ECM Whitepaper for Insurance and Healthcare
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IBM Information Management software

Empowering Health Plans to Make Better Decisions with IBM ECM

Overview

Today's health plans are struggling to continue to deliver value to their members, providers and other stakeholders as a way to maintain their own competitive standing in the marketplace. But this marketplace keeps getting more complicated whether it is due to escalating health care costs, industry consolidation, and increasing regulatory requirements. Technology offers a way for health plans to balance out the health care equation.

Rising cost of health care

The growth of national health expenditures in the U.S. continues to escalate. In just one decade, the amount spent on health care per person increased by 77 percent from 1995 to 2005.[1] Not surprisingly, total health spending in the U.S. reached nearly $2 trillion in 2005, $6,700 per person or 16 percent of Gross Domestic Product (GDP), amounting to about $5 billion a day. [2] By 2015, these health expenditures are expected to reach 20 percent of GDP or $4 trillion. [3] Acknowledged by industry experts, the health care delivery system in the U.S. is in need of its form of emergency triage and a treatment plan to recovery.

Industry consolidation

In the health insurance marketplace, industry consolidation through mergers and acquisitions has become a means of increasing membership, improving efficiency, broadening product and geographical diversification. Aggressive health plans are acquiring other plans in new geographic markets, helping expand the range of products by migrating from fee-for-service to more profitable products such as managed care or consumer-directed health care plans, and benefiting from more profitable business models and market conditions. At the same time through this industry consolidation, health plans gain already established provider networks, distribution channels and information systems, which all must be smoothly integrated into the existing structure of the acquiring company. Merger and acquisition activities are expected to continue especially as health plans seek to insulate themselves from economic conditions endemic in their own regional markets. [4]

Regulatory requirements

Health plans are now tasked with compliance to governance and regulatory initiatives such as: the Patriot Act, Gramm-Leach Bliley Act, Sarbanes-Oxley, California SB 1386, and the last remaining standards of the Health Insurance Portability & Accountability Act of 1986 (HIPAA). Compliance with government legislative or regulatory actions also leads to increased costs in membership enrollment, claims processing and administrative expense trends such as the required two-day minimum hospital stays for normal baby deliveries, and the relaxation of pharmaceutical advertising increasing members' demands for certain high-profile drugs.

Role of technology

The smart use of technology speeds up processes and significantly reduces costs, helping keep premiums affordable. The effective implementation of technology also reduces administrative expenses to help health plans maintain their competitiveness. Yet, often the implementation of technology within these plans has been accomplished in a piecemeal fashion by automating existing processes, rather than focusing on aligning the enrollment and claims processing functions with customer-centric process initiatives and the ability to process applications and claims electronically. In the event of mergers and acquisitions, it is the resident legacy systems that become cumbersome to integrate. As a result, health plans are focusing on the use of Service-Oriented Architectures (SOA) to ease this integration and enable them to frequently restructure as market needs dictate. [5] Without SOA, legacy systems are often difficult to integrate and tough to continue supporting in light of new technological initiatives.

Self-service portals provide "just-in-time" information to members about their benefit plans, such as applicable co-payment amounts and the status of claims.

Improving business processes in enrollment and claims helps health plans achieve and sustain their competitiveness. Fundamentally, these processes themselves remain the same; however, they are now further complicated by the demands placed upon them due to customer expectations and regulatory compliance. To achieve true benefits from technology, changes must occur to the processes themselves, as well as to the culture within the health plan. Health plans can gain insight with a focus beyond that of processing transactions to the value embedded within the trends and data itself.

Self-service portals provide "just-in- time" information to members about their benefit plans, such as applicable co-payment amounts and the status of claims. By providing all of this information through self-service portals, health plans eliminate the calls, correspondence and e-mails associated with such inquiries.

Transforming Key Health Plan Processes with IBM Enterprise Content Management

Health plans recognize the necessity of improving their ability to manage and control their key processes as one of the key components of their overall competitive advantage. Executives have found that projects targeted at reducing administrative costs such as online customer self-service and electronic claims processing can help provide significant financial and customer service advantages. Traditionally, the nature of enrollment and claims processes has been labor-intensive, rules-based operations, further complicated by compliance to governance and regulatory initiatives.

IBM FileNet P8: A Platform for IBM Enterprise Content Management

The mere act of enrolling members and paying a claim faster improves relationships with agents, brokers, providers, and members while generating more timely data for actuarial analysis; lowering administrative costs and avoiding potential litigation. One way to help health plans make quick, smart and cost-effective decisions is through IBM FileNet P8, a reliable, scalable and highly available enterprise platform for IBM ECM and IBM Business Process Manager. The FileNet P8 platform provides a robust, high-performance, scalable unified content repository that handles billions of objects and supports

hundreds of thousands of users. The platform uses an open, standards-based J2EE architecture, and is designed to operate within a SOA, and also supports Microsoft.NET environments. As a result it offers maximum operational flexibility, accelerates application deployment and lowers total cost of ownership.

Via the FileNet P8 platform, customers can leverage leading ECM capabilities for a wide range of enterprise scalable solutions – managing business processes, content, email, forms images, records and web site content, along with the ability to benefit from a team collaborative effort. Used together, these solutions provide a unified platform to deliver information, active and in context; provide core business process management services within SOA to support componentized application development; and realize embedded compliance and records management services. Through an integrated information infrastructure, FileNet P8 and ECM help health plans make better decisions faster by managing content, optimizing associated business processes and enabling compliance.

IBM ECM: Combining Content, Process, Compliance, Search and Discovery

Health plans are challenged by the exponential growth of unstructured content that they need to securely capture, store, manage, integrate and deliver all forms of content across the value chain whether it be to workers, members, agents, brokers, providers or other stakeholders. Regardless of their size, health plans all have complicated business processes that form the foundation of all operations. And often, these processes are not as automated and optimized as health plans would prefer.

Using IBM Business Process Manager, health plans can automate, streamline and optimize processes to improve the flow of work within both the local and global enterprise. IBM ECM combines business process management capabilities with content management to activate content in business applications and execute event driven, information-related decisions empowering the workers within these health plans to make the right decision with the right information the first time a specified event happens. Health plans are often addressing the risks and costs associated with litigation as well as adjusting to meet constantly changing regulations and enforcement initiatives. IBM ECM ensures that electronic information is captured and managed in accordance with records policies and regulations with minimal impact on workers.

The IBM ECM solution leverages a company's existing technology infrastructure across the entire enterprise to support any application. Health plans struggle to fully leverage their organization-wide information assets to deliver the information needed by their workers to make effective decisions. The FileNet P8 platform is a layer that integrates with one or more of a health plan's systems so that any worker can have secured, authorized access to appropriate information whether the information is in data, text, or image form. Workers can have unique views of the information based on log-on or workflow rules and be able to perform work based on pre-defined business process management rules. The primary goals are to decrease error rates due to missing information or human misrepresentation of the rules for transacting business, detect fraud, lower exceptions processing, reduce the effect of pended claims and ultimately, achieve straight-through processing.

Supporting New Business Initiatives

The true value of IBM ECM emerges in how it can transform the operational specifics of an organization to support new business initiatives such as helping health plans set up the appropriate infrastructure to support the delivery of new personalized products, improve customer service and self-service options, and drive disease management and preventive healthcare initiatives. To take advantage of these opportunities, health plans require a powerful and flexible platform to accommodate the changing business requirements, challenges, and goals to which it is applied, along with a deep understanding of the process and regulatory realities of the industry. IBM ECM solutions can help health plans activate content with processes; automate and optimize complex processes across the enterprise, and improve visibility and control of content; gain additional insights into unstructured information with secure search, content classification; all through a unified content, process and compliance platform.

Managing Content and Processes

For unstructured content (documents, correspondence, faxes, email and rich media) submitted to health plans, IBM FileNet Capture Professional provides the ability to capture, manage, and distribute content for centralized and decentralized enterprise-wide applications. As a highly scalable document capture solution, Capture Professional solution captures content based on individual content repositories, records management policies and business processes. It integrates with Image Manager Active Edition, Content Manager, Records Manager, Image Services, Remote Capture Services and Content Services, all from the same workstation. It also automates the indexing process and provides consistently indexes content to a FileNet repository, ensuring that workers have immediate access to the most accurate, current information right when it matters the most.

IBM FileNet Image Manager Active Edition provides secure storage and management of enterprise-level volumes of fixed information. It securely and permanently stores immense volumes of fixed information in a robust and highly available environment. It delivers rapid, high-performance information retrieval for thousands of users to billions of fixed objects and content. To enhance the value of existing investments, Image Manager Active Edition integrates content with current business

systems as well as with the FileNet P8 platform. Once content is scanned and indexed, the paper documents can be shredded, eliminating the need for off-site storage and the costs associated with maintaining such storage.

With content securely stored and indexed, IBM FileNet Content Manager provides health plans with full content lifecycle and extensive document management capabilities for digital content. Health plans can automate and drive their content-related tasks and activities such as enrollment and claims using its document management with out-of-the-box workflow and process capabilities. Using IBM Federated Records Management, it delivers the ability to actively manage content across the enterprise regardless of what repository is used.

Managing business processes, especially reducing delays between information gathering, the pending of applications or claims awaiting the requested information and acting upon that information, is a way to improve efficiency, responsiveness and control costs of membership enrollment and claims processing. One of the top ten strategic responses for the insurance industry for 2007 as identified by The Tower Group, Inc. is straight-through processing with the objective of launching scalable solutions that automate transactions from the point of customer contact to routine services and inquiry.[6] Business Process Manager increases process performance, reduces cycle times and improves productivity by automating, streamlining and optimizing complex processes to manage the flow of work and content throughout the health plan.

Using advanced analytics and simulations with real data or assumed scenarios, health plans can achieve comprehensive process management. Changes to processes can be deployed rapidly while minimizing the impact on normal business operations. Managers can use Business Process Manager to more effectively optimize operational efficiencies and resource utilization while enforcing the policies of the health plan and improving process consistency. Integrated with FileNet P8 platform, it provides interoperability with the widest selection of database, operating system, storage security and Web server environments.

Simulating and analyzing workflow as it happens helps identify what is working and what is not working. Using IBM FileNet Process Analyzer, managers can evaluate business performance and analyze productivity, efficiency and cycle time. It provides these managers with a comprehensive and dynamic data delivery by utilizing an advanced data structure that supports high-performance queries, allowing them to analyze data from a variety of perspectives.

Health plans are faced with a myriad of corporate governance and regulatory requirements. As a result, health plans must be able to demonstrate ongoing compliance to avoid costly fines. IBM FileNet Compliance Framework provides an enterprise platform for managing multiple risk and compliance initiatives, reducing the cost of compliance while achieving, sustaining and proving compliance. This framework brings together FileNet P8 compliance core products such as Records Manager, Business Process Manager, Forms Manager and Content Manager.

When Problems Arise

Improving the accuracy and quality of key processes like enrollment and claims processing contributes to bottom-line profitability and also avoids possible litigation. If these business processes are not managed appropriately, consequences can result. For example, Cigna Corp. was required to spend $70 million in 2003 to repay doctors, $55 million for attorneys' fees and $15 million to create a healthcare foundation along with allocating $400 million to improve its billing systems in the settlement stemming from a class action lawsuit filed by doctors challenging its HMO's business practices. [7] In a similar class action lawsuit, Aetna was required to make changes in speeding up its claims processing procedures of which Aetna noted would cost $300 million to implement such changes in addition to a settlement of $170 million in 2003. [8] Recently, the Blue Cross and Blue Shield Association and 30 Blue Cross health plans settled for $128 million a class-action lawsuit brought by 900,000 doctors that also mandates that the Blue Cross revise their claims payment procedures. [9]

Improving the accuracy and quality of key processes like enrollment and claims processing contributes to bottom-line profitability and also avoids possible litigation.

Reducing processing times contributes to profitability by streamlining exception processing and deploying distributed processing to achieve economies of scale whether to locations, regional or globally, internal or outsourced. Using Business Process Manager, health plans can facilitate exception processing by providing instant access to critical information. With the control of business processes and content, continuous process improvement is easy because health plans are able to identify problem areas quickly and take appropriate action to resolve the problem(s).

Reducing Claims Leakage

Reducing claims leakage is a key step in improving accuracy, quality and ultimately, profitability. Without Business Process Manager and the ability to model business processes, health plans may not be aware that claims are being overpaid, particularly at amounts insufficient to trigger a routine overpayment request. The potential of claims leakage can be minor on an individual basis yet substantial on a cumulative basis, resulting in million of dollars paid in error. By controlling claims leakage, health plans prevent the unnecessary overpayment of claims.

Legacy Systems

Critical to the health plan marketplace is the ability of IBM ECM solutions to seamlessly integrate with core legacy business systems. As health plans have evolved, it is their legacy systems that often contain critical information that must be referred to during various processes. Through this integration with legacy systems, health plans can gain greater value from their existing investments, leveraging the historical value of their legacy systems. In the event of mergers and acquisitions, health plans are often faced with the dilemma of how to integrate the information contained within these legacy systems. At these times,

the integration of legacy systems presents their true value because the data that resides on legacy systems is often critical to the proper administration of enrollment and claims policies in accordance with the original risk management profiles.

Electronic Claims Submission

Electronic claims submission provides many advantages to insurance companies: helps eliminate paperwork, reduces the time to process claims, posts payments faster, reduces errors in processing, and provides an audit trail of claim activity. For the provider, time and money are both saved via electronic claims submissions and office productivity is improved without having to deal with paper files.

One of the planned benefits of the administrative and simplification standards of HIPAA is its integration with electronic claims processing. With an auto-adjudication system, claims examiners are involved in processing only those claims that require exception handling. Benefits for health plans include increased automation, reduced errors plus increased use of Electronic Data Interchange (EDI) capabilities. Gaining the ability to receive transactions and process claims electronically is important in achieving the goals for auto adjudication. Health plans estimate the cost to process a paper claim is almost double the cost to process an electronic claim. [10] Currently evolving on the HIPAA horizon are claims attachments whose standards has not yet been fully finalized.

For managing the submission of electronic claims forms, IBM FileNet Forms Manager provides the ability to design, deploy and process electronic forms (eForms) – across the health plan to speed business decisions. It can enable health plans to transform cumbersome paper forms into fully interactive eForms that directly connect to enrollment and/or claims processing applications to reduce costly errors, to expedite service, to increase efficiency and overall customer responsiveness.

An eForm can be intelligently routed across the entire enterprise directly into a specific business process such as enrollment and claims processing. Because eForms are integrated seamlessly with existing legacy systems and applications, these eForms become interactive, usable forms that can be embedded into the

intelligent workflows of Business Process Manager to automatically verify the content against the company's criteria or template. Missing information can be automatically requested and then matched to the application upon receipt using Business Process Manager.

Moving from Paper to Electronic Communication

One way for health plans to differentiate themselves is in their approach to their relationship with their members. Typically, the relationship has been focused on how a claim is resolved. The provider or member submits a claim, the health plan evaluates it for coverage and an Entitlement or explanation of benefits (EOB) is provided that shows the results of the plans' evaluation. This EOB can be good or bad news for the member. If bad news, the member may contact the health plan to ask detailed questions. By enhancing the type of communication included in these EOBs, the health plan has the opportunity to alter the focus of this good news/bad news scenario by providing more personalized health education information to their members. [11]

Nowadays, members have the option to select the delivery of inbound or outbound communication, either in paper or electronically. With the introduction of HIPAA electronic transactions, the industry has eliminated vast amounts of paper in inbound communication. However, the industry still to a huge extent relies on paper in outbound communication like EOBs Coordination of Benefits (COB) and other member information. EOBs are now available online from almost all of the major health plans with areas hyperlinked for additional information. The delivery of information electronically improves customer service in terms of its timeliness, provides an open channel of communication, and the ability to improve the appearance of this communication through the use of graphics or video.

A key enabler with this migration from paper to electronic is through the use of IBM ECM print output capture capabilities. Health plans can enhance their EOBs by providing additional information regarding the respective procedure along with educational resources concerning the proper disease management protocol.

HIPAA: The Second and Last Decade of Change

With its wide-reaching legislation, HIPAA transformed the ways that insurance companies and health providers dealt with patient information and how they handle claims. This transformation is coming to an end with Electronic Claims Attachments Standards being one of the last additions to the HIPAA transaction set that is not yet effective. The majority of claims today are transmitted electronically to health plans and significant portion of these claims are auto-adjudicated, realizing the potential as promised by HIPAA's EDI standards.

HIPAA Claims Attachments

The assumed last major HIPAA electronic transaction standard is the Claims Attachments Standards that propose common methods for how additional healthcare information is to be submitted in the form of electronic attachments for processing. Because claims attachments bridge billing and medical records, they cause problems for auto adjudication, often requiring exception processing. HIPAA intends to incorporate a more efficient process by using existing EDI communications networks and middleware to route the attachments to payers and associate specific data within specific service lines of the claim.

The Standards for Electronic Health Care Claims Attachments was proposed in late 2005 by Centers for Medicare & Medicaid Services (CMS) with an estimated Final Rule publication slated in September 2008. The Standards are expected to cover six attachment types: emergency department services, clinical records, laboratory results, ambulance services, medications and nine rehabilitation services. Based on the anticipation of what type of attachments are necessary to resolve particular claims, the HIPAA rule will further outline specific requirements, remove the tendency of providers to send everything to avoid a second request and subsequent delay in pending their claims to await the receipt of additional information. Providers and health plans will also eliminate extra copying costs, paper processing costs, storage and mailing costs plus limit the risk by managing PHI according to privacy and security rules.

To allow claims examiners to view a version of the claim on screen, health plans will be able to use Extensible Stylesheet Language (XSL) to create the XML document. Without re-engineering their claims adjudication processes, health plans can handle HIPAA Claims Attachments and be responsive to EDI/XML/Health Level 7 attachments by using a robust image-based business process workflow system to control the flow and access to this information, and connect to legacy systems for continuity. This image-based workflow system must also be versatile in its support for EDI, XML and paper claims.

Along with Image Manager Active Edition, Content Manager and Business Process Manager can form the basis of a solution to address the implementation of HIPAA Claims Attachments. Image Manager Active Edition can deliver high-performance information retrieval to business users and integrates seamlessly with other enterprise applications and systems to give health plans the ability to quickly respond to changing business conditions. Content Manager can also activate the company's content for delivery at the appropriate time and to the right recipient. Business Process Manager provides the capability of integrating most rules engine on the market to ensure that rules and regulations are followed uniformly with any insurance organization.

Records and Email Management Using IBM FileNet Records Manager and IBM FileNet Email Manager

Compliance and records management are becoming critical tasks because health plans must adhere to a variety of governance and regulatory records retention requirements. To address key business requirements for recordkeeping and compliance, IBM FileNet Records Manager allows health plans to securely capture, declare, classify and dispose of both electronic and physical records. With Records Manager, a document that is identified as a "record" upon receipt is managed as a record immediately. As a record, the document becomes a digital object and cannot be altered or changed and it can also drive various business processes as defined by Business Process Manager.

As more and more health plans rely on email for communication with providers, members, agents and brokers, and other stakeholders, they need a means of capturing records contained in email. IBM FileNet Email Manager helps reduce operational problems introduced by the increasing amount of email and electronic messaging data stores by managing mailboxes, increasing server performance, enabling faster backup and restore, providing easier upgrades, leveraging storage management's best practices for email and applying simple retention rules. It also helps extract knowledge buried in email and other electronic messaging and automates workflow steps and associate email and electronic messaging content in processes, cases and line-of-business systems.

As more and more health plans rely on email for communication with providers, members, agents and brokers, and other stakeholders, they need a means of capturing records contained in email.

Records Manager is designed to uniquely combine content, process and connectivity to automate and streamline all records-based activities, eliminate burdensome end-user participation, enforce compliance and create business advantage through a compelling return on investment.

Records Manager, powered by "ZeroClick" technology, helps address regulatory compliance challenges and delivers tangible ROI by: reducing risk by automating the entire records management lifecycle process ensuring consistent policy enforcement; lowering operational risk by reducing storage, discovery, training and infrastructure expenses; and improving productivity by automating routine business user and records management tasks and enabling staff to focus on higher value activities.

Hundreds of documents remain uncontrolled on network file share drives where documents are disorganized, are not secured by standard compliance guidelines, can contain inappropriate content and/or exist as duplicates. Health plans must determine how to cost-effectively bring documents on the network file share drives under control and ensure that they are handled in a manner compliant with corporate and regulatory policies. IBM FileNet Records Crawler monitors, analyzes and takes action on documents to enforce policies on objects stored in Microsoft network file shares, local drives, Content Services, and Image Manager Active Edition.

The Art of Collaboration; IBM FileNet Team Collaboration Manager

Because of the complexity of some applications for membership and claims, it is often necessary to have claims referred to managers, supervisors, in-house counsel, and third parties. IBM FileNet Team Collaboration Manager integrates content and processes with collaboration tools to streamline decision-making by removing barriers between people, data and processes. By optimizing interactions between team participants, it facilitates both structured and ad hoc processes to drive applications and claims towards resolution. Rather than having to sequentially review and comment on an application or

claim, or photocopying voluminous supporting documents or claim files and sending them for a review, Team Collaboration Manager offers a Web-based solution that leverages BPM, ECM and Records Management out-of-the-box, providing a framework for team collaboration within the context of the health plan's business processes for speedier resolution.

Consumer Directed Health Plans

With the approval of health reimbursement accounts and the creation of health savings accounts in 2002 and 2003, respectively, Consumer Directed Health Plans (CDHP) were on their way to revolutionizing the way that employers offered health coverage to their employees. A study from Frost & Sullivan stated that the premium revenues for the U.S. consumer directed health plan markets were $39.7 billion last year with the expectation that these revenues will grow to $399.1 billion in 2007. [12]

The adoption of CDHPs reflects a shift in the marketplace. Aside from enabling legislation, this shift is due to a number of factors such as the option for some employers to trade lower premiums for higher deductibles. With CDHPs, the role of health plans broadens to become a source for wellness information, provider networks, discounted services, care management and patient advocacy, education, decision-support tools, and financial information. This new role requires flexible business processes, information management and transparency plus refinements in health plan administration. Health plans must focus on improving their own internal administrative processes to addresses various transaction metrics, support the management of health reimbursement account funds and optional flexible savings accounts, and track medical benefits, other care options, preventative care and real-time self service access.

A new law, the Health Opportunity Patient Empowerment Act of 2006 became effective on January 1, 2007 and has made Health Savings Accounts (HSAs) more consumer-friendly. [13] This law lessened the restrictions associated with HSAs and increased the maximum contributions allowed for individuals and for families, along with allowing for easier transfers between other types of accounts such as individual retirement accounts, flexible spending accounts, and health reimbursement accounts. [14]

Fraud

The National Healthcare Anti-Fraud Association notes that more than 4 billion health insurance benefit transactions processed in the U.S. each and every year are fraudulent. [15] In California alone, insurance fraud costs $15 billion a year. [16] Examples of fraud discovered by health plans include unnecessary procedures, services related to false diagnoses, charging for services not provided, false health plans, rent-a-patient schemes in which "patients" undergo unnecessary surgeries and the false billing of brand name drugs instead of generic drugs. Perpetrators of fraud are getting more creative as evidenced by the California doctors who recruited healthy patients to perform unnecessary procedures on them, resulting in billings of $98 million to various health plans. [17]

To combat fraud in claims, health plans search for abnormal and unusual patterns, similar and frequent claims that are received from the same provider or for the same insured, and when certain thresholds are consistently exceeded. Using Business Process Manager, claims analysts can be alerted to these questionable patterns, allowing corrective action to be taken in detecting and preventing fraud.

Outsourcing

For some health plans, outsourcing claims processing in one form or another is a way to reduce overall administrative costs, augment existing staff resources and achieve economies of scale. Outsourcing helps control the costs of claims processing; however, health plans must ensure that their outsourcing vendor is also in compliance with all regulatory requirements as well as their own internal quality standards. Recently, there has been a reluctant migration to the use of business process outsourcing for processing claims due to service interruptions. [18]

IBM FileNet P8 and ECM: The Largest Installed Base in the Insurance Industry

With the largest installed based in the health insurance industry, health plans have selected FileNet P8 and ECM as a way to help them make better decisions by managing both content and process. IBM ECM is installed in the majority of BCBS organizations and in all of the top 25 insurance companies, making it the leading ECM provider in the industry. IBM ECM understands the issues faced by leading health plans to improve their profitability through more efficient business processes, improved customer service, broker and agent loyalty, and sustained competitive advantage.

A Look at ROI Achieved with IBM ECM

By gaining control over the content and various processes that drive their operations, health plans have realized cost savings, improved claims processing cycles, better customer service, the ability to readily detect fraud and reduce claims leakage, and improved compliance to both corporate governance and regulatory requirements. Most health plans are reluctant to share their

precise ROI realized from deploying IBM ECM solutions as they view it as a competitive advantage. While the name of these customers cannot be disclosed, the results below demonstrate the results achieved from the use of IBM ECM:

- Reduction in expenses, increased productivity: With manual routing of work eliminated, operations cycle times dropped from hours to minutes for this health plan. The organization realized 12 percent reduction in G&A expenses and an increase in productivity among its operations employees of 20 percent.
- Improved First Call Final completions, improved accuracy of claims payments: This health plan realized completed 95 percent of its customer service inquiries on the first contact and reached 99.5 percent accuracy on its payments.
- Reduced excessive email retention costs, improved access to critical email and digitally stored phone conversations: In defending itself against a lawsuit, this health plan reduced expenses related to litigation discovery and easily located relevant email and related content to use in its defense.

About IBM ECM

IBM ECM helps companies make better decisions faster by managing content, optimizing associated business processes and enabling compliance through an integrated information infrastructure. For more information on IBM ECM software, go to http://www.ibm.com/software/data/ecm.

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