



## From Onboarding to Lifelong Relationships

How leading health insurers create meaningful connections through every member touchpoint



## Introduction

Across industries and verticals, customer expectations are changing at an unprecedented pace. Digitization and technology advances have enabled consumers to access goods and services at the click of a button, which has redefined the way customers interact with brands. Today's customer has more control than ever and expects simple, efficient experiences at every touchpoint.

Health insurers are no exception to these changes and have a significant opportunity to improve member engagement and retention rates – if they act quickly. Unlike many other industries, when customers are interacting with a health insurance company, it's often due to undesirable circumstances, like denied claims or authorizations, and typically comes at a time when a member or their loved one is dealing with a stressful health-related issue. However, from the very first interaction with a new member, to onboarding, to long-term relationship management, health insurance plans now have access to the necessary technology and resources to provide two-way conversations that create the ultimate member experience.

**This white paper explores how improving member conversations throughout their journey can positively affect engagement, improve retention and reduce costs.**



## Member Engagement and Communications Go Hand in Hand

Optimized communications strategies play an integral role in providing an excellent experience while also improving overall engagement rates. From direct mail to email, mobile applications, text messaging and online chat features, health insurers must be able to effectively use all of these channels to reach members in their preferred way. This means that the carrier must make the best of every interaction they have with a member, starting with enrollment and onboarding, managing ongoing claims processes and introducing care management initiatives.





# A Year in the Life:

## Optimizing Every Touchpoint of a Member's Experience

Opportunities to improve engagement exist throughout a member's relationship with a carrier. In this white paper, we will follow Alice, a typical American healthcare consumer, throughout her journey with her health insurance plan. Alice has just started a new job with a company that provides health insurance via a national carrier. She is married and has three children. Her spouse is self-employed, so the family relies heavily on Alice's health benefits. As Alice progresses through her journey with her new health insurance carrier, we will identify areas that they can improve her overall experience.



**STEP 1****Plan Selection & Enrollment**

## STEP 2

## Health Risk Assessments

## STEP 3

## Care Management Processes

## STEP 4

## Claims, EOBs &amp; Appeals

Before Alice begins the enrollment process, her company's human resources (HR) department has already been hard at work – they have reviewed and selected several health plans with multiple levels of premiums, benefits and ancillary coverage (e.g. dental, vision and disability). And as Alice begins her new job, insurance enrollment is one set of forms among many during her onboarding period.

With the average American changing jobs about once every four years<sup>1</sup>, health insurance carriers might have an opportunity only twice a decade to stand out and create a seamless experience in an otherwise overwhelming time. Because the enrollment period is a member's first interaction with a new carrier, it's critical this process is as frictionless as possible.

The volume of forms required when an employee starts at a new company is often very high and the process can be time-consuming. Insurance carriers have an opportunity to partner with employers to improve this process, pre-populating forms and ultimately creating a pleasant onboarding experience for the new employee and a more efficient and cost-effective process for the employer – and the plan.

In Alice's case, the HR department provides both printed paperwork and fillable PDF forms for plan selection. Neither of these includes comprehensive details of the health plan options, as this information is included separately in a Summary Plan Description (SPD). These documents can be long and confusing, especially for someone who is not accustomed to frequently interacting with them.

There are opportunities for improving this process, however. Using a more digital-first approach, health insurers can prepopulate digital forms with data collected previously or pulled from core systems. This means that information that has already been provided is only verified, not requested again multiple times. In addition, the existing data and the data collected by the digital forms can be used to personalize communications between the employer, carrier and employee.

Digital forms can include business logic, dynamically showing or hiding fields based on data entered or selections made, creating a guided experience.

**Key Takeaway:**

A new employee's name, address and more should be available in a company's HR system to establish payroll and other administrative requirements. Via a digital enrollment solution, this data can be pulled directly from the HR system, prepopulated in the form and presented to the new employee for confirmation. If something is incorrect, the employee can easily rectify it and it will be automatically updated in back-end systems. This ensures core systems are always up to date, thus improving data quality across the board and limiting opportunities for future data-related issues, as well as optimizing the member experience.



More than  
**60%** of **Adults**

in the U.S. have at least one chronic condition, **while 40% have two or more.**<sup>2</sup>

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Once Alice has selected and enrolled her family in a new plan, the next step is to complete a health risk assessment (HRA), a screening tool that identifies potential areas of intervention or preventative care. The assessment includes questions related to an individual's health history and prescriptions, well as demographic and lifestyle information. The intent of the assessment is to improve the long-term health prospects of the member, determine if there are chronic conditions that need management, give the member a sense of control and offer lifestyle changes in support of their health. It also provides an opportunity for the carrier to position itself as a helpful, useful resource for the new member – better managing chronic conditions to create better outcomes for the patient and the carrier.

Participation in the health risk assessment can help insurance carriers, employers and employees get in front of potential issues and reduce the long-term costs for everyone involved. However, it typically includes more than 50 questions and requires input from not only the new member, but also a primary care physician, leading to completion rates as low as 25 percent<sup>3</sup>. And while many organizations offer incentives for completion, there are opportunities to make the process itself a smoother experience for the new member.

For Alice, her new insurance carrier provides a printed version of the HRA that must be manually completed and scanned to return it to the insurer. She also must give demographic data that she has already provided in the enrollment process, like her name, birthdate, address and more. Ultimately, she gets frustrated and abandons the process.

With a digital form, however, Alice would receive a link that is already pre-populated with information previously provided. She can share and even collaborate on the form with her doctor to eliminate delays. The digital option also automatically analyzes Alice's health profile based on new information she provides, and immediately offers the option to enroll in a wellness program that is specific to her needs. This not only keeps Alice engaged, but also reduces costs on the carrier's end as Alice adopts preventative health initiatives.

A digital form not only increases the completion rate, but also improves the overall quality of data collected. Filling out identical information (e.g. name, address, birthday and social security number) can be a frustrating and time-consuming experience for the member, while also negatively impacting data quality for the carrier. The right technology, however, creates a more efficient experience that keeps the new member engaged.

**Key Takeaway:**

The HRA is the first opportunity after enrollment for a plan to showcase its value to new members. Printed paperwork or fillable PDF forms create inefficient processes and IT headaches, as well as a poor member experience. However, if the employer or insurance carrier provides an intelligent digital solution for the HRA, they are able to enhance the employee's experience by pre-populating known information, providing personalized details on wellness program availability and adjusting the questionnaire on the fly in response to specific situations or conditions that are flagged during completion of the form.

# 83% of Insurance Carriers

reported that low member engagement limits the effectiveness of chronic condition management. <sup>4</sup>

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After completing the health risk assessment, Alice's insurance carrier evaluates her for future health issues in the risk stratification process, which categorizes members based on their health status and other factors. The intent of this process is to identify individuals with more severe health conditions and focus on beneficial and necessary services to support them.

While Alice's health is under control, her spouse has multiple chronic conditions, and is an ideal candidate for intervention and care management services, including prescription compliance. However, insurance carriers often have a difficult time getting members engaged in these services and Alice's spouse is no exception in this case. He receives impersonal direct mail pieces to encourage participation, but never takes the time to enroll in the program.

Health insurance carriers invest significant resources in developing and overseeing care management programs, but often are frustrated at the lack of member adoption. The low engagement rates oftentimes are due to the outdated, single-channel communication styles of insurance carriers. Carriers must communicate with members on their preferred channels and move away from one-way, outdated approaches. A member that is engaged in a two-way conversation with their carrier is more likely to feel empowered to invest in his or her health and participate in care management services.

If Alice's insurance carrier optimized its communication strategies and invested in technology that captures members' communication preferences, they could increase the likelihood of individuals engaging in care management. This not only reduces the costs of future medical needs, but also provides an experience that feels tailored and unique to the individual member.

**Key Takeaway:**

When managing chronic conditions and encouraging members to take control of their health, plans not only need to clearly articulate the value of care management services, but also ensure these messages are actually getting to the member and acted upon. Using sophisticated customer communications management technology, carriers can progressively build out profiles tailored to each member. These profiles include information gathered throughout the member's time with the carrier, including demographic information, health history, preferred communication channels, and any subsequent actions or responses.



# 69% of Customers

cite “long resolution times”  
as a source of extreme  
frustration.<sup>5</sup>



**STEP 1**

## Plan Selection &amp; Enrollment

**STEP 2**

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## Claims, EOBs &amp; Appeals



Throughout the year as Alice and her family visit healthcare providers, Explanation of Benefits (EOBs) detailing the portion of costs covered by the plan are mailed and uploaded to the online member portal after claims are processed. Unfortunately, EOBs often go unnoticed until a problem arises.

One of Alice's children required care and the provider used the wrong procedure code when submitting the claim to the plan, which resulted in a denied claim. This came as a surprise to Alice when she received a bill from the healthcare provider for a significant sum of money. Alice felt caught off guard and frustrated with her insurance carrier.

Imagine instead if Alice's insurance carrier had a process that facilitated conversations regarding claim denials to establish a dialog with the member to understand the issue. Typically, errors in the billing process that resulted in a denial will be corrected between the provider and the carrier. However, if there is a question of medical necessity, the member usually needs to get involved to provide supporting details to the insurance carrier. This process can be cumbersome and frustrating, and often takes multiple attempts to rectify. With optimized communications processes, the denial notification can be sent to the member via their preferred channel – ensuring the member is informed and engaged while also reducing the time to a resolution.

**Key Takeaway:**

Adopting a more digital approach, health insurance carriers can minimize the frustration members feel when appealing claims. Optimizing member conversations enables insurance companies to provide electronic EOBs that not only detail how a claim was processed, but also provide the member with a link to appeal the denial. This link could take the member to an electronic form that helps ensure they provide the needed information the first time and to establish a more real-time connection with the carrier. The member could even opt to receive SMS notifications for changes in the status of the appeal or requests for additional information. Using a multi-channel approach reduces the time to a resolution of the appeal as well as minimizes member frustration.

## Conclusion:

Beginning with the enrollment process, health insurance carriers can leverage sophisticated technology to better understand member preferences and behaviors. This allows for two-way conversations throughout a member's time with a carrier that goes beyond collecting information and checking boxes.

**SMARTER** customer conversations enable insurers to understand members on an individual level and uncover new ways to meet their needs and provide additional value. Involving members early and cultivating a mutually beneficial relationship ultimately increases both engagement and satisfaction. And by staying connected, health insurers can offer new programs or incentives that will add value to their members' lives.

It's time for insurance plans to adopt the best processes and technologies that will drive change and set them up for future success. Smart Communications is ready to help.



## About Smart Communications

Smart Communications™ is the only provider of a customer conversations management platform. More than 500 global brands rely on Smart Communications to deliver SMARTER conversations across the entire lifecycle—empowering them to succeed in today’s digital-focused, customer-driven world while also simplifying processes and operating more efficiently. This is what it means to scale the conversation. Smart Communications is headquartered in the UK and serves its customers from offices located across North America, Europe, and Asia Pacific. The Smart Communications platform includes the enterprise-scale customer communications management power of SmartCOMM™, forms transformation capabilities made possible by SmartIQ™ and the trade documentation expertise of SmartDX™. To learn more, visit [smartcommunications.com](http://smartcommunications.com).



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