Revolutionizing healthcare:

A how-to for payer digital transformation success

Capgemini

In brief

- Complex healthcare communications cause member confusion and payer inefficiencies.
- Simplifying products, standardizing documents and using AI/automation can improve operations and satisfaction.
- Digital transformation enables personalized care and proactive member guidance through integrated data.

Healthcare communications have become increasingly complex, creating challenges for both payers and group members. As a simple example, consider a member's frustration upon receiving an 18-page bill for a hospital visit in which only two pages contain relevant information – and there is no clear way to know where that information can be found.

Outdated systems and inefficient processes slow down payer operations and impact customer experience in a significant way. This is not a hypothetical problem: fully 85% of healthcare consumers consider communication highly important to their experience and 66% would consider switching providers due to poor communication.[1]

There are significant competing technology priorities for insurers impacting their ability to invest in better experiences for their insureds. As an example, in the wake of major security breaches many payers are dedicating over 7% of their IT budgets to cybersecurity.[2] These and other areas of focus result in the average healthcare organization relying on nearly 976 different software applications, many of which are outdated legacy systems.[3] These systems not only complicate data management but also slow the progress of digital transformation.

As healthcare systems evolve, payers must focus on modernizing their operations by addressing these legacy issues and embracing digital transformation. This will allow them to streamline communications, improve member satisfaction and enhance overall operational efficiency.

Challenges of complex health insurance documents

The current landscape of healthcare communications is riddled with issues that impede both member understanding and operational efficiency.

- **Lack of clarity:** Complex, confusing language in documents leads to misinterpretations, unexpected costs and diminished trust between members and payers. In fact, 51% of insured adults have at least some difficulties understanding their health insurance eligibility.[4] When members don't understand their coverage, they are more likely to seek unnecessary care or miss preventative care, both which only add to the burden on payers.

- **Increased workload:** Misinterpreted benefits cause members to reach out to customer service for clarification, leading to a high call volume, overwhelmed call centers and increased costs.

- **Operational inefficiencies:** Payers struggle to manage large amounts of data across disconnected systems, leading to delays in claims processing, incorrect data entries and overwhelmed customer service teams. For example, sending multiple explanation of benefits (EOBs) for a single treatment could cause more calls to customer service.

- **Customization and compliance:** Managing state-specific regulations and customized plans for large employer groups without streamlined processes makes document management more difficult. The larger the employer group, the more this complexity will grow with customization, increasing the risk of non-compliance or errors in communications as well as patient confusion.

- **System integration challenges:** Legacy systems and disconnected channels between providers and payers further complicate efforts to streamline operations and offer personalized, real-time support to group members. This could result in extended product development cycles for new healthcare and wellness products, for example.

Complex healthcare documents don't just confuse group members- they slow down operations across the payer's entire system. Inconsistent communication, data management issues and the challenge of keeping up with regulatory compliance make it difficult for payers to adapt to market needs quickly. When speed to market is affected, innovation slows.

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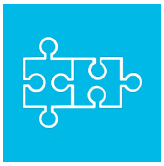
6 measures to simplify health insurance documents

Simplifying health insurance documents is essential to improve both regulatory compliance and member experience. Below is a step-by-step guide for payers to streamline their document processes:

Simplify insurance products and language- By standardizing the language used in product descriptions, members can better understand their coverage, reducing the chance of misinterpretation and unnecessary calls to customer service. Moving toward configurable, rather than fully customized products, allows for flexibility without overwhelming members with complex product lines.

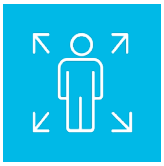
Improve document design and formatting- Key information, such as coverage details and claims processes, should be clear and prominently displayed. Documents like benefit booklets or EOBs should be concise, structured logically and stripped of complex legal jargon. For instance, 22% of members rate transparency and predictability as essential to improving their experience.[5]



Standardize documents across payers and providers- Standardized documents across groups and plans ensure consistency and help members understand their options more easily. Consistency across documents is critical. Payers must standardize member-facing communications to ensure the same format and structure are applied across all touchpoints. This includes aligning benefits documents with what providers communicate so that members receive consistent information at every stage.

Collaborate with providers to co-develop products- Payers should focus on reducing the complexity of insurance products by offering a core set of benefits with customizable options. Payers and providers should work together to develop products that align both medical needs and insurance requirements. This collaboration ensures better coverage, clearer communication and more aligned care for members.

Enhance content management systems- Investing in advanced content management systems (CMS) will allow payers to manage document versions efficiently and ensure that regulatory changes are reflected in member-facing documents in real time. This also helps prevent outdated information from being used, ensuring accuracy across all communications. Centralized content management systems ensure that regulatory updates are instantly reflected in all communications, reducing the risk of outdated information being used across member touchpoints.



Centralize member data and portals- Having all member information in one place makes it easier for both payers and members to access and manage. Centralized data eliminates the hassle of navigating multiple systems to find details, ensuring clear and consistent information. Modern member portals should bring everything together- policies, claims, and updates- in a simple, easy-to-use platform. This not only improves the member experience but also streamlines operations for payers.

Case study: Streamlining document automation

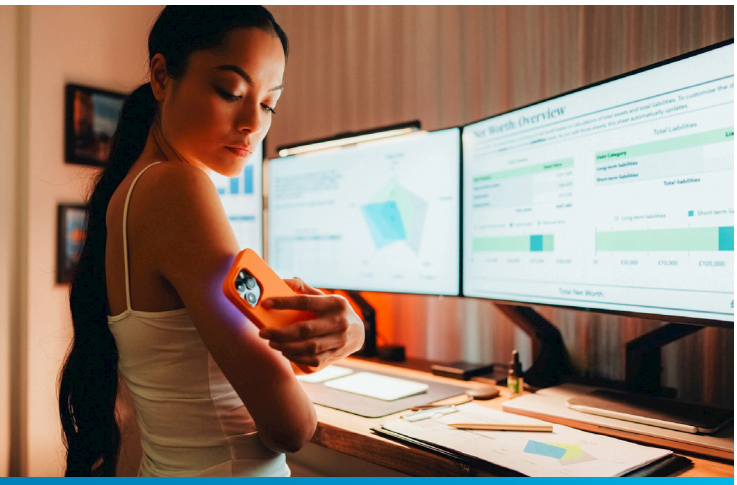
A leading health insurance company struggled with outdated tools and manual processes, which delayed benefit booklet production and led to errors in compliance. These inefficiencies impacted member satisfaction and increased operational costs.

The insurer implemented a document automation tool that centralized benefit updates and standardized language, ensuring accurate and compliant communications. Automation streamlined workflows, reduced manual errors and supported high-volume production during enrollment periods.

The initiative achieved a 40% increase in productivity and improved compliance turnaround times by 60%, while reducing training time for new staff from six months to one month. Member satisfaction improved due to faster access to accurate benefit information.

Automating document processes reduces compliance errors, improves operational efficiency and ensures members receive accurate, timely benefit details—critical steps in simplifying health insurance documents and improving member experience.

Streamlining data operations for improved business agility



Case study: Transforming member communication efficiency

A third-party administrator [6] faced high operational costs due to transactional member communications and low adoption of digital channels. Complex, paper-based processes led to inefficiencies and group member dissatisfaction.

By streamlining communications into a single digital portal and consolidating payment and claims information, the organization enabled real-time updates and member access to comprehensive healthcare data.

The transformation reduced operational costs by 46%, increased electronic communication adoption by 52% and tripled member satisfaction scores. This demonstrated the effectiveness of optimizing communication processes.

Streamlining fragmented communication systems drives operational agility, reduces costs and aligns with member expectations for faster, clearer access to their healthcare data.

To remain competitive, payers need to streamline their data operations by simplifying data structures, ensuring data integrity and leveraging automation.

- **Integrate simplified data structures**- Simplified, standardized data structures allow payers to manage information consistently across all departments. Standardizing treatment codes and other data points ensures that multiple systems work together, preventing misalignment between what members expect and what is documented. This alignment reduces friction when claims or service coverage details are processed.
- **Ensure data integrity and accuracy**- A centralized approach to data governance eliminates silos, allowing all departments- claims, customer service and compliance- to access the same data. This reduces the chance of manual errors and ensures that members receive consistent, accurate information. A single source of truth across all departments improves communication accuracy, preventing errors and minimizing delays in claims processing.
- **Leverage automation and AI**- Automation and AI tools, including Generative AI, can be used to monitor regulatory changes and flag updates that need to be made to member-facing documents. This allows payers to quickly adjust to new laws, streamlining processes and cutting down on operational costs. AI can also improve the speed and accuracy of claims processing. In fact, 47% of members now prefer digital communication methods like text messages, app links, or emails.
- **Track data changes with version control**- Maintaining version control is essential. AI-driven content management systems can track changes and ensure the latest documents are always in use. This prevents outdated versions from being distributed, ensuring compliance and operational efficiency and promoting transparency with group members and patients.

Benefits of simplification: Personalized products and care

Clearer, standardized documents help payers improve the overall group member experience. With simplified documents, payers can better tailor insurance plans to members' needs.

When documents are simplified, members are empowered to make better-informed decisions about their coverage. This allows payers to offer core benefits with add-ons that meet specific member needs without causing confusion.

By integrating provider data, payers can create a more comprehensive view of a member's health journey. This enables better coordination of care and allows payers to offer personalized recommendations based on a member's medical history and preferences.

Data is key to enabling precision care. By leveraging data insights, payers can develop personalized wellness programs and offer incentives for members to choose cost-effective healthcare options. AI and automation help tailor plans in real time, based on the evolving healthcare needs of members.

Nearly half (47%) of healthcare consumers believe Gen AI can improve communication, though two-thirds express concerns about security and ethics. Digital transformation addresses these concerns by implementing robust data security measures alongside AI-driven insights.

Case study: Streamlining SBC generation for better member engagement

An East Coast healthcare payer [7] faced significant challenges with an outdated tool and an inefficient process for generating Summary of Benefits and Coverage (SBC) documents. This created difficulties in displaying accurate, up-to-date plans and benefits information to members, ultimately hindering their ability to make informed decisions.

The payer implemented an automated SBC generation system integrated with a central data repository. This transformation included reusable content and rules, ensuring real-time, compliant information was accessible across multiple channels. The new system also supported member self-service, delivering personalized and accurate benefits information seamlessly.

The automated solution reduced the time required to generate SBCs by 50% and doubled productivity and operational efficiency. Additionally, duplicate content was reduced by 80%, enhancing the member shopping experience and providing a more transparent view of benefits.

Streamlining SBC creation not only improved operational efficiency but also empowered members with better access to clear and personalized information. This enhanced transparency strengthened member engagement and trust, demonstrating the value of modernizing document management for improved care and satisfaction.

In conclusion

The way forward for health insurers

As healthcare insurers streamline their operations, simplify products and integrate data, they position themselves to offer a more seamless experience for members. Moving forward, digital transformation, including AI and GenAI will help insurers combine administrative and clinical data, predict member needs, offering members proactive care recommendations and personalized products that enhance both health outcomes and financial sustainability.

By embracing these strategies, payers will be better equipped to meet member expectations, reduce operational costs and stay competitive in an increasingly complex healthcare landscape.

Meet our experts

Adam Denninger

Global Industry Leader for Insurance

Adam Denninger leads Capgemini's global strategy and product management for the insurance industry and manages its relationships with the insurance technology ecosystem. Adam has 20+ years of experience creating and delivering solutions at the intersection of business and technology.

Sanjay Pawar

Global Health Insurance Portfolio Lead

Sanjay Pawar leads Capgemini's global Health Insurance Portfolio, driving strategy and coordinating across Capgemini services to deliver thought leadership and GTM offerings in the health insurance domain. Sanjay brings over 20 years of expertise in crafting and delivering business-technology solutions.

Vicky Bhalerao

Healthcare Domain Expert

With 18 years of industry experience, Vicky specializes in product management and member-centric digital solutions, focusing on Collaborative Care Models and value-based partnerships to improve healthcare delivery and outcomes.

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