

Health Claims Opportunities

Taking Control of Health Insurance Claims

Health insurance companies in Asia enjoy enviable demographic and economic developments. Besides the growth in population and increasing life expectancy, Asia boasts significant growth in GWP and rising income levels. But these developments alone are only enablers for a significant increase in the demand of health insurance. Realized growth in health insurance can only be achieved when people are convinced of the importance of taking responsibility for one's healthcare expenses. Drivers for this awareness are a mix of trends like Lifestyle of Health and Sustainability (LOHAS), modern technologies like Apple's Health app, increased healthcare costs and the rise in the incidence of chronic diseases. The low penetration of health insurance in Asian markets combined with an out-of-pocket health expenditure of about one third of the overall spending substantiates the positive outlook¹. The current premium growth rate of 10% each year is therefore expected to remain on a high level².

The steady increase in health insurance business will lead to more health related claims being processed. Health claims currently account for the biggest share of total claims. They are considered the most complex; with different aspects to consider for each health claim. The following are just some of them:-

- Is it a Group or Individual policy ?
- Is it an Inpatient or Outpatient ?
- Cash to the Customer or Reimbursement to the Hospital?
- What ICD code system should be used?
- Which drug catalogue applies ?
- Which preconditions have to be considered ?
- Which medical network is part of the treatment?

We will explain how health claims can be managed holistically and efficiently.

External and Internal Requirements

To stay ahead of the competition, insurance companies have to address certain requirements which can be grouped under external (customer) expectations and internal (insurance) goals. Customers expect a smooth

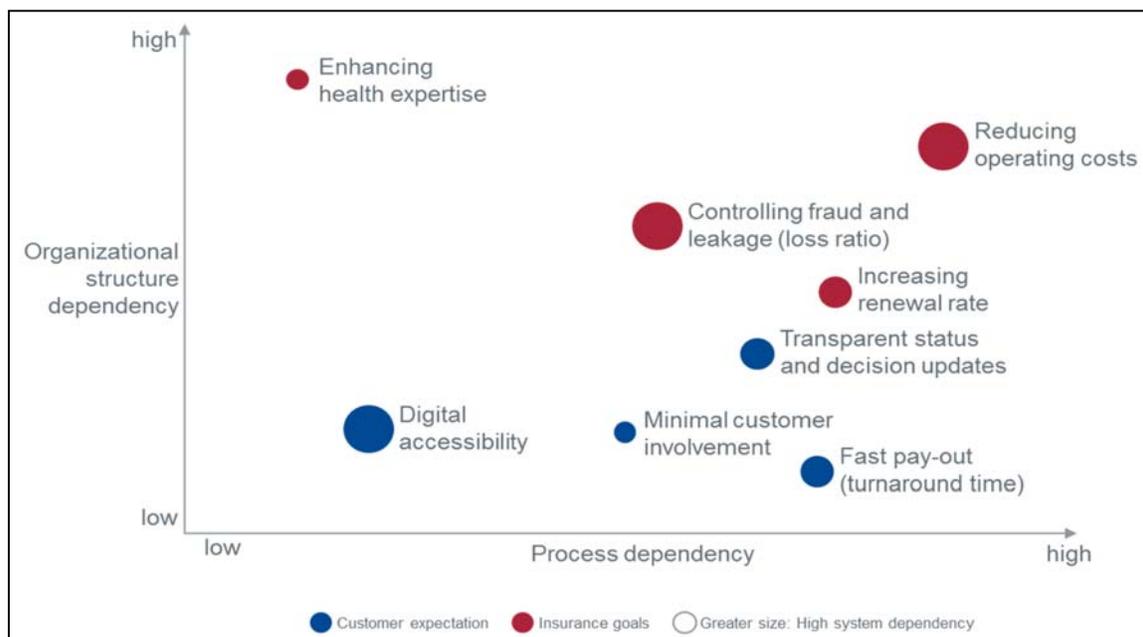
¹World Bank; Out-of-pocket health expenditure; share of health care expenditure which is paid from uninsured population

²Swiss Re & RGA (2013) – Projected annual growth rate from 2010 - 2015

claims process. At the same time, updates about claims status and decisions should be provided in a timely and clear manner. The turnaround time has to be short and status updates must be accessible via digital media.

While they aim to increase the renewal rate, insurance companies aspire to reduce operating costs & TPA expenses and eliminate fraud and leakage. To achieve these goals three items are essential:

- 1) a modern IT system
- 2) optimized processes and
- 3) an organizational structure with the right skills and health expertise.



Source: Synpulse Research

Although these expectations and goals are not new to the insurance industry, technological advancements enable new possibilities to address them more efficiently.

In order to assess how well insurance companies are prepared to address these external expectations and internal goals, the following questions can help to assess the current situation.

A) Questions regarding customer expectations:

ID	Question	Yes	Partly	No
1	Are digital channels supported for claims submission (web portals, smartphone apps, email etc) ?			
2	Is the turnaround time for claims processing above average (less than 1 week) ?			
3	Is a 360° view of the customer available (claims history, additional information from policy admin, integration of social media etc.) ?			
4	Are customer touch points properly managed throughout the whole claims process (focus on all touch points during the claims customer journey and definition of respective actions and targets)?			
5	Can the customer access his / her claims status at all times?			

B) Questions regarding insurance goals:

ID	Question	Yes	Partly	No
1	Is the claims process more than 70% automated (the highest levels are at 80% and the lowest levels are below 40%) ³ ?			
2	Is the calculation of benefits automated through a rule-engine (consideration of benefit limits, co-payments, sub-limits, deductibles etc.) ?			
3	Is the care provider validation supported by a rule-engine (are details available and can provider matching be done automatically) ?			
4	Are standardised drug catalogues and ICD coding supported (coding like ICD-9, ICD-10, ICD-10CM etc.) ?			
5	Can a closed file review be automatically processed with minimal human interaction (random samples, workflow guidance etc.)?			
6	Is predictive analysis in place (rule based validations, forecasts, linkage of similar cases and claims history etc.) ?			

Target Situation

If most of the questions above have been answered with “Partly” or “No” there is still a gap between the current and the target situation. To make the target situation more tangible **Synpulse** has defined a comprehensive set of approximately 100 target requirements for the health claims process. Some of the target requirements are introduced on a high-level below:

A) Target requirements related to customer expectation:

- Fast turnaround time
 - Provide connectivity to peripheral systems and output solutions
 - Transform non-digital data

³ Synpulse Research

- Check for missing information
 - Transparent status
 - Answer inquiring partner automatically
 - Provide status updates to claimants
 - Support multiple countries and currencies
 - Digital accessibility
 - Allow input through digital channels
 - Integrate new digital channels
 - Upload and access archived documents
- B) Target requirements related to insurance goals:
- Increasing renewal rate
 - Choose preferred customer channel
 - Show all customer details
 - Calculate coverage from multiple products
 - Reducing operating costs
 - Validate claims formally
 - Validate involved parties (e.g. medical providers)
 - Reject claims based on rules
 - Controlling fraud and leakage
 - Conduct predictive analysis
 - Link claims, invoices, documents and customer history
 - Map product specific coverage

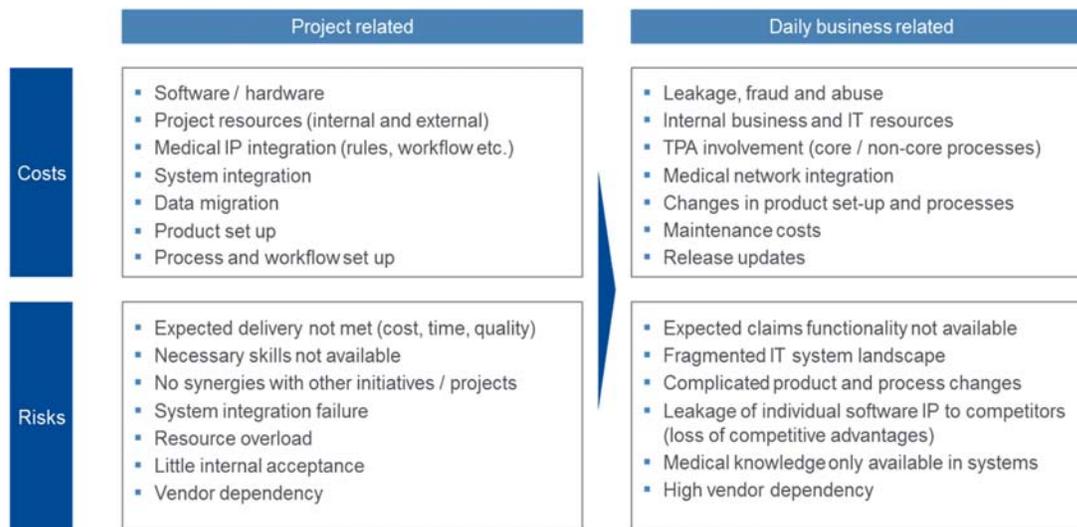
These target requirements can be linked either to a specific step in the health claims process (claims input, formal validation, care provider validation, policy validation, benefit calculation, reimbursement) or be defined as general requirements that apply to several process steps.

Although all of the requirements are system-related, they cannot be realized without considering all the dimensions of a target operating model including the processes of an organization and its structure.

The three dimensions therefore need to be carefully assessed and based on the outcomes improved in order to reach the desired target situation.

System Improvements

When it comes to system improvements, one must first decide between buying and building new functionality. This decision is dependent on several factors that can be grouped into project and daily business related costs and risks:



Source: Synpulse Research

After the buying versus building decision has been taken, several other factors need to be considered in order to identify the most suitable system solution. They include:

- **Functional requirements:** Fulfilment of target requirements, set-up possibilities of products, cross-system information availability, digitalization, analytics etc.
- **Non-functional requirements:** Usability, scalability, reliability, customization etc.
- **Technology:** Modern architecture, release capability, high security, reliable performance etc.
- **Integration:** ESB connectivity, modular concept etc.
- **Vendor:** Sound references, implementation capability, health expertise etc.

All these factors and their detailed requirements need to be covered during the Request for Information (RfI) and Request for Proposal (RfP) stages. For the remaining vendors beauty contests and a Proof of Concept (PoC) need to be prepared and conducted thoroughly with use cases and detailed questionnaires. Vendor and software selection are critical in order to avoid a tremendous increase in effort during the implementation phase and to minimize the risk of project failure.

Process Alignment

Process alignment should be done after selecting a suitable software solution. This is because standard software comes with predefined processes that can be mapped and compared to the existing processes within the insurance company. For each process there are three possible decisions: 1) keep the existing process, 2) adopt the (external) standard process or 3) adapt the processes. In any case an as-is analysis followed by a gap analysis need to be done in order to identify the processes where a decision is necessary. After the process portfolio has been refined, clear responsibilities have to be assigned to each process. During and after the system implementation the processes have to flow into the daily business habits of the operational staff. This can be achieved with testing activities and training sessions for key users. Regular updates to the process documents and their representation in the process flow of the claims system enables KPI measurements and a manageable control of agreed service levels with customers, agents and other stakeholders.

Structural Adaptation

Adaptations to the organizational structure are not in any case necessary. Although the introduction of a new health claims system provides the momentum and a good opportunity of rethinking the organizational structures and ties with external stakeholder. To maximize the effect of a new system, the adaptation of organizational structures can be favorable. In order to do this, it is suggested to proceed in four high level steps while always considering the own company, connected TPAs and medical networks as well as other stakeholder like agents and brokers. The first steps is to analyze the as-is situation to get a complete picture of internal and external structures, skills and relationships. In a subsequent step the various principles are defined. This covers service levels, criteria for segmentation of cases, employee guidelines as well as criteria for outsourcing decisions. The third step consists of planning the reorganization. This will be done by defining teams and their responsibilities in terms of processes and products. Furthermore required skills for these teams as well as their sizing are determined. With the distribution of new documents (organizational charts, guidelines, responsibilities etc.) and conducting trainings, the structural changes will be communicated to all involved parties which forms the last high level step of the structural adaptation.

Business Impact

According to **Synpulse'** experience there are three monetary impacts that can be measured after introducing a new health claims system with respective changes in the procedural and structural dimensions. According to our experience the GWP can be increased by 3-5% due to higher customer satisfaction which leads to potentially more renewals. Because of better capabilities in predictive analysis and the integration of intellectual property a decrease in the loss ratio of approximately 2-3% can be expected. The cost decrease based on our experience is between 15% and 20%. Project costs can be distributed 40% to the internal business team, 25% to the internal IT team and 35% to the external software vendor. All these figures depend on the current system of the insurance company. If the IT architecture is characterized by legacy systems the impact will be more significant.

Conclusion

In Asia there are many opportunities related to the health claims business of insurance companies. The promising demographic and economic developments and the rise in individual awareness of a healthy life will increase the overall demand for health insurance. With the right alignment of measures in processes and organizational structures insurers can facilitate renewal rates and at the same time save costs with respect to operations and leakage. This will lead to a sustainable competitive advantage in the coming years when overall competition is expected to increase and issues like social media, big data and telematics are becoming even more important than they are already today.



Contact us

Synpulse is happy to discuss with you the opportunities in health claims and possible ways to realize them. Please contact our topic experts Marco Kamerling (marco.kamerling@synpulse.com) or Mirko Heinbuch (mirko.heinbuch@synpulse.com).