Customer Lessons Learned from the **Health Insurance Exchange Rollout**

A look at what steps can be done to smooth the ACA's bumpy experience road

Customer Strategist

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Executive Summary

A top story in the U.S. recently has been the nationwide rollout of health insurance exchanges as part of the Patient Protection and Affordable Care Act, otherwise known as the ACA, or Obamacare. For the first time in the country's history, every citizen is required to have health insurance. Previously uninsured individuals, families, and small businesses can purchase insurance as a block via state-run health insurance exchanges (HIXs), designed to eliminate historical barriers such as prohibitive costs or pre-existing condition policies. Thirty-four states opted out of creating their own exchange, so the federal Healthcare.gov exchange was established to connect citizens in those states with participating insurers. Open enrollment began on October 1, 2013, and runs until March 31, 2014. As of February 2014, 3.3 million Americans have enrolled, with a goal of 6 million by the end of March.

Key Takeaways:

- Consumers are taking a more active role in their healthcare, interacting with different players throughout. They expect an experience similar to what they find in other industries. All the necessary entities must align around serving the consumer.
- Payers in particular have a significant opportunity to build relationships with the largest influx of health insurance consumers to hit the market in decades.
- Common pitfalls: Lack of coordination and communication, unrealized expectations, and internal focus that supersedes the customer perspective.
- What's working: Flexibility, cross-team alignment, consumer relationship focus.

Whatever your politics, the fact is that the law is in place, and there are many facets and players involved in its implementation. Legislators made and revised elements of the law, federal and state agencies have built and maintain the exchanges, insurance carriers changed their plans and policies, and doctors and hospitals have new procedures to follow, to name a few. It makes for a very complicated experience. Consumer and other data must be shared and integrated, and collaboration must happen among groups that never interacted before.

It's easy to find news about Healthcare.gov's technical issues, enrollment statistics, and potential repeal votes to the law. But little media coverage has focused on the overall customer experience: what's working, what's not, and what kind of experiences are the main players providing consumers as they try to maneuver through this new system? What can agencies, insurers, providers, and others learn about improving the customer experience going forward?

Why care about customer experience?

Though nothing is as personal as an individual's health, the U.S. healthcare industry has traditionally lacked a consumer focus. Insurance companies worked primarily with company benefit administrators or back-office clerical staff regarding plans, policies, payments, and processing. The consumer, or "member," was a peripheral figure. State agencies monitored regulations, and doctors and providers were on their own to charge and figure out reimbursements. Now, consumers are taking a more active role in their healthcare, interacting with different players throughout. Insurance carriers must now compete for the best consumers—healthy young adults. States are incentivized to meet certain enrollment numbers, and providers compete for newly insured patients, as well as to retain current patients.

At the same time, consumers expect a consistent experience as they move along the continuum from the exchange through to insurance companies and providers. Their experiences with customer-centric leaders such as Amazon, USAA, and Zappos likely influence their overall expectations for information, accessibility, and service in all industries. Healthcare is no exception.

There's also the data issue. Consumer information is being collected on the exchanges, verified by the IRS and other government agencies, and passed to insurers before relevant plans can even be offered. The consumer just considers one experience, "signing up for health insurance," but on the back-end many disparate systems must integrate and coordinate. All the necessary entities must align around serving the consumer.

So far, that alignment has largely been absent. The customer experience took a back seat to internal issues and political posturing. When Healthcare.gov and the state exchanges went live in October, the experience was downright atrocious. *The Guardian* newspaper reported that 4.7 million people visited the federal exchange website on its first day, but only six people successfully enrolled. Pages didn't load correctly. Users couldn't input information. In many cases, visitors got a simple message telling them to come back later. A Gallup poll from November 2013 found that 63 percent of Americans reacted negatively to the exchange websites, and only 5 percent of uninsured Americans who logged into any of the exchange sites found the experience to be "very positive." Improvements have been made since, but the overall impression is one of a poor customer experience, even if the user eventually enrolls.

Other HIX interaction channels, such as call centers and walk-in centers, are not much better. Many in-person centers were not physically ready to open by the October 1 launch date, and call centers have been plagued by long wait times, language barriers, and outdated information. In February, California's exchange announced it was hiring 400 more agents to help alleviate its 51-minute average wait time and other issues. And Maryland is investing $6 million to improve operations to its call center, which receives more than 3,000 phone calls per day, according to the *Baltimore Sun*.

Much has also been written about post-enrollment difficulties with insurers. Some have not captured correct member information, been late with sending out membership cards, and have delayed instituting coverage. The entire end-to-end customer experience so far is cumbersome, complicated, and frustrating.

Ezekiel Emanuel, a University of Pennsylvania professor and an architect of the ACA for the White House, recently said at a healthcare forum: "The interface isn't perfect and I'm sure by next year when we do this for the 2015 season, you're going to have systems that work better. It won't be the Amazon.com experience but it will be getting close. By 2016, the experience will be the equivalent of Amazon shopping and most people will be happy with it."

That's a tall order, even in a two-year timeframe. There are many customer experience issues that need to be resolved and leveraged before Emanuel's optimistic goal can be realized.

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—Ezekiel Emanuel, ACA architect

Customer pitfalls of the rollout

In fairness, a national healthcare exchange that is accessed by millions of consumers represents "an extraordinarily complex ecosystem" that will take years to smooth out and optimize, says Rick Parrish, senior government customer experience analyst at Forrester. But where the customer experience has been uniformly flawed throughout the system "is the lack of communication and lack of managing messages to the citizens around what the expectations should be," adds Skip Snow, another Forrester senior analyst.

"There's no one place to get information to tell consumers exactly what they need to know," says David Oscar, an insurance broker and board member of the New Jersey Association of Health Underwriters. He works as a "navigator" to help consumers and small businesses choose the best health plans. There are many fine-print details to plans listed on the exchanges, and there is little consistency across states when it comes to plan information, how it's presented, and what gets updated. People get confused about what doctor networks they're in, or the difference between gold, silver, bronze, and platinum plans, for example. "There are so many heads to this monster, and no head talks to each other," Oscar says. "The burden is on consumers to figure it out."

Further muddying the state of customer experience is that health insurers are each handling post-registration processes differently, Snow says. One of the critical steps that federal officials and contractors will need to take is to provide customers with fluid cross-channel experiences. Until the national exchange is able to pull that off and provide interoperability and ease of navigation across various channels used by consumers, the system will be "outmoded," Parrish adds.

Forbes echoed the lack of coordination as a root cause of trouble. It reported on a survey from healthcare IT consulting firm Edifecs, which found that "93 percent [of payers] said that exchanges were not seeking enough feedback from insurers; and 75 percent were 'very concerned with being able to reconcile premium, enrollment, and payment records' from exchanges."

Another lesson learned from the rollout of the exchanges is that many participants could have done a much better job of managing customer expectations, Snow says. Oscar agrees. "Our expectations were built way beyond the reality," he says. "The problem is that the people in charge already know this, they know what the current experience is actually like, but they don't manage those expectations."

In addition, many of the exchanges (with Healthcare.gov leading the pack) didn't leave sufficient time for end-to-end testing of the entire experience, instead focusing on individual internal pieces of the project. "If you talk to the people who rescued Healthcare.gov, they made sure people working on this talked to each other on a daily basis through a 'war room,'" Snow says. They didn't allow people to work on the overhaul of the exchange in isolation.

These challenges are very familiar to anyone who has worked on a customer-based project: lack of coordination and communication, unrealized expectations, and internal focus that supersedes the customer perspective. With the HIX rollout, it just happened very prominently, on a nationwide scale, with future political ramifications.

"There are so many heads to this monster, and no head talks to each other."

— David Oscar, NJAHU

Five Opportunities for Improved Payer Experience

By Pat McCaffrey, SVP of Healthcare and Public Sector, and Dawn Aston, VP of Sales, Healthcare Services, TeleTech

With the extended March 31 enrollment deadline fast approaching, the implementation phase is picking up speed, and the spotlight is shifting from the exchanges to individual insurers, which, as a result of the ACA, are seeing the largest influx of new members in several decades. This creates enormous opportunities for the healthcare industry. To take advantage of this situation, we have identified five opportunities that payers should leverage:

1. Manage the influx of calls: Navigating the healthcare landscape is complicated at best. Especially the first-time insured are likely to need help understanding their eligibility and gaining familiarity with their benefits and terms. Moreover, because of the complex issues and sensitivity of healthcare, members are more likely to want to speak with another person.

This means that insurance providers need to equip their contact centers to cater for this growth while still delivering a good experience. There are two approaches—either ramp up their internal contact centers or team-up with a partner that can help with staffing the contact center and providing the necessary training for agents. Since traffic is expected to fluctuate, it's good to have a scalable system, both in the member service centers and in supporting technology.

While call centers are expected to be the main mode of contact, insurers shouldn't forget other touchpoints, and their communication strategy should consist of multi-touchpoint interactions, including leveraging smartphones through apps or text capabilities.

2. Leverage data and member insights: Healthcare is a sensitive topic, with members and patients expecting that their information is respected and kept private. However, non-medical information can help insurance providers understand where they need to make improvements to their messaging and can highlight areas in their campaigns to educate members. Insurance companies need to understand what is working well and what needs to be improved by leveraging data from different touchpoints. For example, if many members are calling their insurer with a similar question, there might be an opportunity for an outreach campaign to inform members about that specific topic.

Front-liners need to be recognized as great sources of information, since they are constantly in touch with members and can identify trends in member pain points. Their additional exposure to member insights means that agents can often be instrumental in identifying the reasons behind customer issues and help find a speedy solution.

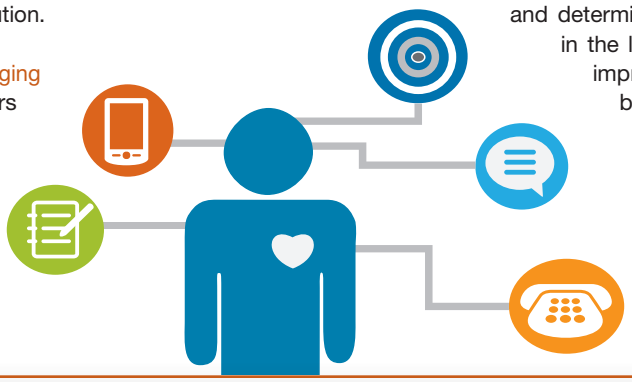
3. Embark on targeted messaging campaigns: Equipping members with the correct information can be instrumental in ensuring that they have access to the right treatment, as well as take preventative action to avoid future health problems. This is a win for both insurance providers and members themselves. Therefore, insurers need to leverage member data to create very targeted and personalized outreach programs, with information that resonates with individual members.

TeleTech's customer growth services unit worked with a health insurance provider to send hyper-targeted communications to employees, who were also members. After collecting data from 16 disparate repositories and analyzing it, the insurer was able to identify individual concerns. For example, a member suffering from high blood pressure that increases his risk of cardiovascular disease could be sent tips on lifestyle changes that could help address his hypertension problem.

4. Create a member acquisition strategy: A substantial number of new members across the board are chronically ill and not enough healthy members are signing up. Resources-strapped providers are struggling to find time to reach out to prospective members who are healthy, which would help them gain a more balanced member base. In order to attract new types of members, providers need to embark on an outreach strategy that acknowledges and leverages prospective members' different needs. Social media and digital marketing can be integral parts of the campaign.

5. Design an integrated multichannel and multi-model marketing approach: The most successful state health insurance exchanges have been leveraging multiple channels with varying approaches including traditional media, email, text, and social media. An integrated multichannel approach is critical since different customer segments use various channels both to interact with brands and to gain information, which has been an important part of the ACA rollout.

Just as Rome wasn't built in one day, neither will a thorough change in the healthcare system. Healthcare reform is a journey. We need to look at it from the eyes of members and determine what needs to be addressed in the long term. This not only includes improvements to current systems, but also requires an understanding of what new products need to be created. As the journey continues, plans will become better positioned to support members in a way that's relevant to them and is also successful for the company.



Customer experience plans that work

It's not all bad. More than 3 million people have successfully enrolled in health insurance plans, according to the Department of Health and Human Services' February 2014 report. The exchange websites received more than 63 million visits and call centers answered nearly 16 million calls through February 1, 2014. The sought-after 18-34 age group represents 25 percent of those enrolled, which bodes well for cost analysis, and some states running their own exchanges have already exceeded enrollment goals.

Connecticut is one of those states, announcing in early February that it had enrolled 121,000 people, having easily surpassed its goal of 120,000 enrollees by March 31, 2014. Part of its success is attributed to the multiple channels through which it interacts with consumers, and the personal assister network available to help consumers through the end-to-end experience.

Kate Gervais is the manager of the Connecticut Navigator and Assister Outreach Program, a division of the state's exchange. Her office oversees more than 300 community groups that assist individuals in their local neighborhoods to get coverage. They include church groups, child and family agencies, libraries, and organizations for the homeless, aging, and others. "To move into this new age where insurance isn't a barrier to the lives we want, we need to provide a way to communicate information that's easy, accessible, and culturally sensitive."

The assisters walk people through the application process, answering questions about Medicaid eligibility, tax credits, and small business issues, for example. "You may know them, they're in your community," Gervais says. "They're passionate about the opportunity the ACA brings, and want to help." They won't recommend a specific health plan, but they can answer questions and be of general assistance. "The assister owns the relationship. We stay with the consumer and try to share information when we can."

Gervais' team is part of a multichannel effort to enroll Connecticut residents, which also includes the AccessHealthCT.com website, a 300-agent call center, and two walk-in centers in cities with large uninsured populations. "It's a web, and we're building up that web all the time," Gervais says. To that end, each Tuesday every consumer-facing group meets together to share insights about processes, information, and what they're hearing from consumers, both good and bad. "It's very important that we're on the same page. We talk to consumers every day. We have the opportunity to share that voice with every department. We take that seriously."

Beyond Connecticut, the non-partisan State Health Reform Assistance Network's December study: *Report from the States: Early Observations* looked at success factors in five other states that operate their own exchanges: Kentucky, New York, Minnesota, Rhode Island, and Washington. They include:

Being nimble—States' ability to be nimble has been very important in the early months of marketplace operations. "New York State of Health was deliberate in building fail safes that would allow the marketplace to be responsive to problems and issues that might emerge at launch," the report reveals.

Prioritizing what's critical, and deferring what's not—"Washington State described setting goals and expectations early, taking a disciplined approach to scoping their marketplace and consistently focusing on what had to be done for day one rather than adding a bunch of nice-to-haves," the report states. As of February 1, 2014, more than 33 percent of eligible Washington residents have signed up for care on the state's online insurance exchange, according to the *Washington Post*.

ACA Enrollment
3.3 million

Exchange website visitors
63 million

Calls to exchange call centers
16 million

Source: U.S. Department of Health and Human Services, 2/1/14

Cohesive teams with clear lines of authority—The report lauded states that created cross-functional teams of experts with clear missions. "By building cohesive and collaborative teams, states were able to stick to the vision and work plan for marketplace implementation and, most notably, drive timely and effective decision-making."

Connections to stakeholders—Internal and external stakeholders are critical to keeping the project focused and moving in the right direction. These states have a "close connection to 'on the ground' stakeholders, including consumers, navigators/consumer assisters, agents/brokers, call centers, and health plans."

Again, these are best practices in any successful customer initiative. The federal program and future state exchanges would be wise to leverage these success factors.

Move forward or get left behind

The exchange experience gets much of the attention in the media, but it's only half the story. The total customer experience involves interactions with insurance companies, as well. These companies have historically scored low on customer experience metrics and satisfaction. The reality of the new healthcare ecosystem means that the old ways of doing business must change. A focus on the individual consumer experience can take a company from regulatory compliance to true competitive differentiation.

Practitioners in the exchanges and payer worlds can benefit from learning more about the interests and profiles of individual customers to personalize messaging, better address their needs, and identify and act on cross-sell and upsell opportunities. For instance, a particular customer may be a good prospect for ambulatory services but doesn't qualify under a plan they're applying for. Working together, the exchanges and insurers can share data and insight to craft a personalized offer for separate ambulatory service, says Omer Minkara, senior research analyst, contact center & customer experience management at Aberdeen Group.

New ways of interacting with customers are beginning to happen. Taking a page from a customer-centric company playbook, *Bloomberg* recently reported that some consumers complaining about poor experiences to news organizations and on social media were contacted by case workers from the Department of Health and Human Services with a goal to resolve their case within 24 hours. Maybe Emanuel's ideal Amazon-type experience isn't as far off as originally thought.

Just because the March 31 enrollment deadline is approaching doesn't mean that the program is ending. More states are building their own exchanges, new insurance plans and different payers are being added to exchanges, and there is much to do to align all the players for the next enrollment period and enhance the entire system going forward. If the leading players put the customer in the center of the experience, the state of the HIX program and ACA will only get healthier.

"The assister owns the relationship. We stay with the consumer and try to share information when we can."

—Kate Gervais, AccessHealthCT

75%—Payers that are 'very concerned with being able to reconcile premium, enrollment, and payment records' from exchanges.

Source: Edifecs, October 2013

About the Customer Strategist journal

The *Customer Strategist* journal provides executives with insight that leads to innovative strategies for building more profitable customer relationships. It facilitates learning and action by presenting the most progressive thought leadership; providing access to Peppers & Rogers Group proprietary consulting methodologies; and featuring in-depth research on customer value management, engagement, and related customer strategies that readers can harness to create a long-term, sustainable competitive advantage.

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