Benchmarking Liability Claims Management

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Abstract

The performance of claims management operations are often considered in terms of the performance against operational process metrics and as an expense item in the profit and loss. We provide the results of a survey of liability claims managers assessing the performance of the industry relative to descriptors of poor, average and best practice and also rating the performance of their own claims operation relative to the industry.

We use the results of the survey to provide analysis of claims operations in terms of how they can deliver value to an insurer's bottom line and how management can benchmark the performance of their claims operations relative to good practice and between claims teams and whether (and to what extent) claims management is delivering value to the business.

Keywords: Liability, Claims Management, Best Practice, Benchmarking, Performance

1. Objective

This paper sets out our views of best practice techniques for the management for liability claims and benchmarks, based on feedback from experienced liability claims managers, current industry practice against our defined best practice.

2. Best Practice Claims Management

Our model of best practice claims management for liability claims is based on the experience we have gained over a number of years in reviewing, assessing and monitoring claims management operations both in Australia and overseas. It reflects the observations we have of the key elements of an effective claims operation and current leading practice in these elements

We note that best practice is not fixed but constantly evolving and changing. Best practice also must be considered in context and what is good practice for a large public liability portfolio will vary from that for a small niche portfolio. It is also noted that insurers may, for financial or other reasons, choose not to target best practice but to maintain a lower, more easily achievable standard or may be aiming to move there incrementally over a period of time.

Nevertheless we expect that every insurer would aim to ensure that their claims operation is as efficient and effective as it can be given the nature and size of the portfolio and the constraints (budgetary and otherwise) that they operate under.

The quality of an insurer's claims management operation can provide a competitive advantage to an insurer. It is our experience that for liability claims the difference in claims cost outcomes between good (not necessarily best) practice and poor practice can exceed 20 per cent of claims costs. As claims management expenses are only a fraction of total claim costs it can make sense to invest significantly in improving claims management in order to deliver a significant net saving.

Best Practice Elements for Liability Claims

In assessing best practice liability claims management we generally look to examine performance under a number of key headings:

- Effective claims management model
- Early claims reporting
- Effective triage and segmentation
- Timely effective communication
- Appropriate reserving
- Proactive management
- Identify and address outlying claims
- Effective provider management
- Optimal resourcing
- Claims systems
- Performance management

While we have not attempted to weight the relative importance of the above elements, in our survey we have sought to gain views of practitioners as to the importance of the criteria. It is our view that while some may be more important than others, they should be considered holistically as claims management performance may be limited by the weakest link.

3.   Best Practice Liability Claims Survey

Survey Objective

For this study, we undertook a survey of experienced liability claims managers in order to understand views of

- The general standard of liability claims management across the industry
- Their company's current position relative to industry.

Methodology

For each of the best practice elements (above) we identified a number of components that contribute to that element. We identified between 2 and 7 components for each element depending on the element. For each component descriptors of "Poor", "Satisfactory" and "Best" practice were drafted.

A survey questionnaire was developed which asked respondents to rate current "average" industry practice against these descriptors and also to assess their company's current practice relative to industry. For each component practitioners were asked to nominate a rating of 1 to 5 on the following basis:

Descriptor	Rating
Poor	1
Midway between poor and satisfactory	2
Satisfactory	3
Midway between satisfactory and best	4
Best practice	5

The survey also asked if the respondent considered that any significant best practice elements were missing and if any of the eleven best practice elements included did not warrant inclusion. Lastly it asked the respondent to list the best practice elements that they considered most critical in getting best practice claims outcomes. A copy of the survey template can be found at Appendix A.

We issued the survey questionnaire to a range of senior experienced liability claims managers – where possible we sought a response from the most senior claims manager within the firm. The firms targeted ranged from small niche insurers to major insurers with large public liability portfolios. We also sought responses from a small number of individuals who were not current claims managers but who had considerable liability claims experience.

The survey questionnaire was sent to approximately 30 people in the insurance industry with experience in liability claims. We received a total of 20 completed surveys. While the number of responses is relatively small in absolute terms, they represent a good cross section of the industry, including a majority of the major players in liability insurance.

We would like to thank all those who responded: without them this paper would not be possible.

The detailed data for each question component can be found at Appendix B.

4.   Comments on Best Practice Model

Best Practice Elements considered missing

Of the 20 people who responded, five respondents listed one or more additional elements that they considered to be missing from our list of eleven best practice elements. The elements these responses identified were (identified by one respondent unless otherwise stated):

- Culture (2 respondents)
- Approach to declinature of indemnity under policy
- Communication with underwriting
- Negotiation methodology
- Recovery/contribution identification and pursuit
- Training – enhance training to include knowledge of policy wordings and coverage.

We acknowledge that each of the above items would be appropriately included in any best practice model. In particular that culture and recovery/contribution could warrant a separate element. We will extend our best practice model to incorporate these activities and include results for these activities in future benchmarking exercises.

Best Practice Elements listed that should not be included

There was not a single response that indicated that any of the eleven best practice elements listed should not be included or were in any way inappropriate.

We consider that this represents a validation of our best practice model for liability claims management.

5.   Performance of liability claims management across the industry

In this section of the paper we set out the responses to the questions relating to the individual assessment of the industry current average performance relative to our best practice scale. Practitioners were asked to make their assessments based on their experience of the liability claims management industry.

A number of respondents commented that their experiences were limited (with direct exposure to a limited number of claims management operations and/or types of liability claims) and therefore were in a limited position to comment on the industry as a whole, these respondents were asked to respond based on their experience.

Our approach in assessing the current state of play was to identify the proportion of responses where industry performance was rated as being "best practice" or "above satisfactory" (scores of 4 or 5 on our survey scale). Based on the survey results across all questions we arbitrarily set 60% as representing the proportion which indicated that the industry as a whole is performing at a "good" level.
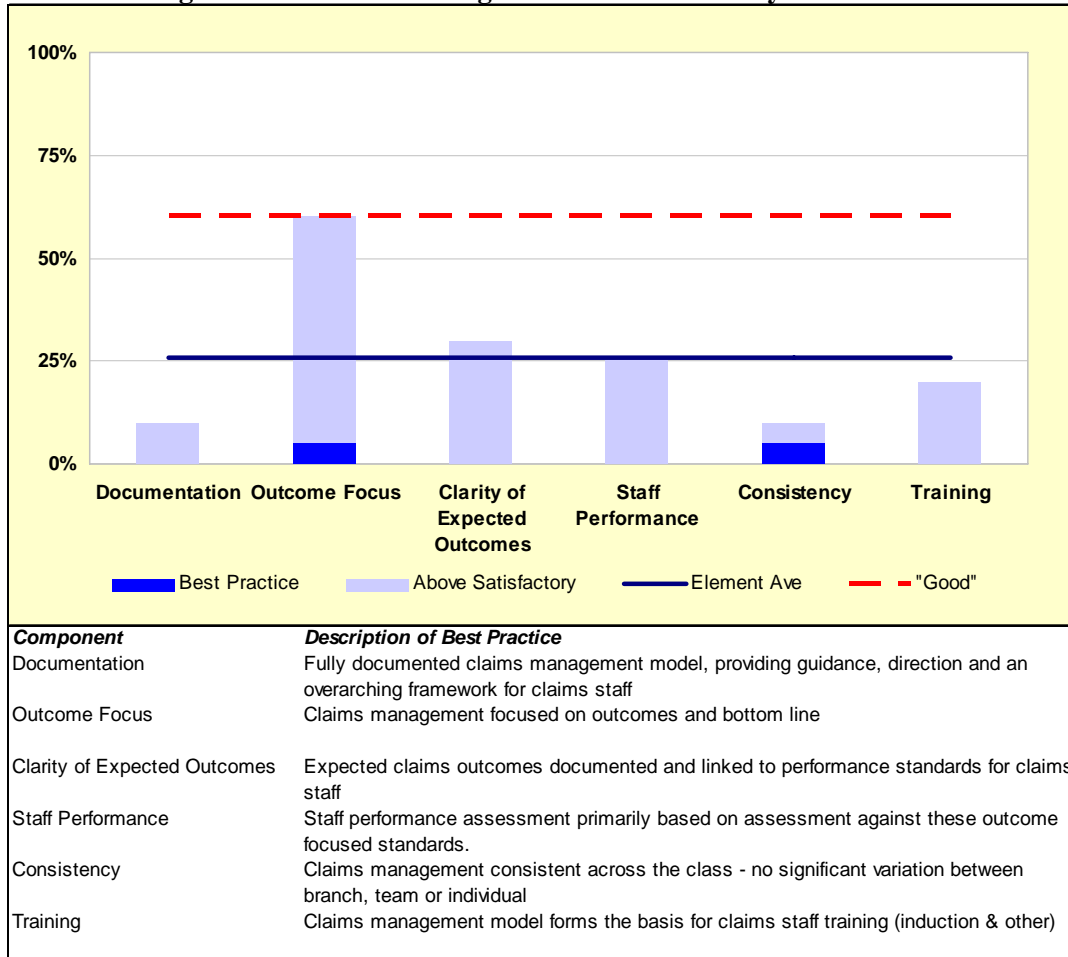
The extent to which the proportion of responses for any question fell short of this benchmark acted as a means of identifying areas where the opportunity exists for a good return on investment from improving the approach to claims management.

Element 1 - Claims Management Model

Claims Management Model incorporates the development and documentation of a claims management model or a policy and approach to how claims are managed (but not a "claims manual") and how that model is disseminated and made operational consistently throughout the business. Figure 5.1 sets out a description of the components considered under this element that we believe constitutes Best Practice and the survey respondent's assessment of the industry's current state of play.

Figure 5.1 – Claims Management Model: Industry Assessment

Component	Description of Best Practice
Documentation	Fully documented claims management model, providing guidance, direction and an overarching framework for claims staff
Outcome Focus	Claims management focused on outcomes and bottom line
Clarity of Expected Outcomes	Expected claims outcomes documented and linked to performance standards for claims staff
Staff Performance	Staff performance assessment primarily based on assessment against these outcome focused standards.
Consistency	Claims management consistent across the class - no significant variation between branch, team or individual
Training	Claims management model forms the basis for claims staff training (induction & other)

These results show that for most aspects of the underlying business model, practitioners feel that the industry is falling well short of the 60% benchmark for "good" performance. The one exception is "Outcome Focus" which reaches this standard. The poorest ratings were for the documentation of the *Claims Management Model* and the consistent execution of the *Claims Management Model* across the whole organisation. There is considerable scope for improvement in these areas.

Element 2 – Early Claims Reporting

Early Claims Reporting relates to how early reporting is promoted, facilitated and monitored by the business. Figure 5.2 sets out the components of the *Early Claims Reporting* best practice element and the survey respondent's assessment of current industry performance.

Figure 5.2 – Early Claim Reporting: Industry Assessment

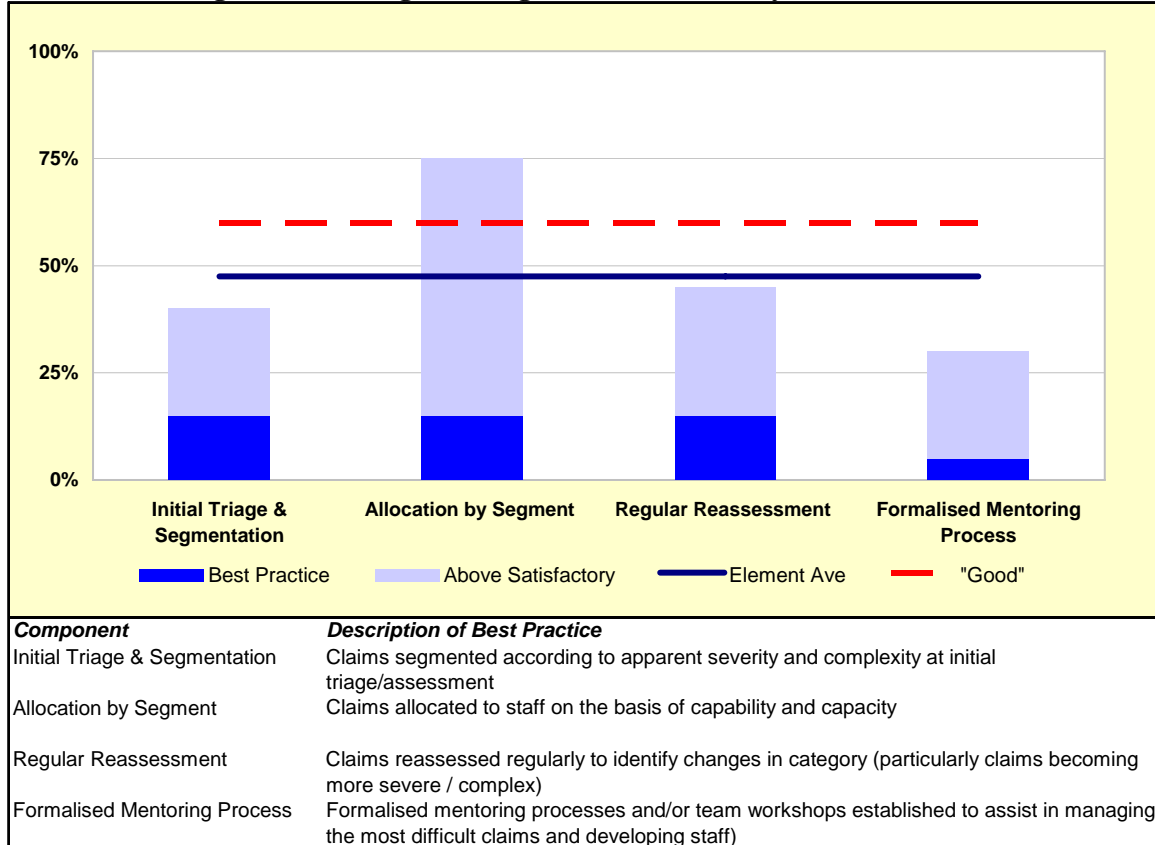| Component	Description of Best Practice
Promote Early Contact	Early claims (and potential claims) reporting actively promoted to front-line staff, policyholders and brokers.
Monitor Delays	Reporting delays (from time of loss and time policyholder was aware) monitored – policyholders/brokers with significant delays followed-up
Systems to Facilitate Reporting	Systems in place to facilitate reporting of claims and potential claims, ie including in advance of a formal claim where liability is apparent

The survey results indicate that in relation to *Early Claims Reporting* industry performance falls short of the 60% "good" benchmark. The results are relatively consistent across the components of best practice, although monitoring delays was rated best and there is considerable scope for improvement in the provision of systems to facilitate early reporting.

Element 3 – Triage and Segmentation

Triage and Segmentation relates the segmentation of claims according to apparent severity and complexity with the appropriate allocation of resources for the identified severity and complexity. Our definition of best practice *Triage and Segmentation* and a summary of the survey results for this element are shown in Figure 5.3.

Figure 5.3 – Triage and Segmentation: Industry Assessment

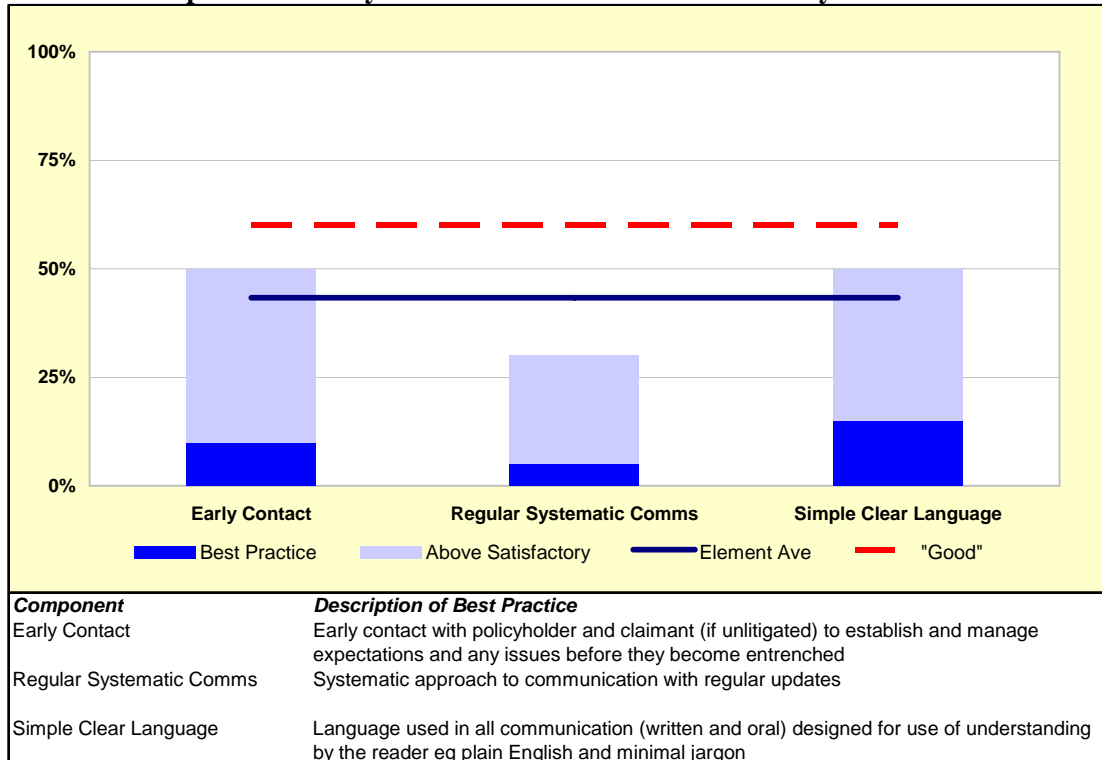| Component	Description of Best Practice
Initial Triage & Segmentation	Claims segmented according to apparent severity and complexity at initial triage/assessment
Allocation by Segment	Claims allocated to staff on the basis of capability and capacity
Regular Reassessment	Claims reassessed regularly to identify changes in category (particularly claims becoming more severe / complex)
Formalised Mentoring Process	Formalised mentoring processes and/or team workshops established to assist in managing the most difficult claims and developing staff)

The survey results show industry performance below the "good" benchmark of 60% for most components of the *Triage and Segmentation* best practice element. The exception is 'Allocation by Segment' which was rated as best practice or better than satisfactory by 75% of respondents.

Element 4 – Timely Effective communication

Timely Effective Communication incorporates timely and effective communication with the policyholder, the claimant (and/or their representative) and providers to ensure relevant information is obtained and expectations are managed. Figure 5.4 shows a definition of the best practice components of *Timely Effective Communication* and the survey results for this element.

Graph 5.4 – Timely Effective Communication: Industry Assessment

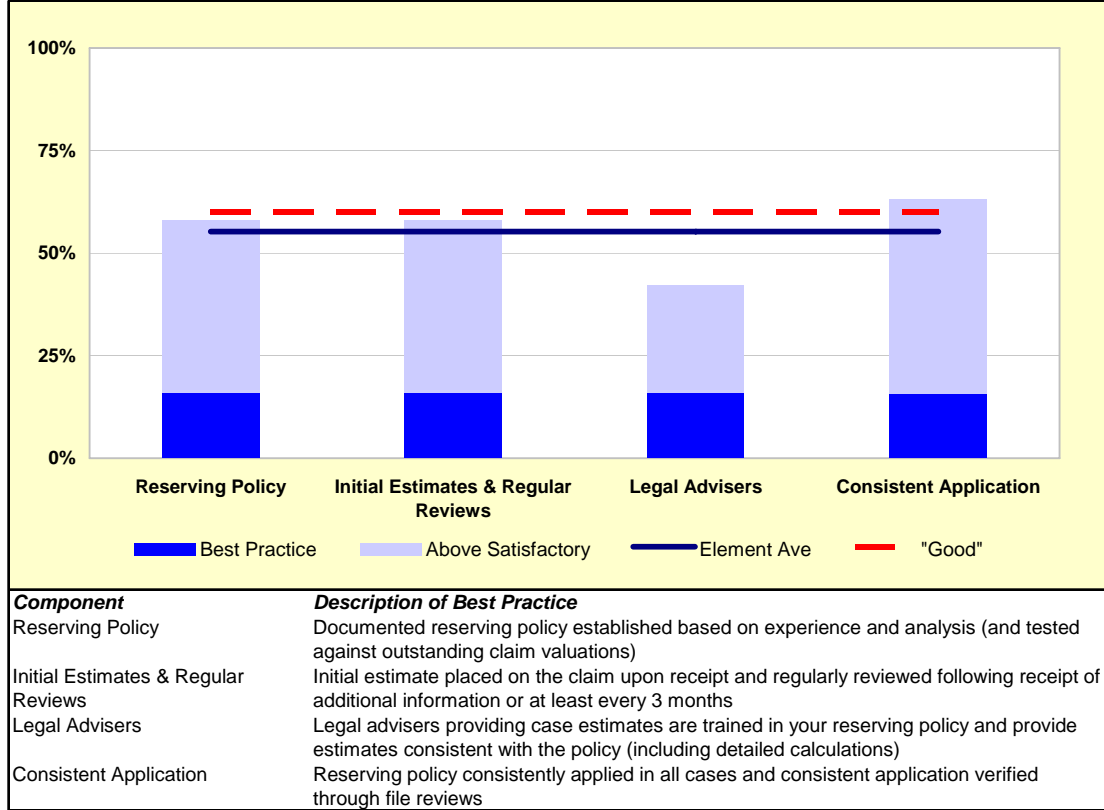| Component	Description of Best Practice
Early Contact	Early contact with policyholder and claimant (if unlitigated) to establish and manage expectations and any issues before they become entrenched
Regular Systematic Comms	Systematic approach to communication with regular updates
Simple Clear Language	Language used in all communication (written and oral) designed for use of understanding by the reader eg plain English and minimal jargon

Timely Effective Communication was rated below the 60% "good" benchmark for all components. The area with the greatest scope for improvement is 'Regular Systematic Communications' which had only 30% of respondents rate it best practice or above satisfactory.

Element 5 – Reserving

Reserving incorporates establishing a reserving policy, the consistent application of the policy (internally and by legal providers) and regular reviews of estimate. The results for the *Reserving* element of best practice claims management and the best practice descriptions are summarised in Figure 5.5 below.

Figure 5.5 – Reserving: Industry Assessment

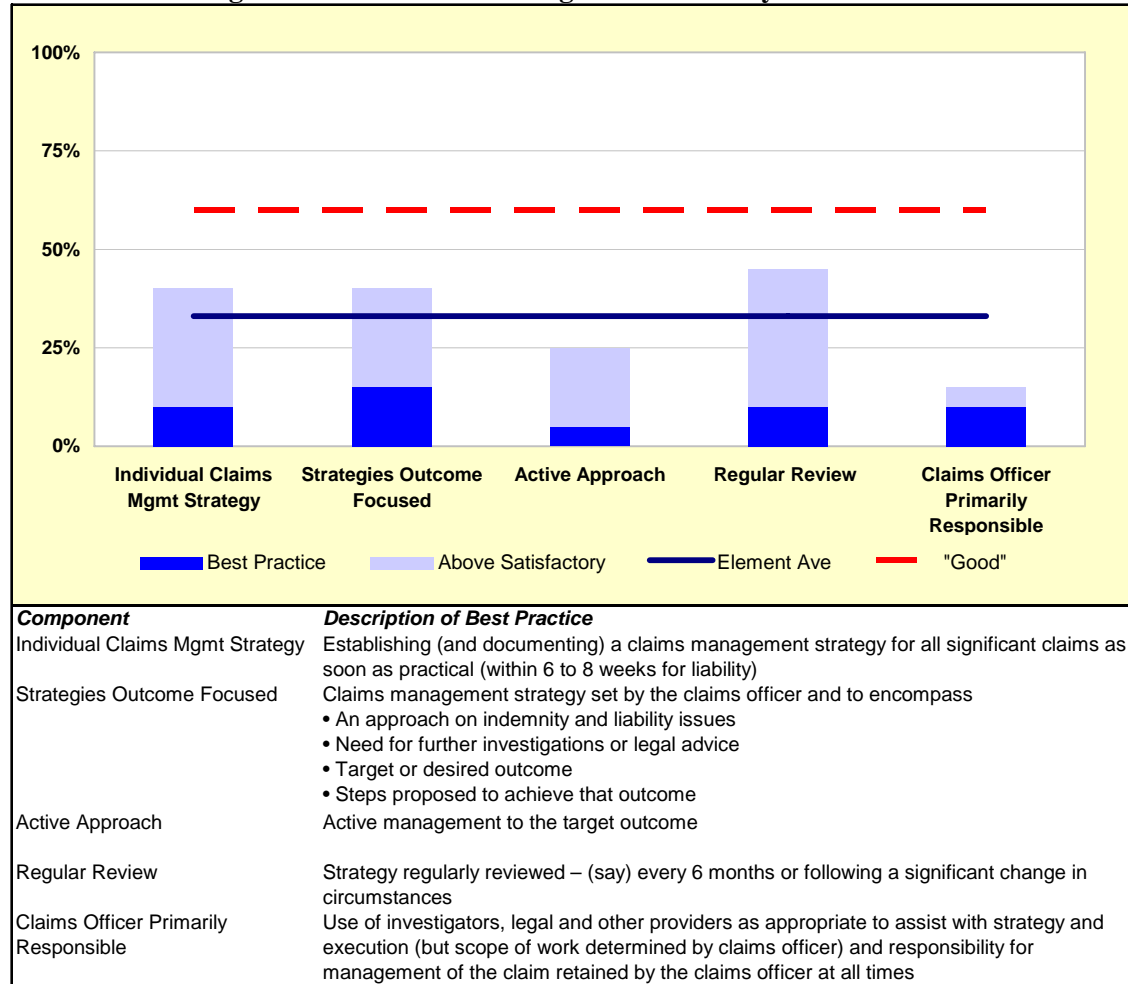| Component	Description of Best Practice
Reserving Policy	Documented reserving policy established based on experience and analysis (and tested against outstanding claim valuations)
Initial Estimates & Regular Reviews	Initial estimate placed on the claim upon receipt and regularly reviewed following receipt of additional information or at least every 3 months
Legal Advisers	Legal advisers providing case estimates are trained in your reserving policy and provide estimates consistent with the policy (including detailed calculations)
Consistent Application	Reserving policy consistently applied in all cases and consistent application verified through file reviews

Reserving practice across the industry was generally rated very close to our 60% "good" benchmark. The only exception related to legal advisors using the claims manager's reserving policy when advising on reserves which scored a lower result with 42% rated best practice or above satisfactory.

Element 6 – Proactive Management

Proactive Management relates to the claims officer taking the initiative with claims and actively driving the claim towards their preferred resolution. Figure 5.6 below shows the results for the *Proactive Management* element of claims management, together with our description of best practice..

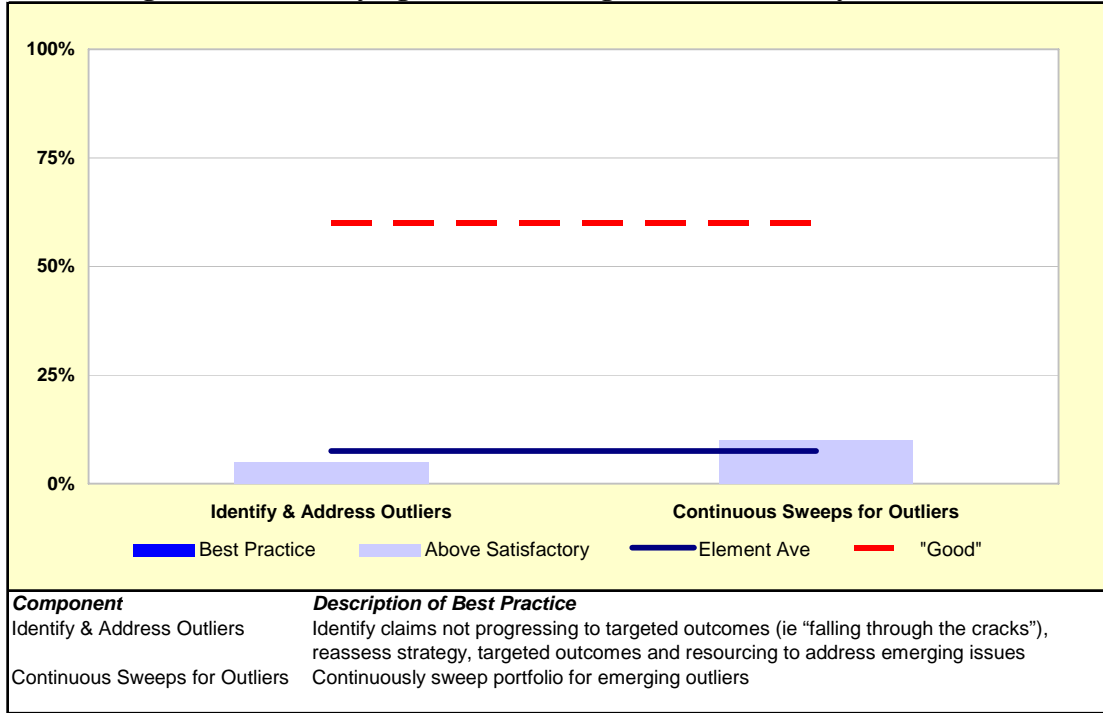**Figure 5.6 – Proactive Management: Industry Assessment**

Component	Description of Best Practice
Individual Claims Mgmt Strategy	Establishing (and documenting) a claims management strategy for all significant claims as soon as practical (within 6 to 8 weeks for liability)
Strategies Outcome Focused	Claims management strategy set by the claims officer and to encompass • An approach on indemnity and liability issues • Need for further investigations or legal advice • Target or desired outcome • Steps proposed to achieve that outcome
Active Approach	Active management to the target outcome
Regular Review	Strategy regularly reviewed – (say) every 6 months or following a significant change in circumstances
Claims Officer Primarily Responsible	Use of investigators, legal and other providers as appropriate to assist with strategy and execution (but scope of work determined by claims officer) and responsibility for management of the claim retained by the claims officer at all times

Proactive Management practice across the industry was rated below the 60% "good" benchmark across all components of this best practice element. Two components were rated significantly lower than the remainder: 'active management to the target outcome' and the 'claims officer being primarily responsible for the claim'. These two components have the greatest scope for improvement and are also arguably the most critical.

Element 7 – Identify and address outlying claims

Identify and Address Outlying Claims relates to the regular reassessment of claims to identify and address claims not responding as expected to the chosen claims management strategy. The figure below summarises the results for *Identify and Address Outlying Claims* and also describes best practice.

Figure 5.7 – Identifying and Addressing Outliers: Industry Assessment

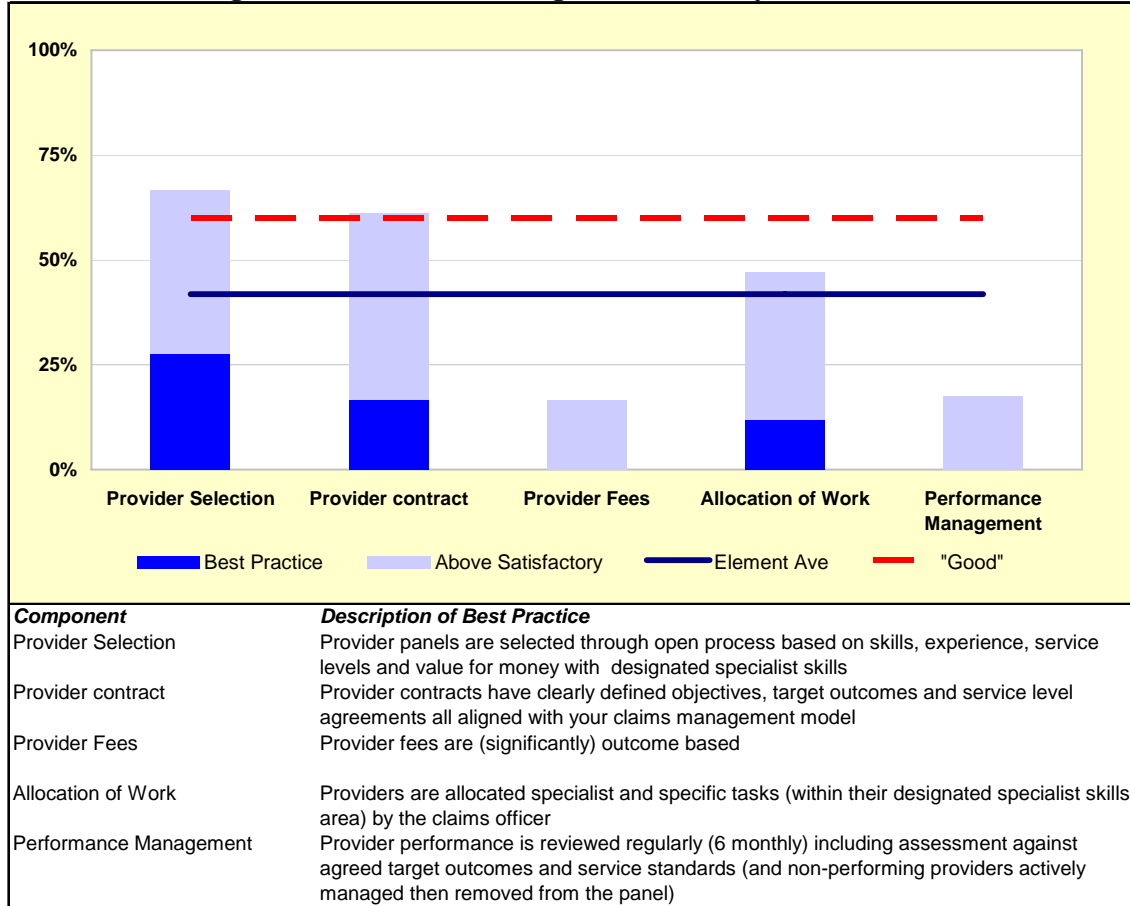| Component	Description of Best Practice
Identify & Address Outliers	Identify claims not progressing to targeted outcomes (ie "falling through the cracks"), reassess strategy, targeted outcomes and resourcing to address emerging issues
Continuous Sweeps for Outliers	Continuously sweep portfolio for emerging outliers

The results for this element are poor with around 8% of respondents rating it as best practice or above satisfactory. This indicates substantial scope for improvement in these areas.

Element 8 – Provider Management

Provider Management involves all aspects of the management of providers including selection, contractual arrangements, fee arrangement, work allocation and performance management. A description of best practice *Provider Management* and a summary of results are shown in Figure 5.8.

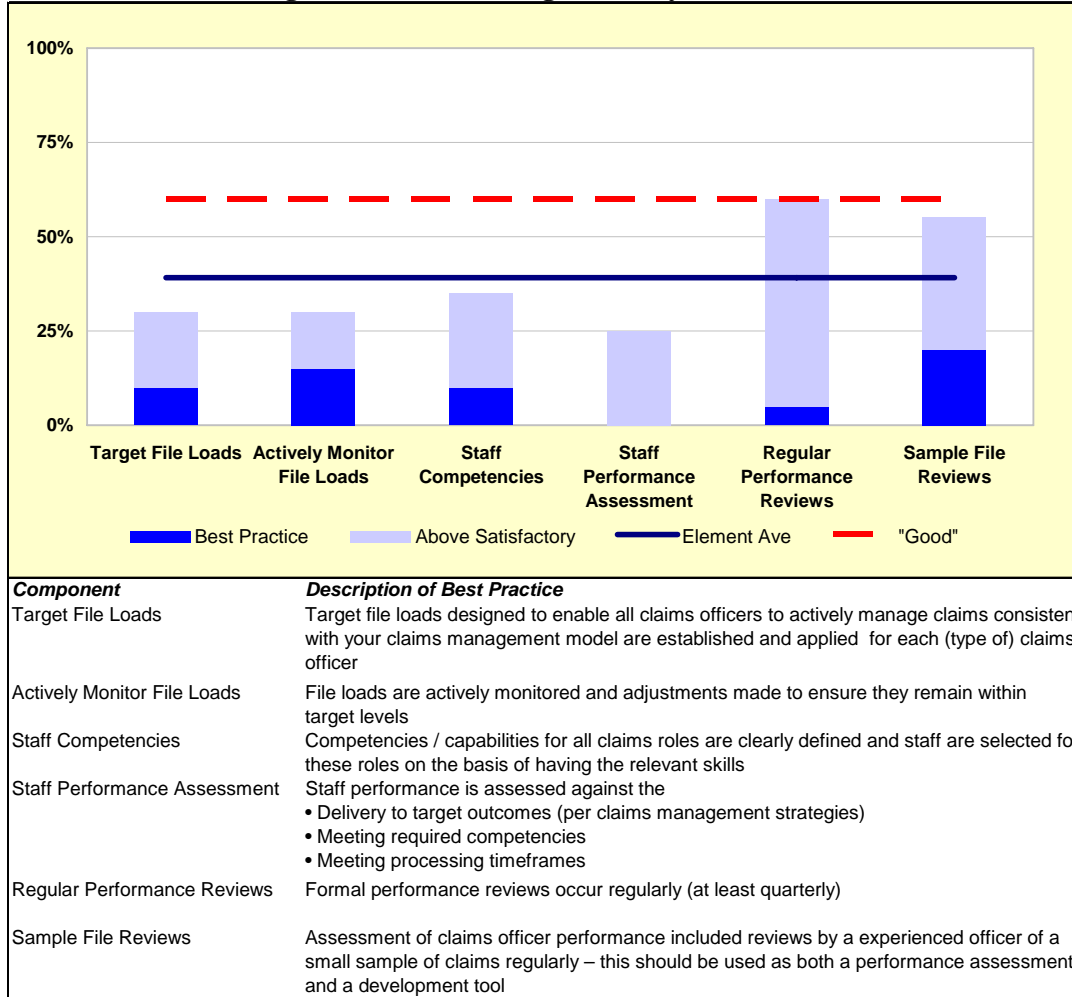**Figure 5.8 – Provider Management: Industry Assessment**

Component	Description of Best Practice
Provider Selection	Provider panels are selected through open process based on skills, experience, service levels and value for money with designated specialist skills
Provider contract	Provider contracts have clearly defined objectives, target outcomes and service level agreements all aligned with your claims management model
Provider Fees	Provider fees are (significantly) outcome based
Allocation of Work	Providers are allocated specialist and specific tasks (within their designated specialist skills area) by the claims officer
Performance Management	Provider performance is reviewed regularly (6 monthly) including assessment against agreed target outcomes and service standards (and non-performing providers actively managed then removed from the panel)

Provider Management was rated below our 60% benchmark for most of the components. The exceptions being 'provider selection' and 'provider contract' which did meet this benchmark. The 'provider fees' and 'provider performance management' components both rated relatively lowly with less than 20% of practitioners rating these components at best practice or above satisfactory . This indicates significant scope for improvement across the industry in these areas.

Element 9 - Resourcing

Resourcing encompasses establishing appropriate claims staffing levels, ensuring staff have appropriate competencies, monitoring resource levels and reviewing staff performance. The overall results for the *Resourcing* element of claims management and a description of best practice are summarised in Figure 5.9 below:

Figure 5.9 – Resourcing: Industry Assessment

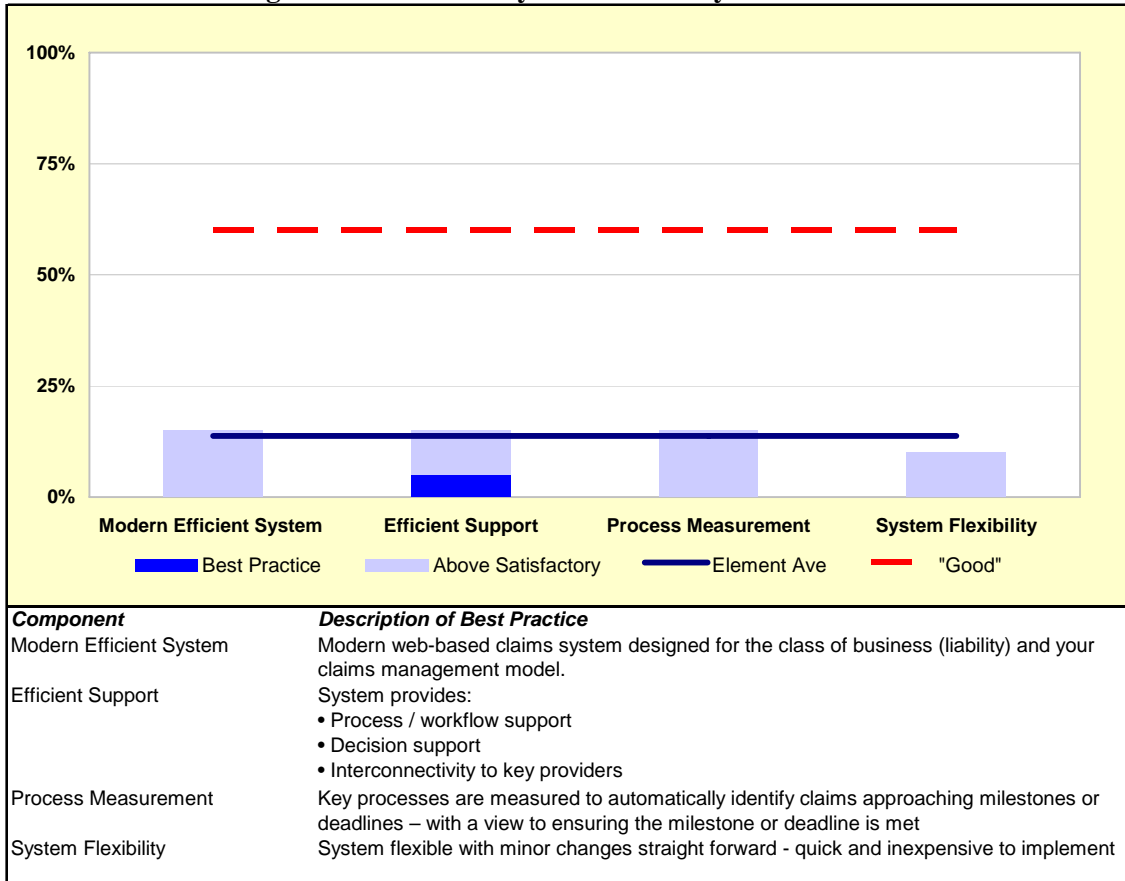| Component	Description of Best Practice
Target File Loads	Target file loads designed to enable all claims officers to actively manage claims consistent with your claims management model are established and applied for each (type of) claims officer
Actively Monitor File Loads	File loads are actively monitored and adjustments made to ensure they remain within target levels
Staff Competencies	Competencies / capabilities for all claims roles are clearly defined and staff are selected for these roles on the basis of having the relevant skills
Staff Performance Assessment	Staff performance is assessed against the • Delivery to target outcomes (per claims management strategies) • Meeting required competencies • Meeting processing timeframes
Regular Performance Reviews	Formal performance reviews occur regularly (at least quarterly)
Sample File Reviews	Assessment of claims officer performance included reviews by a experienced officer of a small sample of claims regularly – this should be used as both a performance assessment and a development tool

These results show that for most aspects of *Resourcing,* respondents considered that the industry is falling well short of the 60% standard. The two exceptions were 'regular staff performance reviews' and 'use of sample file reviews' which were rated at or close to the 60% benchmark. The remainder were rated best practice or above satisfactory by 25% to 30% of practitioners showing significant scope for improvement.

Element 10 – Claims Systems

Claims Systems are expected to be modern efficient systems (ie internet based) that are flexible and provide effective support to operational claims staff and management. The results and description of best practice for the *Claims Systems* element are summarised in Figure 5.10 below.

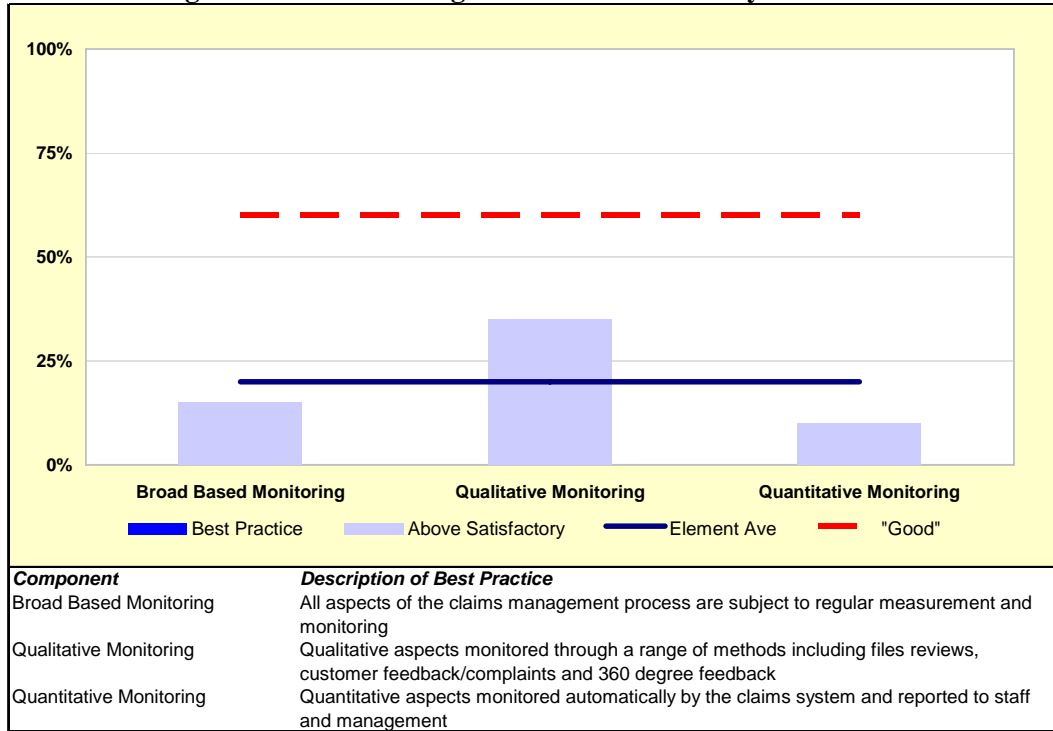**Figure 5.10 – Claims systems: Industry Assessment**

Component	Description of Best Practice
Modern Efficient System	Modern web-based claims system designed for the class of business (liability) and your claims management model.
Efficient Support	System provides: • Process / workflow support • Decision support • Interconnectivity to key providers
Process Measurement	Key processes are measured to automatically identify claims approaching milestones or deadlines – with a view to ensuring the milestone or deadline is met
System Flexibility	System flexible with minor changes straight forward - quick and inexpensive to implement

The *Claims Systems* element has the lowest ratings of all the best practice elements with practitioners rating of all components being well below the "good" benchmark of 60%. There is clearly scope for substantial improvement across all aspects of *Claims Systems.*

Element 11 – Measuring performance

The final best practice element, *Measuring Performance*, related to the regular monitoring of all aspects of claims management using both quantitative and qualitative assessments. Results and best practice descriptions for *Measuring Performance* are summarised in Figure 5.11 below.

**Figure 5.11 – Measuring Performance: Industry Assessment**

Component	Description of Best Practice
Broad Based Monitoring	All aspects of the claims management process are subject to regular measurement and monitoring
Qualitative Monitoring	Qualitative aspects monitored through a range of methods including files reviews, customer feedback/complaints and 360 degree feedback
Quantitative Monitoring	Quantitative aspects monitored automatically by the claims system and reported to staff and management

Practitioners rated *Measuring Performance* well below the 60% benchmark for all components. This indicates there is significant scope for improvement across the industry and particularly in ensuring monitoring encompasses all aspects of the claims management process and quantitative aspects are monitored automatically by the system.

Summary

The average results for all elements of best practice liability claims management are summarised below in Figure 5.12. The 60% benchmark for "good" industry performance is also included for reference.

Figure 5.12 – Summary of Industry Assessments
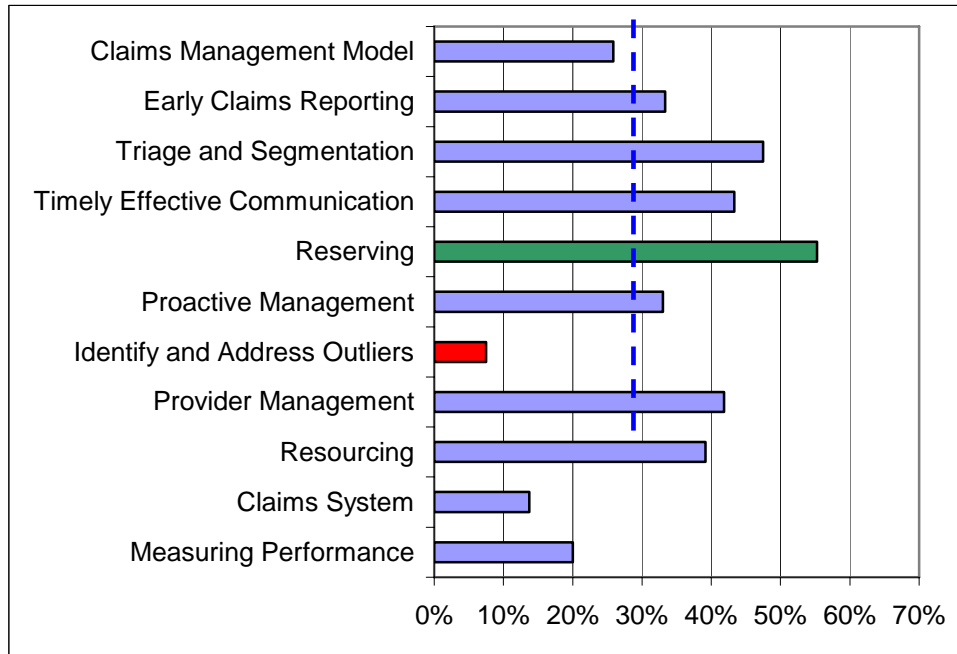
This shows that across the best practice elements there is a broad range of results. *Identify and Address Outliers* and *Claims Systems* are the elements with the lowest ratings. These areas have the greatest opportunity for significant improvements across the industry. It is also noted that none of the elements achieve the 60% "good" benchmark we have set which indicates there is scope for improvement across all aspects of liability claims management.

6. Company Claims Management Performance

In this section we present results of the assessment of individual company liability claim management operation relative to industry average. A small number of respondents considered they were unable to respond to these questions because they were not currently employed in a claims operation or because they considered this information confidential. For these reasons response numbers to these questions are less than the full 20 respondents.

Respondents were asked to rate, across the eleven key best practice elements, liability claims management at their company relative to their assessment the industry average and the description we had provided of best practice. The rating scale used was as follows:

a – Generally below industry average
b – About industry average overall
c – A mixture of industry average and higher than average
d – Consistently higher than average
e – Best practice.

Figure 6.1 below combines and summarises the results for all responses and all of our elements of best practice. We have only included the overall summary as results were relatively consistent across all elements. Detailed results are included in Appendix B.

**Figure 6.1 – Overall Self Assessment Results**
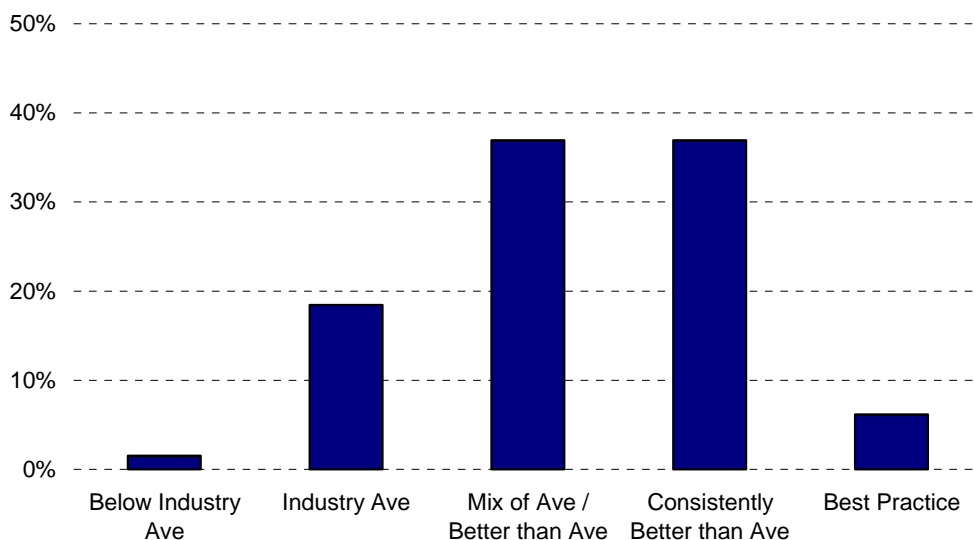
Only 20% of responses indicated their claims management operation was at or below industry average. This indicates a degree of bias in these self assessment ratings by claims managers. We sought in our analysis to allow for this bias and provide meaningful interpretation of the data.

In interpreting these survey results our aim was to identify the extent to which individual insurers fell short of good/best practice across the different dimensions. We have defined the proportion falling below "Consistently Better than Average" and "Best Practice" as representing a "performance gap" – areas where there would be an a priori case for investment in improving the management approach.

The results for each best practice element are summarised in Figure 6.2 below showing the proportion of respondents with a "performance gap" and the proportions with self assessments of "Consistently Better than Average" and "Best Practice".

Figure 6.2 – Best Practice Self Assessment
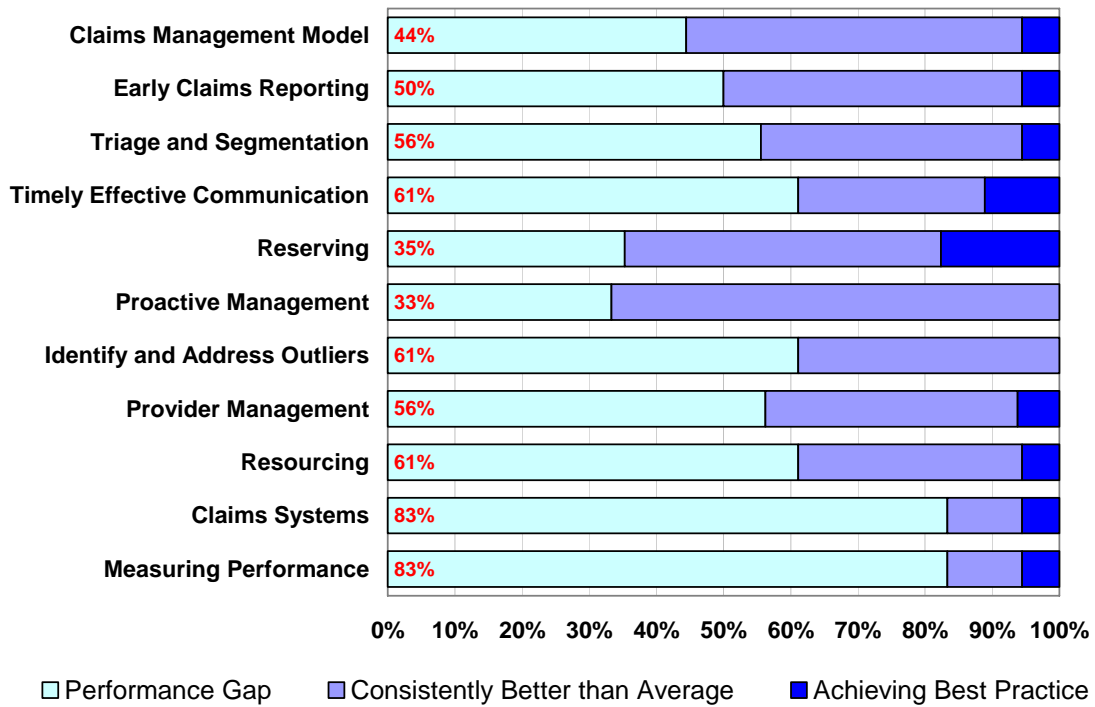
These results show that the *Claims Systems* and *Measuring Performance* best practice elements have the largest proportion of claims managers who consider they are lagging behind industry leaders. Meaning that more insurers have to make up ground to be at, or near, current leading industry practice. Alternatively the small numbers of insurers performing well in these elements have a competitive advantage over a high proportion of their rivals.

Conversely for the *Reserving* and *Proactive Management* best practice elements the majority of claims managers, around two thirds, are already at, or near, current leading industry practice. This indicates the performance differential in these elements across the industry is lower.

## 7.   Most Critical Best Practice Elements

The survey asked for respondents to list which elements they considered the most critical in getting best practice claims outcomes, i.e. what do you need to get right first? Most of those surveyed listed one or more elements as outlined in Table 7.1 below.

Table 7.1 – Best Practice Elements Rated Most Critical

Most critical elements	Responses
Proactive management	5
Reserving	5
Resourcing	5
Timely effective communication	3
Claims management model	3
Triage and segmentation	3
Measuring Performance	2
Provider management	2
Claims systems	1
Identify and address outliers	1
Early claims reporting	1

The Figure 6.1 below compares the industry average for each best practice element to the importance of each element as shown in Table 7.1 above.

Figure 7.1 – Average Industry Rating and Rated Importance
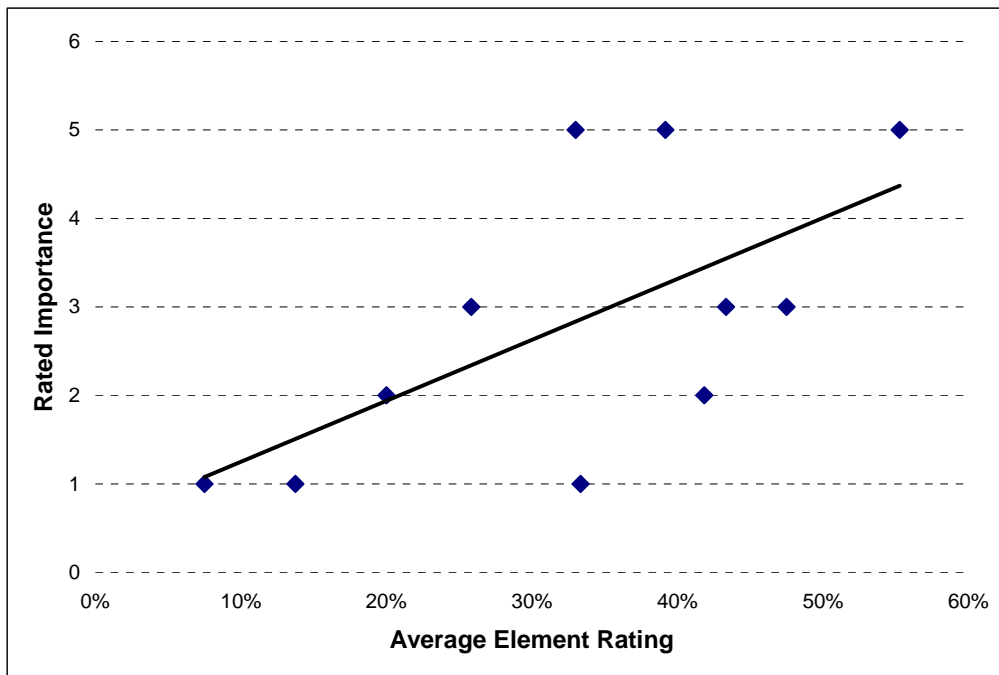
The trendline suggests there is some correlation between the average industry rating and the rated importance with those best practice elements with higher importance ratings tending to also have high performance score. This suggests, as might be expected, that the industry may have focused on improving its performance in those areas that it considers most important.

8. Overall Conclusions

Conclusions – Industry Performance

There are a number of comments that can be made about these results.

Firstly there is a large degree of variability in the assessment of "average" industry practice. We consider the primary reason for this is that respondents' experience of the "industry", in general, is narrow. As a result the assessments provided are in reality limited to:

- A subset or industry niche
- The companies where the respondent worked
- The respondent's current employer (we had one respondent who specifically commented that they considered they felt unable to comment on practice outside their company).

In general, most respondents rated themselves at or better than their peers (or the industry overall). Clearly this reflects a degree of bias. Perhaps the bias is partly a reflection of a respondents' tendency to over-estimate their own performance and partly the lack of knowledge of the actual position of the industry (as discussed above).

There are two conclusions we draw from these observations:

1. *There is not generally a good or consistent understanding of the current performance of the industry as a whole by claims managers within liability line of business.*

2. *Claims managers are not necessarily well placed to objectively assess the performance of their own claims operations relative to their peers*

Notwithstanding that many responses may be a greater reflection of individual insurer experiences (as opposed to broader industry experience) we consider the overall results to be representative as we have responses from the majority of the major liability insurers in Australia ie the responses are a fair representation of the market in any case.

3. *There is significant scope for improvement in the quality of liability claims management across the industry.*

As we have indicated previously, best practice claims management can deliver substantial claims cost savings to insurers. Based on our review the greatest opportunity for improvement is in the following areas (in priority order):

- Identify and Address Outliers
- Claims System
- Measuring Performance
- Claims Management Model
- Proactive Management
- Early Claims Reporting

We also consider that some of these represent potential quick wins, and in particular, *Proactive Management* and *Identify and Address Outliers*, where nature of the improvements required are very much operational.

From a management perspective it is always important to be in a position to know your relative performance against your peers and accepted good/best industry practice and to understand the nature and extent of any competitive advantages and disadvantages. It is also important to understand where to focus improvement initiatives to achieve the greatest return for effort.

While in many cases, insurers may choose for many reasons, including budget constraints and capacity limitations, not to pursue "best" practice, these decisions should be conscious ones. That is decisions made with the knowledge of implications for their bottom line and their competitive position relative to the market. We consider, however, that all operations should be pursuing opportunities for improvement – any that do not risk stagnation and being left at a significant competitive disadvantage.

For long tail classes of insurance, such as the liability classes, making assessments about current performance is difficult, particularly for insurance executives and claims managers, to undertake independently because of the lack of available data. A best practice framework provides a mechanism for identifying and prioritising improvement opportunities.

> 4. *Insurers need to understand where their claims operations sit relative to best practice*

Benchmarking studies, such as this one, are an important tool for assisting the industry and individual insurers understand evolving industry practice and best practice in liability claims management. Further benchmarking work in this area would assist to improve the knowledge of industry and individual insurer performance and to identify priority areas for improvement for insurers.

> 5. *Further benchmarking would assist in improving knowledge of insurer performance and prioritising areas for improvement*

Appendices

A - Best Practice Liability Claims Management Survey

Instructions

Please assess the performance of liability claims management across the whole of the industry based on your experience (ie not reflecting your company's experience).

Read the practice descriptions across the page and circle the description that fully describes the average or the most common claims management practice for the industry. Where there are elements of two descriptions select the mid-point (eg if you consider there are elements of both "average" or "best" then circle the mid-point between the two or 4).

Best Practice Questions

Section 1:   Claims Management Model

No.	Poor		Satisfactory		Best
1.1 Documentation					
	1	2	3	4	5
	Limited claims documentation – reliant on individual expertise	*Mid-point*	*Claims documentation focused on processes ie claims manual – not on philosophy and approach*	*Mid-point*	*Fully documented claims management model, providing guidance, direction and an overarching framework for claims staff*
1.2 Outcome Focus					
	1	2	3	4	5
	Claims management not focused	*Mid-point*	*Claims management focused on process and timeliness*	*Mid-point*	*Claims management focused on outcomes and bottom line*
1.3 Clarity of Expected Outcomes					
	1	2	3	4	5
	Expected claims outcomes not clear	*Mid-point*	*Expected claims outcomes not documented but generally "understood"*	*Mid-point*	*Expected claims outcomes documented and linked to performance standards for claims staff*
1.4 Staff Performance Assessment					
	1	2	3	4	5
	Staff performance assessment entirely subjective	*Mid-point*	*Staff performance assessment partly based on quantitative assessment but this is limited to process measures*	*Mid-point*	*Staff performance assessment primarily based on assessment against these outcome focused standards*
1.5 Consistency					
	1	2	3	4	5
	Claims management approach varies significantly between individuals	*Mid-point*	*Claims management approach reasonably consistent between individuals in teams but some variation between branches/teams*	*Mid-point*	*Claims management consistent across the class - no significant variation between branch, team or individual*
1.6 Training					
	1	2	3	4	5
	Training on-the-job	*Mid-point*	*Training of claims staff focused on process (eg claims manual & IT system)*	*Mid-point*	*Claims management model forms the basis for claims staff training (induction & other)*

Benchmarking Liability Claims Management

Section 2:   *Early Claims Reporting*

No.	Poor		Satisfactory		Best

2.1 Promote Early Reporting

1	2	3	4	5
No emphasis on early reporting	*Mid-point*	*Reporting obligations in policy wording but not promoted*	*Mid-point*	*Early claims (and potential claims) reporting actively promoted to front-line staff, policyholders and brokers.*

2.2 Monitor Reporting Delays

1	2	3	4	5
No monitoring of reporting delays	*Mid-point*	*Reporting delays between date of loss and report monitored but issue rarely raised with policyholder/broker*	*Mid-point*	*Reporting delays (from time of loss and time policyholder was aware) monitored – policyholders/brokers with significant delays followed-up*

2.3 Systems to Facilitate Reporting

1	2	3	4	5
Rely on formal lodgement of a claim on the policyholder and the policyholder forwarding that to you in due course	*Mid-point*	*Rely on policyholder for advice of a claim or potential claim*	*Mid-point*	*Systems in place to facilitate reporting of claims and potential claims, ie including in advance of a formal claim where liability is apparent*

Section 3:   *Triage and Segmentation*

No.	Poor		Satisfactory		Best

3.1 Initial triage and Segmentation

1	2	3	4	5
No segmentation or triage	*Mid-point*	*Some segmentation but effectively only by estimate size*	*Mid-point*	*Claims segmented according to apparent severity and complexity at initial triage/assessment*

3.2 Allocation according to Segment

1	2	3	4	5
No attempt to allocate claims on the basis of staff capability or capacity - allocation random or client based	*Mid-point*	*Manual allocation (by, say team leader) taking account some capability / capacity factors*	*Mid-point*	*Claims allocated to staff on the basis of capability and capacity*

3.3 Regular Reassessment of Segmentation

1	2	3	4	5
No reassessment of claims segmentation	*Mid-point*	*Reassessments haphazard and not formalised – largely triggered by a significant change in estimate*	*Mid-point*	*Claims reassessed regularly to identify changes in category (particularly claims becoming more severe / complex)*

3.4 Formalised Mentoring Process

1	2	3	4	5
Seeking assistance passively discouraged (ie it seen as the claims officer demonstrating a lack of knowledge or capability)	*Mid-point*	*Assistance encouraged but generally dependent on the claims officer seeking it*	*Mid-point*	*Formalised mentoring processes and/or team workshops established to assist in managing the most difficult claims and developing staff)*

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Section 4:   *Timely Effective Communication*

No.	Poor		Satisfactory		Best

4.1 Early Contact

1	2	3	4	5
Initial communication irregular and usually formal	*Mid-point*	*Early communication encouraged but largely conducted as a process (not focused on any particular outcome)*	*Mid-point*	*Early contact with policyholder and claimant (if unlitigated) to establish and manage expectations and any issues before they become entrenched*

4.2 Regular Systematic Communication

1	2	3	4	5
Communication irregular and usually formal	*Mid-point*	*Regular communication encouraged but little available to support systematic approach (or left to the individual claims officer)*	*Mid-point*	*Systematic approach to communication with regular updates*

4.3 Simple Clear Language

1	2	3	4	5
Language used legalistic and formal (with significant insurance jargon)	*Mid-point*	*Some use of plain English in standard documentation but other communication contain significant jargon and legalistic*	*Mid-point*	*Language used in all communication (written and oral) designed for use of understanding by the reader eg plain English and minimal jargon*

Section 5:   *Reserving*

No.	Poor		Satisfactory		Best

5.1 Reserving Policy

1	2	3	4	5
Estimates required but no formal policy documented	*Mid-point*	*Reserving policy documented based on experience*	*Mid-point*	*Documented reserving policy established based on experience and analysis (and tested against outstanding claim valuations)*

5.2 Initial Estimates and Regular Reviews

1	2	3	4	5
Estimates required but reviews haphazard and currency of estimates questionable	*Mid-point*	*Initial estimates and regular reviews required but not consistently applied and generally less frequent than 3 monthly*	*Mid-point*	*Initial estimate placed on the claim upon receipt and regularly reviewed following receipt of additional information or at least every 3 months*

5.3 Legal Advisers

1	2	3	4	5
Legal advisers rely on their judgement to advise on case estimates providing an overall figure with little on detail on their calculations	*Mid-point*	*Legal advisers provide estimates with detailed calculations (but not necessarily consistent with your reserving policy)*	*Mid-point*	*Legal advisers providing case estimates are trained in your reserving policy and provide estimates consistent with the policy (including detailed calculations)*

5.4 Consistent Application

1	2	3	4	5
Reserving practice varies by individual claims officer	*Mid-point*	*Reserving policy usually applied but consistency not verified or assured*	*Mid-point*	*Reserving policy consistently applied in all cases and consistent application verified through file reviews*

Section 6:   Proactive Management

No.	Poor		Satisfactory		Best

6.1 Individual Claims Management Strategy

	1	2	3	4	5
	Strategies not documented nor clear (in the claims officers mind)	*Mid-point*	*Documented claims management strategies limited to recommendations in advice from legal or other providers*	*Mid-point*	*Establishing (and documenting) a claims management strategy for all significant claims as soon as practical (within 6 to 8 weeks for liability)*

6.2 Strategies Outcome Focused

	1	2	3	4	5
	The target outcome not clear and next steps dependent on and reacting to claimant and/or provider input	*Mid-point*	*General approach understood but not documented nor claim specific and focus more on next steps rather than outcomes*	*Mid-point*	*Claims management strategy set by the claims officer and to encompass* • *An approach on indemnity and liability issues* • *Need for further investigations or legal advice* • *Target or desired outcome* • *Steps proposed to achieve that outcome*

6.3 Active Approach

	1	2	3	4	5
	Management reactive	*Mid-point*	*Management active but more to a timetable than an outcome*	*Mid-point*	*Active management to the target outcome,*

6.4 Regular Review of the Strategy

	1	2	3	4	5
	Reviews haphazard – significant gaps without any apparent activity evident	*Mid-point*	*Regular reviews occurring but strategy (and target outcome) not reassessed*	*Mid-point*	*Strategy regularly reviewed – (say) every 6 months or following a significant change in circumstances*

6.5 Claims Officer Primarily Responsible

	1	2	3	4	5
	High dependence on providers and in particular legal providers for all but simple claims. Legal providers effectively managing these claims ie claims officer only ever acts on legal advice	*Mid-point*	*Significant dependence on providers for complex claims particularly for determining strategy*	*Mid-point*	*Use of investigators, legal and other providers as appropriate to assist with strategy and execution (but scope of work determined by claims officer) and responsibility for management of the claim retained by the claims officer at all times*

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Section 7:   Identify and Address Outlying Claims (ie claims not behaving as expected)

No.	Poor		Satisfactory		Best

7.1 Identify and Address Outliers

	1	2	3	4	5
	No process in place for identifying claims not progressing to plan	*Mid-point*	*Processes for identifying claims not progressing to plan essentially reactive*	*Mid-point*	*Identify claims not progressing to targeted outcomes (ie "falling through the cracks"), reassess strategy, targeted outcomes and resourcing to address emerging issues*

7.2 Continuous Sweeps for Outliers

	1	2	3	4	5
	Problematic claims only identified after the problems become entrenched	*Mid-point*	*Identification of outliers left largely to the individual claims officer*	*Mid-point*	*Continuously sweep portfolio for emerging outliers*

Section 8:   Provider Management

No.	Poor		Satisfactory		Best

8.1 Provider Selection

	1	2	3	4	5
	No formal panel - providers are selected by the claims officer	*Mid-point*	*Provider panels formally in place but panels are generalist and ongoing (ie no formal review process)*	*Mid-point*	*Provider panels are selected through open process based on skills, experience, service levels and value for money with designated specialist skills*

8.2 Provider Contract

	1	2	3	4	5
	No formal agreements in place or rely on provider standard terms and conditions	*Mid-point*	*Formal provider contracts in place, possibly with some service level requirements, but not outcome focused nor aligned with your claims management model*	*Mid-point*	*Provider contracts have clearly defined objectives, target outcomes and service level agreements all aligned with your claims management model*

8.3 Provider Fees

	1	2	3	4	5
	Provider fees are hourly rates	*Mid-point*	*Provider fees are fixed prices for specific services*	*Mid-point*	*Provider fees are(significantly) outcome based*

8.4 Allocation of Work

	1	2	3	4	5
	Files allocated by claims officers based on their preferences with an open ended brief	*Mid-point*	*Files allocated to providers from panel with consideration of specialist skills but brief tends to be open ended*	*Mid-point*	*Providers are allocated specialist and specific tasks (within their designated specialist skills area) by the claims officer*

8.5 Performance Management

	1	2	3	4	5
	No formal performance monitoring of providers (other than subjectively by the claims officer in selecting providers)	*Mid-point*	*Provider performance monitoring focuses on service levels*	*Mid-point*	*Provider performance is reviewed regularly (6 monthly) including assessment against agreed target outcomes and service standards (and non-performing providers actively managed then removed from the panel)*

Section 9:   *Resourcing*

No.	Poor		Satisfactory		Best

9.1   Target File Loads

	1	2	3	4	5
	No target file load established	*Mid-point*	*Target file loads established but not necessarily applied (ie enforced) or are not specific (ie only averages). Targets are often over-ridden for example if there is a desire to reduce expenses*	*Mid-point*	*Target file loads designed to enable all claims officers to actively manage claims consistent with your claims management model are established and applied for each (type of) claims officer and applied*

9.2   Actively Monitor File Loads

	1	2	3	4	5
	Workloads determined subjectively	*Mid-point*	*File loads monitored but unforced adjustments rare (eg other than when someone leaves)*	*Mid-point*	*File loads are actively monitored and adjustments made to ensure they remain within target levels*

9.3   Competencies

	1	2	3	4	5
	Required skills for claims staff not documented	*Mid-point*	*Position descriptions focus on duties with general statements of skills required*	*Mid-point*	*Competencies / capabilities for all claims roles are clearly defined and staff are selected for these roles on the basis of having the relevant skills*

9.4   Staff Performance Assessment

	1	2	3	4	5
	Staff performance is determined subjectively	*Mid-point*	*Staff performance incorporates some objective elements but overall depends on supervisors judgement*	*Mid-point*	*Staff performance is assessed against the* • *Delivery to target outcomes (per claims management strategies)* • *Meeting required competencies* • *Meeting processing timeframes*

9.5   Regular Performance Reviews

	1	2	3	4	5
	Limited or no formal performance review process	*Mid-point*	*Formal annual performance review but otherwise informal or irregular*	*Mid-point*	*Formal performance reviews occur regularly (at least quarterly)*

9.6   Sample File Reviews

	1	2	3	4	5
	No file reviews by senior staff	*Mid-point*	*Irregular file reviews (eg spot checks) and incorporated into performance assessment subjectively*	*Mid-point*	*Assessment of claims officer performance included reviews by a experienced officer of a small sample of claims regularly – this should be used as both a performance assessment and a development tool*

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Section 10:   Claims Systems

No.	Poor		Satisfactory		Best

10.1 Modern Efficient System

	1	2	3	4	5
	Old legacy mainframe system	*Mid-point*	*Legacy mainframe with more modern front end*	*Mid-point*	*Modern web-based claims system designed for the class of business (liability) and your claims management model.*

10.2 Efficient Support

	1	2	3	4	5
	Little or no value-add support	*Mid-point*	*Provides some process and workflow support*	*Mid-point*	*System provides:*

System provides:
- *Process / workflow support*
- *Decision support*
- *Interconnectivity to key providers*

10.3 Process Measurement

	1	2	3	4	5
	Process measurement generally not supported	*Mid-point*	*Some process measurements (usually linked to front-end system)*	*Mid-point*	*Key processes are measured to automatically identify claims approaching milestones or deadlines – with a view to ensuring the milestone or deadline is met*

10.4 Flexibility

	1	2	3	4	5
	Any system change needs major change process requiring considerable time and effort	*Mid-point*	*Front end more flexible but issues with legacy mainframe remain*	*Mid-point*	*System flexible with minor changes straight forward - quick and inexpensive to implement*

Section 11:   Measuring Performance

No.	Poor		Satisfactory		Best

11.1 Broad based Monitoring

	1	2	3	4	5
	Little or no monitoring of processes (usually not supported by the system)	*Mid-point*	*Monitoring partially implemented*	*Mid-point*	*All aspects of the claims management process are subject to regular measurement and monitoring*

11.2 Qualitative Monitoring

	1	2	3	4	5
	Qualitative monitoring based on subjective assessment by supervisor	*Mid-point*	*Emerging introduction of (some of) file reviews, customer feedback, complaints and 360 degree feedback but largely focused on compliance*	*Mid-point*	*Qualitative aspects monitored through a range of methods including files reviews, customer feedback/complaints and 360 degree feedback*

11.3 Quantitative Monitoring

	1	2	3	4	5
	Limited quantitative monitoring – generally not supported by the claims system and needs to be done manually	*Mid-point*	*Emerging introduction of automated monitoring but largely used as a compliance tool*	*Mid-point*	*Quantitative aspects monitored automatically by the claims system and reported to staff and management*

Other Questions

Q12: How would you generally rate claims management at your company relative to industry average (across each of the key best practice elements)?
   a) Generally below industry average
   b) About industry average overall
   c) A mixture of industry average and higher than average
   d) Consistently higher than average
   e) Best Practice

Best Practice Area	Rating (circle one)				
1. Claims Management Model	a	b	c	d	e
2. Early Claims Reporting	a	b	c	d	e
3. Triage and Segmentation	a	b	c	d	e
4. Timely Effective Communication	a	b	c	d	e
5. Reserving	a	b	c	d	e
6. Proactive Management	a	b	c	d	e
7. Identify and Address Outliers	a	b	c	d	e
8. Provider Management	a	b	c	d	e
9. Resourcing	a	b	c	d	e
10. Claims Systems	a	b	c	d	e
11. Measuring Performance	a	b	c	d	e

Q13: Are there any significant best practice elements you consider missing?

Q14: Are there any significant best practice elements listed above that should not be included?

Q15: Which element do you consider most critical in getting best practice claims outcomes?
What do you need to get "right" first?

B - Detailed survey response data

B.1 Question 1 to Question 11 - detailed data

Question No.	1	2	3	4	5	Ave	Median	SD
Q1.1	1	3	14	2	0	2.85	3	0.67
Q1.2	0	1	7	11	1	3.60	4	0.68
Q1.3	0	5	9	6	0	3.05	3	0.76
Q1.4	1	3	11	5	0	3.00	3	0.79
Q1.5	2	7	9	1	1	2.60	3	0.94
Q1.6	0	6	10	4	0	2.90	3	0.72
Q2.1	0	1	12	5	2	3.40	3	0.75
Q2.2	3	3	5	8	1	3.05	3	1.19
Q2.3	3	1	12	3	1	2.90	3	1.02
Q3.1	2	1	9	5	3	3.30	3	1.13
Q3.2	1	0	4	12	3	3.80	4	0.89
Q3.3	0	2	9	6	3	3.50	3	0.89
Q3.4	0	2	12	5	1	3.25	3	0.72
Q4.1	2	0	8	8	2	3.40	3.5	1.05
Q4.2	2	1	11	5	1	3.10	3	0.97
Q4.3	2	1	7	7	3	3.40	3.5	1.14
Q5.1	0	2	6	8	3	3.63	4	0.90
Q5.2	0	1	7	8	3	3.68	4	0.82
Q5.3	0	1	10	5	3	3.53	3	0.84
Q5.4	0	1	6	9	3	3.74	4	0.81
Q6.1	1	1	10	6	2	3.35	3	0.93
Q6.2	1	1	10	5	3	3.40	3	0.99
Q6.3	2	3	10	4	1	2.95	3	1.00
Q6.4	2	2	7	7	2	3.25	3	1.12
Q6.5	1	6	10	1	2	2.85	3	0.99
Q7.1	3	6	10	1	0	2.45	3	0.83
Q7.2	3	6	9	2	0	2.50	3	0.89
Q8.1	0	1	5	7	5	3.89	4	0.90
Q8.2	0	2	5	8	3	3.67	4	0.91
Q8.3	7	4	4	3	0	2.17	2	1.15
Q8.4	0	1	8	6	2	3.53	3	0.80
Q8.5	1	3	10	3	0	2.88	3	0.78
Q9.1	0	4	10	4	2	3.20	3	0.89
Q9.2	2	2	10	3	3	3.15	3	1.14
Q9.3	1	2	10	5	2	3.25	3	0.97
Q9.4	0	1	14	5	0	3.20	3	0.52
Q9.5	1	1	6	11	1	3.50	4	0.89
Q9.6	0	1	8	7	4	3.70	4	0.86
Q10.1	3	5	9	3	0	2.60	3	0.94
Q10.2	4	6	7	2	1	2.50	2.5	1.10
Q10.3	5	6	6	3	0	2.35	2	1.04
Q10.4	5	6	7	2	0	2.30	2	0.98
Q11.1	3	3	11	3	0	2.70	3	0.92
Q11.2	2	3	8	7	0	3.00	3	0.97
Q11.3	4	4	10	2	0	2.50	3	0.95

B.2 Question 12 - detailed data

	Below industry ave	Industry ave	Mix of ave / higher than ave	Consistently higher than ave	Best Practice
Claims Management Model	0	0	8	9	1
Early Claims Reporting	0	5	4	8	1
Triage and Segmentation	0	3	7	7	1
Timely Effective Communication	0	3	8	5	2
Reserving	0	2	4	8	3
Proactive Management	0	1	5	12	0
Identify and Address Outliers	1	6	4	7	0
Provider Management	0	0	9	6	1
Resourcing	0	2	9	6	1
Claims Systems	2	9	4	2	1
Measuring Performance	0	5	10	2	1