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Cruise Through the Health Plan Enrollment and Billing Journey

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The open road for enrollment and billing

Healthcare payers navigate a perilous road riddled with continuous margin pressure coupled with demands for new levels of customer service and pricing transparency. Today, payers have new opportunities to boost their bottom line, improve the customer experience, and facilitate regulatory compliance at two of the most critical junctures in the customer and policy lifecycle—enrollment and billing. It's time to smooth the curves and chart a clear path to a healthy future with core administration modernization.

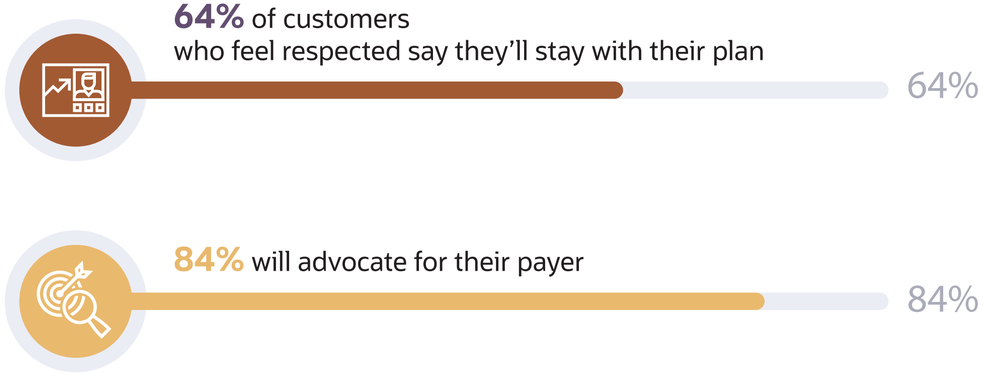
It’s not all downhill for enrollments

We’ve all been reminded, “You have one chance to make a first impression.” For healthcare payers, the first impression happens during enrollment. And, customers are measuring their healthcare payer experience—for better or worse—against the frictionless and immediate transactions they enjoy elsewhere in their daily lives.

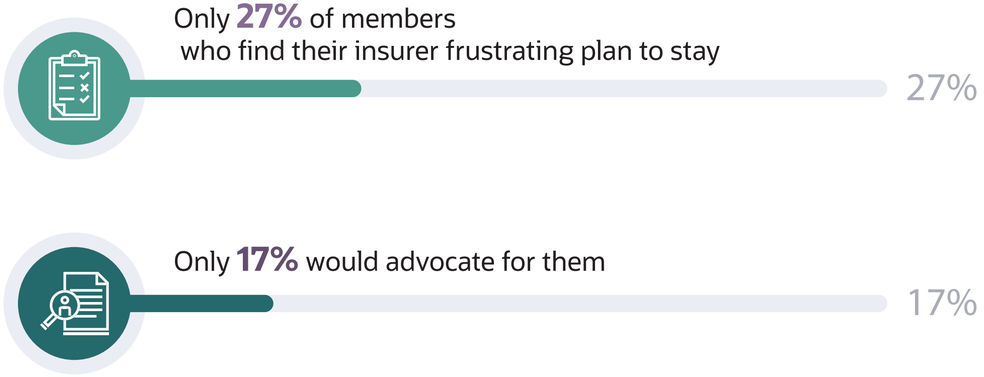
Payers are struggling to deliver. According to OpsDog, the median number of members receiving their ID cards on or before the policy effective date is 46.7 percent. And, on average, it takes almost two days (1.8 days) to process new member electronic enrollments.

These experiences matter. In 2021, Forrester surveyed members of 17 of the largest health plans in the United States and found an industry average customer experience score of 70.2 on a 100-point scale. Forrester categorizes this as an “OK” rating. Also, as part of the study, members say they’re more likely to stay with an insurer that makes them feel appreciated, respected, and valued, and are put off by frustrating interactions.

Respect drives loyalty



Frustration fuels attrition



Source: Forrester: These are the payers with the best customer experience | Fierce Healthcare

Rocky terrain for revenue management and billing

Revenue management is equally challenging. From the macro perspective, the pandemic reshaped the face of the industry. Medicaid and Children's Health Insurance Program rolls have grown while employer-sponsored plans have seen some declines. States were barred during the health emergency from removing Medicaid enrollees from coverage. However, this is likely to change, and insurers expect states to restart eligibility determination for Medicaid coverage.

There's also growing evidence that providers are caring for sicker patients, due to delayed preventive care and postponed treatments during the health emergency. This trend is expected to create headwinds for payers as they see patient care costs rise.

Customer experience challenges also factor into the billing phase of the member lifecycle, which is often another point of friction for individuals seeking greater flexibility and expanded online capabilities.

Finally, the regulatory environment continues to grow more complex, specifically around pricing transparency. Regulatory requirements have wide-reaching billing and revenue optimization ramifications, and many organizations struggle to achieve compliance using their inflexible legacy systems.

Legacy processes and technology compound headwinds

The insurance industry is, by nature, risk-averse. This mindset extends to process and technology modernization. For many years, insurers bet on the risk of change outweighing the efficiency, customer experience, security, and business opportunity gains that modernization could afford.

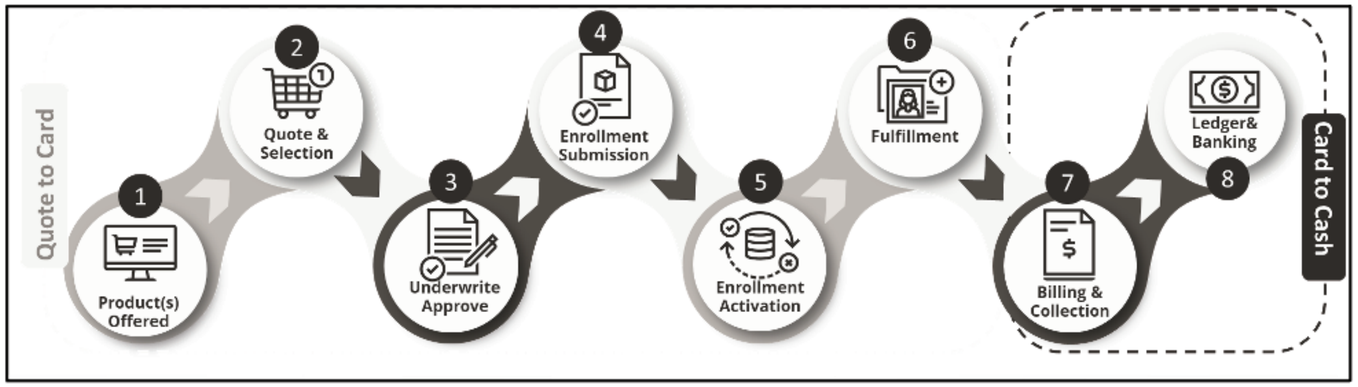
That's no longer the case as their continued success hinges on the ability to capitalize on the following critical business opportunities and meet burgeoning requirements across the enrollment, membership management, and billing phases—all of which require modernization at scale:

- Automated and integrated end-to-end processes across the lifecycle that boost efficiency, speed transactions, improve the customer experience, and reduce risk
- Highly personalized services and frictionless communications and support
- Real-time enrollment
- Rapid time to market for new products and billing models
- Ability to create value early in the consumer acquisition process
- More flexible, accurate billing, especially related to contracted charges
- An expanded insight that optimizes enrollment and revenue management
- Greater agility and efficiency in meeting changing regulatory requirements
- Platform flexibility and ecosystem simplification

The member journey: enrollment and billing processes and workflow

The enrollment-to-billing journey encompasses two phases: quote-to-card, which spans all enrollment processes, and card-to-cash, which encompasses billing and revenue management. (See figure 1).

Every phase of the journey provides opportunities to add value to relationships, improve operational efficiency, and facilitate compliance. Insurers, however, face challenges at every turn. For example, a large corporation is evaluating its employee health insurance plan. It's looking for a highly specialized health plan and would like to roll it out in the next open enrollment period. They discover, however, that their preferred health insurer cannot **configure, price, and quote** the specified plan options in time to meet the open enrollment deadline. As a result, the payer did not get the deal. This same insurer struggles to adapt products as regulatory requirements change, elevating risk. The inability to agilely configure, price, and quote also constrain its ability to expand into new geographic markets.



The member journey: enrollment and billing processes and workflow

Another health insurer faces chronic delays in the **underwriting** phase. It's mired down in paper-based processes, data that must be rekeyed from different systems, and email-based approval chains and workflows. These disconnected processes require significant manual intervention that elevates costs and negatively impacts customer relationships at the earliest stages. The insurer faces similar hurdles in the **enrollment submission, activation, and fulfillment** phases as it, once again, requires data from many different sources and channels, and relies on manual processes to collect and validate missing data. As a result, it's consistently late in issuing enrollment cards, which triggers financial penalties as well as member complaints.

The challenges don't end when cards are issued; they continue throughout the **billing and collections** process. For example, a large insurer finds that many of its tier-one clients are beginning to request a consolidated bill for all the products it purchased. The insurer is struggling to meet this request as it has multiple billing systems across its various lines of business. In addition, as it continues to grow, it's challenged to efficiently manage the creation of customer structures, including billing hierarchies, and to achieve real-time insight into billing status. Finally, it offers limited self-service capabilities for members, so they are forced to email or phone the company's customer service center for the simplest of inquiries. This approach drives up costs, slows service responsiveness, and builds customer frustration.

Navigating the bumps in the road

These are just a few examples of the challenges—and opportunities for improvement—at each stage of the lifecycle. Several root causes underlie these challenges, limiting payers' ability to boost profit, improve the customer experience, and reduce risk:

1. Fractured data flows—Payers struggle with duplicative data stores and inefficient integration across the entire enrollment and billing lifecycle. Rigid legacy applications and incompatible technologies prevent seamless data exchange and a single view of the customer across all lines of business. This translates to missed opportunities to create exceptional value early in the customer acquisition process and throughout the relationship.

2. Inefficient processes—Disjointed point systems, which lack API compatibility, and legacy manual processes lead to inefficiency that drives up costs and makes it difficult to rapidly launch new products, offers flexible billing, and bill for all contracted charges. E-mail-dependent workflows and approvals delay processes across the lifecycle, including launching new offerings, calculating pricing, providing customer information updates, and delivering a seamless billing experience.

3. Slow systems and limited scale—Most legacy systems, which require hardcoding and extensive IT team intervention for even the simplest updates, cannot pivot rapidly to meet changing business needs. Further many continue to rely on batch processing that does not deliver the real-time information and decisions that the market demands. And, many organizations struggle to scale their infrastructures, which complicates their ability to add lines of business, expand geographically, and grow through acquisition.

4. Security and privacy complexity—Security threats and requirements continue to escalate. Legacy infrastructures typically contain multiple data stores that fuel dozens of point solutions and often lack adequate preventative controls and audit trails. This reality complicates compliance with internal controls as well as regulatory requirements and elevates overall risk.

Essential capabilities to navigate the four challenges

Six core administration capabilities are essential to empowering payers to overcome these persistent challenges, unlock new opportunities, and build stronger relationships. They include:

- A central golden member record and automate end-to-end processes
- A microservices architecture that enables progressive transformation, flexibility, and performance
- Rules-based and highly configurable applications
- API-rich approach to enable real-time processing and data access
- Multiple consumption models—functional components, end-to-end solution, calculation engine
- Security with preventable controls and extensive audit trails

Building a direct path for your future

Oracle Health Insurance Core Administrative Solution, a leading SaaS solution, which includes Policy Administration and Revenue Management and Billing for Healthcare Payers—is purpose-built to help healthcare payers compete agilely in a constantly changing landscape, delivering the essential capabilities identified previously and much more. Our solution drives frictionless onboarding, creates a central golden member record, enables efficient member management, and ensures accurate, efficient, and flexible billing. And, it also supports both commercial and government health insurance and billing from a single platform.

The component-based solution spans the complete lifecycle—and enables payers to begin their enrollment-to-billing modernization journey where they want and proceed at their own pace.

Oracle Health Insurance Core Administration Solution

Membership and policy administration

Revenue management and billing

Comprehensive digital core SaaS offering on Gen 2 Oracle Cloud Infrastructure

Several hallmarks define our solution

- Support for multiple lines of business on a single platform to create a central golden member record and automate end-to-end processes
- A modern, microservices architecture that enables progressive transformation, flexibility, and performance—empowering healthcare payers to go from technology innovation to business impact faster and with less risk
- Rules-based and highly configurable
- API rich for real-time processing and data access
- Multiple consumption models—functional components, end-to-end solution, calculation engine
- Cloud-native—delivered as Software as a Service—to support innovation and extreme scale as you need it
- Purpose-built for the healthcare payer market and backed by the power and stability of the Oracle ecosystem
- Best-in-class security

Let’s explore how it all comes together.

Policy Administration:
Manage enrollments and memberships with ease and efficiency

Policy Administration provides ease of case setup, enrollment, and member services for payers' commercial and government businesses, all on a single health insurance software platform.

Our solution drives frictionless onboarding and creates a central golden member record—two essential ingredients for customer satisfaction—while improving operational efficiency through automation, accelerating time to market for new offerings, simplifying regulatory compliance, and advancing population health.

Our approach to enrollment begins and ends with a focus on the customer:

1

Understand your member

Capture numerous custom member attributes via business configuration layer to create full longitudinal member record

2

Frictionless Enrollment

Automated multi-channel digital enrollment and streamlined group setup process to reduce expensive enrollment errors

3

Proactive Member Service

'Set-it-and-forget-it' automation to simplify management of membership changes

4

Holistic Care Coordination

Available integration to personal wellness tools for early identification of care needs during enrollment process

Policy Administration performance test

Enrollment test completed Jan. 2022 (large payer in North America)

- Policy load, write, and process, with a callout: 197 policies per second delivered for downstream tasks
- Achieved 197 policies per second against a target of 104 (Customer current legacy = 5.6)
- Goal: Scale and process a file to 3M members, and proved to be successful

Transforming enrollment and membership management

Simplify and streamline group and membership administration

- Boost operational efficiency with automated enrollment and premium calculation
- Create base products and reuse them across the group and individual plans for faster time to market
- Capture extensive custom member attributes via a business-user configuration layer, including membership information for Medicare, Medicaid, and other government programs
- Reduce total cost of ownership by creating a single rating engine for payors to create, modify, and maintain rates
- Enhance distribution management by easily integrating with Federal and private exchanges and enabling straight-through processing

Automate multi-channel enrollment

- Interface with diverse enrollment sources, including standardized EDI 834 formats, non-standard custom files, public programs, portals, and other digital front ends
- Automate enrollment verification, pause enrollments with errors for manual intervention, and automatically reprocess them once corrected
- Ensure that membership data is clean, complete, and consistent
- Support on-demand requests for enrollment information, e.g., eligibility checks, via prebuilt web services
- Conduct off-cycle special enrollment periods with ease

Our vision is to deliver the highest quality healthcare at an affordable cost and build trust with our members, patients, colleagues, and partners. The software we use at HealthPartners, including Oracle, is more than just technology. It provides the foundation we need to advance our operational excellence and ultimately improve service to our members and patients.

PENNY CERMAK

Chief Financial Officer, HealthPartners

Transforming enrollment and membership management

Achieve seamless premium calculation

- Define flexible premium schedules based on a variety of membership attributes
- Calculate premiums based on simple tables, external lookups, complex calculations, and more
- Apply penalties and subsidies automatically
- Create billing accounts and map them to the group account structure at any level
- Create bills at any frequency with a variable lookback period for enrollment

Deliver service excellence

- Generate value quickly, including automated ID card production based on various attributes
- Enable end-to-end transaction visibility
- Achieve full visibility into membership information and historical changes across all lines of business, and automate the generation of data needed for capitation calculations
- Enable self-service for group and member management transactions, including address changes, plan changes for life events, renewals, and more
- Automate corrective financial transactions based on membership changes

Revenue Management and Billing

Rev up revenue assurance, operational efficiency, and member satisfaction

Revenue management and billing empower payers to:

- Optimize pricing strategies and billing efficiency with a single cloud-native system that spans all insurance programs and lines of business
- Maximize revenue assurance and growth in an increasingly dynamic market
- Rise to the challenge of rigorous customer experience expectations

Our end-to-end vision for revenue management and billing includes six elements:

1

Customer Centric

A holistic view of revenue and financial transactions across plans and lines of business

2

Complete Pricing Simplified

Complex rules-based and attribute-based pricing.

Comprehensive ASO pricing rules, including stop loss and claim-based admin. fee(s).

Ability to set up state-specific pricing rules

3

Streamlined Billing

Billing consolidation

Split billing

Scheduled/ad-hoc billing

Subsidy billing

Billing anomalies detections

Granular transparency

4

Integrated Sub-ledger

Payment application

Payment reconciliation

DRR

5

Revenue Insights

Native workflows and dashboards to proactively manage accounts receivable

6

Delinquency Management

Delinquency events specific to rules

Delinquent notices

Delinquent penalties

Payment arrangement

Transforming revenue management and billing

Revenue Management and Billing for Healthcare Payers is built on adaptive, configurable business rules—letting you quickly change your billing operations as your business needs dictate and scale seamlessly in the cloud as you grow. The solution gives you the flexibility you need to keep pace with dynamic market shifts and changing customer requirements, support new products, and comply with new regulations as they arise—all while improving operational efficiency.

Fully insured group

- Cobra premium and admin fees
- 9/10 monthly
- Split billing
- Premium holidays
- Retirees

Self Funded Groups

- Claim/ancillary
- SSL, ASL, level funding, MPP
- Administrative charge
- Discount fee calcualtion

Fully Insured Individual

- State, health plan-specific business rulers
- Premium, discount
- Binder payment management
- APTC Management

Govt. Sponsored Plans

- Group/individual Medicare
- Benefit and penalty billing - LIS/LEP
- Premium withhold management
- CMS payment reconcilation

PBM

- Rebate billing

A big benefit with consolidating to a single billing system is the ability to report internally and externally, so we can track delinquency, unbilled, and all other types of metrics to show we are billing timely and accurately.

RICK MISCH

VP of Commercial Billing and Collection Services, Anthem

Transforming revenue management and billing

Optimize member service

- Support all lines of business, including group, individual, Medicaid, Medicare, and Pharmacy Benefits Manager (PBM)
- Create a single, consolidated bill showing a member's complete coverage
- Provide member reconciliation capabilities for self-billed customers
- Achieve flexibility in applying charges based on pricing rules
- Gain workflow-based ability to set up customer structures—billing hierarchy, invoicing accounts, policies, and plans

Improve plan management

- Optimize revenue through accounts receivable (AR) consolidation across lines of business
- Process high-volume group bills and list bills with the utmost precision
- Perform speedy reconciliation and reduce manual processing
- Offer self-service options to reduce bill inquiries, back-office activity, field audits, and bill adjustments—while boosting customer satisfaction
- Integrate easily with existing policy administration, accounting, and payment systems to improve enterprise revenue management and cash flow

Starting your journey today

The journey through enrollment, membership management, and billing and revenue management has its share of curves and obstacles. That said, every twist and turn brings new opportunities for healthcare payers that can respond agilely to challenges and opportunities. Modernization is imperative, and today, with Oracle's componentized approach, you can chart your course while taking advantage of all that our industry-leading cloud-based solution—Oracle Health Insurance Core Administration—has to offer. Our solution helps payers to surmount persistent data, performance, scale, compliance, and security challenges to enable frictionless onboarding, a central golden member record, efficient member management, and more accurate, efficient, and flexible billing. And, you can manage all lines of business from a single platform to help you shed complexity and redundant technology costs.

Learn more about Oracle Health Insurance Core Administration.

Start today