Everest Group®

Effective Claims Operations through Scaled Digital Adoption

Business and IT Collaboration Is Critical to Maximize Value from Digital

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Introduction

While the healthcare industry is modernizing many of its processes across the value chain, payers' claims management processes still run largely on legacy systems. On an average, a payer spends 85-90% of its revenue on claims payments, and, hence, an efficient claims management process is crucial for cost optimization. However, the current workflow is characterized by heavy dependence on manual processes and siloed operations, resulting in pricing and billing errors, incorrect claims denials, and high claims processing times. While these inefficiencies primarily create a financial burden for payers, they also deliver an unpleasant experience to members and providers.

In this Everest Group research, we showcase the current state of payers' claims management processes and the associated inefficiencies, such as a high claims settlement time and inaccuracies. Digital immaturity in the current workflows is the root cause of these inefficiencies. While a majority of payers have embedded Robotic Process Automation (RPA) in their processes for simple use cases that involve highly structured documents, they need to quickly adopt Artificial Intelligence (AI) and Machine Learning (ML) to automate processes that involve semi-structured and unstructured data, increase auto-adjudication rate, support claims adjudicators in decision-making, and enable intelligent fraud detection.

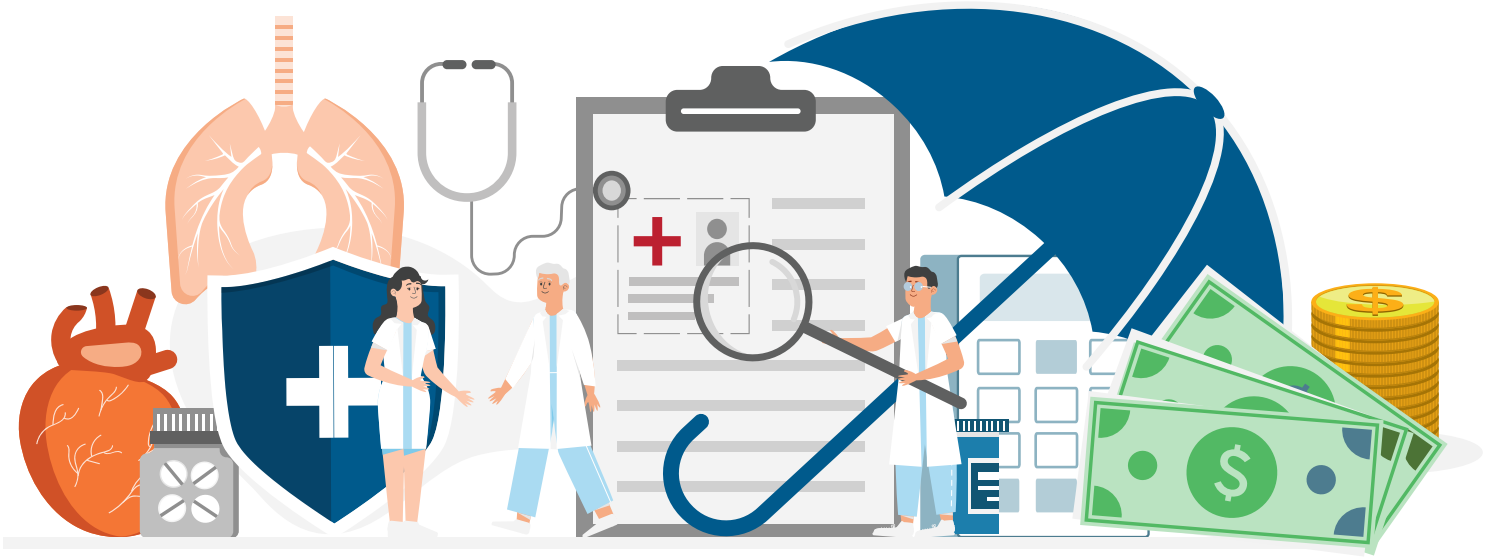
We also believe that payers need to adopt a digitalization approach that allows them to build a digital layer over their existing claims management systems, rather than embracing a rip-and-replace approach, which is marred by limitations such as high costs, downtime, and data loss. Critical and sensitive data flows across a claims management system and an in-situ modernization approach will allow payers to avoid migrating their data to a new system, thereby reducing the risk of security breaches, as well as data loss and corruption.

However, no transformational initiative can succeed without a shared goal and an actionable plan. This is especially true for digital transformation. If an enterprise's operating model is not aligned with its digital strategy, it cannot achieve the desired returns from its transformation initiative. This means that enabling the digital claims management process requires strong collaboration and a shared vision between the business and IT teams.

While the IT team owns IT operations and innovation, business leaders need to pitch in to drive adoption and determine common metrics for evaluating performance and RoI. IT and business alignment can reduce/eliminate workflow silos, resulting in agile workflows, increased visibility into business problems, reduced costs, better decision-making, and improved outcomes. All these benefits result in better customer experiences, boosting payers' growth.

Through this viewpoint, we demonstrate that a digital claims management workflow built on strong business and IT collaboration not only enables payers to accelerate the claims settlement cycle and improve accuracy, but also drives cost savings. We define three distinct stages of digital, IT, and business collaboration maturity – industry standard, best-in-class, and aspirational – that exist across payer organizations. We then offer a case-based analysis of the claims processing cost of an approximately 40-million-member health plan and identify the cost savings for each category.

The best-in-class claims management model, characterized by AI/ML tools and strong IT and business collaboration, achieves significantly better results than a digitally immature and siloed model. The aspirational claims management model, characterized by end-to-end automation across the claims management workflow and employees cross-trained on IT and business functions, can result in even higher cost savings. However, it is yet to make its way into the mainstream, due to hinderances such as data security and privacy concerns, multiple stakeholder ecosystems, and cost and regulatory constraints.



Inefficiencies in the existing claims management workflow

Current state of claims management in payer organizations

The US spends close to US$3.8 trillion on healthcare, almost twice as much as the amount spent by any other major world economy. This high spend is attributed to the complexities and inefficiencies within the US healthcare system. While inefficiencies plague the entire healthcare ecosystem, payers are the worst affected, with an average net margin of 2-4%, much lower than a for-profit health system (8-10%). This cost pressure, coupled with a fast-changing regulatory landscape and evolving member needs, is impacting payers' business demands, adding to their financial distress.

Payers spend 85-90% of their revenue on claims payment (medical + administration/IT cost), and, hence, a cost-effective and efficient claims management process, which incorporates strategies to reduce costs and processing time, minimize errors, and identify Fraud, Waste, and Abuse (FWA), while keeping customers satisfied, is vital for payers' success. However, payers' claims management processes today are characterized by legacy/outdated systems. In fact, payers currently spend less than 3% of their revenues on IT, and most of it is allocated to maintaining existing infrastructure and information systems with limited funds for innovation or modernization of existing systems.

Heavy dependence on manual processes and fragmented/siloed systems, coupled with increased claims complexity (due to rising volumes and expanding lines of business) have created inefficiencies such as pricing and billing errors, incorrect claims denials, and a high claims processing time. The administrative waste from inefficient and manual claims processes accounts for roughly 10% of the total administrative complexity cost of the US healthcare ecosystem. While these inefficiencies primarily result in a financial burden for payers, they also create unpleasant experiences for members and providers.
High medical costs due to FWA are an even larger issue for payers.

Most payers today use legacy/outdated systems for claims management, resulting in high administrative and medical waste.

Inefficiencies in the current workflow

There are two key inefficiencies in the current claims management workflow, which not only impact payers' productivity and margins, but also adversely impact payers' relationships with healthcare providers and members, as described below.




Inefficiencies	Impact on payers	Impact on providers	Impact on members
High claims settlement cycle time	• Increased administrative costs • Regulatory implications • Negative impact on relationships with providers and members	Inability to meet short term financial goals, such as paying staff salaries and bills for necessities	• Decline in satisfaction and experience • High inclination to switch to another plan
Low claims accuracy	• Financial leakage due to overpayment • Additional administrative cost for ever reappealed claim • Damage to reputation, resulting in member attrition	• Revenue loss due to underpayment • Unpleasant experience and increased administrative costs due to effort and time spent on resubmitting or appealing denied claims • Abrasion in relationships with payers	Unstipulated out-of-pocket costs due to underpayment, resulting in low satisfaction

The need for digital to mitigate inefficiencies

Digital immaturity is the root cause of the above inefficiencies. The current claims management workflow lacks advanced digital technologies, such as AI/ML and advanced analytics, to support faster claims processing and claims accuracy. Scaled digital adoption across the claims management process can help payers curb inefficiencies and reduce administrative costs, while advanced digital solutions can streamline the workflow by automating repetitive tasks and improving claims processing accuracy.

A majority of payers have embedded RPA to streamline certain functions that involve highly structured documents and a deterministic process. While RPA can address simple use cases, AI and ML are key to improving speed, efficiency, and accuracy. AI and ML models automate processes that involve semi-structured and unstructured data, increase auto-adjudication rate, support claims adjudicators in decision-making, and enable intelligent fraud detection.

Scaled digital adoption not only results in operational efficiency, but also improves member and provider experience and enables faster innovation, as the benefits listed below suggest:

- **Increased claims management efficiency:** Advanced digital solutions can help payers streamline traditionally disjointed claims processes, resulting in faster processing and reduced claims error rates
- **Higher claims accuracy:** With well-trained AI/ML models in place, payers can easily detect billing errors, mismatched claims information, and faulty claims
- **Better decision-making:** AI-supported decision-making allows claims adjudicators to process claims faster by predicting and recommending best actions for pended (non-auto-adjudicated) claims
- **Improved member and provider experience:** Introducing advanced digital solutions in the workflow allows payers to detect and solve bottlenecks/challenges in an accelerated manner, as well as enable better communication channels with internal and external stakeholders, improving the overall settlement time and member and provider experience
- **Boost to innovation:** Advanced data analytics capabilities help payers better understand their members' care journeys. This understanding not only helps payers modernize their claims operations, but also infuses efficiencies into other functions, such as product development

Scaled digital adoption in the claims management workflow

Approaches to scaled digital adoption

To establish a digitally mature claims management workflow that enables claims accuracy, process efficiency, and better member and provider experience, payers can consider the following two options:

- **Rip and replace:** migrate to a new digital system/platform
- **In-situ (in-place) modernization:** develop a digital layer on top of existing systems

While the core objectives of both the approaches are same, they are significantly different from each other:

Rip and replace

- Replacement of the in-house and/or legacy claims management system with a new, best-of-breed platform, which is digitally mature
- Extraction, conversion, and loading of data from legacy databases to the new system
- Source code change to integrate the new system with existing third-party applications

In-situ modernization

- Auditing and fixing operational issues, such as data scalability, frequent system outages due to high user workloads, and integration issues with third-party applications, in existing systems
- Development of a co-existing digital layer that works alongside existing systems and business applications
- Source code review and changes to integrate modern business applications / digital solutions with existing systems

Payers are skeptical of migrating to a new digital system/platform due to the associated disadvantages, such as the cost of decommissioning existing systems, significant upfront maintenance and training costs linked with the new system, and downtime and data loss during migration. The following statements from CXOs and business heads of large and mid-sized payer organizations represent the larger industry sentiment:

Migration to a new platform requires long-term commitment. Any transformation or change is a massive undertaking for a company because it is locked in. What companies need is a configurable solution that can be implemented without retiring the original platform.

– Chief Information Officer, a large healthcare payer

When working on any development work, we always look for the cost and downtime associated with that project. Migration to a new system not only requires a heavy upfront investment and high downtime, but also associated costs in terms of resource training and hiring talent with experience on the new technology.

– Senior Director, a mid-sized healthcare plan

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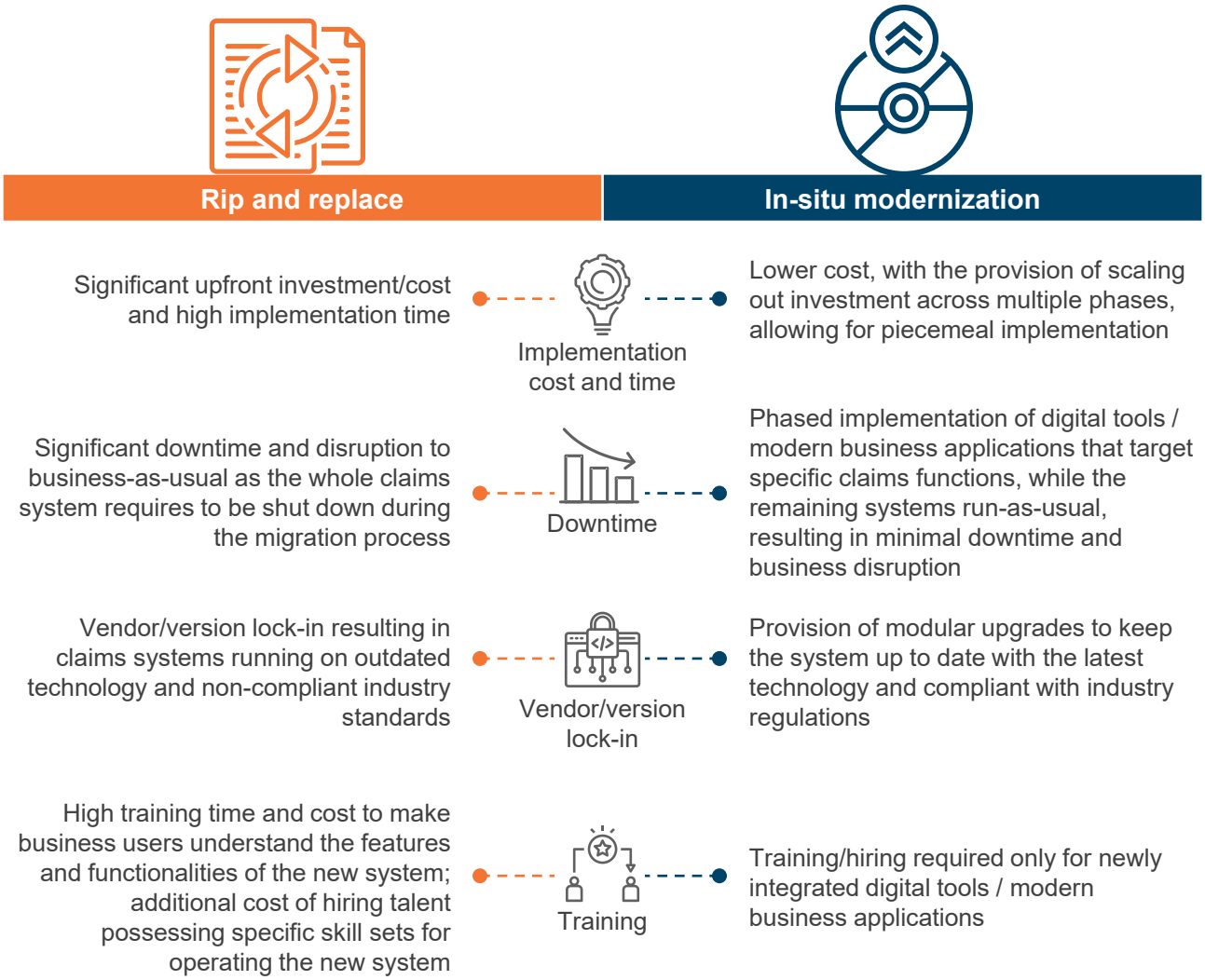
– Senior Director, a mid-sized healthcare plan

An approach that allows payers to retain and digitalize their existing systems (in-situ modernization), can help them mitigate most of the challenges associated with the rip-and-replace approach, as illustrated in the below exhibit.

EXHIBIT 1

Benefits of in situ approach to digitalization

Source: Everest Group (2021)



Critical and sensitive data flows across a claims management system. The in-situ modernization approach does not require payers to migrate this data to a new system, thereby reducing the risk of data loss, inconsistency, data corruption, and security breaches. Additionally, a majority of the existing (legacy) claims management systems run on operating systems and hardware that are actually relatively new. These machines are extremely powerful, and infusing digital layers within these existing systems can resolve most challenges that payers face.

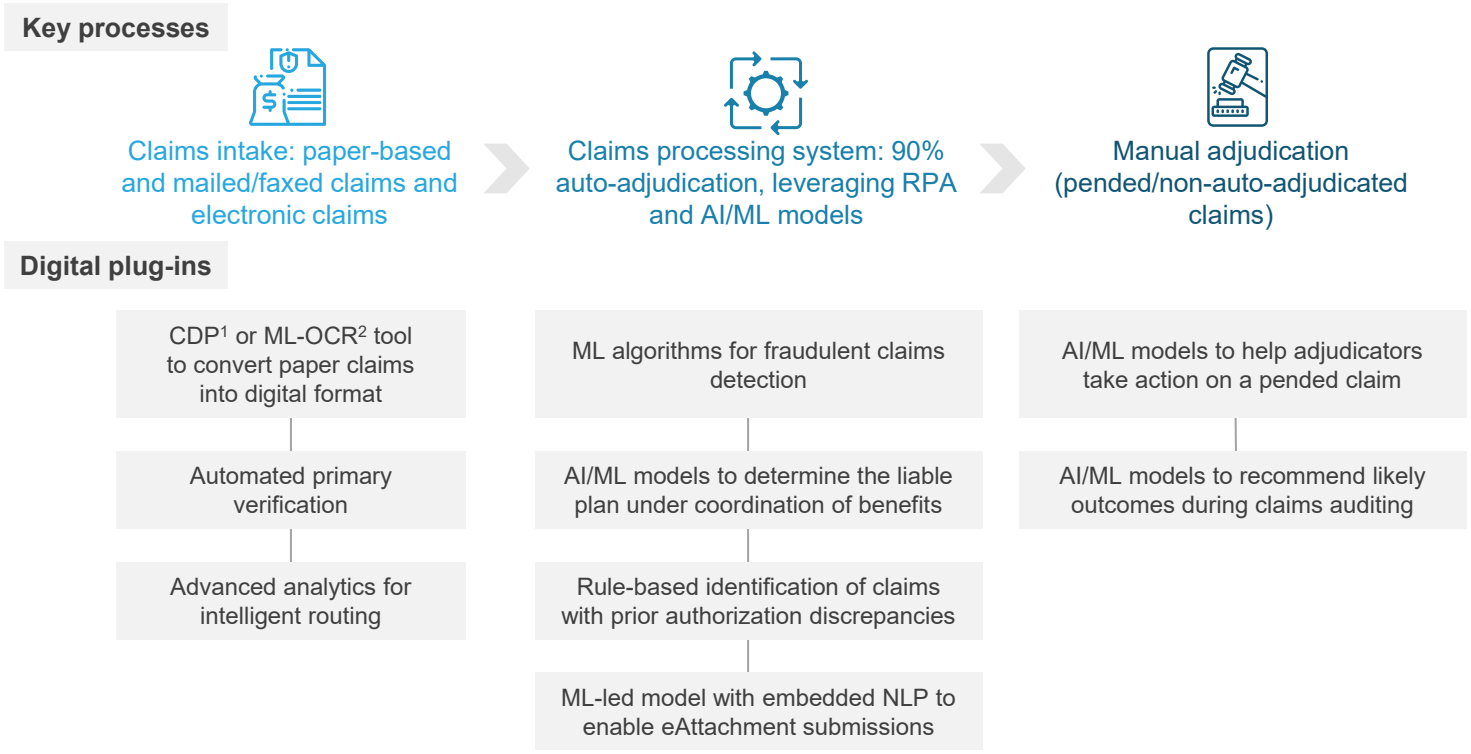
Digitalization of existing claims management systems

With the incorporation of digital solutions in the existing claims management workflow, payers can see significant improvement in the overall accuracy, efficiencies, and productivity. The exhibit below illustrates how the right digital plug-ins can mitigate the inefficiencies that exist in a traditional claims management workflow.

EXHIBIT 2

Digital claims management workflow

Source: Everest Group (2021)



1 CDP – Cognitive Document Processing
2 ML OCR – Machine Learning Optical Character Recognition

Establishment of a digital layer allows payers to bring in efficiencies (accelerated claims settlement cycle and high claim accuracy) in the claims management process, including:

CDP/ ML OCR tool to convert paper, mail, and fax claims into electronic claims, reducing the time spent on manual data entry

AI-/ML-led models for primary verification of claims, requiring claims administrators' inputs on flagged claims only

Advanced analytics to assess the complexity of a claim and routing it to the right adjudicator based on the skill set and workload

Automation of processes such as FWA detection, coordination of benefits, and medical attachment submission, improving the auto-adjudication rate

AI-/ML-led model to analyze pended claims and provide insights to help the claims adjudicator make an informed decision

Despite many payers making significant investments to digitalize their claims management workflows, the investments are not yielding the desired results. This is because the biggest hurdle in enabling a digital initiative is not the availability or implementation of technology, but collaboration between IT and business teams. No digital transformation initiative can succeed without a shared goal and an actionable plan. If an enterprise's operating model is not aligned with its digital strategy, it cannot achieve the desired returns from the transformation initiative. In a collaborative model, the IT team owns innovation and the risk of running operations, while business leaders need to pitch in to drive adoption and determine common metrics to evaluate performance and RoI.

Enabling business and IT collaboration

The key to successful digital transformation

Historically, IT has operated as an independent function and has been considered as a cost center – responding to technology requests and fixing system errors. In the claims management function, the IT team has the mandate of managing and maintaining IT infrastructure for claims processing, updating existing systems, ensuring security, and implementing new solutions, while business heads are responsible for developing business strategies to meet objectives such as better auto-adjudication rate, improved member experience, and reduced claims management costs. There is minimal interaction/communication between the teams, which translates into the IT team lacking business perspective and taking a long time to understand and fix business users' pain points, and the business team having limited understanding of technology's role in achieving its objectives.

The lack of business and IT collaboration creates information silos, creating inefficiencies in the claims management workflow, such as:

- Difficulty in integrating new technologies/systems
- High amount of rework due to Chinese Whisper effect (for instance, the updates/fixes done by the IT team are not per business requirements, resulting in delays and rework)
- Slow decision-making
- Organizational resistance to change

However, the pace of digitalization in the healthcare payer industry has accelerated significantly over the last two years. Payers are looking to solve critical operational issues and drive innovation to enable fast-paced digitalization. This pace of innovation demands that IT moves quickly to address business needs. The role of business leaders has also significantly changed with the advent of digital applications (cloud-based applications, AI solutions, etc.) and they need to ensure that this transition is supported by appropriate IT skills and talent. This means that the IT team should function as a strategic enabler, making integrated efforts and decisions to achieve a shared business vision. Meanwhile, business leaders are expected to have visibility into the IT function and its importance in achieving core business objectives such as cost reduction and modernization. One of the key business imperatives of digital adoption is enhancing customer experience, which requires aligning IT and business teams under common language and goals that directly support the customer.

From a claims management perspective, IT and business collaboration would mean:

- Ensuring that the IT team understands the pain points of claim administrators/adjudicators to identify use cases that require AI- and ML-led intervention models
- Mutually agreeing on metrics for model performance and estimating business value
- Identifying data sources and gain access to the right sample set for model development and training
- Evaluating the model's implementation impact on operations and adjusting the workflow to ensure the best output
- Incorporating inputs from the business team to improve the model's output or adapt to changing regulations

IT and business alignment can reduce/eliminate workflow silos, improving operational efficiency and productivity, increasing visibility into business problems, reducing costs, enhancing decision-making, and improving outcomes. All these benefits improve customer experience, boosting a payer's growth. Business agility is the key enabler to drive digital transformation – which again requires an integrated and collaborative operating model.

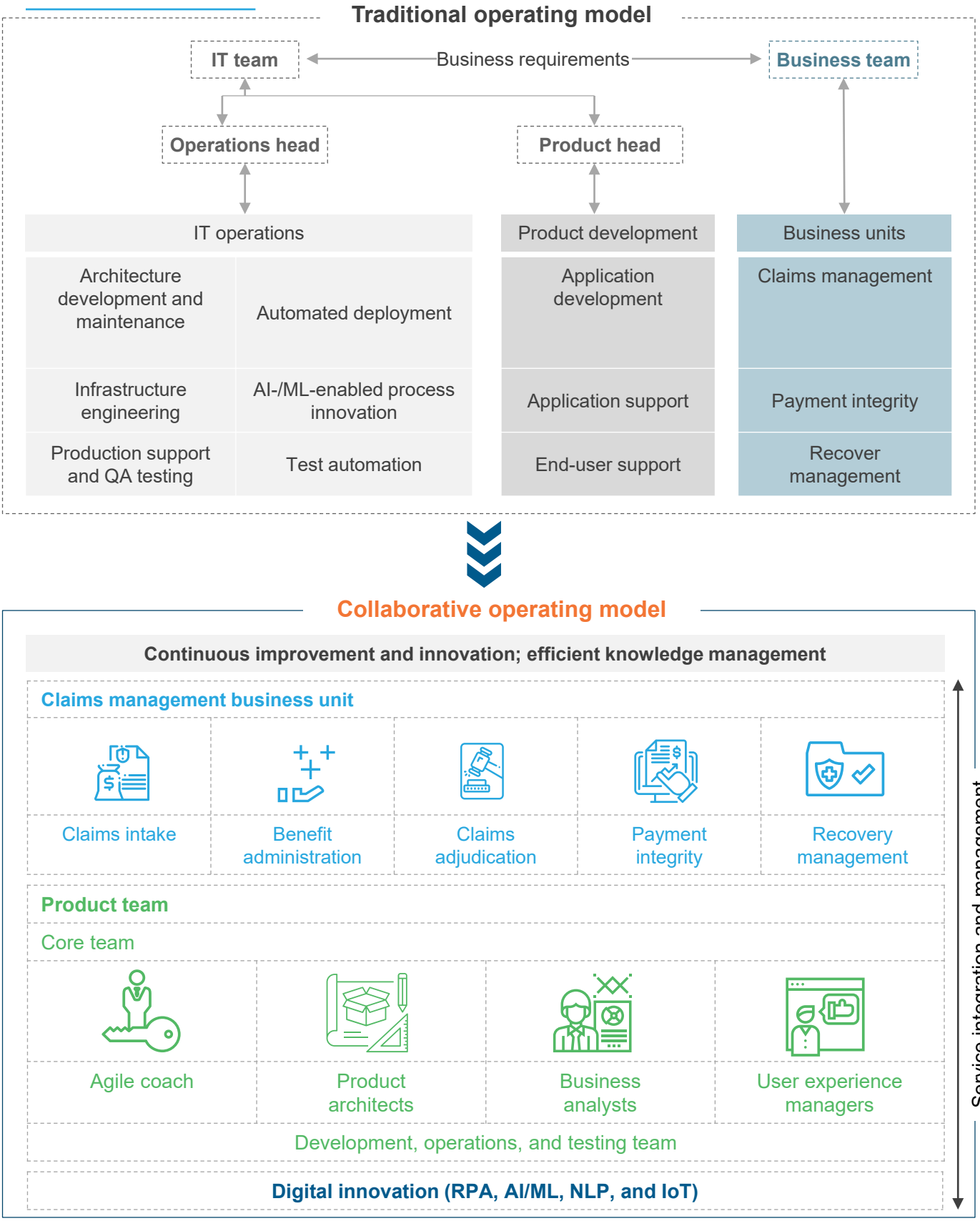
Shift from a traditional to a collaborative operating model

While organizations realize the need for IT and business collaboration, their initiatives to transition to this model are hampered by legacy organization structures. Meaningful alignment requires breaking down silos and decentralizing IT. To enable a true collaborative model, payers need to adopt a new operating model, as illustrated in Exhibit 3.

EXHIBIT 3

Traditional vs. collaborative operating model

Source: Everest Group (2021)



The table below lists the key characteristics of the two models:

Traditional operating model	Collaborative operating model
• Siloed team structure • Minimal collaboration between IT and business teams • Fragmented information flow • Inefficiencies due to broken workflows	• Product-centric operating model • Business and IT heads as co-owners of the solution • Effective and efficient information flow • Agile workflows

A collaborative team model facilitates decentralized and agile workflows within the claim management function by introducing a focused product team that comprises both IT and business stakeholders. In this model, the business team can share domain expertise, articulate business needs, and share required data, while the IT team can educate the business team on the digital models – their logic and functioning. This creates a coordinated and aligned vision on digital technologies that ensures the success of digital transformation initiatives.

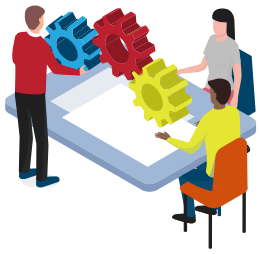
Enablement of a collaborative operating model

As payers move to a collaborative operating model, they need to think of changes across multiple dimensions, as illustrated in the below exhibit.

EXHIBIT 4

Focus areas for enabling a collaborative operating model

Source: Everest Group (2021)



People

- **Team structure:** establish multidisciplinary/cross-functional teams, with representation from business and IT functions; enable strategic movement of resources between teams to drive cross-skilling
- **Hiring:** onboard specialist roles such as ML engineers and data scientists to accelerate the alignment of business and IT teams
- **Training and upskilling:** curate training programs for employees' holistic skill development and cover modules for both business and IT domains; payers can sponsor certifications such as AHM-250 and SAFe

Process

- **Performance:** align incentives with collective outcomes and IT and business teams' initiatives to promote a culture of shared accountability
- **Operating framework:** adopt methodologies such as agile, DevOps, SAFe, open-source, and platform Ops to strategically enable the cross-team collaboration culture

EXHIBIT 4 (continued)

Focus areas for enabling a collaborative operating model

Source: Everest Group (2021)

Technology

Collaboration tools: implement collaboration tools such as JIRA, Confluence, Basecamp, Github, and Trello to enable visibility, information transparency, and collaboration between cross-functional teams working on similar workstreams

Change management

- **Change management frameworks:** leverage established change management methodologies, such as the Lewin Model, Kotter's 8-step Model of Change, and ADKAR, to accelerate change management
- **Senior leadership buy-in:** align senior management on the vision of change and ensure effective communication to get everyone on board; leaders should assume accountability for all aspects of organizational change – culture, process, technology, and people
- **Change governance:** establish dedicated metrics to track the pace of people, process, and technology changes

The business case for change

A digital claims management model – comparison of different maturity stages

On an average, a legacy claims management platform with an RPA layer has an 80-85% auto adjudication rate. The remaining claims require manual intervention. To price these claims correctly, adjudicators have to look at multiple systems to get the required information. The manual workflow also poses challenges such as workforce fatigue, provider abrasion, poor member experience, and higher claims cost due to administrative waste and incorrectly priced claims.

To address these challenges, payers need a digital model for claims management built on strong business and IT collaboration. Presently, healthcare payers are at varied maturity stages of this model. We have evaluated three distinct categories of payers to compare the cost benefits.

- **Category 1: industry standard**
- **Category 2: best-in-class**
- **Category 3: aspirational**

Exhibit 5 lists the benefits and limitations of the three categories.

EXHIBIT 5

Benefits and limitations of different payer categories

Source: Everest Group (2021)

	Benefits	Limitations
Category 1: industry standard 	• RPA presence across value-chain areas such as claims adjudication and claims intake • Auto-adjudication rate: 80-85%	• Lack of advanced digital capabilities such as analytics and AI/ML • Minimal automation across claims management processes, resulting in significant manual intervention (for processes such as entering paper-based claims into the system, primary information verification, and pricing of pended claims) and scope for human error • Business and IT teams work in silos, with minimal communication and alignment in goals
Category 2: best-in-class 	• Payers leverage both RPA and AI/ML models to enhance claims operations • Auto-adjudication rate: 88-90% • Processes such as ePrior authorization, eAttachment submissions, AI-powered claims adjudication are implemented, reducing the error rate and increasing workflow productivity • Business and IT teams work in a collaborative manner with a shared vision, resulting in scaled innovation • Focus on change management	• Scope of manual intervention in processes that are not automated • Lack of cognitive customer-service tools such as bots and virtual agents across member and provider touchpoints • Minimal cross-skilling of talent across business and IT functions
Category 3: aspirational 	• Cognitive automation and AI/ML models implemented across the entire claims management process, minimizing/eliminating the need for manual intervention • Auto-adjudication rate: 93-95% • Presence of cognitive bots and virtual agents across member and provider touchpoints • Employees cross-trained across IT and business functions to enable agile workflows	

Comparing the different categories

Every payer organization across the healthcare industry falls under one of the mentioned categories of digital maturity and IT and business collaboration across the claims management process. We assessed each category's cost-saving potential leveraging data from a 40-million member plan, and below are the results.

Case scenario – a plan with ~40-million members	
Annual revenue (2020)	US$122 billion
Annual claims volume	252 million claims
Auto-adjudication rate: industry standard	85%
Auto-adjudication rate: best-in-class	90%
Auto-adjudication rate: aspirational	95%

This sample scenario is based on a large US healthcare plan. Members, revenue, annual claims volume, and the auto-adjudication rate (industry standard) are based on actual figures, while auto-adjudication rates for the best-in-class and aspirational categories are estimated based on industry use cases.

Key activities involved in a claims processing function include claims intake, eligibility and benefit verification, prior authorization, adjudication, medical attachment intake, coordination of benefits, and claims payment. A payer falling in the industry-standard category typically spends US$647.6 million on operations required to process 252 million claims annually. The following table shows the degree of automation in the entire workflow for the industry-standard category.

Low ⟶ High

Industry-standard category							
Transaction type	Claims intake	Eligibility and benefit verification	Prior authorization	Adjudication	Medical attachment intake	Coordination of benefits	Claims payment
Manual	■■□□□	■■□□□	■■■□□	■■□□□	■■■□□	■■■□□	■■□□□
Electronic	■■■□□	■■■□□	■■□□□	■■■□□	■■□□□	■■□□□	■■■□□

Best-in-class

The best-in-class model adds significant value, as it not only automates basic processes such claims intake and primary validation, but also leverages AI/ML models to implement more complex processes such as ePrior authorization, eAttachments submissions, and AI-powered FWA detection. The AI/ML models also help claims adjudicators accelerate the claims settlement time and make insight-driven decisions for pended claims. Additionally, IT and business collaboration reduces the turnaround time for error detection and corrections in the workflow, further translating into reduced administrative wastes. A payer falling in this category can achieve 25-27% reduction in the claims processing cost compared with the industry-standard category.

The exhibit below illustrates the potential cost savings that payers can achieve with the best-in-class category.

EXHIBIT 6

Savings for the best-in-class category; US$ million

Source: Everest Group (2021)

Low ⬛⬛⬛⬛⬛ High

Best-in-class category							
Transaction type	Claims intake	Eligibility and benefit verification	Prior authorization	Adjudication	Medical attachment intake	Coordination of benefits	Claims payment
Manual	■□□□□	■□□□□	■■□□□	■□□□□	■■□□□	■■□□□	■□□□□
Electronic	■■■■□	■■■■□	■■■□□	■■■■□	■■■□□	■■■□□	■■■■□

The process's main drawbacks are the scope of manual error in processes that are not automated and potential talent shortages and internal dependencies due to the absence of roles cutting across business and IT functions.

Aspirational

While the category remains futuristic, a payer falling in this category can achieve 22-24% reduction in claims processing costs compared with the best-in-class category, as depicted in Exhibit 7.

EXHIBIT 7

Savings for the aspirational category; US$ million

Source: Everest Group (2021)

Aspirational category							
Transaction type	Claims intake	Eligibility and benefit verification	Prior authorization	Adjudication	Medical attachment intake	Coordination of benefits	Claims payment
Manual	■□□□□	□□□□□	■□□□□	■□□□□	■□□□□	■□□□□	■□□□□
Electronic	■■■■□	■■■■■	■■■■□	■■■■□	■■■■□	■■■■□	■■■■□

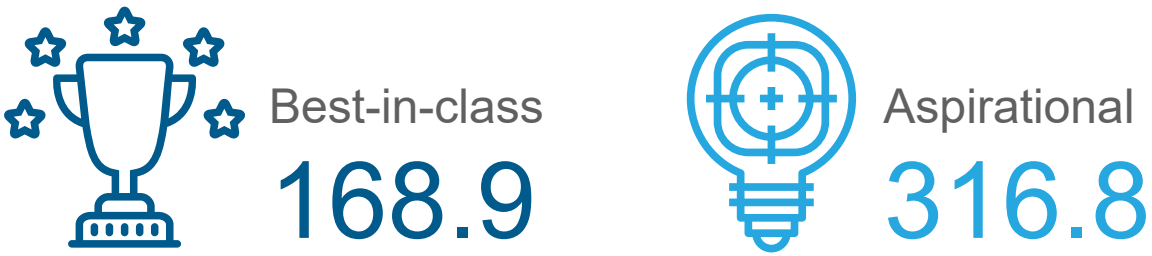
The aspirational category involves the end-to-end claims management workflow's automation with self-learning AI/ML models. The model aims at eliminating or minimizing manual intervention, thereby improving productivity and eliminating the scope of any human error. Additionally, resources skilled across business and IT functions can significantly reduce dependencies and bottlenecks and ensure agile workflows.

As our analysis shows, payers can significantly increase cost savings by transitioning to the best-in-class or aspirational category, as showcased in the exhibit below.

EXHIBIT 8

Savings across different categories (compared to the industry-standard category); US$ million

Source: Everest Group (2021)



Most payers today fall in the industry-standard category and suffer from high costs and operational inefficiencies in their claims management processes. Moving to the best-in-class category by building a scaled digital adoption strategy and establishing active communication channels between IT and business teams can help payers achieve potential cost savings, along with better productivity and improved provider/member experience.

The aspirational category will experience mainstream adoption in the future. Cost and complexity remain the gating factors in most organizations that prevent end-to-end automation. An aspirational model also demands high investment in areas such as security, data management, talent, and governance. Hence, an ideal way to scale automation is to take a phased approach or the best-in-class model. Organizations need to start with identifying use cases that can yield the highest RoI if they were streamlined and automated, aligning business and IT teams on a common vision, and gradually moving to a scaled/end-to-end automation model.

Conclusion

Rising costs and inefficiencies in claims management are among the most pressing challenges for the payer industry. Digitalizing the claims management workflow can help payers streamline processes and boost efficiency and accuracy. This digitalization effort can help reduce costs and deliver better member and provider experiences. End-to-end digital claims management is still a distant vision due to hindrances such as data security and privacy concerns, multiple stakeholder ecosystems, costs, and regulatory constraints.

However, payers can benefit significantly by digitalizing parts of their claims processes by plugging in RPA and AI/ML capabilities in their existing systems/platforms. To enable a digital claims management process, an effective approach to change management with a strong focus on culture and mindset is paramount. The success of a digital initiative is based not only on technology implementation, but also on change management – availability of the right in-house talent, people's willingness to adapt, purposeful communication from the leadership, and strong governance mechanisms. In addition, enterprises need to ensure business-IT collaboration and build cross-functional claims teams to ensure agile workflows. Payers need to take a step back to understand the changing customer expectations and align their products, services, digital strategies, and business models to match those expectations. Only the ones that take necessary steps now and decisively adapt to the changes shall sustain and flourish.

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