securian FINANCIAL®

Employee Benefits Solutions
January 2024

Flipping the script: making the claims experience employee-friendly

Think about a favorite customer experience - maybe it was with an airline or a retailer. What are the characteristics that gave you a good feeling about that experience? Maybe it was easy. Maybe you acquired the item or assistance you wanted or needed. Maybe you talked to someone who was especially helpful. Chances are several factors put that experience at the top of your list.

Would you expect an insurance claim event to match that favorable experience? You probably do. Historically, people may not have expected much from insurance companies due to old legacy systems, excessive paperwork and fraud management giving insurance companies little grace. After all, life insurance was introduced when online resources weren't an option, leaving insurers to play catch up as technology progressed. And while supplemental health insurance products, due to their relative "newness," are typically released with digital claim accoutrements, the industry affiliation may mitigate consumer perceptions of a top-notch experience.

An additional area of consideration in the claims process is the fact that expectations can vary by products. Expectations for filing claims for a one-time event, such as a life insurance benefit versus the potential need to frequently file a claim for an ongoing benefit can vary. Certain industries, such as insurance, no longer get a pass on subpar experiences because customer expectations are now shaped by all their interactions, such as the leading customer journeys found in retail, banking and technology industries.

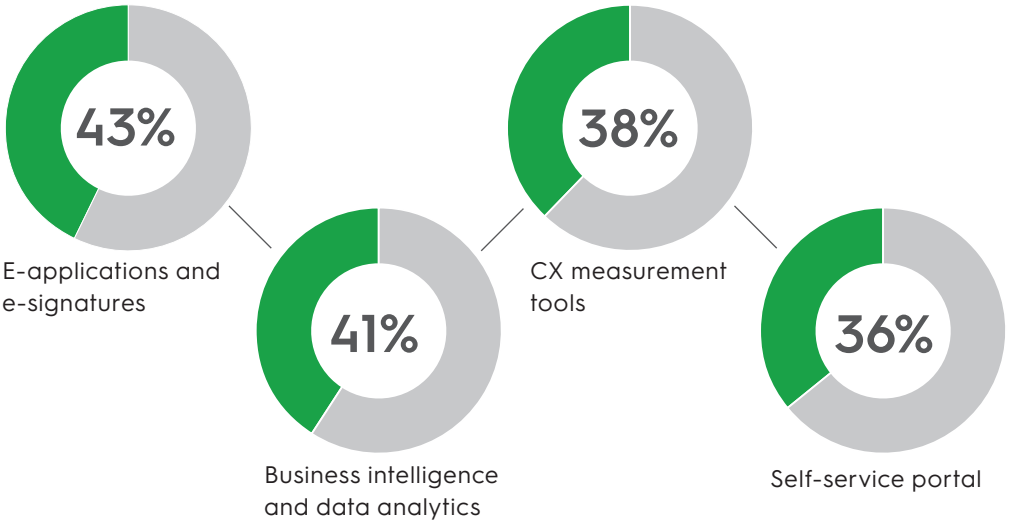
Written by

Ross Stedman
Securian Financial
Second Vice President,
Business Services

Taking action

Insurance companies are aware of the need for a dynamic approach to the claims process and are prioritizing the enhancement of various aspects of the customer experience (CX). A recent study found:[1]

What capabilities are you planning to invest in?



They realize that advancing the claims experience is critical to remaining competitive in today's technology-forward environment. Let's examine some key areas of focus within the process:

- **Turnaround** It's important to measure and decrease the time to payment as much as possible. This is likely done in the form of overall cycle time (claim notice to decision). When an insurance company receives notice of a claim, it can often be days or weeks after the actual event, especially when waiting for an explanation of benefits (EOB) from the medical carrier to submit the claim, and that will factor into customer perceptions. It's also essential to remember there's likely a point of diminishing returns on the journey. Maybe customers think the cycle time should be 10 days or less, but they don't really care if it's five (juice isn't worth the squeeze) if there is transparency in the process and individuals are kept informed of the claim status.
- **Easy** This might be the single most important area of focus, particularly for supplemental health benefit claims. This is all about minimizing the friction in the process. Examining where customers are encountering problems is a good place to start. Where is abandonment happening in claim submissions? What are people calling about?

  New technology and data sources can be key enablers. Artificial intelligence can support a more intuitive claim initiation, fraud solutions can streamline authentication, and medical claims data can replace or augment traditional forms of proof such as getting a form completed by a treating physician.

  The benefits of utilizing innovative technology to simplify the claims process are real. Not only do CX measures improve, better employee experiences are likely to be included as well. And when it comes to supplemental health benefits, an easy process can support utilization and retention. Said differently, if there is too much friction, customers may not retain coverage.

- **Personalized** This aspect goes hand in hand with a focus on designing an easy process. It's about executing the basics well by setting expectations, educating customers about the product and process, and only requesting relevant information.

  This is also where consistency across channels is critical. Many customers expect to interact with digital or self-service resources, but when they need to talk to a live person, it needs to be a seamless transition and the representative needs to be knowledgeable and empathetic.

  In the employer space, a consistent experience across channels can be particularly challenging when the purchase decision is made with one set of stakeholders and ongoing plan management impacts a different set of individuals at the employer or with their benefit administrator. Insurance companies need to lean into their relationships with both decision makers and benefits administrators to support consistent, clear communication and a seamless customer experience.

Measuring success

Examining the results of actions taken to enhance the claims experience is critical to meeting client expectations and advancing processes for the future. As upcoming generations of customers may place a larger emphasis on experiences rather than products, insurers need to shift the focus from executing transactions to creating experiences and ultimately driving engagement. So, if individuals carry their experience expectations from other industries to the insurance claims process and knowing there's a business benefit to life and supplemental health insurance carriers improving this experience, it seems obvious that this should be an area of investment.

Several key analytics can help carriers evaluate process improvement:

- **Customer satisfaction score:** Captures customers' sentiment toward the entire journey, including digital data collection. This data collection enhances the CX by streamlining and personalizing interactions, resulting in higher overall satisfaction scores.
- **Net promoter score (NPS):** Measures customer loyalty and willingness to recommend an insurer's services to others. It reflects how well carriers create positive experiences for customers.
- **Claim processing time:** Calculates average duration required to process a claim
- **Customer effort score:** Measures ease with which customers can purchase policies, file claims and resolve inquiries

Summary

Insurers will be able to reduce the frustrations that dissuade many consumers from fully utilizing benefits by working from a "customer-in" rather than a "company-out" approach. Developing a superior, digital-enabled CX that compares favorably with those created by other industries is a promising approach to increasing retention, utilization and even sales of additional offerings.

1. Forrester Opportunity Snapshot: A custom study commissioned by Equisoft, June 2022.

Insurance products are underwritten by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life is not a New York authorized insurer and does not do insurance business in New York. Both companies are headquartered in St. Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

Securian Financial is the marketing name for Securian Financial Group, Inc., and its subsidiaries. Minnesota Life Insurance Company and Securian Life Insurance Company are subsidiaries of Securian Financial Group, Inc.

securian.com

400 Robert Street North, St. Paul, MN 55101-2098

F105792 1-2024 DOFU 1-2024
3318749