Scenario: Disability Insurance Claims Handling at InsureIT

We consider the following business process at an insurance company InsureIT.

The process starts when a customer lodges a disability claim. 1 To do so, the customer fills in a form including a 2-page questionnaire describing the disability. The customer can submit the form physically at one of the branches of InsureIT, by postal mail, fax or simply via e-mail (digitally-signed document).

When a claim is received, a junior claims officer first enters the claim details into the insurance information system. Data entry usually takes 10 minutes. The same junior claims officer performs a basic check to ensure that the customer's insurance policy is valid and that the type of claim is covered by the insurance policy. The basic check takes 10 minutes. It is rare for the claim to be rejected at this stage (it only happens in 2% of cases). Otherwise the claim is marked as “eligible” and moves forward in the process. Next, the claim is moved to a senior claims officer who performs an in-depth assessment of the reported disability and estimates the monthly benefit entitlement (i.e. how much monthly compensation is the claimant entitled to, and for what period of time).

In the case of short-term disability benefits, the senior claims handler can perform the benefit assessment without requiring further documentation. In these cases, the benefit assessment takes 20 minutes. Once a decision is made, the senior claims handler registers the entitlement on the insurance information system and informs the customer of the outcome via e-mail or postal mail.

However, in the case of long-term disability claims (more than three months), the senior claims handler requires a full medical report in order to assess the benefit entitlements. Senior claims handlers perceive that these medical reports are essential in order to assess the claims accurately and to avoid fraud. Once the senior claims handler has received the medical report, they can assess the benefits in about one hour on average. In rare cases (2% of cases), the claim is rejected after the benefit assessment (i.e. the customer does not have right to receive any benefit given their medical condition). The senior claims handler sends a notification of the outcome of the assessment to the customer (by e-mail and post). If applicable, the notification includes the amount of the monthly entitlement and the conditions of this entitlement (e.g. when will the entitlement be stopped or when is it due for renewal). The entitlement is recorded in the insurance information system.

Later, a finance officer triggers the first entitlement payment manually and schedules the monthly entitlement for subsequent months. The finance officer takes on average 20 minutes to handle an entitlement. Finance officers handle payments in batches, once per working day.

When a medical report is required, a junior claims handler contacts the customer (by phone or e-mail) to notify them that their claim is being assessed, and to ask the customer to send a signed form authorizing InsureIT to request medical reports from their health provider (hospital or clinic). Health providers will not issue a medical

1 From Wikipedia: “Disability Insurance is a form of insurance that insures the beneficiary's earned income against the risk that a disability creates a barrier for a worker to complete the core functions of their work.”
report to an insurance company unless the customer has signed such an authorization. Customers are required to provide the authorization form at most 14 days after being requested to do so. If the authorization is not received within this delay, the claim is deemed to have been withdrawn. On average, it takes about 4 days to get the authorization form from the customer.

Once the authorization has been received, the junior claims handler sends (by post) a request for medical reports to the health provider together with the insurer's letter of authorization. Hospitals reply to InsureIT either by post or in some cases via e-mail. On average, it takes about 15 working days for InsureIT to obtain the medical reports from the health provider (including 4 working days required for the back-and-forth postal mail). This average however hides a lot of variance. Some health providers are very cooperative and respond within a couple of working days of receiving the request. Others however can take up to 30 working days to respond.

As a result, the average time between a claim being lodged and a decision being made is 3 working days in the case of short-term disability claims, and 20 working days for long-term disability claims.

Naturally, so long waiting times cause anxiety to customers. In the case of long-term disability claims, a customer would on average call or send an e-mail enquiry twice, while the disability claim is being processed. Such enquiries are answered by the junior claims handler and it takes about 10 minutes per enquiry. In about a third of cases, junior claims handlers end up contacting the health provider to enquire about the estimated date to obtain a medical report. Each of these enquiries to health providers takes 10 minutes to a junior claims handler.

The total benefit paid by the insurance company for a short-term disability is EUR 5K (typically spread across 2 or 3 months). For long-term disability, this amount is 20K, but some claims can cost up to 40K to the insurance company. In case of long-term disability, the duration of the benefit (number of months) cannot be determined in advance when the claim is lodged. In these cases, the benefit is granted for a period of 3 months and the case is reviewed by a senior claims officer every 3 months in order to determine if the benefit should be extended. Half of the benefit renewals are done after a simple check, which takes 30 minutes to the senior claims handler. But in the other half of renewals, the senior claims handler requires a new medical report, which means that the whole process of obtaining a medical report has to be repeated (except that the letter of authorization signed by the customer during the initial assessment can be reused). It often happens that the renewal takes too long and customers stop receiving their monthly benefit temporarily during the renewal process.

The insurance company receives 2000 disability claims per year, out of which 20% are for short-term disability and 80% for long-term disability.

The company employs two full-time junior claims handler and two full-time senior claims handler dedicated to disability insurance.

Given the persistent problems with obtaining health reports in a timely manner, claims handlers have tried to negotiate with several health providers a faster approach to obtain medical reports. A handful of health providers (the more cooperative ones) are willing to accept medical report requests by e-mail to save 2-3 working days. However, the majority of health providers do not see any incentive to put more resources into issuing medical reports for insurance companies. They
perceive that their customers are the patients. The process of issuing medical reports to insurers is secondary for them.