


Eight Steps to Exceptional Member Experiences for Health Insurance Plans

WHITE PAPER

Cincom In-depth Analysis and Review



SIMPLIFICATION THROUGH INNOVATION®



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Executive Summary

The health insurance environment has undergone significant changes over the past few years and continues to evolve at a rapid pace. Today's health insurance plans are not only facing the prospects of unprecedented healthcare reform that promise to impact every aspect of their business, they are also experiencing significant growth in the "individual market" due to increased job losses and smaller companies eliminating healthcare coverage due to rising costs.

At the same time, health plans are under intense pressures to improve the quality of services and deliver greater transparency to members, providers and other stakeholders. Those pressures come, in part, from federal regulatory mandates to do so as well as state-based pressures. All levels are being called upon to provide more responsive service to better collaborate with members and to become more proactive about improving member satisfaction.

These pressures are also the result of a broader marketplace environment where member and provider expectations continue to rise. People simply demand that they be able to get fast, accurate and consistent answers from their health plan, and they will clearly express their dissatisfaction if their expectations aren't met.

To make matters worse, members and providers now expect to be able to deal with health plans across many different communications channels including phone, e-mail, the web and walk-in visits to bricks-and-mortar offices.

Now is the time to focus attention on improving current operations and begin preparing for business growth in an uncertain reform-laden environment. Technology is the differentiator that health insurance plans should depend on to drive operational improvement and business innovation. And, with statistics showing that the member experience in the health insurance industry has not significantly improved in the last five years, improving member relationships should move to the top of the list. Together, innovative technology and superior member service can be the key drivers for successfully running and growing your business.

Fortunately, there are proven best practices that health insurance plans can adopt to optimize the quality of the member experience across all channels in spite of their limited resources. An exceptional member experience, after all, is primarily about delivering the right information to the right place at the right time. By getting better at delivering information, health plans can significantly improve services while driving down costs.

These best practices can be summed up in eight simple steps:

1. Give users a more active role.
2. Optimize IT's role.
3. Centralize templates and content.
4. Create once, use multiple times.
5. Empower frontline users.
6. Offer a multi-channel choice.
7. Listen to your members.
8. Review regularly/improve continuously.

This white paper outlines the eight steps that are being applied by health insurance plans to meet today's difficult member experience challenges. By adapting these best practices to their own specific situations, health plans can fulfill rising member expectations, comply with internal and external mandates, improve staff morale and gain deeper insight into conditions that impact their mission.

Member-Experience Challenges for Health Insurance Plans

“Member experience” is not a mere buzzword or overhyped theory; it is a concrete term that refers to the real, everyday interactions between health insurance plans and their members. Health plans that deliver a superior member experience are fulfilling a key aspect of their mission. Plans that deliver a substandard member experience are not and will eventually feel the wrath. The “experience” is important no matter if it’s a member, provider, employer, government agency or third-party administrator.

Health insurance plans must be able to provide the information members need, when they need it. They must do everything possible to ensure they deliver every time. And, they must have some way of measuring the quality of their member experience so that they take appropriate improvement steps as necessary. Unfortunately, health plans seeking to deliver a consistently excellent member experience currently face a wide range of challenges including:

Rising expectations – Companies like Zappos, Amazon, Southwest and Nordstrom have made exceptional customer experiences a core component of their business strategies. Customers’ interactions with these companies significantly raise their expectations about all aspects of service—including speed, ease, relevance and personalization. As a result, these expectations are projected onto health insurance plans as well, even though they may lack the resources or have unique regulations that guide how they interact with members.

Multiple communication channels – Today’s members want to interact across multiple communication channels including phone, e-mail, the web, fax, interactive voice response (IVR), interactive chat and/or walk-in visits to brick-and-mortar offices. This intensifies the member experience workload. It also presents health plans with the new, additional challenge of providing a consistent level of service and consistent information for members regardless of channel.

Constrained budgets – A downturn in the economy is reducing consumer spending, and thereby impacting the business’ bottom lines. In turn, businesses are forced to cut costs and this generally means layoffs. The result for health plans is flat or falling revenues that lead to tighter budgets for most departments. Even in cases where departments within the plan receive additional funding, that funding may be earmarked for specific purposes other than improvements in member service. As a result, health plans must typically come up with strategies for improving their member experience without hiring additional staff. In fact, they may even have to achieve such improvements despite staff cuts.

Legacy systems integration – Few, if any, health plans can afford the cost or disruption of a wholesale “rip and replace” of their existing information systems. Whatever initiatives plans implement to improve their member experience, they must be capable of effectively integrating with existing technologies and resources.

Retiring subject-matter experts – Many health insurance plans are experiencing a generational shift as their aging “baby boomer” staff retires. They take years of irreplaceable expertise and experience with them when they go. Such losses can have a significant adverse impact on service levels—unless plans can take immediate action.

Ongoing legislative/regulatory change – Health insurance plans do not operate in a vacuum. State regulations as well as a rising tide of federal oversights are not static and neither is the information they have to provide to their members and other stakeholders. This ongoing flux adds to the difficulty—and potentially, the cost—of delivering a standout member experience.

The bottom line is that health insurance plans must somehow overcome the member experience/cost dilemma if they are to optimally fulfill their business objectives. They must become more adept at delivering exceptional member experiences across all communication channels within their existing resource constraints. Having to do more with less is not just a saying; it is a way of life. And, to really succeed, they have to keep getting better at continuously doing more with less.

Eight Steps to Exceptional Member Experiences

Before embarking on any attempt to overcome the member experience/cost dilemma, it's important to understand exactly what constitutes an effective member experience.

At the core of any good member experience is information. Health insurance plans that can successfully deliver the right information to the right member at the right time via the right channel will achieve superior member satisfaction. Those that can't won't. Therefore, any effective member experience strategy will focus on communicating timely, consistent and personalized information where and when it is needed.

Yet, few health insurance plans have given any great thought to what is often their most common and consistent form of communication, their member correspondence. Health plans may do a better job of providing information to their members on a more frequent basis but still struggle to effectively engage with their members, often suffering from disjointed or inconsistent communications that also create satisfaction issues. Effective member correspondence ensures that members are engaged. An engaged member is a satisfied member.

Efficient, effective member correspondence isn't something health plans accomplish by just trying to get employees to perform tasks more quickly or by just implementing a piece of software. They have to have a strategy. A strategic approach requires health plans to understand who their members are, what their members want and how those needs can best be met through member correspondence. Based on this understanding, the health plan can begin to modify its member correspondence processes, policies and systems to optimize the member experience—regardless of resource or budget limitations.

There are eight proven steps that health insurers can take to implement these modifications. These eight steps are based on nearly three decades of experience with hundreds of clients and have repeatedly enabled health plans to break the lockstep relationship between service quality and service cost. They also provide a practical methodology for making the transition to more effective member correspondence management with minimal disruption to ongoing operations.

Step 1: Give Users a More Active Role

While effective member communications predominately and ultimately take form in documents, they always begin with the development of templates. And for the majority of health insurance plans whose member correspondence systems make use of proprietary coding languages and are therefore hard to use, the development and management of document templates is and still remains the domain of highly skilled information technology (IT) staff. It doesn't matter if it's welcome kits, certificates of coverage, pre-existing-condition notifications or Medicaid approvals/denials, IT has its own challenges and priorities, and these are not always aligned with users' needs. As a result, the delivery of timely, relevant and personalized content via correspondence is hampered by IT's responsiveness to the creation of new templates or the editing of existing ones. It's a conundrum facing health plans of all sizes, and it's further compounded as the plan grows.

Obviously, health insurance plans can only deliver information if they have empowered the right resources. More precisely, they can only deliver information effectively and efficiently if they are effective and efficient in the way they design, deploy, deliver and manage member correspondence. If the tools to create and deliver correspondence only exist in the hands of IT staff who are furthest away from the member, if they are scattered across a bunch of entirely disparate systems and databases and/or if they are supplemented by manual processes using everyday office tools, like Microsoft Word, then it will be difficult—if not impossible—for the health insurer to effectively and efficiently communicate with members wherever and whenever they are needed.

The alternative to such "hard-to-use" approaches to the design and delivery of member correspondence is new correspondence software solutions designed to move template development out of IT and into the hands of frontline users (e.g., member services representatives). By separating data mapping and query development functions—the domain of IT—from authoring and maintaining content, formatting and business rules that makeup correspondence—the domain of frontline users—the health plan can easily and quickly reap the benefits of focused specialization. Using a familiar Windows/Microsoft Word interface, non-technical users can easily design templates with complex logic, guided workflows, formatting and real-time data. Templates can be easily imported from other sources or created, edited and tested directly within a familiar Microsoft Word-enabled design environment—lessening the burden on IT departments and speeding time-to-market. Once created, these templates are then stored in a centralized repository and serve as the basis for personalized correspondence—from a complex administrative order to a highly customized notification containing barcodes, images and dynamic tables.

But this doesn't mean health insurers have to engage in a massive, costly overhaul of their information systems to create an easy-to-use member correspondence solution. On the contrary, with today's field-proven technologies and user-centric interfaces, a new wave of correspondence systems can be seamlessly integrated into a plan's existing infrastructure with minimal effort and disruption to operations. Now health insurers can more easily move correspondence creation and management out of IT and into the hands of frontline users who can ensure that their communications remain accurate, up-to-date and closely aligned with members' needs.

Case in Point: Molina Healthcare

Shortly after the implementation of a new member correspondence solution featuring a highly intuitive interface that fully leverages the content-editing and formatting capabilities of Microsoft Word, Molina Healthcare's correspondence authors became proficient in developing templates in record time. Within one week, Molina's two authoring professionals were able to easily design and deploy all of the documents required to correspond with members in real time. In addition, by taking full advantage of the solution's comprehensive facilities to test and preview correspondence directly within the authoring design environment, Molina's authors have reduced the time to develop templates from days to hours—and even to minutes in some cases.

Step 2: Optimize IT's Role

Getting the right information to members means starting off with correct information. Efficient, effective member correspondence requires the right resources accessing correct information at precisely the right time. With most health insurers storing information in a multitude of disparate systems from core administration to care management, automating data access/integration with existing databases and applications as well as empowering users at the point-of-need are the keys to delivering correspondence that is accurate, personalized and compliant.

But, unlike traditional systems of the past, today's member correspondence systems streamline the creation of templates through a roles-based interface that provides users access to only those features/functionality needed to perform their unique responsibilities. This separation of roles is important because it not only gives frontline users a more active role, it also provides IT departments with the "peace of mind" they need to feel comfortable with pushing more power to users' desktops. The tools to easily oversee and manage security, deployments, data integrations and system performance remain in the hands of IT resources. IT can now easily provide specific access rights to template development and production environments, allowing users to create, generate, assemble and deliver correspondence, while maintaining control over user settings, rights, languages, data integration and roles.



Step 3: Centralize Templates and Content

Obviously, health insurance plans can only deliver information if they have information. More precisely, they can only deliver information effectively and efficiently if they are effective and efficient in the way they accumulate, manage and provide access to information. If information only exists between the ears of their most experienced subject-matter experts, if it is scattered across the organization on users' desktops, if it resides in a bunch of entirely disparate databases and/or if it is completely uncontrolled, then it will be difficult—if not impossible—for the health plan to deliver it wherever and whenever it is needed.

The alternative to such "ad hoc" approaches to the accumulation, management and accessibility of information is the establishment of a central repository that is found in today's member correspondence solutions. A central repository provides the foundation to store and manage all of the content components used to produce document communications. This includes the approved, compliant templates themselves as well as document content, images, barcodes, address blocks, logos, signatures, business rules and database queries. Intuitive management capabilities allow users to easily create test sets to exercise templates for data inclusion/exclusion, data-driven logic and formatting before consuming vital production resources. Today's member correspondence solutions also include rich content-management facilities, including version, check-in/check-out, roles-based security and access control. Users can also directly compare content across different document template versions, providing a highly efficient and intuitive tool for rapidly reviewing and approving or rejecting changes to critical content.

Case in Point: One of Virginia's Largest Healthcare Management Companies

Serving over two million members throughout Virginia, this health plan implemented a member correspondence solution to centralize its template inventory and eliminated the need and expense of maintaining software on over 800 workstations in different locations. Frontline member services representatives have "point-and-click" access to a central repository containing templates with pre-approved content components, data-driven logic and pre-configured workflows that easily guide the assembly and generation of correspondence while interacting with members in real time—all from a standard web browser. This capability not only speeds response times but also relieves frontline users from the burden of having to choose which template to use for a given situation, which reduces compliance risk and ultimately improves member satisfaction.

Step 4: Create Once, Use Multiple Times

Once a central repository for templates and content is in place, health plans can begin to fully leverage it for delivering highly effective member correspondence. One key to optimizing the accumulation of information in a central repository lies in the creation of "reusable" components—including content, images, headers/footers, logos, business rules and data queries—that can be shared across any number of document templates. This "create-once-use-multiple-times" approach to content components has several benefits:

- **Speeds time-to-market** – Instead of having to sift through every template within the central repository to make a change to the same content, such as a logo or paragraph, over and over again, users can simply locate and edit the single, shared content component. At document generation time, the solution pulls in the most current shared content component into the template.
- **Simplifies management** – Rich audit and impact capabilities enable users to quickly determine which shared content components are in use, what versions are active and in which templates they are being used within the content repository.
- **Ensures compliance/branding** – Even if some components allow user edits, administrators can "lock" certain compliance- or brand-oriented components from subsequent changes.
- **Reduces the burden on IT resources** – Today's intuitive interfaces allow frontline users to effect changes across the entire template library with minimal IT involvement.

In addition to shared, reusable content components, another effective method to optimize the accumulation of information in the central repository is through template variations. In the same manner as content components, template variations allow users to easily develop multiple versions of a single template. These variations are combined into a single template master that further minimizes the number of document templates needed to support multiple jurisdictions, effective dates, languages, output types and delivery channels.

Case in Point: Medica

Previous to the implementation of a new member correspondence solution, Medica, a health insurance company serving over 1.6 million members in Minnesota, North Dakota, South Dakota and Wisconsin, was struggling with the development and creation of complex policies in high volume. Medica's IT department was spending in excess of 3,000 hours each year developing and maintaining document templates. After the installation of a new solution featuring a more intuitive user interface, Medica's IT department was able to decrease its involvement in template development and testing by over 90% as the majority of these functions are more efficiently handled by business users.

Step 5: Empower Frontline Business Users

Health insurance plans are now waking up to the fact that delivering a truly exceptional member experience through document communications isn't accomplished by simply responding to inquiries with generic correspondence produced in high-volume batch. Health plans also have to take the initiative and contact their members. Proactive document communication answers questions before they are asked and often solves problems before they occur. Health plans that get proactive about member correspondence also reduce costs because they are often able to pre-empt large numbers of separate phone calls and e-mails through a single, well-crafted outbound message.

Several aspects of proactive member correspondence are particularly important for optimally enhancing the member experience:

- **Segmentation** – Not all messages should go out to every member every time. Health insurers generally need to be selective about only sending member correspondence that's relevant to each individual member's needs. They do this by using their member data to segment communications by relevant attributes such as demographics, geography, current and historical activity or explicitly expressed preferences.
- **Personalization** – Correspondence with members should always be as personalized as possible. This personalization can be as simple as using the member's name in a salutation. But it can also be extended to other aspects of the member's relationship with the health plan including types of cases, account balances, upcoming deadlines, etc. This kind of personalized content can increase the value of proactive communications to the member and enhance their overall experience by giving them the sense that they are more than "just a number or claim" to the health insurer.
- **Timing and frequency** – Members do not want to be inundated with correspondence, so health plans have to be careful about the frequency with which they communicate with their members. It doesn't help to tell a member on the 24th of the month about a program that is only available until the end of the month. So health plans also have to be smart about the timing of their correspondence.

Health insurance plans need to acquire a variety of capabilities to be able to effectively manage and deliver proactive correspondence with their members. Obviously, they need member information to segment and personalize it. This is typically the domain of core administration, care management or claims management systems. But they also need collaboration tools for developing message content and a delivery

management system to ensure that messages get to the intended recipients. This is the domain of member correspondence solutions that empower frontline users with the tools to assemble, generate and deliver highly personalized correspondence in real time, right at the point of need. That way, even relatively inexperienced staff will be able to assist members and providers as if they were veteran subject-matter experts.

Case in Point: Wisconsin Physicians Service Insurance Company (WPS Health)

With the prospect of being awarded three new Department of Defense (DoD) contracts that would double the contact center staff and more than triple document volumes on the horizon, WPS needed a more efficient, dependable system with the scalability to meet the increased claims-processing workload, as well as the flexibility to address strict DoD service-level requirements. After the implementation of a new correspondence solution, WPS' claims service representatives utilize a standard web browser-based interface to select from over 120 document templates to dynamically assemble and generate correspondence in real time. With WPS' call volumes exceeding 25,000 per day, their document production has increased threefold to an estimated 4.5 million documents produced in the first year alone—with 1.5 million of those being generated "on the fly" as service representatives are interacting with claimants on the phone. Despite the rapid growth, WPS is able to generate claims documents faster and thereby reduce claimant call times by over 40%.



Step 6: Offer Multi-Channel Choice

Members today expect and demand service through whatever communication channel happens to be most convenient for them at any given time. They may receive a letter, send an e-mail with a question about their letter and then follow up with a phone call or walk into an office. Health insurance plans that don't have a good strategy in place for dealing with these channel-bouncing members won't be able to service them effectively and will often wind up operating far less cost-efficiently than they could.

To successfully serve members across multiple channels, health insurers must:

- **Utilize a single solution across all channels** – If members get one answer from a letter and a different one from an e-mail, they won't trust either one, and they definitely won't perceive their experience as being positive. Health plans need to leverage a single solution across all of their communication channels.
- **Manage all channels in a common manner** – Frontline users need to be able to see whether the member or provider they're helping has recently received correspondence and in what form. Health insurers want to avoid sending out an e-mail in response to an issue that has already been resolved with a previous letter. These examples highlight the importance of not treating each channel as a fragmented "silo" of communication—but instead managing all channels in a common manner.
- **"Use right-channeling"** – Health plans don't have to be passive in how they use their various communication channels. They can take steps to direct members, providers and other stakeholders to the channel that is most appropriate in terms of effectiveness and cost. This can be done, for example, by sending e-mails to members with links to the plan's web self-service resource. Hard-copy letters can educate members on the benefits of signing up for e-mail correspondence. By employing techniques like these, health insurers can reduce costs, provide better service and ensure that frontline resources are allocated to issues that really require personal attention—rather than on endless routine ones.

Health insurance plans also want to be careful about over-extending themselves by offering too many channel choices before they are ready to adequately support them. They should make sure that they are delivering quality member experiences with their existing channels and then add additional channels as appropriate. The right channels vary. Some health insurers may support e-mail, web self-service and mail while others may support phone, walk-ins and web self-service first. There are many factors in making these decisions, including the member's channel preferences and what resources are available to support channels.

Step 7: Listen to Your Members

Members want their voices heard—and they want health plans to act on their input. Health insurers also have a big stake in listening to their members, because they can only improve the experience if they know where it falls short.

There are several ways to capture member input. One is to do "batch" surveys on a periodic basis. This approach can be useful when considering potential changes to services or for performing broad evaluations of performance. But periodic surveys only help health plans discover problems long after they've occurred. They also tend to be relatively generalized and unfocused.

That's why it's essential to also capture feedback at "the moment of truth." This is done by sending out short surveys immediately following some interaction with the member. These short, simple surveys allow health insurers to find out exactly what members think about the experience they just had. The health plan can then immediately react to any problem that may have occurred—thereby rescuing the member experience, while also gaining valuable insight into potential shortcomings in work processes.

Health insurance plans should also let members know that they are responding to their input. This is done through personalized, individual notifications (letting specific members know that the health plan has responded to their specific input), targeted notifications (letting the members who have complained about a given problem or who use a particular service know about an improvement made based on their input) and general notifications (letting all members know about various improvements that have been made as a result of member input).

Real responsiveness to the member's voice is the result of a mindset that has to pervade the culture of the health insurer. This "listening culture" can be promoted in various ways such as holding regular meetings where frontline employees can discuss the kind of feedback they're getting from members, or rewarding member representatives who make good suggestions based on feedback with appropriate recognition or incentives.

Step 8: Review Regularly/Improve Continuously

A superlative member experience isn't achieved just by putting better service mechanisms in place. It's also achieved by continuously measuring and improving the effectiveness and efficiency of those mechanisms. That means that health insurance plans have to have ways of measuring the quality of the member experiences they deliver and set specific objectives for process improvement.

There are a variety of ways to measure member experience. One is to use traditional objective metrics such as first-contact resolution rates, average response times, average time to resolve an inquiry and transfer/escalation rates. Another is to get subjective evaluations from members. Evaluations can also be performed using member-experience "scorecards" such as the one at the end of this paper.

The specific metrics or Key Performance Indicators (KPIs) that a health plan uses will depend on their particular mission and objectives. However, there are some general principles that all health insurers should apply as they pursue continuous improvement in member experience:

- **Clearly communicate performance goals** – People are more likely to achieve performance goals if they understand exactly what those goals are. Metrics and KPIs should therefore be clearly explained.
- **Make metrics visible** – Desktop dashboards and whiteboard displays can help frontline employees track their own progress toward goals by creating an immediate feedback loop connecting behavior with results.
- **Reward achievement** – Health plans may be limited in their ability to provide bonuses or other financial incentives for performance, but they can still recognize it and reward it. Competitions between internal teams also provide a fun and effective way to motivate employees toward concrete, achievable goals.
- **Set new goals** – Goals should be periodically reviewed and adjusted as new performance levels are reached and as member expectations continue to rise. The performance of other health plans may also be a factor, as emerging best practices reveal just how well health insurers are able to perform.

These eight steps provide a powerful, proven model for improving the member experience. The best thing about them may be that they can be approached incrementally. Health insurers don't have to overhaul all of their processes and policies overnight. Instead, they can solve their biggest problems first. Then, building on that foundation, they can keep improving their performance over time until they also achieve standout experiences—despite resource constraints and competing organizational priorities.



Tangible Benefits for Tangible Improvements

To reap tangible benefits doesn't mean health insurance plans have to engage in a massive, costly overhaul of their information systems to create an all-encompassing member correspondence solution. On the contrary, with today's technologies, a member correspondence solution is best created by:

1. Capitalizing on the knowledge of your existing resources—IT and frontline users.
2. Leveraging processes and field-proven technologies that are already easily accessible within your organization.
3. Communicating based on member needs rather than internally driven schemas.

By adopting an ongoing, dynamic approach to member correspondence, health insurers can ensure that their document communications remain accurate, timely and closely aligned with members' needs. In fact, most health plans discover that a relatively large percentage of members' needs can be met with a relatively small amount of information—since members often have the same issues that need addressing.

With resources constrained—and with so many other demands competing for those constrained resources—health insurance decision-makers can only move forward with a strategy for an improved member experience if they can be sure that it will yield tangible benefits for both the health plan and its members.

The results achieved by other health plans that have followed these eight steps provide demonstrable proof that such results can be quickly and cost-effectively achieved. These results include:

- **Significantly improved member satisfaction** – Health plans that implement these eight steps are better able to communicate with members in a one-to-one manner that creates strong, positive relationships. The result is that members are more satisfied in the short term, and they remain more satisfied in the long term.
- **Better allocation of limited budget dollars** – Many of the best practices associated with these eight steps—especially those that support multi-channel delivery—enable health insurance plans to achieve substantial cost savings. These savings can be allocated to further improvement of the member experience or to other urgent priorities.
- **More effective fulfillment of the health plan's mission** – The ability of a health plan to fulfill its stated mission is contingent on its ability to inform members about

available programs, services and support. By enhancing the member experience, execution of an eight-step strategy ensures that this information delivery and support are performed with excellence.

- **Compliance with regulatory mandates** – All health insurers are being required to fulfill federal and/or state mandates for response, customer service and/or organizational transparency. The eight steps facilitate that compliance within time, resource and budget constraints.
- **Improved staff morale** – Health plans can't perform well if their frontline employees are discouraged and unmotivated. By empowering these employees to have real impact on the organization's performance—and by making that impact measurable and rewardable—these eight steps consistently result in noticeable improvement in staff morale.
- **Deeper insight into member needs and marketplace conditions** – Health insurance plans have to keep up with the changing needs of their members as well as broader changes in the economy, society, technology, etc. Implementation of these eight steps promotes this insight by enabling health insurers to better capture and act upon information about members and the world in which they live and work.

These benefits are available to any health insurance plan. The key to achieving them is to start with the first step. A standout member experience isn't something that happens overnight. It is the result of a methodical, ongoing strategy. But such a strategy typically starts yielding its initial benefits right away, as health plans become intentional about delivering exceptional member correspondence. And it is from this starting point that they go on to achieve the kind of operational excellence to which every health plan leader aspires.

About Cincom

Cincom delivers the most intuitive, member correspondence solutions in the industry. By streamlining the design, deployment, delivery and management of high-volume, highly personalized documents, Cincom has helped hundreds of organizations worldwide acquire, strengthen and expand member relationships, minimize compliance/regulatory risks, reduce operating costs and accelerate time-to-market for all of their document communications. With over two decades of experience, Cincom leads the industry in providing solutions that are easy to integrate, easy to use and deliver a rapid and continuous return on investment.

To learn more, visit our website at documentsolutions.cincom.com, or contact us at 513-612-2034.

Member Experience Scorecard – Baseline Your Experience Delivery

Quickly assess how you're doing when it comes to delivering an exceptional member experience through your document communications.

	Strongly Agree (5 points)	Agree (4 points)	Neutral (3 points)	Disagree (2 points)	Strongly Disagree (1 point)
Our frontline users have an active role in designing document templates.					
When it comes to member correspondence, the roles of IT and frontline users are clearly defined, separate and optimized.					
We have a central repository for storing and managing all of our content and document templates.					
We create components for our content (e.g., images, logos, headers/ footers) that can be shared/reused across our entire template library.					
Our frontline users are empowered with the tools to deliver member correspondence—in real-time and high-volume batch.					
We have the ability to deliver member correspondence according to individual member preference (e.g., mail, web, e-mail, fax and text/SMS).					
We actively conduct periodic, "batch" surveys.					
We have the ability to generate personalized, targeted and general notifications and letters on demand.					
We continually exceed our service goals (e.g., first-contact resolution, average response times).					
SCORE					

Summary statement: When it comes to delivering an exceptional member experience through document communications, we are _____.

Score assessment: 35-45 – A member-experience "superstar"
 20-34 – In need of targeted improvements
 0-19 – In need of broad improvements

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