PPI

Claims Process Improvement: Choose the Optimal Road to Success

Claims is **the** make-or-break moment between customers and their insurance carrier. A superior claims experience can be a powerful marketplace differentiator for the insurer. So can a bad one. And a claims organization has many opportunities to shine or fail. In a typical P&C organization, every policyholder is likely to present at least one claim in any 10-year period. In the health and dental segments, the frequency is much greater. Managing claims is obviously critical to attracting, satisfying and retaining customers.

In today's competitive insurance marketplace, the attention focused on claims is increasingly urgent. Over the last decade insurers have recognized that claims is not just a cost center—the place where money goes out, where losses have to be controlled, fraud prevented, and expenses contained—but a center of strategic value that repays thoughtful investment, and a critical driver of long-term growth.

Claims is also a vital source of strategic data used across the organization. Claims data, if effectively captured and analyzed, provides a unique window on an organization's actual customers and costs, and a basis for shaping the future. Business decisions are only as good as the information that informs them, and the analytics behind it. Modern product development, underwriting, and marketing depend on the data supplied by claims.

Today's Claims Challenges

Claims organizations across the insurance landscape have to master a complicated balancing act between managing the claims themselves, managing the expenses of claims resolution, and providing a favorable customer experience, while at the same time meeting the needs of many internal stakeholders and external partners and satisfying increasingly stringent regulations. The organization's strategic, operational and financial goals may be competing for the same limited resources. A number of challenges are particularly noteworthy:

Service delivery

The volume of claims has been growing rapidly, while the resources available to claims organizations generally have not. In addition, insurers have been actively developing and selling new products and plans, and creating multiple new variations on the old ones, all of which place additional burdens on the platforms and processes needed to service them. At the same time, customers increasingly demand personalized service of their claims. Systems and resources must be both more efficient and more flexible to handle the increase in traffic and product complexity while meeting goals for quality and financial results. Processes need to support effective claims segmentation to ensure that resources are correctly allocated and cases appropriately escalated to contain loss costs while maintaining service excellence.
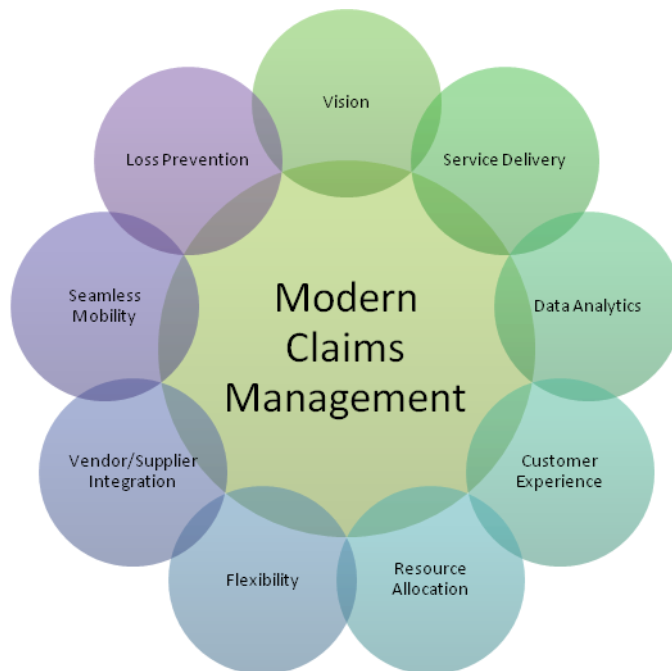
Technology

The historical lack of investment in claims technology has left many organizations with aging, inflexible, hard-to-maintain systems and fragmented processes that hamper innovation, suck up resources and drag down productivity. Manual processes slow turnaround time and increase the chance of processing error. Aging infrastructure make it difficult for carriers to use advanced telematics to determine loss circumstances, automate recurring payments or document delivery, or perform ad hoc reporting. Business rules embedded deep in system code are difficult to update. Older systems lack the ability to link to vendor and customer portals and streamline the end-to-end

process. Rigid and cumbersome data architectures do not allow the organization to integrate data across the business or support the complex analytics that provide usable business intelligence and customer insights, much less modern Big Data applications. Organizations that have invested in modern, flexible systems and updated processes quickly see significant ROI. The performance gap between industry leaders and the rest of the pack only grows wider with time.

Talent

Claims departments need a lot of specialized expertise to perform essential functions and the competition is stiff for qualified talent. A shortage of over 85,000 claim adjusters in the US alone has been projected. Shortages and misallocation of resources leaves many departments overworked and understaffed.

Modern Claims Management — Vision, Service Delivery, Data Analytics, Customer Experience, Resource Allocation, Flexibility, Vendor/Supplier Integration, Seamless Mobility, Loss Prevention

Industry Trends

Recognizing the challenges they face, many claims organizations have been taking steps to address them. Approaches common to many of them include:

Efficient claims processing
Faster turnaround from claim initiation to final adjudication & payout reduces costs significantly. Using automated rules-based processing and workflow increases process accuracy as well as speed, reduces costs and improves control. Intelligent triage processes on intake that can accurately assess exposure and complexity enable suitable routing and assignment of resources with the appropriate skills to support resolution of the case, as well as identifying potential fraud early. With integrated claims management systems, virtual claims files can be shared and updated simultaneously by multiple resources in various locations to provide accurate information where it's needed and reduce wait-time and handoff delays

Adherence to standards
The industry-standards and definitions for claims inputs and processes that are relevant to a specific segment of the insurance industry

(e.g. ACORD, HIPAA/ICDM/CPT) should be applied throughout the claims lifecycle and enforced as much as possible to enable rules-based processing and workflow, ensure consistency, and minimize the need for manual and exception processing.

Extend claims process management to include suppliers, vendors and claimants
The boundaries of a claims process are porous – true improvement often requires involving the outside parties so that they can provide and receive usable information, coordinate services correctly, etc. This can include managing process, service levels, scheduling, and ranking/scoring vendors, partnering with the supply chain (e.g. nurse hotlines, linkage to auto repair shops & rental cars) to streamline customer experience & provide more service options, connecting to third-party & upstream/downstream systems to reduce costs, time, complexity, and enabling claimants (policyholders, medical providers, etc.) to provide sufficient usable data in initial contact to minimize follow-up requirements.

Focus on data
Claims are a rich source of internal & external data for business insight, claims prevention, fraud management, and customer service. Sophisticated data analytics are a powerful tool to enhance segmentation and manage the claims process. Modern claims systems should be able to capture all the details of the claim, link it to meaningful metadata, and make it available for analytics and reporting across the business. Information needs to be available on-demand 24/7.

Seamless multi-channel claims service
Consistent information needs to be available to internal and external users everywhere, regardless of the channel used to access it. This includes (but is not limited to) call centers, agents, mobile apps, social media and self-service portals. Customers, including policyholders, agents and providers, increasingly demand and require easy instant access to claims information and service via their channel of choice. This should integrate seamlessly with the back-end systems used for actual claims processing to enable efficient two-way communication, as well as input and delivery of documents and data

Other improvement options can work for you too

Obviously there can't be a one-size-fits-all solution for claims that can be applied to every insurance organization. The business requirements of different types of insurance products are clearly different in many ways that can impact their claims priorities. And organizations need to develop approaches to claims that fit their own business goals and capabilities.

Technology is not the universal answer
Many of the solutions described above focus on technology and IT improvement as the key to improving the claims experience and using claims to drive strategic objectives. Before committing to a full-scale claims-improvement IT program, however, important considerations may include:

- Budget and timeframe
- Level of management support
- Age and architecture of the existing IT infrastructure surrounding claims
- How IT improvement can support overall business strategy and market positioning

For example, the benefit of highly automated claims processing is most easily seen in a business where claims tend to be relatively homogeneous – the same types of claim submitted repetitiously with a standardized set of inputs and a low level of individual distinctiveness can readily be processed in bulk by a straight-through well-controlled workflow. If the nature of the claims is inherently more

complex, automated workflow and document handling can aid efficiency, but automated adjudication for most claims may not be a realistic goal.

And it may not make sense to invest heavily in a sophisticated system to collect massive amounts of claims data if the organization does not have modern data warehouse and reporting capabilities, or at least a firm plan to implement them. Cutting-edge claims systems can only earn back their ROI if the upstream and downstream systems can take advantage of their capabilities.

Large-scale IT programs require significant commitment from upper management and a willingness to embrace significant change. They tend to be expensive. And they generally take longer than initially planned to achieve their goals – if, that is, they actually succeed, which in too many cases they do not.

Transformation does not require technology
Any major change in the technology used for claims will necessarily require significant changes in the surrounding processes and organization structures. Even without implementing big new claims systems, a claims organization can achieve significant improvement by focusing on changes in process, training and culture. There are a variety of approaches that claims organizations can use effectively, including:

- Invest in the development and training of the workforce to achieve outstanding service

- Focus on attracting, developing and retaining key talent to gain competitive advantage

- Enable claims professionals to play a consultative role, not just administrative

- Align processes with functional skill sets. Determine where centralization or

distributed processing would be most effective

- Consider the relative benefit of specialists vs. generalist models in staffing and assignment

- Establish processes to segment claims appropriately at intake and direct cases to the optimal resources.

- Identify process bottlenecks and explore ways to alleviate or eliminate them

- Evaluate organizational structure impacts on performance, and aligning them to support desired outcomes

- Establish metrics and KPIs that are transparent and actionable, and use them to drive performance improvement and manage indemnity costs and expenses, settlement and payment patterns, and reduce loss ratios

PPI can help you optimize your claims improvement initiatives

Performance Plus Inc. is well positioned to help a claims organization develop and implement an accelerated improvement program. As experts in process with experience in the claims departments of many different types of insurance organizations, we can help you with practical, short-term improvements that leverage your existing capabilities and resources, and use our expertise and industry best practices to help design roadmaps to longer term answers that fit your organization's needs and strategies.