

Achieving Claims Excellence with Guidewire ClaimCenter

A White Paper by
Guidewire Software



Overview

Who should read this document?

Property & Casualty insurance executives in key insurance operational positions (Chief Executive Officer, Chief Operations Officer, Chief Financial Officer, Chief Claims Officer, etc.) and claims management and claims adjusting professionals who are concerned about:

1. Maintaining profitability in an increasingly soft market;
2. Experienced personnel “brain drain” in their claims professional and IT communities;
3. Increasing the efficiency, productivity, cost effectiveness and service levels of their claims operations;
4. Obtaining the benefits that a leading, proven, modern claims solution can bring to a property & casualty insurer; and
5. Incurring the high cost and long time to benefit of large internal software build efforts, “ERP projects” or “consulting firm” style “custom development” efforts.

This paper is designed to accomplish four major goals:

1. Provide an educational update around the critical need for property & casualty insurers to replace their core claims systems;
2. Underscore that core claims system replacement must be accomplished now;
3. Provide an overview of what a modern property & casualty insurer should look for in a modern claims system; and
4. Examine the capabilities of Guidewire ClaimCenter® to meet the needs of a modern property & casualty insurer’s core claims system needs.

Key facts to keep in mind while reading this paper:

1. Combined ratio results in the high 80s to low 90s are required to achieve “Fortune 500” results; ⁱ
2. Combined ratio is on the way up and the market is soft – operational profitability pressures are – and will continue to – intensify; ⁱⁱ and
3. Estimates are that a 4% to 6% reduction in pure losses and a 10% to 12% reduction in loss adjustment expense are feasible through the appropriate selection and application of modern claims technologies. This estimate represents a 4 to 5 point improvement in the carrier’s combined ratio. ⁱⁱⁱ

Is this an opportunity that you can afford to ignore?

Executive Summary

A Property & Casualty (P&C) insurer's financial performance depends heavily on its claims organization. Combined losses paid and loss adjustment expense routinely account for sixty-five to seventy-five percent of the money flowing out of an insurer. The opportunity for P&C claims improvement to impact insurer profitability is enormous in several key areas:

- **Claims Indemnity Leakage** – Estimated at an annual rate between 6 to 10 percent of net written premium (NWP) ^{iv}
- **Loss Adjustment Expense Leakage** – Inefficient processes, inappropriate use of claims adjusting resources and excessive legal bills, etc. add another 1 to 4 percent of NWP in leakage each year. ^v
- **Claims Adjusting Efficiency** – Well above 40 percent of claims adjuster's time is spent on activities that do not actively assist in bringing the claim to a prompt and reasonable settlement – and this includes time spent working with code-driven, less claims functional legacy claims systems. These inefficiencies lead to longer claim settlement times which can impact customer satisfaction, drive up litigation rates and negatively impact leakage. ^{vi}
- **Customer Retention** – Carriers achieving high levels of satisfaction retain customers. Among customers who indicate high levels of satisfaction with their carrier overall, 88 percent said they “definitely would” renew their policy with their auto insurance provider. Conversely, only 16 percent of customers who report low levels of satisfaction said they would definitely renew their policy. ^{vii} Satisfaction with claim handling drives 44 percent of the overall insurer impression by customers who filed a recent auto claim. ^{viii}

Savvy insurance executives understand the tremendous advantages that a cost effective, streamlined, and efficient claims organization can deliver to the business. Still, many find it extremely challenging to achieve their goals in this critical area. Why? One key reason is that they lack the appropriate system resources necessary to successfully make the journey. The state and capabilities of claims technology has held insurers back, and the lack of appropriate modern claims adjusting systems continues to be a key reason that adjusting inefficiencies, and their attendant costs remain large issues for P&C insurers.

In the last few years, the Property & Casualty industry has enjoyed historically low combined ratio numbers – 2006's 92.7 was the best combined ratio result since 1949. These strong results may tempt you to overlook the critical need for core claim system replacement and continue business as usual. However, the market remains very soft and projections are showing combined ratio estimates of 93.8 for 2007 and 97.3 for 2008. Further projections indicate that – with “normal” catastrophe losses – profitability will fall to 12.5 percent in 2007, to 10 percent in 2008, and insurers could well be experiencing low single digit rates of return (under 5 percent) as soon as 2010 – and probably no later than 2012. ^{ix} In a soft market, where top line growth is extremely challenging, improving bottom-line results through claims adjusting efficiency, reduced leakage and loss adjustment expense, and increased customer retention, is an opportunity you cannot afford to ignore.

This document will examine the needs of P&C claims organizations, the evolution of technology in support of these needs, and how Guidewire ClaimCenter can improve insurers' control over core claim operations by enhancing rules-based automation of the claim process, expanding seamless integration with preferred claims adjusting business partners, increasing visibility into key performance metrics, and improving overall system flexibility.

Core Claim Requirements

At Guidewire Software, we have spent thousands of hours talking to claims professionals of all levels from all types of P&C and workers' compensation insurance carriers. What has emerged from our research is a shared vision of what claims adjusting operations need in order to be successful. That vision encompasses three core elements:

- *Workflow*: comprehensive management of the end-to-end claim process, tailored to the requirements of each individual claim.
- *Guidance*: systematic application of the skills and “best practices” that characterize expert claim handling, e.g. judgment, risk assessment, negotiation skill, and prioritization, etc.
- *Visibility*: continuous monitoring of the claims operation, with proactive delivery of real-time information to supervisors and managers to ensure successful outcomes.

Guidewire ClaimCenter – an end-to-end, web-based claims system for all lines of business – was built from the ground up specifically to meet the critical needs of all members of the P&C claims organization:

- *Managers* can define their optimal claim processes in the system, which then applies these processes to each incoming claim;
- *Adjusters* benefit from proactive guidance at key points in the claims process;
- *Supervisors* have real-time visibility into the claims operation, with specific claims proactively flagged for additional attention; and
- *Executives* can track key performance metrics in real-time.

The Evolution of Claims Systems – Where are You?

The average age of an insurer's policy administration, claims, and billing systems today is 24 years. ^x The majority of insurers' existing claims systems can provide little or no help in improving the claims adjusting process. In fact, many of these “legacy” systems were never intended to be claims adjusting applications in the first place.

Claims System History – Phase I

The first “claims systems” – deployed in the 1970s or 1980s – were simply transaction screens – usually bolted on to an existing system – built on mainframe platforms and accessed through text code-based, “green screen” interfaces. These systems typically allowed users to enter reserve and payment transactions for accounting purposes but provided no other claim handling functionality.

Claims System History – Phase II

In the late 1980s and 1990s, the first systems dedicated to claims processing were developed. These systems ran primarily on mainframes or minicomputers (such as the AS/400). Although some were built on more modern client/server architectures, all shared the same cryptic, text-based interfaces navigated by arcane, mysterious, and numerous key stroke combinations. They served (and still serve) as the system of record for claims, responsible for financial transactions and reporting.

Some of these claims systems may include diary and notes features, allowing claim handlers some control in planning their own work and documenting the adjustment process. But these rudimentary tools provide neither expert guidance for frontline professionals nor the visibility and control that managers need to ensure an efficient operation, timely and consistent claim handling across the entire book of claims.

It is not surprising to conclude that systems built for financial tracking and reporting are not likely to provide support for the critical human activities involved in actually adjusting a P&C insurance claim. In these existing (legacy) systems it is very common that all steps – except, perhaps, setting up a new claim, entering reserves, and issuing payments, remain entirely manual and off-line.

Today, despite the tremendous advances in software technology in the last ten years, most available claims systems still cling to this basic model of financial transactions, notes, and diary. And most are still constrained by legacy architectures and primitive user interfaces while they attempt to “morph” into “multi-tasking” claims handling systems that struggle to support the claims adjusting process, while leaving the critical decisions and activities of claim adjusting entirely up to the adjuster’s unassisted judgment.

An unfortunate result of this evolution and the difficulties in changing these highly modified systems is that the existing world of “high touch”, multi-step, paper-based, and time-inefficient business processes remains and multiplies as demands on adjusters increase.

Claims System History – Phase III: Working around the Claims Core via Expert Point Solutions

What progress the industry has seen has come in the form of expert systems, designed to help the adjuster make specific decisions during the claim lifecycle. Damage estimation tools from companies such as Mitchell, CCC Information Services, Audatex, and Marshall & Swift/Boeckh are widely used to assess the cost or settlement value of auto repairs, total losses, or damaged properties. They are typically used by adjusters to double-check an estimate provided by a vendor (e.g., repair shop) or to determine the starting point for a settlement negotiation. CSC’s COLOSSUS pioneered the field of statistically-based injury evaluation, and similar tools have been developed for issues such as fraud detection and comparative liability estimation.

A sound claim handling strategy and technology plan has a place for such expert systems. However, these tools largely do not guide the adjuster through the claim process, and do not assist the adjuster in the core activities of handling a claim. They also do not help with proactive claimant management, effective investigation, negotiation planning, regulatory compliance, and follow-through on salvage or subrogation recognitions or recoveries. Instead, they only provide analytical assistance at one or more “single points” across the life of the claim. Additionally, these systems are generally not integrated into the core claims system, thus the power of the tool and its attendant value is diminished by the additional business process flows, time-frames, and re-keying of data that come with their use.

Claims System History – Phase IV: Workflow and Imaging

Two additional tools have emerged to assist in the shortcomings of traditional claims systems: workflow and imaging.

Workflow tools allow insurers to chain together some routine steps in the claim process, such as checking reserves at each diary date or notifying a supervisor if an action on the claim diary has not been completed.

Imaging tools improve upon traditional paper files by enabling shared, electronic access to scanned images of paper documents, relieving adjusters of low-value, time-consuming, paper-pushing tasks.

These tools should help claim operations eliminate manual tasks and increase productivity. But because document handling is only one type of currently inefficient claims related activity, the larger – and more intractable – sources of leakage are not addressed by these tools. Document-focused tools are at best tools to assist in solving the problem, but they provide only a partial answer. And implementing a new workflow tool in conjunction with a legacy claims system is a complex and difficult proposition, taxing even to the most sophisticated IT departments.

Current State

While today's systems store (some) information and allow users to enter financial transactions, they have little influence over the claim process itself; where the root causes of operational inefficiencies and leakage live. The current system environments do not embed best practices in claims handling, nor do they monitor the claims operation to ensure that those best practices are followed. In addition, the proliferation of expert systems and additional tools has only increased adjuster workload, confusion, and stress levels, and indeed may have exacerbated claims timeliness and consistency challenges instead of reduced them.

Overview of a Modern Claims System

If you are like most carriers, your claims adjusters want an intuitive, user-friendly interface that provides easy access to the information they need, when they need it, along with helpful guidance through the claim adjusting process. Your claims managers want the ability to define their preferred claim handling processes and monitor their operations in real time.

Celent indicates that a modern core claim system should provide the following functionalities and should “provide several ways to integrate these and many other functions from many independent software vendors (ISVs) that an insurer may choose”.^{xi}

- Record the first report of a claim and verify existing policies and coverage;
- Assignment of a claim to one or more adjusters;
- Provide easy access to information, images, tasks, and diaries related to an adjuster's assignment claims;
- Create, use, and store documents, correspondence, and information;
- Set and revise loss and expense reserves;
- Identify and subrogate claims against responsible third parties;
- Track efforts to obtain value for damaged property (salvage);
- Customization and configuration for products, processes, and decisions; and
- Integration with internal systems and databases; and with external customers, partners, and processes.

Unfortunately, most insurers' claims systems don't provide for these types of capabilities. As a result, they continue to miss out on the benefits of modern software and Internet technologies.

In addition, as insurers recognize that their current claims systems are lacking, CIOs are facing increasing pressures and it is apparent that IT is increasingly being requested to be a business partner to the core business of the insurer. Forrester reports that, while 41 percent of insurers look to their IT organizations to lower the company's operating costs, 38 percent also expect their IT organization to assist in acquiring and retaining customers “to a great extent”.^{xii} Multi-year, high cost, highly customized, in-house claims system development efforts or long consulting engagements do not lend themselves to either of these goals – costs are too high and perceived benefits streams too far in the future.

As they look towards their technology futures, P&C carriers seek proven technologies, rapid deployment, high flexibility, configurability ease and integration flexibility. Modern, web-enabled “service-oriented architecture” (SOA) applications meet these goals, are now a reality and carriers have taken notice. Expenditures specific to SOA are on the rise with more than 65 percent of insurance companies agreeing that SOA is the trend for modern IT architecture flexibility, agility, and cost reduction^{xiii} and 48 percent agreeing that SOA is “widespread” in their plans for technology deployments.^{xiv} This shift away from legacy towards modern systems is apparent in looking at carrier's current IT hiring. Fifty percent of large carriers and 70 percent of mid-size carriers are seeking “new technology skills” as one of their “Top IT Recruiting Needs”.^{xv}

The Time Is Now

Guidewire believes that a clear case exists for the significant value that modern claims technology can bring to an insurer. Leading analyst firms agree that the time for legacy claims system replacement is now. Carriers that do not take action will find themselves at significant competitive disadvantage – as early as 2010, and no later than 2012. ^{xvi, xvii, xviii}

Fortunately, carriers don't need to think about building these solutions themselves, or hiring consulting firms to build them. The critical need for modern claims applications can now be addressed by vendor solutions. Analyst firms estimate that modern claims solutions from leading vendors can meet 70% to 80% of requirements out of the box, leaving little for configuration and/or customization ^{xix} and that certain specific insurance software vendors have insurance vertical expertise that can be leveraged by the carrier community. ^{xx}

Guidewire ClaimCenter

ClaimCenter provides a central point of control for all of the activities and decisions of the claims process, while offering an intuitive, productivity-enhancing workspace to adjusters and supervisors.

The Rules-Driven Claim Process

Traditional claims systems take a data-centric approach to the claims process; they exist to receive, store, and retrieve claims information as it is generated through the process. ClaimCenter provides web-based, intuitive access to that important information, as well as the ability to store and retrieve electronic documents related to claims. However, it goes well beyond current systems, taking an activity-centric approach to claims.

ClaimCenter does not simply record the claims process, but orchestrates the complex array of activities involved, including planning, investigation, evaluation, judgment, consultation, negotiation, and collaboration. ClaimCenter helps adjusters "plan their work," identifying all the activities that need to be performed for a specific claim, taking into account: loss information, account-specific rules, state regulations, best practices, and so on. These activities are recorded on the claim's individual workplan, which is used to track and manage the claim process. ClaimCenter then helps adjusters "work their plan," making sure activities are assigned to appropriate handlers and completed in a timely manner.

At the core of ClaimCenter is a flexible rules engine, designed specifically for the needs of P&C insurers. This rules engine allows each insurance carrier to define exactly how each type of claim will be handled: what tasks will be added to the workplan, what types of handlers they will be assigned to, when they are due, what happens if they become overdue, etc. The rules engine's flexible architecture makes it possible to define virtually any claim handling rules, such as state-by-state regulations or account-specific guidelines.

By managing claims as dynamic sets of activities driven by flexible business rules, ClaimCenter makes possible a new level of control over the claim process. During the lifecycle of a claim, ClaimCenter:

- *Segments* the claim or exposure based on loss type, policy type, state, severity, or any other parameters;
- *Creates a workplan* including the initial set of activities required for each individual claim;
- *Assigns* each claim, exposure, or activity to the appropriate owner, taking into account skill levels, claim type, and resource availability;
- *Guides* the adjuster to identify potential issues in coverage, recovery, or investigation;
- *Organizes and prioritizes* activities for adjusters and supervisors across multiple open claims;
- *Responds* to new events by executing escalations or adding items to the workplan;
- *Facilitates* activities by providing built-in tools, or linking to other in-house tools as appropriate; and
- *Continuously monitors* claims and activities to identify claims requiring additional attention.

Tailored to Your Business

In the past, a claims organization implementing a new claims system would often have to adapt its business processes to the requirements of the system. This was the case because traditional systems are largely "hard coded," meaning that screen layouts and workflow are defined in low-level code, inaccessible to the Insurer.

By contrast, claims organizations can tailor Guidewire ClaimCenter to their individual needs. Any data elements can be added to the system's data model, and any fields on any screens can be added, removed, or modified. All tables and drop-down lists can be filled with the values required by each carrier. And all business rules – including segmentation, assignment, workplans, escalations, exceptions, validation, default reserves, etc. – can be modified using a graphical user interface suited for business users, freeing the claims department from its historical dependence on IT for even the smallest changes.

As a result, each insurance carrier can configure ClaimCenter to match its own business, using the rules engine to tailor the claim process to suit each individual claim. And instead of being locked into a single configuration, claims organizations can modify the system as their business needs change, analyzing claim outcomes to refine their best practices and implementing those in the system in turn.

Of course, ClaimCenter is delivered with a complete set of screens and business rules for all major lines of business and types of losses, so insurers without the time, staff, or appetite for configuration can begin using the system rapidly.

Fitting Into the Claims Ecosystem

Although Guidewire ClaimCenter is the primary control center and processing system for the claims operation, it is designed to support and work in concert with the other systems, processes and requirements that are critical to the modern insurer. These can include:

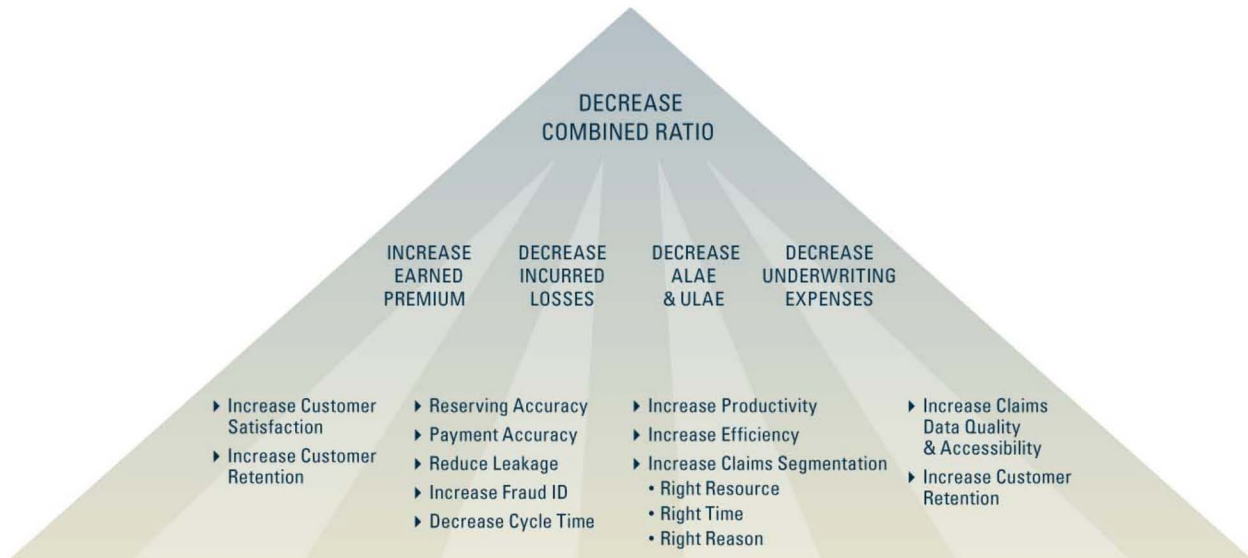
- An FNOL or call center system for importing new losses;
- A policy administration system for identifying valid policies and importing coverage information;
- Back-end general ledger, accounts payable, and check processing systems;
- Expert desktop systems for damage estimation, injury evaluation, liability estimation, medical bill review, etc.;
- External claim handling services such as glass claim administration services, emergency water extraction services, etc.;
- External data sources such as claim history indexes, predictive analytic partners, total loss valuation, etc.;
- Public record reporting services such as police reports, court search, etc.;
- Service provider management to select, schedule, execute, and monitor external claims handling activities with selected preferred service providers;
- Geocoding information providers for “proximity based” claims task assignment, field work efficiency, and catastrophe claims handling assistance;
- Cross-regional and cross-border claims task scheduling that respects time-zone and regional calendar differences (work week, business hours, holidays, etc.);
- Ability to issue claim payments in multiple currencies, regardless of the policy currency basis to enable and smoothly execute claims settlement activities regardless of the base currency of the loss or repair locale; and
- Ability to be quickly configured to keep pace with the rapid pace of regulatory demands, insurance product evolution, and ever increasing demands for superior, cost effective, and service sensitive claims handling.

ClaimCenter provides the primary interface that adjusters and supervisors use to manage their work, and either retrieves information from other systems or links users to those systems when required – limiting the clutter and confusion that can afflict adjusters' desktops. Since it was first released in 2003, ClaimCenter has been successfully integrated with more than 100 internal and external systems and Web services at existing production sites.

ClaimCenter Value

Guidewire ClaimCenter is an end-to-end, web-based claims system designed to run an insurer's entire claims operation and positively impact all key elements of an insurer's combined ratio.

ClaimCenter Impacts Key Elements of Combined Ratio



Software solutions succeed only to the extent that end-users find them intuitive and indispensable to their job. ClaimCenter was designed from the beginning with the involvement of veteran adjusters and supervisors. They helped shape ClaimCenter's unique approach by emphasizing four key objectives:

- *Guidance*: focus handlers on the highest-value activities and help them make the best decisions possible with given information;
- *Productivity*: facilitate routine tasks and manage the onslaught of activities required by ever-increasing caseloads;
- *Coordination*: involve multiple participants in a claim to apply specialized expertise where necessary; and
- *Visibility*: allow supervisors and executives to monitor the claims operation, identify issues, and intervene effectively.

Not surprisingly, these objectives are intimately connected to the typical causes of leakage. Poor *productivity* can lead to long claim cycles and expensive litigation. Frequent or mismanaged handoffs reflect *coordination* problems that can fuel leakage, decrease productivity and negatively impact customer service. Lack of frontline *guidance* leads to poor decisions such as improperly accepted liability, missed recovery opportunities, and overly generous settlements.

ClaimCenter provides specific benefits in each phase of the claims lifecycle; a few examples are detailed below.

Notification and Assignment

Every claims professional knows that it is critical to get the right information to the right adjuster as soon as possible. However, many claims still get bogged down by faulty information capture and manual assignment procedures.

As soon as a claim is received by ClaimCenter, it is divided into different exposures, each assigned to an adjuster based on claim attributes, skill levels, and current workloads. Basic setup activities can be distributed to clerical staffs, who use loss-specific prompting to gather all critical facts as early as possible. As a result, adjusters have the information they need to identify potential issues such as coverage exceptions or recovery opportunities, at a lower overall cost to the insurer.

Investigation

In complex claims, establishing coverage and liability can be tricky issues that cannot be resolved by consulting a policy “dec sheet”.

Accurately identifying potential grounds to deny coverage or limit liability can be worth tens of thousands of dollars on a single claim.

ClaimCenter connects to the carrier’s policy system in real-time to import detailed coverage information, including deductibles and limits. Financial transactions can be compared to policy limits to flag potentially unnecessary payments. Potential coverage issues can be identified using exception rules and flagged for expert follow-up.

Fraud

The Insurance Information Institute estimates that fraud accounts for 10 percent of the P&C insurance industry’s incurred losses and loss adjustment expenses, or about \$30 billion a year. The Coalition Against Insurance Fraud puts the number closer to \$80 billion a year, or nearly \$950 for each family in the United States.

Regardless of the actual number, fraud is a huge issue for insurers and – although many carriers have turned to special investigative units (SIUs) to look into potentially fraudulent claims – SIU effectiveness is limited by the ability of frontline adjusters to flag the right claims for investigation in time to have beneficial effect. An insurance Fraud Management Conference survey in 2004 indicated that 87 percent of insurers have fraud referral rates to Special Investigation Units (SIU) below 5 percent.^{xxi}

Traditional methods of fraud identification and alerting SIU are slow, inefficient, inconsistent, and are difficult to learn from:

- “Per adjuster” fraud potential recognition;
- Manual and paper-based referral process;
- No single view of claim file to share with SIU – “I’ll photocopy it and send it too you...”; and
- Success stories and “look out fors” are word of mouth or are non-integrated “SIU Bulletins”

In short, these are time consuming review processes that are out of synchronization with normal claims adjusting workflows and the intense pressures to move claims to closure quickly. With no systematic way of screening claims for potential fraud, the SIU wastes time on routine claims and fraudulent claims may go unnoticed.

ClaimCenter allows each insurer to implement its own fraud “red flags” as exception rules to flag claims for SIU attention. This can be accomplished by “rules based” dynamic questioning, “claim data to claim data” comparisons or insurers can combine these approaches. In addition, red flags can be combined with monetary value to prioritize claims for investigation, ensuring that these experts focus on the claims where they are most needed. Random sampling of smaller claims can also be used to discourage vendors from attempting to “beat the system.” Claim flagging can be used for other purposes as well – for example, to identify claims with multiple reserve changes or claims reserved just below adjuster’s authorities and escalate them for review before they spiral out of control.

Negotiation and Settlement

For many insurers, one of the largest sources of leakage is unnecessarily generous settlements, due to a combination of poor (or nonexistent) planning, inappropriate incentives (leading adjusters to close claims at any cost), and a lack of access to key information.

Using ClaimCenter, adjusters can be required to complete a settlement plan for each claim, specifying their initial offer, target settlement, and maximum authorization, as well as key negotiating points and objection handling guidelines. The plan can be reviewed or approved by a supervisor in advance, ensuring proper preparation for the negotiation. Alternatively, expert negotiators can be invoked for complex or high-value cases, instead of leaving them to the judgment of frontline adjusters. ClaimCenter can also identify settlement issues in routine claims; for example, the system can flag minor workers' comp claims where an indemnity payment stream continues longer than medically necessary.

Recovery

Foregone salvage and subrogation opportunities constitute a major source of leakage, primarily caused by a failure to identify all potential recoveries early in the claim lifecycle. Even when identified, recoveries are often under-prioritized by adjusters trained primarily to close files quickly at reasonable cost.

ClaimCenter uses business rules to identify salvage and subrogation opportunities early in the claim process. Where an opportunity exists, the claim workplan incorporates the required activities and assigns them to the adjuster or to a dedicated recovery team, enforcing company policies where applicable (e.g., soliciting a minimum number of competitive bids for vehicle salvage, tightly tracking aging salvage charges, etc.). Specialized subrogation screens ensure prompt and consistent subrogation claims activities and follow-up. The result is increased recoveries from all sources and lower net loss costs.

Insight

Many claims executives are frustrated by not knowing whether their current policies and procedures are, in fact, appropriately calibrated to minimize leakage. Currently, insurers have little choice other than expensive, labor-intensive file reviews conducted by external consultants or by internal audit groups.

ClaimCenter transforms the review process by capturing detailed process information about each claim that can be mined using ClaimCenter's real-time dashboards, ClaimCenter's Standard Reporting Module, or other in-house or 3rd party reporting tools. Insurers can use this information to identify the key drivers of leakage and adjust their procedures accordingly in ClaimCenter's rules engine, creating a cycle of continuous improvement.

Summary

There are only two levers available to drive operational profitability in the P&C insurance market. One lever is to increase profitable revenue; the other is to reduce costs. An insurer's claims department serves a critical role in applying each of these levers.

Providing outstanding claims service is key to ensuring profitable retention. Outstanding claims service means providing a quick response, accuracy, fairness, and consistency.

The ongoing soft market condition has fueled insurers search for opportunities for operational cost reductions. With claims accounting for the lion's share of insurers' cash outflows, carriers are insisting their claims departments increase their efficiencies and lower leakage while providing even better and more timely claims service to support customer retention goals.

This cannot happen without modern claims systems. Without immediate action, antiquated claims adjusting technologies and a shrinking pool of both IT and adjusting talent will prevent claims departments from achieving their critical contributions to a P&C insurer's operational profitability.

This paper has discussed only a few of the many ways in which Guidewire ClaimCenter helps insurance carriers improve claims performance. ClaimCenter enables insurers to define any preferred claims handling processes as business rules that are then automatically implemented, enforced, and monitored across their entire claims operations. In short, ClaimCenter gives claims executives the tools they need to translate consulting reports and internal reviews into consistent, effective action on the front lines of the claims process – and thereby recapture the dollars lost to leakage while improving adjuster productivity, efficiency, satisfaction and enhancing customer service.

About the Guidewire Insurance Suite

Guidewire is a leading provider of modern technology solutions to P&C and workers' compensation insurers and provides **an integrated suite of core applications** designed to address the specific operational needs of insurance companies.

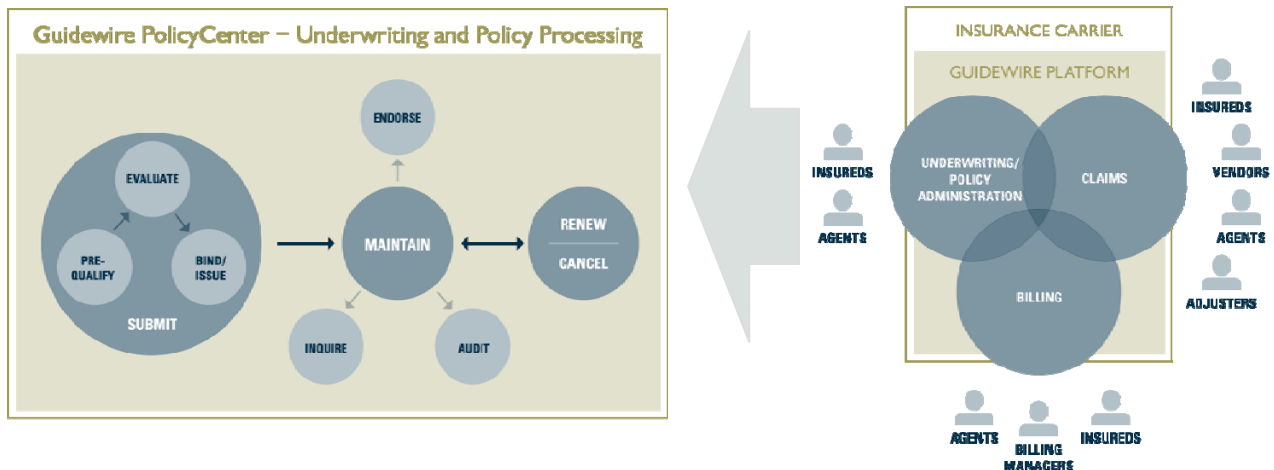
Guidewire delivers **proven software** to run mission-critical insurance operations, including underwriting, policy administration, claims, and billing.

The Guidewire Insurance Suite™, comprised of Guidewire PolicyCenter®, Guidewire BillingCenter®, and Guidewire ClaimCenter® provides a modern, web-based platform for all lines of insurance. All Guidewire applications are available as part of the Guidewire Insurance Suite or as stand alone applications.

Guidewire's applications are architected around modern web-based Services Oriented Architecture (SOA) and can integrate in to virtually any system or expert point solution that an insurer may be using – including existing legacy system structures.

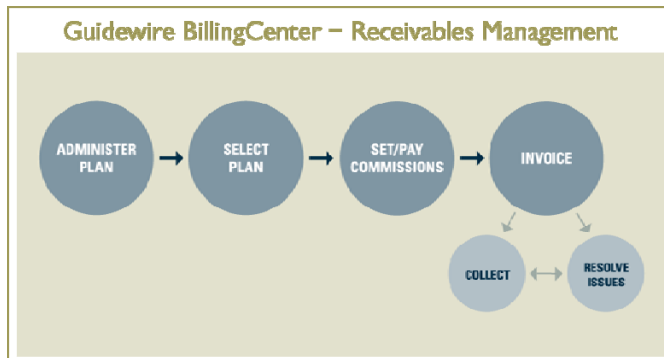
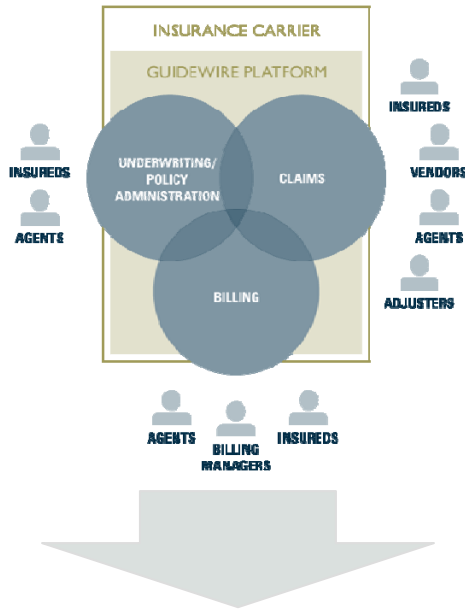
Guidewire PolicyCenter

Guidewire PolicyCenter is **a complete policy administration system** that helps organizations improve overall underwriting accuracy and efficiency, increase premium revenues at lower loss cost and lower expense, and respond flexibly to business opportunities.



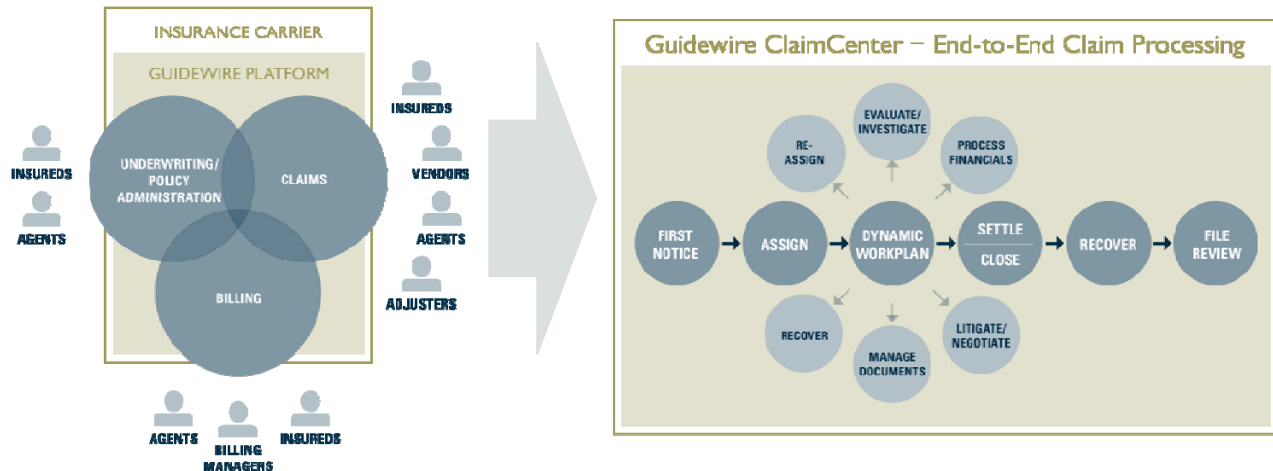
Guidewire BillingCenter

Guidewire BillingCenter is a complete billing system that enables insurers to implement more flexible billing models, increase billing accuracy and **reduce leakage, and optimize float**, while streamlining the overall billing process.



Guidewire ClaimCenter

Guidewire ClaimCenter is a comprehensive claims system that manages the end-to-end claim process for all lines of business, from new loss entry through investigation, settlement, and recovery. ClaimCenter has been the leading claims system on the market since 2003.



Insurers must look towards modern, web-based core insurance systems in order to compete in the highly competitive and rapidly evolving insurance market. Guidewire Software is proud to deliver modern, flexible, and proven systems that are used every day by insurance carriers to run their core operations.

About Guidewire Software

Guidewire Software is a leading global provider of technology solutions to property and casualty and workers' compensation insurers. Guidewire delivers proven software to run core insurance operations, including billing, underwriting, policy administration, and claim management. The Guidewire Insurance Suite™ consists of Guidewire ClaimCenter®, Guidewire PolicyCenter®, and Guidewire BillingCenter®, which provide a modern, web-based platform for all lines of business. Guidewire is headquartered in San Mateo, California, USA, with offices in London, Munich, Paris, Sydney, Toronto, and Tokyo. For more information, please visit www.guidewire.com.

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Footnotes

- i ISO, Insurance Information Institute
- ii Earlybird Forecast 2008 (17 December 2007) - Dr. Robert P. Hartwig, President and Chief Economist, Insurance Information Institute
- iii Celent – “Technology Enabled Claims Performance Improvement” – September 6, 2006
- iv Estimates by consulting firms including Accenture, McKinsey & Co., and PricewaterhouseCoopers (now IBM) and leading industry publications put leakage and excess loss adjustment expense at 10-15% of NWP
- v ibid
- vi Estimates by consulting firms and industry analysts including Accenture, Tata and Celent
- vii J.D. Power and Associates, 2007 National Auto Insurance Study
- viii J.D. Power and Associates, 2006 National Auto Insurance Study
- ix “2006 - Year End Results” (18 April 2007), “Earlybird Forecast 2008” (17 December 2007) – Dr. Robert P. Hartwig, President and Chief Economist, Insurance Information Institute
- x ACORD/LOMA Study, 2004
- xi Celent – “Core Claims System Vendors” – June, 2006
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