


**How
Technology
Helps
Healthcare
Payers
Maintain a
Leading Edge**

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Introduction

Staggering problems resulting from today's business climate are pressuring the U.S. healthcare industry's payer sector to consider new business solutions. In their extremely competitive marketplace, insurance companies cannot afford negative impressions of poor service; and many are desperately in need of a strategy that enables them to compete with, or outperform, competitors.

Payers really have only two options to stay ahead. They can impact their profitability by increasing their membership numbers (which can be achieved on an individual insured basis or in larger quantity through mergers/acquisitions), or they can take steps to reduce their operating costs.

To stay competitive, many are considering investing in expensive new software and/or hardware systems. Unfortunately, some strategies are easier to

**"There is no resting place
for an enterprise in a
competitive economy."**

Alfred P. Sloan, Jr. (1875 - 1966)
US auto executive

conceptualize than they are to execute. Most organizations cannot afford the initial investment in Information Technology (IT) solutions, ongoing maintenance and support, or developing the appropriate skilled workers to operate such an IT infrastructure. While an IT system might prove to be

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scalable, reliable and effective in streamlining processes, that does not mean the people and processes associated with it will be comparably aligned. Moreover, implementing a new system can be troublesome and require more time and effort of management and key staff members than anticipated.

What, then, is the best way for a payer to position itself for future success? This white paper discusses the business requirements and constraints the healthcare payer sector now must tackle and defines a business model for success in supporting those conditions.

The Healthcare Payer Landscape

Payer chief executive officers (CEOs) throughout the U.S. share the same primary concern – how to survive and stay competitive while medical care costs escalate. In the past two years, many companies approached this challenge by rolling out 20 – 40 percent premium rate increases to their customers.

This strategy, though, is met with resistance from employers objecting to the increased cost of providing benefits to their employees. Traditionally, payers have grown their market share by selling products to employers, rather than to individual subscribers, and the majority of insurance customers are still employer-based.

With a growing backlog of claims and continually rising costs for administrative processes and medical care, the market is ripe for IT solutions that reduce a company's operating costs. But the healthcare insurance industry lags behind and has been slow in adopting technology improvements. Indeed, many payers are very much behind the curve, still

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bound by paper and business processes that have not changed over the last 20 years.

With market demand for solutions other than premium rate increases, payers now are beginning to see the need to embrace technology to save money and improve efficiency in their workflow and processes. For those considering adopting technology solutions, the decisions range from automating the claims processing and adjudication systems, membership, billing and customer service processes, to operating a data center to run all the required software.

Key Success Factor Equals Risk

Industry analysts believe the level of automation in a payer's business processes is now becoming the key success or failure factor within the payer sector. In fact, Gartner research predicts payers that do not implement effective automation strategies will lose their market share by 2005¹. The following case study illustrates the situation in which many payers now find themselves.

Case Study: XYZ Insurance Co.

Profile

XYZ Co. provides a broad spectrum of managed care, health insurance and special products and services to more than 700,000 covered lives. Products are marketed nationally through more than 48,000 independent, licensed sales agents.

Situation

The company was losing its competitive edge in the market

- Skilled resources spread too thin and focused on non-competitive activities**
- Money lost because of inefficient accounts receivable process**
- Software for plan booklets was inefficient and difficult to maintain**
- Unable to bring significant product line changes to market for more than five years**

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In addition to old-fashioned paper processes, studies show that many payers are affected by a high inefficiency factor in the automated systems they currently use. Often, they achieve less than 50 percent of the possible efficiency in their back-office systems simply because they are unaware of benchmarks and what they should be able to accomplish. In small to mid-size companies, executive focus is on increasing revenue; back-office functions rarely receive the close review that is needed to correct inefficiencies.

Saving time means saving money, but IT tools bring risk along with business process enablement. Because of the immaturity of healthcare payer application technology, the marketplace is likely to face volatility for the next three to four years. Buyers, therefore, must understand not only what technology solutions to adopt, but also how to mitigate risks in those business solutions as existing technology evolves or new technology emerges.

Hot Spots

Within the healthcare payer sector, current hot spots of challenge can be categorized into three major focus areas that keep CEOs up at night. All three hot spots represent huge hurdles to payers unable to afford building the IT systems necessitated by these requirements.

Focus Area #1: HIPAA Compliance

Any organization that is storing, sharing or transferring patient medical data among payers, providers and patients must take steps to comply with the privacy and security mandates of the Healthcare Insurance Portability and Accountability Act of 1996 (HIPAA).

Although some companies appear to be delaying their HIPAA compliance programs (banking on further government delays), the ramifications of non-compliance are clearly an enormous business risk. System upgrades or replacements to comply with HIPAA mandates are extremely expensive; indeed, for some organizations the cost is estimated to total more than Y2k IT initiatives.

Focus Area #2: State Mandates

Each state has different laws regarding various types of health benefits. As more companies expand their geographic markets, the need for knowledge of multi-state issues in resolving processing employees' claims increases.

Focus Area #3: Prompt Pay Laws

Many states now legislate how quickly payers must transmit payment to healthcare providers and members (insured patients). Financial penalties, including fines and accruing interest, are a consequence of consistently missing these legislated timelines.

Approximately 15 states now have prompt pay laws; it is predicted that within the next 24 months, every state will enact such legislation, with various nuances within each state.

As an example, one state's prompt pay law now requires a payer to determine a member's eligibility for benefits within 28 days – or it must pay the healthcare provider 80 percent of the medical claim by the 28th day while it continues to investigate the claim.

Prompt pay laws will necessitate IT system programming, as well as reengineering of business workflow processes in order to accommodate these new payment requirements.

These hot spots of sophisticated, large-scale IT adaptivity simply are not affordable to most payers that are not large companies (revenue threshold of less

than \$1-\$2Billion, with most falling into the \$50-\$500Million range). Smaller companies spend a lot of time and money just determining what resources they need in order to stay on top of changing technology requirements.

As illustrated in Figure 1, below, the healthcare payer landscape faces enormous challenges, with each component of requirements and constraints tightening the squeeze.

Figure 1



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Technical Functionality Improves Patient Care

To compete in today's business world, companies need optimal functionality in their solutions and ability to connect with related enterprises. Whole industries, such as supply chain management and customer relationship management software and service vendors, have sprung up and are thriving on the principle of interconnectedness.

Nowhere is this foundation of doing business more necessary than in the healthcare industry. Unfortunately, many healthcare companies have implemented costly IT systems and applications, only to find a lack of useful functionality. Within the healthcare industry, hospitals, physicians, payers – and their members, employer groups and brokers/agents – need to share data on various levels.

The Internet is the vital link to increasing functionality and interconnectedness in sharing data and information. Hospitals and



Image: www.freeimages.co.uk

physicians need quick access to medical history and to payer records to verify health benefits coverage of their patients and status of medical claims. In fact, because this communications functionality expedites the process of obtaining payer verification of benefits and approval of particular medical procedures, it increases patient safety while reducing medical costs.

In addition, Internet functionality of a business process and its related data facilitates a payer's ability to increase customer (employer groups and individual subscribers) satisfaction and loyalty, by providing Web access to claims and deductible status, medical education, and the ability to quickly change mailing addresses or other personal information online.

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Recommended Business Model

In assessing their needs (requirements, internal constraints, and competitive objectives), payers now are coming to the realistic conclusion that the most effective business solutions require costly, long-term investments in IT infrastructure and skills – both of which can be arduous if attempted with internal capabilities.

In contrast, by turning over responsibility for the work to a business process outsourcing (BPO) provider, payers benefit from:

- Scalable, state-of-the-art IT resources that integrate enterprise-wide and include upgrades
- Highly skilled, scalable IT workforce
- Business process and insurance expertise
- Industry best practices
- Accountability for service level performance
- Risk elimination or mitigation because of provider's expertise
- Faster time to market
- Regulatory compliance
- Avoidance of capital investment
- Predictable IT costs
- Access to new source of capital investment to accomplish strategic goals
- Smooth transition when IT solutions are implemented

Essentially, by outsourcing its non-critical but important processes (such as claims processing and adjudication, billing and customer service), a payer is able to focus on its core activities, thus bringing about market differentiation.

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XYZ Company, in the prior case study, decided to outsource several business processes and IT systems, achieving the notable outcomes cited below.

Case Study: XYZ Insurance Co.

Outsourced Processes

- Data Center services and hosting
- Claims Processing
- Customer Service
- Financial Services (billing, commissions, reporting)
- Membership
- Provider Network Access

Benefits and Outcomes

- New technology that streamlined the claims administration process from beginning to end
- Management and provision of appropriate pool of skilled IT staff
- Developed new IT system allowing accounts receivable payments to be made directly to XYZ's lock box – which reduced posting time by 50%
- Reduced administrative costs associated with manual handling of bills; reduced incidents of fraud
- Developed user-friendly bill format
- Developed new IT system to produce (and revise) plan booklets more flexibly
- Implementation of the payer's new product, adding 600 plan variations to its existing product line, was completed ahead of schedule and plan booklets were efficiently produced
- Changes to systems regarding rate loading, online processing.
- Developed a subsystem for "disclosed conditions"

In the following case study, the effectiveness of a payer using outsourcing as its business model is evident not only in improving its processes but also in risk mitigation and an award-winning outcome.

Case Study: ABC Insurance Co.

Profile

A large and well-established insurance company, serving more than two million members. ABC offers a variety of high-quality, affordable health insurance products through point of service, preferred provider organizations, health maintenance organizations, major medical and traditional indemnity plans.

Situation

- ABC's telecommunications technology was 15 years old, in need of replacement parts, and experienced frequent outages.
- The company's existing Web site was not state-of-the-art technology and was unable to keep up with competitors.
- ABC lacked an efficient means for timely communication of compliance and government regulatory information to its entire company, thus facing loss of revenue because of missed deadlines and requirements that had not been communicated.
- ABC struggled with an excessive amount of paperwork and a steady volume of calls from broker agents.

Outsourced Processes

All systems management and IT services, including:

- Data Center and Help desk
- Networking, Voice, LAN, WAN
- Communications / Call Center
- Software Development and Delivery of Applications

Benefits and Outcomes

- New technology to enhance productivity of Call Center.
- New, award-winning Web site, placing ABC Company in an industry-leading position with Internet capabilities.
- Developed area on ABC's Intranet, dedicated to government regulatory information and compliance items.
- Developed a Web site for brokers, allowing 24/7 access and tools to facilitate membership enrollment/renewal, benefits, claims processing, commissions, risk assessment and educational information. Online features reduced ABC's paperwork and call volume and allowed real-time tracking.

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Some payers, including very large companies, decide to outsource all the administrative services revolving around one particular product. The case study below illustrates this strategy.

Case Study: National Insurance Co.

Profile

A large and well-established national insurance institution with multiple lines of business and products, with more than 10 million members.

Situation

National evaluated its business and decided to keep a non-core product in its product portfolio to continue providing a wide variety of products to its customers. However, the company had not considered this product a main line of business and, over time had reduced its resources and staff skilled in knowledge of this product. At the same time, the processing system for this product needed substantial enhancements in order to achieve HIPAA compliance.

Outsourced Processes

All administrative services for this particular product, including:

- Billing and collection
- Deposit and disbursement of funds
- Claims processing
- Call center
- Maintenance of records
- System support
- Complaints, appeals, grievance processes
- General administrative functions

Benefits and Outcomes

- Hosted solution with flexible, state-of-the-art, HIPAA-compliant system
- Staffing resources skilled in the product line
- Quick, efficient, cost-effective processes

Conclusion

Outsourcing is a highly effective strategy that achieves short- and long-term improvements in cost savings, services, agility, and in meeting competitive objectives. In today's business climate, leading companies are outsourcing as many non-core processes as possible.

Buyers who adopt this business model, however, need first to clearly understand the strategic and tactical goals they hope to achieve through outsourcing. They must understand that the role of a service provider in an outsourcing alliance is to decide how to achieve the buyer's goals and then leverage the provider's resources and expertise to accomplish those outcomes.

A business solution must be scalable to accommodate the buyer's rapid or unexpected growth, meeting its needs both now and in the future. It also must be flexible enough to operate on a variety of IT platforms. It must meet the buyer's functional "wants" as well as its critical needs.

The success of an outsourcing alliance strategy hinges as much on the choice of service provider as it does on the solution details. The buyer's desired business outcomes will set the course in choice of provider. In evaluating potential providers, healthcare payers should seek the following characteristics:

- ⇒ World-class resources
- ⇒ Capability and willingness to adapt to unexpected events throughout the relationship, such as:
 - mergers/acquisitions/divestitures
 - evolving and emerging technology
 - changing government regulations

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- ⇒ In-depth knowledge of the healthcare payer sector business, how the healthcare industry is evolving and how those developments impact payers
- ⇒ Accountability for best practice skills and buyer-specified service level performance
- ⇒ Methodology for eliminating or mitigating risks involved in the implementation and transition phases of an outsourcing arrangement, including change management
- ⇒ Investments into technology research and development (such as voice recognition technology, which will lower customer service costs and increase satisfaction), affecting the provider's choice of systems to add to its capabilities
- ⇒ Vendor-independent software solutions (the provider's solution should be tailor-made to the buyer's needs, rather than squeezing the buyer into a favored product line)
- ⇒ Willingness to accept service level specifications with penalties for not performing to the buyer's specified levels, or willingness to use risk-reward pricing incentives
- ⇒ Compatibility of the provider's culture with the buyer's culture and way of doing business
- ⇒ Reputation for fostering strong business relationships with clients

Outsourcing is a long-term business solution and, as such, the importance of a “partnership” approach to the relationship cannot be overemphasized. Wise buyers spend time in due diligence investigations of potential service providers, becoming comfortable with a company's credibility and whether it can and will deliver what it claims. Mutual trust takes time to develop, but it is the foundation of successful outsourcing relationships and sets the expectations for how the parties interact with each other on an ongoing basis.

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While providers may have good systems, not all providers are focused on mutually beneficial long-term growth opportunities. A long-term relationship needs a provider that offers value-add services and fosters a give-and-take approach to doing business together, rather than a stringent contractual approach.

Finally, beyond seeking a service provider that can meet its critical business needs, a payer's decision-makers should seek an outsourcing partner that can answer the following questions with credibility:

1. Other than your company's basic capabilities, how is your company different from its competitors?
2. Why should I believe you?
3. What will you do to nurture our relationship and ensure its long-term success?

¹ Young, Janice, "A Framework for Health Plan Automation," Gartner Research AV-14-8542, 19 March 2002, accessible at www.gartner.com.

ABOUT ANTARES MANAGEMENT SOLUTIONS

Antares is an IT and business process outsourcing solutions provider specializing in services to insurers across the United States. The Antares business model focuses on three facets: (1) a **Client Services methodology** that (a) provides an interface between Antares and its clients; and (b) provides effective management and increases client satisfaction; (2) **service level agreements, guaranteed** with financial penalties; and (3) a **partnership approach**.

Connexionⁱⁱ by Antares is the provider's Internet-based application that provides instant, secure 24/7 access to a payer's membership, eligibility and claims transactions. User-friendly customized screens are also accessible by a payer's members, employer groups, healthcare providers, and brokers/agents and sales representatives. This state-of-the-art solution provides competitive advantage for Antares' clients and assists healthcare providers and patients in understanding payment policies.

Antares is a subsidiary of Medical Mutual, the oldest and largest health insurance company based in Ohio. As such, Antares has access to a broad base of market intelligence and knowledge about the evolving healthcare industry and how to shape Antares' capabilities for better client solutions. The company also works with industry experts and analysts in monitoring trends and industry benchmarks.

For more information on how Antares can help your company in achieving its strategic goals, please call 1-866-268-2737.