

# The Trust Factor: An Imperative for Success in a Consumer-Driven Health Insurance Market

Using technology and outsourcing to create transparency, build trust and differentiate your organization.



## Executive summary

While the new consumers entering the health insurance market offer an opportunity for potentially lucrative new business, they come with a built-in distrust of the product they are purchasing. They are wary of interactions with health plan representatives and quick to form opinions, compare their current plan with other available options and shift their patronage if they aren't satisfied with the service. At the heart of much of this adversarial relationship is a lack of cost transparency. Consumers are confused by the complexity of their coverage and frustrated by the inability of providers and payers to tell them what their costs will be.

Given the fierce competition for individual health plan members, this environment offers an opportunity for an organization to differentiate itself from the clutter of commoditized products. By building trust with consumers and creating a reputation for service and transparency, health plans can gain a significant edge over competitors that cannot easily be duplicated.

This white paper discusses how effective use of advanced technology and outsourcing can improve service and increase cost transparency for members, building trust and creating relationships that last beyond the next open enrollment.

# Table of contents

The rise of consumerism: Three key trends	3
Creating differentiation and stickiness through trust	4
Invest in understanding member behavior and proactively manage the relationship	5
Responsiveness matters, especially to new members	6
How technology and outsourcing can help gain member trust	7
Becoming a healthcare advisor	8
Consider retail access points, remote patient monitoring and telemedicine	8
Conclusion	9

## Written by:

### John Hurd

John Hurd is a solution architect consultant on the health plan innovation and consulting team and is responsible for creating new business-process-as-a-service solution offerings and business development on the health plan innovation and consulting team. He has 15 years of experience working in healthcare business process outsourcing, supporting both solution and new business development activities.

### Karen Branz

Karen Branz is a healthcare journalist helping the NTT DATA Services team develop thought leadership content that examines how technology is transforming the way that patients, physicians, hospitals and health plans interact with the healthcare ecosystem. She has spent 30 years studying and writing about healthcare.

## The rise of consumerism: Three key trends

The number of new health plan members enrolling through the exchanges created by the Affordable Care Act continues to grow. In 2015, an estimated 11.7 million people used the exchanges to purchase individual or family coverage.<sup>1</sup> In 2016, the number was approximately 12.7 million.<sup>2</sup> While there may be dispute about the exact numbers, there is no denying that the individual health plan market has grown substantially.

For health plans, this means more members to serve and more customer service interactions to manage — with many of these new members wary of these interactions and ready to take their business elsewhere if they aren't satisfied.

In this new marketplace, there are three key differences from the environment of the past decade: Members want more transparency, they are being asked to engage more in their own care and management of their health costs, and they expect to be able

to use their preferred method of communication for interactions with their health plan and healthcare provider. With more responsibility and greater expectations about how service is delivered, consumers demand a new level of service from health plans. Given the fierce competition in the consumer market and the trend toward commoditized products, health plans need to differentiate themselves by building a stronger, more trusting relationship with their members.

### Three key trends in the individual health insurance market

Members are seeking greater transparency.

With the rise in consumer-driven health plans such as high deductible health plans with health savings accounts (HSAs), members are more involved in their healthcare decisions and have a financial stake in controlling costs. They want clear information about options, costs, value and quality on which to base their healthcare decisions.

Payers and providers are seeking to engage members in managing their health.

Approximately 75% of U.S. healthcare dollars are spent on chronic disease care.<sup>3</sup> Cost control is increasingly focused on preventing expensive complications and hospitalizations that result from chronic disease. Payers and providers are seeking to engage patients in managing their own care and expecting patients to participate in prevention and wellness activities.

Members expect to use multiple channels to obtain and manage their health insurance and healthcare.

The consumer market expects a comprehensive menu of access points for managing health insurance and, increasingly, for obtaining healthcare. Mobile apps, retail kiosks, web portals with chat windows, email, text messaging and live phone conversations are now baseline expectations for interacting with a health plan. As health plans begin to cover videoconferencing and e-visit consultations, telehealth and telemedicine kiosks and portals, remote biometric monitoring and retail-based, easy access clinics, consumers will also expect these access points for healthcare.

# Creating differentiation and stickiness through trust

To stay in the game, health plans will need to differentiate themselves by offering consumers value beyond the commoditized components of coverage and price. If consumers feel they receive value above and beyond the details of coverage, they are less likely to shop for new coverage each year. They will acquire the stickiness that health plans seek.

The one component of health insurance that can differentiate one plan from another is trust in the company offering the plan. If customers feel they are being treated fairly and with respect, they are more likely to trust a health plan.

That may seem basic, and many health plans will say they treat their members fairly and with respect. However, consumers don't share that view. According to research published by PARTNERS+simons, less than 49% of health plan members trust their health plans.<sup>4</sup>

That 49% statistic is actually an improvement over previous research. A 2012 survey found that less than 38% trusted their health plans. The improvement reflects improvements in communication and availability of information that health plans have made in response to the new consumer-focused market. But with more than 50% of members distrustful, there is an opportunity for health plans that can earn the respect of these skeptical members. Since benefits and price can easily be duplicated by competitors, a health plan that can build trust will have a powerful differentiating factor that transcends comparisons based on these commoditized factors. They will be able to attract new members and build relationships that will outlast the next open enrollment.

## Transparency fosters trust

A clue to consumer dissatisfaction lies in a recent survey by Transunion Healthcare. In that survey, 54% of respondents said they were confused by their medical bills and 62% were surprised by their out-of-pocket costs.<sup>5</sup> Though the respondents faulted their providers for not providing pretreatment cost estimates, this lack of transparency also reduces trust in health plans. When people encounter unexpected medical payments, they often feel as though they are being cheated in some way — even if their health plan clearly spells out their responsibilities for copayments, deductibles and co-insurance amounts. In the survey, 80% of respondents said they need pretreatment estimates that are more clear and precise.

The message to health plans in this survey is that a lack of transparency underlies the lack of trust. If a member cannot get clear cost estimates from a provider, the next step is to seek that information from the health plan. Often, the member is told, "You have to ask your provider for that." Since the provider has already failed to provide the information, the member is left in limbo, feeling that either the provider and health plan are conspiring to conceal costs or that they are too inefficient, lazy or uncaring to provide it. No matter how nice your agent is or how clear your plan documents are, the inability to provide cost transparency fosters distrust. This is not a rare scenario. The previously mentioned Transunion survey also found that only 25% of patients were getting the cost information they wanted.

The health plan that finds a way to provide cost transparency may be able to use that ability to foster trust and differentiate itself from the greater herd of available health plans.

## Provider trust is also low

Much of the distrust felt by members is echoed in health plans' relationship with providers. ReviveHealth does an annual payer survey and trust index which measures the behavioral reliability, honesty and fairness of payers as perceived by hospitals and health systems. The 2015 survey found that, while overall operation performance of payers was good, provider trust of payers remains generally low.<sup>4</sup> This has consequences for member satisfaction.<sup>6</sup> Poor relationships between health plans and providers can bleed over into the provider/patient relationship, further eroding member trust and satisfaction. While this paper focuses on the relationship and trust between health plans and members, attending to the needs of providers for responsiveness and transparency should also be considered.

---

## Less than 49% of health plan members trust their health plans.<sup>4</sup>

— 2015 National Healthcare Trust Index, PARTNERS+simons 2015

---

A clue to consumer dissatisfaction lies in a recent survey by Transunion in which only 25% of people said they were getting the cost information they wanted and 62% were surprised by their out-of-pocket costs.<sup>5</sup>

## Invest in understanding member behavior and proactively manage the relationship

Beyond cost transparency, health plans can use the data in their systems to proactively manage the relationships with their members. Understanding your members' concerns and preferences can help a health plan anticipate issues, better design plan coverage to meet member expectations, and respond to negative attitudes and comments in more productive ways.

J.D. Power and Associates does an annual survey of health plan members that includes more than 30,000 individuals enrolled in over 130 plans across the U.S. The 2014 study found that 41% of existing health plan members feel they do not have enough coverage for routine visits, serious illness or injury, health and wellness programs, routine diagnostics and drug coverage.<sup>7</sup> But what, specifically, do they want changed?

A 360-degree view of your customers can answer that question. To get that view, you can combine clinical and claims data with member-generated social media and lifestyle data to get a real-time view of your customers. The insights you gain can make your marketing more effective, help detect fraud, and help you recognize and intervene when members are dissatisfied with medical care or your services. You gain the power to make a difference when it matters the most. Even on its own, social media listening,

which involves monitoring sites such as Facebook, Twitter, Pinterest and other social interaction forums, can offer useful insights to help answer this question. Listening can:

- Provide insight to member sentiment and product/service performance
- Identify dissatisfied members early on
- Promote payer brand awareness among existing and potential members
- Monitor share of voice compared to other plans or products
- Provide an outreach or advertising platform for member-related activities such as health camps, webinars, seminars, new plans or products
- Improve outreach by identifying key influencers and social media channels of interest
- Provide business and market intelligence
- Improve member satisfaction with knowledge gained from proactively reengineering the process

Health plans can use advanced analytics to find trends in data collected through social media listening that indicate community health issues, consumer attitudes toward their brand, preferences in medical care and other useful insights. If, for instance, the data shows an increase in a particular geographic area in searches about telemedicine and retail clinics, this could indicate a readiness by consumers to use these access points. Or an increase in searches about diabetes symptoms could indicate a population with a high risk of type 2 diabetes. Conversely, an increase in searches and conversations about fitness events and classes could indicate that a population would respond positively to wellness incentives. The possibilities for increased understanding of member behavior are endless.

Better understanding can help a health plan provide options that are better fits for particular markets and that are priced to be both competitive and profitable. And a plan that is a better fit can signal to a community that the health plan organization is paying attention to their needs, which will help engender trust.

Health plans can use advanced analytics to find trends in data collected through social media listening that indicate community health issues, consumer attitudes toward their brand, preferences in medical care and other useful insights.

## Responsiveness matters, especially to new members

As many health plans have learned over the past two years, responsiveness during the months immediately after the open enrollment period are important. Given the inherent lack of trust between members and health plans, the first few interactions are critical to setting the tone for the future. If a new member finds that your plan's customer service function is responsive, easy to contact and able to answer questions clearly and quickly, their generalized distrust will begin to erode, opening a path to a positive relationship.

The rising rates of trust in health plans are at least partly attributable to increased investment by health plans in their customer service infrastructure. That infrastructure includes the customer web portal and chat system, email system, phone system and call center management system and staff. Let's take a look at how each of these systems affects customer trust.

### Web portal and chat system

This may be the first experience a prospective member has with your health plan, and confusion, lack of clarity or insufficient detail can discourage a consumer from considering your plan. Conversely, a robust site that allows easy comparison between options will encourage a consumer to apply for coverage. A chat system is vital, especially for younger consumers who are accustomed to texting and instant messaging (IM) as their default communication choices. Also, for consumers over age 45, who are less comfortable with text and IM channels, the ability to convert the chat to a verbal conversation (either online or via a phone call) can help if the conversation becomes complex.

Your portal should also include estimators that help members figure out what their costs will be when they are comparing plans and when making treatment decisions after they enroll. The cost transparency that an estimator allows can foster trust if it is reasonably accurate. Most consumers will understand that actual costs may vary, though erring on the high side is preferable to underestimating out-of-pocket expenses. Your members will be delighted if the actual cost is lower than expected and disappointed if it is higher than expected (and possibly angry if it is a lot higher).

### Email system

The key to using this channel effectively is speedy response. While it is not as fast as chat or phone, an email response within an hour or two will surprise and impress prospective members who are used to an unresponsive system. During open enrollment and the first quarter of the benefit year, you should assign extra staff to monitor and respond to member emails. Make sure they are well trained and have access to a digital knowledge base to ensure higher accuracy and productivity.

### Call center and phone system

This is your most vital link to prospective members. Don't leave them on hold! During open enrollment and the first quarter of the benefit year, plan to either outsource some of the call center load or hire temporary staff to augment your regular agents to ensure that wait times are minimal. Every consumer has heard, "Please hold, your call is important to us" so often that this automated message now indicates the opposite — that the call (and the caller) isn't important enough to actually staff the call center sufficiently. Since consumers will expect heavy traffic and long waits during this critical period, getting through to an agent quickly will earn their trust and appreciation. They will begin to think of you as the health plan that really considers their needs important.

It's also important that staff be well trained and supported by a knowledge base that can be quickly accessed and searched. If your agents cannot accurately answer questions, you'll lose the ground you gained from answering the call quickly. Invest in a call management system that allows you to route calls to the most appropriate agent and to escalate calls easily and swiftly when the need arises. Intelligent data management and call routing systems can pay for themselves if they shorten the time an agent spends finding answers. The quicker the response, the more productive the agent can be — reducing the number of staff needed. Since salaries are the biggest percentage of call center costs, the more productive your agents are, the lower your costs will be.

Staff should also be well versed in empathetic customer interactions. Most people find health issues stressful, and many callers will be anxious, frustrated and scared. Finding someone who will listen and understand their issue will reassure them and reduce their emotional distress, allowing for a more productive interaction.

### Better communication pays off

A 2015 survey by JD Powers found that member satisfaction has improved in recent years. "The increase in satisfaction is driven by improved performance across all factors, most notably in information and communication (+17 points), which is primarily a result of efforts among many of the health plans to retool their approach by refining messaging, adjusting message frequency and upgrading their website. Satisfaction in the customer service factor has increased by 11 points, driven partially by matching communication methods to member preferences, such as mobile and text."<sup>8</sup>

## How technology and outsourcing can help gain member trust

As many health plans have learned, outsourcing customer service to an advanced customer contact center can actually improve member interactions. A good contact center will have the technology needed to maximize agent productivity and present a unified communications approach to consumers. It will also be able to present a unified view of the consumer to the health plan. Many plans still have back-end applications, such as customer relationship management (CRM) software, that do not provide the ability to support multiple channels. By outsourcing customer interactions to an advanced contact center, the health plan can avoid the cost and operational disruption involved in upgrading its back-end systems.

Choose a center that has these technological capabilities combined with a workforce that has the knowledge and skills to handle sensitive issues well. If the health plan trains this already skilled workforce in the details of its plans and operations, the result can be a superior customer service experience that increases transparency and trust.

Call centers also have deep resources that allow them to shift agents to accounts when call volume increases. Health plans seldom have the ability to scale up and down as needs fluctuate. By outsourcing this function to a professional call center organization, health plans can provide the level of service needed at a much lower cost than if they do it themselves.

An advanced call center will also have the technology to interface with the health plan web portal and chat system, providing a seamless communication experience for members. The call center should also be able to provide prompt and detailed reports on member interaction. This data can be used to identify problems, confusion and other barriers to member satisfaction, giving the health plan an opportunity to modify communications or operations as necessary to fix the issues that come to light.

### Set member-centric metrics to measure progress

Health plans should design strategies to monitor their performance as viewed by individual members and formulate metrics that indicate positive and negative progress. An example of this is the Member Touchpoint Measures set by the Blue Cross and Blue Shield Association to measure performance and operational efficiencies for claims, enrollment and customer service. Your metrics should measure factors such as:

- Timely resolution of inquiries and claims payout
- Sensitivity in handling grievances and appeals
- Efficiency of enrollment fulfillment
- Premium billing accuracy
- First-call resolution
- Claim payment accuracy

These factors should be closely monitored as they can immediately affect how a member feels about your plan.

As many health plans have learned, outsourcing customer service to an advanced customer contact center can actually improve member interactions.

### Become a healthcare advisor

Health plans can learn from other industries, such as financial services, where consumers have advisors to manage their account as well as help portals that provide tips and advice.

Similar to the role of financial advisors, health plans can play the role of health advisor and health information coach to support members' ability to improve their health. This will add to member trust and may encourage more appropriate treatment choices, reduce non-compliance and lower overall health costs for both the plan and the member. It may also improve the relationship with network physicians and their staffs, who will likely welcome help with patient education and compliance.

### Consider retail access points, remote patient monitoring and telemedicine

Consumers in many markets are ahead of both providers and health plans in their acceptance of treatment access points that increase convenience. Many consumers favor use of retail clinics and telemedicine kiosks for episodic care. While most still want a traditional physician relationship, consumers also want convenient and affordable access to videoconferencing and e-visit consultations for urgent needs such as minor illnesses. Depending on the specific market, providing coverage for these access points can lower costs for both the plan and members, improve case management and increase member satisfaction.

Innovative telehealth, remote monitoring and mobile technologies for chronically ill members or members recently released from an inpatient hospital stay can increase a member's sense of security and reduce risk of complications or readmission, benefiting both the member and the health plan. Combined with the support of a health advisor/care manager, these modalities can help foster trust between members and their health plan.





# Conclusion

Earning the trust of members is a foundational strategy for differentiating a health plan in a competitive individual market. Understanding member needs, providing transparency and responsive customer service, and providing services and support that go beyond the conventional way of doing business can engender trust in an inherently distrustful population. To succeed at this complex task, health plans should employ a comprehensive toolset that includes:

- A robust customer web portal with integrated chat and email
- Outsourcing of customer service to an advanced customer contact center that uses an integrated communications and knowledge platform and has a large pool of well-trained agents
- Social media listening and analytics
- Health advisors
- Innovative access points such as retail kiosks, remote monitoring and telemedicine

## References:

- <sup>1</sup> Nationwide nearly 11.7 million consumers are enrolled in 2015 Health Insurance Marketplace coverage <http://www.hhs.gov/about/news/2015/03/10/nationwide-nearly-11-point-7-million-consumers-are-enrolled-in-2015-health-insurance-marketplace-coverage.html>
- <sup>2</sup> About 12.7 million people nationwide are signed up for coverage during Open Enrollment <http://www.hhs.gov/about/news/2016/02/04/fact-sheet-about-127-million-people-nationwide-are-signed-coverage-during-open-enrollment.html>
- <sup>3</sup> Chronic Diseases: The Leading Causes of Death and Disability in the United States <http://www.cdc.gov/chronicdisease/overview/>
- <sup>4</sup> What's happening with trust in consumer healthcare <http://www.healthcarelive.com/news/whats-happening-with-trust-in-consumer-healthcare/407924/>
- <sup>5</sup> TransUnion Healthcare Survey Finds Cost Transparency is a Top Priority for Patients <http://transunioninsights.com/healthcarecostsurvey/>
- <sup>6</sup> ReviveHealth Annual Payer Survey and Trust Index <http://www.thinkrevivehealth.com/payorsurvey2015>
- <sup>7</sup> J.D. Power Reports: Concerns about Not Having Enough Health Coverage Drive Down Member Satisfaction <http://www.jdpower.com/sites/default/files/2014020%20Member%20Health%20Plan%20U.S.pdf>
- <sup>8</sup> Member Satisfaction Significantly Increases as Health Plans Take Customer-Centric Approach <http://www.jdpower.com/press-releases/2015-member-health-plan-study>

## About NTT DATA

NTT DATA is an end-to-end service provider of IT and business solutions for health plans. Our level of service differentiates us from other companies with a business model that emphasizes listening to and engaging with our clients. We are equipped to partner with health plans, enabling payers to address their strategic vision of being a member-centric organization while remaining competitive in the evolving consumer-driven market.

Visit [www.nttdataservices.com](http://www.nttdataservices.com) to learn more.

NTT DATA partners with clients to navigate the modern complexities of business and technology, delivering the insights, solutions and outcomes that matter most. We're a top 10 global IT services and consulting provider that wraps deep industry expertise around a comprehensive portfolio of infrastructure, applications and business process services.

**NTT DATA**