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Prospecting For Members

What the health insurance industry can learn from other business sectors.

by Anand Madhavan

Redefining marketing efforts after the health care reforms initiated by the Patient Protection and Affordable Care Act has given health insurance companies the opportunity to tap a larger prospective member base. Health insurance companies must strive to acquire a larger member pool and manage risk adjustment associated with accepting members with pre-existing conditions.

Analytics will provide the disruption model to enable health insurance companies to shift from their existing traditional approach to a new approach of making acquisitions dynamic and cost-effective. The key to making this shift successful will be in the implementation of best practices collected from other sectors such as banking, insurance and retail that can be modified for use in the health care sector.

According to the Census Bureau's 2011 Current Population Survey, 49.9 million Americans do not have any health insurance. When it comes to the number of people who are uninsurable owing to pre-existing conditions, the numbers range from two million to 50 million. The actual number can be debated given the criteria adopted by the studies, but it is significant.

The U.S. health care system is the most expensive in the world, and it is also one of the most underperforming. In view of this, the Affordable Care Act is a watershed law, both for health insurance companies and patients. The act seeks to extend

Key Points

- **The Background:** The Affordable Care Act is a game changer for health plans, creating challenges even as it offers sizable opportunities.
- **The Situation:** The act expands the member pool for these companies by bringing more people under insurance coverage, thus enabling growth.
- **Watch For:** Health plans can adopt best practices from other industries, such as retail and banking, which have embraced analytics to shape marketing and drive revenues.

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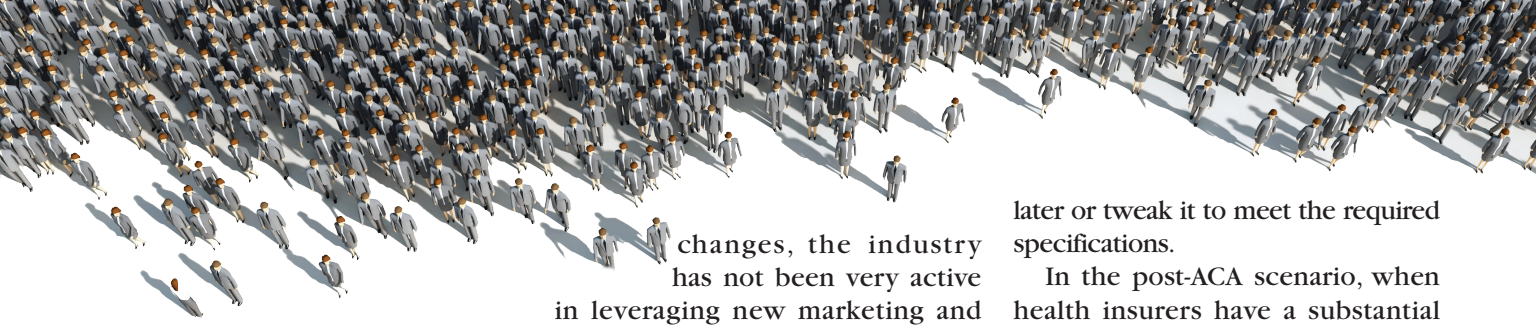


insurance to more than 30 million people by facilitating an insurance system that provides near-universal coverage. No longer can insurance companies turn down applicants for pre-existing conditions.

As a result, the ACA is a game changer for health plans, creating challenges even as it offers sizable opportunities. The act expands the member pool for these companies by bringing more people under insurance coverage, thus enabling growth. At the same time, by compelling insurers to cover all applicants—whether or not they have a pre-existing condition—the act increases the risk exposure of the companies.

Therefore, the challenge before health plans is twofold.

First, how can they acquire the maximum number of members in the most cost-efficient manner now that the available pool is bigger? Health insurance companies must increase the uptake of products by targeting the right product to the right person at the right time via the right channel. This can increase the conversion rate, transforming prospects into members.

Second, how can health insurers expand their member pool smartly, minimizing the associated risks they must incur since they must extend cover to applicants with pre-existing conditions? Health insurance companies must separate the applicants with pre-existing conditions into two segments: those whose illnesses are more manageable, and those whose conditions are severe. Applicants with more-manageable conditions—involving lower costs—can be added to the general member pool.

To address these challenges, health plans are turning to a disruptive tool—analytics. Even as the customer relationship management cycle in the health care industry is evolving rapidly in response to ecosystem changes, the industry has not been very active in leveraging new marketing and technology-based solutions.

Thus, health plans need to turn to other industries to gain answers in analytics. In doing so, they can adopt relevant best practices from other verticals—such as retail and banking—which have been at the forefront of embracing analytics to shape marketing and drive revenues. These best practices can be suitably modified to fit the health insurance sector in meeting the above two objectives.

Analytics will provide the disruption model to enable health insurance companies to shift from the existing traditional approach to a new approach of making acquisitions dynamic and cost-effective.

Customer acquisition is operationally the most expensive part of any customer relationship management cycle. Traditionally, it has involved peppering prospective members with what the health insurance company believes to be the most relevant products through any available channel, be it calls, mailers or advertisements.

This "spray-and-pray" approach can be ineffective and expensive and has an undefined return on investment.

If the health insurance company fails to convert prospects into members, the reasons may be manifold—the prospects may not want the product; the product may be offered through the wrong channel; or the prospect may not be able to afford it. However, the insurance company will not know the reason for the failure. Similarly, if the campaign is successful, the company may not know the reason for its success—leaving it unable to replicate the campaign successfully later or tweak it to meet the required specifications.

In the post-ACA scenario, when health insurers have a substantial community of prospects, they must clearly shift to a new approach that is effective in helping them grow their member base. This new approach involves integrating their member acquisition program with constant testing and learning—what is referred to as A/B testing—where the health insurance company:

- **Incorporates** customer relationship management insights into the campaign strategy.
- **Designs and tests** multiple variables that may impact campaign success, such as channel, product, population segment and the like.
- **Establishes** an iterative loop that feeds on past experience.

This approach has been used extensively in retail, banking and property/casualty insurance. Companies in these sectors follow a closed-loop cycle—Set Vision, Create Roadmap and Realize Benefits—in running acquisition campaign strategies.

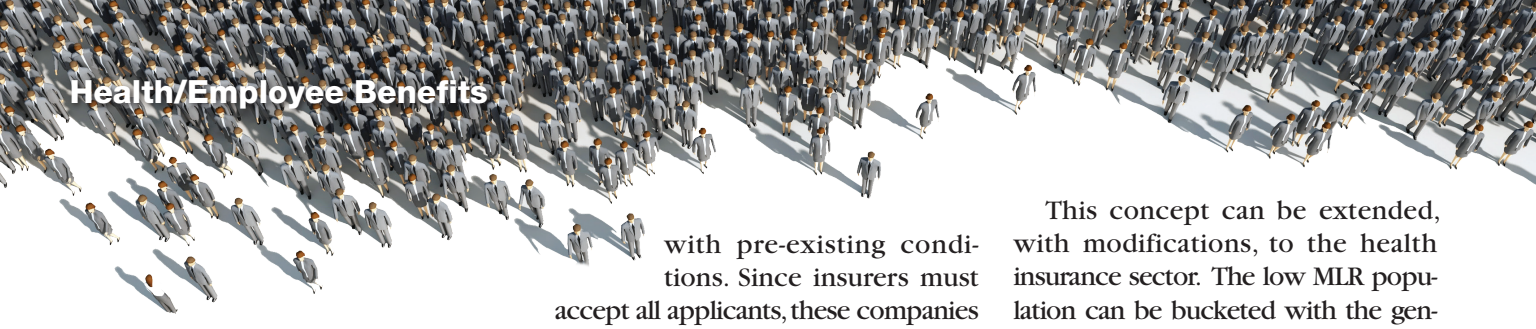
Health insurance companies can apply the knowledge gained from these verticals with modifications:

Set a Vision. The management sets objectives and devises marketing strategies to achieve these objectives through multiple campaigns. Metrics to measure ROI are agreed upon.

Create a Roadmap. Harmonizing CRM insights with campaign insights defines the initial campaign framework. Subsequent factors are decided by hypothesizing about questions such as: What segments of members respond to which products? Which channel do they prefer? These factors are a combination of analyses of historical data and company objectives.

Once the factors are decided, companies run constant A/B testing with individual factors like product, population, channel and others, along with their permutations and combinations.

With such an approach, health



insurance companies can try combinations of factors on an iterative basis to learn what succeeds and what fails. Thus, with sustained campaigns, they can reach the right segment of the population via the right channel with the right insurance plan.

For example, an insurance company can reach busy, single parents more effectively through an online channel or texts as opposed to flyers sent by ordinary mail. Such an approach allows dynamic changes to be made to factors and helps improve conversion rates.

Since such an effort is expensive, the health insurance company can begin working on a pilot basis with a smaller population. Based on the results, the effort can then be rolled out to a larger pool of prospects.

Realize Benefits. The last leg of the closed-loop cycle is essentially using analytics for benchmarking the performance of different campaigns against the defined success metrics and against each other. Deviations can be addressed by revisiting the first two steps.

Mitigating Risks

With the ACA dictating that health insurers cannot deny coverage to those with pre-existing chronic conditions, insurance companies need to find an approach to mitigating the risks involved in this undertaking.

The costs involved in covering this segment of the population are substantial. According to a study by the federal Agency for Healthcare Research and Quality, the top 5% of health care spenders in both 2008 and 2009 accounted for nearly 50% of health care expenditures.

The Affordable Care Act disallows health insurance companies from varying premium rates based on the health status of applicants, such as by increasing premiums for those with pre-existing conditions. Since insurers must accept all applicants, these companies become vulnerable to risk when they have a higher-than-normal percentage of members with pre-existing conditions or in poor health. In these scenarios, analytics offers health plans a viable solution for adjusting risks.

Applicants with pre-existing conditions have a differing severity of illness. Some patients are chronically ill and have a high medical loss ratio—diabetes with cardiovascular complications for example—while the health of others is manageable through minimal medication and lifestyle changes.

Borderline diabetes is a case in point, and such applicants have a low MLR. Both categories of applicants can be bucketed separately. Health insurance companies can tailor suitable new products for high-MLR members in line with the costs associated with managing their conditions, and thus meet the mandate of the act.

When creating this model, health insurance companies can apply the lessons learned by the banking and credit card industries. Many banks have realized to their advantage that there is a creamy layer among subprime borrowers who are not as risky as the rest of the subprime population. Credit card issuers depend on the Fair Isaac, or FICO, score to ascertain the risk value of a prospect. Parameters such as source of income, outstanding credit lines, credit history and defaults, among others, go into determining the score.

While prospects with scores below 600 may be considered risky, certain factors—such as absence of previous charge-offs, no default on scheduled payments, and low utilization limits—may still allow the prospect to qualify for credit. However, the card will come with strings attached—the issuing company will impose stricter terms and conditions on cards issued to such individuals.

This concept can be extended, with modifications, to the health insurance sector. The low MLR population can be bucketed with the general population since the costs associated with both categories would not vary greatly. At the same time, health insurance companies can apply a risk adjustment scoring to those with a high MLR and tailor products for them, with associated costs.

This scoring-based mechanism needs to be explored further to derive answers on how measurements can be made. However, it is a direction worth considering since insurance companies can apply this learning to reassess the pre-existing condition population and create a whole new market.

Such a managed costs model can help health plans mitigate risks in the post-ACA scenario.

Striving to extend insurance to all, the ACA has transformed the health care domain for insurance companies. Since these insurers cannot turn down applicants, the companies need to overcome several challenges if they are to realize the potential benefits in the act. They must acquire the maximum number of members in the most cost-efficient manner and they must minimize the risks associated with growing their member pool.

Analytics can help health plans tackle both challenges by applying the learning of other industries. A/B testing undertaken in the retail setting can help health plans with targeted marketing, enabling them to convert a greater proportion of prospects into customers.

Similarly, differential credit scoring used by the banking industry can teach insurers how to segregate applicants with pre-existing conditions into two groups: those with manageable illnesses and those with chronic diseases. Applicants with more manageable conditions—involving lower costs—can be added to the general member pool. BR