Preparing for the Unknown: How Healthcare Payers Can Get Ready for Reform
Executive Overview

Looking back a decade, the industry landscape appeared much easier for healthcare payers to navigate. Change came gradually, market share was high, and product offerings were less complex. In recent years, unprecedented changes in legislation, competition, new offerings, and market segments have turned the industry on its head.

As healthcare payers analyze their business processes, the vast majority are finding themselves constrained by aging and inflexible IT systems that limit their ability to introduce new products, respond to competition and legislation, and improve operational efficiency. This has led many healthcare payers to consider replacing their existing systems with modern, rules-driven solutions that will help them adapt to rapid and unpredictable market changes.

There are a number of things that healthcare payers can start doing now to prepare for change down the road—even while the final shape of that change is still uncertain. Core systems, business intelligence, billing, customer communications—each of these areas can be a starting point for implementing adaptive processes in the business, depending on where the payer’s need is greatest. This paper will discuss the benefits to be gained with adaptive systems—including improved speed to market, easier compliance with industry regulations, and improved customer satisfaction—and highlight several areas on which healthcare payers can focus now.
Introduction

As legislators argue, legal challenges loom, and the healthcare debate is poised to become a major issue in the 2012 election cycle, the final shape of U.S. reform remains uncertain in many respects. Court rulings in Florida and Virginia have called into question the law’s constitutionality, and political parties continue to be split along ideological lines. With so much uncertainty, the Patient Protection and Affordable Care Act may not be final for months, or even years.

Despite the lack of clarity on the path forward, healthcare payers cannot afford to sit idly on the sidelines while opposing teams battle for victory. Instead, they would be well served by moving forward with their own game plans for success in a new era of healthcare finance and coverage. But how do healthcare payers prepare for change in such an uncertain environment?

The answer is, “By being prepared for anything.” This may seem overly ambitious, but it’s not as difficult as it sounds. The introduction of adaptive systems and technologies to the market is helping healthcare payers to become more adaptive themselves, ready to change their business processes to comply with new regulations—and with new business opportunities—as they arise.

The Need to Be Adaptive

The U.S. health insurance marketplace has undergone a historic transformation over the last decade. Even before rumblings of healthcare reform, the industry was already experiencing tectonic change—in everything from market dynamics and regulations, to business processes, to the technologies that payers use to run their organizations and satisfy customer demand.

What was previously a stable, static industry marked by incremental change has become a volatile environment where things are shifting faster than ever. Enrollment in group plans has been static for several years, while increasingly, individual consumers are becoming purchasers of health insurance. Yet as the velocity of change has increased, the ability to forecast change has decreased, inhibiting payers’ ability to see five, or even two years out.

In the new economic reality, healthcare payers must accept that rapid change is constant, and work within the ambiguity that now exists in the planning process. Change can lead to new opportunities that will help insurers transform and grow their businesses. The key to taking advantage of these new opportunities is to put in place adaptive technologies and systems—providing the flexibility and agility to quickly adapt to changing market dynamics. Adaptive systems should be flexible, open, and transparent enough to let your business processes flow like water.

So what is an adaptive system, and how can it help healthcare payers become more adaptive themselves?

How Adaptive Systems Help

Simply put, an adaptive system is one that provides the flexibility needed to handle any process the business requires. Many healthcare payers face challenges when they want to introduce a new product...
or implement a more efficient way of doing business, because their legacy systems are hard-coded to process transactions and data in a certain way. When a change is required, it leads to a protracted IT engagement in which developers must rewrite the underlying code of the IT systems in order to support the new business need.

By contrast, an adaptive system relies on business rules to support new products, processes and regulations.\(^1\) Skilled business users can write and re-write the rules as needed, quickly and easily—and these business rules can be used to support new products (such as innovative offerings for the individual health insurance market), new processes (such as offering Web-based self-service to customers) and new regulations—whatever form they may take.

The flexibility of an adaptive system eliminates many of the traditional dependencies on IT, which often are impediments to the timely introduction of new products and services. Allowing skilled business users to take ownership of implementing such changes also eliminates many of the missteps resulting from business requirements that get “lost in translation” to IT developers.

**Where to Start?**

There are a number of things that healthcare payers can start doing now to prepare for change down the road—even when the final shape of that change is still uncertain. Legacy systems abound among healthcare payers; depending on the payer, the IT environment might consist of a heavy reliance on hard-coding in core systems, a high degree of manual claims processing, business intelligence managed by spreadsheets, or multiple rating engines, billing systems, or document production systems.

No healthcare payer wants to tackle all these systems at once—nor should they. However, payers can look at their current technology environments and uncover which systems and processes are causing them the most pain. If getting new products to market quickly is your biggest challenge, you may decide to look at an adaptive, rules-driven policy administration system that can help you speed time to market. If your competitors are undercutting you with lower-cost offerings, you may want to look at an adaptive rating engine that helps you price products more accurately based on many more factors.

Once the biggest challenges have been addressed, payers can iteratively implement adaptive systems in other areas of the business. This “progressive renovation” can begin now, with the eventual goal of implementing a truly adaptive insurance enterprise.

Let’s look at some common lines of business where healthcare payers are experiencing significant pain, and how adaptive systems can help in each of these areas.

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\(^1\) For a more detailed description of adaptive systems, please refer to the strategy brief, *Transforming the Insurance Enterprise through Adaptive Systems* by Chuck Johnston, Oracle, 2009.
Strengthen Your Core

With the ongoing shift away from group plans and towards individual coverage, today’s health insurers need the ability to quickly implement new products to meet shifting market conditions and capitalize on new opportunities. This need is expected to intensify upon full implementation of healthcare reform provisions. Healthcare payers will need to adopt new mandated products to participate in state exchanges, and will likely make adjustments to the product portfolios of other lines of business as the broader impact of changes to the individual market is understood.

Adaptive core systems—including policy administration and rating solutions—are increasingly important for health insurers as they work to meet these challenges. An adaptive, rules-driven policy administration system can greatly accelerate the introduction of new products, enabling business users to configure and reconfigure products with minimal assistance from IT. Flexible, adaptive rating systems can provide infinite tiers of rating, so that healthcare payers can rate coverage based on multiple factors and offer the right insurance, at the right price.

Insurers also are seeking to provide more convenient channels for interacting with policy holders throughout the entire customer lifecycle—from quote, through claims, to renewal—requiring open, easy-to-integrate applications that offer a single source of truth across all channels. Rules-based systems built on an open architecture can facilitate integration between internal systems, as well as enable links to external organizations, such as healthcare exchanges—key requirements for enabling rapid new product introduction.

Clean Up Claims

Many of the changes to U.S. healthcare implemented under the first wave of reform (or slated for phased adoption over the next few years) are aimed at reducing costs and improving access through the introduction of new products, benefits and reimbursement models. Such changes are likely to have significant down-stream impact on claims processing. Claims systems must be able to quickly and accurately uptake these changes; delays in doing so will be costly, undermine compliance, and adversely impact both member and provider satisfaction.

Under these challenging circumstances, a rules-based approach to claims adjudication significantly lessens the implementation burden, freeing healthcare payers to focus scarce resources on understanding reform provisions and evolving marketplace conditions. A rules-based system allows skilled business users to take ownership for implementing the claims logic behind new products and benefits. This eliminates much of the inevitable back-and-forth and frequent misinterpretations that occur when implementation responsibilities depend on individuals who are not focused on the business drivers. Avoiding the traditional dependency on IT and custom coding allow highly configurable, rules-based systems to deliver far more timely and cost-effective results.

A rules-based approach to claims processing also promotes savings and quality by allowing health insurers the flexibility to quickly expand or restrict the applicability of specific claims logic as needed. In doing so, they can avoid expensive and potentially error-fraught code duplication. As well, the elimination of costly custom coding pays future dividends by simplifying the system upgrade process.
Sort Out Document Automation

As more consumers secure coverage on the individual market, healthcare payers must be prepared to manage higher volumes of document production and distribution, and face expanded customer service requirements, including the need to leverage new communication channels (such as text messaging and social media). They must also find ways to keep costs in check while ensuring that communications comply with industry regulations, company policies, and consumer expectations.

To meet these expanding requirements, healthcare payers should take an enterprise view of document functions, with the focus on measuring and improving efficiency, productivity and impact. Among many healthcare payers today, document production is divided along departmental lines, with separate divisions often producing their own documents on disparate software platforms—for example, marketing may be responsible for producing sales brochures, contracts for issuing policies, legal for compliance forms, and so on. Each department may be using a different piece of software to produce these documents. This situation leads to inefficiency, cost overruns and lack of insight; and disparate systems may lead to inconsistency in the information that is presented to insurers.

With an adaptive, rules-driven document automation system, healthcare payers can use a single system to manage documents and communications across the entire enterprise. Such a system provides business rules that can be configured to meet the needs of every department—from sales to claims—while providing workflow to ensure that all communications comply with regulations and company standards. The documents required to support new products can be produced with a simple reconfiguration of business rules. And members can expect a consistent experience spanning all communications.

Provide Better Billing

In many healthcare payer organizations, billing systems were designed, built and implemented with the group model in mind. In addition, many companies have multiple billing systems, either acquired through mergers and acquisitions, or implemented to handle multiple lines of business. This has led to siloed, cumbersome and inefficient billing processes that prevent a holistic view of each customer. It also entails a lengthy IT engagement every time the payer wants to support a new product, integrate a new system or make information available to customers via the Web.

With an adaptive, rules-based billing system, it becomes much easier to implement new products and services. Business users can reconfigure the business rules as needed, without the hard-coding that is often required in many legacy system environments. The rules-based approach enables the health plan to much more effectively tailor its needs to the individual consumer, who is becoming a much more important purchaser.

Additionally, an adaptive, rules-based billing system enables the healthcare payer to efficiently manage multiple product lines from a single system. Rules can be configured and reconfigured to govern specific products, services, regulations, customer types, and more. Because the rules are not tied to the data model, they can manage any number of billing criteria. An adaptive billing system lets the healthcare payer alter and add products easily, yet still gives the payer a complete financial and product view of the customer.
The ability to manage multiple lines of business from a single system not only improves operational efficiency; it has the potential to significantly reduce IT costs. As with document automation above, the existence of multiple systems performing the same function leads to high maintenance costs. With an adaptive, rules-driven billing system, the payer can consolidate all billing onto a single application, potentially saving millions in maintenance costs over the long term. Finally, the ability to output a single, consolidated bill is something that customers expect and are demanding, and giving them one will go a long way towards increasing customer satisfaction.

Help Customers Help Themselves
Self-service enables healthcare payers to provide more convenient service at a lower cost—yielding benefits today and tomorrow as healthcare reforms are implemented and volumes increase. Insurers can help members to locate providers, pay premiums, determine eligibility and check claims status using multiple channels. In addition, as consumers increasingly bear more of the cost of healthcare, they require expanded information about provider quality and treatment costs and outcomes. Self-service web portals can play an important role in putting this vital information directly into the hands of consumers.

Insurers can also use self-service to deliver new convenience and add value to providers and group administrators, while lowering call center and support costs. For example, providers can track and inquire about claims payments online, rather than calling the insurer for status updates.

Boost Your B-IQ
Business intelligence (BI) and analytics are increasingly important on many levels, becoming an essential tool to:

- Determine profitability
- Assess risk when rating and issuing policies
- Evaluate the effectiveness of providers and treatments
- Analyze claims
- Identify possible provider and/or subscriber fraud
- Analyze market trends to help develop innovative new products
- Cross sell and upsell product and services

Adding to the complexity for healthcare payers, the Patient Protection and Affordable Care Act includes reporting requirements around medical loss ratios. Adaptive, rules-driven BI systems can help provide the information needed to address all these business needs – payers can configure reports and dashboards using business rules to meet the specific needs of different departments, or even individual users.

BI and analytics will become even more vital as healthcare payers enter unknown territories, serving expanded populations and managing participation in new types of exchange models. The ability to assess profitability and drill down into data for insight into specific products, markets, populations and
providers will be essential to continued growth and financial sustainability. Adaptive business intelligence systems also can play a vital role in helping to evaluate the effectiveness of various providers and treatment courses.

Medical fraud is a problem that is expected to grow as the volume of claims expands, with millions of Americans securing new coverage under healthcare reform. Sophisticated analytics are vital in helping healthcare payers to identify patterns that may indicate fraudulent activity and to effectively target cases for further investigation. Adaptive BI solutions integrate information from multiple sources, thereby improving the efficiency and effectiveness of fraud detection, and ultimately saving costs.

Conclusion

While many of the details of healthcare reform remain uncertain, insurers can act now to begin a progressive renovation—implementing adaptive systems and processes to help them keep pace with ever-changing regulations, improve business performance, and outpace competitors in bringing products and services to market. The flexibility of adaptive, rules-driven systems can help healthcare payers to become more adaptive themselves—ready to introduce new business processes, support new customers, and meet the challenges of future market conditions, no matter what they might be. With industry change becoming a constant, the time is now for healthcare payers to begin looking at revitalizing their people, processes and technology—and implementing the adaptive culture that can help them succeed.

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About Oracle Insurance

Oracle believes that insurers should be able to leverage technology to help transform their business. Oracle Insurance provides adaptive, rules-driven systems that let insurance companies easily change business processes as their business needs change. These systems position insurers to become more adaptive themselves, ready to respond to dynamic market conditions and take advantage of new opportunities as they arise. Engineered to work together, Oracle’s solutions support the entire insurance lifecycle – from product development, to marketing and sales, to customer service and support, to management and compliance.

For more information on Oracle Insurance, please visit oracle.com/insurance, contact us by e-mail at insurance_ww@oracle.com or call 1.800.735.6620 to speak to an Oracle Insurance representative.