TEACHING CASE – PART 2 BUSINESS PROCESS ANALYSIS AND SOLUTIONING

Banking and Insurance Domain

BPAS Team

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1. STUDENT ACTIVITY

1.1 Objective

To understand the approach for the static analysis and need for domain and industry background to design the recommendations for the given process. Apply the concepts of RCI and RCR model in the given MIPS as-is process.

1.2 Team

This exercise is to be completed in project teams.

Team Number: ***T_***	***Team Members (Present in class)*** ***1.*** ***2.*** ***3.*** ***4.*** ***5.*** ***6.***

1.3 Submission

In class submission.

1.4 Timeline

Approximate time to complete the task	1 hrs
Start time	Week 4
End time	Week 4

1.5 Task

Read the case and get familiar with the

1. As-Is Process Issues
2. Market analysis
3. Recommendations for new process
4. Align root causes to the recommendations provided:

Note: Some recommendations may not be from the root cause perspective but from the domain and industry expertise as well. Some recommendations can tackle more than one root cause.

Fill the Root Cause column with the possible root causes or best practices based on the suggested recommendation.

No	Recommendation	Root Cause/Best Practices
1.	Introduction of a **new online portal- Claims management portal** to streamline the insurance claim process. This replaces the current claims entry system.	
2.	**Collaboration with medical institutions** to streamline the insurance claim process.	
3.	**Implementation of business rules** in PAS to automate the validation of claims	
4.	Checking of insurance validity and coverage type to be done **before** sending for approval.	
5.	Checking of fraudulent cases to be done **before** recommending settlement amounts.	
6.	CMPortal send **notifications** (SMS & email) to inform claimants of claim status where further details can be found on a website (CMPortal).	
7.	Make use of **data analytics to identify fraud**. Develop analytics engine in the CAJ system.	
8.	HQCOs to undergo **training** to help with the checking of fraudulent claims.	
9.	Implement **self-service kiosks** at the branch for claimants to enter claim details, auto validations and scan supporting documents which will be recorded electronically.	
10.	Implement **claim management mobile app** for claimants to enter claim details and scan supporting documents which will be recorded electronically.	
11.	Claim payments can be done via **direct bank transfer**.	

2. AS-IS PROCESS ANALYSIS - STATIC

2.1 As-Is process static analysis - Issues

In this section, we provide a brief summary of the issues in the current process. Table 1 describes the root causes and the descriptions of the issues in the process.

Root Cause	Example Activities and issues
Paper Based Process	1. BCSO, BPO and HQCO often cannot comprehend the illegible writing on the hardcopy claim request form. 2. Customer experiences difficulty with completing form accurately. 3. Courier delivery and office dispatch process adds a lot of time to the entire claim process 4. Policy guidebooks are hardcopy and tend to be outdated. HQ Claim Officer have to keep their own notes on the latest changes and wastes time in validations. 5. BPO has to manually issue the cheques and claimants have to personally collect the cheque which is time consuming and tedious process.
Lack of checklist for document checks	1. When BCSO informs claimant about the rejection of claims due to insufficient documents, it results in an unhappy conversation which takes up additional time. 2. HQCO spends additional time to re-check documents to see if they are incomplete.
Inadequate training of the employees	1. HQCM is the only employee to detect the fraud cases which is a complex and time consuming task. 2. BSCO proceeds with the invalid claims submission to the HQCM.
Lack of automation for validations	1. Manual checking by HQCO of claimants insurance validity and coverage type on PAS against the submitted claims documents takes a long time 2. BCSO takes a long time to validate the claim supporting documents. 3. HQ Claim Officer have to keep their own notes on the latest changes in the policy validations. 4. Validating the claims forms takes a longer time by HQCO. 5. Fraud detection is complex and time consuming task.
Lack of system integration	1. Courier delivery and office dispatch process adds a lot of time to the entire claim process 2. Customers are not getting status updates after three working days resulting in many customer complaints. 3. Many corrections are made to create a claim case in CAJ that uses up a lot of time 4. Manual data entry of claimant information and cheque details into CAS/CES is time consuming
Late validation checks	1. Fraud cases are detected relatively late into the process which incur resource wastage costs and can only be done by the HQCM.

Multiple roles with redundant tasks	1. The document validations are re-checked by HQCO, and missing or incorrect document cases are rejected by the HQCO staff. The results in wastage of cost and time on the rejection cases.
Lack of automation for notifications	1. BCSO informs claimant about rejection of claims due to insufficient documents or due to policy lapse resulting in customer complaints and time wastage. 2. BPE call to customer to customer to comedown to the branch which is a manual process.

Table 1: As is process static analysis summary

We have studied the manual tasks involved in the as-is process and aim to improve these activities either totally automating them or introducing technology to the activities to reduce the activity time and cost. The following manual activities in AS-IS process;

1. BCSO passes claim form for claimant to fill
2. BCSO creates claim request in CES, enter claimant's information and receive supporting documents
3. BCSO inform claimant to resubmit the claim with required documents
4. BCSO photocopy supporting documents
5. BCSO call to inform claimant of rejection and reason due to disapproval from HQ
6. BCSO call to inform claimant to collect payment cheque at bank branch
7. ODU deliver approved hardcopy claims to payment officer
8. HQCO check for claimant's insurance validity and coverage type using PAS
9. All tasks involving the tidying of hardcopy claims
10. All delivery tasks involving the courier

2.2 Market Behaviours Study for Recommendation Model

To design the solution effectively, it is of paramount importance to understand the surrounding circumstances of the targeted audience and more importantly, their expected market behaviorism. The following are the findings.

1. The Philippines is renowned for being the text capital of the world, experiencing an estimated 400 million Short Messaging Services (SMS) messages per day as of 2014. Also, the cost of one SMS is an estimated 1 Peso (S$0.03). With an average salary of 43,306 pesos, SMSs are considered extremely cheap for both consumers and businesses (Salary Explorer, 2014).

2. Mobile penetration in the Philippines has also reached an impressive 105%. (Budde.com.au, 2014)

3. In addition to the Filipinos being familiar with SMS and mobile phones, they are also not new to the idea of mobile banking even in the rural areas (On mobile banking services in the Philippines: YouTube, 2014; Chemonics International Inc, 2014). Today, as a relevant and salient example, farmers welcome mobile banking as essential conveniences as they do not have to travel long distances to ATMs which may be out of operation or closed (On mobile banking services in the Philippines: YouTube, 2014; Chemonics International Inc, 2014).

4. Filipinos are known to be both outgoing and outspoken and through these, actively indulge in a form of photo taking, also known as "selfies" (The Guardian, 2014). Today, an estimated 90% of Filipinos are engaged in some form of social media. (The Guardian, 2014)

5. The Internet Penetration of Philippines is an estimated 39%, with over 40 million users benchmarked against a total population of 100 million users (Internetlivestats.com, 2014).

6. Health Level 7 is a widely adopted set of international standards for transfer of clinical and administrative information. In the Philippines, both major government and private hospitals have adopted HL7 through software systems such as Medcurial, HarmoniMD and HarmoniHIS. With regards to security concerns – one of the most prominent issues of the 21st century – the above software such as Medcurial, HarmoniMD and HarmoniHIS all complies to Health Insurance Portability and Accountability Act (HIPAA). HIPAA is a well-adopted and established standards for ensuring Protected Health Information (PHI) is securely protected.

7. The banking industry and system in the Philippines is well developed and interbank transfer between two parties is possible for a fee of 25 Pesos (S$0.75) (Bancnetonline.com, 2014).

8. The micro insurance industry is designed and known to be written with simple terms (Micro insurance Philippines, 2014; Access to Insurance Recommendation, 2014). The micro insurance claims process is also known to be a lot faster, taking only up to 10 days as compared to the traditional claims process which takes up to 60 days (Access to Insurance Recommendation, 2014).

9. In the event of claims that involve death, the claimant is required to provide a death certificate as proof of death (National Statistics Office, 2010). This document is issued by the National Statistics Office which includes details such as the personal details of the deceased, place of death, date of death and cause of death (National Statistics Office, 2010).

2.3 Considerations for the Recommendation Model

Based on the market behaviours, the following list of aspects are considered in designing the to-be process.

1. Filipinos are highly receptive to SMS. Couple this with both the fact that the mobile penetration rate in the Philippines are high and cost of each SMS is low, most Filipinos will have no problem being introduced to interactive Information Technology services encompassing SMS.

2. The familiarity of mobile banking, even with the farmers in the rural area, signals an immensely ripe opportunity for our team to introduce SMS related services with little to no resistance to our user base. As a matter of fact, it is arguable that our clients could perhaps be the most welcoming amongst all our stakeholders towards the introduction of a SMS related services.

3. Owing to the hospitable and outgoing nature of the Filipinos, they have taken to social media well. This sets the foundation for our team to potentially introduce IT services revolving around the Internet and online portal for customer and employees for claims management. In addition, internet penetration is a growing trend in the Philippines and this will help support the above trend of growing adoption of online portal environments.

4. Given how major government and private hospitals have laid the foundation of adopting Health Level 7 standards, this lays the foundation for an integrated Electronic Medical Records (EMR) system. The feasibility and precedence of EMR systems are essential to establish in our assumptions as we intend to introduce IT Systems evolving around Electronic Medical Records System Integration with MOB internal systems.

5. MOB, through its micro insurance products, deals with only the following claims: health illnesses (medical claims), personal injury, death, property damage and risks such as theft or fire. Other claims and their impact or risk is not studied in this project.

6. MOB has the capacity to integrate its insurance process with its banking functions or other banking institutions. They have their own bank account that they use for internal and external finance administration. This allows claims settlement amount to be transferred directly to the claimants' bank account, instead of issuing a cheque.

7. During the sales process, MOB has already captured the mobile number of the client. The clients without the mobile phones will be treated as special cases and should indicate the mobile number of the next of the kin.

8. A Claimant's supporting documents can be obtained from hospitals, The Philippine Police Department and the National Statistics Office. This works when claimants can provide a reference number or the identity proofs and authorization forms, and MOB is able to receive the relevant documents from the respective agencies.

2.4 Recommendations for the new process

2.4.1 Recommendations 1

Introduction of a **new online portal- Claims management portal** to streamline the insurance claim process. This replaces the current claims entry system.

Rationale
As MOB relies heavily on the use of paper-based documents. The manual entering of information into systems increases the chances of human error. We recognize that the accuracy of information is critical to the overall processing time as any inaccuracy will incur unnecessary manpower and time wastage. As a result, non-value adding activities such as checking and verifying of documents are inevitable. One of the issues identified is also the lack of system integration among the MOB claims systems; CAS, CAJ, and CES. Additionally, transferring of paper-based documents to other departments is being done manually by batches and this will also lengthen the total processing time. This manual transfer of information takes a longer time as compared to using a shared system. CMPortal ensures the system integration and reduction of the paper based activities.

2.4.2 Recommendation 2

Collaboration with medical institutions to streamline the insurance claim process.

Rationale
It is inevitable that some claimants would not have the required documents for their claim. When BCSOs inform claimants that they are unable to proceed, this often ends up in an unhappy conversation which can last up to half an hour and in turn delay the processing time of other claims. The fraud detection cases also involved the forge documents and HQCO spends more time on fraud detection. Develop an electronic data exchange platform for external parties (i.e. hospitals) to share claimants’ information. In our preliminary analysis as shown in Section 2.2 and 2.3, it is possible for MOB to integrate with the external parties and acquire the documents digitally for processing the claims.

2.4.3 Recommendation 3

Implementation of business rules in PAS to automate the validation of claims

Rationale
One of the bottlenecks observed was due to the manual checking of claimant's insurance coverage type and validity. A significant amount of time is spent on checking and making decisions after accessing the validity of the claim. As HQCO follow several business rules strictly to determine the validity of the insurance claims and coverage type, we believe this task can be semi-automated by integrating the straight forward rules in the PAS system. Only the manual intervention is needed for the complex rules and decisions. This can aid in reducing the time taken by HQCO for policy validations.

2.4.4 Recommendation 4

Checking of insurance validity and coverage type to be done **before** sending for approval.

Rationale
Currently, each claim case has to go through a relatively long process before the checking of its validity. A significant amount of time and effort is wasted for claims which are found to be invalid and subsequently rejected. This results in a huge waste of resources as several cases fall into the rejection path. By moving the validation process to the beginning of the process, any claim case that is not valid will be rejected accordingly and will not continue on in the process. This shift in process will allow the company to cut down on resources such as labour and processing costs. Employees will then be able to focus on more value-adding tasks. The validations will be integrated in the newly proposed CMPortal application.

2.4.5 Recommendation 5

Checking of fraudulent cases to be done **before** recommending settlement amounts.

Rationale
In the As-Is process, the checking of fraudulent cases is done only after recommending a settlement amount. In the event of fraudulent cases, which results in the rejection of the claim, resources allocated to recommending a settlement amount would be put to waste. By putting checking of fraudulent cases before recommending settlement amount, we could avoid unnecessary tasks done on potential fraudulent cases.

2.4.6 Recommendation 6

CMPortal send **notifications** (SMS & email) to inform claimants of claim status where further details can be found on a website (CMPortal).

Rationale
For every claim request, BCSOs have to call to inform claimants about their claim request status, whether it is rejected or approved. Phone calls that update the claimants about the rejection status take a significant amount of time and cost. Notifying the claimant about the status via SMS and email will save time and effort as compared to informing them through phone calls. Claimants who prefer a more informative view of their claim status can then visit the CMPortal website for additional details and reasons of possible rejections.

2.4.7 Recommendation 7

Make use of **data analytics to identify fraud**. Develop analytics engine in the CAJ system.

Rationale
Currently, HQCMs are required to check the claims manually for possible fraud cases, which can be time consuming and sometimes inaccurate. By implementing data analytics to aid in identifying fraud, we aim to reduce the amount of manual work and also keep our company up to date with prevailing standards of fraud detection. Frauds that can be detected earlier in the process saves time and resources. Also, HQCOs detect fraud cases with more evidence based approach and hence the risk of missing fraud cases can be reduced.

2.4.8 Recommendation 8

HQCOs to undergo **training** to help with the checking of fraudulent claims.

Rationale
Currently, the only task done by HQCMs is the checking of fraudulent claims. By allowing HQCOs to undertake this responsibility together with advanced technology like analytics, we can improve the time taken for this activity. The decisions at this activity can be more evidence based and thus reduces the risk of missing fraud cases. This recommendation requires the change in the internal policy of HQCO's rights to study the fraud cases.

2.4.9 Recommendation 9

Implement **self-service kiosks** at the branch for claimants to enter claim details and scan supporting documents which will be recorded electronically.

Rationale
Currently, there are situations where claimants are unable to fill up the application form correctly and hence the BCSOs have to check with the claimants to help them amend and verify the information. With the kiosk, the claimants have more supportive system to fill up the forms and submit the documents. The validations of the documents are also performed electronically. This allows to reduce the paper work and dispatch of the documents among the departments. The claim submitted in the kiosk will be saved in the CMPortal and BCSO will be able to view and amend accordingly. For cases where claimants need human support, BCSO can assist claimant to submit the claim to the CMPortal directly.

2.4.10 Recommendation 10

Implement **claim management mobile app** for claimants to enter claim details, auto validations and scan supporting documents which will be recorded electronically.

Rationale
Currently, claimants fill up the application form manually. Since the mobile is prevailing, the use of mobility can be useful in the process to reduce customer complaints. This can aid to save time for the claimant to travel to the branch to submit the claims. The mobile app stores the new claim submissions in the CMPortal for the process to be triggered. Also, the auto validations can aid in checking the documents submitted.

2.4.11 Recommendation 11

Claim payments to the claimant can be done via direct transfer to their bank account.

Rationale
Payment is currently made via cheque, which has to be manually prepared by the BPO. The drawbacks of this are two-fold: the claimant has to make an additional trip to the branch and

the BPO will be required to put in the man effort to prepare the cheque. In this case, we proposes replacing the above current process with seamless interbank (accounts payment file transfer to the banks) transfer. This would reduce the time needed for claimants to travel to the branch for cheque collection.

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