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Insurance

Modernizing Claims Processing and Adjudication

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Modernizing Claims Processing and Adjudication

When it comes to claims management, few areas of the healthcare lifecycle deliver greater opportunity and risk. It's the playing field where relationships are sealed or severed, and business performance is strengthened or forfeited.

Health insurers know the stakes and understand that claims management and adjudication is ripe for innovation. Let's survey the playing field and map a game plan for happier customers and stronger business performance.

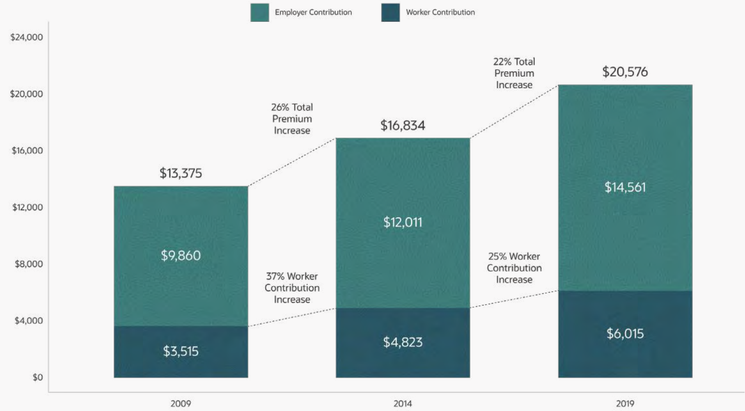
Claims as Key to Customer Experience

In 2019, health insurance companies ranked near the bottom of the American Customer Satisfaction Index, on par with airlines and just below wireless telephone service providers. Numerous factors contribute to this standing, and claims is an important player. In looking at specific customer satisfaction benchmarks for health insurance providers, satisfaction with timeliness of claims payment is at the bottom of the list, followed only by call center experience satisfaction.

In Australia, customer satisfaction of private insurance fluctuates—with a rating of 72.2% in August 2019 after reaching its lowest rating of 70.5% in June 2018. As a result, Australian enrollment in private health insurance is declining. According to the latest Australian Prudential Regulation Authority (APRA) figures, private hospital treatment memberships fell by 30,174 in June 2020—a decline from 44.3% of population in June 2019 to 43.6% in June 2020.

At the same time, plan sponsors and consumers are paying more than ever for premiums and out-of-pocket costs. In the U.S., The Kaiser Family Foundation's 2019 Employer Health Benefits Survey found that average annual family premiums for employer-sponsored health insurance rose 5% in the past year to $20,576. Consider, too, that the average premium for family coverage has increased 22% over the last five years and 54% over the last ten years, significantly more than either workers' wages or inflation. Employees are paying more as well. The average dollar contribution for family coverage has increased 25% since 2014 and 71% since 2009.

Figure 1
Average Annual Worker and Employer Premium Contributions and Total Premiums for Family Coverage, 2009, 2014 and 2019



SOURCE: KFF Employer Health Benefits Survey, 2019; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009 and 2014

Plan members and sponsors want more for their dollar, including a better claims experience.

High Cost of Claims Processing—For Health Insurers and Providers

Claims processing is an expensive proposition for both health insurers and participating providers. Let's consider the impact:

> The medical industry in the U.S. spends $4.5 billion annually on claim submissions, representing 13% of the total medical industry spend on administrative transactions.

> Australia reported a deterioration of insurance performance in June 2020 as a result of lower premium revenue, higher claims, and higher management expenses. Management expenses alone increased by 15.8% to $650 million in June 2020.

> The medical industry—providers and health plans—could save an additional $454 million annually by transitioning to fully electronic transactions—$355 million for providers and $99 million for plans.

Figure 2
Claim Submission: How Much is Being Spent and How Much More Can Be Saved With Full Adoption? 2019 CAQH Index (in millions)

> Claim status inquiry was the second most expensive transaction to conduct manually ($10.13) and electronically ($2.41) for the medical industry. The medical industry could save over 42% of the existing spend on claim status inquiries, or $2.2 billion, by moving manual and partially electronic web portal inquiries to fully electronic transactions. The savings potential associated with claim status inquiry is the second highest savings opportunity for the medical industry behind eligibility and benefit verification.

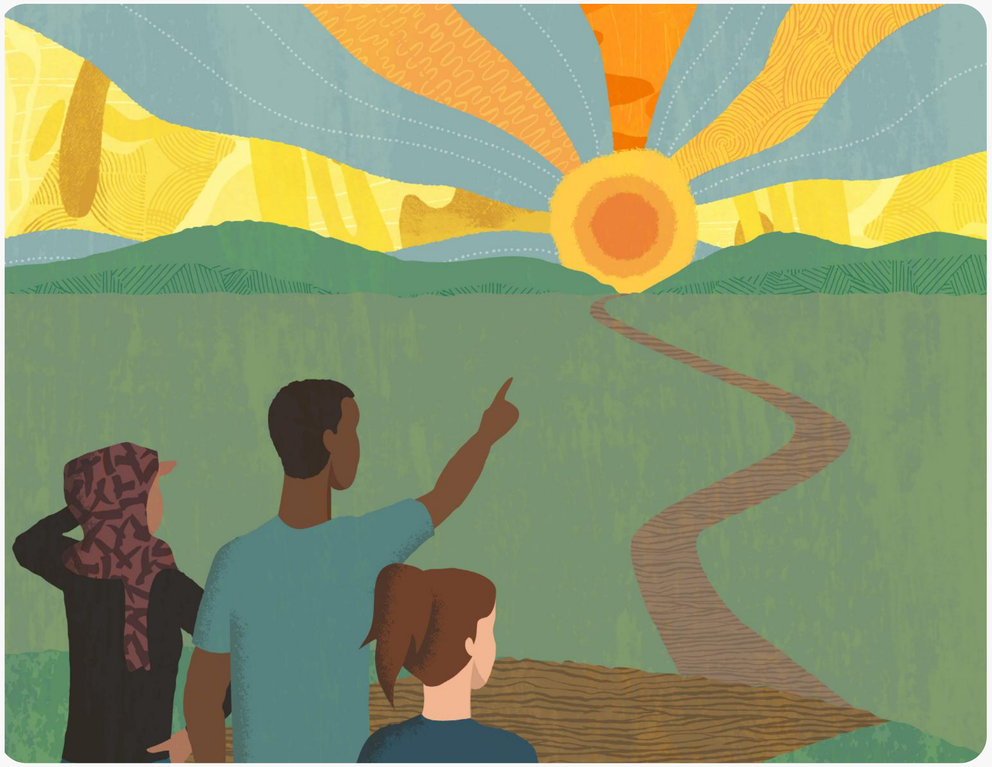
Strong Foundation for Emerging Markets

Private health insurance is expanding in markets around the global. Public health systems in Hungary, Poland, and Romania are underfunded—driving consumers to private insurance. Romania's private healthcare industry grew to $2.6 billion in 2018, up 13.8% from 2017.

Africa is experiencing a similar trend. In Kenya, for example, health spending from private sources tripled between 2010 and 2014, and predictions indicate that spending on private health insurance in Nigeria will grow to $530 million in 2021, up from $400 million in 2016.

In South America, Brazil's overall private health insurance membership has grown to $47 million. While privately insured individuals represent just under one quarter of the country's population, there is tremendous market potential for expansion of private health insurance offerings.

As firms establish a presence in emerging markets, they are looking to build a solid foundation for growth—and that requires a modern claims infrastructure from the start.



Time to Go Digital

The increased cost and complexity of claims processing and adjudication presents both an urgent challenge and unique opportunity for health insurers. In many countries, insightful claims analytics remains a challenge. With restrictions on data available from insurers and the lack of consistency in diagnosis coding, the burden falls on the policy holder to access better claims data. Digitizing claims processing and adjudication can streamline operations, increase accuracy, and boost efficiency—and ultimately provide a better customer experience.

Even moving to a partial digital model can help transform claims management. Payers can save as much as 10-20% of medical costs by turning to a digital solution and reduce operating expenses for claims processing by up to 30%.

Establishing A Game Plan

In order to win with customers while reducing operational costs, health insurers must simplify, modernize, and digitize core systems. This means pursuing flexible and adaptable solutions and all-in-one platforms that streamline claims management—and in turn, provide a better customer experience. Cloud plays an increasingly important role. Cloud-based solutions offer scalability and the capability to adjust to rapid demands, enabling faster deployments, greater employee productivity, and improved stakeholder collaboration—all priorities in the modern insurance enterprise. Additionally, the economic benefits of cloud computing are significant and allow for cost flexibility and optimization.

When selecting technology to support a claims modernization initiative, health insurers should focus on four critical capabilities:

Establishing A Game Plan

Flexible Product Definitions

Insurers should look for a solution that offers tiered categorization of health services and separates benefit specification from the cost-sharing model—driving maximum configuration reusability. In addition, it is important to have the flexibility to define benefits in a wide range of code sets and store parameter definitions separate from parameter values to simplify changes during renewals.

Agile Claims Pricing

Today's health insurers need to support a wide range of pricing methods, so they require extensive business rule-types for pricing calculations. Insurers should seek a solution that offers template-driven setup of provider contracts and pricing clauses, automates support for pricing claims, and enables provider payment amount per claim line, per admission, and per diagnosis. A solution should also calculate retrospective or prospective bundled payments across multiple claims and multiple procedure reductions within a single claim and across multiple claims.

Establishing A Game Plan

Real-time Claims Adjudication

This capability is a high priority for insurers and one that can offer considerable savings while elevating service. It starts with the ability to automate bundling of claims into a single episode of care. Insurers should seek a solution that offers pre-configured process flow and the ability to achieve high auto-adjudication rates through flexible benefit selection, iterative authorization matching, duplicate claim recognition, automated filing limit detection, and external callouts. In addition, insurers require configurable claims messages, the ability for mass reprocessing, and integration of benefit accumulation and external providers. To ensure control, insurers also require the ability to place global financial holds on payment transaction.

Automated Authorization

This capability goes hand-in-hand with real-time adjudication. Health insurers seek full authorization and referral management capabilities that enable authorization from multiple case and clinical management systems and support unlimited service lines per authorization. While insurers seek automation, they also need the flexibility to grant key one-off authorizations directly into the system. In addition, a claims modernization solution should offer the ability to capture extended data and attachments with the authorization request and enable fully configurable pre-authorization matching rules.

Winning in a New Era

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Liberty Health saw its business changing as customers seek greater transparency, personalization, and convenience. However, the company's legacy infrastructure wasn't equipped to propel it into the future of digital information and healthcare.

Liberty Health selected Oracle Health Insurance as the vehicle for its transformation journey. The organization is focusing first on automation and improving process efficiency as a foundation for a better member experience.

Business processes that used to take two to three days now take just seconds.

The cloud is an important priority for Liberty Health. It's focusing on standardizing and optimizing as much as possible using Oracle, and then moving processes to the cloud-based Oracle Health Insurance platform to ensure a future-proof environment.

> "The community that comes with Oracle Health Insurance was key for us. The solution not only offers seeded capabilities, but also numerous supporting and development frameworks that help us further expand our innovation efforts."

Christo Groenewald,
Divisional Director for Health Business Enablement,
Liberty Health

Modernizing the claims management and adjudication process through automation and real-time operations does more than boost efficiency—it improves member satisfaction, the lifeblood of any health insurer. Members are seeking digital-forward, transparent processes; insurers seek greater operational efficiency. A flexible, adaptable solutions can deliver a winning experience for both teams.

Learn more

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