Case Study: The Claims Bottleneck at Guardian Insurance

By Akhil Bhaskar and Keith B. Carter with Emeritus for the Genpact Aspire Program 2025

Synopsis

Guardian Insurance entered Q4 expecting a stable renewal cycle. Instead, mounting inefficiencies in claims processing turned the quarter into a warning sign. Delays stretched close to a week, error rates crept higher, and customers began voicing frustration in surveys and social media. Competitors, particularly Apex Insurance with its AI-driven claims platform, seized the opportunity to lure away high-value accounts.

By the end of the quarter, Guardian's NPS had dropped 12 points, operating costs had risen 23% year-over-year, and three corporate clients representing tens of millions in premiums had defected. What appeared to be routine operational friction exposed a deeper issue: the company's ability to adapt to digital expectations is lagging behind the market.

Guardian's Q4 Reckoning

The silence in the boardroom was heavier than the mahogany table. David Chen, CEO of Guardian Insurance, slid the Q4 report across its polished surface. The numbers didn't just speak; they screamed. Net Promoter Score, the company's pride, had plummeted 12 points. Operating costs were up a staggering 23% year-over-year. But the final bullet point was the one that landed like a punch: three major corporate clients, representing tens of millions in premiums, had defected to competitors.

"Apex Insurance," David said, his voice dangerously low, "is settling claims in 36 hours. We're averaging nearly seven *days*. This isn't a slump; it's a systems failure." Every eye in the room swiveled to one man: Arthur Vance, the Chief Information Officer.

Arthur felt the familiar heat of the spotlight. He had the data in front of him, a grim litany of operational decay. A 32% follow-up rate on claims meant his people and Sarah's were doing the same work multiple times. The 8.2% error rate wasn't just a number; it was $1.2 million in compliance penalties. He knew the cause wasn't his team's competence. It was the architecture. The company was running on a patchwork of siloed applications tethered to a legacy core platform that fought integration at every turn. "We're flying blind," he had warned his own lead architect just last week. "We can't automate what we can't connect."

His diagnosis, however, was not shared by everyone.

Later that day, Arthur found Sarah Jenkins, the Head of Claims Operations, walking the floor where her team was battling a backlog of 4,200 claims. The 18% spike in staff overtime was visible on their faces.

"Another three spreadsheets to reconcile before we can approve a payment," Sarah said, gesturing to a junior handler's screen. She didn't look at Arthur. "You know what my team needs? A system that works. Not another dashboard. Not another promise of 'synergy.' Your systems are forcing us to re-key data, chase down emails, and apologize to clients for delays we can't control."

The suspicion was undisguised. To Sarah, this wasn't a strategic challenge; it was an IT failure. She saw Arthur's talk of "fragmented systems" as jargon to mask a lack of delivery. Her team's cost per claim was $148 against an industry average of $96, and she was convinced the bloat was due to the clunky software, not her people's performance.

The tension came to a head in a Friday executive meeting. Arthur presented a slide showing the direct chain of failure: siloed systems led to manual checks, which created errors and delays. These delays drove up costs and frustrated clients, leading directly to the churn of high-value accounts.

"The root cause is a lack of integrated, real-time visibility," Arthur concluded, carefully choosing his words.

Sarah countered immediately. "The root cause is that my team spends half its day fighting your software. We can hire more people for what Apex is spending on their AI platform. Let's fix the *process* before we throw millions at another IT project that won't deliver for two years."

The room was split. The CFO winced at the cost-per-claim data, while the Head of Sales recounted a brutal call with the latest defecting client, who had praised Apex's "flawless digital experience." The board's directive to Arthur had been to "develop a transformation strategy that balances credibility with speed". But how?

A tactical RPA "Efficiency Bot" could automate data collection and reduce errors quickly, an immediate, tangible win that might placate Sarah. It would be a ceasefire. But Arthur knew it was just a bandage on a gaping wound; it wouldn't provide the strategic insights needed to compete with Apex.

The alternative was far more ambitious: an AI-enhanced "Claims Command Center". It would offer predictive insights, simulate scenarios, and transform how managers made decisions. It was the right long-term answer and the only one that could truly protect their $45M enterprise premium base. But it was complex, expensive, and required the very

cross-departmental trust that was currently in tatters. In this climate of blame, proposing it felt like career suicide.

David Chen stood up, ending the debate. "I don't want two competing theories. I want one plan. Arthur," he said, turning his full attention to his CIO. "You have the weekend. On Monday, I want your definitive proposal. You need to get Sarah and the entire executive team on board, and it needs to start showing results this fiscal year."

Arthur looked across the table at Sarah, who stared back, her expression a mixture of challenge and exhaustion. He then looked at his CEO, who needed a win. Everyone was looking for a solution, but they were also looking for someone to blame if it failed.

The Question

How should Arthur Vance structure his proposal to bridge the deep mistrust between IT and Operations? Which path should he recommend: the fast, limited RPA solution to build political capital, or the comprehensive AI Command Center that addresses the core problem but requires a level of organizational unity that Guardian Insurance clearly lacks?

The Challenge

The CIO reviewed Q4’s operational metrics:

- 6.8 days average claims cycle.
- 32% of claims requiring multiple follow-ups.
- 8.2% error rate.
- 23% rise in operating costs YoY.

Behind the numbers were structural challenges:

- Fragmented Systems: Claims, underwriting, and service teams each work in siloed applications with no integrated dashboard.
- Aging Core Platform: The legacy policy system complicates integration, limiting automation opportunities.
- Reactive Communication: Customer updates often lag days behind, eroding trust at the frontline.
- Competitive Pressure: Apex Insurance has reset client expectations with a digital model that processes many claims in under 36 hours.

The board's directive is clear: develop a transformation strategy that balances credibility with speed, avoiding "hype" while delivering measurable gains.

Data Appendices

Table 1: Claims Performance

- Backlog: 4,200 claims (1,800 open > 7 days)
- Avg. cycle: 6.8 days
- Follow-ups: 32% of cases
- Error rate: 8.2%

Table 2: Cost & Resources

- Staff overtime: +18% YoY
- Cost per claim: $148 vs. industry average of $96
- Compliance penalties: $1.2M in 2024

Table 3: Customer & Market Impact

- NPS: –12 points in Q4
- Corporate churn: 3 major clients
- Competitor benchmark: Apex 24–36 hr claims settlement

Instructions for Case Study Analysis: The Guardian Insurance Claims Bottleneck

Objective

To analyze Guardian Insurance's claims process failures and propose a technology-driven solution that improves efficiency, reduces costs, and protects high-value customer relationships.

Step 1: Deconstruct the Case Narrative

- **Identify Key Actors:** CIO, claims handlers, customer service reps, corporate clients, board. What is each group's priority (speed, accuracy, retention, cost control)?
- **Map the Process Flow:** Trace a claim from submission to closure. Where do breakdowns occur — multiple follow-ups, error-prone manual checks, siloed systems?
- **Define the Core Failure:** In one sentence, summarize the root cause — is it technical debt, fragmented systems, or the absence of integrated, real-time visibility?

Step 2: Synthesize the Data Story

Use all three tables (claims, cost, customers) together.

- **Claims Analysis (Table 1):** What do cycle times, follow-up rates, and error flags tell you about process quality? Where are SLA breaches most common?
- **Cost Analysis (Table 2):** How do overtime and error rates translate into higher cost-per-claim? Which teams are most inefficient?
- **Customer Impact (Table 3):** Which accounts are churning, and how do their claim metrics line up with poor NPS and revenue loss?
- **Integration:** Build the chain: inefficient claim processing → higher costs → client frustration → churned Enterprise accounts ($45M lost).

Step 3: Design an Automated Claims Solution

Outline two approaches:

A) RPA "Efficiency Bot"

- Automates claim data collection, SLA checks, and customer notifications.
- Reduces manual re-keying and email chains.
- *Benefit:* Immediate efficiency and fewer errors.
- *Limitation:* Limited adaptability, doesn't provide strategic insights.

B) AI "Decision Support"

- Identifies patterns in errors, claim delays, and follow-ups.
- Simulates operational scenarios (e.g., what if more automation coverage is added?).

- Recommends actions (e.g., redistribute workload, flag high-risk accounts).
- *Benefit:* Insightful and predictive.
- *Limitation:* Requires integration and governance to avoid compliance issues.

Step 4: Propose the AI-Enhanced "Claims Command Center"

1. **Workflow:** Describe how a claims manager's daily work changes. Instead of firefighting with spreadsheets, they see real-time dashboards showing SLA breaches, cost overruns, and churn risk.
2. **AI Decision Memo (sample):**
    - **Summary:** "Enterprise account AC-0007 ($18M premium) has 19 open claims. Avg. cycle time = 11.2 days, error rate 9%, NPS delta –22."
    - **Constraints:** Handler team at 150% workload, automation coverage only 5%.
    - **Options:**
        - Option 1: Increase automation coverage to 25% for repetitive claim types. Estimated reduction in cycle time = 3 days.
        - Option 2: Add 2 additional handlers at $200k annual cost; projected NPS improvement = +10.
    - **Recommendation:** Option 1; projected retention of $18M account. Confidence 90%.
3. **Quantifiable Benefits:**
    - Reduce avg. cycle time from 6.8 → <4 days.
    - Protect at-risk $45M Enterprise premium base.
    - Cut cost-per-claim closer to $96 benchmark.
    - Increase decision velocity — from quarterly reporting to real-time alerts.

Rubric for Evaluation (20 Points Total)

Step 1 — Deconstruct the Case Narrative (4 pts)

- 1 pt: Lists actors only.
- 2–3 pts: Maps claim process, identifies breakdowns.
- 4 pts: Clear, concise root cause statement linking systems, process, and customer frustration.

Step 2 — Synthesize the Data Story (6 pts)

- 1–2 pts: Uses one table in isolation.
- 3–4 pts: References multiple tables, shows partial links.
- 5 pts: Builds integrated chain from ops → costs → etc.
- 6 pts: Exceptional synthesis, quantifies links, highlights Enterprise results.

Step 3 — Design Automated Solution (5 pts)

- 1–2 pts: Mentions automation vaguely.
- 3 pts: Provides concrete RPA or AI examples.
- 4 pts: Differentiates RPA vs. AI roles clearly.
- 5 pts: Proposes realistic automation + AI design with compliance considerations.

Step 4 — Propose the "Claims Command Center" (5 pts)

- 1–2 pts: Suggests generic dashboard.
- 3 pts: Provides workflow or AI memo.
- 4 pts: Links solution to measurable benefits (NPS, revenue, etc).
- 5 pts: Full vision: Well thought through

Step	Criteria	1 Point	2–3 Points	4–5 Points	Score
Step 1: Narrative(max 4)	Actors, flow, root cause	Actors only	Flow mapped, some breakdowns	Clear root cause linking systems, process, and clients	/4
Step 2: Data Story(max 6)	Integration of data	One data sources only	References multiple data sources	Full integrated chain: delays → costs → ...	/6
Step 3: Solution(max 5)	RPA vs AI design	Vague mention	Concrete steps, partial distinction	Clear distinction, realistic design	/5
Step 4: Proposal(max 5)	Workflow, AI memo, ROI	Generic dashboard idea	Workflow or memo with benefits	Full proposal: workflow + memo + quantified ROI	/5

Case FAQ

The Business Context: Commercial Insurance

- **Type of Insurance:** Guardian is a provider of **Commercial Property & Casualty (P&C) Insurance**. This means their clients are businesses, not individuals. Claims involve events like workplace accidents, commercial vehicle damage, or property damage to a factory. This context explains why the "corporate clients" are so valuable and why claim complexity can be high.
- **The Role of the Claims Experience:** In commercial insurance, the claims process is one of the few tangible touchpoints a client has with the insurer. A slow, error-prone experience doesn't just frustrate an individual; it can impact the client's business operations and cash flow. This is why the 12-point drop in NPS is a critical business risk[1].

2. Operational & Process Details: "The Anatomy of a Bottleneck"

- **A "Day in the Life" of a Claims Handler:** the manual, multi-system process causes the delays.
- **The Source of "Multiple Follow-ups":** 32% of claims requiring follow-ups are often due to simple, preventable issues. For example, if a required field is left blank on the submission form, the system doesn't flag it automatically. A handler only discovers the omission mid-process, forcing them to stop work and email the client, adding days to the cycle
- **The Nature of Compliance Penalties:** what these penalties are for.

"The $1.2M in compliance penalties stems from failing to meet regulator-mandated Service Level Agreements (SLAs), such as the requirement to acknowledge a new claim within 24 hours or issue a coverage decision within 5 business days." This directly links the operational delays to financial losses.

3. The Technology Landscape: Legacy and Competitors

- **Defining the "Aging Core Platform":** Here is a description of the technical debt.

The company's core platform is a 20-year-old mainframe system. While reliable, it cannot easily connect with modern tools. Data is extracted in overnight batch files, not in real-time, making an integrated dashboard impossible with current technology.

- **How Apex's AI Platform Works:** competitor's advantage.

Intelligence reports indicate Apex Insurance's platform uses AI-powered document scanning (OCR) to automatically read and classify incoming claims, a rules engine to

instantly triage and assign them, and automated communication bots to provide clients with real-time status updates.

- This paints a clear picture of what "good" looks like.

Frequently Asked Questions (FAQ) for Students

Q1: A 6.8-day average claims cycle doesn't sound that bad. Why is this considered a crisis?

- The crisis isn't just the 6.8-day average; it's the gap between Guardian's performance and the new market standard set by competitors like Apex, who settle many claims in under 36 hours. For a business client, a week-long delay can mean a week of business interruption. Guardian is no longer competing on its own terms but against a new, much higher customer expectation.

Q2: What is a claims "error," and why is the 8.2% error rate so significant?

- An "error" can range from a simple data entry mistake (e.g., typing the wrong policy number) to a major miscalculation of a settlement amount. The 8.2% rate is significant because each error requires rework, which adds cost and delays the process further. It's a direct driver of the high cost-per-claim ($148 vs. the $96 industry average) and contributes to the staff overtime and customer frustration.

Q3: The case mentions an "aging core platform". Why can't they just replace it?

- Replacing a core insurance platform is a massive undertaking, often costing tens or hundreds of millions of dollars and taking several years to complete. These projects are notoriously high-risk. The board's directive to "avoid 'hype' while delivering measurable gains" suggests they are not looking for a risky, long-term "rip and replace" project. This is why an AI and RPA solution, which can work with the existing legacy systems, is a more practical and immediate proposal.

Q4: How are the 23% rise in operating costs, the higher cost-per-claim, and the 18% staff overtime connected?

- They are all part of a vicious cycle.
    - The inefficient, manual process means each claim takes more time and effort to close.
    - This leads to a growing backlog of claims.

- To manage the backlog, staff must work more hours, causing the 18% increase in overtime pay.
- The combination of more staff hours per claim and rework due to errors inflates the total cost-per-claim to $148.
- All these inefficiencies contribute to the overall 23% year-over-year rise in operating costs.