Job Description: Claims Manager

Job Summary

The Claims Manager leads and oversees the Claims Department, providing hands-on leadership and daily collaboration with staff and key departments including IT, Account Management, Stop Loss, Medical Help Line, Customer Service, and Sales. The role is responsible for ensuring timely and accurate claims processing while implementing initiatives to improve efficiency, productivity, workflows, and cost management.

The Claims Manager develops and motivates team members, drives performance, and builds strong cross-functional partnerships to support change initiatives. This position executes the company's strategic vision by developing and implementing plans aligned with both short- and long-term business objectives and facilitates cross-divisional collaboration with internal and external partners to support effective decision-making.

Supervisory Responsibilities

Manages the Claims Department

Reporting Structure

This position reports to the VP of Operations Texas

Job Logistics

This position is in office, hybrid or fully remote, working 40 hours per week

Duties/Responsibilities

- Plans, organizes, and manages all Claims functions, including High Dollar Claims, Plan Build, ID card creation and distribution, provider setup, and VBA testing; maintains a hands-on presence on the floor and actively coaches team members.
- Develops and executes strategies to increase auto-adjudicated claims to 50%.
- Drives performance by ensuring employees are properly trained and that work is completed accurately, timely, and in compliance with company and contractual standards.
- Monitors and evaluates staff performance against established productivity and quality metrics, including conducting regular audits to assess departmental performance.
- Proactively identifies and addresses positive and negative performance trends to ensure operational goals are achieved.
- Supports quality initiatives related to technical, financial, and processing accuracy, ensuring compliance with company standards and addressing performance issues as needed.

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- Oversees claims inventories and work queues, minimizes claims on hold, ensures plan builds are completed by effective dates, and prioritizes exceptions to meet turnaround standards (100% of claims processed within 30 days; 90% within 14 days).
- Resolves complex and escalated claims issues from team members, account management, and other departments by developing solutions, communicating effectively, and implementing measures to prevent recurrence.
- Participates in daily, weekly, and ad hoc cross-functional meetings to address and resolve operational and technical issues.
- Reviews claim audits to ensure completeness, accuracy, and compliance with company policies, standards, and procedures.
- Recommends improvements to workflows, procedures, and policies, ensuring all Claims staff are informed, trained, and compliant with changes.
- Leads, develops, and coordinates training, retraining, and cross-training for new and existing employees in partnership with Human Resources.
- Prepares and presents management reports, including analysis of variances, key trends, and recommendations, keeping leadership informed of issues, risks, and resolutions.
- Partners with Sales and Account Management to support benefit design solutions, new client implementations, and renewals, ensuring smooth and timely transitions.
- Performs other duties as assigned.

SUMMARY OF QUALIFICATIONS	Required	Preferred
Education		
High School Diploma or equivalent	X	
Bachelor's degree in business related field or relevant professional experience	X	
Experience and Skills *(list specific skills and years of experience if applicable)*		
Minimum of 5 years supervisory and 3 years management experience preferred in a group health claims environment	X	
Proven ability to strategically design and implement effective workflow and staffing plans	X	

Working knowledge of commercial health insurance products, including HMO, PPO, EPO, high deductible plans, copay/coinsurance variations, and HRA/HSA plans.	X	
Expertise in claims adjudication, including payer interactions (delegated or non-delegated), eligibility and benefit determination, and member copay/coinsurance allowances.	X	
Strong understanding of stop loss carriers.	X	
Experience with and understanding of Direct Agreements with providers/facilities.	X	
Exceptional ability to communicate effectively with senior management, peers, supervisors, and claims staff.	X	
Demonstrated ability to foster a team-oriented, positive work environment and culture.	X	
Knowledge of CPT and ICD-10 coding.	X	
Excellent business communication skills; both verbal and written.	X	
Proficient in Microsoft Office applications.	X	
Experience managing changing priorities in a high-volume, fast-paced environment.	X	
Exceptional organizational skills and attention to detail	X	
SUMMARY OF QUALIFICATIONS	**Required**	**Preferred**
Physical Requirements		
Ability to sit for multiple hours		X