Reimagining Reimbursements: Enhancing Claims Submission Experiences

Overview

Role: Lead UX Researcher

Timeline: January 2024 – February 2024

Research Methods: Mixed-method approach (Qualitative & Quantitative)

Participants: 1,107 survey respondents, 12 in-depth interviews (IFP & Medicare members), Call center data analysis

---

Problem Statement

Via Benefits was facing a significant volume of post-submission calls related to claim denials and reimbursement inquiries. Nearly 25% of all call center interactions are related to claim status and payment issues, indicating a lack of clarity in existing communication channels. The primary concerns include:

- **Confusion around claim denials** – Users find rejection reasons vague, leading to repeated calls for clarification.
- **Unclear claim status updates** – Ambiguous claim status indicators cause unnecessary anxiety and engagement with customer support.
- **Excessive reliance on customer service** – Many users struggle with self-service options and default to calling the support center.

This research aimed to uncover user pain points and propose solutions to improve communication, reduce support dependence, and enhance the overall claims submission experience.

Research Approach

Methodology

A mixed-method research approach was employed, combining qualitative and quantitative data collection:

- **User Interviews:** 12 in-depth interviews with Via Benefits participants (aged 60–79, mix of IFP & Medicare users)
- **Survey:** 1,107 responses from Via Benefits participants
- **Call Center Data Analysis:** 542,183 calls reviewed (March–September 2023) to identify common issues
- **Sequential Experience Questionnaire (SEQ) Data:** Insights into users' digital and call center interactions

Key Research Questions

1. What are the primary reasons for post-submission calls?
2. How can we improve rejection clarity to reduce confusion?
3. How can we enhance claim status updates to minimize support dependency?
4. Will improved communication strategies effectively alleviate these issues?

Tools

In-depth Interview

- **Recording and Transcription Tools:**
  - Zoom was used for remote in-depth interviews (IDIs) to accommodate participants' schedules.
  - Sessions were recorded and transcribed using Otter.ai, enabling detailed analysis and direct quotes.
- **Discussion Guide:**
  - A structured guide ensured consistency across interviews while allowing for flexibility to explore unique participant experiences.

Survey

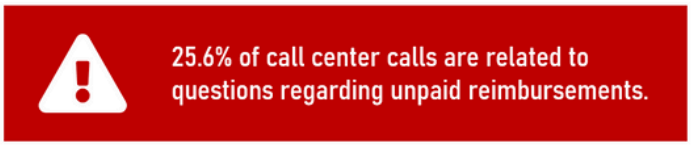
- Qualtrics was used to design, distribute, and manage the survey.
- Features like skip logic, conditional branching, and custom reporting ensured a seamless respondent experience and precise data capture.

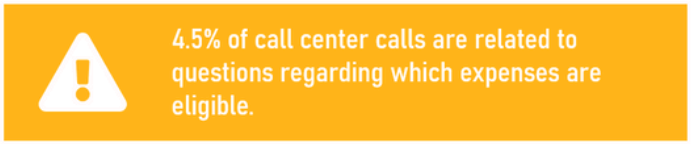
Key Findings & Insights

1. High Call Volume Related to Unpaid Reimbursements

- 25.6% of all support calls were related to unpaid reimbursements, highlighting significant gaps in communication.
- 4.5% of calls focused on questions about eligible expenses for reimbursement.

Call Reason	Count	%
Unpaid Reimbursement	138533	25.6%
Questions about Enrolling	65070	12.0%
What is my Account Balance	52656	9.7%
Needs to Enroll	48405	8.9%
Questions about Plan Details	35163	6.5%
Received a Letter or Email	25332	4.7%
What Expenses are Eligible for Reimbursement	24170	4.5%
Direct Deposit	21348	3.9%
Requesting Reimbursement Forms	20142	3.7%
Why is my Account Balance what it is	19101	3.5%
Unable to Log In to the Website	14591	2.7%
Help Using the Website	13394	2.5%
Report a Death	12667	2.3%
Address Change	8214	1.5%
Schedule Appointment	7854	1.4%
Checking Status of the App/Policy	7514	1.4%
Turn AR On or Off	7351	1.4%
AR Payment Not Received	4646	0.9%
Lost Reimbursement Check	3924	0.7%
Ghost Call	3707	0.7%
Wants to Cancel their Plan	2900	0.5%
Asking for Plan ID Cards	2010	0.4%
Calling to Activate Funding	1785	0.3%
Make IFP Funding Election	1411	0.3%
Report a Divorce	295	0.1%
	542183	100%





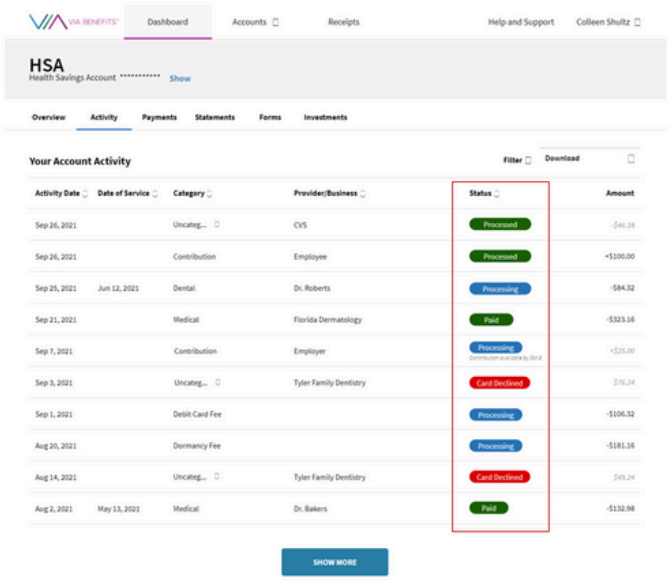
2. User Confusion Around Claim Rejections

- Lack of clear rejection reasons – Users received vague messages like "claim denied, additional information required" without specifying what was missing.
- Unclear documentation requirements – Users were unsure about necessary supporting documents.
- Cognitive overload from multiple communication channels – Users received conflicting information via email, text, and portal updates.

The correct procedure for submitting claims.	*"I'm always unsure if I'm submitting claims correctly. The process seems a bit convoluted."*
Understanding which expenses are eligible for reimbursement	*"I wish there was a straightforward list of what's reimbursable. I'm always second-guessing."*
Knowing what documentation is necessary to support their claims.	*"What kind of documents do I need to provide for my claim? The guidelines are not very clear."*
Confusion about the acceptable formats for uploading supporting documents.	*"Every time I try to upload documents, I run into issues. A list of acceptable formats should be provided upfront."*
Lack of understanding about the reason for claim denials.	*"It was disheartening to see my claim denied without a clear explanation."*
Challenges faced in rectifying errors during the reimbursement process.	*"I received a letter saying my claim was denied and to submit additional information, but it wasn't clear what more they needed."*
Uncertainty surrounding the payment process after a claim is approved.	*"Are reimbursements paid on only certain days of the month? If you could put a date to be reimbursed by the processed date that would be awesome."*

3. Ineffective Claim Status Updates

- Claim status "pills" (status indicators) were unclear, leading to misinterpretations (e.g., “Processed” vs. “Paid” was indistinguishable).
- Delayed updates on reimbursement timelines caused frustration, as users were unaware of when payments would be issued.
- Lack of interactive support within status updates left users with unanswered questions.



If there is a denied issue it is difficult to know what is really needed to get it resolved.

“I would like an explanation of the reason claims were rejected.”

“I would like a better explanation of what processing means.”

“Green shows the same for Processed and Paid. What's the difference??”

“I don't understand a reimbursement status of on hold, if it has actually been approved.”

“If claims are processed for payment, indicate the ETA for payment.”

4. User Education Gaps

- Many users did not understand basic funding concepts, even after years in the system.
- Users relied on trial-and-error approaches to navigate the reimbursement process.
- Inconsistent claim approval criteria made the process feel unpredictable and unfair.

Recommendations & Impact

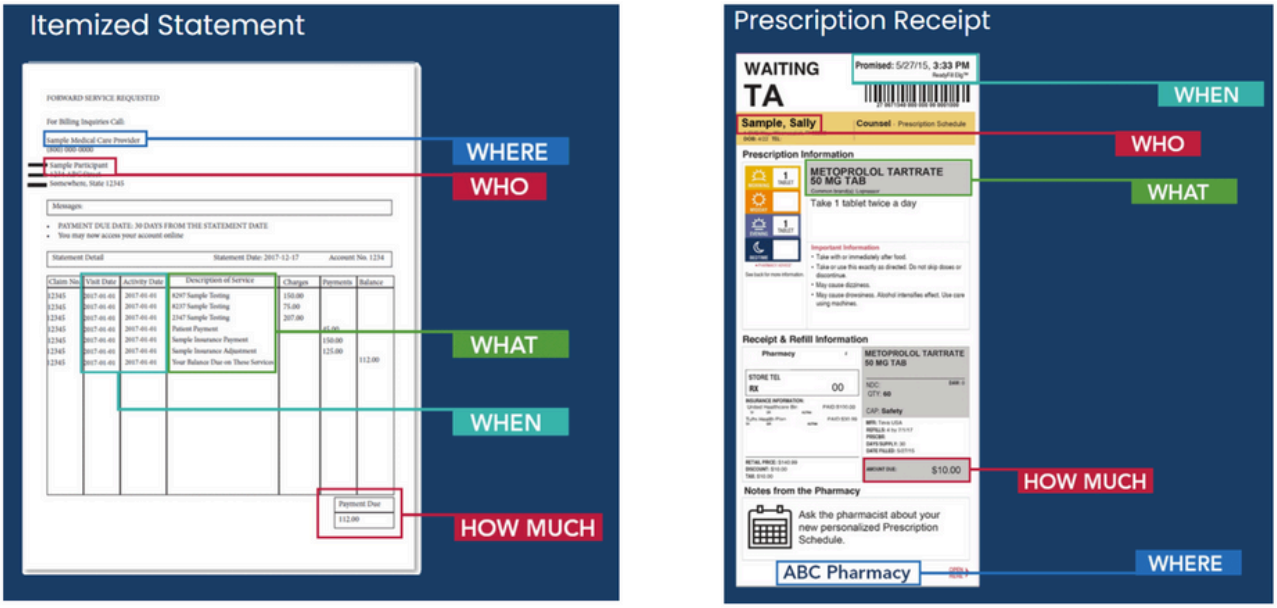
1. Example itemized statement and receipt examples

✅ Ensuring our users are well-informed about the requirements before submission can reduce the need for post-submission calls.

✅ We should provide clear examples and resources which can demystify the process and requirements for users.

✅ MidAmerica provides an eligible expense guide and clearly instructs on what acceptable documentation looks like by providing examples, calling it “The Who, What, When, Where + How Much of Claims

Documentation”



2. Improve Claim Status Communication

✅ Refine status indicators – Clearly differentiate between "Processed," "Paid," "On Hold," etc.

✅ Include estimated payment timelines in claim status updates.

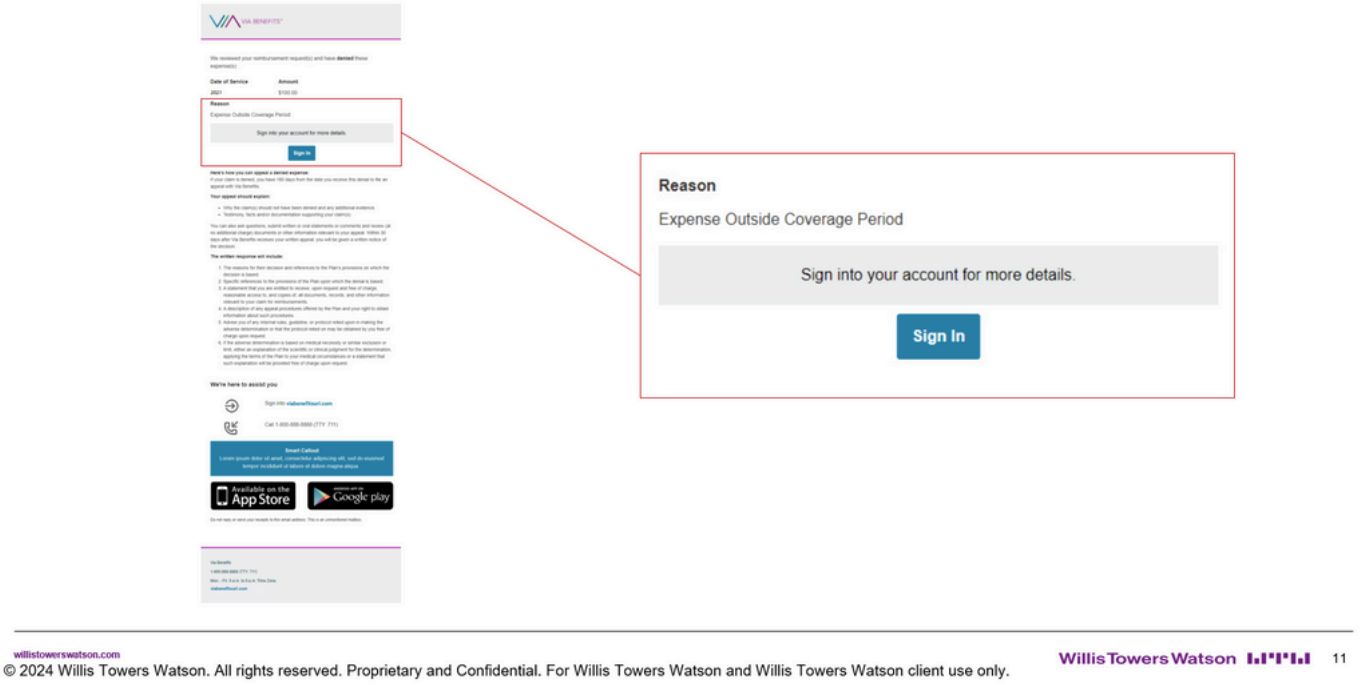
✅ Add interactive elements like links to FAQs or live chat for real-time clarification.

3. Enhance Rejection Clarity & Resubmission Guidance

✅ Specify exact rejection reasons (e.g., "Missing receipt for transaction dated XX/XX/XXXX").

✅ Provide a checklist or resubmission guide alongside rejection notices.

✅ Improve accessibility of support resources by linking relevant FAQs and step-by-step guides.



3. Reduce Call Center Dependency Through User Education

✅ Create an onboarding module for new members explaining the "happy path" for successful reimbursement.

✅ Develop a reimbursement eligibility tool where users can check expense eligibility before submission.

✅ Improve help center resources with user-friendly content (e.g., short instructional videos, step-by-step guides).

Conclusion

The research identified critical pain points in the reimbursement experience, particularly around claim status updates, rejection clarity, and user education. By implementing the recommended solutions, Via Benefits can expect:

📉 **Reduction in call center volume** related to claims inquiries

📈 **Increased user self-sufficiency** in navigating the reimbursement process

✅ **Higher user satisfaction** due to clearer communication and improved digital tools

Future efforts will focus on testing and validating these changes through usability studies and iterative improvements to the claim submission process.