claims.

If the future of claims is to be bright, it needs to be interwoven with trust building measures like these. Hopefully the CII's claims faculty project on future skills will provide the necessary lead on this.

Conclusions

Claims management companies and insurers will soon be regulated on equal conduct terms. So who then will be able to say that one side is good and the other side is bad? That will be difficult without potentially bringing similar questions down upon oneself. With insurers trusted less than banks or estate agents, that could be a brave call to make.

The cultures of the two types of firm may be different, but then it is a competitive market, big enough to encompass more than one way of thinking, more than one way of addressing an issue. The outcome will be a continued tradition of rigorous negotiation, and that is not a bad thing.

Where insurers have an advantage however is that their hand is on the tiller. How claims are settled, and how complaints about settlement are dealt with, will ultimately feed or starve the market for CMCs. For insurers to secure the high moral ground on claims, they will need to see this new era for claims as an opportunity to regain consumer trust, through greater professionalism across the spectrum of claims operations, through engaging with claimants in ways that build understanding, through handling issues like fairness and conflicts of interest more astutely, and through products with better designs. Get these things right and CMCs become largely redundant.

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