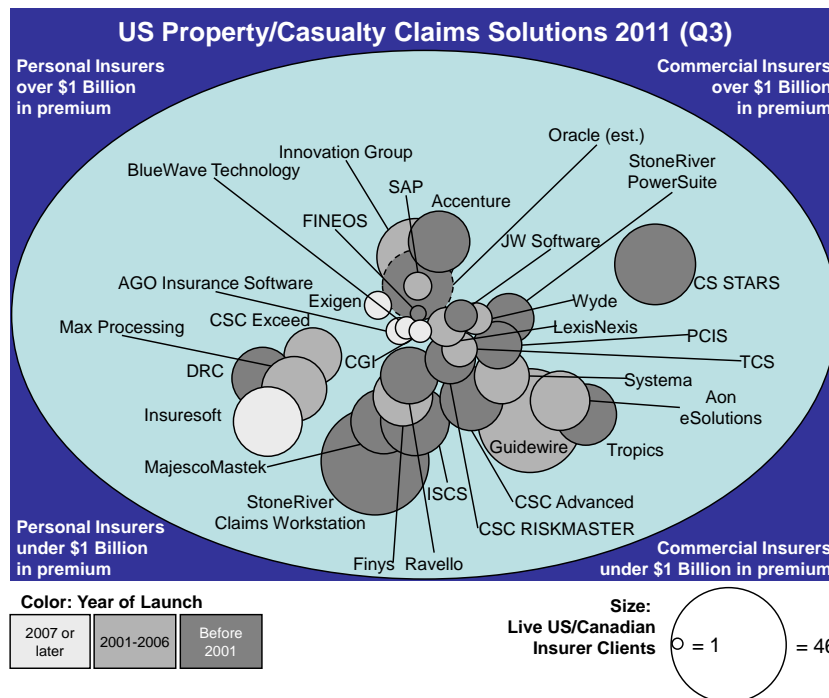




Excerpt from
NOVARICA MARKET NAVIGATOR™
US Property/Casualty Claims Solutions 2011 (Q3)
 July 2011

NOVARICA MARKET NAVIGATOR



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SUMMARY

This report provides an overview of the available claims management solutions for US property/casualty insurers. The information in this report was collected directly from the solution providers using Novarica's proprietary universal RFI. This authorized excerpt includes a brief profile of CS STARS. The full report includes profiles of all solutions that appear in the graphic above.

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INTRODUCTION

Purpose

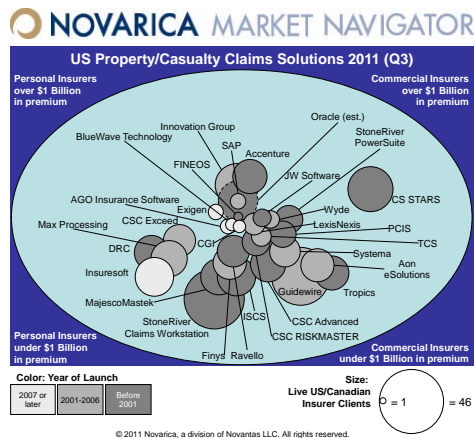
This report is designed to provide an overview of the current solution provider marketplace for property/casualty claims administration systems, and to assist insurers in drawing up their shortlists of potential providers based on vendor market position and offering details.

About this Report

Novarica Market Navigator™ reports do not provide subjective analysis or render judgment on each vendor's solution. They are based on factual responses to a universal RFI distributed by Novarica and subsequent conversations with the vendors to validate and confirm responses. The RFI covers details of organization, technology stack, client base, and key functionality. In cases where vendors chose not to respond to our RFI, we summarized the publicly available information about the solution.

Novarica ACE Ranking™ reports provide information on Average Customer Experience of insurers using specific technology solutions, and *Novarica Vendor Solution Reviews™* evaluate offerings from individual vendors, based on validated responses to targeted RFIs, in-person product demonstrations, and in-depth client reference interviews. Novarica ACE Rankings or Novarica Vendor Solution Reviews have been published on some of the vendors included in this report, and more may be published in the coming months, based on client demand.

About the Novarica Market Navigator Graphic



The Novarica Market Navigator Graphic is designed to show relative market position of multiple solution providers in a single space.

The graphic for this report plots vendors by age of solution (color), number of live clients (circle size) and composition of client base (position).

The position of each circle relative to the four corners of the field represents the **average** client for that solution. Solutions

are plotted by the number of customers in each sector, resulting in an average market position that represents their **typical** customer. Thus Accenture, for instance, has a client base composed predominantly of large commercial lines insurers but also has some personal clients, mostly large. More detailed information about each solution's customer base is available in the profiles themselves.

MARKET OVERVIEW

The insurance industry is coming out of the slowest growth rate since the 1930's. The economic downturn had a significant impact on revenues, and competition has reached some of the highest levels seen in years. This has made the reduction of insurance carriers' cost base and generation of underwriting profit an imperative. Now, more than ever, maintaining and improving customer service is a key competitive differentiator and a critical strategic goal for carriers focusing on driving retention.

P/C carriers are looking for ways to drive growth and improve operational effectiveness, and claims is one of the areas they are investing in. In fact, over 30% of carriers surveyed by Novarica say that claims is one of the top three projects they are focusing on for 2011. Claims play a critical strategic role in the overall success of a carrier. Close to 70% of their revenue is spent on claims – and about 20% of that is spent managing the claims process.

The quality of a carrier's claims service heavily impacts the customers' view of the carrier because other than the bill, claims are typically the only contact a customer has with a carrier – and a bad claim experience is one of the top reasons for non-renewal. In today's competitive environment, where retention is a critical imperative for carriers, claims handling is a major source of competitive advantage for property/casualty companies.

The economy has driven other changes in claims. Claimant behavior is changing, which will require new strategies from carriers. Customers are looking for ways to save money. There is a lot more comparison-shopping happening, especially online. In addition, evidence is emerging of increasing fraud and abuse with anecdotal evidence of owner-caused arsons, premium evasion, personal health care claims being disguised as workers' compensation, and claim malingering. All of these changes cause new challenges for carriers, many of which can be addressed through modernizing claims processes.

Claims organizations face the challenge of balancing their loss costs, expenses, and the services they provide to customers. While the goal is to offer a fair settlement and pay the appropriate amount, carriers also need to minimize leakage and reduce fraud. Loss costs can be kept low when carriers subrogate where possible and take advantage of salvage opportunities.

However, doing all of this in a cost-effective manner – both keeping internal operating costs low and minimizing external loss costs such as attorney fees or expert witness fees – can prove difficult without solid support from technology. When you add in the need to provide a high level of customer service as a differentiator to drive retention, the challenge becomes more taxing.

To address all these challenges, many carriers are examining, investigating, and implementing upgrades to their core claims administration systems and other technology areas that impact claims.

Claims administration systems are being replaced at an increasing pace in the insurance industry. While many carriers have already upgraded and others are in the middle of a claim replacement project, the majority of carriers are in the planning phase for a core claims system replacement.

Traditionally, claims handling has been a very labor-intensive process for carriers with lots of paper, handoffs, and relationships to manage. Claims administration systems are aging. For many carriers, these solutions were installed twenty years ago or more. Older systems are quite expensive to maintain. The available resources to handle maintenance are shrinking as employees with skills in older code bases retire. Typically, business rules and logic are embedded in the code. Modifications require skilled developers. Older systems were usually rooted in managing the financial side of claims rather than service. This makes it difficult to deliver excellent service in anything other than a manual fashion. Claims systems typically are decoupled from policy or customer systems, which makes simple tasks like coverage verification challenging. This decoupling also makes it difficult to integrate the data for business intelligence or predictive analytics.

Until recently, there were not a lot of choices for modern systems. Today, carriers have a broad choice of claims solutions to meet their needs.

A robust claims management system for an insurance carrier supports automated processing and management of claims functions. Generally, modern claims systems provide integrated workflow management and task or process management as well. Most come with some level of document generation and document management. User interfaces have dramatically improved with easily navigable screens and easy-to-find contextual help. Adjuster portals, wizards to open new claims, scripting, and recursive questioning all allow carriers to create very intuitive processes and deliver consistent service.

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

With these kinds of features, it is no wonder that we are seeing a continuing interest in replacing core claims systems. Novarica estimates that between 30-40 claims systems new sales were completed in the last year.

KEY COMPONENTS

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, and reinsurance, it should easily integrate to modules with that functionality. Tools providing easy access and navigation to the traditional functions handled by an adjuster are standard.

Administrative Features

Nearly as important as those lines of business, rules, or workflows that are already built within the system is the relative ease with which additional capabilities can be added. Look for easily configurable rules, workflows, roles, pages, and forms. Some solutions have robust tools to allow massive configuration; some are simple enough to be configured by business users.

Billing

Some vendor management solutions include data transfer interfaces allowing vendors to submit invoices electronically and enabling carriers to make automated bulk payment to vendors.

Catastrophe

Some solutions have robust catastrophe management tools that come out of the box. These include features such as the ability to define catastrophes by peril, geography, date, or other criteria. Those with catastrophe tools typically also support attaching multiple LOBs or causes of loss to a single catastrophe (cat). Generally, they have the capability to automatically identify claims that meet the criteria of the cat to assist carriers in identifying those claims that may be eligible for reinsurance. Look for the ability to do geographic mapping, either using a tool within the system or by easily integrating with Google maps. The most robust claims functionality includes the ability to identify those policies that are likely to experience a cat claim (in the flood zone or in the path of a hurricane), pre-assign a cat claim number, and notify the customers in advance of the cat.

Contact Management

All of the solutions in this report include contact management capabilities to help adjusters stay on top of customer communication tasks and schedules. They typically capture contact information for all parties to the claim including the vendors. Some are more robust at acknowledging the multiple roles that a contact may play on a claim. Most include some level of diary to trigger ongoing communication.

Disability Management

Functionality specific to workers' compensation is not available in every solution. Those that specialize in this line have a higher probability of including modules to support return-to-work programs. Look for tools to look up recovery guidelines and jurisdictional information, calculate recovery dates, and manage return-to-work programs.

Disbursements

A common facility for managing checks and drafts (issuing, tracking, and reconciling payments) is a standard capability for a claims solution. Typical features include authority verification, confirmation against reserve limits, and integration to an external disbursements module to print checks. Many, but not all, solutions also support partial payments, split payments, and multi-claim payments. For long-tail medical claims, many support recurring payments, multiple pay parties and garnishments, and offsets against Social Security. For those with recurring payment capability, some allow for suspending payments temporarily, simplified holiday calculations, and easily changed payment dates.

Documents

All of the solutions described here have some sort of a correspondence or forms library for the most common letters and forms. Some handle storage of the documents, images, or other media by integrating to a third-party document management solution such that users access the documents directly from the claims solution. Others support document storage within the application itself.

First Notice of Loss / First Report of Injury

The First Notice of Loss / First Report of Injury (FNOL/FROI) process is where a claim begins. Most systems have some sort of web-based claim intake capability. Those that are most advanced include capabilities for scripting for the claims intake coordinator. Recursive questioning allows a tailored process designed for optimizing the customer service process. Many solutions also include some level of scoring in the background. This typically is used to send alerts if special handling may be needed either due to the complexity of the claim or due to a potentially fraudulent situation. Business rules may also be used to support automatic adjuster assignment. Integration to a policy administration system allows automated coverage verification to occur during the FNOL/FROI process.

Fraud Detection

Fraud detection looks for 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 claims systems have these capabilities inherent within the software. Others have pre-integrated to external solution providers to provide this functionality.

Litigation Management

Not all solutions include robust litigation management modules. Those that do vary in the level of sophistication provided. Some simply configure workflows to track the litigation process while others are quite robust, keeping a record of the litigation process: demands and offers, tracking negotiations strategies, and calculations of potential outcomes. Diaries, workflows, and task management are typically configured slightly differently for litigation management. Some claims systems also provide tools to electronically receive, review, adjust, and pay legal invoices submitted by panel counsel.

Medical Case Management

Solutions with robust workers' compensation tools generally include medical case management capabilities. Typically, these allow for injury detail maintenance such as

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 monitor and manage patient care, featuring activities such as large case management, utilization review, referrals, and pre-certifications or authorizations.

Mobile/Multi-Channel Access

Many, but not all, of these solutions include some level of secure browser-based self-service portal access for agents, policyholders, or claimants to submit notice of loss and access claims information. Some include a simplified series of interview questions or scripted steps that also validate data. Some come configured for mobile capabilities, either the ability to send text messages to customer mobile devices, or more often, the ability for adjusters to access the system in the field using a mobile device. Typically, this is done through offline management of claims that later syncs to the application once reconnected.

Recoveries

Many, but not all, of these solutions include modules to support subrogation and salvage. These modules come in multiple flavors. Some include analytical tools to score and evaluate open and/or closed claims to identify missed subrogation opportunities. Others include workflow to guide, track and manage the process, and help adjusters utilize best practices.

Reporting and Analytics

These capabilities vary widely. All solutions have some level of pre-built standard reports and ad hoc analytic tools to deliver operational and performance reports. All easily integrate to third-party BI packages. Some have particularly robust features such as dashboards with drill-down capabilities, graphical interfaces, benchmarking, or activity-based costing reports.

Reserve Management

Both manual and statistical reserve tracking track changes to reserve and payment detail information on a claim, with reports to show period-to-period change in claim values. Some include dynamic determination of reserves based on specific claims characteristics. Typically, multiple reserve types are supported, ranging from individual case reserves to average or factor reserves. Many solutions use business rules to permit automatic reserve calculations to be created based on characteristics of the claim. For workers' compensation solutions, look for links to jurisdictional information for wage and rate calculations. Some do a particularly nice job of aggregate tracking to monitor the erosion of policy limits. Many, but not all, also include deductible tracking: both small deductibles as well as self-insured retentions.

Vendor Management

Vendor management tools assure that accurate information is continually available for payments and accounting purposes. Some support tracking service agreements including multi-tier service agreements and scheduling of provider services. Look for the ability to associate providers with multiple networks. Most capture the data needed for 1099s, and some include 1099 modules. Some solutions also support scoring or ranking of vendors, allowing for improved utilization of preferred providers.

Workflow

Most of the solutions in this report include some level of workflow. Tasks can be generated and assigned manually or automatically through business rules. Typical features include notes, diaries, reminders, and calendaring capabilities. Automated adjuster assignment and claim and sub-claim routing are normally based on authorities and service levels, and some support multiple adjusters on a single claim. All the solutions described in this report include date and time stamps for logging audit trails. Some include supervisor management tools such as workload management, easy reassignment of claims, and vacation rerouting.

CS STARS: STARS ENTERPRISE

CS STARS is based in Chicago and has approximately 500 employees. Annual revenue is over \$100 million. CS STARS is a member of Marsh & McLennan Companies.

CS STARS' claims solution, STARS Enterprise, was launched in 1998 and last re-architected in 2009. It also provides business intelligence functionality. CS STARS reports that STARS Enterprise is the industry's only integrated suite of claims, risk, and compliance management software and services for insurers, third-party administrators, corporations, and organizations that self-administer claims. STARS Enterprise is designed to support the entire risk management and claims lifecycles to reduce cycle times and loss costs, improve productivity, and decrease administrative expense. Key differentiators cited by the company include community cloud hosting, extensive conversion experience, and tech partners that include SAP, Oracle, Microsoft, and HP.

Much of the functionality surveyed by Novarica is available in STARS Enterprise. All functionality is integral except benchmarking and mobile capabilities, which are stand-alone. Litigation management, which is also integral, includes customizable tasks, screens, and attachments. A policyholder portal, workload management, and scripting and scoring of FNOL are not included.

Clients are live on STARS Enterprise in all 50 US states for all commercial lines of business surveyed, including professional liability, specialty, workers' comp, and surety. Personal lines are not supported.

STARS Enterprise requires Windows with an Oracle database if locally implemented and Microsoft IE if accessed via the CS STARS Community Cloud hosted solution. The solution is written mainly in .NET/C#, and all functions are browser-based. The solution does not currently support ACORD XML.

A unit of 450 employees supports STARS Enterprise, 125 of those in customer-facing roles. Support staff average 12 years of experience. Each client has a named account executive as well as access to a shared pool of technical and support resources.

There are 26 US insurers live on STARS Enterprise, including 17 with over \$1 billion in annual premium. All write commercial lines. There are also four P/C reinsurers live on the solution. 35% of clients are on the latest release. CS STARS declined to provide client names.

CS STARS reports that the solution can be ready for initial go-live in 9 months or less and fully rolled out in an additional 90 days or less. Average implementation cost is \$100K-\$500K.

CONCLUSIONS

Claims management has become an area for strategic innovation as technology allows carriers to increase efficiencies, deliver a better customer experience and glean new insights through easier access to data. Carriers with leading claims organizations are implementing modern solutions with tools that make it easier to meet their goals and objectives.

We recommend that insurers who are looking at these systems narrow the overall market to a short-list of three or four by focusing on four main areas: **staff**, **organization**, **functionality**, and **technology**, 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 really 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 much of a role do clients have in product development?
- *Functionality*
 - Does the solution support the lines of business, states, and high-level functionality that you need?
 - Which functions are actually live at reference clients?
- *Technology*
 - Is the solution's technical architecture compatible with your enterprise standards?
 - Does your IT staff have the skills to support it?

Using a handful of questions in each of these categories, insurers should be able to narrow their range of potential suppliers to a handful of candidates. This approach is also much faster and more effective than distributing a large RFP, which can be saved for the final one or two potential suppliers after all the other evaluations have been completed.

ABOUT NOVARICA

About the Company

Novarica provides information, insights, and perspective on markets, operations, and technology to financial services and insurance executives. The company delivers its service through published research, retained advisory services, and project-based consulting. Novarica's research includes market and trend analyses, best practices research, case studies, and independent analyses of insurance software vendors. Novarica draws its knowledge from the personal experience of its principals, the ongoing information gathering initiatives of dedicated research staff, and regular communication with insurer executives through informal networks and through the Novarica Insurance Technology Research Council.

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Karlyn Carnahan is a principal in Novarica's insurance practice, focused on e-business, claims, and IT planning. Karlyn is the primary researcher and author of the market leading reports on claims core systems, reinsurance, and Web 2.0 and is a widely recognized expert on these topics who has presented at numerous conferences and conducted numerous vendor selection projects for US insurers. She joined Novarica with an extensive career in the insurance industry including serving as Vice President of Marketing for Fireman's Fund commercial lines division, where she successfully launched several programs, expanded online customer self-service capabilities, and took a leading position in formulating IT strategy. She also served as Global Industry Manager for Sun Microsystems and Senior Vice President of Product Development for InsWeb. Earlier in her career, she held a variety of marketing and underwriting positions at NORCAL and Fireman's Fund. She holds an MBA from Stanford Business School and a Certified Property Casualty Underwriter (CPCU) designation. She can be reached directly at kcarnahan@novarica.com.

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