Project scenario

# Health insurance claims handling at InsureIT

Fundamentals of Business Process Management

## Health insurance claims handling at InsureIT

The InsureIT claims handling process starts when a customer lodges a claim. The customer is required to fill in a form plus a 2-page questionnaire describing their current health condition. The customer can submit the form physically at one of the branches of InsureIT, by postal mail, fax or simply via email.

When a claim is received, a junior claims handler enters the claim details into the insurance information system. Data entry usually takes 10 minutes. The same junior claims handler performs a basic check to ensure that the customer's insurance policy is valid and that the type of claim is covered by the insurance policy. This check takes about five minutes. It is rare for the claim to be rejected at this stage (it only happens in 2% of cases). In case of rejection, an automated notification is sent to the customer explaining the reason for rejection.

Next, the claim is moved to a senior claims handler who first examines the claim to determine if it involves a short-term or a long-term benefit entitlement. A short-term benefit entitlement means that the reported health condition is likely to last for less than three months. Otherwise, it is classified as a long-term claim. It takes about five minutes for the senior claims handler to classify the claim.

*"...in the case of long-term claims (more than three months), the senior claims handler requires a full medical report..."*

In the case of a short-term health benefit entitlement, the senior claims handler can perform the claim assessment without requiring further documentation. This claim assessment takes 20 minutes on average. Once a decision is made, the senior claims handler informs the customer of the outcome via email or postal mail. This latter notification step takes 10 minutes on average.

However, in the case of long-term claims (more than three months), the senior claims handler requires a full medical report before assessing the monthly benefit entitlement. Senior claims handlers perceive that these medical reports are essential in order to assess the claims accurately and to avoid fraud. Once the senior claims handler has received the medical report, they can assess the benefits in about one hour on average. The senior claims handler then sends a response letter to the customer (by email and post) to notify the customer of their monthly entitlement and the conditions of this entitlement, e.g. when the monthly benefit entitlement will be stopped or when the renewal would fall due.

Later, a finance officer triggers the first entitlement payment manually and schedules the monthly entitlement for subsequent months. The finance officer takes, on average, 10 minutes to handle an entitlement. Ninety-five percent of claims (both short and long term) that undergo an assessment by a senior claims handler lead to a payment.

When a medical report is required, a junior claims handler contacts the customer (by phone or email) to notify them that their claim is being assessed, and to ask the customer to send a signed form authorising InsureIT to request medical reports from their health provider (hospital or clinic). Health providers will not issue a medical report to an insurance company unless the customer has signed such an authorisation. A junior claims handler spends, on average, 10 minutes to make the authorisation request to the customer.

Customers are required to provide the authorisation form no more than 14 days after being requested to do so. If the authorisation is not received within this timeframe, the claim is deemed to have been withdrawn. In general, it takes about four days to get the authorisation from the customer.

Once the authorisation has been received, the junior claims handler sends (by post) a request for medical reports to the health provider together with the insurer's letter of authorisation. This latter step takes 10 minutes on average. Hospitals reply to InsureIT either by post or in some cases via email. On average, it takes 14 working days for InsureIT to obtain the medical reports from the health provider (including four working days required for the back-and-forth postal mail). This average, however, hides a lot of variance. Some health providers are very cooperative and respond within a couple of working days of receiving the request. Others can take up to 30 working days to respond.

As a result, the average time between a claim being lodged and a decision being made is three working days in the case of short-term claims, and 22 working days for long-term claims.

Naturally, long waiting times cause anxiety to customers. In the case of long-term claims, a customer would, on average, call or send an email enquiry twice while the claim is being processed. These enquiries are answered by the junior claims handler and it takes him/her about 10 minutes per enquiry. In about a third of cases, junior claims handlers end up contacting the health provider to enquire about the estimated date to obtain a medical report. Each of these enquiries to health providers takes 10 minutes for a junior claims handler.

The total benefit paid by the insurance company for a short-term health claims is EUR €5,000 (typically spread across two or three months).

For long-term health claims, this amount is €20,000, but some claims can cost up to €40,000 to the insurance company.

- The insurance company receives 2000 claims per year, out of which 20% are for short-term claims and 80% for long-term claims.
- The company employs two full-time junior claims handler and two full-time senior claims handler dedicated to health insurance.
- The sales department estimates that the extreme delays in handling claims costs EUR €50,000 per year in lost sales of insurance policies due to unsatisfied customers and the resulting negative publicity.

 

In case of a long-term health condition, the duration of the benefit (number of months) cannot be determined in advance when the claim is lodged. In these cases, the benefit is granted for a period of three months and a senior claims handler reviews the case every three months to determine if the benefit should be extended. Half of the benefit renewals are done after a simple check, which takes 30 minutes for the senior claims handler.

However in the other half of renewals, the senior claims handler requires a new medical report, which means that the whole process of obtaining a medical report has to be repeated (except that the letter of authorisation signed by the customer during the initial assessment can be reused). It often happens that the renewal takes too long and customers stop receiving their monthly benefit temporarily during the renewal process.

Given the persistent problems with obtaining health reports in a timely manner, claims handlers have tried to negotiate with several health providers to establish a faster approach to obtaining medical reports. A handful of health providers (the more cooperative ones) are willing to accept medical report requests by email to save 2–3 working days.

However, the majority of health providers do not see any incentive to put more resources into issuing medical reports for insurance companies. They perceive that their customers are the patients. The process of issuing medical reports to insurers is secondary for them.

## Image sources


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