

Property & Casualty Insurance

Mastering Medical Information


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Introduction

Property and Casualty insurers operate in an environment characterized by intense price competition, a lack of product differentiation, and ever-increasing requirements for service and efficiency. Within this context there is recognition that the claims function occupies a unique place in determining the success of the organization—claims represent a significant portion of the insurer's balance sheet, consuming nearly 80 percent of the premium in the form of claims payments and processing costs.

Clearly, insurers need to be on the lookout for meaningful innovation that enables them to improve both the quality and efficiency of their claims function.

Accenture's ongoing, systematic study of insurance claims performance—dating back to the 1990s—has shown a mixed bag of successes and clear signs that the industry overall continues to struggle to achieve durable performance improvements. Nearly 10 years of research—compiled across more than 50,000 claims reviews, 4,000 interviews with claims professionals, and across companies operating in more than 10 countries—has confirmed that there is significant room for insurers to improve the claims function.

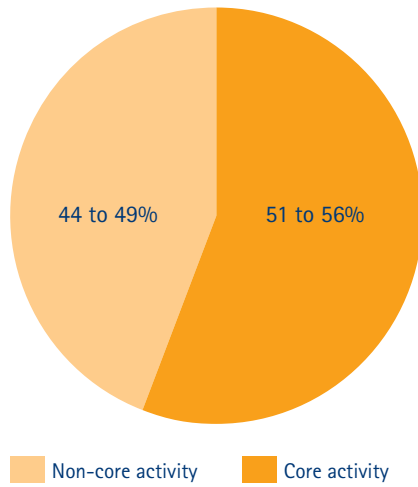
Claims professionals still spend nearly half their day on activities that do not impact the outcome of the claim (see Figure 1). Claims outcomes overall remain mixed, with varying degrees of consistent top-level performance (see Figure 2). And perhaps most importantly: information is significantly under-exploited, resulting in disappointing levels of settlement accuracy and efficiency.

A critical hurdle that must be overcome on the road to high performance is the usage, and ultimately the mastery, of medical information. By harnessing the power of this largely untapped and often misunderstood information, insurers can stem the tide of settlement variances and rising severity.



Figure 1. Claims efficiency

Distribution of Work by Core vs. Non-Core Activities



Source: Accenture analysis

Time Allocation

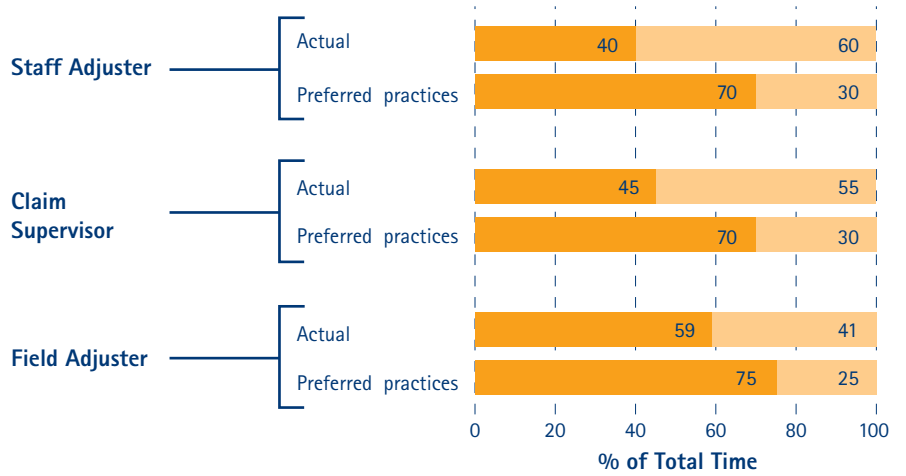


Figure 2. Claims effectiveness

Class	Loss Economic Opportunity		
	Below average	Average	Above average
Personal & commercial auto liability: bodily damage	>14%	10-14%	<7%
Commercial: general liability	>12%	8-12%	<5%
Accident/disability	>8%	4-8%	<3%
Workers' compensation	>16%	12-16%	<7%

Loss Economic Opportunity (LEO) is defined as the savings potential associated with achieving consistency in claims handling, in accordance with good market conduct and consistency of application of company procedures.

LEO is derived through a comprehensive fact-based review of claims cases using Accenture's patented Claims Data Analysis methodology.

Source: Accenture analysis

Using data to transform injury claims

Insurance is fundamentally an information industry. Insurers have long recognized the value of data and analytics as a means of creating meaningful competitive advantage.

These tools have been successfully used to develop pricing and segmentation strategies that have dramatically changed underwriting policies and practices in all parts of the industry, not least of which is the Bodily Injury sector.

However, while the underwriting side of the business has come to rely heavily on data and analytics, the claims function has only just begun to tap into their potential. In this arena, we believe the greatest opportunity for extracting value from data and analytics is in the management of injury claims. There are three reasons for this:

1. Injury claims are a significant portion of a carrier's loss portfolio

Across Bodily Injury, No Fault, Medical Payments, and Workers' Compensation coverages, injury claims account for 50 to 60 percent of paid losses.

2. The severity of these claims is increasing faster than inflation

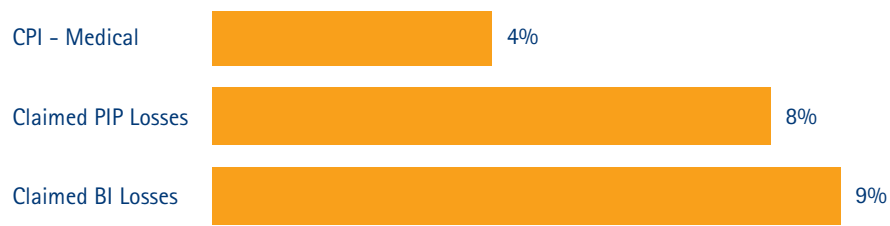
According to the Insurance Research Council, annualized claimed losses for Bodily Injury and No-Fault coverages between 2002 and 2007 exceeded increases in the medical consumer price index by a large margin: 8 to 9 percent annualized for Bodily Injury/Personal Injury Protection as opposed to 4 percent for medical inflation (see

Figure 3). As medical costs continue to rise at rates that exceed other components of loss, namely claimed wage losses, the ratio of injury losses will continue to increase. What is more, if recent declines in frequency reverse themselves, these increases in severity will come into focus as the core issue in managing overall loss costs.

3. Injury claims drive variability of loss costs

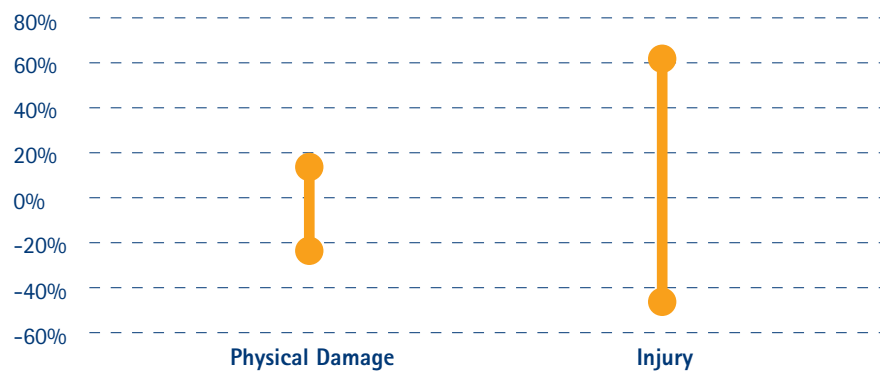
A deeper analysis of the components of claim severity, by company and market across the industry, reveals that the core component of severity difference between competitors is the average loss on the injury portion of a claim. For instance, within Bodily Injury, we have found that whereas auto physical damage losses per claim

Figure 3. 2002-07 annualized growth in inflation and claimed loss



Source: Insurance Research Council

Figure 4. Range of industry variance from average loss, by loss type



Source: MedNeutral research/RA5 exhibits from state filings/Accenture analysis

have been fairly consistent across competing firms, the severity of injury claims for the same firms deviates by as much as 65 percent from industry averages (see Figure 4). This suggests that significant opportunity exists to standardize and improve the accuracy of injury investigation and handling for more consistent financial performance.

This situation is exacerbated by the current economic crisis, in which we expect the frequency of injury claims to increase, which will place a higher burden on the claims organization to prepare and execute a thoughtful response to protect the bottom line.



The lost information within medical records

For years, most organizations have tried to control injury loss costs in two ways: by using tools which help determine how much they should pay for each charge (bill review/adjustment), and by using formulaic approaches to building range estimates for medical and general damages.

While these approaches play a useful role in cost management, they miss the mark in terms of bringing the entire medical context of a particular claimant into the adjudication process. These methods support the decision of how much to pay, while leaving the overworked adjuster to sort out if the diagnosis and treatment are reasonable, necessary and/or related to the cause of injury and coverage. They also encourage decision-making around an incomplete information set, leading to criticisms regarding the consistency and fairness of the claim settlement.

This missing bridge between injury and outcome is the story presented by the medical records themselves. Medical records are the single most important source of information for determining claims strategy. Records provide details of patients' medical history (including pre-existing conditions), treatment

path, and rehabilitation progress that enable informed decisions on the appropriate levels of care for relief from and cure of an injury.

Thus, instead of utilizing the full complement of available information, claims handlers base their decisions on incomplete information sets.

In our work with leading carriers across multiple lines of business, we have researched the use of medical records by claims organizations and have confirmed that key sources of medical information are often ignored or under-utilized. Claims handlers reported that, on average, they looked at approximately 60 percent of all medical records in their claims files. This is in spite of their universal acknowledgement that medical records were extremely valuable in the proper adjudication of a claim.

There are four core reasons why this information is not optimally leveraged:

1. IT infrastructure

The health of any claims operation rests heavily on its information technology infrastructure—the processes, applications, customer and policy databases, and all the electronic channels through which the operation is accessed. Accenture's 2007 Global Claims Study indicates that there is more work ahead of the industry than behind it with regard to issues such as information "blackouts" between parties, inflexible processing rules, and a lack of agility to meet changing demands.

The simple fact is that the underlying IT infrastructure is not well suited for detailed capture and analysis of the rich information in medical records.



2. Organization

Unlike other forms of information that are routinely used to make payment and adjudication decisions, medical records come to handlers in highly unstructured formats. Records are often delivered in piece-meal fashion—out of chronological order, in different formats, and hand-written. As a result, claims handlers must make significant investments in organizing and deciphering these sources to extract the relevant pieces of medical data.

3. Training

Claims personnel are not well equipped to interpret the information that they do review. This is particularly true of new hires within claims organizations who have little or no knowledge of medical terminology and treatment

paths. These less experienced handlers tend not only to shy away from the record review process, but also rely on more experienced staff for the evaluation and interpretation of this information when they do view records.

4. Time

Current demands on the time available to claims handlers clearly affect the thoroughness with which they can conduct a medical record review. Many insurers struggle with statutory response times as they try to manage lean operations, relegating investigation and evaluation to lower priorities. In our research, claims personnel have reported wanting to spend an average of 30 percent more time reviewing the records at their disposal to seek additional information that would help them make the right decisions.

The end result of these factors is that the information that is most valuable to injury claims handlers is also the most widely under-utilized.

What can insurers do to master the use of medical information?

Based on the same experience and research, we recommend a number of actions that will help insurers drive high performance through their injury claims operations.

Action No. 1: Tackle the whole, not the pieces

Insurers simply cannot achieve high performance by pursuing isolated, quick-hit systems and process improvements at the periphery of their claims operations. Instead, they must take a holistic view of claims personnel, processes and technologies, rooted in enterprise data management and executed across the operation. Insurers must adopt well-defined processes supported by meaningful metrics and enabled by effective tools and technologies.

Action No. 2: Reinvent the role of the claims professional

In most insurance companies today, the claims professional performs a job that is 80 percent clerical and 20 percent professional. The claims professional

of the future will be at the center of a service offering powered by real-time access to relevant data and information. Equipped with the most effective set of tools and supported closely by strong back-office capabilities, the professional will bring claims to a more rapid and satisfactory resolution for both the policyholder and the insurer.

Action No. 3: Foster an outcome-focused culture

Today's common claims metrics, focusing primarily on "inventory" such as file counts, closure rates and average pendlings, are becoming less and less relevant in a world where a claim may be touched by a number of people, each with a specific responsibility and contribution to the ultimate outcome. These traditional measures will need to give way to a balanced scorecard of measures that are reflective of each individual's impact on the claims outcome.

Action No. 4: Improve predictability through better use of data

What is missing in the injury claims life cycle of most insurers—due in part to the limitations of legacy claims systems—is predictability of processes and outcomes. The wealth of information available to them in medical records constitutes a tremendous opportunity to improve the efficiency and effectiveness of the claims process. However their aging systems—having evolved from financial systems focused on payment processing and reserving, lacking integration with other applications, and being unable to access data in unstructured paper files—help to perpetuate a manually intensive claims life cycle in which vast quantities of useful data are ignored or swallowed up, never to emerge in any useful form.

Gaining a competitive advantage through superior claims management

Insurance companies that continue to take the traditional route to injury claims improvement through localized technology, people and process initiatives may enjoy modest benefits.

However, history has shown that improvements which are garnered through such quick hits—and which fail to address the infrastructure, organization, training and time constraints that impede the exploitation of information—inevitably erode over time.

The only way to ensure durable competitive advantage and high performance is to rethink the claims organization, embracing a new vision that is built on a foundation of optimized, innovative systems, improved human performance, and unconstrained access to information.

The prospect of reinventing the claims function may seem daunting given its critical role in determining profitability and the constantly evolving demands that are placed upon this function. But the rewards can far exceed the time and resources invested in transformation.

A claims operation characterized by world-class capabilities in the areas discussed above is much better equipped to help the organization compete and win over the long term. The key is to put the claims professional and the customer—with all relevant information—at the center of a transformed claims function. This will help insurance companies build a more durable competitive advantage, both near-term and long-term, and will ultimately help them achieve high performance.

To learn more about transforming your claims operation, visit www.accenture.com/insurance.



Unlocking the power of medical data

Medical Records Optimization (MRO) is a next-generation service that creates a structured process and platform through which medical data are consistently and efficiently assembled, analyzed, and presented to the claims organization. MRO addresses the key reasons why medical information is under-utilized:

File assembly

Through the MRO process, unstructured medical records and the data which they contain are organized and returned to claims handlers in a consistent fashion. The medical records are sorted and arranged in chronological order (with sorts also available by other fields). Raw medical data are further transformed into a set of electronically scanned, chronologically based, consistently indexed, and formatted records packages that are accessed by handlers via a Web-based software application. Structuring not only makes record review more efficient and consistent, but it also creates an information asset that can be used by the insurer for future training, benchmarking and analytical evaluation.

Presentation of information

Valuable outputs of the MRO process include medical abstracts for key record types, which summarize the medical facts contained within the files. These processes leverage the knowledge and expertise of experienced medical professionals who are trained in reviewing records for the evaluation of injury claims. The medical context presented in these summaries enables claims handlers to focus on interpretation and evaluation rather than on the clerical tasks of

organization and extraction. This improves the quality of decisions that are made.

Search and analysis

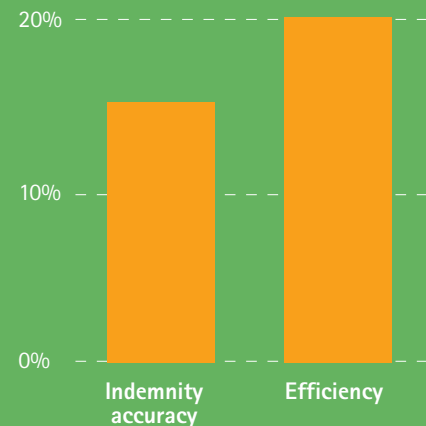
The core advantage of structuring medical records and information electronically is that the user is able to make use of cutting-edge tools for data organization and management. Search and indexing tools embedded in the MRO solution allow adjustors to quickly call up facts and medical context around specific treatments or body parts. Tracking algorithms enable automated identification of changes in diagnosis, medication, provider or facility.

Collaboration

MRO also features collaboration tools to facilitate rapid sharing of abstracts, facts and adjustor analysis with supervisors, managers, legal counsel and external experts. This leads to improved organizational productivity and faster decision making.

By making medical information easy to access and use, MRO not only improves the accuracy of decisions made by claims handlers, but also the efficiency with which these decisions are made. MRO has resulted in improvements in indemnity accuracy of as much as 15 percent, and claims-handler efficiency gains of more than 20 percent (see Figure 5). These results, in combination with the organizational benefits which stem from improved collaboration and analytical capability, position MRO as a truly revolutionary way to transform the management of injury claims.

Figure 5. Performance improvements stemming from MRO implementations



Source: MedNeutral/client results

Enhancing costs and service through optimized medical bill review

Medical Bill Review Services provides insurers with the most efficient, flexible and easy-to-use cost containment tools for improving the outcomes and reducing the expenses associated with workers' compensation, personal injury protection and bodily injury claims. We have a proven track record of generating bottom-line medical savings of between 5 and 15 percent, and of reducing operational expenses by as much as 60 percent.

We achieve these outcomes with a combination of advanced technology and a powerful business process outsourcing (BPO) offering.

Accenture utilizes StrataCare's fully integrated, Web-based suite of medical bill review systems, which extend from electronic bill acceptance all the way through to electronic payment transmission. These systems feature the most advanced workflow technology, and comprise a complete document management system, a paperless electronic bill review system, and a rules writing module that enables insurers to create their own routing rules based on their unique business criteria.

Among the features and benefits that distinguish this system are:

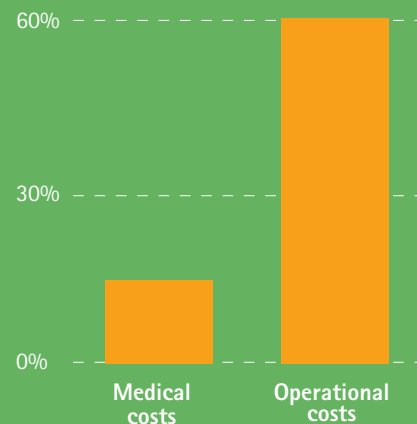
- An advanced electronic data interchange (EDI) module that reduces IT expenses. Real-time claims and provider EDI dramatically reduces the number of IT personnel required to manage the EDI facility.

- Secure online access allows claim handlers and clients to check the status of the bill review and to get information such as the explanation of review (EOR). This reduces the volume of telephonic and other queries, and saves time spent by bill review personnel responding to these queries.
- Improved bill review accuracy—levels above 99 percent are typically achieved—dramatically cuts the number of reconsiderations and re-evaluations that are required, accelerates payment, and goes a long way toward improving customer satisfaction.

Medical Bill Review Services is provided as an offshore BPO service that utilizes Accenture's network of nine BPO centers in various locations around the world. Medical bills are obtained from healthcare providers or customers, in electronic or hard-copy format. They are scanned, matched against the claims, and checked for duplication and missing information. The bills are then reviewed, utilizing the insurer's configurable set of rules. Repricing is effected with a combination of manual and automated processes, and by referencing the latest state fee schedules, usual and customary rates, and preferred provider organization discount arrangements. Every single bill is audited, with those requiring a special review being flagged for attention. An EOR is produced and sent, together with payment, to the provider.

In addition to processing the bills, the service includes an inbound and outbound call center. Missing information is sourced, and queries by medical providers and the insurer's claims adjusters, regarding the EOR or the status of the review, are resolved. The service center also provides technical and other support to clients and providers.

Figure 6. Cost reductions achieved by Medical Bill Review Services



Source: StrataCare/client results

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