# Health plans need to transform back office to achieve consumer engagement goals

## Expert presenters

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Many health plans recognize that their future growth will come from participating in health care exchanges and adopting new business models, but what they may not have considered is that streamlining their current back-office operations is essential to realizing that growth faster and in a manner that builds their relationships with consumers.

"As the health care market changes in a dynamic fashion, plans need to focus their attention on their back-office strategy, on levers that can be pulled by payers to optimize costs, and on metrics, such as auto-adjudication rates, in order to fund new initiatives and transformation," according to Jim Mapes, senior vice president, Optum, who spoke Oct. 29 in an Optum webinar, "Transform the Back Office to Better Engage Consumers on the Front Line."

## Shifting resources from claims to communication

Plans need to find a new paradigm "so that the investments we make, which include the true time that we spend and the capital we have on an annualized basis, are focused on the consumer and on those growth drivers," Mapes said.

Without a big-picture strategy for the business, he explained, plans are not going to be able to move forward during post-health care reform changes, which include accountable care organizations, value-based delivery and compensation models, consumer- and individual-based customized care, and state exchanges. Under this new paradigm, plans must reexamine the market dynamics that are at play:

- Focus on clinical quality
- Medicaid privatization
- Market consolidation
- Consumer health revolution
- Operational efficiency
- Health benefit exchanges
- Aligning network and incentives
- Payer/provider convergence

These market factors are pushing plans toward three key areas: 1) population and consumer management; 2) acceleration of automation; and 3) operations and administrative results. If plans do not move in these directions, Mapes asserted, they are unlikely to survive in future market models.

## Population and consumer management

Payers need to focus on ensuring growth and financial success in a consumer-driven marketplace, according to Mapes. "Consumer engagement is key to moving forward. When competing in an exchange, plans need to ensure that the consumer's first experience is a great experience," he said. Plans must focus on sales and retention solutions, innovatively retool benefits administration and product management as well as financial risk management, and communicate with consumers in a clear manner.

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## Acceleration of automation

"Delivering on goals takes a lot of hard work, but focusing on automation and data integration will allow plans to do real-time claims adjudication, provide benefit design flexibility and facilitate clinical quality/accountable care integration," Mapes stated. "Plans need to be able to turn on a dime when regulatory changes are made, and automation and technology are the foundation for that ability. These are becoming the table stakes — the pipes and wires for building a house."

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## Operations and administration results

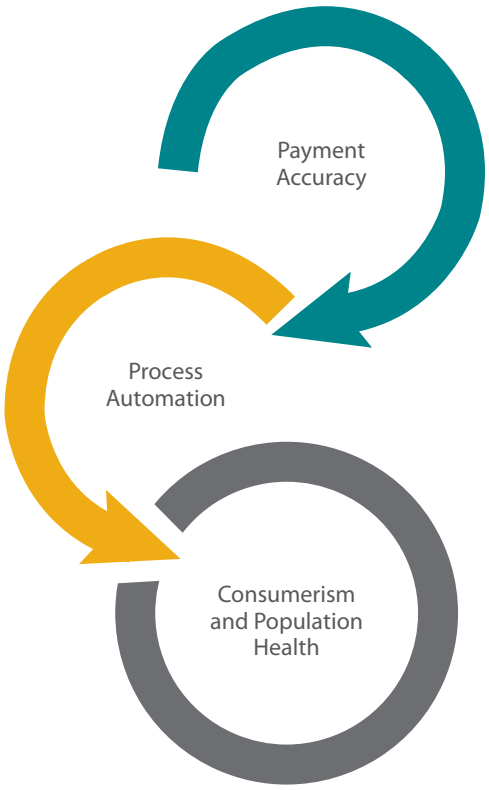
Plans also need "a laser-like focus on cost and deployment strategies, with benefits delivered at a price that keeps them in business," Mapes said. Core administration and business services, payment integrity and claims accuracy, and ICD-10 support solutions can create cost reductions and drive efficiencies, he noted. "In the past, prompt payment and delivering and responding accurately to claim inquiries were enough, but now the stakes are going up. Transparent models make timeliness and accuracy apparent to everyone and being able to deliver is critically important," he said, noting that the results — "true, bottom-line unit costs and unit price results" — are what need attention.

He further explained that the "truth is in the numbers" when it comes to claims adjudication. Plans need to reduce their current operational and administrative costs to less than $10 per member, per month (PMPM), which can only be achieved through automation, because auto-adjudication is eight to 10 times less expensive than manual adjudication. Failing to pursue automation in this area "leaves a lot of costs on the table and leaves a lot of dollars on the table from a health care standpoint," Mapes emphasized.

He cited an American Medical Association statistic stating that if claims are paid accurately, an estimated $43 billion[1] in cost savings can be achieved by the industry, and noted that anti-fraud programs can save 1 percent of medical expense and increase profitability by roughly 16.7 percent.[2] He also remarked that payment integrity and payment accuracy "can fund a lot of the initiatives that are needed for a consumer approach" (see Figure 1).

Figure 1

**Transformation levers**




Part of cracking the code to achieving consumer engagement is understanding what the back office needs to look like, how to set the transformational drivers in motion — such as payment accuracy and process automation — and what the strategy will be for taking the cost and accuracy of delivering health plan benefits to a new level, according to Jim Mapes, senior vice president, Optum. "Without the first two, you cannot tackle consumer engagement and population health," he said.

Figure 2

**Proactive member onboarding and retention**


## Case study: Regional health plan attacks first-year attrition

Clay Heinz, vice president, Optum, shared a case study that focused on a regional health plan that offered individual products (both Medicare and underwritten) for consumers who are both over 65 and under 65. Before meeting with Optum, the client was not building loyalty within the first 90 days of members' terms and had trouble retaining members past the first year.

"The plan utilized common tools in the marketplace, but interacted with all members in the same manner, using a generic welcome letter, the same messaging regardless of plan, region or needs, and with a reactive service model," Heinz said. "If an individual had questions about the directory, online tools or a delinquent payment, the plan was in reactive mode and had no online tools for self-service. All of these factors are ingredients for a disaster for a health plan, and as a result, this plan had high member turnover."

The plan needed to establish a meaningful relationship with consumers within the critical first 90 days of membership, and Optum developed an onboarding strategy for the plan — including the creation of microsites designed to specifically for each consumer — that "bucketed the messaging for consumers into three main components," Heinz explained (see Figure 2).

By helping members to manage 1) their plan, 2) their health and 3) their money, the regional plan's members were more satisfied, and the approach established by Optum allowed the plan to cut first-year attrition by 48 percent, according to Heinz. By combining initial outreach, follow-up contact, and appropriate and varied outreach tools, "plans can leverage every possible communication channel to deliver the right message at the right time to the right person," he stated.

He added that satisfied customers are:

- 87 percent more likely to renew.[3]
- 83 percent more likely to recommend.[4]
- 43 percent more likely to purchase other products.[5]

"There has been a paradigm shift to really engage consumers, so plans need to change to become trusted advisors and co-navigators with the members," he said. "Plans don't want to just be a card in the member's wallet anymore."

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Mapes also noted that the most important factors plans need to consider to enable migration to a new business model are leveraging data to focus on cost structure and back-office automation, looking at where the plan needs or wants to be in three to five years, and determining where to invest capital.

"Being able to deliver from a PMPM standpoint by initiating projects that create true cost take-out, such as automation, eliminating redundancy, working with vendors and looking at globalization, will be necessary as plans refocus their attention on getting new members and retaining them," Mapes concluded. "These levers have to be pulled to be more forward-thinking and build relationships with consumers. The time to act is now."

## How Optum can help

Partner with Optum to transform your back office to ensure growth and financial success in a consumer-driven marketplace with a strategy focused on:

- Improved payment accuracy
- Accelerated administrative automation and real-time data
- Proactive member onboarding and retention

## Want to learn more?

Visit optum.com
or call 1-800-765-6807.

1. American Medical Association, 2013 National Health Insurer Report Card (NHIRC)
2. Optum estimates based on client experience
3. J.D. Power and Associates 2012 study
4. ibid.
5. ibid.

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