Best Practices in Claims management

Features of an efficient health claims management systems

Introduction

Health insurance claims management has evolved significantly in India over the past 10 years. Since the introduction of Mediclaim in the mid 1980s till the advent of TPAs in 2002, claims management focused primarily on reimbursement claims. The process was slow and entirely paper based, with no real role for IT. With the advent of cashless hospitalization, the entire claim process changed. New processes, such as prior authorization became vital for providers and payers. Time, which was not a crucial element in processing reimbursement claims earlier, all of a sudden became a vital parameter. Frequently the patient was already admitted when an authorization request reached a TPA, this meant that a response had to be given within 4-6 hours so the full treatment could commence. Authorization limit enhancements were also sought as the treatment progressed or as the patient was ready for discharge, they also required an urgent response. To meet these challenges, increasingly the TPA’s turned to IT.

The early claim systems were ad-hoc applications, frequently improvised upon to incorporate the ever changing multitude of payers / providers requirements, customer expectations and health insurance products. They were mostly reactive systems, supporting existing products and practices and not designed to support future requirements. Thus a peculiar chicken and egg scenario existed- how could an insurer introduce a new product when systems to service it did not exist?

A good claims management system must service existing products well while having the in-built flexibility to support products with new and unique features, such as outpatient coverage or products with a savings component. Increased flexibility to incorporate on-the-fly modifications in benefits and processes, in-built intelligence to standardize routine processes and rules based prompts and alerts are now available in newer claims system. Not only do they reduce manual intervention and improve process efficiencies, they can auto adjudicate and process claims which meet all compliance parameters thus enabling claims staff to provide more time for claims that require detailed analysis.

Features of Efficient Claims management Systems

Over the next decade, the insurance industry will witness continuous evolution in health insurance products and processes. The trend to move the claims function in-house may also be adopted by more insurers. This will create a unique opportunity for claims system vendors who can offer systems and applications with a high level of flexibility and automation. The starting point is a well defined and intelligent work flow management module to ensure optimum work routing and distribution, in-built escalation and strong external communication features (like auto letter generation for various scenario’s or SMS gateway). The ability to easily configure new products at a granular level is a vital requirement-this enables the automation of various validation checks on policy, claimant, benefits and provider. A product configurator interacts with a rules engine to define product benefits and exclusions to facilitate automated adjudication of claims. Appropriate pre-processing edits before the adjudication can substantially increase efficiency and process claims faster. In fact in the U.S. auto adjudication rates of
65% to 85% are not uncommon, albeit a very high percentage of these are simple primary care claims. Since new products will attempt to differentiate themselves with new service models, the claims systems will require business process builder to build operational workflow compatible with the product. In summary, the product configuration module, business process builder and rule engine is already becoming the core of the new generation claims systems. Such integrated solutions enable the claims teams to achieve significant automation of validation checks at the policy and the product level including verification of benefit and coverage limits to streamline prior authorization for cashless claims. Access to data in the policy administration system and provider module is vital at this stage.

Once the claim data is in the system, pre-defined rules and product specific processes can be applied. After ensuring that all mandatory information is provided and is valid, the first step would be to match the claim against the prior authorization. The second step would be to conduct checks for medical appropriateness, compliance with provider contracts and variation from usual and customary practices. Much of this can be automated through the use of standard treatment guidelines embedded in the system to identify excessive or unwarranted billing item, therefore generating cost savings for the insurer. An ideal claims management system should also include a fraud management module that identifies possible fraudulent patterns based on policy holder profile, underwriting information and provider profile. Since fraud or abuse patterns frequently reoccur, such a tool can be very useful.

Once a claim has been processed the claim payment process starts. Integration with payment gateways is a common feature now and significantly simplifies this process when paying network hospitals. In case of non-network hospitals or reimbursement claims, it helps to have a good cheque printing module. Finally, an effective claims management system can provide excellent insight to management. Not only can past trends be identified and leveraged, the vast amount of claims data can be combined with enrollment data to be efficiently used in actuarial pricing and underwriting.

In summary, underwriting and claims handling are two core functions of an insurer and technology offers a lot to streamline both these functions. The recent advances in claims system ensures that in a few years a significant portion of claims in India will be processed without any significant manual intervention. Technology, business practices such as contracted rates and standardized processing guidelines will do much to change claims management in the near future.

Alam Singh
Assistant Managing Director
Alam.singh@milliman.com

Milliman India Pvt Ltd 121 Sector 44 Gurgaon 122003 in.milliman.com
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