A new paradigm for healthcare payor operations

From back office to center stage
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Executive summary

**Consumer empowerment**, integration of healthcare delivery, and new technologies are driving a radical transformation across the healthcare ecosystem. Over the next decade, market forces will compel payors to exchange today’s compartmentalized structures for flexible operations, horizontally integrated processes, and analytics capabilities that serve the evolving needs of members and providers.

To thrive in this new environment, payors need to embrace a new model for the future, one that redefines payor operations as the entire set of interactions with both consumers and providers and the end-to-end processes that support and engage them. To build and maintain these connections, they must invest in three transformation imperatives: expand their operations footprint horizontally across the payor value stream; become analytics driven; and leverage a distributed ecosystem and operating model.

Chief operating officers who see around the corner — and respond proactively to these market forces — can differentiate their organizations, deliver far greater value to consumers and providers, and operate much more effectively and profitably.
Major challenges ahead

It’s a familiar and frustrating scenario for healthcare consumers and providers everywhere — and for the payor operations professionals who support them. Plan members seek engagement at various stages of their healthcare journey, but no one they talk to has a detailed understanding of their profile. Whether they’re interacting with brokers or self-service portals at the point of sale or with call center administrators, members of the care management team, or the providers themselves, they’re served by professionals who see only a part of the picture. As a result, patients and physicians don’t benefit from analytics that generate actionable insights on behaviors and interactions — the kind of insights that ultimately improve health outcomes and reduce the cost of care. At the very least, members and providers experience inconsistent service, administrative hassles, and a generally negative experience navigating the health system. At worst, members suffer from higher costs and inferior health outcomes, in part because no one guides them to the best providers and treatment options.

Operations professionals — the membership enrollment, claims, and member and provider service associates who perform vital back-office functions — are paying a steep price, too. Because service professionals too often work in unconnected departments, they can’t access member information and insights collected elsewhere in the value chain. As a consequence, the industry suffers from a reactive, transactional, and fragmented operations model that impedes decision making, increases costs, inhibits customer understanding and intimacy, and invites administrative errors that often lead to redundant manual transactions, rework, and inaccurate administrative outcomes (see Exhibit 1, next page).

As bad as this friction is today, it will only increase as change accelerates, new technologies take hold, and megatrends and market forces reshape healthcare. Before long, empowered consumers will expect payors to deliver truly integrated service based on in-depth knowledge of their health conditions at every stage of the life cycle. What’s more, capitated payment models that pay the providers set fees for each enrollee will remove the need for intermediaries and bring the industry suffers from a reactive, transactional, and fragmented operations model.
Exhibit 1
Service operations model today

<table>
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<tr>
<th>Customers</th>
<th>Health payor functions</th>
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<td>Prospective members</td>
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<td>Patients</td>
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<td>Service operations</td>
<td>Back office</td>
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<td>Providers</td>
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<td>Enrollment and eligibility</td>
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<td>Claims</td>
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<td>Member services</td>
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<td>Provider services</td>
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Source: Strategy& analysis

Product and market analytics
Network and clinical analytics
Service analytics
more automated processes to many administrative and utilization management functions in traditional health plans. These models will also place greater emphasis on functions like coordinated care management and predictive analytics, which require different skill sets. These changes challenge payors to develop and implement new operating models that will integrate functions that are now fragmented — and empower service professionals to work across the value chain. Transformation of this magnitude will require executive vision, innovative thinking, radical operating model innovations, savvy investment in technology and human resources, disciplined execution, and effective communication across the value chain.

To prepare for this future, payors should consider the implications of several market trends that are altering the landscape. Guided by this insight, payors can redefine their operations as the entire set of their interactions with both consumers and providers and the end-to-end processes that support and engage them. Chief operating officers need to respond proactively to these trends to prepare their organizations for the future.
Healthcare professionals across the value chain are very familiar with three important trends and market forces that are effectively reshaping the industry. Together, consumer empowerment, integration of healthcare delivery, and new technologies are already driving a radical transformation across the healthcare ecosystem. The implications for payor operations will be especially profound, as market forces over the next decade will compel payors to adopt more flexible operational structures and skill sets, integrate processes and platforms across business functions, and build analytics capabilities that serve the evolving needs of members and providers.

The decisions that payors make about how and where to serve this evolving market will dictate which of them will capture the incremental revenue, cost savings, and customer loyalty that are there for the taking. And ultimately, their success will rest on operational decisions such as how to expand their horizontal footprints, how to embrace analytics, and how to leverage a distributed ecosystem to optimize their capabilities.

**Consumer empowerment.** In the traditional model, payor operations sits in the back office, where professionals help consumers understand and access coverage, check their benefits, look for providers, inquire about claims, and dispute bills. But because operations staffs have limited vision across functions and lack customer insights driven by analytics and information, they typically cannot provide proactive services that reflect an informed understanding of medical conditions and individual clinical and administrative needs. As a result, their “one size fits all” approach makes it increasingly challenging to give members the personalized attention they value.

These operations services will evolve as more consumers shop for their own preferred health plans and engage more in their courses of treatment. Payor operations will need to support members and providers much more proactively and effectively throughout the entire care life cycle — even using provider and industry data to monitor consumers they do not currently insure but who may seek coverage.
later in life. To meet evolving consumer expectations for individualized service, all areas of a health plan must work together as one to understand, appeal to, and satisfy consumers. Payors must adopt the playbook of great consumer companies like Apple and Amazon — leader brands that create value through great analytics, deep insight into consumer preferences, and seamless service.

**Delivery integration.** Operations will need to make additional investments and changes to adapt to the ongoing transformation of care delivery. Today, a distributed care delivery model is emerging whereby various players collaborate to improve quality of care and patient outcomes. To effectively coordinate member care, payors will need to establish new processes that forge tighter connections between care delivery players. They will also need real-time access to data collected from internal functions, wearable devices, and the entire value chain, so they can take full advantage of advanced analytics that turn data into insights about diagnostics, costs, and product design. This information will help them advise members on appropriate treatment options, engage them and enroll them in care coordination options or pathways, detect early symptoms, and identify providers that deliver high-quality, cost-efficient care.

Today, payors are constrained by disparate processes where different teams pursue independent objectives. Within care management operations, for example, network management, quality, and utilization management (UM), case management (CM), and condition & lifestyle management (DM) each play a specific role in managing sick populations and improving economics, yet information does not flow across these functions because there is limited capability to process clinical and operations data and share it across the value chain. As a result, payors miss many opportunities to create medical value. Consider the example of a member who visits multiple providers for hypertension over the course of three years. Without integrating, analyzing, and interpreting data collected through multiple member interaction channels (e.g., phone, Web, wearable devices), the payor’s care management team cannot help the member detect severe symptoms early on, assign a risk score (or risk profile) to the member using predictive analytics, enroll the member in a care management program tailored to his or her condition, and thereby avoid high-dollar claims that may arise if conditions deteriorate later in the member’s journey. These actions would have been possible if insights and information flowed across the distributed network — from data collected using wearable devices to patient health records to analytic data on symptoms and outcomes.

**Technology innovation.** The emerging digitized environment will give consumers unprecedented power to monitor their health in real time
and choose the delivery system that suits them best. As wearable technologies, implant devices, and smartphone apps take hold, payor operations can play a key role in the new healthcare ecosystem by integrating these technologies into their business models and translating information into actionable customer insights.

Today, most payors struggle to meet this technology challenge. Some continue to invest in their outdated core administrative platforms, draining funds that could be used to spearhead innovation. Others lack either the savvy to extract digital information from consumers, or the technical talent necessary to ride the wave of innovative new technologies. Without the ability to access real-time data collected from members’ wearable devices, social apps, or other types of technologies, payors cannot guide members toward timely interventions that improve health outcomes and lower costs.

Diverse new players are flooding the marketplace, and operations can rely on these innovators to help fill service, technology, and infrastructure gaps. These resources can help build a distributed ecosystem that allows greater consumer choice while providing integrated and comprehensive support.
A new paradigm for payor operations

With the advent of integrated health systems, patients now play a leading role in their healthcare and treatment choices. To emerge as key players in the new ecosystem and enable the model of the future, payors must move beyond administration to become the consumer’s “trusted advisor” — a proactive healthcare navigator that advises the consumer on how to identify risks, monitor conditions, weigh treatment options, select delivery channels, choose quality providers, manage costs, and even arrange payment plans.

This enhanced role for payors will be supported and enabled by a new model that shares execution risk with providers through predominately value-based arrangements. Payors will create value by taking on key administrative services like risk aggregation and analytics, while also helping providers integrate care around the whole person and his or her total health and lifestyle needs. They will also play a central role in transitioning patients through various care touch points (i.e., digital, outpatient, inpatient, and post-acute). And together, payors and providers will develop care bundles, capitation, and other reimbursement structures that will create economies by making today’s claims process obsolete. In some cases, payors will team up with providers, and the providers will take on the responsibility of co-delivering specific processes supporting certain member interactions and health outcomes, such as care integration and coordination. Overall, this new model will create a seamless consumer and provider experience across the life cycle — one that pushes all players to focus on an integrated care delivery model with minimal waste (see Exhibit 2, next page).

To optimize this new model, payors should dramatically change the role and makeup of their operations and build new capability sets to serve members and providers. Specifically, they must invest in three transformation imperatives: (1) expand their footprint horizontally across the payor value stream; (2) become analytics-driven; and (3) leverage a distributed ecosystem and operating model (see Exhibit 3, page 13).
Exhibit 2
Future role of service operations

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<td>Members</td>
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- **Customers**
  - Prospective members
  - Patients
  - Providers
  - Collaboration partners
  - Members

- **Health payor functions**
  - Front office
    - Product
    - Marketing
    - Digital sales
    - Actuarial
    - Underwriting
  - Middle office
    - Network management
    - Medical management
      - Digital service
    - Pharmacy
  - Back office
    - IT-enabled automation
    - Account setup
    - Enrollment and eligibility
    - Billing
    - Claims
    - Digital self-service
    - Member services
    - Provider services

- **Service operations**
  - Exchange-to-exchange product implementation
  - Sales navigation
  - End-to-end medical cost optimization
  - Wellness coordination
  - Clinical coordination
  - Pharmacy support
  - End-to-end payment integrity
  - Collaboration support
  - Customer guidance

- **Coordination and integration of enterprise analytics**

Source: Strategy& analysis
Exhibit 3
Vision for service operations

Expand horizontal footprint across the value stream

- Look beyond traditional silos and expand operations footprint to create deeper consumer interactions
- Transform operating model structure and processes by aligning to customer needs
- Segment interactions and transactions into high-volume services and high-touch or highly tailored engagements to drive more integration across processes and functional silos

Become analytics driven

- Deliver consistent service while generating the 360-degree view of consumers that is needed for advanced analytics
- Leverage predictive analytics to help reduce medical cost leakage
- Apply real-time analytics to design the right products, network, and care solutions while providing the ability to track quality
- Leverage consumer medical analytics to advocate on behalf of members and guide them to the right providers and treatment options
- Leverage provider quality and financial data to negotiate rates and network agreements

Leverage a distributed ecosystem and operating model

- Work with partners to develop new differentiating capabilities while reducing per-member per-month operating costs and gaining the flexibility to invest in future initiatives
- Work with providers and other partners collaboratively to consolidate redundant administrative processes and functions
- Establish relationships with external partners to gain insights on existing members (e.g., health data received from wearable devices)

Source: Strategy& analysis
Theme 1: Expand horizontal footprint across the value stream

To thrive in a customer-centric environment, payors must understand how different consumer segments define value. They should look beyond traditional silos and across the payor value stream for new service opportunities and create an expanded and integrated operations footprint that supports broader and deeper consumer and provider connections. For example, sales and marketing can become member advocates that offer real-time, multichannel, proactive outreach during the sales process to help employer groups and individuals select the right product. Billing can generate a single payor-originated invoice and billing statement that improves cost transparency while eliminating the confusion and cost of duplicate invoices from providers. And care management teams can provide a multichannel service for consumers, offering advocacy, guidance to providers and treatment options, and even full-fledged customer care units that deliver virtual doctor benefits, advice through hotline nurses, and cost-effective care guidance through the use of benefit value advisors. If the service operation can move across silos and play a role in sales navigation, care management and coordination, and administration, it will deliver consistent service while also generating the truly 360-degree view that’s needed for advanced analytics.

In many cases, this strategy will require payors to radically transform their existing operating models. Whether new models are structured by process or by customer journey, they should be flexible enough to provide each customer segment, tier, or demographic with flexible, customized service across the member and/or provider life cycle. At a minimum, this will require payors to segment interactions and transactions in high-volume services and high-touch or highly tailored engagements to drive more integration across processes and functional silos where the high-touch value is required. The model may also call for new information flows, motivators/incentives, and decision rights across the entire payor value chain. In some scenarios, payors and providers will need to integrate specific components of their respective operating models so that both can deliver critical processes.

Theme 2: Become analytics driven

Analytics can produce valuable insights across the value chain — from product design to quality management to individualized treatment recommendations to innovative payment arrangements. Yet although most payors have pockets of analytic capability, few boast cross-functional collaboration, analytical processes, flexible data architecture, technology infrastructures, and data science skill
sets that make analytics readily available. By building new analytics capabilities as well as integrating and coordinating existing specialized analytical capabilities located in functional domains (e.g., marketing analytics, clinical analytics), payors can fully leverage their existing data to support multiple internal and customer-facing functions.

• Operations can use predictive analytics to help address an especially onerous challenge: medical cost leakage. By analyzing data from segments or clusters of members touched by specific interventions, the operations division can predict whether specific care management programs will function as designed and how product, network, and medical policy changes will impact medical costs. By tapping into multiple sources — including claims, electronic health records data, lab results, and eligible Medicare beneficiary guidelines — to integrate data longitudinally, from the same subjects across different points in time, payors can employ statistical analysis to align utilization patterns with clinical interventions.

• Payors can apply real-time analytics to design the right products, network, and care solutions. They can track quality of design and adherence to design changes — and then feed information from back-office operations into design functions based on actual product, network, and care intervention performance.

• Analytics can help operations teams detect breakdowns in medical policies that impact both member experience and bottom-line performance, and then redefine the policies based on utilization, reimbursement patterns, and medical policy adherence. And by mapping medical policies to claims and to industry benchmarking, payors can reduce overpayment by building greater specificity into high-reimbursement medical policies.

• Call center employees can tap into data on patient populations, predictive analytics on high-value claims, and information on medical policies and medical management interventions to advise patients on courses of treatment and ways to manage conditions. Both the service and clinical staffs can access consumer medical analytics to advocate on behalf of members and guide them to the right providers and treatment options.

• Data on customer navigation and preferred sales channels can help marketing and sales develop user-friendly products, deliver targeted sales campaigns, and inform future product design and development.

• Network operations can leverage provider quality and financial data to negotiate rates and network agreements.

Payors can feed information from back-office operations into design functions based on actual product, network, and care intervention performance.
• Actuaries and underwriters can leverage consumer analytics and real-time health telematics (remote transmission and processing of individual consumer health data) to effectively determine pricing based on improved risk profiles. They can also utilize population data to help providers calculate costs and maintain profitability based on the risk of their specific population.

These examples demonstrate how analytic engines that look across utilization, claims, and care management can empower payor operations to model and predict consumer behavior, provider quality, utilization, and unit cost trends, and use these insights proactively to improve internal and member-facing processes along with health plan economics.

Theme 3: Leverage a distributed ecosystem and operating model

As payors embrace a more central role in the healthcare value stream, they will face strategic decisions about how to deliver an integrated service experience. Specifically, payors must determine whether to build new capabilities and systems themselves or with partners, or source them from vendors, providers, or even competitors across a distributed ecosystem.

Many payors are turning to outside partners to access new technology platforms and Web portals that transform the entire customer and provider experience. Such platforms improve transparency by giving operations service employees and members integrated access to accurate cost estimates and quality data on providers. Payors can reduce per-member per-month operating costs and gain the flexibility to invest in future initiatives.

Payors are also creating value by working across the ecosystem to close vital information gaps. For example, some are purchasing longitudinal data on specific demographic segments to bolster their advertising and social media strategies. This data allows them to tailor products and pricing to individuals and population segments. As the regulatory environment continues to evolve, payors will also be able to integrate data collected through telematics and monitoring devices to give members individualized care management options, along with financial incentives to embrace them.

Payors, providers, and other partners can also collaborate to consolidate redundant administrative processes and functions. This is an especially important consideration at a time when margins are declining and competitive dynamics require significant new investment. Some payors
are joining forces to build state-of-the-art membership and claims processing systems. Others are sourcing key functions like invoicing from established players, thereby reducing costs and simplifying the entire payment process.
Delivering new capabilities

Industry trends are placing intense pressure on payor organizations to transform their operations by integrating the end-to-end processes that support and engage both consumers and providers. New operating models are emerging that expand service operations beyond the back office, leverage new analytical insights and information pathways, include new incentives and rewards, and build strategic partnerships across a distributed ecosystem. To build the optimal model, executives should define a clear vision and goals for future operations — where and how they want to participate in an increasingly consumer-centered healthcare market. They should then determine what capabilities and tools they need to enable their vision. These skills may include care management capabilities tailored to different member and provider segments, and expanded enterprise-wide reporting and analytics to support proactive member and provider services. By finding the optimal operations model, and determining the path to achieve it, payors can stay a step ahead of change and meet the many challenges of consumer empowerment and integrated delivery.
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