READY? PLANS MUST CHANGE MEDICARE MARKETING OR RISK MILLIONS VIDEO TRANSCRIPT
Hello and welcome to today's webinar: Ready? Plans Must Change Medicare Marketing or Risk Millions. Before we get started, I'd like to announce a few brief housekeeping details. Today's session is being recorded and an online archive of today's event will be available a few days after the call. You will receive an email from AHIP that will ask if you would like to receive the archive. Please respond to the email if you would.

I'd like to remind of AHIP’s anti-trust statement, and ask that you reference it in the Handouts tab. The anti-trust statement prohibits us from discussing competitively-sensitive information. Please keep in mind that you may ask a question at any time during the presentation by typing your question in the Question and Answer area on the right of your screen. Once complete, please press enter. Please refresh your screen at any time if you are having trouble seeing the slides presented in today’s webinar.

We're very fortunate to have with us today Scott Overholt and George Dippel. Scott Overholt is a managing direction in Accenture's healthcare practice, and a leader of Accenture Interactive. Scott's area of focus included consumer-centered healthcare, marketing strategy and design and implementation of consumer engagement across Medicare, Medicaid, individual and small-group markets to increase sales, retention, satisfaction and profitability. Scott is a national award winner for integrated marketing of a client’s first ACA campaign launch in 2013, and an innovator of Medicare age in marketing programs with an emphasis on growing digital independence.

George Dippel, senior vice president of client services at Deft Research. He’s brought 12 years of healthcare consumer market research expertise at Procter & Gamble’s renowned Healthcare Consumer Institute to Deft Research in early 2010. And since then, has assisted Deft Research with client-facing work, survey design, data interpretation and client consultation. His range in healthcare consumer research expertise spans Medicare Advantage, MedSupp, small group, ACA off-exchange, uninsured, [recording defect] and Part D. Over the past six years, George has been part of over 100 health insurance consumer quantitative research projects.

At this time, I would like to turn the floor over to Scott.

Scott:

Thank you very much, and good afternoon everyone. Good morning to our friends on the West Coast. I believe it’s still about 11:00 a.m. out there. It’s very nice to be talking about Medicare today, after the years that were consumed by the ACA and also with my partner here, George Dippel, who I’ve been working with for several years to look at important insights out of the research and to present to you today some creative responses to those.

We’re starting out with a little stake in the ground, that Medicare marketing is more important than ever before. There are 55 million beneficiaries, and most of what is happening in Medicare is both irrefutable and irreversible. There are 11,000 new eligibles aging in every day as the baby boomers continue to populate Medicare, even your 71-year-olds now are baby boomers. And they’re a little bit different than the generation before them. And it’s projected to grow by 75 million by 2030. And these are demographic facts that were established back in the ‘40s. And they’re not going to change very much.

And then also in an era of healthcare uncertainty, it’s strange to say, but Medicare is not only stable, but it’s growing. But it’s very hard to touch politically. And so we see a lot of clients now coming back to Medicare and looking at the fact that reimbursements are increasing this year, meaning there’s an opportunity for enhanced benefits or higher margins. And the market is just becoming very attractive.

So today, we’re going to talk a little bit about the people who soon be new to Medicare. We sometimes call them age-ins. We sometimes call our campaigns to talk to them, Turning 65 Campaigns or Birthday Campaigns. But we’ll see today why that concept needs a little bit of an update. Of the four million age-ins each year, perhaps 19 percent — perhaps even more of them — are delaying their entry into Medicare.

In fact, delayed retirement and delayed Medicare has become so substantial that Deft Research changed its methodology recently to include people over 65 in their age-in study. So when we get to George, we’re going to talk a little bit about this disconnect between the age of Social Security eligibility — which is now 66 — and Medicare eligibility, which remains at 65. And what
that’s doing to confuse and confound people’s decisions about when and how to get into Medicare. Those ages are no longer aligned.

And then the other phenomenon is, these folks are boomers and not seniors. So all age-ins now are boomers. They’ve been America’s economic engine for as long as they’ve been alive. They reject the senior citizen label, and they reject all associated stereotypes like silver-haired seniors on bikes with helmets in parks looking happy. That’s not an own-able or a differentiateable message, so we’ll talk about that a little bit today.

And they’re also accustomed to a more personalized engagement. Remember, these are folks that have had computing devices on their desktops for 30 years or more. And on their dashboards and in their pockets in the form of smart phones for 15 years. So they expect their information to be well organized, their experiences to be personalized, their interfaces to be intuitive and their approach to this to be easy.

There’s a phrase we use called “liquid expectations,” which means that people take the experiences that they have in one industry or from one vendor or merchant, and they apply those expectations to other categories — even categories that are less mature like healthcare. So they are, in fact, expecting those kinds of experiences from you.

So the two fundamental shifts that are affecting behavior are late retirement, and people are more and more digital all the time. Forty-eight percent, according to the Deft research, intend to wait until after their eligibility to enroll in Medicare. And 53 percent went online to shop for Medicare when near eligibility. So these are two unassailable and irreversible social trends that are conspiring to make marketing programs that center around the 65th birthday, and that invest heavily in non-digital media like direct mail, somewhat obsolete. The campaigns that hound you with direct mail from the day you turn 64 to the day you turn 65, and then shut off if you don’t enroll, are leaving behind these folks right here.

So the conclusion is that current marketing approaches are becoming increasingly obsolete. The linear path through direct mail, TV and call center at age 65 has been disrupted, so that the 65th birthday is less meaningful, and digital has taken over as the source of choice — proof to come from George.

And so the first step that we recommend is to shift from an aging focus to a new-to-Medicare focus regardless of age. You take into account the intent of the individual to personalize their experience so that you can capture the sale of those folks that are delaying Medicare, rather than ignoring them if they don’t at first respond.

So now to kick us off, George Dippel is going to walk us through the research. Following that, we’ll look how to make marketing more empathic and relevant to people’s actual intentions, and not just their birthday. George, I believe the clicker is yours.

George:

Well thank you so much there, Scott, for that introduction and that lead-in. As you heard, my name is George Dippel with Deft Research, and I’m here to share with you some insights from our most recent Deft Research age-in study. But before we touch on that, just a few broader comments.

For most carriers, when you think about new-member acquisition, there are an all-reality-possible, three paths to pursue. One of them is what we’re going to discuss, age-in approaches. Reaching out to consumers who are 64, 65 and 66, who may not be current members, but to bring them into your own coverage. A second approach, of course, is converting current commercial members into Medicare coverage at 65. And then a third approach, one that we’ve spent a lot of time discussing and investing in over the years, is gaming switchers during AEP.

Well before we get into our Deft age-in study, a couple words about AEP marketing and switchers. If we take a look at our most recent Deft Research Medicare shopping and switching study — a study that looks at the overall consumerism of consumers during the fall AEP — we can see the lay of the land as it relates to active consumerism with today’s seniors. The left side of this slide shows us different consumer segments, and how they participate. The headline of this slide tells us that 70 percent of consumer — seven out of 10 seniors, whether they’re in
Medicare Advantage, MedSupp, original Medicare with or without a Part D plan — seven out of ten of today’s seniors were in active participants during the most recent AEP.

We all hear from our bosses about the thousands of Medicare eligibles that are there for the taking every fall. We can see on census reports, the 50 or 100 or 150,000 Medicare eligibles that are out there that we need to market to. But in all reality, only 30 percent of that total are truly addressable seniors who will participate with some sort of shopping activity. In all reality, whatever that census number tells us is the total of Medicare eligibles, we need to multiply that by a factor of 0.3. Thirty percent represents the total active number of today’s seniors.

Now a little bit further down on that slide, we can see in the text box, what is today’s actual switch rate? Again, for all of Medicare — MAPD, MedSupp, Part D combined — the switch rate is only nine percent. So if we use a factor of 0.3 against the total Medicare eligibles in our service area, we need to use a factor of 0.09 when trying to calculate how many folks will likely be switchers. Switching in this market for AEP is down.

Part of the reason it is down, is due to what we can see on the right side of this slide. On the right side, we can look at year-over-year comparisons of what actual AEP switching looks like. Folks can switch a lot of different ways — from MedSupp into MedSupp, from MedSupp to MAPD, and original Medicare only into MAPD. Well the lion’s share of switching has always been MAPD to MAPD. We see that in the top right of this slide, representing 54 percent of all switching that occurred last AEP. But that number is slightly down from what we saw the year before, 61. And if we compared it to another year before, it's down from 64. The fact of the matter is, there is less MAPD switching this year, and that is putting pressure on age-in strategies and AEP strategies alike.

If we take a look at switching data, trended over seven years, we can see just exactly what is occurring in the MAPD space. On this slide, the blue line represents MAPD switching over a seven-year period. Now from 2012 to 2015 — the house [inaudible 0:12:20] days of AEP marketing — we saw switch numbers from 20 percent up to 23 percent. That means every AEP, carriers and agencies alike, had their pick of the litter with one out of five, or almost one out of four MAPD consumers switching. Those were good times.

Why was switching so high? Why was AEP enrollment so relative easy? Well, because benefits were instable. During that period of time, we had a lot of private fee for service plan exits. We had a lot of changes to network. We also had a lot of changes to formulary. In many cases, we moved up to a fifth tier. We had preferred and non-preferred, not just brand but also generic. And with those changes came October 1st and messy ANOC that seniors read.

When seniors would see their annual notice of change letters, and see multiple different changes to their plans, that spurred them into action. We didn’t see 70 percent inactivity back then. But what has happened since that time? Since 2015, that switch number has nothing but go down from what was 23, to 18, to 14 now today to just 11 percent for MAPD. Why the decline? Benefit stability.

During these past few years, CMS reimbursement has been at par or above par industry expectation. We also see more carriers today, and more eligibles, in four-star plans. And at that four-star quality threshold, the five percent quality bonus payment comes into play. Any time carriers have more wherewithal coming in from the government, it affords them the opportunity to hold the line on benefits and hold the line on cost shares. That means we’re not sending out messy ANOC October 1st.

Instead, seniors see clean ANOC. Your benefits, your network and your cost shares are the same this year as last year. To a senior, that gives them permission to not shop. Hence why we’ve seen that switch rate decline all the way to 11 percent.

Now our bosses make comment on the six million more Medicare eligibles that are out there. And why can’t we bring more of those folks in during AEP? Well even though there’s six million more Medicare eligibles these last three years, when you have the switching rate that means there are actually 1.3 million fewer switchers out there. And we’re all going after the same ones.
The truth of the matter is, the three pathways to build enrollment — AEP switching, commercial group conversations and age-in programs — it really now is becoming more of two pathways. We simply can’t win during AEP like we used to due to benefit stability. That means we have to hit a grand slam when it comes to age inactivity.

Now if we move to our age-in study, we can see two trends that we follow at Deft Research to help us understand when consumers are ready to be marketed to. Trend number one on the left, unemployment data. Said plainly, consumers have to stop working before they get serious about Medicare. Trend two on the right, taking Social Security. Let’s start on the left.

The left-hand chart shows us historical data from the US Department of Labor spanning 17 years. And that blue line represents age-in unemployment risk. Well if we look at 2011-2012, we can clearly see that was not a good time to be employed as an agent. In fact, your unemployment risk was three-and-a-half times higher, and significantly worse for consumers who were below age-in years.

Let’s walk a mile in those folk’s shoes. It’s right before the recession. You’re planning on three or four or five more years to pay down debt and to build up your 401(k). Suddenly the recession hits, the rug is pulled out from underneath your feet and you have no income and two much debt. What did these folks do? Well they did what we all would do. They tried their best to find replacement work. But at that age, during that high of unemployment, very difficult — if not impossible — for someone in their early 60s to find similar benefit paying work. So these folks did what they could then do next. They took unemployment. That unemployment helped, but it ran out after 52 weeks. Now what?

Well the now what is what we see on the right side. Taking Social Security early. Folks back in 2013 had no choice. Their income dried up. Their unemployment checks stopped. In order just to sustain, they had to get some sort of income. And we see then that nearly 50 percent of age-ins took Social Security as soon as they could — at age 62. They had no other choice, even though that meant they would have less financial wherewithal in terms of Social Security payments the rest of their lives.

Well what’s happened since then? The left side tells us that since 2012-2013, unemployment has come back down. In fact, right now we see unemployment at historical lows. That manifests itself in fewer consumers being forced to take Social Security early. We don’t see 50 percent of age-ins taking Social Security benefits at 62 anymore. In fact, that number’s been cut in half to just a quarter. More folks, instead, are going out to 66 — full benefits — or even trying to push all the way to 70 — max benefits.

The fact that employment is better and is not forcing consumers into Social Security early means that fewer folks are ready to come into Medicare “on time.” This next slide demonstrates that. Here the blue line shows us over five years, the percent of 64-year-olds who plan to come into Medicare “on time” around age 65. Well just two short years ago, two-and-a-half years ago, if we were to follow a basic marketing tactic of buying a list of consumers age 64 and mailing to them, we could rest assured that any such lists we would buy would be “73 percent good,” meaning 73 percent of the names and addresses would be of folks who planned to come into Medicare on time.

Well now that the economy has improved, and fewer folks are taking Social Security early, that same tactic that worked 73 percent of the time now only produces 52 percent good names. The fact that folks are working longer means that any such list that just focuses on age 64, has been reduced in efficacy by almost a third. This means we need to explore what the new definition of age-ins is, and how we need to think about them in terms of the overall pie.

This slide shows three different designations of age-ins that we use at Deft Research — traditional IET age-ins in the blue — folks who plan to come into Medicare around their IEP or initial enrollment period, 64 and 9 months to 65 and a quarter. The yellow are what we call Social Security age-ins. They didn’t come in during their initial enrollment period, but they may come in sometime around age 66. Their 65 and a quarter to 66 and a quarter. And then in gray, we have the truly late to Medicare — folks older than 66 and a quarter who did not come in during the initial enrollment period, nor did they come in around 66 and full Social Security.
Well who should we focus on today? Clearly, we still need to work against the blue section of this pie. There are still a lot of consumers, 52 to be exact — 52 percent to be exact — who are 64 to 65 and a quarter and plan to come into Medicare “on time.” We still need to start early with age-in campaigns. But what about the yellow green? What about the folks who did not come in during their initial enrollment period who are 65 and a quarter to 66 and a quarter — so-called Social Security age-ins. Well our data tells us six out of ten of those plan to come into Medicare within the next 12 months. We need to focus on them.

Well what about even extending this longer? Folks who we say are gray — late to Medicare, older than 66 and a quarter. Here’s where it gets dicey. Only 20 percent plan to come into Medicare within the next 12 months. Hard to find a good ROI after we push it out past 66. So with this, our new thought or definition of the addressable market — the folks we want to target — really spans a 27-month window. From 64 for commercial conversion campaigns, all the way to 66 and a quarter — a full year after the conclusion of the initial enrollment period.

Now when we go after these folks, when we target these people, how do we need to address them? Well we also take a look at the channels that people use when they shop as they age-in. And on this chart, we can see the three most prominently sited areas that age-ins pursue when it comes to shopping. They ask trusted friends and family, the go online — and yes — they still do read direct mail.

But if we take a look at these top three shopping areas, we can see on the farther right how much actual time is spent with each. Sure, six out of ten folks are going to read their direct mail — the same as that go online. But folks are generally spending two times the amount of time online as they are versus any other shopping channel.

If we think back to our consumers, and we go on our 27-month window — again, 27 months starting on the left, age 64 all the way to now 66 and a quarter, that new age-in period. We can see popular shopping channels show here. Now in the red, when folks are shopping online. In the blue, when they’re reading direct mail. Yellowish-green, agent. And in the purple, attending a seminar.

Now this out-of-mind depicts traditional IEP age-in campaigns. Initial enrollment period, let’s say 64 to 65 and a quarter. The dotted then transitions into those Social Security age-ins, 65 and a quarter up to 66 and a quarter. Well whether we’re talking Social Security age-ins or initial enrollment period age-ins, the same truth exists. These aging consumers are 10 to nearly 20 percent more likely at any time point during this 27-month interval, to be shopping online versus reading direct mail.

Now with that, I’m going to transition back over to Scott. And then we will be back at the end for questions and answers.

Scott:

Thank you, George. It’s always fantastic when a researcher hands a marketer insights like those. So, we’re going to talk a little bit about how we take those insights and make them into profitable new campaigns. I think on the prior side, it talks about personas and this one talks about personalization. Personas have been with us for a while, some done well and some quite overdone, to the point of being silly. But they’ve been useful to help health plan marketers get into the lives and the heads of consumers, which is something that we as an industry had to deliberately do.

Consumerism, as a word, was necessary as sort of a North Star to completely turn these ships in the right direction, towards the consumer. And with today’s marketing communications technology, we can go quickly from personals to true personalization of the customer journey based on the intent of the customer himself or herself — intent, for example, to take or delay Medicare at age 65.

So to quote Forrester, “To succeed in today’s digital environment, firms must deliver smarter, more customer-centric interactions that feel like they were tailored for each user and his or her specific set of circumstances.” And circumstances is what we were just talking about. Now this was written for all industries, but it applies in particular here.
So we have two groups of people now. We’re starting to get into personas a little bit. The current approach is primarily focused on people who are ready to buy at age 65. That’s the current target, and we can call them the ready ones. But it often ignores people who are not ready to buy at 65, so we call that not ready. And when I talk to other marketers, whether they’re with plans or with agencies or other organizations, we talk about this ready versus not ready, because it’s sort of easy to understand now that there’s a big piece of people who are ready, a big piece of people who are not ready. And then non ready are a missed opportunity, because they do want and need information now so that they don’t make mistakes.

All this dictates a new approach to Medicare and new-to-Medicare marketing. So it resets it to ready to buy versus not ready to buy and understands that we have two groups of people of equal — almost equal — importance. So you personalize an approach to be relevant and helpful to the ready and the not ready. It puts digital at the center of engagement.

That bar chart that George showed could not be more compelling about how heavy the usage of digital channels are by these baby boomers who have had technology in their lives for decades, and how much time they spend on it, but how under-invested a lot of our industry is in digital channels. And it replaces digital point solutions, which most of us have, with integrated digital-driven Omni-channel journeys. And then it creates an automated personalization engine to streamline those journeys based on your intent.

So we’re back to our personas. Now on the left, under the ready column, we have Tom. He turns 65 in October. He was laid off in 2013, struggles to find a job. George described these people in very clear and personal ways during his own talk. So you understand what’s happened here. He applied for Social Security at 62, at his first opportunity, and he enrolled in an ACA individual plan for medical coverage. This age group — 55 to 64 age group — had the highest update of ACA coverage. It bridged the gap for them between the healthcare they had and the healthcare they were about to get when they aged into Medicare. Medicare will be seen as a welcomed thing for them, because it’ll be like getting a raise. Their Medicare premiums are bound to be far less than the ACA premiums at their age. So they’re ready. They’re really ready.

Emily turns 65 in November. Her home and investments lost value in the recession. They’ve recovered, but not increased in value since 2008. So for ten years, she’s sort of been treading water. She receives medical coverage through her employer with her spouse, and the spouse will not turn 65 for another two or more years. So she’s not ready. She’s not ready to get into Medicare. She’s not ready to stop her spouse from healthcare coverage, and have the spouse be on their own.

So now what does a new personalization look like given these scenarios? I’ll take you through a few things. I’ll take you through paid media. We’re going to look at what can be done with the way a website responds to a person’s information. And the nurturing campaign once a person is engaged. And all of these things are going to be driven by an ever more personalized experience based on information and intent of the individual user.

So what does this look like for Emily? First we’ll talk about paid search. Emily searches for, “Do I have to sign up for Medicare at 65?” Now she, Emily, got a Medicare card in the mail with probably a six or eight-page letter telling her about all the things that she has to do and all the consequences for doing it wrong, with a couple of caveats that say, “If you fall into this category or that category, maybe this doesn’t apply to you.” Go online and such, and so she does. “Do I have to sign up for Medicare at 65?”

But what you see here would be a search result that takes her question itself into account. When I’ve done this search different places around the country — so no matter where I’m geo-located. I almost never get a commercial response at the top. It’s always Medicare.gov, SocialSecurity.gov, Wiki.pdf and those sorts of things. There’s nobody out there that is developing a paid search routine for someone who’s asking this question to bring them into the fold and make them a source of engagement for a person who has this question, needs an answer and is going through this process.

So, Emily’s been searching. She’s gonna be retargeted again. Now we have paid media. She happens to like thenewyorker.com. I know this is a little hard to see. This presentation is typically animated, but the animation is not functional on our software here, so that’s my
disclaimer. But that little ad at the bottom right screen says, “Delaying Medicare and still working? Click here to find out what you should do.”

So again, it’s not something that says, “Oh, she searched on Medicare. Let’s pump her with shop, shop, buy, buy, zero premium, zero premium. Let’s make sure that we are delivering her content and offers that are still relevant to her intent to delay Medicare. And a website.

So Emily lands on a personalized website that greets her by name and shows repopulating custom content based on her attributes and input. This is assuming now, Emily has become known to us. But if she’s unknown, it will personalize in the way I’m about to show you, except calling her by name when she first gets there. And once again, this should be animated. I’m going to click through it, and I hope it goes fairly smoothly.

So Emily gets onto the website. In this case, Emily is known to the website — greets her by name. And it gives her some questions to answer. Are you enrolling in Medicare at age 65? Now in this use case that I’m describing, Emily doesn’t click any of those things just yet. She scrolls down the page — in my animation, this scrolls — and she says, “Oh, Medicare eligibility is your rewards for years of hard work. I’m ready. And I’m not ready.” So it’s giving Emily an option, an option that pertains to her, even though we don’t have a lot of personalization — she hasn’t told us her intent. We’ve given her the opportunity to show us her intent right away.

She scrolls down again and says, “Well I can get a free packet.” No, not yet. I’ll go up and answer these questions. So she goes back to the questions and are you enrolling in Medicare at 65. And she clicks, “No.” The next question asks here, will you be working past age 65? And Emily clicks, “Yes.” And this information is going into a record, or even like a DNA-type genome on Emily so that every time she enters a question for us, we have more information with which to personalize.

So she’s clicked on “Yes,” for working after 65. When do you plan on enrolling in Medicare? And she’s going to say, “Two or more years.” And so now the website has scrolled down into that same territory that said, “Ready,” or “Not Ready,” before. But the page has changed. Okay, you’re still working. You have options. And it tells her what are the rules, click here to learn more. Cause she remembers reading something about rules and penalties when the letter from Social Security came. Or watch a video and meet Angela. She’s 67, and not ready to stop working yet. So this is all very relevant to Emily’s situation.

Further scroll down shows and infographic that shows that this company — we’ll call it GeneralCare.com — knows that there’s more than one person like Emily out there. That she’s not buy herself, and that General Care knows how to help her through her own personal process.

And then as Emily opts in for more information from General Care, she gets a nurturing screen via email that again, recognizes her status as not ready, greets her by name, allows her to meet members, do her Medicare prep work and of course, when she becomes ready, to switch and get started and move into the learn shop and buy stream for those who are ready for Medicare. And so this new approach would make Emily much more likely to enroll with that company, than had they not personalized based on her intent and kept her engaged throughout her whole process.

So, mapping this new Omni channel plan. The typical age-in program supports this path from awareness to being plugged into the process to sorting things out to selecting your company and your plan to committing via enrollment in the very linear way that toggles back and forth a lot between phone and mail, phone and mail. Under the sorting part, there’s search and there’s Google and there’s the sort of one-off Medicare websites that a lot of companies put up to put up things like products and required information that the government makes you, makes you put there.

But this is what most agent programs are built to do — print the list, send the mail, take the call, get the enrollment. And that worked link gangbusters for a while. But everything has been disrupted now by A, the availability of digital channels and B, the preference for digital channels that the market is now showing. So there’s a lot more to pay attention to with about the same budget.
So as such, there will be many — and not one — ways to customer interact on their journey to enrollment. These are new channels that are being employed in real life. And investment in many of them does not match their importance. And the lack of integration of them is obvious to any consumer who buys from Amazon five times a month. Amazon learns about you with every interaction. They build a genome — a digital genome — made up of the behavioral building blocks of your unique customer identity. So recognizing the fact that you have multiple journeys now, the first real thing to do, is to figure those journeys out. And we’re about to get to the recommended next steps in just a slide or two.

A couple other facts I threw in there from the Deft Research — so George didn’t present these, but I am, because I think that they’re fascinating for marketers. But the first one is that most people that are aging into Medicare, whether they’re doing it at 64, 65 or 66, are already insured and want to stay insured. The ACA in particular plugged that uninsured gap for that particular cohort. And so only nine percent of people who are getting ready for Medicare are now uninsured. The implication there is they need less education on the value of insurance. They already knew it, they’re paying premium prices for those ACA plans. So focus on education about Medicare itself and products and process.

The second one, George sort of mentioned this, the people who are your commercial members who are aging in. The majority of insured age-ins, particularly those in group plans, don’t know that their current carrier offers Medicare insurance. And that’s a silo issue. So the implication there is to protect, support and concert the membership you already have. Try to break down your silos and keep these people as a lifetime member not just a current member of this plan who might someday get the other plan.

And the last one is, there really worried about making the wrong choice. I see this all the time. I’ve spent a lot of times with people who are getting ready for Medicare and see how they fumble around with Part A, Part B, Part C, Part D charts that we put up there, and make them try to interpret. So just understand it. They’re worried about making the wrong choice. They’re gonna be worried about that before they buy. They’re going to be working about it at the moment they buy. And they’re gonna be worried about after they buy during their onboarding process, which George, I think is another talk altogether from some of your research.

So this can be sort of our North Star. This is what people really are looking for out of their digital experience. Forget the technology. Forget the regulation. Forget the product and the category. It’s, they want it to be easy. They want you to know me. They’ve interacted with you. They’ve given you information. You know information. Act like you know that you know them by giving them value, giving them something that’s highly personal, and giving it to them now. This can be the North Star in the scorecard really for everything we do as an industry in this area.

So finally, some suggested next best actions. Understand your current state. Understand your customer journey options. Look for their points of friction. And develop some KPIs other than response and conversion. You really want leading into care, so neither are trail-in indicators. By the time you have your response and conversation numbers, the journey is over and there’s really nothing that can be done about it. So look for leading indicators such as where the bounce is. We see a lot of bounce going from product description to product enrollment, and that’s the phone rings. And so looking at some of those areas is very important to help fulfill the promise of your digital tools, where the digital tools are not quite perfect yet.

Know your target. So combine internal and external data. And develop productive analytics. You can capture, and you can use behavioral data and preferences into a genome to develop personalization based on intent and based on other things that we could gather as well. Up your channel options. And so the indication here is to create a seamless brand experience across channels, rather than simply point solutions. You see so many times that, well, we need a mobile app. Or we need a portal for this. But the transition between the call center and the portal or the app back to the call center, is often not very good, not very satisfying and very frustrating to the customer.

Nowadays, the experience that the customer has is as important or more important as the products. As George mentioned, most of them are four star, most of them are high benefits, a whole lot of them are zero premiums. So the experience is the differentiator.
And then finally, redefine your offers. Establish test and learn capabilities and plans that’ll help you know with certainty what certain cohorts, or what certain individuals within those cohorts, really like and respond to. The investments in the technology make all of this possible. Battle Lakes, Adobe, Salesforce, what have you. This is a perfect use case to extract value from those investments, while increasing the value you show the consumers.

So that concludes our discussion. It leaves time for questions and answers, and...

Facilitator: All right. Thank you very much.

Scott: ...why don’t we go into that phase now?

Facilitator: At this time, we’re going to address some questions that came in during the presentation. Our first question for today is from Susan. Even though digital tools are provided, we still see tremendous phone volume. Why aren’t our digital channels helping with that?

Scott: I’ll take that one. I think that that actually relates to another one that we got down below. It says, “Although many are using the internet, how many are actually purchasing via the internet versus the agent?” George can help with that one, so I’ll take the first one.

I think because a lot of the mindset has been around one-off, digital tools and not designed online/offline experiences. So companies have been rushing to go digital without a North Star from Medicare. And in some instances, behaving as if this research that we just presented is fantasy. Basically, they won’t believe it. There is an age-ist kind of approach, again, stereotypical seniors who are a little less capable, a little less mentally capable. A little less digitally capable. That is wrong. People turn to phones now, I think, because the phone is easy and the digital journey in our industry is not, especially for this demographic, which tends to get the digital crumbs most of the time.

So they bounce from the online experience, and when it becomes clumsy, they call. They ask questions and get answers. And that trains them to continue to call because it’s easier to get answers to the questions that way. It’ll be interesting, as Alexa gets better for example, to see if Alexa becomes this middle ground between the screen-based online digital experience and the voice-based online digital experience.

George: And Scott, I guess I’ll take the second part that you alluded to there. Why are people buying online or aren’t they? Our age-in research shows that at most, you might get maybe up to 30 percent of folks as they age-in to Medicare for the first time to finish that enrollment application online. Now that number has grown over time, primarily because if we think about someone who’s 64, they’ve been conditioned over the last ten years to enroll in health insurance online. They’re coming from the ACA, that’s how you’ve done it for the last five years. If you have commercial group coverage through your employer or your spouse’s employer, you get an email every fall. Click here, pick your new benefits for the next year. So I think we have conditioned consumers to think about enrolling online. And up to maybe 30 percent when they enroll into Medicare for the first time, are online. But once you come into Medicare, and it’s time to make a switch, it all changes then. Uh, I may feel comfortable enough to try to enroll in Medicare that first time — maybe like 30 percent of consumers — but if my health has deteriorated and I need a new plan, or my plan has changed. My coverage this year, I’m told on my ANOC is much different than it was last year.

When those things happen, that’s usually when consumers want the power of a professional agent, broker, health plan representative to guide them. We see, when it comes to AEP switches for MAPD, that 75 percent had some degree of human assistance. And only may be 10 to 14 percent are enrolling online, switching online. So I think it’s a good question. Not as many folks may be switching online. They’re shopping online, no doubt about it. We see more trying to enroll online, at least initially. But once you’re in Medicare and something is wrong with your health or your coverage, you want a professional to handle that.

Facilitator: All right, our next question. How has the timing of age-in shopping changed over the years?
George: I’ll take that one as well. You know, if we go back — some of the slides that we showed — talked about how consumers as early as 62 or 63 or 64 were suddenly thrust out of the workforce, and kicked into unemployment, and really biding their time until they were eligible for Medicare. Well if you’re out of work, retired early, and anticipating coming into Medicare right around 65, you can believe that those folks were more actively shopping at age 64. Well the percent of folks today who are actively shopping at 64 has come down by about half.

It’s about maybe 15 to 20 percent are shopping as early as 64. Back of the recession, we saw this close to 35, 40 percent. So the fact that people are working longer means you have fewer folks shopping right at 64. We see, right around 64 and a half to 64 and 9 months, that’s where we get about 50 percent of consumers shopping. But the conclusion of the recession and the better work environment means you do have fewer people shopping at 64. More clients that we work with are thinking more about putting more resources closer to age 65. And fewer earlier, around 64, unless it’s a conversation campaign, trying to drive folks from a commercial group plan into Medicare. Good question, thank you.

Facilitator: All right, thank you. Next question. What examples can you give of health insurance companies successfully marketing their Medicare plans in the ways you’re suggesting?

Scott: So I think without naming any names, which would not be proper, most of them are heading in this direction. They’re heading in this direction with capability and they’re heading in this direction with the understanding that liquid expectations have arrived at their doorstep and that they can no longer make the excuse that, “Well, we’re healthcare. We’re behind, but everybody’s behind, so all we have to be is better than our competitor.” They are now understanding they have to be as good as everything else out there.

And so we see a lot of activity in enabling technology. And we see a lot of activity in things like service design, and design synching, human-centered research and those things. So I think as an industry, the mindset is in the right place. And the industry is heading in this direction. But I’ve had several questions along this line that I can see as I scroll down the question box, examples of this. Where is it being done successfully? These phenomena are just hitting now. The attendance at this particular webinar, which is one of the highest that AHIP’s done this year, shows that this is a bit of a new idea, a new discovery, and something that has to be address. And so I think that what we’re going to have is you’re going to have leaders and followers emerge. And happily, the industry is understanding that these kind of opportunities exist, and they can use their technology investments to leverage, to do this well.

Facilitator: All right. Thank you. Our next question. Do these strategies also apply for DSNP plans?

George: I could talk a little bit about the shopping behaviors folks when it comes to decent plans. And if you want to talk more about the strategies, go for it. We also do study the duals at Deft. Now we recently published this study that looks at shopping channels. And as you can understand, full and partial duals, their online shopping is less than you’re going to see in the traditional non-dual MAPD consumer all right. Now that doesn’t mean that they’re not online at all. They are. A partial dual eligibles are actually online at the same degree as are non-dual MAPD members. But we have a lot of full dual eligibles out there — about twice as many dual eligibles are full then partial. And those consumers are not as connected.

So just from a consumer standpoint, is there dual eligible DSNP shopping online? Absolutely. It’s going to be heavier to the partial dual and the partial dual behaves more like a traditional non DSNP consumer. But when you think about the full duals, and there are twice as many full duals as there are partials. Their online activity is going to be a lot less. So that’s just from our standpoint at Deft. Scott if you wanted to add to that, by all means, feel free.

Scott: No, I think that’s fine, George. There isn’t really that age-in component that is so big a part of the talk that we just gave. So thank you for that answer.

Facilitator: All right, next question is from Mitzy. Is there a place to get an interactive website, software or assistance like that?
Scott: Well it’s not a software issue. I think when I was talking about the enabling technology that goes into personalization, such as some of the marketing automation software, some of the CRM software, sometimes you put the two together plus some other systems and you have the capability to reach people individually with personalized messaging based on their intent and the other information that you have about them. So off the shelf, this is something that is designed by technologists and marketers working hand in hand. And so I think that if you’re on the marketing side of things, understand what technology your company is acquiring for these sorts of purposes. If you’re on the technology side of things, get curious and talk to marketers about what they’re hoping to be able to achieve so that the installation actually delivers on the promise of the investment.

Facilitator: Thanks. Next question is from Renee. Can you provide any statistics of organizations that have changed their approach and improved their sales rate of late retirees?

George: So we don’t have sales statistics at Deft Research. One common technique that we have seen more folks take a look at is understanding that for folks who are truly late to Medicare — so they’ve gone past 65, they’ve gone past 64 and those anticipated times of coming in at 65 or maybe full Social Security. We have noted that when you have someone over that age — let’s say 67, 68, 69 — a potential indicator of when that person is ready to come into Medicare has to do with the discrepancy or the difference in terms of head of household age versus trailing household age.

So if I’m 66 let’s say, and I have a younger spouse or partner who is 62, there is a better chance I’m going to go until 69 so my younger spouse or partner can come into Medicare at the same time.

When you think about the expense and the cost for individual off-exchange coverage for someone in their 60s — so not receiving a “Obamacare” subsidy. Those folks can be paying upwards of $20,000, $22,000 in terms of premium and deductible before their coverage kicks in. So the head of household spouse — the older spouse, the leading spouse — has a vested interest to work as long as possible if in fact they have the group coverage so that their trailing spouse doesn’t have to go into ACA coverage. So that sometimes can also be an indicator. But I would say just from a consumer standpoint, we’ve seen some of that. I can’t site any actual sales number. We collect consumer preference data at Deft, so that’s how I look at that.

Facilitator: Thank you. David asks, “Your presentation seems directed more at carriers or plans. What about agents? How can agents take advantage of these trends affordably?”

George: We do see that agent-facilitated enrollment, as we mentioned, is the norm when it comes to any type of AEP switching. Three-quarters of all switchers need some sort of agent or broker or representative facilitated enrollment. There are outfits out there that provide these types of platforms. If we’re talking about a large SMO, a lot of times carriers will have their own online broker portals that are meant to mimic some of these experiences and utilization. But I mean, from our perspective, we do see 50 percent of all switching is agent facilitated. Three-quarters of all switchers reached out to an agent. I think there’s a definite need for the broker world, particularly when we think about age-ins and folks who are switchers. I’d have to defer on terms of the actual software applications that may be available, or approaches. But from a consumer’s perspective, we do see that there is a definite need, particularly when it comes to switching.

Facilitator: All right. How can I prospect for late-to-Medicare consumers other than through search and digital display apps?

Scott: So, this is Scott. And I’ll let George take that too because our answers might be complementary. My answer to that would be focus on search and make search match intent. And then use search to funnel people into personalized experiences that are relevant to that intent so that you can get them engaged, opted in, and with your brand through that journey. I don’t think there’s anything more important from a media point of view that you could use to perfect what happens after someone find you via search. Because search is by far the largest entry point for people in this market. George, anything more on that?
George: Well I agree with what you had there. The other thing too is these are all consumers who have moved digitally. I think the data shows that. We show that shopping digitally, people spend more time online now shopping than they do, let’s say reading direct mail. But that doesn’t mean that direct mail and list scoring or predictive modeling doesn’t work as well. There are methods where you can purchase lists of consumers that will have appended data from various different data organizations.

Our company [recording defect] that we know have shopped or switched or aged-in and bought at a certain time or bought a certain product. There are other firms and other agencies out there that do similar work. So outside of just the digital targeting, there are proven case studies of attracting aging consumers at different times — 65 versus 66 or later — more likely to enroll in Medicare Advantage or MedSupp. There are predictive modeling and list-scoring services that also work. So I would say that’s another avenue to look at.

Scott: Right, and I guess one of your comments having to do with direct mail and other things is that if you get someone engaged through direct mail, make sure that you do understand their intent right off the bat. Because they may be engaging you just to just find out what do I have to do. What can I wait to do? So that’s part of your contact center script, that’s part of your landing page. If it gives that person something that they’re looking for, that they can see right away, it’s there’s, then you’ve used that older fashion medium to reach that newer fashioned customer and continue to engage them.

Facilitator: Okay our next question. With CMS bringing back the OEP for 2019, do you anticipate marketing efforts will continue through that period?

George: Thanks for that. I’ll start that one off and, Scott, if you want to answer or add to it, by all means, please. There was an OEP — I’m dating myself now — several years ago. We had this type of a structure. We used to analyze that in our shopping and switching research and we didn’t see a tremendous amount of activity. Now that said, we do know from past research that we’ve done, not every consumer reads their annual notice of change. So if it’s October 1st let’s say, and I’m an average consumer and I get an ANOC and my ANOC indicated some significant change, I may or may not read that.

And there is a percentage of consumers who don’t read their ANOCs. And let’s say if there’s a premium increase or a network change, those are folks who are going to progress throughout the AEP and not move. Well come January when they need to see a physician, when they need to, when they get a bill for a premium that they weren’t expecting, that’s when it kicks in these changes. And those consumers will be active. Now my guess is, my hunch, is that in markets where the ANOCs that go out from all competitors are for the most part mild — not too messy — you’re not going to see a lot of OEP activity. If you have messier ANOCs, you are going to see OEP activity.

Now we are not a compliance house at Deft Research. We’d ask you to check with your own ad agency. We’re a market research firm. Our interpretation of the final call letter is that any marketing that you may be doing shouldn’t be product-based marketing. So it’s our understanding — and again, we’re not experts in this area. Check with your own legal, check with your own agency. But any marketing that you may do may be restricted to just normal brand marketing. And we only anticipate seeing any type of brand marketing in markets where there has been significant disruption and carriers are trying to catch those procrastinators who didn’t read their ANOC, but feel those issues come January 1.

Facilitator: Thank you. I think there’s time only for one last question. And this is from Sue. What about a market for people aged 65-plus who are still working with an employer medical plan with a high deductible where enrolling in Medicaid at age 65 as a supplemental plan could prove cost effective when employer plans are increasing their annual deductible?

George: Sue, I think that’s a good question. And I’m going to — this is George from Deft Research. I’m going to have to noodle on that if you don’t mind. It sounds like there could be a market there, but in terms of our recent market research studies that we’ve published, that isn’t a type of consumer that we’ve targeted. But if you, I believe we can get ahold of your email address and try to find an answer for you. So I, unfortunately at Deft, we don’t cover that market, so I don’t have anything off the top of my head. Scott, perhaps you do.
Scott: No, I think that’s a very individual thing. It’s a great question. And it happens a lot. And someone is still working with an employer, I think that’s your employer cohort there, George, which is not quite the market that we were discussing today. But I don’t have a ready answer for that one as well. But it’s a very good question and it’s probably worth a look. Probably first is size that market. See what that looks like in terms of number of enrollees.

Facilitator: All right. Thank you very much, gentlemen, for that great presentation and for sharing your thoughts today. Thank you to our audience for participating in today’s conference. That concludes this webinar. Thank you again and enjoy the rest of your day.