MAJOR US HEALTH BENEFITS COMPANY
DELIVERING COST SAVINGS AND AN IMPROVED MEMBER AND PROVIDER EXPERIENCE

Accenture is helping a major US health benefits company to contain costs, deliver bottom-line savings, and help improve the customer experience. By focusing on process improvements, automation, and end-to-end value chain improvements, Accenture assisted in a $2.4M bottom-line improvement in the first year.
DEVELOPING COST SAVINGS AND AN IMPROVED MEMBER AND PROVIDER EXPERIENCE

OPPORTUNITY
This health benefits company faced increasing administrative cost pressures driven by health care reform mandates and challenges in designing and implementing new, cost-effective programs. To address these challenges, we implemented a value program to better leverage Accenture’s experience, technology, and analytics capabilities to contain costs and improve the customer experience, while also extending the existing eight-year BPS relationship for another seven years.

SOLUTION
• Targeted and delivered value opportunities across five business domains, assisted by knowledge of business processes and access to operational data.
• Generated insights for end-to-end value chain improvements in addition to process improvements.
• Implemented solutions to automate manual processes, improve processing time, increase the speed of claim overpayment recoveries, and improve payment accuracy.
• Defined a roadmap of strategic initiatives designed to transform operating models, develop new revenue streams, and apply analytics to capitalize on growth opportunities.

RESULTS
Accenture Health BPS is helping the company move toward improved business outcomes to create industry-leading health care value:
• In the first year, the program saved $2.4 million in administrative costs and medical costs.
• Improved benefit coding quality as much as 14% through implementation of automation and new processes.
• Improved claims productivity by 16% by eliminating non-value-added work and proactively identifying and avoiding errors.
• Eliminated more than 280,000 manual transactions across functions through upstream value-chain improvements.
• Improved member and provider experience by improving the quality and timeliness of claims payments and reducing the claims cycle by an average of three business days.