Supreme Court upholds the Affordable Care Act’s individual mandate; payers – what’s next?

With the U.S. Supreme Court’s decision on June 28, 2012 to uphold the Affordable Care Act’s individual mandate¹, healthcare payer organizations are kicking their reform readiness plans into high gear. But even with many months of careful planning behind them, the hard work is just beginning. Under the new law, millions of individual taxpayers will need to be covered with a qualified health insurance program by January 1, 2014². Failure to secure coverage will result in escalating tax penalties³. Regardless of the ongoing debate and varied public opinions, the court’s decision clears the way for implementation efforts to proceed. Health insurers, employers and the American public are expected to comply with the new legal mandates. For payers, this signifies both great opportunity and tremendous risk.

As payer organizations across the country begin implementing the new facets of their insurance offerings and the supporting infrastructure necessary to comply with the Affordable Care Act, there are two top considerations on the minds of executives: the health and well-being of their current and future members and the competitive landscape of their evolving industry. In order to meet the challenges of dramatic change and still remain competitive, payers should develop and implement a reform compliant enterprise that effectively handles increased capacity and meets current business demands simultaneously. And, they must do this while maintaining the quality and performance standards their members expect.

The organizations that step forward to offer easily attainable and affordable solutions will reap the greatest economic reward, but getting there will require a clear transition plan and dedication to detail. Over the next 18 months and beyond, payers will juggle a variety of complex change factors. Every health payer organization should implement a detailed plan that balances and prioritizes the long list of modernization and compliance requirements to be tackled.

¹ http://online.wsj.com/article/SB10001424052702304898704577480371370927862.html?KEYWORDS=obamacare+supreme+court
² http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf
A Comprehensive Plan
Genpact believes payers must immediately prioritize four efforts to address essential near-term business needs, ensure ongoing quality standards and proactively shape positive membership experiences for both groups and individuals. Each undertaking needs to conform to a formal change management function that ensures coordination, transparency, timely progress and business alignment. These four priorities should include:

1. Modernizing processes
Insurers should continue to maintain focus on customer satisfaction if they hope to succeed in the new American healthcare system. Current customer-facing processes, such as claims handling and membership management, must be run at peak performance before payers can successfully approach the great potential increase in new membership. Keeping existing members happy will be as important as gaining new ones. Customers coping with antiquated processing, slow claims turnaround times or poor customer services are likely to choose another carrier when they are given an easily accessible choice in the months ahead. Payers hoping to optimize their process performance should consider a three step approach to ready their organization.

First, consider the transition to a full lifecycle perspective. Viewing processes in silos, rather than as a connected progression, has historically resulted in unrecognizable value to the business’s bottom line. If not handled carefully and comprehensively, siloed improvements can cause upstream and downstream processes to suffer as workflows adjust to improve the functionality of just one department.

By interpreting and interconnecting business processes in a continuum from the start of the value chain through the end product or desired outcome, organizations are able to break down traditional geographic and departmental silos that have historically created business value leakages and hindered progress. By taking an end-to-end process approach, organizations can expect increased ROI, faster processes, higher levels of customer satisfaction and retention, and highly efficient, effective and integrated operations.

Secondly, look to best-in-class performance as a guide. By outlining process steps and attainable benchmarks to match or exceed that of highly effective competitors, organizations will have a guide to understanding the key performance indicators (KPIs) they need to obtain to maximize effectiveness and reach peak performance. Payers who accomplish the desired result can better anticipate challenges and proactively implement effective adjustments to make the best use of their investments across the entire value chain.

Finally, payers should focus on process effectiveness as well as efficiency. Building a roadmap toward peak performance requires an organization to consider both the efficiency and the effectiveness of the process. Most viable organizations focus on creating highly efficient processes to streamline efforts and reduce costs significantly. Each function or department in an organization optimizes its part for efficiency, but due to leakages at the points where these functions converge, the overall effectiveness of the processes can be compromised. A roadmap toward optimum performance must include a focus on both efficiency and effectiveness to root out waste and close process gaps that stand in the way of best-in-class performance.

These organizational process adjustments should be implemented in systematic fashion to deliver substantially higher impact on customer acquisition as well as customer retention, resulting in improved cash flows, margins and revenue.

### THREE STEPS TO MODERNIZING PROCESS

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2. Increasing capacity
As payers consider the impact and potential growth opportunities presented by healthcare reform, they must also carefully plan for increased membership as well as a new membership profile. Staff readiness can make or break payer organizations in the months ahead, long before the more complex requirements of reform have had a chance to rise to the forefront of industry consciousness. From enrollment to communications, payers should solidify their near term staffing plans to ensure ongoing quality control, increased membership variability, team readiness and talent retention - all with a very short runway that leaves little room for error.

Conducting a comprehensive evaluation of process performance will root out weaknesses in existing systems, making it easier to determine a plan of action that can eliminate inefficiencies and boost the performance of existing teams. Organizations that streamline end-to-end processes across their infrastructure can realize capacity improvements. By eliminating wasteful or non-value adding activities and healing process gaps, organizations can do more work with the resources they have.

But even with all this, it will not be easy to continuously meet the challenges of staffing and capacity necessary to run payer organizations in the evolving industry environment. Although the U.S. Census Bureau has reported over 50 million uninsured individuals\(^4\), it is difficult for any individual payer to accurately estimate just how much growth they need to prepare for - and just how fast they need to move - to make this additional capacity available.

With this large but nebulous influx of new clientele just over the horizon, payers should be prepared to contend with employee burnout and decreased customer service levels. To prevent resulting systematic interruptions, payers can prepare a comprehensive and proactive human resources function to manage the issues that are likely to arise with current staff and new hires alike. Beyond day-to-day staffing, this department needs to be able to adequately address employee needs with standardized processes that achieve continuous organizational improvement. They should also prepare employees for the new and evolving tasks they will face each day with adequate and multi-tiered training programs. A trained and happy staff will provide more scalability and a higher level of customer service, even during times of great transition.

Of course payers must also think about the mission-enablement components of their organization. High on that list of considerations should be the strategy to hire, train and retain an efficient and effective technology staff to monitor claims and membership programs and head off system failures before they occur. In addition, an adequate number of nurses and doctors should be staffed or contracted to ensure additional claims processing needs are addressed.

Whether this workforce is hired or provided through a partner organization, payers must be ready to deliver the interpersonal and industry training, tools and technology needed to help both their client-facing and back-office teams withstand the high demands associated with the exponential growth anticipated.

3. Enabling partners and technology
With the number of changes that will be required over the next 18 months, payer organizations should do more to plan for the future while maintaining their current workloads and performance levels. The way to do this effectively is to select specific partners and technologies that support the continuity and stability of process, as well as those that help hold the organization accountable to critical and overarching change management timelines.

There are a wide range of partners, hardware and software systems that can support claims management, staff training and other critical business functions

\(^4\) [http://www.census.gov/compendia/statab/2012/tables/12s0156.pdf](http://www.census.gov/compendia/statab/2012/tables/12s0156.pdf)
within the typical payer organization. Ultimately, selecting partners and tools that will seamlessly support high operational performance, enhance functionality across the organization, and support compliance demands is critical. Payers must ensure leadership oversight in all partner and technology investments and look for opportunities to leverage convergence trends that help everyone in an organization increase transparency and capability.

4. Reconfiguring plan portfolios

Payers should realign insurance program offerings to meet a new, broader target audience and train their teams to adopt and execute on these new strategies. In the past, companies and member-based organizations often had a benefits office that would compare, contrast, narrow down and select programs for their employees. Historically, most Americans did not participate directly in the selection of their health coverage and have little experience choosing between varied coverage models or understanding the concept of shared risk on which the health insurance pricing structure is based.

To attract these new customers, payers should reconfigure the offerings they provide to meet the questions, concerns and priorities of this new target market. These portfolio adjustments will require a dramatic shift from business to business (BtoB) sales and communication strategies to business to consumer (BtoC) models. Moving forward, payer marketing strategies will need to include targeted outreach designed to attract specific member types and new channels to effectively reach varied audiences.

Payers must embrace their new target market and understand what they are looking for in their insurance coverage as well as how much they are willing to spend for these services. This will require advanced micro-targeting techniques and analytics to determine target customer profiles and assess the value and likely outcomes of new business strategy decisions. Social media monitoring can be an effective tool in helping companies gather information on their target audience, pinpoint valuable market differentiators and then help identify the best place to find target consumers. A sound social media strategy can also provide ongoing member updates and dialogue that fosters good will.

The organizations that use social media strategically will have a leg up on their competition. Reconfiguring plan offerings will be the first step, but it will take an ongoing dialogue with increasingly talkative individual consumers to keep them actively engaged and satisfied with the plan they are investing in.

Get started

Now is the time to think long-term. Customer and claims support systems, staff and marketing strategies will all have to evolve and grow to support the millions of Americans required to have insurance as of January 2014; but these advancements can’t come at an added cost to members.

The pressure is on for payers, and the stakes are high. Americans may still be divided about the future of the healthcare industry, but regardless of political leanings, economic pressure for reform will continue to demand a system that is more affordable and provides better integrated services to achieve a higher standard for quality care.

Payer organizations cannot afford to wait and see what new approach gets suggested in Washington. Now is the time to take the lead by charting the path toward more efficient and cost effective services while continuing to seek the best, and most cost effective, patient outcomes.

To learn more about the steps smart payer enterprises are taking to improve process and performance, visit: http://www.genpact.com.
Damandeep Kochhar joined Genpact in 1999 and has held many leadership positions working in multiple industries. This rich and varied experience has given him insight into transitions, operations, marketing, strategy and client relationship management to drive better outcomes for Genpact’s clients. As a U.S.-based Global Relationship Manager, he was responsible for a $25MM engagement and held responsibility for marketing and sales support for Genpact’s Insurance solutions. With this experience as a foundation, he was instrumental in building the Health Payer practice for Genpact, helping organizations worldwide implement process improvements that drive patient and member satisfaction and strengthen the revenue cycle. Currently, Daman leads a team of over 2,000 in implementing innovative and intelligent solutions that keep our Healthcare clients at the forefront of patient and member care.