How Health Insurers Can Keep Talent and Cut Costs

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> **A confluence of factors means the time-tested approaches to cost control won't work. Insurers need to rethink how they achieve more with less while maintaining a strong customer focus and employee value proposition.**

Health insurers are no strangers to controlling costs. The persistent dynamics of aging populations, razor-thin margins, and intense competition have caused most payers to repeatedly transform their operations through multiple economic cycles, typically pushing harder on costs in bear years and emphasizing growth during more bullish periods. Over

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time, the industry has implemented waves of outsourcing, more robust medical management, and automation. But this episodic approach has left in place inefficiencies, stranded costs, and complexities that are harder to remove. The attacks on costs have also taken a toll on talent, which has endured the ups and downs of hiring sprees followed by workforce reductions.

As we enter an uncertain economy, the confluence of four factors makes the tactics that worked in the past insufficient to deliver the cost savings needed now:

- A new level of pressure on costs stemming from the current inflationary economy and heightened rate resistance among employers and members due to inflation and fear of a downturn
- Continued high service expectations from those same employers and members
- Increased competition from incumbent players and from startups and tech entrants increasingly well positioned to take share by addressing consumer and employer demands
- A talent scarcity that threatens the ability to deliver on day-to-day core services and impedes development of new technological capabilities

Taken together, these factors present payers with a challenge most have not seen before: the need to take massive amounts of cost out of their organizations without cutting staff. Instead, companies must eliminate or streamline basic tasks and redirect their employees to take on higher-value and, in many cases, new, more technology-based types of work.

Incumbents need to upgrade their customer-centric and digital capabilities to meet employer and consumer expectations and keep pace with sophisticated insurgents. Finally, renewed efforts at cost governance will make companies better consumers of products and services from third parties, enabling them to achieve more with less.

We see six moves that serve as the baseline for making this type of transformation happen.

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1. Eliminate No-Value Activities

Every company has activities of doubtful value, such as programs that are no longer aligned with the business's strengths or long-term goals. It's time to cut them. A zero-based budgeting-style approach, which applies a clean-slate, bottom-up methodology to resource allocation, can help companies reset their cost base and cost structure so they can redirect funds to their strategic priorities.

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> Rather than concentrating on how best to eliminate jobs, the focus must be on retaining existing talent and making the organization more attractive to tech-savvy workers.

Many payers are guilty of filling a walk-in closet with forgotten and neglected activities, including care management programs with negative or unproven ROI, products with nearly no members, and "wellness" programs that no one is actually using. While eliminating these programs might seem scary at first, employees will welcome the chance to spend their time, energy, and enthusiasm on tomorrow's health plan rather than yesterday's. The bottom line will benefit as well.

But remember this: in a tight labor market, it's more important than ever to think through in advance the staff impact of any cuts and the opportunities for retaining and redirecting those affected. Communicate these opportunities upfront so team members are not left to worry and consider the exit door.

2. Automate Low-Value Activities

Traditional payer value chains are being reshaped by exponential technologies that promise big improvements in capabilities and performance over a short time. Artificial intelligence and machine learning not only unlock trapped value, they create operating

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leverage in high-touch functions, such as member engagement and value-based care programs. These and other functions can be automated using existing interfaces and bolt-on tools. In addition to generating cost savings, such tools free up existing staff so they can be retrained or "upskilled" to handle more strategic, service-oriented, and value-added work.

Most payers can also exploit data more effectively. Leading companies have learned from digital natives and built modern technology and data platforms that enable small, agile, and independent teams to operate at speed and scale without being bogged down by platform and data interdependencies. They are also able to assess new platforms and technologies and determine how important they are in supporting business objectives—for example, in risk management, regulatory compliance, and growth. They use technology to automate handoffs between humans and between humans and machines in such functions as call centers and sales support. They use machine-learning algorithms to recognize patterns and data-driven predictive decision making to improve spending transparency and capacity management in areas such as claims analytics.

3. Rethink Medical Costs

Keeping medical costs under control while continuing to deliver the service and features patients expect is a multipronged challenge. Providers are wrestling with financial pressures. Many are operating in the red—some losses run into the billions—making it difficult for payers to use traditional utilization management techniques to keep tight control on medical costs. Pandemic burnout and the "great resignation" have hit providers especially hard, and they are being forced to pay up to replace vital staff. Shifting paradigms of care, such as home treatment and the use of remote monitoring, are further exacerbating labor cost pressures by increasing competition for nurses and medical assistants.

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mitigate fraud, waste, and abuse, while recognizing the need to balance cost reduction and customer service priorities. They also need to work with providers on the use of new tools, such as telemedicine, and on developing a better understanding of the underlying causes of health care needs, such as the social determinants of health and mental illness.

The full equation of the value-based health care paradigm, which measures outcomes relative to the cost of achieving improvement, has often been overlooked. Bringing consistent quality to care through the implementation of standardized quality measurement is now an integral function at most payers. But more emphasis needs to be placed on better outcomes, since these are what ultimately reduce spending and decrease the need for ongoing care.

4. Upgrade the Approach to Third-Party Expenses

Supply chain complexity and demand volatility have required payers to rethink spending with third-party service providers. This focus should take three forms:

- Building a cost control structure that examines spending across functions, creating greater ownership among business owners
- Maximizing savings opportunities across all spending categories by revisiting specifications, levels of consumption and waste, potential operating model changes, and other factors
- Looking for advanced solutions that go beyond traditional outsourcing, such as end-to-end partnerships that enable new models of cost effectiveness

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Cross-functional category management scrutinizes spending regardless of budget (thus combating the “As long as it's in my budget, I can spend it” culture) and helps develop a more cost-conscious mindset. Leaders can maximize ROI from such initiatives as marketing campaigns or automation partnerships while reducing contractor costs and encouraging overall transparency.

Enabling delivery of best-in-class care models through new partnerships requires a shift in thinking. For example, can partnerships with providers such as One Medical or CityMD lead to cost-effective and feature-rich plans for certain patient segments? Health care technology companies, such as Nuna, are working with payers to make more effective use of the wealth of data that payers have available in new-product and service design.

5. Streamline—and Flatten—the Organization

Payers can take a page from digital natives and organize themselves into flatter, more cross-functional structures. Leading companies in multiple industries are redesigning their organizations, and in some cases their operating models, to leverage combined human and technical skills. They work in agile teams that are given the autonomy to pursue designated outcomes, such as increasing time to market for new plan features or reducing call center wait times. These digital incumbents, as we call them, outperform their less digitally advanced competitors, delivering more value to shareholders, customers, employees, and partners. In the process, they focus the organization on the customer and give people the roles, coaching, and authority to deliver real results, making themselves attractive employers, maximizing the value of existing talent, and reducing excess attrition. They also speed decision making, eliminate redundant management layers, and focus managers on supporting frontline service delivery.

6. Embrace New Ways of Working

Companies are keen to bring people back to the workplace to regain the benefits of increased collaboration, creativity, and motivation, but many are finding that the best solution lies in a hybrid approach that leverages the advantages of the office and work-from-home models. This flexibility can appeal to employees and shrink overhead costs by

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reducing the need for office space. Smart companies will reexamine their real estate, procurement, and other SG&A expenses in light of the working model they adopt going forward.

At the same time, companies need to explore getting more done with the talent they have by creating incentives to increase workers' productivity or ability to perform additional tasks, for example, or providing education and training programs that upgrade their skills. Claims audit teams trained to work with AI can increase audit volumes. Call center reps with access to data and analytics can help patients make decisions at the time of the interaction. Reconfigured workspaces can improve collaboration and creativity.

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These sorts of changes help attract and retain staff, who appreciate the opportunity to improve their skills and deliver value. High-performing employees who enable differentiating capabilities for the company can easily walk away from what they see as knee-jerk or shortsighted cost cutting. Moreover, payers are now fighting with the tech giants and others for digital talent that they have not needed before. Company and workplace reputation matter more than ever.

Making the Changes Stick

These six measures form the foundation of a value-conscious enterprise and provide a checklist against which to measure progress. The big challenge for any transformation program, though, is making the changes stick. Cost optimization will fail if the organization does not change ways of working or reverts to old practices a year or two

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later. Management can take the following steps to help make sure the changes are embraced and long-lasting:

- Institute a new operating model, including clear governance and decision rights for ongoing ownership of fiscal responsibility.
- Set clear policies and target metrics for both financial and organizational health to maintain progress over the long term.
- Upgrade the planning processes so that progress against targets is transparent.
- Build a data infrastructure and metrics that make it easy for individual leaders to see the impact of their decisions and follow progress over time.
- Create a culture that supports all of the above, rewarding business leaders for making the right decisions as well as recognizing and incentivizing key talent for their contributions.

A cost optimization program can only be built on a foundation of strength. Incumbent payers have durable advantages over less experienced new entrants in many core functions, such as actuarial analysis, benefit design, management of the patient experience and outcomes (including Medicare Advantage STARS measurements), and the ability to manage complex B2B and B2C sales processes. Optimizing costs means building on these strengths. How and how quickly companies adjust, rethinking costs while maintaining a strong customer focus and employee value proposition, and will have a lot to do with separating winners and losers going forward.

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