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BUSINESS INTELLIGENCE CHALLENGES IN THE UK INSURANCE INDUSTRY: A COGNOS / TAH WHITE PAPER

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SYNOPSIS

Faced with an increasingly complex regulatory landscape and harsh penalties for non-compliance, the UK insurance industry is looking to technology to solve its compliance headaches. Simultaneously, insurers are required to maximise sales performance through direct and third party channels, improve operational efficiency of the claims process, minimise fraudulent claims and provide excellent customer service.

The introduction of performance management systems by insurers has allowed them to approach compliance and performance issues as core drivers of change. Instead of seeing compliance with regulations as a burden and streamlining the business as simple 'cost-cutting', performance management is being used to give insurers far better visibility of their own organisation and the power to instigate change that has an immediate impact.

1. MARKET OVERVIEW

The insurance market in the UK

The UK insurance industry, encompassing property and casualty (P&C) and life and annuity (L&A) insurers, is the largest in Europe and the third largest in the world, employing 339,000 people. This equates to almost a third of all jobs in financial services and more than twice the total of jobs in the gas, electricity and water industries. Totals of over £150 million in pension and life insurance benefits, and over £50 million in general insurance claims, are paid out every day.

More than 1,000 companies are authorised to carry out insurance business in the UK – mostly for general business (such as motor, household and commercial insurance). Around one fifth of those are for long-term business (such as life insurance and pensions), while a small number provide both.

The insurance industry was the largest single contributor to net exports of the UK financial sector in 2005, with £6.4 billion of the £19 billion total (nearly two thirds of total UK food, beverage and tobacco exports, or almost half of the value of UK oil exports).

The Financial Services Authority: A new regime

On the 20th January 2004, The Financial Services Authority released final conduct of business rules for the general insurance industry. Insurers and intermediaries were given until the 14th January 2005 to prepare for the start of general insurance regulation.

In taking over regulation of general insurance companies from the General Insurance Standards Council (GISC), the FSA introduced a number of new directives weighted towards consumer protection. Insurers had to adapt business processes to meet the new standards of the regime, which included:

• ***Authorisation***

Anyone dealing with or involved in general insurance needs to be authorised, including independent brokers, those involved in introducing customers to an insurer or even those sending the form itself.

• ***Information***

The rules carefully control how firms approach customers, including full disclosure of policy and price, plus the regulation of direct and indirect marketing material. Face-to-face and telephone sales are also regulated, ensuring customers have all information they need in a 'durable format' before any meeting.

• ***Documentation***

Specific documentation is required by the FSA to be provided to the customer that varies depending on the type of insurance and contract, as well as an application form.

• ***Disclosure***

As well as upfront disclosure of all terms of the insurance contract to the customer, complaints and compensation arrangements, commission structures and charges, renewal terms and information about claims handling all need to be made available to the customer.

• ***Claims handling***

Under the rules, insurance intermediaries need to respond to a claim within five business days to a customer, and ensure payment within five days from an agreed settlement.

• ***Complaints***

Written acknowledgement of a complaint should be given to a customer within five working days, a holding response must be sent within four weeks, and a final response in eight weeks of receiving the complaint.

• ***Training and competence***

An intermediary must ensure levels of training and competence in staff that ensure individuals have appropriate levels of maintained skills, as well as a structure for attaining them and recruiting new staff.

• ***Reporting***

The details and structure of reporting information is also heavily regulated. Insurance intermediaries are required to report changes in standing data, a balance sheet, P&L, capital, training and competence, product sales and complaints to the FSA.

Challenges – the technology landscape

The shakeup of the insurance industry from the new FSA regulations mean insurers are under increased pressure. The need for better reporting, transparency of information and dynamic information that can be shared across a growing number of appointed representatives heralds a new strain on business processes.

While a string of natural and unnatural disasters – the tragic events of September 11th, the tsunami and the flooding in New Orleans due to Hurricane Katrina to name a few – saw increased pressure on a industry already in flux, new compliance regimes brought even more checks and balances to the market.

For insurance companies with a wide range of existing legacy systems in place to store data, the new demands for rapid, frequently changed and easily auditable information quickly put traditional operational systems under strain. For many insurance firms, financial data, claims handling information and customer information were stored in disparate silos of data, making it difficult to get a timely, consistent and holistic view across the organisation.

In addition, the FSA regime had opened up the general insurance market to a massive influx of competition. The first 12 months of the new rules saw a huge increase in the number of providers of insurance products, all fighting for the same customer by attempting to differentiate themselves via innovative products and services while struggling to remain on top of compliance issues.

Providers of general insurance needed to look for ways to introduce and maintain these critical changes within their infrastructure. In order to meet the demands of new regulations and customer expectations, insurers needed to unlock the value of their data and distribute a common view to multiple business units more effectively and efficiently.

Integrated performance management and business intelligence software, closely aligned with business strategy, provided a number of solutions insurers had been looking for:

- Reduced costs and increased efficiency
    1. Gaining deeper insight into sales and marketing with extensive analysis and reporting
    2. Making more timely decisions by getting vital information faster
    3. Creating a self-service reporting environment, reducing the demand on IT
- Care for customers
    1. Delivering self-service, interactive claims information
    2. Enabling greater transparency into claims
    3. Alerting customers on pre-set performance indicators
- Business performance management
    1. Aligning decisions with strategy and data by combining strategic planning, timely monitoring, and deep analytical capabilities
    2. Communicating priorities enterprise-wide with cascading scorecards
    3. Engaging front-line managers with the planning process
    4. Getting everyone operating from a single version of the truth

Benefits and value of performance management and BI

Integrated performance management and business intelligence software means insurers can operate on a platform that allows them to use existing data across their business more easily, while reducing risk and achieving legislative compliance.

BI systems allows insurers and their representatives to:

- Leverage existing data and systems investment to identify, report, and analyse sales effectiveness, staff performance, channel and third party performance and customer profitability
- Aggregate risk (credit, operational, market, country) data from multiple silos, diverse business lines, all regions, and across the organisation to deliver enterprise risk reporting
- Meet the information needs of all users with a flexible, user-friendly means to deliver the right information in the right way – whether managed reports, dashboards, scorecards, online analysis, or self-service reporting and queries
- Extend extranet capabilities to customers, partners, brokers, and suppliers

Performance management systems also enable insurers to improve planning, statutory reporting and consolidation through the ability to:

- Augment or replace cumbersome spreadsheet-based systems with flexible, connected planning software
- Enable driver-based planning
- Reduce consolidation, close, and reporting cycles by days or weeks
- Manage multiple reporting and consolidation standards such as IAS, IFRS and US-based GAAP; inter-company elimination and reconciliation; multicurrency translation; complex ownership calculations, and financial consolidation rules
- Conduct what-if scenarios for different revenue projections or changes in business lines

2. SPECIFIC AREAS OF CHANGE

Performance management software and business intelligence tools are changing the way insurers – with their legacy applications, remote business units, outmoded processes and silos of valuable information – are doing business. The challenges and responses split into three main areas:

- **Sales and marketing effectiveness**
- **Compliance**
- **Claims handling and fraud**

In the following sections, this white paper will look, in more detail, at the way in which new methods of data handling are changing the face of the insurance industry forever, creating a platform for success.

Sales and marketing effectiveness

Insurance firms are often organisations with a long heritage of paper-based information handling and made up of diverse divisions (car, home, life) that have grown through acquisition. As a result, the industry has a high propensity for a silo-based approach to data.

Often, the various business divisions have their own tailored systems from which they deliver information to finance and senior management, as well as other departments such as claims handling, sales, marketing, underwriting and customer service. The use of multiple channels, in particular third party, further complicates sales insight.

The result is a widely dispersed data set that doesn't lend itself to efficient customer communication, service or the spotting of sales opportunities. So how do insurers ensure a multi-lens view of sales? The 'holy grail' is a single view of the customer.

Tracking customer lifecycle is key in the insurance industry. New sales are so much more expensive, and churning customers ruin a business. It is for this reason that up-selling and cross-selling are vital, as ongoing reinvestment in products and developing lengthy relationships with their customers is the preferable business model.

As the insurance market develops, and the opportunity for appointed representatives continues to grow, a number of multi-product companies – that integrate the offerings of different insurance companies and provide a single point of sale – have emerged.

Better insight into campaigns means more value to the customer further up the sales cycle, and greater returns over the longer term. Insurers needed to find a way in which to introduce a policy of customer data excellence without going back to the drawing board.

With the right tools, competitive advantage comes from the ability to:

- Identify and retain high-value customers
- Improve campaign ROI
- Build a stronger brand
- Align marketing plans with corporate financials

Additionally this extends into maximising internal productivity. Insurers should look to work specifically with their HR department to:

- Align sales and marketing staffing needs with strategic goals
- Identify and retain the right people
- Ensure that money spent on training produces a return
- Align compensation and headcount plans with corporate priorities
- Find the managers of tomorrow

Compliance

In today's regulatory minefield, insurance firms need to satisfy a sometimes disconnected network of regulatory and best practice organisations.

But instead of a piecemeal approach, it's crucial that firms take a strategic view of the issues via a compliance framework, integrating each separate regulation into their business model. Compliance should not be seen as a bureaucratic overhead, adding little value to a business.

For example, the FSA's stringent regulation and ability to inflict harsh fines has resulted in the need for ongoing training of the sales force under a new regime of directly authorised firms being allowed to appoint representatives. There are 1,000s of these representative organisations – in fact, the Government's focus on their regulation has seen legal penalties for misinformation or malpractice supersede statutory legislation such as the Rehabilitation of Offenders Act. In other words, if the FSA puts you out of business, you're out of business for the long term.

One example of the FSA's powers in shutting down businesses when and where necessary was in January 2006. It took action against a sole trader who was discovered to have past fraudulent transactions in an unrelated role. The trader's business was terminated.

In a statement, Margaret Cole, Director of Enforcement at the FSA, said:

"The FSA must act to ensure that consumers are protected and markets operate in a fair and orderly way. We took appropriate and proportionate action towards (the sole trader) in accordance with his criminal convictions. Fraud is extremely serious and an individual's honesty in such cases can affect their suitability to run a regulated firm."

"We check that firms are operating within our rules to maintain a level playing field for all. It is an offence for anyone to undertake regulated business unless they are authorised to do so and it could lead to criminal action."

Legislative challenges and the 'virtuous circle'

Alongside the FSA regime and the harsh penalties that go with it, a number of other key legislative concerns are shaping the insurance industry. Each of them brings a greater need for clarity, efficiency and accuracy in accessing data. Insurers need to ensure compliance – either with the regulations directly, or in their processes so financial bodies that deal with them can ensure their own compliance remains watertight.

These legislative challenges include coping with Solvency II legislation. Solvency II addresses several key areas of regulatory compliance including risk management through allocation of risk-based capital and disclosure. The framework for enhanced European insurance solvency rules is currently under preparation and a draft EU directive is set to be published in 2007. Even prior to its implementation, Solvency II will help shape the European insurance industry's agenda over the coming years.

To respond to the emerging regulation, insurers need to take an enterprise approach to the common theme of tighter controls and improved disclosure. By doing so insurers can avoid duplicated investment in reporting and capture any regulatory advantage by discerning how to make best use of that data throughout their organisation. Insurers must take a proactive approach to compliance, rather than reacting to a series of 'box-ticking' demands.

Claims handling and fraud

Processing claims is the bread and butter of any insurance business. However, it is also often an intensively manual process that involves a wide network of partners and suppliers. This is a drag on enterprise performance.

It is essential that insurers constantly analyse claims ratios to ask themselves 'how much of the insurance premiums am I paying out back to customers?' They also need to forecast in minute detail how future claims could pan out. Are they long-tail claims, with a long investigation and possible high-payout, or short-term claims, with a simple solution? Plus, what are the trends that are affecting the business?

In the previously high inflation economy, it was important for claims ratios to be clearly tracked and forecast, as cash reserves had to earn high interest. Nowadays, low interest rates mean insurers need to control underwriting discipline more tightly, as there is less margin to be made. The need for information flow from quotes to claims, as well as operation efficiency across the organisation to minimise costs, is essential. On the flip side, operational inefficiency in dealing with claims can be hugely expensive.

"… we will steadily be paying more attention to firms' arrangements for managing their fraud risks as part of our general supervisory and other regulatory activities. This will be a natural development of our current approach."

– Phillip Robinson, FSA – 26th October 2004

As well as ensuring a healthy cash flow and forecasting activity for claims, efficient handling can help to safeguard public money by ensuring any illegitimate instances are spotted early. Customer information can be blended and centrally reported to the claims handler to ensure decisions are consistent and enterprise-wide.

In reality, insurers and their agents are keen to create a balance between the appropriate cost of managing a claim versus the cost of handling that claim. Integrated data about specific customers' activity can ensure quick decisions and any potential issues (such as uncharacteristic behaviour, either by individual or demographic) are flagged instantly. Those that are classed as serious enough to warrant a full investigation can be escalated to the fraud department automatically. Fraudulent elements tie back into marketing and sales information via the CRM system. It can use reporting on the data to spot large claim deviations. Fraud is effectively, and efficiently, stopped in its tracks.

At the other end of the scale, inefficient claims – which are predicted to cost more to investigate than to pay out – can be isolated and not investigated, leading to greater savings and efficiency in the claims handling process.

In addition, costs from a partner network can be factored in, from contracts with car body shops or hire firms through to locksmiths and utilities contractors. These deals can all be fed into the process and decisions can be made that have a direct impact on the efficiency of the claim. With accurate, real-time information on these variable costs, insurers can use this insight to ensure they are getting the best deal.

Excerpt from a press statement from the Association of British Insurers – 23rd May 2005

£3.5 million a week in insurance fraud now being detected as net tightens on insurance cheats

The net is tightening on insurance cheats. Figures issued today by the ABI (Association of British Insurers) reveal a dramatic rise in the value of fraudulent insurance claims being detected by insurers, with dishonest claims totalling over £3.5 million a week now being exposed.

A survey by the ABI, who cover two-thirds of the general insurance market, showed that fraudulent claims valued at £200 million were uncovered in 2004. This 95 per cent rise on 2002 reflects increased resources, new fraud detection techniques and sharing of information between insurers.

Easing the bottlenecks

Getting the right flow of claims through the organisation is key for insurers in management of their financial position. The industry, with one large segment of its business model relying on intensive, manual work and a heavy legislative framework controlling its every move, must ensure business is flowing through the organisation without hindrance.

Insurers must take responsibility for their claims efficiency and be able to highlight bottlenecks in the process. Claims flow needs to be managed through specific areas, monitored and reported on.

Claims inefficiency can be a result of a number of inconsistencies in workflow. Headcount planning, for example, is a key way to ensure claims handling remains efficient. Why not put more people in call centres? It would mean better customer service and more claims coming in to the business, but with more claims, handlers will soon find themselves put under pressure and slowly turning into a business bottleneck.

3. CONCLUSION AND SUMMARY

The problems

- **How ready are firms to adopt performance management technologies?**

Upgrading business intelligence and performance management is a large, specific area of investment. Performance gains need to be recognised and proven.

The major insurers are beginning to see the benefits of the new way of managing their data, but there is still a deeply-embedded culture of storing information in multiple silos that needs to be addressed.

- **Systems are out of date and have developed organically**

The enterprise nature of business intelligence means that insurers need to understand that it is now a business-enabling platform, not just a departmental tool for extracting selected information. It is a key area that needs to be aligned to business strategy.

As portfolios of products grow, channels to market become saturated and regulatory demands increase, those with the clearest view of their data will be the ones that succeed. Importantly, that doesn't necessarily mean dispensing with the organically developed systems. Their specialised nature means there is often real value available. In fact, the demands of the business environment (project capital and business performance) require insurers to be equipped to extract immediate benefit from that data already available.

- **Developing a bite-sized approach**

Organisations looking to exploit existing investments, such as data warehouses, need to know that the next steps aren't going to require hefty reinvestment further down the line.

An architected, scalable, flexible and robust approach is necessary for insurers to make the leap into the next phase of their technology cycle. Implementation and rollout must be via a standard platform that integrates with existing infrastructure to minimise disruption. The result should be a complete suite of products across all areas.

Building a performance management roadmap for the organisation is key to building in value assessment points. Identifying and prioritising the most pressing business challenges to target, and measuring the return on investment for each, will provide the framework against which selection criteria, investment plans and subsequently individual projects can be created. But this framework is likely to change as the business/project priorities encompass more groups or as the value delivered is seen by more people. In prioritising programs, insurers should identify sponsors who will be the evangelists.

- **Best practice**

Insurers do not want to start from scratch – they have mature infrastructures that rely on silos of data. The key is not moving the data but changing mindsets to a far more integrated approach. Accessing the data efficiently is key, then bringing it all together to make huge differences to reporting, customer service, marketing, claims handling and enterprise planning is the obvious result.

It's time the insurance sector learnt lessons from other industries, ensuring a culture of best practice. It must not only respond to changes to the regulatory framework that governs it, but pre-empt them.

How technology can help

Complex internal business processes within insurance companies create an intensive paper trail. In addition, insurers are under pressure from the FSA to react quickly to claims, complaints and enquiries.

Today's data warehousing, business intelligence and performance management technologies offer a pragmatic response to the challenges faced by insurers.

Data warehousing provides a robust mechanism to extract the right information from legacy sales management, CRM, marketing, premium, claims processing, financial and actuarial systems.

Enterprise-quality business intelligence that provides a consistent and secure view on current and past performance that includes:

- reporting (production and ad-hoc query) of sales, claims, business performance, external client reporting, third party management etc.
- in-depth analysis of concentrations, regional performance, sales and marketing effectiveness etc.
- executive dashboards providing consistent senior management insight
- balanced scorecards for multi-dimensional hierarchy of performance indicators
- proactive event management

Beyond understanding what's happening in the business, and being able to deploy that insight to decision makers throughout the organisation, additional benefits are available through improved planning and financial control.

The budgeting and forecasting process has historically been a painful annual experience that has been time consuming, largely manual and prone to error. Enterprise planning addresses that challenge and is a core component of a performance management architecture. Its combination of collaborative workflow tools, planning and business modelling means that both top-down financial control and bottom-up business influence are not mutually exclusive.

Beyond an aligned budgeting process, planning tools offer the ability to model the impact of various outcomes, for example:

- claims headcount planning in response to sales and marketing campaigns
- changes in premium income from marketing campaigns
- likely sales impact of recruiting a new third party agent in a particular region

To build an efficient, accountable, and performance-driven organisation, strategic management need to adopt technology to:

- **Make their business more predictable and more agile**

A collaborative planning platform ensures sustainable and consistent performance outcomes, and a quick response to changing business conditions

- **Increase visibility into business performance**

Analysing corporate data to understand the 'why' behind performance results

- **Drive company strategy in measurable terms**

Metrics and scorecards monitor performance, pinpoint areas requiring further action, and give everyone a clear sense of next steps

Why Cognos?

- Six of the top ten insurance companies in the world, and seven of the top ten insurance companies in the US, choose Cognos, an IBM company.

These industry leaders, and over 1,000 other banks, insurance companies, and financial services institutions use Cognos software to:

- Increase customer, product, and channel profitability
- Manage and reduce risk
- Address compliance issues
- Improve the predictability of financial performance

Why TAH?

TAH has a proven approach for the financial services market called Infusion, which is a best practice solution to performance management in the insurance industry.

Key components to this approach are:

- Class-leading BI tools
- Ralph Kimball Dimensional Modelling Methodology
- Flexibility to use pre-defined templates or an entirely bespoke development
- Internal skill sets and industry expertise

TAH's clients in the insurance arena include HSBC, Tokio Marine Insurance, Arch Insurance, Helphire and the National Farmers' Union Mutual.

Resources

The Financial Services Authority Handbook (2006)

The Association of British Insurers:

UK Insurance – Key Facts (2005)

Office of Fair Trading

The UK Liability Insurance Market (2003)

Deloitte

The Rules of Engagement: A guide to the regulation of insurance intermediaries (2004)

Jardine Lloyd Thompson

Weathering the Storm – Insurance market overview (2005)

About Cognos, an IBM company

Cognos, an IBM Company, is the world leader in business intelligence and performance management solutions. It provides world-class enterprise planning and BI software and services to help companies plan, understand and manage financial and operational performance. Cognos was acquired by IBM in February 2008. For more information, visit http://www.cognos.com.

For more information

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