



Emerging Trends – What’s Next?

The insurance industry is a highly competitive and regulated market. Insurance companies are consolidating and merging while seeking any competitive advantage they can find to reduce costs, increase efficiency, and remain compliant with the myriad of 50 state statutes. Companies must be vigilant and remain flexible to identify new ways to manage margins and preserve capital by implementing sound decision-making processes and risk mitigation strategies. They must consider everything from trends in investment strategies, diversification, reinsurance, securitizations, and cyber-security; to mergers, acquisitions, joint ventures, strategic alliances, and investment in back office improvements, e.g., claim operations.

As life claim professionals we must continually be aware of changes and emerging trends within the life insurance industry that may affect claim operations. This article takes a high level look at a few of these trends, focusing on three areas: technology, resources and policies.

Trending in technology

E-forms

Simply providing printable claim forms online for claimants to complete and return by mail or fax is slowly becoming *passé*. Life insurance companies are gradually beginning to implement web-based solutions in pursuit of expedited claim processing and to elevate the overall customer experience. This technology provides claimants with a partially pre-filled death claim form for verification of information and completion of additional required details, such as location of death and beneficiary information. Where possible, drop-down lists are utilized to ensure the data provided is properly formatted and can be automatically loaded into a claim database.

Documents are signed via e-signature; however, some companies are utilizing known information from their systems, as well as alternative sources of information, such as credit reporting agencies, to verify the claimant’s identity.

The claimant is also provided the opportunity to scan other required documents and proofs of loss, e.g., medical authorizations, death certificate, foreign death questionnaire, or copy of the policy, directly into the company’s mail server to be attached to the claim. Companies continue to require a hard copy of the death certificate be received by mail; however, the electronic submission of documents allows the claim set-up and adjudication process to begin immediately; thus, enhancing the customer experience by simplifying the process of filing the claim and decreasing the number of days to adjudicate it.

Even though e-forms have been successfully utilized in other lines of insurance, for example, auto, the transformation to life insurance claims has proceeded slowly and cautiously as companies systematically monitor its effectiveness and to ensure proper controls are in place to identify and mitigate the risk of fraud. Currently, this process is primarily utilized for claims on policies with small face amounts or low risk factors, such as advanced age, domestic location of death, or longer policy durations.

E-medical records

As the result of a federal government mandate, all public and private healthcare providers were required to adopt and demonstrate “meaningful use” of electronic health records (EHRs). Failure to do so by 2015 resulted in penalties beginning with a 1% reduction in Medicare and

Medicaid reimbursements, with the penalty increasing each subsequent year, up to a 95% penalty depending on future adjustments. These penalties, along with monetary incentives for completing implementation of an EHR system, provided motivation for medical providers to adopt the digitized formatting of medical records. The utilization of EHRs will indirectly impact the life insurance industry, specifically in the underwriting and claims areas.

From an underwriting viewpoint, it is envisioned that EHRs will feed into an underwriting data base and provide improved integration for automated rules-based underwriting. Properly implemented, automated underwriting will increase efficiency, decreasing turn-around-time from the date of application to the date of an underwriting decision and policy issue. However, there is some concern that including EHR data from wearables like Fitbit, such as daily steps, heart rate, or sleep quality, may result in data overload. In addition, the use of diagnostic code sets and limited context, may increase the need for underwriters to obtain more detailed Attending Physician Statements.

In addition to underwriters, the implementation of EHRs will have an important impact for claim professionals. Digitized data is searchable; thus, identifying claim, risk (biometrics) and fraud trends may become more effective, reliable, and perhaps automated. In addition, EHRs will eliminate the notorious issues with illegible physician penmanship.

On the downside, both underwriters and claim professionals are apprehensive that physicians will become more cautious about documenting medical records since patients and their families now have increased access to view their records. This could cause a physician to be less candid when documenting the file or a patient may request a physician redact the records to leave out pertinent information.

There is currently no standardized format nor dominant platform for EHRs. Furthermore, there is no plan for conversion of paper medical records to EHRs; thus, in order to obtain a complete health history of an insured, underwriters and claim examiners must request both the EHRs and all paper medical records created prior to EHR implementation. Privacy, general public awareness, perception and acceptance also play critical roles on the effect of EHRs to life insurance companies.

It is vital that claim departments work with underwriting, and all other departments affected by EHRs, to ensure consistency and efficiency and to maximize the utility of EHRs within their company.

Data analytics aka “big data”

Data has always been vital to the insurance industry as it provides the ability for companies to analyze and evaluate the risk of insuring a particular industry, event, or individual. The growth of big data through data mining, in-memory analytics, predictive analytics and text mining has enabled insurance companies to more quickly recognize underwriting and claim trends, develop pricing modules, administer policies, decrease processing times, and to detect potential fraud in both the claim and underwriting process.

Through improved systems and the increased accessibility of big data, identification of behavior patterns, utilizing social network behavior, risk scoring, and live data streaming, insurance companies are already initiating fraud detection in the early stages of the application and underwriting process. These methods assist companies to evaluate risk more accurately to either rate the risk appropriately, request additional information, or to reject the risk if it exceeds their underwriting guidelines or if fraud is detected.

Insurance fraud has always had a high cost to both insurance companies and consumers. The Coalition Against Insurance Fraud estimates the impact of claim fraud on the insurance industry to be \$80 billion dollars...each year. While claim examiners must remain able to manually identify red flags and indicators of fraud, big data may assist examiners to detect fraud earlier in the claim process and more accurately identify claims requiring additional scrutiny. By detecting and eliminating fraud more quickly and accurately, these algorithms allow companies to decrease the time necessary to review and pay legitimate claims, as well as assisting to reduce the overall cost of insurance to consumers.

Trending in resources

The human factor

As discussed, with the onset of e-forms, e-medical records, and big data, new technological advances are forever changing the insurance industry. This includes the ability to conduct business from virtually anywhere in the world from a single location, including an employee’s own home. According to Global Workplace Analytics, the non-self-employed work at

home population has grown by 103% since 2005¹. For many insurers, the concept of working from home or “telecommuting” initiated in their I.T. and underwriting departments in an effort to recruit and retain critical employees. This movement has quickly spread into the claims arena as companies are concerned that their most experienced individuals are approaching retirement and they may have insufficient experience remaining in the department. Attracting experienced claim professionals who are willing to relocate is a daunting challenge. In addition, millennials are difficult to attract to the insurance industry; thus, offering the ability to work from “anywhere” can be very appealing to these demographics.

In addition to attracting new talent and improving employee retention and job satisfaction, some companies are able to significantly decrease the costs of office space and related overhead by allowing call center and claim employees to telecommute. This is also an alternative to outsourcing these jobs to third-party administrators or other countries.

The companies that have most successfully implemented telecommuting into their environment have well-defined and written telecommuting guidelines defining the expectations of all parties. This includes the understanding that if the employee does not meet the expectations or other requirements, then their privilege to telecommute may be terminated or they may be subject to other disciplinary action.

Many companies with a telecommuting policy require employees to be present in the office at least periodically. For the individual employee, this varies substantially from one week per month, to 1-3 days each week. These companies usually require all employees to simultaneously be in the office for at least one day of the required office time. This creates balance, allowing the convenience of offsite time for concentrated non-interruptive claim review and production, while maintaining time for team camaraderie and interaction for collaborative discussions.

If not properly planned and executed, telecommuting may increase the risk of a potential security breach, and privacy and confidentiality is also a concern. Strict security and privacy guidelines must be established and be included in the telecommuting guidelines. Each employee should be required to sign an acknowledgment of receiving and having read the guidelines.

Trending in policies

HIV positive

Until recently, individuals living with HIV/AIDS were uninsurable by life insurance companies as being HIV-positive was considered to be an early death sentence; however, due to advances in medical technology and treatment innovations, HIV life spans are increasing. According to statistics by Healthline.com², a 20 year-old-man with HIV, who begins treatment early, can now expect to live to age 77. The increased rate of HIV survival has not gone unnoticed by life insurers. In 2015, a major life insurer began offering life insurance coverage to individuals living with HIV. In addition, another major insurer launched a program to provide financial and retirement planning to individuals living with HIV.

As longevity increases for HIV positive individuals, so will insurance and health care options. This is also true for other medical diagnoses as further advances in medicine are made. It is important for the claims department to collaborate with the underwriting and pricing departments to stay abreast of new products and to collect data and provide important feedback about the claim experience and the policy durations involving these innovative insurance policies.

Critical illness

The U.S. market for critical illness coverage is growing faster than any other insurance product. According to a 2015 survey of 59 critical illness carriers representing approximately 95% of the U.S. market, 43 companies stated they were actively marketing 73 different critical illness products³. Of those already in the market, 59% stated they plan to increase their focus on critical illness sales. This market is being driven by the fact that people are living longer and their chances of surviving a heart attack, cancer or stroke are greater than even a few short years ago. Escalating health insurance pressures due to high deductibles and out-of-pocket expenses are contributing to the need for individuals to have other options to close the gap of paying for health care needs and avoiding depletion of their retirement savings.

Critical illness coverage was initially referred to as “Dread Disease” to pay a “living benefit” or lump sum benefit to a surviving patient of a serious illness. The early versions only covered four conditions: heart attack, CAD requiring surgery, cancer and stroke. Total and permanent benefits were subsequently added. Coverage today often includes: cancer, heart attack, stroke, heart transplant, coronary bypass surgery, angioplasty, kidney

(renal) failure, major organ transplant, and paralysis. Some coverages may also reimburse the insured for screenings, such as EKGs, mammography or wellness tests.

As the demand for this coverage grows, employees are beginning to see critical illness benefits included as an option in their employee benefit package as an incentive to enroll in this consumer-driven health plan. As health care costs continue to rise faster than inflation, the demand for critical illness coverage may be one of the top selling products in coming years. Claims management will need to determine which examiners are best suited to handle this type of claim, e.g., life, disability, and consider their future training and staffing needs as their inforce coverage increases.

Be prepared

The future for life insurance claims is dynamic and the evolution will be challenging for companies caught flatfooted. Companies will steadily move away from manual and legacy systems to streamlined adjudication platforms. With the onset of new products, such as HIV-positive coverage, claims departments will become an even more vital resource of critical mortality data to their pricing and underwriting areas. As more employers offer telecommuting options, they will observe increased productivity and morale, and attract skilled professionals while reducing the overhead for facilities. The claim professional will witness social networks evolving as more than just a source for fashion trends and snapchatting with friends and become an important tool to use for claim adjudication.

To take advantage of these trends and stay ahead of them, insurance companies and claim professionals must commit to identifying, implementing, and managing the transformations these and other emerging trends will have on their daily processes. By doing so, they will already know, “What’s Next?”

References

¹GlobalWorkplaceAnalytics.com

²Healthline.com/health/hiv-aids/facts

³The Gen Re Critical Illness Insurance Market Survey 2015



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