3 Things Your Claims Process Should Do... And How to Get There

A SourceHOV White Paper

SourceHOV

PEOPLE | KNOWLEDGE | INNOVATION

It's a truism: "If you are in the insurance business, you are in the claims processing business." The promise to pay on a customer's claim of damage is what property and casualty companies fundamentally sell. After the policies are written and the premiums are collected, everything else revolves around processing claims—as cleanly and efficiently as possible.

Efficient claims processing is what drives industry innovation at every stage. It's what started the document imaging business. It's the basis for every P&C customer web-portal. It's what separates the best rated insurance companies from the worst, and why you need to continually look ahead at best practices in claims processing, to cut cost, improve service and stay competitively relevant.

According to a recent survey of insurance company claims professionals, executives, managers and adjusters, more than 80 percent of respondents said that improving customer interactions was their top priority in rethinking their claims handling process for 2014. More than 60 percent said improving cycle times was a top claims initiative.[1]

Better customer interaction. More efficient claims handling. Achieve these in your claims process, and you will create a significant competitive advantage for your organization, driving important metrics such as improved customer retention and reduced cost per claim.

The Devil is in The Details

Of course, reaching these ideals is far more complex than meets the eye. The modern claims process is extremely complex, given the multi-channel interactions most insurance companies employ with their customers, adjusters and staff. In addition to incoming mail (a practice that is slowly but surely being replaced by electronic filing), claims can be taken over the phone, via online chat, email, fax, even via text, and often with a photo of the damages attached.

Once a first notice of loss (FNOL) is in, the information must then be input, which may involve any combination of indexing, scanning, photo import or text extraction leading to an electronic file.

As the data tracks through the system to a determination of payment, more people and more reports weigh in.

A Case in Point

Consider a common automobile accident, as a case in point. In addition to property damage, which may involve legal liabilities, repair shops and other third party vendors, bodily injuries, which are far more complex than property damage, will likely be involved. A simple medical coding error or duplicate billing can send an adjuster down a rabbit hole which, if not pursued, can translate into overpayments that burst a policyholder's limits prematurely, or trip an insurance company into an area of bad faith. Throw in a few code reviews, nurse reviews, utilization reviews and a friendly dispute resolution for good measure, and without an intelligent, rules-based process in place to automate as much of the due diligence as possible, worker productivity, profits and net customer satisfaction can quickly evaporate.

What to do With The Data

All this is without to say that, as these claims reach a decision point, the data collected must be tracked and stored within the system. Audits happen. And, either way, smart P&C executives will want to analyze the information to identify patterns that uncover opportunities and support business stability and growth over time.

According to a recent report produced by Aite Group, an independent research and advisory firm, the U.S. P&C industry stands to recover as much as $36 billion in claims loss overhead given a less labor-intensive, paper-based approach to claims processing.[2] As Aite Group senior analyst, Stephen Applebaum, put it, smaller carriers will compete

[1]"Trillium Software's 2013 Claims Survey," by Tim Kosinski, Director of Product Management, A Harte Hanks Company, ©2014.

[2]"U.S. P&C Industry has $36B Opportunity to Reduce Claims Loss Costs," by Chris McMahon, INN Breaking News, June 26, 2013.

more effectively "by reducing claims leakage, cost per claim and cycle time and by increasing cost-effective customer service, underwriting accuracy and profitability."

Stand Pat, Entrench or…What?

So what are the options? Clearly, standing pat is a sure-fire way to be competitively overrun. As technology advances in the way of big data analytics, rapidly evolving infrastructure requirements, and new mobile and social media plays (yes, the consumer is watching and reporting your performance whether you are paying attention or not), paper-based and legacy systems simply won't hold water.

The capital outlay of keeping up technologically, on the other hand, is not much more appealing. Even if you do ante up to the challenge, you will have to find savvy professionals, or train folks in-house, to develop and maintain the necessary systems. At the pace technology changes today, by the time you identify a provider, scope out a viable solution and integrate it as part of your business culture, there is a good chance your investment will be completely obsolete by the time it reaches functionality. Unless you have a very unique business model and/or the financial wherewithal to tote the note, you may not want to get into the separate business of being your own state-of-the-art claims processor.

Yet, that is the very ledge many P&C companies teeter on given today's insurance enterprise landscape.

What started as hiring a few back-office people to open mail and lick stamps, soon evolved into a dedicated document management operation with full-time staff doing nothing but claims processing. The faster technology improved, the more IT staff became a staple on the company org chart, and before long, the fear of letting anyone but a home-grown outfit manage the workflow set in.

A Change in Thinking

The question is, how do you now gracefully get off that treadmill to become the lean, mean organization every P&C company wants to be, expanding margins, delighting customers and whipping up on the competition?

SourceHOV has been helping P&C companies overcome the burden of processing claims for more than 25 years. Our secret is simple. We do what we do best. You do what you do best.

We provide transaction processing solutions, strategic consulting and data analytics services to insurance companies. You provide coverage to customers seeking indemnity from damages.

SourceHOV Meets You Halfway

The fact is you can benefit from our services wherever you are in the continuum. Our technology platform addresses the entire transaction processing lifecycle, from initial data capture, to claims management, through final service delivery in any medium. What's more, we can supplement your team, or replace it entirely, with full outsourcing or co-sourcing services tailored to the specific needs of your specialized industry and seasonal demands.

To minimize business disruption, our engagement framework is transformational. That is, we meet you where you are and tailor a solution designed to improve your performance measures as quickly as possible, where you need it most.

Loss adjustment expense, average time to settle, fraud reduction, customer satisfaction ratings. Our consultants work with you to gradually and seamlessly pivot your inward-facing claims operation to achieve a more customer-centric model. One that builds customer loyalty and retention. One that separates you as a best-in-class service provider.

Get Results With SourcHOV

With more than 600,000 claims received daily, our claims processing service literally incorporates millions of practical business rules, perfected to address claim types from the most basic to the super complex. Some of the results our clients have experienced using SourceHOV claims processing services include:

- Greater than 99% same day turnaround and accuracy
- Claims status views in less than 24-hours in most cases
- An average of 70%+ auto-adjudication rates for paper claims
- Claims payment cycles reduced to 24 hours from 48
- Up to 50% reduction in claims payment cycle time
- Claims payments made in less than 10 business days on average
- 10% average improvement in claims paid on first submission
- A 98% claims resolution rate
- Up to 60% reduction in member-not-found (MNF) cases
- Real-time reporting

Big Time Analytics

In addition, our Alpha Analytics practice supports our P&C clients with the proprietary capabilities they need to extract game-changing, real-time business intelligence from today's foaming, big data mash-up. In practice, these predictive analytics have helped our clients identify high risk claims, focus resources on deterrence, support special investigative efforts and leverage unique policyholder information during specific customer interactions, to name a few.

The idea is simple: migrate from hands-on claims processing to hands-on customer experience management. Finding a partner with the technology, track record and team to achieve that end is the key. SourceHOV provides the solution.

About SourceHOV

SourceHOV is a global provider of transaction processing solutions, strategic consulting and data analytics services to a wide variety of industries including healthcare, financial services, legal, government, publishing, manufacturing, retail and other commercial entities—including more than half of the Fortune 100.

Through our consultative approach, clients achieve high-value business outcomes and experience improved processes, streamlined workflows, reduced cycle times, increased cost efficiencies and enhanced financial performance.

SourceHOV

PEOPLE | KNOWLEDGE | INNOVATION

sourcehov.com | 866.321.5854