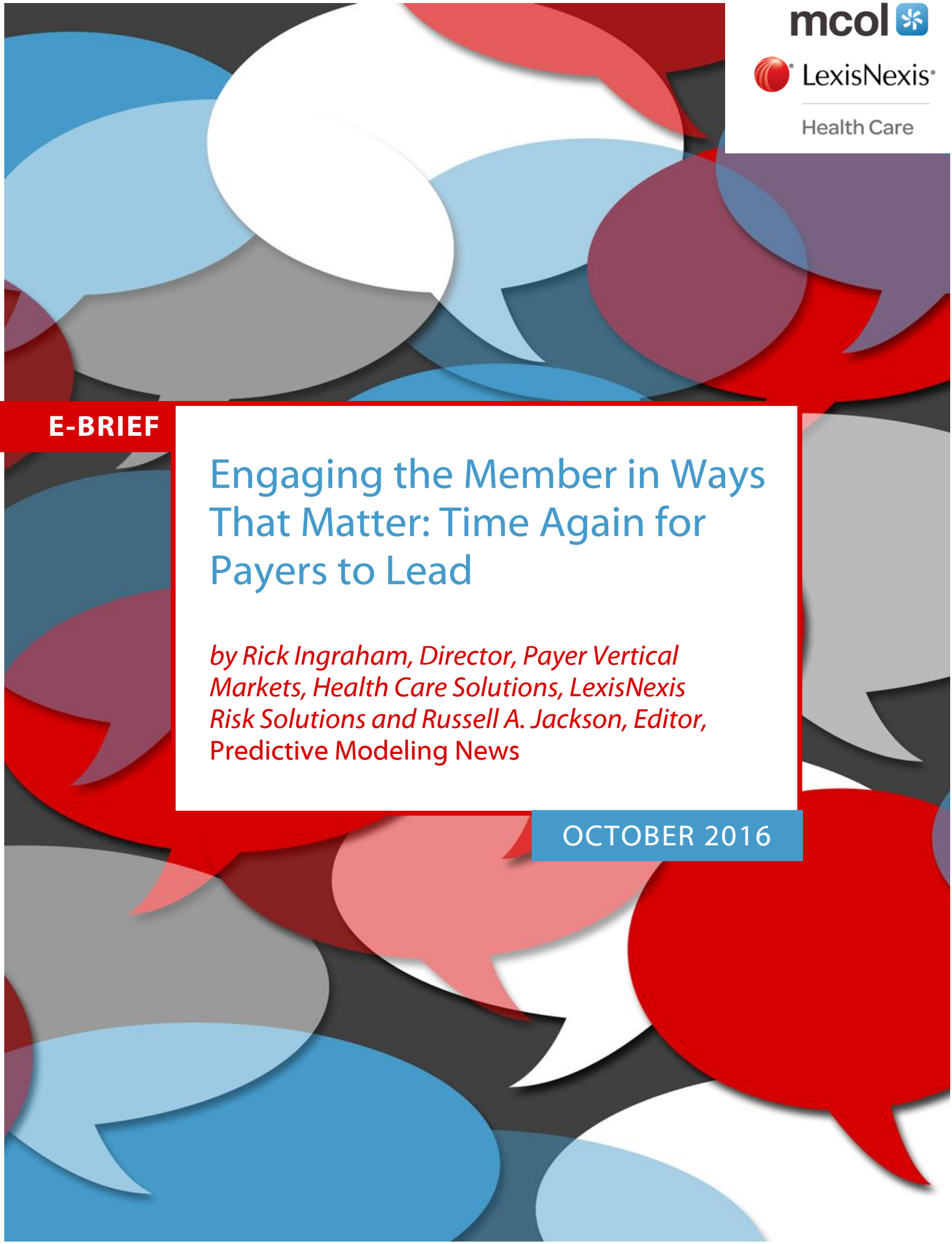

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E-BRIEF

Engaging the Member in Ways That Matter: Time Again for Payers to Lead

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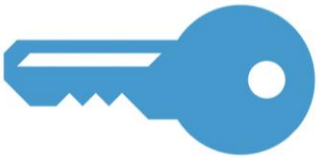
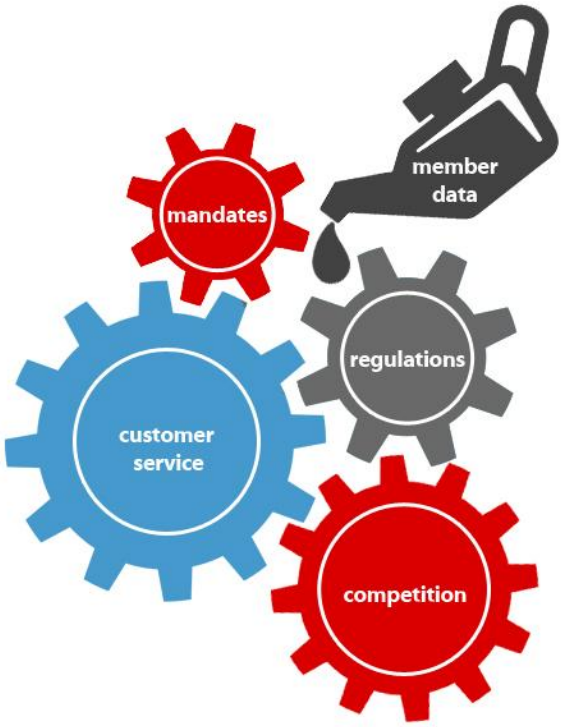
Member data is the key to success in today's competitive market



Health care payers – and the Integrated Delivery Networks (IDNs) they work increasingly closely with – face an environment vastly different from the one that confronted them just a decade ago. In today's value-driven healthcare marketplace, plans and provider organizations must manage an increasingly delicate balance of regulatory and operational issues, including premium retention and aggressively regulated Medical Loss Ratios (MLRs); monitoring provider performance and its impact on costs; making sure care quality and outcomes improvement efforts reduce future claims; and, perhaps most importantly, customer retention that focuses on patients, not premium payers.

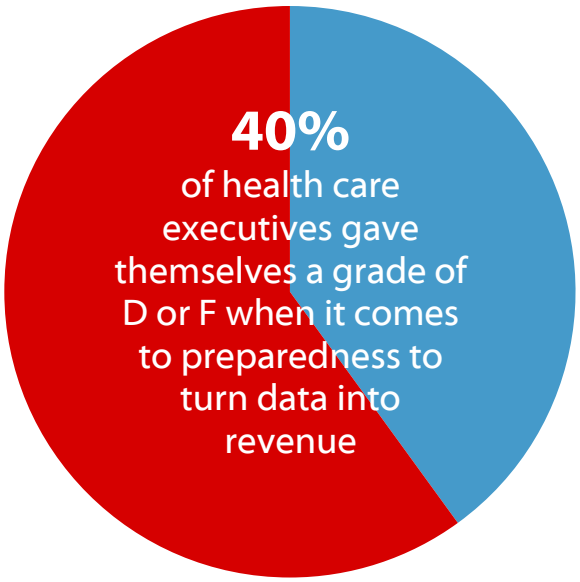
The mounting mandates to provide value instead of volume and to focus on patients instead of processes – the hallmarks of the Affordable Care Act (ACA) in particular and of the move away from fee-for-service health care in general – demand that plans use every resource at their disposal, and that they do what's necessary to bring provider entities along with them. One key resource to meet those challenges that too many plans too often overlook is the member data they already possess. By augmenting it, analyzing it and using the resulting information to link plan and provider performance to improve both – and to encourage providers to make better use of the data, too – payers can accomplish those critical aims and increase member satisfaction at the same time. Those are the keys to success in today's brutally competitive market.

The main question for most payers is this: "How? How do I use data to accomplish those essential goals? How do I revive the 'consumerism' that's been missing from health care? How do I urge providers to do the same?"



Payers and provider organizations know they operate in a world of seemingly endless moving parts when it comes to regulations, mandates, competitive pressures and customer service; they also know they have access to more member data than ever before, and they know they need to use the data to help manage the moving parts. That makes now the perfect time for health plans to take the lead in data innovation by leveraging additional external data sources to further enrich their insight into members for every operational discipline in the insurance business continuum. With the right data partner's assistance, augmenting claims and administrative data with socioeconomic data, identity information and supplemental analytics will jump start consumerism efforts that had floundered – or even foundered – in the past.

The first payer challenge: Expand the value of existing data assets – and their definition



It's probably not possible to quantify any industry's exact store of big data, so it's difficult to say definitively whether health care has the most. By one estimate,[1] the health care "realm" sits on top of about 50 petabytes of data, a total expected to grow to 25,000 petabytes by 2020; that includes diagnosis data, symptom data, claims data and procedures data, among other types. While nobody can really say for certain that that tops the list, most industry experts can agree that health care players aren't using as much data as they could be – nor using it as well as they should be. A recent report[2] explains that while organizations are "accumulating data at unprecedented rates," they're generally "falling short on turning data into revenue." Indeed, 40% of health care executives in a survey discussed in the report gave themselves a grade of D or F when it comes to preparedness to do so.

That shows up in the struggle many plans face in convincing the providers they contract with to use owned data to better manage members. When providers balk at using data "as a useful resource to inform their care," and they often do, it's usually because of concerns about data quality – and format.[3] It's time for that to change, and it's up to payers to make it so. It's time for health plans to pull those providers into today's health care economy by sharing the additional insights into member patients those plans gain when they augment internal member identity data with additional external resources.

Plans' and IDNs' often poor use of patient data also limits member engagement – and increasing engagement is "a significant benefit that health plans can offer provider organizations."[4] But they need provider organizations' cooperation and assistance. When health plans have access to the right data and to sophisticated data analytic tools – allowing them to identify high-risk patients, among other key functions – those plans can then encourage those members to get the care they need and close any remaining gaps.

> ***"When members are more engaged in their care," a report points out, "provider organizations benefit, [and] health plans can improve HEDIS and Star ratings, risk scores and financial performance."***

Additionally, improved member identity information from socioeconomic add-ons makes member campaigns more individualized and focused – and less likely to fall on deaf ears.

How did things get this way?

To change the current paradigm, it's important to understand how it came to be. Payers have a limited view of member data because of basic economics. When the consumer of any service is not the payer, an imbalance occurs in the business model that may keep consumerism from contributing to cost control and proper design and delivery of services. In healthcare, with the exception of the individual market, payers have struggled with that conundrum for decades, and health reform hasn't made the struggle any easier, as the Institute for Healthcare Improvement's Triple Aim for health plan design[5] – "improving the patient experience of care, including quality and satisfaction; improving the health of populations; and reducing the per capita cost of health care" – requires a very specific focus on value and on a 360-degree view of members to understand, or anticipate, their needs & wishes, the very "consumerism" element that's proved so vexing.

Even in their attempts to achieve the Triple Aim, payers & providers have largely ignored in-house member data – like addresses and marital status and even hard-to-find patterns in past use of services. That's because they've traditionally been focused on immediate outcomes and costs. When you're not guaranteed to keep an underwritten life for more than a couple years, the total care experience may be minimized. In those cases, member data may not be viewed as a source of operational intelligence, and members may be seen more as financial exposures than as sources of potential operational – and thus cost – improvements. A unique opportunity to retain membership via enriched member identity data and tailored outreach focused on customer satisfaction and future needs might be ignored.

Member data capture and use for underwriting, enrollment, claims and Explanation of Benefits (EOB) documents tend to be one-directional, like accounting transactions.

Also hindering payers' and IDNs' efforts at using member data is this fact: Member data capture and use for underwriting, enrollment, claims and Explanation of Benefits (EOB) documents tend to be one-directional, like accounting transactions. So even as the key health care players have adopted a variety of focus points in their competitive efforts, each time the focus shifts, the player who impacts and is impacted the most – the patient, and all the data he or she brings to the table – has also been the least considered when attempting to risk-score key performance drivers.

The next challenge: Thrive in the new environment with existing – but enhanced – member data

Now, the total care experienced must be optimized, not minimized – and plans must lead the way. To make the transition from volume to value, plans and provider organizations must recognize that their primary relationship is with the customer – the patient – not the organization paying the premium. The more health plans work with members, the more they impact their own medical costs and the easier it becomes to live within the ACA's regulated MLRs. Indeed, some elements of the ACA have had a jump starting effect on some players, leading them to say, "We can't do it the way we have before." Their challenge is to do things differently with existing data – and whatever needs to be added to the data to allow the players to be more effective.

> ***"We can't do it the way we have before."***

Plans can evince that kind of leadership by offering providers the data they actually want and offering patients the data they really need to help take better care of themselves – and by revamping the data format and delivery for both.[3] And they can continue to sharpen their focus on the patients at the center of everything. The nation's top insurers increasingly seek to fill positions with names like "Director of Consumer Insight" or "Director of Patient Insight" – both powerful examples of the shift in focus that's changing everything about the health care economy. Patients aren't viewed so much as cost exposures anymore, they're increasingly seen as risk management opportunities.

Moving toward 'consumerism': Augmenting owned member data for patient engagement and process improvement

Using data to manage provider behavior and engage patients in their own care – and doing both of them well – requires a partner to assist in maximizing owned data resources, especially in light of the fact that the data health plans and IDNs possess needs to be augmented with external sources to reach its full potential. Socioeconomic data in particular can unlock new ways of thinking about, speaking with and understanding member patients as what they are – people. What's needed, in fact, is a whole new definition of "health care big data."

Health care players, like those in most industries, tend to stay largely within their data comfort zones, focusing, in this case, primarily on claims and enrollment data. Indeed, as one report[1] puts it, "healthcare payers already store and analyze a significant portion of data relative to claims. However, to provide analytic insight, the scope of payer-leveraged information will have to increase significantly." In today's value-based environment, patient caseload must be risk-adjusted to evaluate provider performance, for example; that risk adjustment must take into account patient adherence and patient lifestyle. Now, therefore, health care data needs to include information on whether, for example, a member lives in a neighborhood where lead paint is still an issue because of the myriad ways exposure can affect health.

> ***"Healthcare payers already store and analyze a significant portion of data relative to claims. However, to provide analytic insight, the scope of payer-leveraged information will have to increase significantly."***

Plans and IDNs can use the information they glean from augmented member data to develop stronger provider networks, anticipate medical costs in targeted geographic regions, expand population health disciplines, prevent and detect fraud and evaluate provider performance – examples include using enhanced enrollment data to confirm dependent identity and status and merging data around diagnosis, timing of services and provider usage, all of which is reflected in submitted claims, to sniff out potential fraud. As well, plans and IDNs can use vast libraries of medical care and compliance studies, at the regional and urban levels, along with knowledge of members' career, education and workplace settings to better engage them in their own care and cost management.

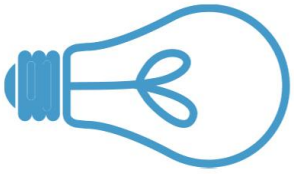
Plans and IDNs can use augmented member data to:

A call to action: Add insight to member data

Indeed, there is virtually no operational process that member data – under the new definition – cannot add value to. In the move to fee-for-value, payers and providers now recognize the criticality of understanding members via data and of engaging them via new and better-focused communications. It's not enough to simply know, through claims, what those members are doing across the health care system. More important is understanding who they are – and the possible motivations for their behavior.

Consumerism may someday be viewed, in fact, as the moment of truth that pushed payers and providers to achieve operational excellence in the provision of and payment for care. It's the place where access, satisfaction, price, outcomes and peer review meet, and it exists in the realms of snow tires and summer dresses and vacation travel as well as health care; unfortunately, in health care, which has been an employer-provided commodity, the patient has taken on a compliant attitude and often doesn't act like a consumer.

Member data powers almost every health care payer and provider workflow.



Plans and providers must change that, and enhanced member data is the best means they have to do so. Because plans have relationships with providers that can be leveraged to encourage them to work with consumers to promote engagement, they're in the best position to lead the change; plans also have relationships with patients that can be leveraged to encourage them to act more like consumers in the first place. Those relationships can be delineated and managed with the data plans and providers possess.

LexisNexis Health Care offers solutions specifically designed to leverage both plan and provider data and LexisNexis' socioeconomic public records data – along with industry-leading analytics. Member data powers almost every health care payer and provider workflow in its current form; its usefulness when augmented with carefully culled and tested socioeconomic data from public records is that much more immense. LexisNexis leverages more than 37 billion public records, 15.8 billion consumer records and 8.6 billion unique name-and-address records; the company leads the industry in helping health plans bring together multiple sources of data and resolve it down to a single identity.

The LexisNexis Member Identity Intelligence suite can empower health plans to meet their business goals, comply with mandates and health reform and protect & grow their customer base. As well, plans can accomplish these critical tasks:

Ensure repeated validation of all descriptive member identity data

Ensure a unique & personalized engagement approach for every member family unit

Maximize return on communication and marketing efforts

Secure accurate demographic profiles of membership

Better target individuals by utilizing attributes designed to provoke response

Position with potential new individual market enrollees by early engagement of dependent beneficiaries approaching age 26

Ensure non-medical expenses are efficiently managed to best comply with MLR mandates

Contribute to the plan's health management programs success by providing more specific sub-segments for engagement

'We'll get you there'

Health plans face unprecedented challenges in a value-based health care economy; they must surface greater detail around membership identity to foster a more holistic approach that will produce positive outcomes. But the health care sector as a whole has been woefully slow to take advantage of the almost infinite amount of data that's available to help them meet those challenges – and payers have fallen behind in urging providers to make better use of it.

But it's not too late. Not having all the necessary data isn't a deal breaker; neither is not knowing exactly what to do with it to thrive under health reform. That's because LexisNexis does have that data, and the company has unmatched experience and expertise at turning the data into the kind of strategic intelligence that powers population health, provider relations and patient satisfaction. Plans must lead providers in maximizing member identity data, but they needn't make the journey all alone. When LexisNexis says, "We'll get you there," you know the destination is in sight.

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Sources:

1 https://knowledgent.com/whitepaper/big-data-and-healthcare-payers/

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3 https://www.advisory.com/research/health-plan-advisory-council/members/expert-insights/2016/three-ways-to-help-providers-use-plan-data

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5 www.ihi.org/engage/initiatives/tripleaim/pages/default.aspx

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