Evaluating the Health of Your **Medical Claims Process**

Rising costs continue to be the key challenge for the U.S. health care and property and casualty (P&C) insurers that process and pay medical claims. Payers must find ways to cut costs so they can avoid raising premiums, afford the growing cost of regulatory compliance, and remain relevant and profitable in the changing markets they serve. One viable target area is claims processing, where most payers are still mired in the decades-old model of manually processing paper claims or relying on a third-party processor, both expensive propositions.

Health care continues to assume a growing share of our gross domestic product, and is on track to exceed **18% in 2016.**[1]

DOES YOUR MEDICAL CLAIMS PROCESS EXHIBIT ANY OF THESE RED FLAGS?

- Are you digitizing paper claims today using an antiquated OCR product, keying from image (KFI) or outsourcing?
- Are there still manual steps in your paper claims process that block employee productivity and lengthen the time it takes to process a claim?

The Congressional Budget Office expects **12 million** to be covered by the marketplaces for 2016, growing to **15 million in 2017** and then stabilizing at **18 to 19 million** between 2018 and 2026.[2]

- Are manual keying errors and re-work causing reimbursement delays that reduce customer satisfaction and increase processing costs/penalties?
- Do your claims managers have difficulty monitoring workflows, statusing claims and reporting issues because they lack process visibility?
- Is your average processing cost per claim higher than it should be?
- Is your organization anxious about serving the growing number of insured Americans with a much different health care utilization profile over the next decade?

If you answered YES to any of these questions, it's time to give your medical claims processing workflow a checkup.

A majority of health plan leaders **(73%)** cite improving their organization's IT capabilities as a key component to success.[3]

CHECK IT OUT! A HEALTHY MEDICAL CLAIMS PROCESS SHOULD EMPOWER YOU TO:

- Drive greater cost- and process-efficiencies by automating paper-based claims processing
  - Automate multichannel capture, extraction and validation of all data from paper-based medical forms
  - Eliminate sorting, routing and reviewing of paper. Improve accuracy by eliminating manual keying

Health insurance companies face average costs of **$2.30 per manual transaction** – versus only $0.04 per electronic transaction.[4]

  - Identify and resolve true biller errors faster through built-in business rules, exception workflows and examiner-biller collaboration
  - Avoid costly penalties through faster, repeatable and more accurate processing

Insurers that fail to meet the 80/20 MLR rule face median costs of $151 per family, across all markets.[5]

- Speed claim reimbursement to enhance provider relationships and increase subscriber satisfaction
  - Shift employee focus from keying to reviewing data for increased speed and accuracy and advancing of only "clean claims" to adjudication

Duplicate billings are to blame for **30%** of payer denials.[6]

  - Leverage pre-built business rules that enforce submission data and EDI requirements and route only true biller errors for review
  - Facilitate capture of an EOB with the claim and automatically convert both to EDI, simplifying the routing, review and adjudication of multi-payer/ COB claims

In a 2015 data collection study by CAQH Index, fewer than half **(49%)** of COB claims were submitted electronically.[7]

- Provide management visibility across operations and gain processing performance insights through business analytics
  - Enjoy earlier visibility into claim status, bottlenecks and processing paths, and deliver accurate, timely data to key stakeholders
  - Enable staff to quickly and accurately respond to provider, subscriber or regulator inquiries via immediate access to claim data
  - Identify necessary workflow improvements with predefined metrics, dynamic dashboards and near real-time reporting
  - Track and analyze throughput, operator performance and executed processes to optimize processing and ensure compliance

The National Association of Clearing House Administrators (NACHA) indicates that 25% of bills submitted to payers give rise to payment status inquiries.[8]

A PRESCRIPTION FOR SUCCESS

High-performance claims processing is essential to success in the new health economy.

Driving out unnecessary costs through automation enables payers to avoid raising premiums and improve relationships with providers and subscribers—while still maintaining margins. And with a short payback period, the savings you realize can also be used to advance strategic initiatives and gain a competitive advantage.

To learn more about deploying automation to improve speed, accuracy and visibility across your claims process, please visit http://www.kofax.com/claims-agility. Contact us at http://www.kofax.com/contact/contact-kofax or call us at (949) 783-1402.

KOFAX

SOURCES

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