

CELENT

CELENT MODEL INSURER 2013

CASE STUDIES OF EFFECTIVE TECHNOLOGY USE IN
INSURANCE

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EXECUTIVE SUMMARY

The vision for Celent’s Model Insurer research is to try to answer an apparently simple question: “What would it look like for an insurer to do everything right with today’s technology?” Given the continued economic global malaise, this question is more applicable today than ever before. Capital-constrained insurers must leverage all available resources to meet market challenges.

The approach Celent takes to identify Model Insurers is to offer, at a high level, some best practices in the use of technology across various areas of the industry—whether in components of the product and policyholder lifecycle or in general areas such as IT infrastructure and management—that a “Model Insurer” would use. These areas are illustrated by case studies of specific initiatives and capabilities, selected from the many submissions received and presented in this report as “Model Insurer Components.”

Model Insurer Components are used to group the case studies and represent portions of the insurance value chain. The components represented in the 2013 report are:

- Billing
- Claims
- Distribution
- Infrastructure/architecture
- IT management
- Policy administration
- Product design/definition and development
- Risk management
- Underwriting

A case study typically includes multiple examples of best practices and/or outstanding results. Celent has organized the general benefits of initiatives into categories to allow readers a summary of the major value areas of each profile. These are summarized in Table 1. Note that each case study provides general information about the projects and the insurer’s strategies. The unique nature of each insurer’s strategies, IT infrastructure, and project suggests that the case studies are examples of best practices and may or may not be applicable to or replicable in other situations.

Table 1: Common Best Practices and Measurable Business Results

IT BEST PRACTICES	MEASURABLE BUSINESS RESULTS
Use of industry standards	Higher productivity, lower staff expenses
Optimization of infrastructure	Increased revenue or market share
Positioning for future reuse	Faster cycle times and more consistent processes
Automation, STP, and system integration	Better decisions, more accurate pricing, and reduced losses
Improved financial risk management, data transparency, and compliance	Decreased time to market

IT BEST PRACTICES	MEASURABLE BUSINESS RESULTS
Improved use of channels	More efficient document and content management
Project risk management through proper development, testing, and project management	Green organization
Use of metrics	Improved compliance and reduction in market conduct penalties
Solicitation of end user review and feedback	Improved customer/agent satisfaction

Source: Celent

INTRODUCTION

WHAT IS A MODEL INSURER?

The vision for Celent’s Model Insurer research is to try to answer an apparently simple question: “What would it look like for an insurer to do everything right with today’s technology?” Of course, the question is not nearly as simple as it appears. The terms “everything” and “right” mean very different things to different insurers depending on their size, the complexity of their operations and product sets, and their technological starting points.

The approach Celent takes is to offer, at a high level, some key best practices in the use of technology across the product and policyholder lifecycle and in IT infrastructure and management that a “Model Insurer” would use.

WHAT IS A MODEL INSURER COMPONENT?

Of course, there is no such thing as a “Model Insurer”—every insurer does some things well, and others not as well, when it comes to technology. Accordingly, Celent gathered as many real world examples of effective usage of technology as possible and then decided on a set that reflected important best practices. These case studies are presented as “Model Insurer Components”—components of a theoretical model of an insurer’s IT systems and practices.

An important note is that a Model Insurer Component is recognition of an insurer’s effective use of technology in a certain area, not necessarily a statement that the insurer is absolutely best in class (although some may be). Model Insurer Components are those that help insurers improve performance and meet market demands. In general, they represent the way things should be done given the strategy being pursued and the infrastructure in place.

Celent refines this summary of best practices and identifies new Model Insurer Components annually.

NOMINATION AND SELECTION PROCESS

For this report, Celent identified Model Insurer Components through the following process:

- Invitations and self-nomination forms were sent to over 140 insurers and 50 vendors (vendors were asked to pass the form along to their insurer clients, and allowed to work with them to nominate their initiatives) in multiple waves over the course of 2012.
- Nomination forms were reviewed by Celent insurance analysts, and submissions that demonstrated innovative uses of technology, the most effective use of technology, a clear best practices approach, and/or quantifiable success metrics were selected as Model Insurer candidates.
- Insurers were interviewed to review their submissions and provide additional information if necessary to finalize the list of winners.
- Celent analysts drafted case studies for the winning submissions which were reviewed by the insurers for accuracy and confidentiality.

The 2013 selection process was extremely competitive. One third of submissions were selected as Model Insurers, and several categories had multiple qualifying “winners” while some categories had none.

Consistent with past practice, Celent selected an overall Model Insurer of the Year for its outstanding application of multiple best practices. We are pleased to report that XL Group has been chosen to receive this recognition in 2013. XL Group's XL GlobalClaim initiative is presented as an extended case study in the final selection of this report.

CLIENT DISCLOSURE

There were no fees charged to insurers or vendors mentioned in this report. Some of the nominating vendors, and many of the selected insurers, are or have been clients to Celent's retained advisory service. (Celent serves dozens of insurers across the globe in this capacity.) However, Celent was not directly involved in the creation or deployment of any of the initiatives that have been recognized, and no preference was given to clients in the selection process.

ABOUT THIS REPORT

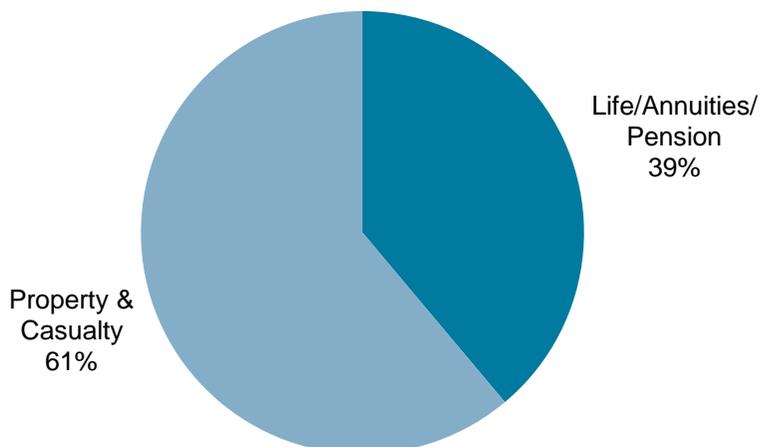
This report is divided into sections for each of the Model Insurer Components of the product and policyholder lifecycle. Each section contains an overview of what makes a component important and how a Model Insurer can distinguish itself in this area through technology. This is followed by one or more Model Insurer Component case studies that illustrate the best practices discussed.

Although the majority of the cases cited in this report are of initiatives in the US, nearly all are equally applicable to insurers in geographies with roughly similar conditions and business practices, including the UK, Europe, and Japan. Although Celent intends this report and future Model Insurer reports to be equally applicable to non-US insurers, US terms (e.g., "property/casualty" rather than "general insurance") are used throughout.

Since there is a high degree of overlap in best practices for effective use of technology between life/health insurers and property/casualty insurers, Celent has combined both types into a single volume to avoid unnecessary duplication. However, differences between the sectors are noted and separated where appropriate.

Thirty-seven percent of the 18 cases are from life/annuity/pension insurance companies; 63% are property/casualty initiatives.

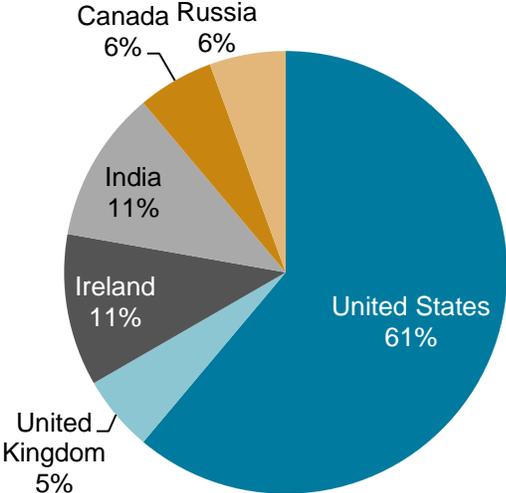
Figure 1: Celent Model Insurer 2013 Awards by Sector



Source: Celent

The cases cited in this report are initiatives from the United States, United Kingdom, Ireland, India, Canada, and Russia.

Figure 2: Celent Model Insurer Awards by Country



Source: Celent

COMMON BEST PRACTICES AND RESULTS

No two projects in the insurance industry look exactly the same, making it difficult to judge which ones qualify as Model Insurer Components. The projects that rise to the top, however, tend to demonstrate a number of similar elements, a cross-section of best practices and quantifiable gains common across all model projects regardless of their particular category.

While this report does not present an exhaustive list of best practices or expected results, Celent has identified a number of the most important items. Any insurer striving to be a Model Insurer in its approach to an IT initiative should consider the following IT best practices. Any insurer looking to achieve Model Insurer results should plan in advance to measure the following business gains and returns on investment in a quantifiable way.

Table 2: Common Best Practices and Results

IT BEST PRACTICES	MEASURABLE BUSINESS RESULTS
Use of industry standards	Higher productivity, lower staff expenses
Optimization of infrastructure	Increased revenue or market share
Positioning for future reuse	Faster cycle times and more consistent processes
Automation, STP, and system integration	Better decisions, more accurate pricing, and reduced losses
Data transparency and compliance	Decreased time to market
Improved use of channels	More efficient document and content management
Project risk management through proper development, testing, and project management	Green organization
Use of metrics	Improved compliance and reduction in market conduct penalties
Solicitation of end user review and feedback	Improved customer/agent satisfaction

Source: Celent

IT BEST PRACTICES

Industry Data Standards

Model Insurers understand that they need to think beyond successful point solutions and create lasting systems that work within a larger infrastructure. Critical to this is the use of industry data standards, such as XML and ACORD.

Using data standards means that an insurer avoids reinventing the wheel and instead manages risk by working with accepted, well-tested, and well-defined models. Even if it requires a little extra work or planning, the reduced risk will save time overall.

Perhaps more importantly, working with industry data standards helps position a new system for easier integration, whether with systems internal or external to the insurer. As more and more systems within the organization conform to the same industry standards, it becomes easier to have them communicate. When looking to bring in vendor software

or integrate with a third party source, such data standards enable a common ground from which to start.

Not every project needs to define itself around industry data standards, and it's likely that even the most disciplined team will find the need to add some unique customizations to suit their needs. However, any model insurer will spend a good deal of time in the planning phase determining how best to utilize these standards, deciding to reject them only when the benefits and risks have truly been weighed.

Optimization of Infrastructure

Model insurers do more than just build or buy modern systems, they also work to rationalize and optimize their existing systems into an ever-modern infrastructure. This can mean different things, depending on the project and the circumstances. An insurer with several policy administration systems may consider consolidation a higher priority than a modern system. An insurer looking to manage expenses in a difficult financial market might seek ways to better leverage its existing legacy system in a modern environment rather than replace it.

The optimization of the infrastructure does not have to trump other business realities. An insurer that licenses a modern policy admin system might decide that rather than going through an expensive conversion process, it will keep the legacy system in place for existing business and utilize the new PAS for new business going forward. Although this may create a suboptimal infrastructure, the Model Insurer knows that the optimal scenario balances many factors.

Positioning for Reuse

Any insurer struggling with a legacy system that is decades old understands that today's technology investment might become tomorrow's burden. And any insurer with multiple systems duplicating similar functionality knows that bringing in a new system might add to the burden even before the day's end.

This is why a model insurer thinks about reuse when investing in new technology. Any system added to the infrastructure will likely be stretched beyond its original intentions, in terms of both functionality and shelf life. It will be easier to achieve these goals by using a service-oriented architecture, industry standards, and easily configurable systems, but a model insurer knows the challenge is not just about the technology, but about the way a system is tested and used by the enterprise.

For example, a new rating engine needs to be leveraged by the policy administration system, the agent portal, and any other user who needs to obtain quotes. Otherwise the investment has resulted in additional processes to keep multiple rate models synchronized. And later, when the legacy policy administration system is no longer supporting the business, the now-older rating engine needs to easily adjust to support the replacement.

Automation, STP, and System Integration

Many of the technology best practices involve thinking about an IT project as a full enterprise strategy rather than an isolated solution. Nowhere is that as crucial as when planning a reduction of manual processes and an increase in automation, a high ranking item on most insurers' priority lists. Manual processes are a burden on an insurance organization, increasing errors and requiring additional staff. Manual processes most frequently arise for one of two reasons:

- A system does not provide the correct functionality and cannot be easily adjusted, requiring manual workarounds.
- A system does its job well but is poorly integrated with other systems, requiring a manual process to pass data or jobs from one system to the next.

In order to reduce these burdens, it is important to build or buy a system that can be configured to fit the company's business process needs and also be integrated into the larger infrastructure.

Manual processes are not just about flaws in the technology, of course. Straight-through processing (STP) is slowly becoming a reality in selected lines of business. However, some decisions, such as complex underwriting, need to be made by a human. The goal, however, is to maximize STP, extending or bringing in systems that can be configured to automate as many decisions as possible. When a process requires human intervention, the workflow should be simple, allowing staff to focus on their high-value activities rather than dealing with systems.

Like the best practice of *Positioning for Future Reuse*, these goals will be helped by service-oriented architecture, industry standards, and easily configurable systems, but they require foresight and planning, and, in many cases, a change to corporate culture.

Data Transparency and Compliance

In an economic environment where regulations are likely to be increasing while expenditures are shrinking, the importance of having a good view into corporate data has not been clearer. Many otherwise excellent projects fail to consider how data will be utilized by other systems, how actions will be audited, or how historic records will be archived and made accessible. Even projects focused exclusively on business intelligence sometimes create new silos of data that only exacerbate the larger problem.

Data is critical in the insurance industry, and model insurers know that any project needs to fit into a broader data strategy. This does not mean an insurer can only be a model if it has a centralized enterprise data warehouse—in fact, at many insurers, failed attempts at just such projects still linger as a model of how not to approach an IT initiative. But new projects will make data accessible and usable, allowing good reporting even if such reports come in a later phase. This allows model insurers to make good decisions about their business and prepares them for audits and to comply with whatever regulations the industry may face.

Improved Use of Channels

The IT best practices listed in this report focus on an approach to a project rather than a specific “feature” of a system, which is why Celent does not demand that new technology utilize the web in order to be considered a Model Insurer Component. It is crucial, however, that insurers think about all their channel options when implementing new technology or enhancing existing systems. Clearly, being a modern insurer typically requires providing agents and customers with easy-to-use web applications, though direct integration to agency systems or simplifying existing paper processes is also important. And while the use of a text messaging channel might push the envelope of technological innovation, it does not win any Model Insurer awards if it is not adopted by agents and customers.

A Model Insurer project that succeeds in this best practice might be an initiative entirely focused on improving a channel, such as (and most commonly) a new producer portal. But it also might be a project in a different area that effectively considers how new functionality will impact existing channels and leverages it appropriately.

Risk Management through Proper Development, Testing, and Project Management

Model insurers don't need to have highly paid or prestigious IT teams in order to succeed, nor does a project timeline have to accomplish huge amounts of revolutionary change in a minimized schedule. By following best practices in project execution—development, testing, and project management—an insurer can accomplish great things over time. Although best practices in execution help guarantee many things, when it comes down to it, they are there to help companies manage risk. What is the risk the

project will be late? What is the risk there will be system errors post-implementation? What is the risk the right features will not be available? What is the risk that by the time the project goes live the needs have changed?

The best practices associated with execution are too numerous to list, but involve effective requirements gathering, proper interaction with the business, usage of both automatic and manual test cases, support at the executive level, and buy-in from users. One of the most crucial practices is having a team of players who can communicate effectively. Many projects finish late and over budget not because execution failed but because the IT group failed to properly estimate and explain the true timeline.

A team that, on the same day, rolls out several new nationwide systems for multiple lines of business can point to its accomplishment as a huge success, but this is not a best practice. Maximizing results by maximizing risk is not typically best for an insurer. Celent considers a company that plans several stages of development, with smaller, localized pilot programs to be a true Model Insurer.

Solicitation of End User Feedback and Review

While it may not sound like an IT best practice, the solicitation of input from end users can be crucial to a project's success. Many times in the industry, after immense efforts are put forth by an IT organization to launch a new system, the response to a solution is only lukewarm. This is not because of a failure to deliver the requirements, but because the requirements were misaligned from the beginning. By building a user group to review early designs and milestones, a project path can be readjusted before time has been wasted on low priority features.

Sometimes a user group consists of other internal staff who sits right down the hall, and getting their participation is easy. But other times, such as when building a portal for independent agents, an insurer must go out and build relationships. Typically, agents and others who will be using a system are happy to participate, if not excited at the chance to give feedback. Model insurers use this as an opportunity not just to build the best system, but also to get a head start on training.

Use of Metrics

Without the ability to quantify results, it is impossible to know what constitutes a project success. All of the business results and returns on investment listed by Celent as necessary for a Model Insurer Component require the use of metrics, meaning that metrics are an implied best practice for all winners.

Using metrics does not mean an insurer needs to practice Six Sigma or a highly repeatable and measurable review methodology to succeed. It does mean that an insurer needs to take a good look at the important metrics of a system before and after a project. It is not enough to measure the time to underwrite new business in a new system if that cannot be compared to the previous environment. It is difficult or impossible to determine the highest priority IT needs if such self-analysis is not available.

By identifying critical business factors and performing realistic measurements, a model insurer is able to focus on the most important IT efforts, point to successes, and continuously discover areas for improvements.

MEASURABLE BUSINESS RESULTS

Higher Productivity, Lower Staff Expenses

The insurance industry—like most industries in today's market—is looking for ways to cut expenses without sacrificing service quality or speed. Smart technology can help insurers achieve more with less. Technology can reduce cycle times, automate tasks (and occasionally entire processes), and give workers the information they need when they

need it. Increased productivity allows the same number of staff to handle increased volumes of work (submissions, service requests, claims, etc.), or a smaller number of staff to handle the same volume of work.

In either case, the key for a model insurer seeking this benefit through a given initiative is to identify where and how things will change, establish baseline measures, track actual project improvements, and then measure the difference post-deployment. The largest cost impact will generally be among operating staff, but savings will be seen in IT operations as well.

Increased Revenue or Market Share

Growth is a goal for nearly all insurers. Growth may be absolute (increase NPW by 8%), or relative (increase market share to 4%). Growth in a shrinking market means taking business away from competitors. A Model Insurer also remembers that improving retention of current business is a foundation of growth (and profitability as well).

Measuring growth is a challenge, but sometimes secondary metrics (for example: number of submissions received, or approved, or renewal rates for claimants) are more readily available.

Faster Cycle Times and More Consistent Processes

Manual, inconsistent, and time-consuming processes are expensive and error-prone. Many new initiatives automate tasks and/or simplify processes. Specifically, several Celent Model Insurer winners automated claims or underwriting rules and shortened the cycle time for these processes. Since complex processes span systems, better system-to-system integration reduces the need for staff time to accomplish hand-offs.

To optimize labor costs, an insurer needs to look across the entire infrastructure before beginning an IT initiative. How will a new system link to existing systems? Will it reduce or add to the overall burden on staff? Sometimes an organization needs to recognize that the first phase of an implementation will actually increase everyone's manual process load, especially when the new system has gone online but the old system still maintains half the business.

A model insurer also knows that new systems do not just take existing processes and put them online. Rather, these new projects provide an opportunity to rethink processes including their minimizing complexity, automating linkages, and improving effectiveness.

Better Decisions, More Accurate Pricing, Reduced Losses

IT projects can help the bottom line by helping grow new areas of business, but they can also help an insurer be smarter about the business the company already has. Managing insurance risk is what insurers do, and that is best done with good data and insight into the customers and policies, and good tools for all the people involved in the process of pricing, selling, and approving business. Measuring this, however, can be difficult, and many IT initiatives are started not to make better product decisions but simply to provide the tools and data needed to understand the decisions that are being made.

Not every project is directly tied to making these kinds of risk decisions, but Model Insurers recognize that all initiatives do involve new opportunities for gathering data. The IT department must think about all systems as an opportunity to feed data to the business.

Decreased Time to Market

Time to market is a "cycle time," but it differs from the previous category *Faster and More Consistent Process Cycle Times* in that the time to market is a cycle that takes place before any business is transacted. Whether a company attempts to roll out an entire new line of business or make one change to a rate table, the time to market can take

anywhere from minutes to months. Being nimble enough to adjust pricing strategies and provide competitive new products is crucial to a company's ability to adapt to a difficult marketplace, but overburdened IT departments required to write code for every alteration can create huge bottlenecks for the business. Time to market is one of the most frequently cited reasons for licensing new systems.

It is not enough, however, to recognize that time to market is a problem. Many insurers see an unacceptably long delay for product adjustments and leap into a new technology acquisition instead of calculating ROI for a new project. While decreasing time to market may be a critical factor in the business, an IT initiative is not always the right or only solution. Once IT is able to implement a change to a rate in a day, an insurer may discover that a six week bottleneck still exists in another area, whether it is business users seeking approval or the time spent updating marketing material. A Model Insurer knows to analyze the whole process and to measure each step before any projects begin.

More Efficient Document/Content Distribution

The interaction of an insurer with its agents and clients all comes down to content: product information, application forms, policies, marketing materials, policyholder statements, adjuster reports, bills, and all manners of correspondence. Moving all of these documents off of paper and into an electronic format has been an industry focus for as long as computers first started showing up on desktops. It is not just about reducing printing and mailing costs; it is also about creating easier, less error-prone ways of interacting. Many companies have gone through the effort of providing agents or customers an online channel for submitting business only to print out those submissions in-house in order to feed them back into an older process. For a certain insurer this might be the right first step, as long as there are plans in place to update the back end document process as well.

Similar to the result *Faster and More Consistent Process Cycle Times*, a Model Insurer doesn't just take a paper process and put it online. Instead, a Model Insurer looks to use new channels to interact in a better way, allowing agents and customers options as to how they will receive policies and information. With more efficient document and content distribution, an insurer can reduce the costs associated with printing and mailing, reduce manual process times, reduce storage needs, and reduce errors associated with rekeying data. In addition to these reductions, an insurer can increase agent and customer satisfaction.

Improved Agent/Customer Satisfaction and Adoption

There has been a great focus in the last few years on providing portals and tools to agents and customers to allow them to more easily interact and transact business with the insurer. Many of the reasons for this investment tie to previously listed business results: reduced cycle times, more efficient content and document distribution, higher productivity, and increased revenue. But these investments also result in a less tangible increase in agent and customer satisfaction. Increased agent and customer satisfaction itself leads to higher productivity and increased revenue, so it may be seen as a means to an end rather than an end in itself, but a Model Insurer knows differently.

One way for an insurer to measure agent and customer satisfaction is to talk to their agents and customers. Though only briefly touched upon in the IT Best Practices section, an important part to making any IT initiative succeed is to involve input from the targeted users of a system, even if those users are outside the organization. This also allows an insurer to track how changes are being received and adjust accordingly. Another way to measure satisfaction is the more concrete metric of system adoption. If a new agent portal is being used by only 5% of the agent force, it's a sure thing that the agents are either unhappy with it or do not know about it. Working with the agents to determine their

opinions will both help an insurer build the best possible system and kick-start the agent education and training process.

Measuring system adoption is not just to gauge user satisfaction. Presumably, a system has been put in place to achieve certain benefits to the organization, and unless the system is being used, those goals will not be realized even if the features are there.

Improved Compliance and Reduction of Market Conduct Penalties

Doing business in the insurance industry means conforming to a broad set of regulations at the state, and increasingly, federal levels. Noncompliance can impact the bottom line, both through market conduct penalties and even more significantly by a tarnished image among producers, prospects, and policyholders.

Given legislators' and regulators' proclivity to pass laws and issue new regulations and guidance, the job of compliance is a constant. And given that any insurance process can be the subject of regulation, achieving compliance is a job for both business and IT leaders, using the best available governance and project management methodologies. These include process, rules, and document management; and reporting and data transparency.

CLAIMS

OVERVIEW

Improving claims systems provides an opportunity to improve the form of claims information and data, how it is accessed, and the processes that depend on it. One of the most common changes is that all (or nearly all) information becomes digital as paper claim files are eliminated—workflow is easier to manage and moves more quickly, the experience of claimants and their agents improves, reserving accuracy increases, and compliance increases as required forms and correspondence are automatically created and sent by the claims system. New claims technology gives insurance companies the opportunity to revisit both their organizational structures and their staffing levels in order to put them in better alignment with organizational priorities and skill requirements. Several insurers are beginning to use claims analytics to provide systematic loss information to their front end product development, pricing, and underwriting activities.

MODEL INSURER COMPONENTS

CNA

Using data analytics to combat fraud

According to industry estimates, nearly \$80 billion in fraudulent claims are made annually in the US. This figure includes all lines of insurance. It's probably a conservative figure because much insurance fraud goes undetected and unreported. For CNA, the nation's seventh largest commercial lines carrier with annual revenues of more than \$9 billion, fighting fraud is mission-critical. CNA traditionally relied on claims adjusters to identify suspicious claims based on their recognition of red flag indicators. CNA found this method to be unreliable because referral volume varied significantly by adjuster and line of business and, as a result, the insurer was unaware of how much fraud went undetected. The National Insurance Crime Bureau (NICB), a not-for-profit US organization that partners with insurers and law enforcement agencies to facilitate the identification, detection, and prosecution of insurance criminals, estimates that elements of fraud may be found in as many as 10% of claims filed. CNA realized that they may be missing opportunities to detect and avoid payment of illegitimate claims presented to the company. Additionally, CNA was wasting time and money on investigating false positives generated by early attempts at an internal technological solution.

After years of testing various methods to identify fraud, in 2011 CNA's Special Investigations Unit ("SIU") began using SAS Fraud Framework for Insurance in four lines of business: workers compensation, general liability, commercial auto, and commercial property. SAS Fraud Framework for Insurance incorporates prebuilt insurance content and industry-specific red flag business rules and models for detecting property and casualty fraud. It can also integrate external data from sources like NICB. SAS worked closely with CNA to build the predictive models based on the company's historical experience with fraud investigations. Using these models, CNA now runs weekly analyses against its structured claims data as well as its unstructured text notes from adjusters. Top scoring "claim alerts" are reviewed and triaged by SIU technicians via a SAS user interface. Files with strong fraud potential are assigned to SIU investigators in the field. In a typical week, CNA is reviewing about 100 alerts a week with a 20% hit rate for follow-up investigation. By the end of 2012, CNA had recovered or prevented payment of fraudulent claims totaling approximately \$2.1 million, directly attributable to the SAS Fraud Framework.

Simultaneously, CNA also began using a Social Network Analysis component of the SAS solution to find broader patterns and connections among providers indicative of fraud

conspiracies. CNA has a separate team of SIU analysts investigating the provider networks, based on links to the individual entities that are potentially perpetrating larger-scale frauds. In the past these linked network investigations took months or years to identify and bring to fruition. In the first eleven months of use, CNA initiated 72 provider investigations, compared to the 12 that they predicted would be identified in a year. Based on current results, it is expected that detection of these fraud rings could prevent more than \$20 million in fraudulent claims during the course of the program, many times what CNA anticipated.

Additional benefits include increased customer satisfaction and improved efficiency for CNA SIU and claims adjusters. CNA business insurance customers have a vested interest in preventing fraud as much as the insurer and appreciate that CNA has a sophisticated, state of the art, antifraud program in place. CNA's investigations unit now operates more efficiently because the company can focus on high-likelihood cases instead of wasting time on false positives. Lastly, by shutting down fraud earlier, CNA benefits from quicker resolution of meritorious claims and lower claims severity.

As CNA moves to a common claim platform for all lines of business, the use of the SAS Fraud Framework will be expanded across more lines of business in 2013 and 2014.

For the best practices of data transparency and compliance, automation, STP, and system integration, and positioning systems for reuse, CNA is recognized as a Celent Model Insurer.

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