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The buck stops with claims

The prognosis for US healthcare payers

IBM Institute for Business Value

A dose of consumer care

In this unprecedented era of ever-advancing technologies and ever more empowered consumers, the wider world of customer service is having an inevitable influence on healthcare. US consumers expect the same type of simple, personalized experiences they have grown accustomed to in their daily lives, from ordering home goods online for swift delivery, to easy web retail returns and instant refunds. When it comes to healthcare claims processing, the prognosis is good for those insurers willing to embrace transformation by removing legacy barriers that shield inefficiencies and compromise the consumer experience. It could be terminal, however, for those resisting change.

Under the microscope

Claims are seldom a differentiator for choosing healthcare coverage, but they are an integral part of consumers' experience and therefore have significant influence over satisfaction with a healthcare payer.

Facilitating fast and accurate claims transactions is little more than a baseline expectation of the healthcare purchaser, whether it's the employer group or the consumer, with no reward to payers for simply getting it right.

An IBM Institute for Business Value benchmarking study of 102 US healthcare payers looked at claims handling through the lens of metrics describing cost, speed and efficiency to help payers see where and why to improve claims handling.¹ Those metrics, coupled with insights from how data, analytics and counter-fraud capabilities underpin claims handling, highlight three areas of improvement that are transferrable to health insurance models all over the world:

- *Payers recognize that consumers expect a more satisfying claims experience.* Typically, only 24 percent of consumers are satisfied with their claims experience.²
- *Payers using more sophisticated analytics have less manual involvement in claims.* Thirty-two percent of payers use advanced data analytics in claims processing and therefore typically have a third less manual effort than others.³
- *Potential for smarter, or intelligence-led, pathways for legitimate claims remains untouched.* Seventy-four percent of payers use artificial intelligence (AI) to predict claims risks or detect fraudulent claims, but improvement in claims outcomes is lackluster.⁴

Data deluge⁵

Exponential growth of data – including that gathered in the claims process - is driving the need for AI technologies in healthcare. Medical data is expected to double every 73 days by 2020. And, each person will generate enough health data in their lifetime to fill 300 million books.

Figure 1

Consumer satisfaction with claims handling experience

Respondents grouped by consumer satisfaction

Top quartile



Other payers

Respondents grouped by profit model

Top quartile



Median

Top quartile



Median

A consumer-facing process

Consumers' satisfaction with health insurance payers has steadily declined.⁶ High premiums, deductibles and copays, and slow claims processing continue to breed annoyance toward health insurance companies.

As claims handling is an intensive consumer-facing process, it provides an opportunity to positively influence satisfaction. Yet the burdens of legacy infrastructure are known to adversely affect satisfaction during claims.

Consumers' satisfaction with claims handling is surprisingly low. The top quartile of our study respondents set a low bar by achieving 35 percent satisfaction with the claims experience they deliver.⁷ For-profit payers were able to deliver better consumer satisfaction (see Figure 1).

For-profit payers set an example for not-for-profit payers to follow. Comparing top quartiles of for-profit versus not-for-profit groups, the for-profit payers attain consumer satisfaction of 53+ percent compared with 36+ percent for leading not-for-profit payers. For-profit payers are better equipped to engage and serve consumers throughout a claim, with 81 percent using digital features, such as text alerts, targeted marketing, real-time claims status and virtual agents, compared with 48 percent of not-for-profit payers.⁸

Our analysis reveals that a seamless process between payer, provider and consumer throughout a claim is necessary to improve patient satisfaction and efficiency. If anything breaks in the chain, the claim will sit in pending status and not move forward, creating headaches all around. Payers must move forward from this fractured, transaction-focused model to create a value chain that can lead to more positive consumer experiences.

More points of value

From narrowing possibilities in diagnosis and pathology, to lowering drug development costs and providing mathematical analysis of troves of data for insurers, one of the greatest sector gains from AI is likely to be in healthcare.⁹ Data insights help providers deliver more efficient care, better engage patients and optimize business performance. Data insights can also help payers differentiate themselves from their competitors through how they handle claims. Our study shows that during claims handling, nearly a third of payers perform advanced data

analysis, such as predictive modeling and data-driven scenario testing, to proactively estimate or reduce risk (see Figure 2).

When armed with data-driven analytics to aid decision-making, the amount of manual involvement required for claims processing lessens (see Figure 3). Collapsing, then re-creating the claims value chain by redesigning processes has the potential to shift a third of manual involvement away from low-value activities such as claims handling, and into higher-value areas such as consumer care.

Figure 2
Use of data analytics in claims processing

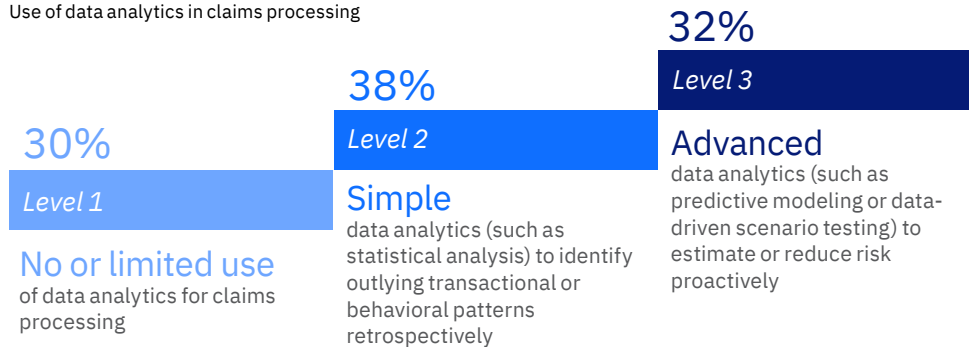
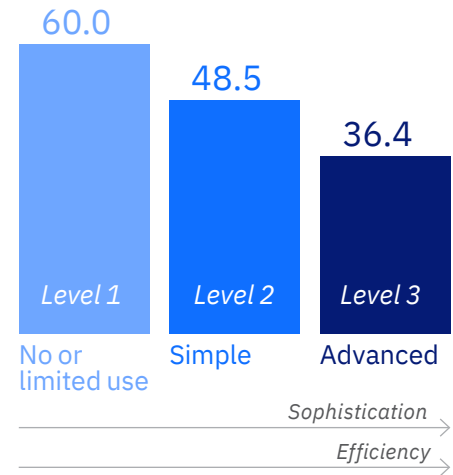


Figure 3
Full-time equivalents (FTEs) manually handling claims per billion dollars of claims



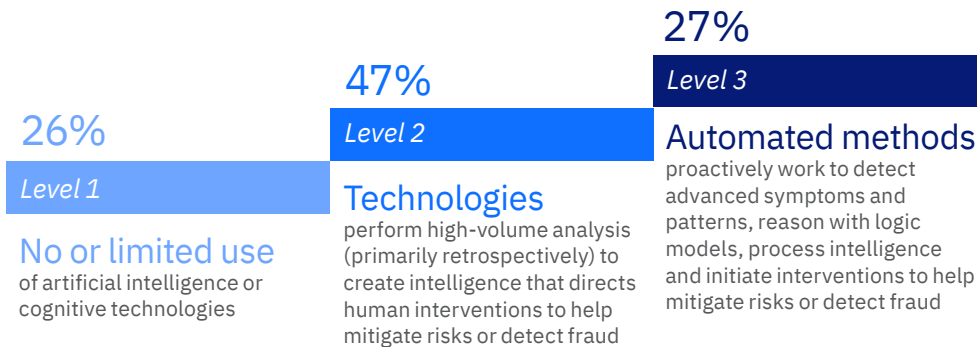
Smarter pathways

Nearly three-quarters of payers are using AI or cognitive capabilities such as machine learning, natural language processing, speech recognition, robotics, computer vision and rules-based systems to predict claims risks or detect fraudulent claims. Even so, they have only scratched the surface of potential benefits (see Figure 4).

Payers making use of AI at Level 2 or 3 only realize benefits of denying 2 percent fewer claims, settling 2 percent more claims and closing 1 percent more claims than others.¹⁰ Applying intelligence to remove friction in the claims process can go a long way to improving the claims experience. Payers can benefit by processing claims faster despite business implications like claims cost and fraud.

By continuously refining data and rules to power fewer, yet more targeted, interventions, AI can pave the way for legitimate claims and better overall claims outcomes, including consumer satisfaction. For example, better-managed rules may reduce excessive false-positives of fraudulent claims before payment. This can eliminate the need for post-payment analysis and investigation. Furthermore, intelligence brings insight from the past that can help build consumer intimacy and a better experience by avoiding unnecessary impediments to claims handling.

Figure 4
Use of artificial intelligence to predict claims risks or detect fraudulent claims



Future cure

Healthcare payers worldwide can benefit from these insights drawn from US healthcare payers to assess the state of their own claims processing functions. In terms of consumer expectations and current state satisfaction, payers should consider how they use data for and from claims to assist claims decision-making, and how much “smarter” their claims interventions could become by applying intelligence.

These opportunities encourage reducing the common frictions that cause claims inefficiencies and make meeting consumer expectations overwhelmingly challenging. To gauge if your organization is ready to act on these opportunities to improve, ask yourself:

- How could your organization engage with consumers’ needs and preferences to improve your claims process and ultimately their claims experience?

- What under-utilized data exists in your organization that could be better used to make faster decisions and close claims more quickly?
- How effectively are you coupling your data with advancing technologies capable of continuously refining your pathway for legitimate claims?

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Notes and sources

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