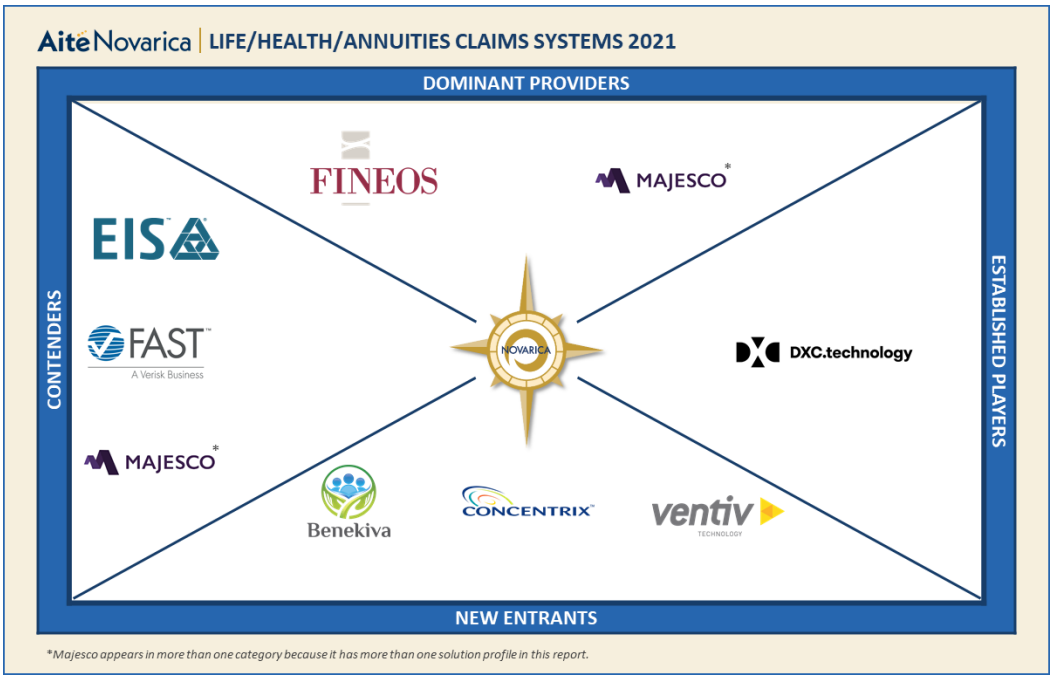
LIFE/HEALTH/ANNUITIES CLAIMS SYSTEMS

AUGUST 2021



SUMMARY

This report provides an overview of the available claims systems and suites for US life/health/annuities insurers. The report contains profiles of nine vendor solutions, summarizing the vendor organization, technology, differentiators, client base, lines of business supported, deployment options, implementation approaches, upgrades/enhancements, and functionality.

Vendors included: Benekiva, Concentrix, DXC, EIS, FAST, FINEOS, Majesco, and Ventiv.

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INTRODUCTION

About This Report

This report provides an overview of the current solution provider marketplace for life/health claims systems. It is designed to assist insurers with creating shortlists of potential providers based on vendor market position and offering details. Health insurance, in this case, is limited to disability (STD/LTD), critical illness, and related products. It does not cover solutions that address things such as major medical/group health coverages.

Novarica Market Navigator™ reports do not provide subjective analysis of vendor solutions. They are based on factual responses to a universal RFI distributed by Aite-Novarica and follow-ups with the vendors to validate and confirm responses.

The RFI covers details of the organization, technology stack, client base, and key functionality. Profiles also include a summary of key differentiators, supported lines of business, deployment options, implementation approaches, and how vendors handle upgrades/enhancements. The profiles feature vendor-provided screenshots of the products where available.

These reports do not render judgment; an insurer's specific situation and needs will determine the fit with a potential vendor partner. Aite-Novarica provides these types of advisory consultations to more than 150 insurer clients through its retained advisory services.

MARKET OVERVIEW

Changing Customer Expectations

Industries outside the insurance vertical—from retail shopping to air travel—are informing customer expectations. Consumers can receive real-time access anywhere from any device; they now expect these capabilities with all transactions.

Property/casualty insurers are setting customer expectations with real-time processing capabilities, including current claim status and mobile computing integration. L/H/A insurers have been insulated from these changes, but the market is evolving. Failing to deliver on these expectations can put insurers at a notable disadvantage, especially with products that have frequent touchpoints (e.g., STD/LTD).

Need for Advanced Capabilities

Insurers are deploying advanced capabilities to keep pace with changing customer expectations. They leverage analytics, data infrastructures, digital channels, and modern applications to deliver innovative business practices. Insurers can use all five elements to streamline claims processes, enable more consistent decision-making, and leverage senior staff expertise more efficiently.

L/H/A insurers are considering triaged straight-through processing and skills-based routing of incoming cases to improve the customer experience. They use digital channels to create paperless processes for claimants and provide mobile loss reporting/claims inception capabilities. Data and analytics are enabling predictive fraud scoring and analytics-driven loss mitigation for long-tail injury or health claims.

Legacy Challenges

Insurers recognize that existing claims environments can be problematic on many levels. These environments are often collections of legacy systems that insurers acquired or implemented over several years or decades. As a result, many insurers have difficulty looking across processing environments to get complete pictures of loss exposures and experiences. This environment also means that insurers process many inbound claims manually.

State Audits

State-sponsored unclaimed property audits highlight notable challenges that insurers can face. Complex legacy environments and acquisitions that have expanded the number of administration platforms can make it a daunting task for insurers to pull the appropriate data for state audits.

Some insurers have responded to these challenges by developing short-term solutions, including end-user tools they built in MS Access or Excel to address immediate financial/control issues audits had revealed. However, these solutions can make insurer desktop environments brittle and challenging to support, especially when moving between versions of Windows and Office.

Recognition of these risks has created a new-found sense of urgency at L/H/A insurers as they consider how to provide robust processing environments that support the capture and preservation of institutional knowledge and the future-state training of a new generation of associates in their claim organizations.

Knowledge Retention

The ability to preserve and leverage knowledge is also an ongoing concern for claims managers. For the past decade, many insurers have experienced low turnover in claims units, supported partly by labor market stagnation during the recession. This stability had benefits in terms of organizational continuity, but it also led to the general aging of this resource pool and created pent-up demand for mobility. Finding ways to capture information systemically and create modern user experiences offers insurers the opportunity to mitigate internal operational risk as the economy changes and baby boomers retire.

Analytics

Claims organizations face the challenge of balancing loss costs, expenses, and the services they provide. Of course, the goal is to offer a fair settlement and pay the appropriate amount, but insurers also need to minimize leakage and reduce fraud. The analytic framework that new solutions offer can substantially improve operations in this regard.

Many of the same proactive claims management capabilities and the associated management practices that workers' compensation insurers (P/C) have deployed offer the potential for better fraud and outcome management for disability insurance insurers (L/H/A). These lines of business and products have operated in separate spheres historically, but L/H/A insurers are now considering the capabilities of the higher transaction systems.

Technology Risk

Aging technology stacks are a growing concern. L/H/A insurers are considering how critical it is to get new products to market, facing increased competitive pressures in certain markets, and recognizing the challenges of supporting technologies that may outlast the careers of the individuals who developed and deployed them. Past "big bang" replacement efforts (including full conversions of in-force blocks of business) have had risky project profiles. Some insurers do not consider these past efforts to have had appropriate reward potential.

Disaggregating monolithic core systems into componentized functional elements is an attractive alternative for life insurers and related lines. This alternative approach allows insurers to pull functionality out of the old core platform(s) on a staged basis, allowing them to improve functionality in a critical area while stabilizing and reducing levels of required change on the old platforms.

Following this general strategy, one area that has emerged as a priority is replacing the claims platform. Doing so can be an opportunity for insurers to address functionality issues and exercise new approaches for integration, e.g., enterprise service buses, SOA approaches. These approaches can be the foundations for future architectural models.

It can be challenging to address technology issues while keeping internal operating costs low and minimizing external loss/fraud costs without a solid platform for moving the impacted lines of business to modern, flexible environments. Providing a high level of customer service to drive retention (high-volume claims lines) or retain assets (low-volume claims lines, e.g., life) without the right future-state solution can exacerbate these challenges.

Increased Interest in Vendor Solutions

Claims administration systems are drawing more attention in the L/H/A space today. A combination of audit concerns, competitive concerns, and evolving market forces (e.g., the rise of millennials as consumers of insurance products with high transaction volumes) have driven the increase in claims interest.

Developing a modern and effective claims strategy can be essential to future profitability as insurers from individual and group lines take advantage of the voluntary benefits and worksite marketing spaces. This is especially true for products with higher transactional frequency (e.g., STD/LTD, LTC).

Insurers had a small number of modern claims platforms to choose from until recently. More options are now available as software vendors recognized and seized market opportunities. Insurers today have a range of claims solutions to choose from to meet their needs.

Emerging solutions like Benekiva LLC, a recent insurance technology startup, offer AI-driven, cloud-based, data-driven solutions to support consumer demands for real-time, digital claims processing. This end-to-end digital claims process capability includes a digital disbursement capability from Fiserv.

Beyond 2021, new information streams will integrate into the claims ecosystem (e.g., third-party data), which the claims application will need to support. Collected data will enable insurers to participate in risk mitigation efforts, shortening the duration and expense of disability and other health-related claims. Additionally, third-party data sources that provide extensive information on insureds can make the claims process more expedient and reliable.

General Characteristics of Modern Claims Systems

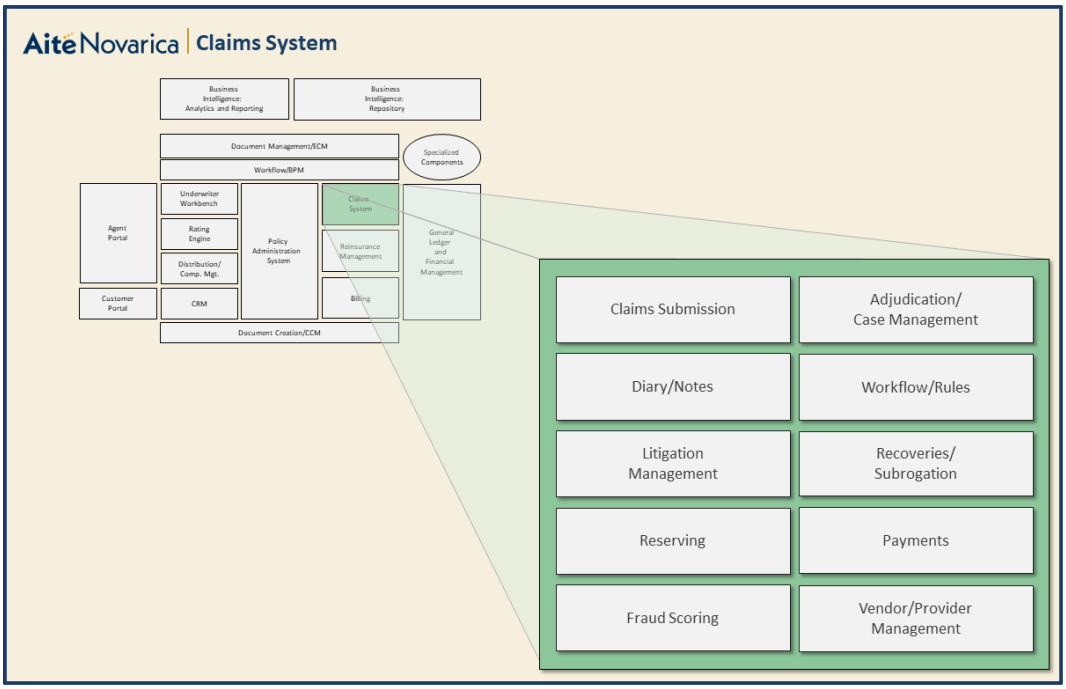
A robust claims management system supports automated claims processing and management functions. Modern claims systems generally provide integrated workflow management and task or process management. In addition, most come with some level of document creation and document management or the ability to integrate with the enterprise packages that many insurers use.

User interfaces have dramatically improved with navigable screens and easy-to-find contextual help. Targeted audience portals, wizards to open new claims, scripting, and dynamic questioning allow insurers to create intuitive processes and deliver consistent service.

Typical modern systems are browser-based with service-oriented architectures. Configuration tools are often available for configuring workflows, pages, forms, tasks, roles, and integration points. Some also have built-in business intelligence tools.

KEY COMPONENTS

Figure 2: Aite-Novarica Insurance Core Systems Map [Exploded View/At-a-Glance]



A well-developed claims system should integrate with policy administration and accounting systems to support coverage verification and disbursements. Additionally, if the system does not include robust modules to handle contact management, document management, or reinsurance, it should integrate with modules for that functionality.

Tools providing easy access and navigation to the traditional adjuster functions are standard. Key claims features and components surveyed by Aite-Novarica include the following:

Claims Submission

The first notice of loss/first report of injury (FNOL/FROI) process is where a claim begins. Most systems have some web-based claim intake capability. The most advanced systems include capabilities for scripting for the claims intake coordinator and support for smartphone/tablet intake. Dynamic questioning allows a tailored process to optimize customer service.

Many solutions also include scoring in the background, sending alerts if a claim requires special handling due to its complexity or potential fraud. The solution may also use business rules to automate adjuster assignments.

Integration to a policy administration system allows automated coverage verification to occur during the FNOL/FROI process. Insureds or agents can report claims in several ways, including call centers or forms submitted via mail, the web, smartphones, tablets, fax, or email.

Diary/Notes

Notes, diaries, reminders, and calendaring capabilities are part of the system's workflow. These are a comprehensive set of activities that the claims adjuster must do to adjudicate the claim. It will incorporate claim-handling guidelines, regulatory requirements, required forms, and automatic review escalations from other claims for supervisors. The system can document important information about the activities related to handling the claim in notes.

Reserving

Manual and statistical reserve tracking monitor changes to reserve and payment detail information on a claim, with reports to show period-to-period changes in claim values. Some include the dynamic determination of reserves based on specific claims characteristics. Solutions typically support several reserve types, ranging from individual case reserves to average or factor reserves.

Insurers should look at the level of granularity that solutions offer to ensure they will support tracking and reporting needs. Many solutions use business rules to create automatic reserve calculations based on the characteristics of the claim.

Fraud Scoring

Fraud-detection tools often include scoring to identify potential fraud, automated alerts and red flags, advanced analytics, workflow processing to route claims to a special investigation unit, and other tools to identify fraud patterns. Some systems have these capabilities inherent within the software. Others have pre-integrated to external solution providers to provide this functionality.

Adjudication/Case Management

Solutions with robust workers' compensation tools tend to include medical case management capabilities. These capabilities typically allow for injury detail maintenance like tracking diagnoses, medical records, treatment plans, and links to ICD9/10 codes or jurisdictional data.

Case management modules often allow case managers and nurses to manage patient care with functions like large case management, utilization review, referrals, and pre-certifications or authorizations.

Workflow/Rules

Most solutions in this report include some level of workflow. Some provide workflow through screen flow; others have robust workflow capabilities to generate and assign tasks manually or automatically through business rules or the ability to integrate another enterprise workflow tool into the claims process.

Typical features include notes, diaries, reminders, and calendaring capabilities. Automated adjuster assignment and claim and sub-claim routing are often based on authorities and service levels; some support multiple adjusters on a single claim.

All solutions in this report include date and time stamps for logging audit trails. Some include supervisor management tools like workload management, easy claim reassignment, and vacation rerouting.

Payments

A common facility for managing checks and drafts (issuing, tracking, and reconciling payments) is standard for a claims solution. Typical features include authority verification, confirmation against reserve limits, and integration to an external disbursements module to print checks. In addition, many but not all solutions support partial payments, split payments, and multi-claim payments.

Other Common Capabilities

Nearly as important as lines of business, rules, or workflows pre-built within the system is the relative ease with which insurers can add capabilities. Insurers should look for configurable rules, workflows, roles, pages, and forms. Some solutions have robust tools to allow massive configuration; some are simple enough for business users to configure.

Contact Management

Every solution in this report includes contact management capabilities to help adjusters stay on top of customer communication tasks and schedules. These capabilities typically capture contact information for all parties to the claim, including the vendors. Some are better at acknowledging the multiple roles contacts may play on claims. Most include some level of diary to trigger ongoing communication.

Documents

Most solutions in this report have a correspondence or forms library for the most common letters and forms. Some solutions store documents, images, or other media by integrating with third-party document management solutions so users can access documents directly from the claims solution. Some vendors are establishing strong partnerships with selected vendors. Others support document storage within the application.

Mobile/Omni-Channel Access

Many of these solutions include some level of secure, browser-based self-service portal access for agents, policyholders, or claimants to submit notices of loss and access claims information. Some have a simplified series of interview questions or scripted steps that also validate data.

Reporting and Analytics

Most solutions have some pre-built, standard reports and ad-hoc analytics tools that deliver operational and performance reports. Some have robust dashboards with drill-down capabilities, graphical interfaces, benchmarking, or activity-based costing reports.

A best practice in this area is real-time claims performance monitoring that shows a claim's current status relative to insurer benchmarks and risk indicators, e.g., potential fraud.

Configuration

This report evaluates configuration capabilities, though not everyone considers them as typical claims functions. Business rules and workflow for claims adjudication, compliance, and file reviews are changing as insurers and vendors leverage new data sources and new regulations are drafted.

Modern claims systems are configurable, but the way vendors implement configuration can vary, as can the breadth of coverage of configuration capabilities. The best way to evaluate configuration capabilities is with hands-on demonstrations, proof-of-concept exercises, and reviewing the underlying architecture.

Disability Management

Functionality specific to LTD/STD and the broader functionality of disability management may not be available in every solution. Those with a history of working with these products have a higher probability of including modules to support return-from-disability programs.

Some may have direct integration with absence management capabilities, while others anticipate that this function may be handled, on the group side, by an alternative platform or a TPA.

NOVARICA MARKET NAVIGATOR GRAPHIC

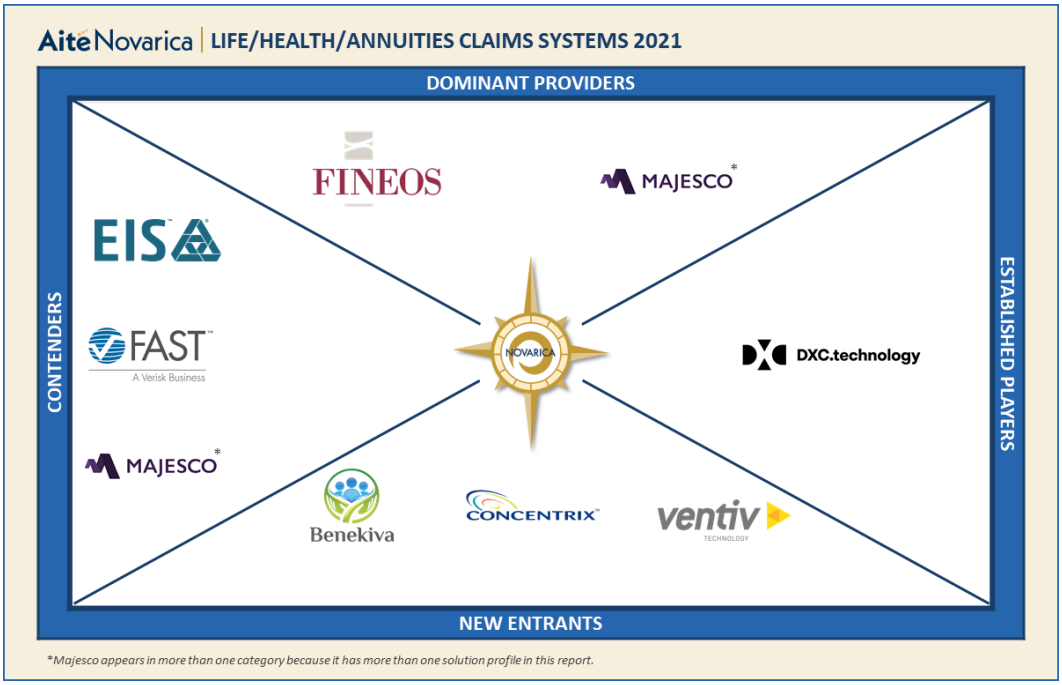
The Novarica Market Navigator Graphic provides an at-a-glance overview of major providers in a specific segment. It is intended to help insurers quickly understand who is active in the space and their approximately relative market positions. Each provider appears in one of the following four categories:

- **Dominant Providers** have strong market positions and momentum. Their solutions in the segment are well-known.
- **Contenders** have substantial customer experience and momentum.
- **Established Players** have generally been in the market longer and have substantial customer experience.
- **New Entrants** are emerging providers in this segment. This category might include new companies or established companies with newer solutions. These typically have limited existing customer bases.

Note that the categories refer specifically to this solution area. A company may be a Dominant Player in one segment but a New Entrant in another based on the maturity of the solution and depth of market experience. Positioning on the graphic within each segment is alphabetical.

Also, note that a provider's category does not imply a subjective judgment on solution quality, delivery, or fitness for any specific company's needs. Companies should carefully evaluate individual solutions relative to their particular needs and consider the company's delivery capabilities and organizational bandwidth in addition to recent customer experience.

Figure 1: Life/Health/Annuities Claims Solution Providers 2021



Comparative Tables

The tables below compare the solution providers in this report across several key differences. Table 1 compares headcount, live US insurer clients, and whether the vendor currently supports large (over $1B) clients. Tables 2 and 3 depict which group, individual, and voluntary lines of business the vended solutions support.

Table 1: Company Characteristics

Vendor	Solution	Headcount	Live US Clients	Large Clients
Benekiva	Benekiva Claims	50	9	■
Concentrix	CXFusion Claims	250,000+	*Undisclosed*	■
DXC	Assure Claims	130,000	3	■
EIS	ClaimCore	1,100	13	■
FAST	FAST Claims Components	240	1	
FINEOS	FINEOS Claims	1,100	31	■
Majesco	Claims Management Software for L&A and Group	2,195	2	
Majesco	ClaimVantage Claims for L&H	2,195	12	■
Ventiv	Claims Enterprise	450	5	■

Table 2: Lines of Business Supported - Life, Annuity, Health

Vendor	Indiv. Life	Group Life	Indiv. Annuity	Group Annuity	Indiv. Health	Group Health
Benekiva	■	☐	■	☐	☐	☐
Concentrix	■	■	■	☐	■	■
DXC	☐		☐		☐	
EIS	■	■			☐	☐
FAST	■	■	■	◆	☐	☐
FINEOS	■	■	☐	☐		
Majesco (Claims Management)	☐	■	■	☐		
Majesco (ClaimVantage)	■	■				
Ventiv						

■ = Live clients ◆ = Clients currently in implementation ☐ = Supported [Blank] = Not Supported

Table 3: Lines of Business Supported - Voluntary Benefits

Vendor	Dental	Vision	Disability	Critical Illness	Accident	Med Supp	Hospital Indemnity
Benekiva	☐	☐	■	☐	■		☐
Concentrix	■	■	■	■	■	■	■
DXC	☐	☐	■	☐			
EIS	■	■	■	■	■	■	■
FAST	☐	☐	☐	☐	☐	☐	☐
FINEOS	☐	☐	■	■	■		■
Majesco (Claims Mgmt.)	■		■	■	■	◆	■
Majesco (ClaimVantage)			■	■	■		■
Ventiv			■				

■ = Live clients ◆ = Clients currently in implementation ☐ = Supported [Blank] = Not Supported

FULL SOLUTION PROFILE

EIS - ClaimCore

Executive Summary

- EIS is a privately owned company that builds adaptable core insurance systems for insurers of all sizes. It has headquarters in San Francisco, CA, and employs 1,100 people. The company did not disclose annual revenue.
- EIS currently has 13 US/Canadian L/H/S insurer clients using ClaimCore in conjunction with one or more components of the EIS Suite. EIS's L/H/S clients are split between larger (over $1B) and smaller (under $1B) companies using the solution in a mix of individual and group lines.
- Publicly announced clients include Guardian, Liberty Mutual, Renaissance, Bankers Life, and Reliance Standard.
- The solution is browser-based for all user interface functions. It is written in Java.
- Configuration for screens, workflow, and rules is via tools for BAs and non-IT staff. Integration to third-party service calls is configurable via developer tools, XML manipulation, or a scripting language. Configuration for document authoring is not available; changes are done by the vendor.
- Implementation is available through company resources or an SI partner. EIS deploys ClaimCore on-prem, hosted at a private/managed data center, and hosted on AWS or MS Azure. EIS offers a SaaS delivery model that includes hosting, license, maintenance and support, ongoing access to the latest version, and the implementation of upgrades.
- The company reports that the average time to initial go-live is nine months or less and that the average cost, including license and implementation fees, is $1M-$2M.

Lines of Business Supported

Individual life:	Live clients offering this product in all 50 US states
Term life:	Live clients offering this product in all 50 US states
Whole life:	Solution is designed to support, but no clients live or implementing
Universal life:	Solution is designed to support, but no clients live or implementing
Variable life:	Not currently supported
Variable whole life:	Not currently supported
Variable universal life:	Not currently supported
Group life:	Live clients offering this product in all 50 US states
Group term:	Live clients offering this product in all 50 US states
Group universal life (GUL):	Clients currently in implementation for this line/product
Variable group universal life (VGUL):	Not currently supported
Group annuities:	Not currently supported
Long-term care:	Not currently supported
Fixed annuities:	Not currently supported
Variable annuities:	Not currently supported
Indexed annuities:	Not currently supported
Single premium immediate annuities (SPIA):	Not currently supported
Dental Care:	Live clients offering this product in all 50 US states
Vision Care:	Live clients offering this product in all 50 US states
Pet Insurance:	Solution is designed to support, but no clients live or implementing
Disability:	Live clients offering this product in all 50 US states
Cancer/critical illness:	Live clients offering this product in all 50 US states
Accident:	Live clients offering this product in all 50 US states
Medicare supplement:	Live clients offering this product in all 50 US states
Hospital indemnity:	Live clients offering this product in all 50 US states
Individual health:	Solution is designed to support, but no clients live or implementing
Group health:	Solution is designed to support, but no clients live or implementing
Other supplemental benefits*:	Live clients offering this product in all 50 US states

*Other supplemental benefits include absence management, STD, LTD, paid family leave, state mandate, and travel protection

Client Base

Globally, EIS has 18 insurer clients (i.e., not MGAs, self-insureds) live on ClaimCore, 14 of which are US/Canadian L/H/A insurer clients using the solution in conjunction with one or more components of the EIS Suite. Clients are a mix of larger (over $1B) and smaller (under $1B) companies using the solution to support individual and group lines. The company does not currently have clients that use ClaimCore as a stand-alone claims system. Publicly announced clients include Guardian, Liberty Mutual, Renaissance, Bankers Life, and Reliance Standard.

Key Functions and Differentiators

EIS cites the key functions of ClaimCore as:

- Workflow-driven, role-based claims
- Fraud detection
- Claims adjuster mobile app
- Integration with Customer 360 and its party model
- EIS BI reporting tool that includes AI for insights

The company cites as its key differentiators the solution's cloud-native microservices architecture, which enables clients to use it stand-alone or with any number of suite components; the depth of configuration across services like Product Studio (configuration), CustomerCore, PolicyCore, BillingCore, and ClaimCore; the breadth of mobile capabilities across multiple personas (e.g., policyholder, CSSR, agent); pre-integration with PolicyCore PAS; and embedded CRM.

Solution Architecture and History

ClaimCore launched in 2003 and was re-architected in 2009. The latest release was in June 2019. EIS reports that 80% of customers are on the latest version, and 20% are on an older version released in the last three years. Approximately 90% of customers have been through at least one upgrade. EIS reports that it releases updates every three weeks and does not have major upgrades.

ClaimCore supports DB2/UDB, Oracle, Microsoft SQL Server, and any DBMS database with a JDBC driver that supports JPA. The solution also supports UNIX/Linux, Windows, AIX, and Virtual server platforms. It is written with Java.

APIs and Integration

The solution provides REST APIs. EIS reports that EIS Suite is an omni-channel solution architected to expose data, services, and business functionality through APIs.

Configurability and User Interface

ClaimCore is browser-based for all user interface functions. The solution offers mobile capabilities through a native mobile app. Clients are not allowed to touch core code, but EIS provides hooks to call external custom code.

Configuration for screens, workflow, and rules is via tools for BAs and non-IT staff. Integration to third-party service calls is configurable via developer tools, XML manipulation, or a scripting language.

Deployment Options

EIS deploys ClaimCore on-prem, hosted at a private/managed data center, and hosted on AWS, MS Azure, or Google Cloud. The company offers a SaaS delivery model that includes hosting, license, maintenance and support, ongoing access to the latest version, and the implementation of upgrades. The hosted solution is a single-tenant app server and database.

Average Implementation Length and Cost

EIS implements the solution through company sources or an SI partner. It reports that ClaimCore can be ready for initial go-live in nine months or less and fully rolled out in an additional 12 months or less. The average cost, including license and implementation fees, is $1M-$2M.

Support

Of the 1,100 people employed at EIS, there are between 250 and 1,000 on the product design/engineering and implementation teams (not counting partnerships) and between 50 and 100 on the support team.

EIS supports the solution from its headquarters in San Francisco, CA, and offices and development centers in Australia, Brazil, New Zealand, the US, Canada, China, Ukraine, Lithuania, and Russia.

EIS offers customer engagement initiatives such as an online community, online training, a customer advisory committee, a user event, and training seminars.

Systems Integrators and Other Partnerships

Publicly announced SI partners include PWC, EPAM, EY, Deloitte, and Cognizant. Publicly announced technology partners include AWS, Microsoft, Google Cloud, Prevail, and Verisk.

Functionality

As a stand-alone claims solution, ClaimCore offers functionality in the following areas:

Adjudication

Injury detail maintenance (coding), disability management, and aggregate tracking (erosion of policy limits) are standard functions. Automated coverage verification and deductible tracking are available with configuration via tools for IT analysts or BAs.

The solution does not currently include medical case management. EIS asserts it has a proof of concept for medical claims.

Disbursements

Calculating and scheduling recurring/repetitive payments, calculating partial or one-off payments, accommodating multiple pay parties (e.g., beneficiaries, service providers), combining multiple pending payments for a single client into one disbursement, and handling multiple offsets and deductions against benefits are all standard functions. Check processing and OFAC checking are available via out-of-the-box integration to a third-party system or service.

Documents

Image and media management, a content repository, content management tools, and multi-channel delivery and output of documents (including PDF, email, web, and print) are standard functions. A correspondence or forms library, state-specific claims reporting templates, and document rendering are available with configuration via tools for IT analysts or BAs. Multi-channel document delivery/output for social media or mobile is available with configuration via developer tools, XML manipulation, or a scripting language.

FNOI/FNOL

Recording and storing new loss notices from a web portal, email, fax, or manual entry; claimant contact management data capture; and checking for duplicate claims are standard functions. Scripting for claims intake with reflexive questioning and scoring claim characteristics to calculate alerts, trigger workflow, assign a claims handler, or otherwise segment the claim are available with configuration via tools for IT analysts or BAs.

Fraud

Provision of multiple search and reporting criteria for fraud detection (via the ability to track common clients across multiple claims) and configurable business rules and tasks (specific to fraud and special investigations) are available with configuration via tools for IT analysts or BAs.

Litigation

Litigation process tracking, including negotiation details and litigation costs, and creating separate tasks, workflow, diaries, and business rules for litigated cases to allow legal case management are available with configuration via tools for IT analysts or BAs.

Multi-Channel

An agent portal with self-service and a policyholder portal with self-service are available with configuration via tools for IT analysts or BAs. E-signature, call center integration for FNOI/FNOL via telephony, and call center integration for checking claim status via telephony are available with configuration via developer tools, XML manipulation, or a scripting language.

Reinsurance

Identifying claims subject to reinsurance through multiple dimensions and initiating reinsurance recovery processes are available with configuration via tools for IT analysts or BAs.

The solution does not currently include assignment to reinsurance treaties or assignment to facultative arrangements.

Reporting

Capabilities like standard reporting of loss results, operational metrics, and configurable metrics for claims reporting are standard. Ad hoc reports, dashboards, reporting that includes jurisdiction-specific reports and forms, and electronic reporting or automated state filings are available with configuration via tools for IT analysts or BAs.

Reserves

Granular tracking of reserves and payments and direct, case, average, factor, and expense reserve types are standard. Automatic reserve calculations using business rules and risk characteristics are available with configuration via tools for IT analysts or BAs.

Service Providers

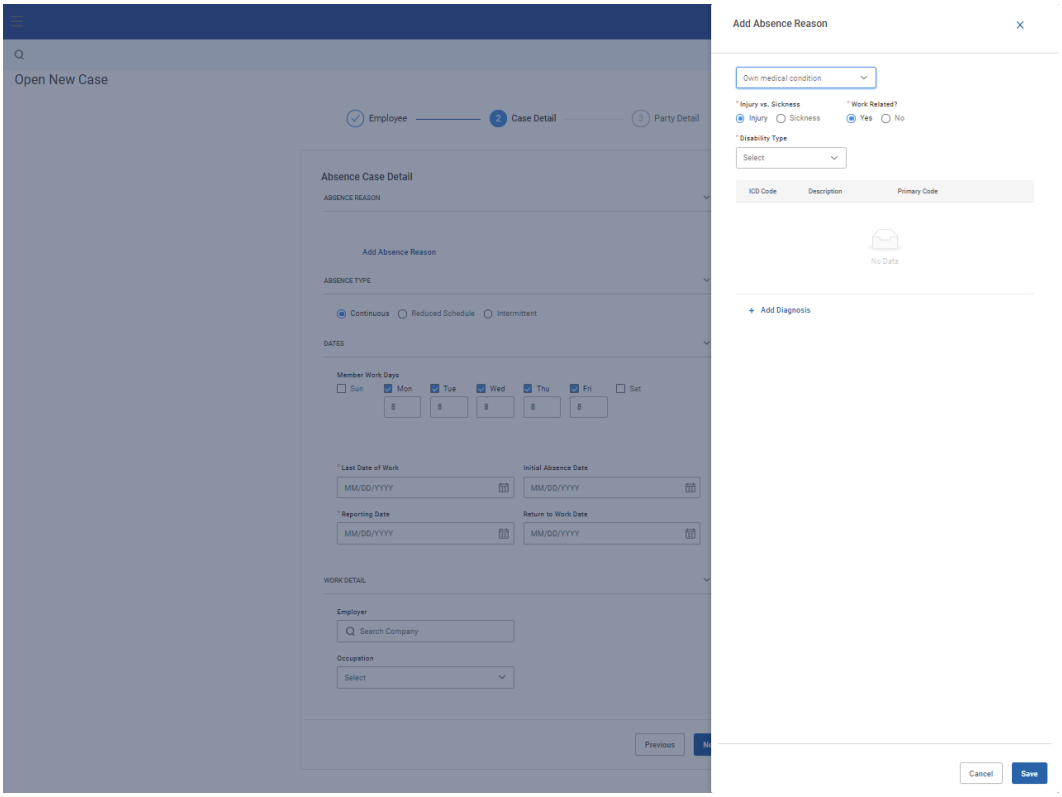
Functions to manage service providers/suppliers (e.g., long-term care facility, pharmacy) are available out of the box. Processing required forms (including 1099s) is available with configuration via tools for IT analysts or BAs.

Workflow

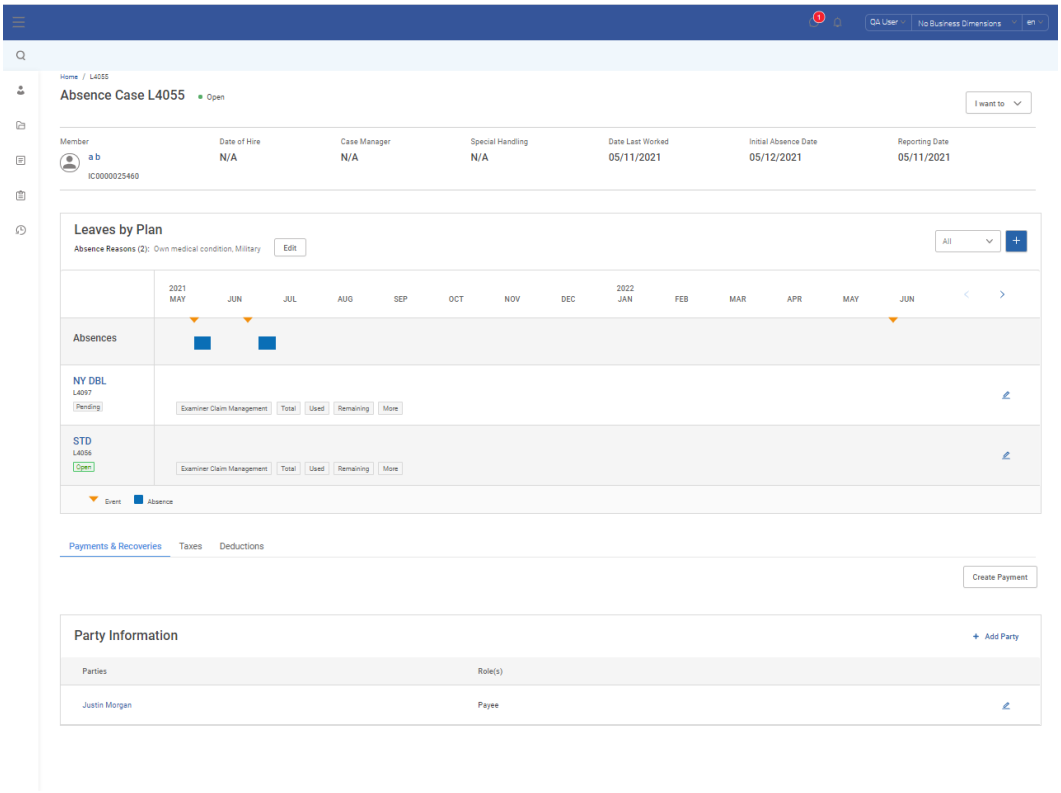
Automatic workflow/task generation, the inclusion of external documents (letters, pictures) in file notes, and assigning multiple claims examiners to a single claim are standard functions. Overriding automated processes and triggering workflow processes manually, automatic work assignment based on configurable rules, compliance with the Document Repository Interface (DRI) standards, and processing claim workflow trigger (CWT) files at insurer-defined intervals are available with configuration via tools for IT analysts or BAs. OCR-triggered workflow is available via out-of-the-box integration to a third-party system or service.

Screenshots

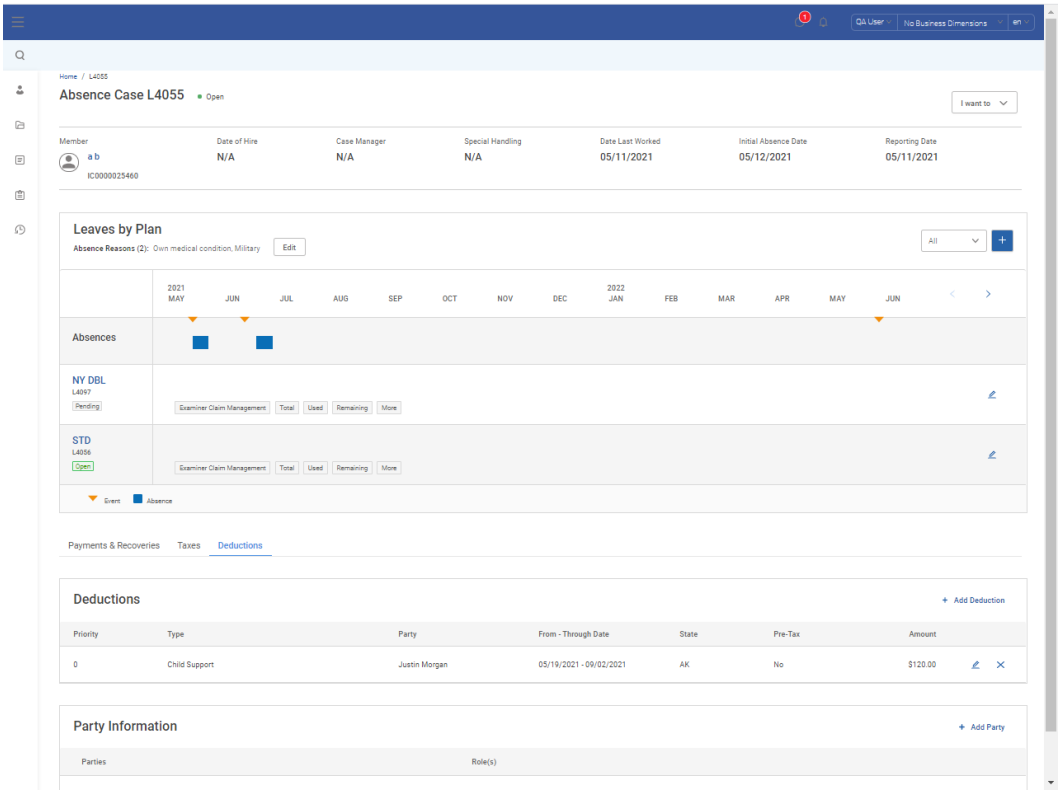
Intake



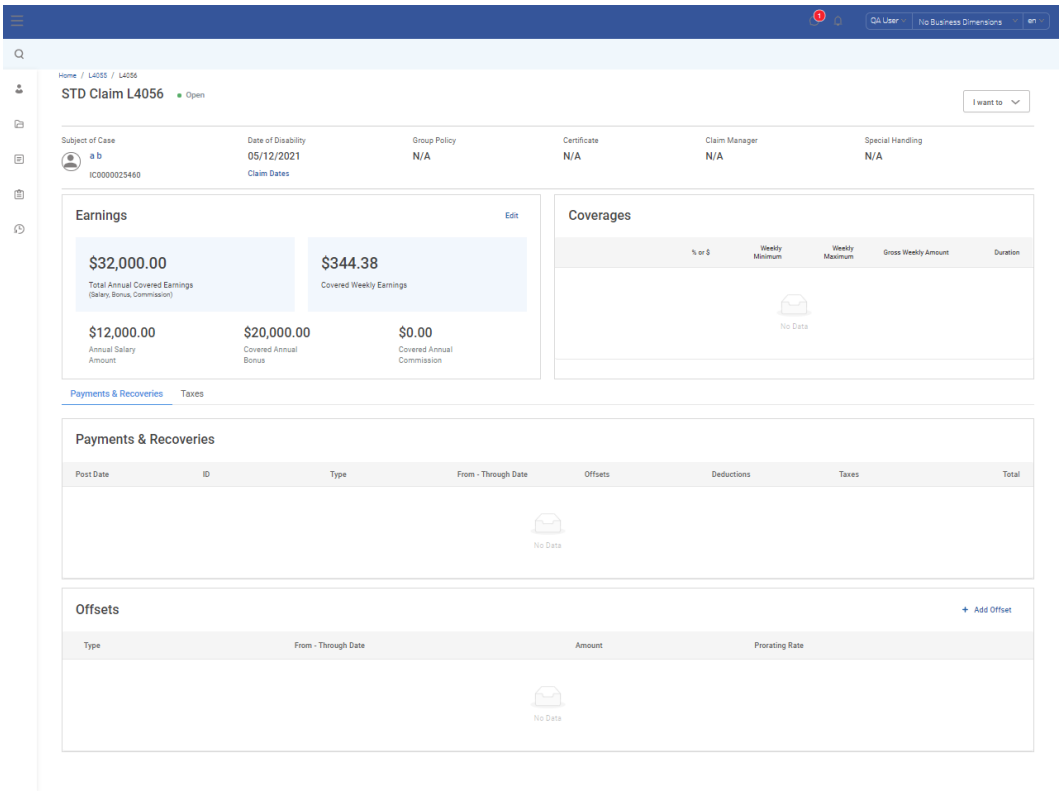
Absence Case - Landing Page



Absence Case - Tax Withholdings and Deductions



Absence Case - Claim Example



CONCLUSIONS

Insurers have a rich vendor market to select from when considering L/H/A claims solution providers. Implementing best-of-breed claims solutions that allow insurers to incorporate intellectual capital by configuring processing capabilities will allow true business benefits. Modern solutions are maturing, giving carriers better options. These solutions are now often part of integrated suites.

Aite-Novarica research indicates that deployments take about one to two years. Challenges still exist with conversion and managing overall project risks, but insurers realize benefits in operations efficiency, improved functional capabilities, better data management, and competitive parity, especially around customer service.

Investments in new claims capabilities often happen in the context of strategic replacements of policy administration, billing, and underwriting capabilities. The business case for a new system must assess processing efficiencies, the ability to pay claims fairly, and customer expectations, the latter of which can be difficult to quantify.

A claims focus allows some insurers to disaggregate existing core system environments and implement modern and flexible architectural capabilities (e.g., ESBs, SOA orientation). It is also a way for insurers to build institutional knowledge and organizational muscle around deploying a new solution in lines of business where more than a generation may have passed since the company executed a comparable project.

Advances in technology are transforming each step of the claims workflow. Customers can now initiate new claims entry and FNOL/FNOI through mobile channels, for example. These advances drive opportunities to support automatic examiner assignment or, for simple claims, straight-through processing. Segmentation and routing of claims use rules in conjunction with examiner and third-party data to get claims where they need to be for quick adjudication.

Integrated desktops are enhancing the claims process. These gather data from third-party data sources in real-time, track alignment to best practices and insurer standards, generate and track work plans, facilitate collaboration, and develop real-time dashboards and reports. Insurers can use them to customize workflows to fit their organizations and claims processes.

The ability to analyze the data for the claims process is key to managing the entire process. Insurer-defined key performance indicators (KPIs) allow managers to find inefficiencies or issues their organizations need to address. Daily metrics are essential for the operation to be effective. Long-term views of the data are important to gain insights and highlight areas of the organization that require review and rework.

Insurers can use data going into predictive analytics engines to identify and operationalize processes to increase customer retention, reduce fraud through scoring, and create better loss reserving. They often integrate claims systems with customer self-service portals or producer portals. Integration allows for better and more self-directed support for set up, subsequent support to add documentation during the life of a claim, and the opportunity to track claim status.

Claims management continues to be an area for strategic innovation as technology allows insurers to increase efficiencies, deliver better customer experiences, and gain new insights via data. Insurers with leading claims organizations implement modern solutions with tools that make meeting their goals and objectives easier. For group insurance, the time of claim adjudication may be the first time an insurer definitively knows who plan members are; it becomes a critical touchpoint in a decidedly limited customer relationship journey.

Organizations can use the information from the claims management process to enhance the underwriting process, creating a virtuous cycle in which insurers can turn data into actionable information.

Aite-Novarica recommends that insurers looking for a partner narrow the market to a shortlist of three or four vendors by focusing on four main areas: **s**taff, **o**rganization, **f**unctionality, and **t**echnology, easily remembered by the acronym **SOFT.**

- *Staff*
  - Does the vendor's staff have the right skills and experience?
  - How well are they likely to understand your needs?
  - What resources are available for implementation and support?
  - What assurances will you have that the staff you meet during the sales process will be the staff that you work with?

- *Organization*
  - How stable is the organization?
  - Is it big enough for your company to do business with?
  - Who are their other clients?
  - How focused are they on the insurance industry?

- *Functionality*
  - Do the solution and services support your needs for modeling services, lines of business, states, and model maintenance that you need?
  - Which solutions and services are actually live at reference clients?

- *Technology*
  - Is the solution's technical architecture compatible with your enterprise standards (or can you build your enterprise standards around the solution's technical architecture)?
  - Does your IT staff have the skills to support it?

Insurers should be able to narrow their range of potential suppliers by using a handful of questions from each category. This approach is faster and more effective than distributing a large RFP, which carriers can avoid altogether or save for the final one or two potential suppliers after all other evaluations are complete.

NEXT STEPS AND RELATED RESEARCH

- Contact Aite-Novarica Group at client-support@aite-novarica.com to set up a conversation to discuss this topic.
- Read related reports:
  - *Life/Annuity/Benefits Policy Administration Systems*
  - *Insurer IT Budgets and Projects 2021*
  - *Business and Technology Trends: Group Life and Voluntary Benefits*
  - *Novarica 100 Digital, Data, and Core Capabilities for L/A Insurers*
  - *Business and Technology Trends: Annuities*
  - *Business and Technology Trends: Individual Life Insurance*
  - *Innovation in Insurance: Expansion and Key Issues*

ABOUT AITE-NOVARICA GROUP

Aite-Novarica Group is an advisory firm providing mission-critical insights on technology, regulations, markets, and operations to hundreds of banks, insurers, payments providers, and investment firms—as well as the technology and service providers that support them.

Comprising former senior technology, strategy, and operations executives as well as experienced researchers and consultants, our experts provide actionable advice to our client base, leveraging deep insights developed via our extensive network of clients and other industry contacts.

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