A VISION FOR FEEL GOOD CLAIMS.

A 2019
report by

LifeSEARCH

MorganAsh

The Big Picture.

LifeSearch and MorganAsh have a shared mission which we would love insurers, intermediaries and re-insurers to join: We want to make enthusiastic supporters out of the people we help; the bereaved, the critically ill and the disabled. Far more so than our market has ever thought possible.
How? By making those who have claimed on their policies feel so satisfied with how they have been dealt with that they wish to spread the word.

Claims are awful. Not because insurers claims teams aren't doing a good and ever improving job. And certainly not because we have to pay out. We've never met anyone in the industry that didn't feel great about that. No, they are awful for the obvious reason that something ghastly has happened to the person making the claim: they are either bereaved, critically ill, or so disabled they cannot do their job. But claims are where all our promises are proven true. And in that moment the awful becomes a wonderful thing.

The core of our promise is "peace of mind", and claims are our key chance to give consumers an experience that turns them into fans of what we do. In an age where power is flowing rightly to the consumer, we should be making the sharp end of our world – the end that matters most – utterly brilliant. Or to put it another way,

"The claim is our core product, not the policy."

- Tom Baigrie

INTRODUCTION.

Protection advisers have long held claims high on their list of priorities, only just behind the critical processes supporting new business. But now, for the first time, the 2019 Defaqto Protection Service Review reports advisers put claims first in what matters to them. This makes complete sense, given that the claims experience is the litmus test of whether they've done a good job.

If Advisers could confidently tell clients that "The insurers we trust to protect you and your family will do the right thing by you when it matters," without ever being made to look like fools thanks to the claims experience making a ghastly situation worse, then the UK protection market could become a shining example to all insurance markets.

This is why LifeSearch are stepping forward with MorganAsh to inspire you with proposals for how we can move towards this grand vision.

We propose a re-balancing of how our customers experience the claims process, by paying as much attention to the emotional as to the functional aspects of getting the transaction right. In partnership with MorganAsh and specialist protection advisers with the necessary capacity, we believe that together insurers can achieve this re-balance in the following ways.

1. **Customer champion:** Allow specialist advisers or nurse case managers to facilitate the claims process on the customer's behalf.

    a. Manage expectations and the awaiting-news anxiety using technology and customer champions to deliver timely communication.

    b. Amalgamate the claims process and nurse case management process to deliver smoother customer service and costs efficiency.

2. **Up the support elements:** Make it more a rehabilitation and support process than a claims process.

    a. More actively promote rehabilitation and treatments to speed up and improve recovery from disability.

    b. Encourage immediate reporting of serious illness before deferred periods, to permit early intervention treatments.

    c. Assume all our bereaved, seriously ill and disabled customers are most likely suffering stress or anxiety and pro-actively offer emotional support.

3. **Provide support for ALL policy holders:** offer ALL policy holders who are seriously ill, nurse case management, without waiting to prove there is a valid claim.

4. **Measure and report on what's great:** make reporting on rehabilitation and recovery a cross-industry measure and help the positive customer stories get out there.

With focused and personal care, at the heart of a timely, empathetic, practical and straight-forward claims process, we can deliver brilliant outcomes, the blossoming in consumer sentiment protection deserves and transform the amount of good we do.

LifeSearch and MorganAsh

Partners in Making Claims Great

LifeSearch and MorganAsh are collaborating on this paper as long-standing champions of the claimant experience.

We both have the cultural values and scale to relish being in the front line of making claims experience great for claimants.

LifeSearch Loves Helping Those In Need.

Specialist protection distributors have evolved well beyond simply being a sales channel for insurers. LifeSearch and other members of the Protection Distributors Group have customer service at the heart of what we do which means the sale is only the beginning. We make it our business to stick with our customers, keeping in contact and taking any opportunity to remind them of how their cover may be able to help them.

This approach delivers help to our customers when they need it most. LifeSearch is well known for having plenty to say about how the claim is the most important thing. But it's not just words. It's also built into what we do. We see the claim as validating our existence, and so we invest in delivering any and all help our customers and insurers need.

We routinely spot ways to ease the process. Like what to do when there's a hold up with the coroner. Or why it's best to alert your insurer early about your potential income protection claim, even if you're only signed off work for less time than the deferred period. Or getting two different insurers to co-operate with sharing evidence needed to unblock one of the claims.

LifeSearch Loves Helping Those In Need.

Hold up with the coroner
We heard from Mrs Hill that her husband had sadly died, and her friend was dealing with the claim for her to be able to pay off the mortgage. We learned there was a hold up months into the claim, because the cause of death was yet to be established by the coroner.

So we contacted Mrs Hill's friend to suggest they or we could explain the urgency of the report to the coroner. They were happy to do this, and the claim was settled and mortgage cleared soon after.

Alert your insurer early
Mrs Nasir contacted us in a bit of a panic about her husband's broken arm. Mr Nasir had been signed off for 4 weeks, but their policy had a 4-week deferred period. They had chosen this to keep premiums low, but hadn't appreciated how big the financial impact might be.

We encouraged them to start the claim process on the basis Mr Nadir might end up needing longer than 4 weeks off and so they could then immediately receive income protection payments.They were glad we did, as Mr Nasir was unable to work for 10 weeks in the end.

Getting insurers to co-operate
Mr Carnelly was claiming under his dad's two life policies on behalf of his mother. We explained the claim process and probate, along with our services, and all went as expected with the AEGON claim.

But the Canada Life claim stumbled over medical information they needed from the GP records, which by then had been sent off by the surgery to the Health Authority. Records are not often quickly retrieved in this situation.

We informed Canada Life that AEGON had already paid and asked them to see if AEGON would share the information, to help get the money to the family sooner.

Delightfully they did, so the claim could be paid just a few days later.

The LifeSearch Plea

We simply ask that insurers support us and other protection specialists who want to take on this work and treat us as part of their extended team by building communications processes that:

- Promptly alert us to every missed direct debit payment –
  Usually this just helps get payments back on track and avoids potential lapses – but it can be that someone's life has gone off the rails in a way their cover was intended to help with. This is our chance to help identify that need, inform them of the help available and get it to them sooner.

- Promptly alert us when a claim is made –
  It not only saves us inadvertent inappropriate contact, but also enables us to offer our support or advice for those customers who would welcome it.

- Provide on-line claim tracking technology –
  This is essential to smooth the process for any claims handling service advisers might give and needs to include the status of added value services being offered.

Re-positioning claims

We propose to turn the claim process on its head, by focusing on the consumer, their condition and rehabilitation state as the primary task, and then collecting all the information for the claim as a secondary process.

Proposed Support is:	Benefits for insurers by:
- Provided for all policy holders not just claimants - Provided by experienced medical professionals - Provided for all physical and mental conditions - For the emotional as well as practical elements - Independent - Not conditional on a successful claim - Not dependent on the insurance product	- Getting customers back on track in the most effective, caring way. - Giving the best chance of recovery with early intervention, regardless of claim status particularly for mental health and musculoskeletal conditions. - Enabling caring empathetic service to be provided when claims 'fail to meet the definitions'. - Reducing complaints and negating bad publicity. - Reducing cost of gathering further medical evidence for claims. - Avoiding duplicate costs for claim services and nurse care services.

MorganAsh has been processing claims for over ten years for major insurers in the UK, Ireland and Germany for CI and IP and has smoothed the way for over 5,000 claimants. So we've learnt a lot from being on the personal side of ill, disabled or bereaved customers' experience which we want to share with you now.

Our combined claims and nurse support service is called "Crisis Support"

Understanding the customer experience of the claims process.

Despite all the great progress the industry has achieved on how it manages claims and publicising the increasing levels of payout rates, we all know how difficult it is proving to shift the deep-rooted public perception that payout rates are poor.

Whilst there are drivers of this perception we can't do much about, such as what happened with PPI, there is one powerful impression maker within our control and that is how we make people feel when they make a claim.

Progress lies not in pressuring claims managers to pay out ineligible claims. Instead the main areas ripe for further improvement are around what actually happens beyond the financial decision: personal interactions, processes, expectations, anxious waits, unexpected but brilliant practical support services.

The Temkin Experience Rating

The Temkin Group are consultants and researchers into customer experience, and regularly rate the top consumer brands, using their Temkin Experience Rating. The rating uses a model to understand customer experience. The model breaks down consumer experience into three underlying elements.

Element	Description
Functional/Success	**Are customers able to do what they want to do?**
Accessible/Effort	**How easy is the company to work with?**
Emotional	**How do the customers feel about the interactions?**

Despite the substantive work already done in improving claims processes, it will be no surprise that the insurance industry is not at the top of the Temkin rankings of industries for customer service.

So it's very useful to see how we stand up to the Temkin model in the customer experience of the claims process.

The functional / success element of customer service

Are customers able to do what they want to do?

For protection, the success element boils down to whether the customer gets what they paid for. This is where most of the potential improvements have already been made over the last decade. In most cases the customer gets the money they think they are owed, as we declare in the published claims statistics.

The accessibility / effort element of customer service

How easy is the company to work with?

The industry has generally improved the effort element of the claims process, although some still lag behind. More pragmatic approaches are increasingly being seen on methods of validating both the validity of the claim and getting the money to the right person as promptly as possible.

Tele-claims has become the norm for most companies, greatly improving speed and reducing the amount of medical evidence required, along with reducing scope for unnecessary misunderstandings over potential non-disclosure. But where medical evidence is still required, obtaining this from an independent medical specialist is the main source of delay for payment

For many companies, claimants can submit data on-line or over the phone, and have their claims processed in hours and days rather than months. Indeed the days of paper application forms are mostly relegated to history.

But while Fintech, Apps and AI are very fashionable at present we doubt the consumer demand for claims apps that they would have to download, due to the fact very few people will claim and only when they are in distress.

What we do believe is that insurers should provide on-line and phone services, so customers can choose the way they would like to interact with the insurer.

The emotional element of customer experience

*Emotion is **50%** of the customer experience*

The emotional element is our richest seam of opportunity to make further strides in improving the customer experience.

Temkin report the emotional element accounts for 50% of the total customer experience. Insurance is not alone here, in that most companies struggle most with the emotional component of customer experience.

Functional/Success - 25%

Accessible/Effort - 25%

Emotional - 50%

For most protection claims we consider there is a big gap in providing the emotional element of customer service and this can and needs to be bridged if we are to fill the customer experience gap.

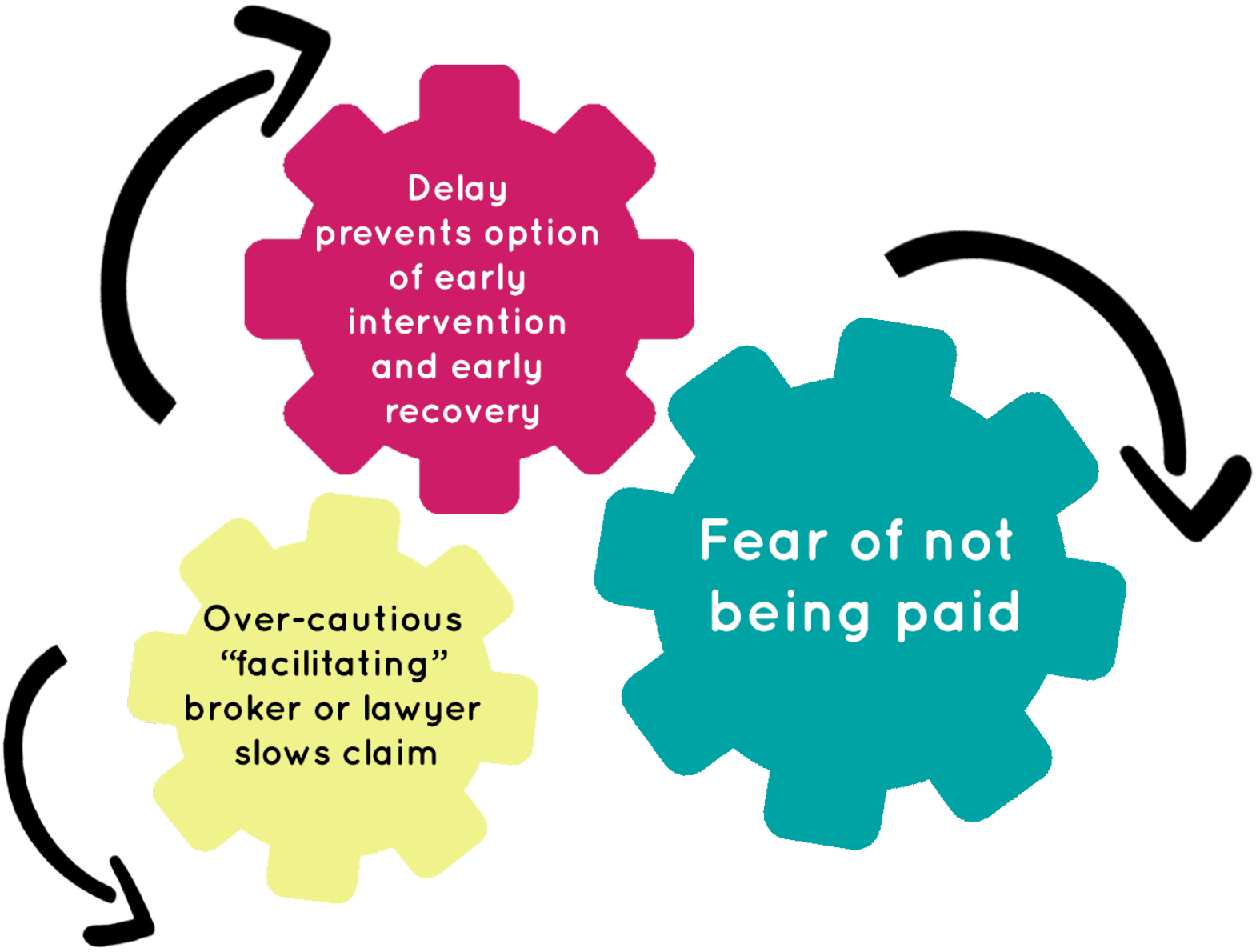
The bridging foundations are increasingly in place, with added value services like rehabilitation, nurse case management, and second opinion services becoming more commonplace. In many cases these are talked about as functional improvements, although their greatest value is in the emotional element of customer service.

The fear cycle

One of the problems for claims is that many consumers are fearful and anxious about their claim. Even if 99% of claims are paid, that's a 100% non-payment for you if you land in the 1% not paid.

Some brokers have similar fears, which lead to inadvertently making things worse. A keenness to ensure all the evidence is gathered and double checked before submitting it to insurers can slow the whole process down. A knock-on effect can be a delay in access to offers of intervention to support recovery. Barriers to engagement with the insurer can be even worse if the claimant insists on using lawyers.

It's important to get on the front foot to avert these problems by making a smoother path immediately clear.



Every claimant suffers stress

Anyone who suffers from the type of serious medical condition that's behind a claim under Critical Illness or Income Protection cover is highly likely to suffer some sort of stress, anxiety or depression whether or not it's defined as a mental health issue.

How we as an industry engage with the consumer can help or hinder the recovery process. One approach is to assume that everyone with these conditions will suffer and to tailor the process to accomodate this.

This not only provides a better customer experience, but there is solid evidence that a reduction in stress helps recovery.

Similarly, it goes without saying, bereaved claimants are also likely to be feeling at their most vulnerable and least able to cope. Any help we can give beyond a payout at this point is bound to be appreciated.

To sum it up, the success and the effort elements of customer experience certainly matter, but the emotional element matters most. Luckily, that's the bit where we've got most room to do more

The Claims Experience

We want to radically change the customer experience of the claims process and here's how we suggest we can do it.

Customer Champion -

Reducing anxiety of non-payment

Customer champion: Allow specialist advisers or nurse case managers to facilitate the claims process on the customer's behalf.

When ill or bereaved, the mere fact of going through the claim process can itself cause anxiety. As we know, there's a significant fear that the insurer won't pay out. And just the practicalities of proving your case can seem pretty daunting. In cases of mental health issues, this obviously just compounds the anxiety. But for claims based on illness of any sort, anxiety risks hampering recovery.

A good way to reduce this anxiety is to provide a "customer champion", an independent person on their side who can deal with the insurance company or companies for them. This can be their broker or an independent nurse case manager. Having an "expert" in their corner can at least give them some confidence that they will be treated fairly. Moreover, it's a chance to address up front the perception of poor payout rates and set more accurate expectations of how the process is likely to unfold for that particular claim.

"What if the insurance won't pay out?"

We are treating the perception of injustice. Even if the claims department are the most benevolent and customer friendly, it's what's perceived by the customer that matters.And having someone else to share the burden of moving things along can be a huge relief. So this not only helps with the accessibility / effort element of the claim process, but also how the customer feels about it.

Customer Champion - Easy access and managing expectations

Manage expectations and the awaiting-news anxiety void:
Ensure technology and customer champions can deliver sensitive and timely communication.

The other source of anxiety is the waiting. For patients with a serious illness, one of the worst things they endure can be the endless waiting. Waiting for an appointment, waiting to hear from their doctor, waiting for tests, waiting for treatment, waiting for their wound to heal, waiting for their drugs to kick in, waiting for the pain to ease, and especially waiting for the all clear.

Waiting for an insurance claim decision just adds to the weight of all that waiting. And very often, it's poor communication and management of expectations that causes frustration and worry, rather than the speed of the payout itself.

"When am I going to hear?"

Here's where using nurses for tele-claims can help.

The main hold up in processing protection claims is gathering the medical evidence from third parties. Using nurses for tele-claims has already reduced the amount of third party medical information required and is backed by the reinsurers.

Also, by combining the tele-claims process into the nurse support service the customer becomes party to the medical data gathering process. This way they are kept informed of the progress and of what's been said about them, even when their broker might be their main point of contact as customer champion. So obviously, brokers should be informed of progress, just as quickly as the insurers.

And technology can help too.
Keeping communications flowing requires some different options on how patients can interact with us.

As well as being able to submit a claim form on-line or over the phone customers should be able to:

- **Check they have valid policies**
- **Book nurse appointments on-line**
- **Download images or files of their medical, financial status and supporting information**
- **Choose if their broker is to be kept informed**
- **Select how they want to be contacted email, phone, text or letter.**

Similar capabilities are needed for brokers acting on behalf of patients. But as a general rule, we've found customers are best kept informed by phone, whilst advisers are best kept informed online.

Customer Champion - Combining nurse care service and claims processes

***One stop shop**: amalgamate the claims process and nurse case management process for smoother customer service, and claims handling and costs efficiencies.*

At the moment there is duplication of effort, with nurse care services and the claims process itself. Both of these processes require information on the patient's diagnosis, tests undertaken, the stage of treatments, medications and operations received and the recovery path.

With claims processing in-house and nurse care service provided externally, there is often a disconnect and the nurse care service suffers or is not even used. But if this duplication is eliminated, it not only reduces hassle for the patient, it also saves considerable costs as the nurse collects all the information needed for claims while looking after their patient. The involvement of a nurse also gives the advantage of better medical information and better results for dealing with potential non-disclosure.

Combining the claims processing and added value service may well cross interdepartmental budgeting areas, namely claims and marketing. The benefits to both areas make a good case for some cross-departmental collaboration.

Innocent until proven guilty

The risks of non-disclosure and the case for nurse care involvement

As part of tackling the tensions from fear of non-payment, there's the tricky issue of checking for non-disclosure whilst avoiding a sense of over-defensiveness or suspicion from the insurer.

Apart from anything else, it does take time and sensitivity to review the evidence to determine if the error was deliberate or a genuine error.

This is another reason that combining nurse care services with the claims process provides a real advantage.

Firstly, it's right that all claimants should be treated as innocent until proved guilty and given the benefit of nurse care services during this period. At worst, this may result in some fraudulent patients obtaining nurse care service, but this is better than those patients who do make innocent mistakes being denied these services.

But for the small minority of claimants who are not ill or who down-right cheated in their application, then this can quickly be discovered by the nurse care service.

This obviously can save a great deal of time and money. However, the main benefit is in the customer experience for all-claimants. The innocent have been treated as such from the start, with less impression of insurer defensiveness. While those who unluckily don't meet the claim definition and even the chancers have been shown care and help with their condition.

All round this should pay for itself, in general customer experience and net promoter scores, along with lower aggravation and complaints. Which makes us all happy.

Focus on recovery – Looking after policy holders' health

***Up the support elements**: Make it as much a rehabilitation and support process as a claims process.*

We propose turning the claims process on its head, firstly focusing on the patient and their condition ahead of weighing the evidence and processing the claim.

Prioritising the policy holder's health and their situation. As soon as they contact the adviser or insurer they would be referred to a nurse care support service. The only check should be that they have a policy. First checking there might be a valid claim, would hold up the process.

From the customer's perspective the service should look after them when they are ill regardless of their product, definitions, deferred period or small print. In other words, we meet customer expectations – to be looked after when they are seriously ill. It's a **"You suffer, we support"** approach. Some customers won't want the medical assistance, which is fine. They can continue as normal into the usual claims process.

Where nurse care support and claims processing have been combined, the costs savings can be used for treatments of more customers.

Providing early intervention to all

*More actively **promote rehabilitation** and treatments to speed up and improve recovery especially for mental health and musculoskeletal conditions.*

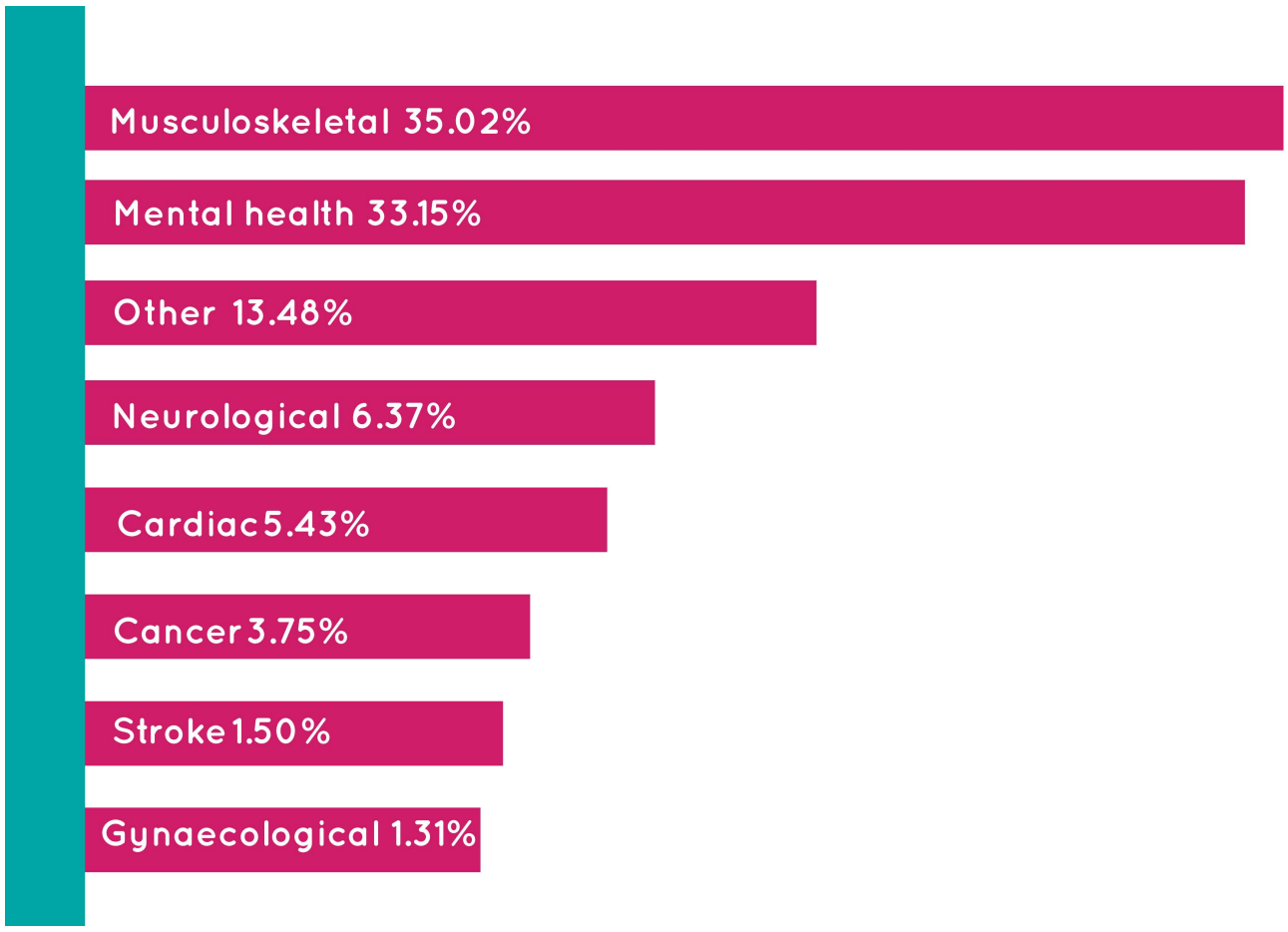
***The sooner, the better**: encourage immediate reporting of serious illness for all policy holders, before deferred periods, to permit early intervention treatments.*

For group income protection, early intervention has become common place. It has proved to be a win-win with patients recovering quicker and claims payouts reduced for insurers.

The most common treatments used for early intervention are CBT for mental illness and physiotherapy for back issues. These can be very effective if deployed early. If left untreated for many months than conditions can become worse and the approach to recovery become entrenched.

The graph on the following page shows the breakdown of conditions for Income Protection.
For musculoskeletal and mental health conditions there is often a real opportunity to assist in their recovery if early intervention is used. You can see that around 2/3rds of claimants are in these categories with the potential to reduce the amount of claim payout or even make it unnecessary.

Breakdown of conditions for IP



***Breakdown of condition of IP claimants**; Source – MorganAsh claims 2017-2018 from multiple companies across the UK and Ireland.*

On a discretionary basis, there can even be a place for early Intervention treatments for critical Illness or life cover policy holders.

Many of the providers of Individual IP are now keen to provide early intervention services too. However, frustratingly, they are only usually informed of the claim when the deferred period is over. Historically, advisers have actually been told to wait for the deferred period before submitting a claim.

So to get the same benefits of early intervention as the group market, the whole of the individual market needs to change - to inform of a claim as soon as the patient is ill, not when the deferred period is over.

There is a virtuous cycle to be created here. As more providers offer good early intervention services and get the word out, more advisers and claimants will notify early. And the more they do so, the more both individual cover policyholders and insurers will benefit.

Emotional support for all claim types

***De-stress all round**: Assume all our bereaved, seriously ill and disabled customers are most likely suffering stress or anxiety and pro-actively offer emotional and practical support.*

Most claimants for CI and IP will suffer some form of stress at some point in their illness, with unhelpful implications for their recovery.

So rather than waiting for the claimant to ask for help with this, we propose our starting point is to offer all claimants ongoing emotional support. This is best provided by nurses, and where these nurse support services have been provided the emotional support has been gratefully received.

A generous life cover offering could also include such an approach for bereaved claimants. Just imagine what a difference that could make to how they feel, not just generally, but about how brilliant life insurance turned out to be.

Providing support even if claim definitions not met

***Provide all-policyholders nurse case management**: offer this help to ALL policy holders who are seriously ill, ahead of claim acceptance and even if claim not valid.*

There are some policy holders who are very ill, but their illness does not meet the policy definitions to trigger a financial payout. This is a very difficult situation for them, which we can at least mitigate somewhat by still providing emotional and medical support for a period of time. This would be while going through the claim, as a minimum, and preferably for some time after, ideally until their situation has stabilised.

So, even though there's no payout, at least we will have supported the policy holder in their illness and misfortune. It's not only kind, but has scope to greatly reduce the potential for bad feeling about the insurer from these customers. It's one way of reducing the fuel for bad press and FOS complaints.

Broadcasting the good news

***Seeing and saying what's great**: make reporting on rehabilitation and recovery a cross-industry measure and help the positive customer stories get out there.*

After all this good work, we need to track what's working and what's not. And all the good news we will have generated deserves a place in the spotlight.

Again, the customer champion, be it adviser or nurse case manager, can help with this. Who better than the midwife to the claim or the provider of nursing specialist support to follow up to see how things have gone?

We suggest metrics below that will promote industry-wide performance indicators of how well we've done in improving the customer experience. These will help us all to improve and give advisers confidence in making recommendations.

But for the public and our potential customers, it's stories that bring to life what a difference having protection can make.

Unfortunately, the personal and difficult nature of what the customer has been going through makes these stories difficult to collect. But when they feel great about how they've been helped, there's a good chance they might be willing to share their feedback in one way or another. Some might be feeling gung-ho enough to be willing to jump straight onto Trustpilot. But more often, allowing corporate use of some of their words to build positive reviews might well be acceptable.

However, it needs sensitive identification of the chance to collect such positive feedback and equally to tactfully pull out areas that could have been improved on. This is something the customer champion is well-placed to do once the claim has been paid or service concluded.

How about a friendly follow up call to check all has happened OK, how the customer is, and what else they need? That will tell us what we need to improve but also whether they have a happy story they might be able to share of how our cover and service has helped them.

"It's stories that bring to life what a difference having protection can make."

Let's Shift the Balance

At the heart of every claim is a heartache. Claims are painful by their very context, but the process needn't feel that way

In the forum of public opinion, we are all painted with the same brush, so it is in all our interests to collaborate to shift the balance towards feel good claims.

**Relieved, Listened to, Surprised,
Same side, Supported, Trust, Helped,
Life-saving, Enthusiastic,
Evangelistic.**

**Warm and Knowledgeable,
Well explained and informed
from start to finish.**

Practical help and made well again.

**Worry, Stress, Anxiety, Suspicion,
Vulnerable, Frustration, Exhausted**

**Paid BUT, Slow, Bureaucratic, Defensive,
Uncommunicative, Seemingly grudging.**

Declined or reduced payout.

**Shock, Fear, Crisis, Confused, Conned,
Angry, Furious.**

Measuring and Marketing Success

Measure by activity

The long game is to protect more families across our whole market. That will take time But as we start this journey in earnest, we need to introduce new markers of success to chart our course. We already measure the functional element of customer experience with the proportion of claims paid. Next we need to extend this to measure how we're doing by activity and by outcomes on the effort and emotional elements.

Following some good examples in the group market we could report on the activities we are undertaking:

- **The proportion of patients suffering with mental health issues taking up some form of counselling**
- **The proportion of claimants engaging in some form of treatments**
- **The proportion of treatments provided by insurers and the NHS**

If we measure the results of looking after our bereaved, ill and disabled customers, and even compare against national averages, then we will have better metrics and stories to market our products.

Imagine these:

“67% of our policy holders with mental health issues took up our free counselling service and agreed this had helped with their recovery.”

“We provided emotional support to all our policy holders suffering with cancer and 67% reported this helped with their recovery”.

What matters counts, so let’s count what matters.

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