RESEARCH REPORT

Advisory Board

The Member-Centric Virtual Service Model

Hallmarks of virtual customer service models that prioritize personal needs

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BEST FOR

Member experience, customer service, and care management health plan leaders

READING TIME

20 min.

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Obvious demands from expectant consumers

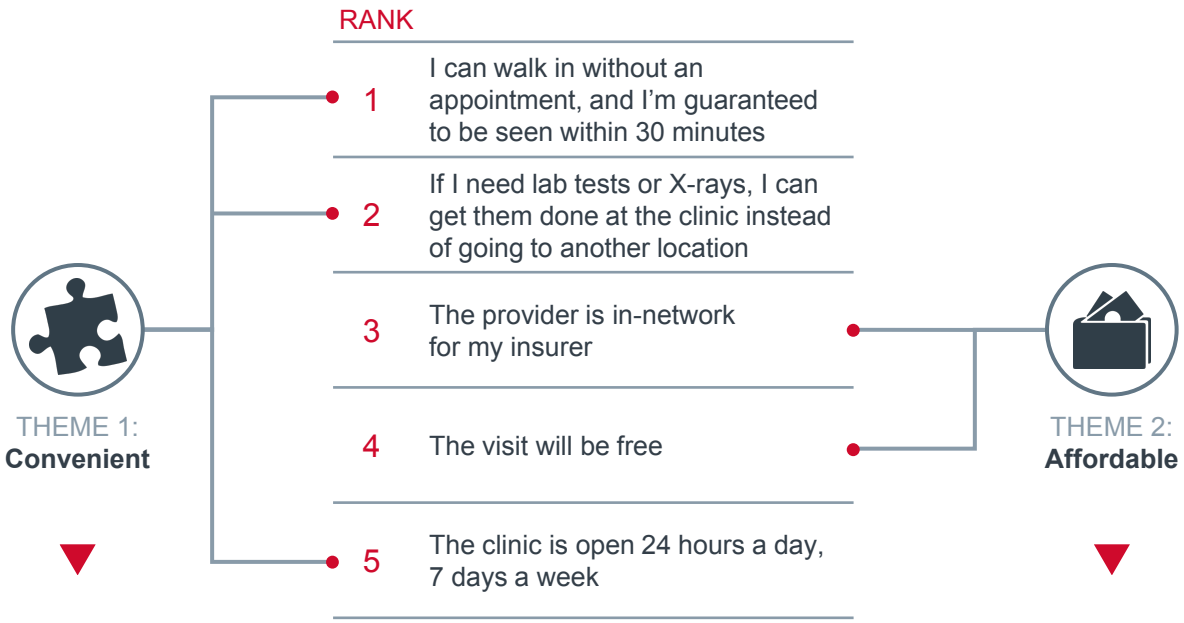
Core member preferences vary little across populations. Above all, members want provider-directed care, and they want clinicians to spend enough time with them to give clear, specific instructions.

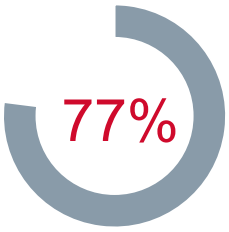
But outside of the clinical relationship, members' other priorities require health plan action. Members want a convenient experience—from appointment availability and location, to parking and mobile interfaces. Just as crucially, members demand care that's affordable—with known, specific costs.

Refer to our publication **Deliver the Member Experience That Matters** to learn how health plans can ensure that members receive personally appropriate, provider-directed care.

Top 5 preferred primary care attributes

n=3,873 consumers





Of members would rather have lab and imaging services on site than a five-minute drive time to clinic

Of members would rather go to another clinic than not know how much the visit costs (for lab tests, X-rays, or pharmacy)

Source: *What Do Consumers Want from Primary Care?*, Market Innovation Center, Advisory Board; Health Plan Advisory Council interviews and analysis.

Unmet consumer needs open doors for competitors

Unfortunately, health plans are not meeting consumer preferences for convenience and affordability.

Insurance is confusing for the most adept individuals, meaning plans must provide personal support where possible. Further, members rarely have accurate information about possible care costs prior to visits, which can lead to unwelcome surprises.

As a result of this service gap, new entrants are offering members what they want—clear next steps and obvious prices. In addition to competing for member mindshare, new entrants highlight plan complexity and add scrutiny of the current service model's inadequacies.

Health plan shortcomings on member priorities

Convenience

25%
of members receive care coordination support from their health plan

64%
of members are currently unable to schedule doctors' appointments online[1]

Affordability

62%
of members do not sufficiently know how much they will need to pay when scheduling a doctor's appointment[1]

57%
of consumers have been surprised by a medical bill they did not expect

Competitive threats from alternative sources

Navigation services expose needless plan complexities

Transparency tools diminish the perceived value of insurance

1) Percentage responding "I don't have this" or "Not at all satisfied" to service feature.

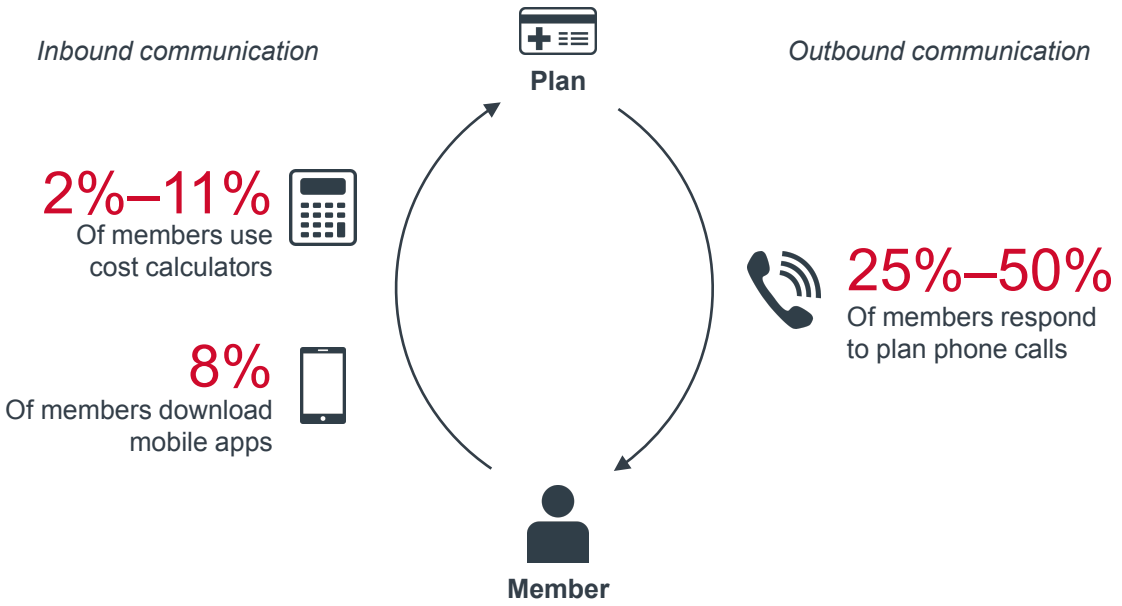
Source: "NORC AmeriSpeak Omnibus Survey: Surprise Medical Bills," NORC, August 2018, http://www.norc.org/PDFs/Health%20Care%20Surveys/Surprise%20Bills%20Survey%20August%202018%20Topline.pdf; "Care Coordination Software US Overview and Outlook," Frost & Sullivan, May 2015; "US Member Health Plan Study", J.D. Power, 2017, http://www.jdpower.com/resource/us-member-health-plan-study; Consumer Services Preference Survey, 2016, Health Plan Advisory Council; Health Plan Advisory Council interviews and analysis.

The elusive promise of member engagement

Threatened by these new entrants, health plans want to improve their virtual interactions with members through phone, email, and web services, so that they can guide them to appropriate care.

But plans consistently struggle to reach their members, as they generally do not want to interact with health plans. Members rarely proactively contact plans for help in advance—and few respond to outreach from plans.

Utilization Rates of Plan Engagement Efforts



Source: Gourevitch RA, et al., "Who Uses a Price Transparency Tool? Implications for Increasing Consumer Engagement," *Sage*, May 2017, https://doi.org/10.1177/0046958017709104; Johnson CY, "The tech industry thinks it's about to disrupt health care. Don't count on it." *Washington Post*, February 9, 2018; Health Plan Advisory Council interviews and analysis.

The member-centric virtual service model

Plans are not top-of-mind for members at key care decision moments, so plans can't assume members will reach out with questions. A reactive service model will leave members unprepared to use care in a cost-effective manner and dissatisfied with the with the plan overall.

Instead, plans must build a service model that immediately demonstrates how plans will deliver on member priorities. They must focus on the personal relevance of any services promising convenience, and also the predictability of care costs.

Hallmarks of the member-centric virtual service model

Convenient ▶ **Relevant interactions**

Respect personalized, practical member preferences:

1. Showcase instant value
2. Build daily habits

Affordable ▶ **Predictable spend**

Ensure clarity on costs at key moments:

3. Practice extreme transparency
4. Dramatize financial choices

Source: Health Plan Advisory Council interviews and analysis.

Relevant interactions

Respect personalized, practical member preferences

- Showcase instant value
- Build daily habits

Hallmark 1: Showcase instant value

Pair the virtual experience with a dedicated guide

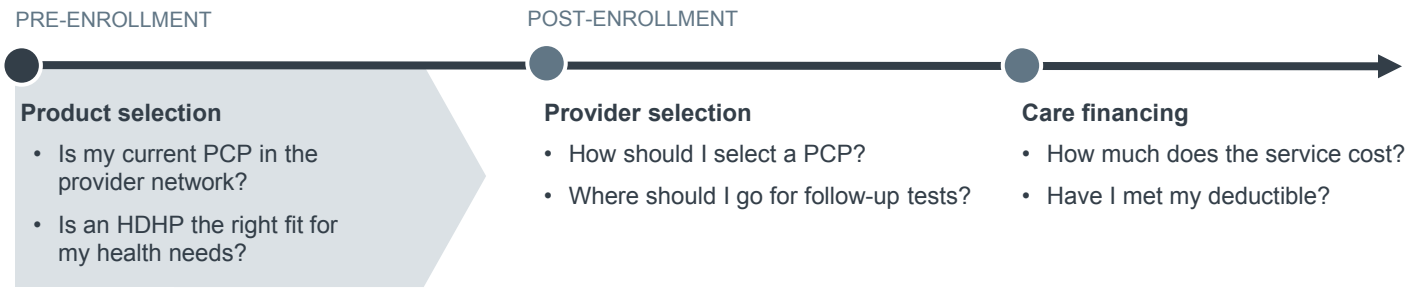
Most health plans have readily available customer service staff who can help ensure members stay in network or avoid high out-of-pocket costs. But that service is only successful if members contact the plan at the outset of care.

There's only one moment when plans always know that members could use their help: when they're choosing a product. Cigna takes advantage of that moment to show how contacting customer service can solve member problems.

Cigna launched One Guide®, their specialized customer support service, in 2017. The service connects members with a dedicated One Guide specialist via phone and "click-to-chat" options. Predictive analytics and machine learning provide information and support to members early in their care journey. Cigna's team of experts provides personalized and relevant information about high-performing providers, health programs, low-cost care options, and mobile and online tools that can help members make informed choices.

Cigna One Guide® model service components

Cigna One Guide® sample customer interactions



Cigna provides their members with guidance from the very beginning. Members are paired with a specialist team during open enrollment to assist with choosing the most appropriate plan product for their needs.

Crucially, this specialist team remains dedicated to the member for all care navigation needs that might arise, such as selecting a primary care provider or finding the lowest cost options for follow-up treatment. The original support from the specialists during enrollment primes members to turn to Cigna for help in the future.

Source: Cigna Health Insurance, Bloomfield, CT; "Cigna introduces plan selection service One Guide," *Becker's Hospital*, https://www.beckershospitalreview.com/payer-issues/cigna-introduces-plan-selection-service-one-guide.html; Health Plan Advisory Council interviews and analysis.

Engagement drives better health at lower cost

Make it easier for customers to get affordable, quality care

Overall, Cigna has seen promising results from its One Guide service. Members with access to Cigna One Guide have 34% higher engagement in health and wellness programs, and up to 84% compliance with gaps in care—driven by the value of plan support proven at the outset.

Higher engagement rates

12%
Higher completion of chronic care calls[1]

34%
More interaction[2]

16%
Higher customer satisfaction[3]

Lower costs and increased closures in care gaps

14%
Reduction in inpatient days[4]

14.2%
Reduction in avoidable admissions[4]

3%
Reduction in ER utilization[1]

84%
Gaps in care compliance rate[1]

CASE EXAMPLE

Cigna

Health plan with 10 million commercial, Medicare, and Medicaid enrollees • Bloomfield, CT

- Cigna One Guide is a high-touch, analytically driven customer advocacy model that combines a powerful digital experience with the empathy and expertise of a personal guide. The service was launched in 2017 as a buy-up service to employer purchasers.
- Customers have access to a team of specialists during the benefits selection process to help the member select the most appropriate plan product and assist with other care navigation needs such as selecting a primary care provider, finding the lowest cost options for follow-up treatment, and finding out how much a given service will cost.
- Use of Cigna One Guide has led to a higher completion rate for chronic coaching calls, greater closures in care gaps, and improved member satisfaction.

1) Cigna October 2017 internal analysis; includes entire One Guide population and non-One Guide populations using 1/2017–6/2017 data.
2) Cigna September 2017 internal analysis; 34% more interaction with Cigna One Guide digital and agent solutions than non-Cigna One Guide customers. Includes the entire One Guide and non-One Guide populations using 1/2017–8/2017 Book of Business data (43% vs. 32%; representing the unique percentage of customers that called or had a digital login). Cigna One Guide results.
3) Jan – June 2018 Voice of Customer Survey Results.
4) Cigna Analytics Health Matters Care Management Complete program evaluation, 2015. Results derived from Nationwide ICMS Proclaim Business Pilot. Results based on 12 months of claims data using match case control study compared to PHS+. Individual client results will vary.

Source: Cigna Health Insurance, Bloomfield, CT; "Cigna introduces plan selection service One Guide," *Becker's Hospital*, https://www.beckershospitalreview.com/payer-issues/cigna-introduces-plan-selection-service-one-guide.html; Health Plan Advisory Council interviews and analysis.

Hallmark 2: Build daily habits

Feature members' priorities to lead them to plan priorities

Health plans (often correctly) presume that members don't want to be bothered by their plans unless necessary. But to offer effective support, plans need members to see them as partners who are always available to assist.

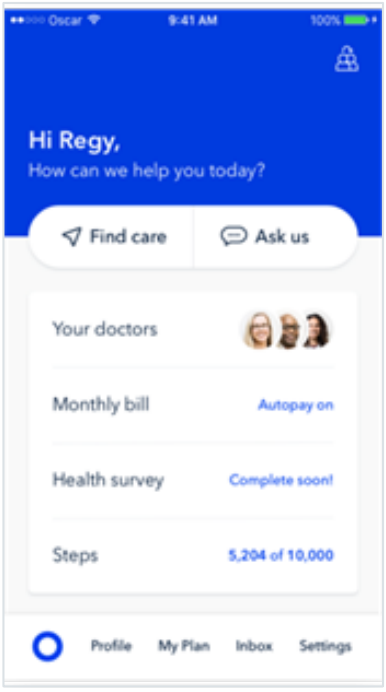
Oscar Health, a health plan with a focus on digital platforms, strives to make its digital platforms mirror how members want to think about their health. One of the ways Oscar drives use of their digital member platform is by putting their members' top personal interests first in their interface design—not necessarily their health care interests.

Oscar conducted tests of multiple versions of their app and learned that the top point of interest was the step tracker feature. Oscar has a steps incentive program already in place—one dollar a day for hitting 10,000 steps. The design of the front page substantially drives utilization: Oscar found that members preferred a version of the platform that prominently featured the steps tracker at the top when they opened the app, rather than a navigation support tool like a doctor finder.

Oscar's A|B Test for Member Priorities

OPTION A

App features tools that relate directly to care or impact costs

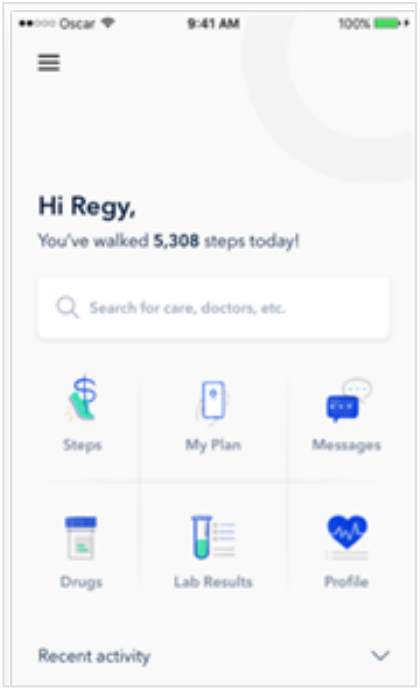


Steps Tracker

Steps Tracker

OPTION B

App features step tracker prominently



Preferred by member testers

Source: Perlera Regy, "How We Designed Oscar 2.0," *Medium*, August 29, 2017, https://medium.com/@perlerar/how-we-designed-oscar-2-0-fbba97087bae; Deep Dive, Oscar, 2018, https://www.hioscar.com/deepdive/virtual-care-platform; Oscar Health, New York, NY; Health Plan Advisory Council interviews and analysis.

Small steps to broader use

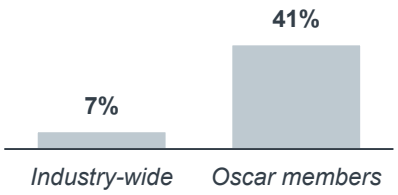
Strategic app design breeds familiarity with plan tools

After Oscar released the preferred app design, they saw increased engagement with the tool. Oscar members who use the step tracking feature are more likely to use the app for other services such as telehealth.

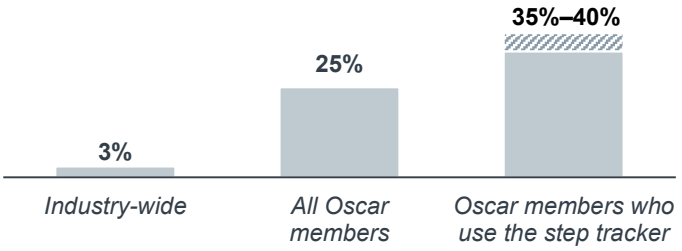
Oscar drove this increase in utilization by consistently investigating how prominently they were featuring actual member interests, rather than what plans themselves assume on behalf of members.

Oscar's app utilization results

Monthly active app users, 2017



Oscar's telehealth utilization rates



CASE EXAMPLE

Oscar Health

Health plan founded in 2012 with 230,000 members in individual products • New York City, NY

- Oscar emphasizes the step tracker on their app so members will become accustomed to using the Oscar app every day and eventually for care navigation.
- Oscar conducted A|B testing and discovered that members found more value in the daily step tracker than in the care navigation tools that are also available on the app.
- By featuring member priorities and offering an incentive of $1 per day for hitting 10,000 steps, Oscar has a 25% telehealth utilization rate for all members and a 35-40% utilization rate for members who use the Oscar app for step tracking (compared to a 3% telehealth utilization rate industry-wide).

Source: Perlera Regy, "How We Designed Oscar 2.0," *Medium,* August 29, 2017, https://medium.com/@perlerar/how-we-designed-oscar-2-0-fbba97087bae; Deep Dive, Oscar, 2018, https://www.hioscar.com/deepdive/virtual-care-platform; Oscar Health, New York, NY; Health Plan Advisory Council interviews and analysis.

Predictable spend

Ensure clarity on costs at key moments

- Practice extreme transparency
- Dramatize financial choices

Hallmark 3: Practice extreme transparency

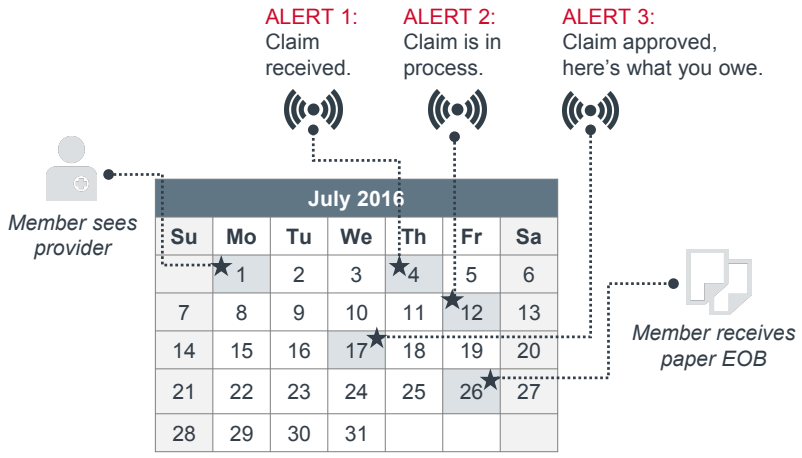
Bite-size claim status alerts ease member claim concerns

Members face a wide array of unknowns in health care coverage—even basic administrative information that should be easy to know. On average, it takes 18 to 30 days to process a claim, so a member might be waiting a month to be certain their visit is covered, and longer to make sure they won't get another bill from the provider.

Anthem is focusing on this essential information gap, speeding up how quickly they tell members about coverage. Anthem noticed that their members were most frequently calling to ask about their claim status. Accordingly, they decided to stop waiting until claims are fully processed to share updates with members.

Anthem now sends an email or text alert updating members on claims as they are processed. Now, when Anthem knows something, their members know it too. As shown on the calendar below, Anthem sends alerts when they receive, approve, and process the claim—much earlier than the final EOB, and a lot easier to understand.

Anthem's "What's my status?" claims alerts



SAMPLE EMAIL ALERT

Anthem BlueCross BlueShield

Your claim is approved

Hi Susan, we got your claim ending in 3443 from 03.03.17—and it's been approved. Check to see if you owe anything at Anthem Blue Cross Blue Shield.

Check your claim

Source: Anthem, Inc, Indianapolis, IN; Health Plan Advisory Council interviews and analysis.

Status: Informed

Anthem's focus on fundamental alerts builds broader engagement

Anthem is eliminating member delays in finding out the implications of their care selection. Anthem has seen a lot of appetite for these types of alerts. Fifty percent of members who get these emails open them, and half of those who open them click through to Anthem's website. Less than 1% of members unsubscribe to these emails.

Anthem is also exploring how to use this system to alert members about their balance from the provider and pay it directly through the portal—which will further simplify billing.

Widely-used alerts program increases engagement, reduces information delays

50%	<1%		13–25 days
Of members open alerts	Unsubscribe rate	Increased online engagement	Eliminated from standard wait time for claims updates

CASE EXAMPLE

Anthem

National BCBS health plan serving 69 million members nationwide • headquartered in Indianapolis, IN

- After noticing high call center volumes, the plan conducted an analysis which revealed that the most common reason members called was to check on the status of their claim.
- Anthem then implemented the "What's my status?" program, which proactively sends out email and text alerts to members to inform them of the status of their claim soon after they see a provider.
- Members receive alerts when the claim is received, in progress, and approved. Members can then click to find how much they owe the provider.
- Since initiating the program, Anthem has noticed an increase in member engagement with online tools.

Source: Anthem, Inc, Indianapolis, IN; Health Plan Advisory Council interviews and analysis.

Hallmark 4: Dramatize financial choices

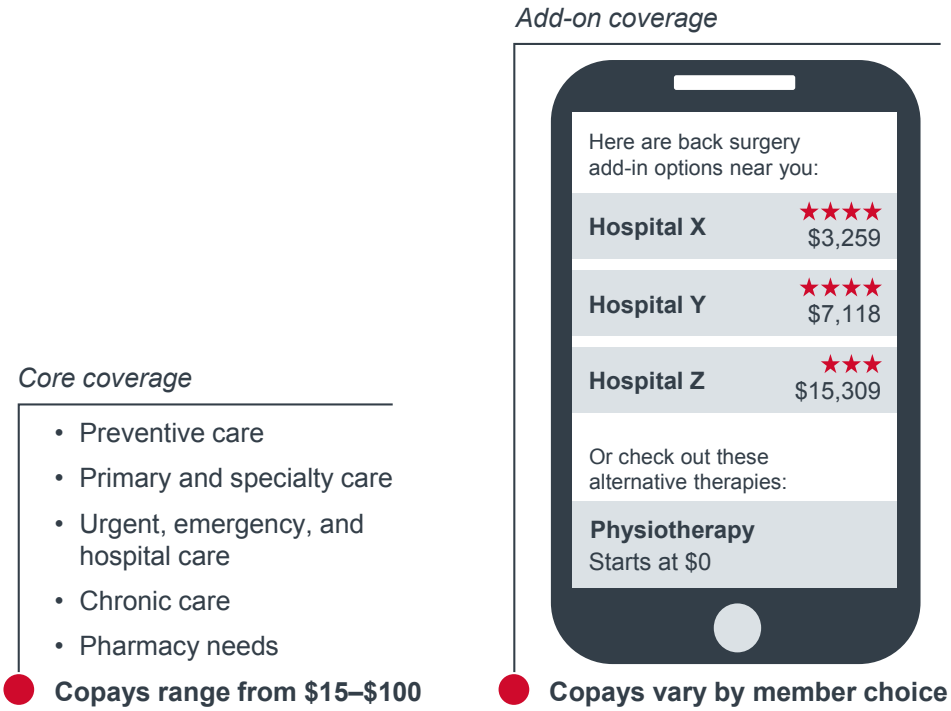
Predict procedure costs to guarantee prices for members up front

Guaranteed prices are the most daunting—and desirable—frontier. Bind Health has set out to eliminate the biggest plan vulnerability with members: unclear prices.

Bind is a new plan, currently operating only in the self-funded space, providing a new type of "on-demand insurance."

Bind members pay low premiums for a core benefits package which covers most health care services, including preventive, emergency, and chronic care. When a member wants a planned service that isn't part of their basic coverage policy, such as back surgery, they must buy it as an add-on benefit.

Bind Health's simplified product design differentiates elective care



Bind adjusts the monthly premium when members purchase an add-on according to the service and specific provider—so when a member buys that coverage option, the member is also choosing the provider they'll use.

Bind calculates these prices based on their historical data for that provider, including the range and variance of what that provider has charged for the service over the years.

Most importantly, Bind presents that price as the final, exact, subsidized price to the member, and it can be paid monthly, like a premium. Any deviation in the charges is absorbed by the health plan—fully eliminating surprise bills.

Source: Bind Health, Minneapolis, MN; Health Plan Advisory Council interviews and analysis.

Bind to just one price

Transforming the traditional insurance model for a different type of uncertainty

Bind is currently saving employers 10%–15% on their health spend. The plan is steering members to the more cost-effective providers by first forcing members to consider their options before getting a service, and giving them the exact costs when they make the choice.

Right now this is possible only in the self-funded market, where coverage regulations are more flexible. But opportunities for this type of price transparency exist through demonstration waiver options with government programs, and changes to the individual market regulations might open up more flexibilities for this model.

This is a new way of thinking about insurance; offering members clarity in what they're purchasing from the insurer. The old insurance model protects members from unexpected high costs; Bind's new model protects members from unexpected unknown costs. And in today's world, where care choices are unclear, that might be the more valuable form of insurance.

Bind Health's performance

$82M	10%–15%	75%
Funding raised as of June 2018	Savings for employers compared to previous plans	Of members have an account through Bind's mobile app

CASE EXAMPLE

Bind Health

Health insurance start-up with $82M funding raised (as of June 2018) • Minneapolis, MN

- Bind offers on-demand health insurance with a baseline core product. Coverage for additional plannable procedures not included in the core product is offered through add-on coverage, with upfront prices for treatments.
- Bind sets treatment prices up front using cost predictions based on each provider's historical average cost, clinical variation, and quality ratings.
- Members can see prices on Bind's mobile app; 75% of members have an account on the app.
- Bind boasts 10%–15% savings off traditional self-insured products.

Source: Bind Health, Minneapolis, MN; Health Plan Advisory Council interviews and analysis.

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