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Business Process as a Service (BPaaS) in Healthcare: the Way Forward to Maximize Value and Improve Outcomes

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Introduction

According to the Centers for Medicare and Medicaid Services' (CMS) latest factsheet, the US spends close to US$3.8 trillion or 17.7% of its Gross Domestic Product (GDP) on healthcare. This is almost twice as much as what an average Organization for Economic Cooperation and Development (OECD), an intergovernmental economic organization that includes the world's major economies, country spends. However, a high spend does not necessarily guarantee better outcomes, as the US lags other OECD countries on many health outcomes, including life expectancy, chronic disease burden, and obesity. This shows that while healthcare is one of the major areas of government spend, there are many complexities and inefficiencies within the US healthcare system that make healthcare costly and impact outcomes.

The US healthcare ecosystem comprises three key stakeholders – providers (hospitals, physicians, and health systems that provide care), payers (health insurers that finance the care), and pharmaceutical companies. Of the three stakeholders, payers have the lowest profit margins – 4.3% compared to 6.1% for for-profit health systems and 19.4% for pharmaceutical companies. Hence, there is a need for payers to reduce their cost of operations, maximize revenues, and improve margins. The fast-changing regulatory landscape and evolving member demands are also adding to the payer burden. Thus, payers are seeking innovative solutions that can help them address these issues. Business Process as a Service or BPaaS platforms are one such solution gaining traction in the healthcare market due to the many benefits they offer to healthcare payers.

This viewpoint studies BPaaS platforms in the healthcare payer market and provides insights on the current and potential future adoption of BPaaS to achieve the healthcare industry's objectives.

The case for platform-based modernization of payers

While healthcare payers already face numerous financial, regulatory, and technology issues, the COVID-19 pandemic has exacerbated these issues manifold. In the short term, the pandemic has had a positive impact on payers' bottom lines, but it has also ushered in significant operational and market changes that payers need to prepare for. For instance, after two consecutive years of decline, US states are expecting Medicaid enrollment to increase by 8.2% in 2021[1]. Similarly, the exchange market is likely to grow, as payers such as United Healthcare, Anthem, Centene, and Oscar Health have renewed their interest in this segment due to COVID-19-induced enrollment pattern changes.
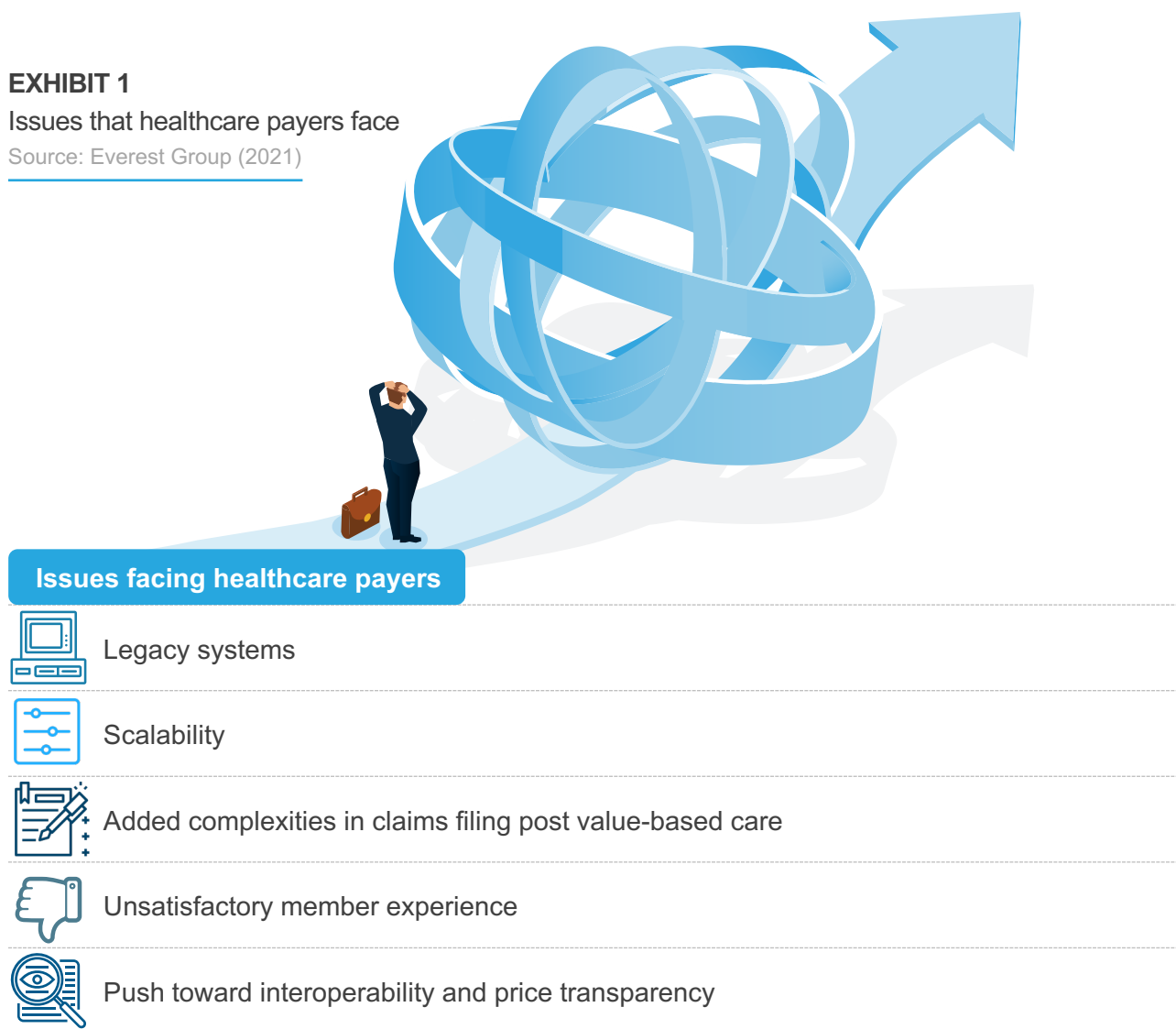
These changes, coupled with the pace at which they are being implemented, are making it increasingly difficult for payers to scale their operations in line with the changing market requirements. Payers also face the twin challenges of a lack of trained resources and inflexible and ineffective legacy systems, which are increasing their operations costs and impacting their member engagement strategies, leading to an unsatisfactory member experience.

Exhibit 1 illustrates some of the key issues that healthcare payers face.

EXHIBIT 1

Issues that healthcare payers face

Source: Everest Group (2021)

Issues facing healthcare payers

Legacy systems

Scalability

Added complexities in claims filing post value-based care

Unsatisfactory member experience

Push toward interoperability and price transparency

1   Source: KFF's Annual Medicaid Budget survey conducted in 2020

Issues impacting healthcare payers

Legacy systems: Many health plans use legacy systems, which are inefficient, costly, and difficult to upgrade. These legacy platforms are incompatible with next-generation technologies such as advanced analytics, which are actively deployed across processes such as claims management.

Scalability: The current business environment requires payers to be more agile and flexible to meet the changing demand patterns, which are putting pressure on health plans to scale efficiently with the existing infrastructure. A case in point is the COVID-19-induced enrollment pattern changes, which are compelling health plans to ramp their operations up/down for certain types of claims (such as COVID-19-related claims) or certain types of plans (such as Medicare Advantage).

Added complexities in claims filing post value-based care: The American Medical Association (AMA) estimates that the health industry could save US$10 billion-20 billion a year if insurers process claims efficiently. Health plans have been dealing with complexities in claims processing arising from the lack of a standard claim format and the tendency of certain providers to submit paper-based or manual claims. The implementation of risk-adjusted reimbursements and the associated documentation and coding have further increased the complexities in claims.

Unsatisfactory member experience: The lack of member engagement and subsequent member dissatisfaction are important issues facing healthcare payers. According to a recent study of 149 health plan members by a leading consumer intelligence firm, only 36% of commercial health plan members believe that their health plan acts in their best interest "always" or "most of the time." A bad member experience can also negatively impact health plans' STAR ratings, thereby affecting the plan's membership and reimbursement.

Push toward interoperability and price transparency: The Interoperability and Patient Access final rule mandates Medicaid, the Children's Health Insurance Program (CHIP), Medicare Advantage (MA), and qualified health plans to make enrollee data immediately accessible to members through Application Programming Interface (API) by July 2021 (likely to be extended). This regulatory pressure will require payers' investments in areas such as member transparency, data sharing, and data security.

The need for a platform-led modernization approach

Payers can choose from two approaches to address these issues – a point solutions-led approach, wherein process-specific solutions target a specific business requirement, or a platform-led approach, which provides comprehensive end-to-end solutions.

While point solutions are easier to implement and are cost-effective, the disparity among multiple point solutions makes the payer ecosystem complex and fragmented. Additionally, the presence of multiple solutions exacerbates the issue of interoperability and increases the total cost of ownership for the payer. Platform solutions, on the other hand, are end-to-end offerings that provide payers workflow visibility, pricing transparency, and business analytics. In fact, Everest Group's interactions with 50+ payer references in 2020 reveal that payers prefer a platform-based approach over a disparate point solutions-led digital transformation. Additionally, payers prefer a modular versus integrated platform, a pre-configured versus bespoke model, and a composable versus proprietary platform, as illustrated in Exhibit 2.

EXHIBIT 2

Key platform characteristics that payers demand

Source: Everest Group (2021)

Composable

Payers prefer composable to proprietary platforms, as the former ensure smooth integration with core business software and other third-party platforms without making architectural changes.

Modular

Payers prefer a modular platform, as erstwhile integrated platforms are monolithic and fail to offer a seamless and scalable experience.

Pre-configured

Payers prefer pre-configured over bespoke platforms, as the latter involve complete ground-up development of a system, while pre-configured platforms come with a customizable common set of functionalities.

Approach to BPaaS adoption

Platform adoption is just one part of the solution, which addresses the technology-related challenges and process inefficiencies that healthcare payers face. A comprehensive solution will require healthcare payers to adopt a three-pronged approach aimed at people, processes, and technology, as illustrated in Exhibit 3.

EXHIBIT 3

Three-pronged approach to address payer issues

Source: Everest Group (2021)

People	Technology	Process
A highly skilled, low-cost, and scalable workforce with deep industry knowledge	Platform-led approach to address the challenges of siloed and disjointed legacy systems and reduce the total cost of ownership	Best-in-class processes to reduce the total cost of operations, promote data-sharing, and improve outcomes

To implement this three-pronged approach, payers can use sourcing models such as:

- Traditional shared services models – build their own dedicated units structured as centralized points of service for defined business functions

- Traditional outsourcing models – outsource to service providers and partners, largely driven by cost considerations rather than a structured roadmap

- BPaaS – address the twin challenges of financial distress and legacy systems through an agile and flexible transformation model

The traditional models are accompanied by certain key challenges. For instance, a shared services model requires significant investment in terms of capital and time, as well as a re-examination of the way payers run their processes. This is easier said than done, as most payers do not have the required capital, technology expertise, or talent to execute the model. The traditional IT/BP outsourcing model can address some of these issues, but, often, it addresses only a part of the problem and adds limited value. Hence, enterprises are increasingly turning to BPaaS, as it combines the platform approach with best-in-class business process services. Exhibit 4 compares the value realization among different sourcing models.

EXHIBIT 4

A comparison of different sourcing models

Source: Everest Group (2021)

	Model 1: Traditional shared services model	Model 2: Traditional outsourcing model	Model 3: BPaaS model
Value drivers addressed	• Greater control over the operating environment • Standardized and cost-effective services • Enhanced ability to own the talent pipeline	• Large external teams to augment capacity • Cost optimization through labor arbitrage	• Stronger contractual adherence driven by service providers' integration with the client environment and the linking of outcomes to business KPIs • Sunk costs avoided by converting capital spend into operating expense, and capital allocation issues addressed • Enhanced ability to ramp up/down as needed • Platform-led • Accelerated value realization of new initiatives
Value drivers not addressed	• Increased time-to-value to acquire and retain local talent • Lack of enterprise-wide sourcing strategy and operational visibility • Limited flexibility to scale up/down • High CapEx orientation	• Opacity in consumption (given fixed price or time and material models) • Delays in value realization due to bespoke feature development • Missing link to business outcomes and inability to ramp up/down quickly • Mixed CapEx-OpEx orientation	

In the following section, we take a closer look at the BPaaS model.

Understanding BPaaS and its advantages

There is no clear definition of BPaaS in the healthcare industry, and many solutions that claim to be BPaaS offerings are existing solutions that are repackaged and do not provide the value that enterprises are looking for. This increases enterprises' confusion about BPaaS and makes them skeptical of its benefits. Hence, it is important to understand the characteristics of a BPaaS solution, as depicted in Exhibit 5.

EXHIBIT 5

Everest Group qualifies a solution as BPaaS if it meets the following conditions

Source: Everest Group (2021)

Layering

The solution should have at least the application and business process layers included. It can be deployed either over the cloud or on-premise.

Technology leverage

- There should be meaningful technology leverage to provide services. While in many cases the underlying technology solution can be a System of Record (SOR), but, in others, it can be a System of Engagement (SOE) that substantially enhances the efficiency, effectiveness, and impact of the services provided
- Typical stand-alone solutions, such as workflows, RPAs, wrappers, and analytics, are excluded

Pay-as-you-go pricing model

- The solution should be offered on a pay-as-you-go basis (i.e., either output-/transaction-based or outcome-/gainsharing-based or some combination of the two)
- Input-/FTE-based pricing is not eligible

Contractual relationship

- The enterprise should have a contractual relationship with a single entity for both technology and business process services
- Even if the provider is bringing a third-party solution, the enterprise holds the BPaaS provider responsible and accountable for the entire stack (process and technology)

A BPaaS solution is, thus, an interplay of people, process, and technology. From an offering standpoint, the solution provides both the underlying platform and the associated IT and business process services. However, a single service provider need not own both the technology and the services stack but could provide this in partnership with a specialist. What is important is that the health plan or the enterprise under consideration should have a contractual relationship with a single service provider / vendor and hold that service provider / vendor accountable for the entire technology and services stack. Also, the BPaaS solution could cover processes across the entire payer value chain or cater to only a selected part of the value chain, such as claims, care, or member engagement.

Depending on the coverage across the payer value chain and the number of partners involved, a BPaaS solution can be classified into four categories, as illustrated in Exhibit 6.

EXHIBIT 6

Classification of BPaaS models

Source: Everest Group (2021)

Everest Group classification of BPaaS approaches		
Broad-based solution (end-to-end coverage across multiple processes)	**End-to-end (E2E) traditional BPaaS** • Broad-based platform solution bundled with services • Example: A service provider offering end-to-end business process and related services along with the core administrative platform	**E2E best-of-breed BPaaS** • Broad-based third-party SaaS solution and related BPS services • Example: A service provider providing broad-based payer services leveraging a third-party platform
Focused solution (focused coverage for specific processes)	**Process-specific traditional BPaaS** • Platform solution, along with services for specific processes • Example: A service provider providing solutions and services for a particular process, such as care management	**Process-specific best-of-breed BPaaS** • Process-specific third-party SaaS solution and related BPS services • Example: A service provider offering services for a particular process leveraging a third-party platform
	One-stop solution One provider offering business process, its own application, and/or infrastructure solution	**Multi-provider solution** Provider different from application/infrastructure provider but holds the overall contractual relationship

Solution coverage

Number of providers involved

While traditional BPaaS solutions have experienced more traction among enterprises, best-of-breed solutions are catching up following higher commercial SaaS adoption. Factors such as increasing availability of a BPS partner ecosystem for technology platforms and improvements in data security and compliance standards will further pave the way for best-of-breed BPaaS models. However, this trend is more prominent across BPS horizontals such as HRO, where third-party solutions such as Workday and SuccessFactors are mature, and their adoption is high. For verticals such as healthcare payer, the end-to-end traditional model – wherein a single provider offers an end-to-end one-stop BPaaS solution – is the most popular choice, as showcased in Exhibit 7.

EXHIBIT 7

BPaaS adoption by solution type among healthcare payers; percentage

Source: Everest Group (2021)

Best-of-breed BPaaS	Traditional BPaaS
20-30%	70-80%
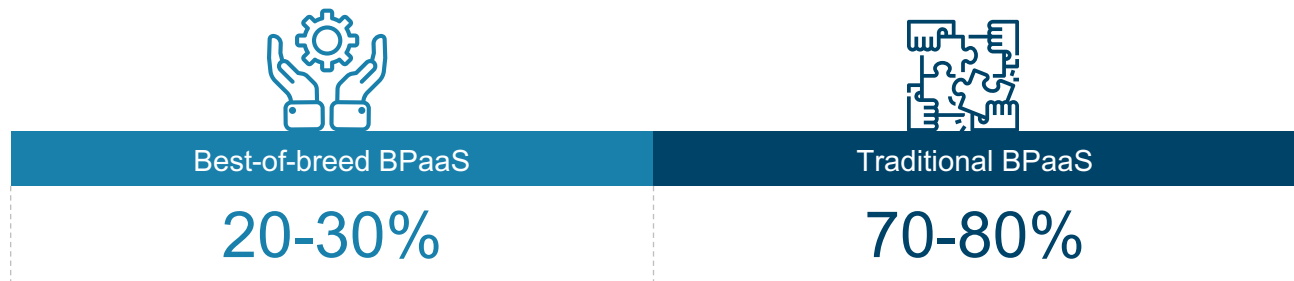
Irrespective of the BPaaS model adopted, BPaaS offers many advantages, including lower cost of ownership and improved operational agility and efficiency, as highlighted in Exhibit 8. Payers have gradually begun to realize these benefits, and hence the BPaaS market is growing at a strong pace.

EXHIBIT 8

Benefits of BPaaS for healthcare payers

Source: Everest Group (2021)

Lower total cost of ownership: BPaaS involves very little capital from payers and provides flexible pay-as-you-go pricing, which reduces the operational costs for health plans

Stronger contractual adherence: BPaaS contracts are generally single contractual relationships and hence put higher pressure on vendors to perform. Additionally, the payments are tied to outcomes instead of a fixed FTE model

Better access to a high-skilled and scalable workforce: BPaaS provides access to a domain-rich workforce that can easily scale according to health plans' needs without a considerable lag time, as in a typical IT/BPS outsourcing model

Efficient processes: BPaaS automates manual processes such as claims adjudication and reduces reliance on human intervention, leading to efficient processes and improved outcomes

Access to better technology: BPaaS provides a modern alternative to legacy on-premise platforms, which payers operate on. The as-a-service model provides flexibility and easy integration with multiple other platforms

BPaaS growth trends and adoption in the healthcare payer market

The rising adoption of BPaaS among healthcare payers is evident from the fact that BPaaS engagements accounted for 30-40% of the healthcare payer business process outsourcing revenue in 2019-20. Further, the shift toward value-based care, accelerated by COVID-19, is driving the growth of the payer BPaaS market more rapidly than the traditional payer BPS market, as illustrated in Exhibit 9.

EXHIBIT 9

BPaaS penetration in the healthcare payer BPS market, 2019-20

Source: Everest Group (2021)

100% = US$12 billion-13 billion

⬆ CAGR 2016-19

⬆ **3-5%**
Non-BPaaS market

60-70%

30-40%

⬆ **11-13%**
BPaaS market
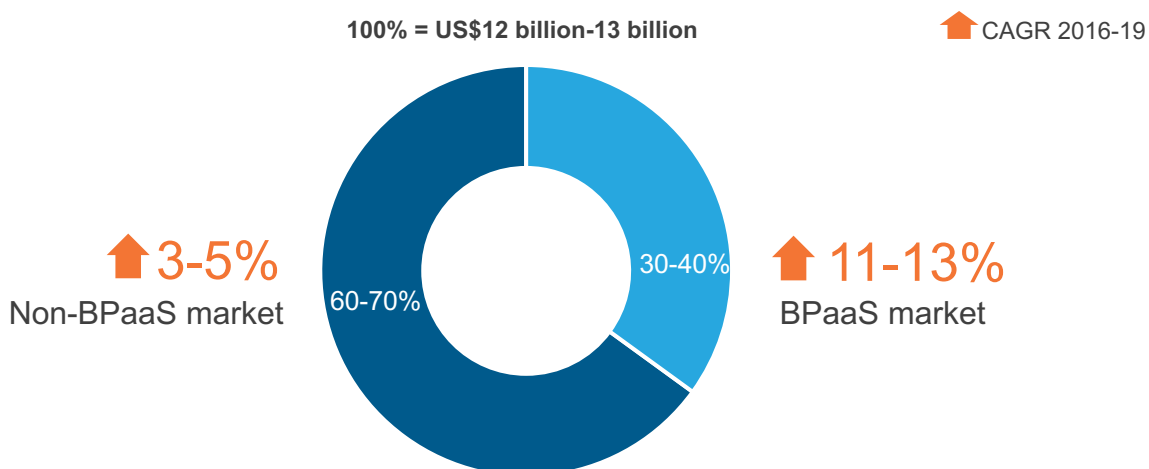
However, BPaaS adoption is not uniform among healthcare payers and there are variations across buyers, depending on the plan type, buyer size, and value chain processes, as shown in Exhibit 10.

EXHIBIT 10

Buyer adoption trends in the healthcare BPaaS market

Source: Everest Group (2021)

Adoption by buyer type	Adoption by processes	Adoption by buyer size
Adoption by different buyer segments, such as commercial vs. government buyers	Adoption across processes, such as claims management vs. member engagement vs. care management	Adoption by different buyer sizes, such as small vs. midsized vs. large buyers

Adoption by buyer type

Government plans have traditionally been the dominant buyer segment for BPaaS due to their modular Medicaid Management Information Systems (MMIS) implementations. US states have sought the help of service providers in the design, development, and implementation of MMIS platforms, as well as their operations and maintenance. With CMS pushing the modularity agenda, more states are modernizing their legacy monolithic systems and gradually adopting the as-a-service-model. These states are typically leveraging service providers' BPaaS offerings for administrative modules such as claims management, provider management, and financial support services (third-party liability). States such as Wyoming and Montana have also started adopting the BPaaS model for core medical processes such as care management.

While government plans account for a majority of the healthcare payer BPaaS market, the market's BPaaS adoption is driven by regulatory push or the CMS mandate and not really the states' intent to achieve operational and technological efficiencies. Hence, we see many states still coming to terms with a modular BPaaS approach. In contrast, the commercial payer segment is rapidly adopting this model, and we will hence focus on the key BPaaS adoption trends in the commercial segment. Exhibit 11 illustrates some of the major challenges impacting various types of commercial plans.

EXHIBIT 11

Impact of challenges facing commercial plans

Source: Everest Group (2021)

Relative impact of challenges facing health plans   Low ▬▬▬ High

Challenges facing health plans / type of plan	Scalability	Claims complexity	Unsatisfactory member experience
Medicare advantage	▬▬▬	▬▬▬	▬▬▬
Managed Medicaid	▬▬▬	▬▬	▬▬
Individual health plans	▬	▬	▬
Employer-sponsored health plans	▬	▬	▬
Comments	The already rising MA and Managed Medicaid enrollment has got a further push following COVID-19. A study by Medicare Advantage Plans found that 45% of Medicare beneficiaries are switching from an original Medicare plan in 2020 to an MA plan in 2021. Further, a huge surge in ESRD patients is also expected in MA plans due to the 21st Century Cures Act. On the Medicaid side, Managed Medicaid enrollment is also rising, with enrollment increasing to 15.2% from March 2020 through December 2020 (Source: KFF).	MA plans deal with higher claims complexity due to the medically complex nature of their population, which makes it important for them to identify miscoding/upcoding instances by providers and conduct proper medical-necessity reviews. Also, MA plans need to access and validate claims, medical records, and other data from providers, which determines the risk-adjusted reimbursements they receive from the CMS.	CMS has doubled the weight of patient experience measures, which will come into effect for the STAR ratings calculation in 2021. An MA plan's finances are directly correlated with higher rated plans, as the plan ratings govern their membership and the bonus that they receive from the CMS.

As is evident from the exhibit, these challenges profoundly impact certain plans more than others and thus there is a pressing need to leverage the BPaaS model. MA and Managed Medicaid are two segments emerging as ripe business cases for BPaaS. While enrollment in these plans is rising, they also face significant operational challenges, making it difficult for them to contain costs while improving the care and experience of their member population. Consequently, these plans are drawn toward the scalability, flexibility, and efficiency of the BPaaS model, which is typically deployed for transactional processes across functions, such as claims processing, member enrollment, provider credentialing, encounter data management, and billing & financial reporting. Additionally, the access to a scalable, domain-rich talent pool helps improve compliance and quality measures such as STAR ratings and HEDIS scores, which ultimately affect enrollment and the top line.

Payvider is another buyer segment that is well suited to capture the BPaaS opportunity.

A payvider refers to a combined payer-provider entity working for the common goal of ensuring better care for the population at a reduced cost. Payviders have existed since decades, but their presence increased in number and significance following the Affordable Care Act.

Depending on the roles of the payer and provider entities, there can be different payvider models:

- A payer developing provider capabilities, for example, Humana's investment in primary care clinics and acquisitions such as Kindred at Home
- Healthcare providers starting their own insurance plans, such as UPMC Health Plan, Kaiser Permanente, and Geisinger Health Plan
- A joint venture between a payer and a provider, for instance, Banner Health's joint venture with Aetna

The payvider model has increased in importance alongside two emerging themes in the healthcare industry: a rising focus on value-based care and increasing consumerism. By combining the payer-provider workflows and platforms, payviders can solve the discontinuities of a siloed ecosystem by enabling data-sharing between systems. As providers have direct control over the care members receive, a payvider entity can deliver better care and outcomes for the member. This promise of value-based care, reduced cost, and interoperability between multiple systems is driving increased interest in the payvider segment. Further, the huge upsurge in MA enrollees and hefty reimbursements through value-based reimbursement programs are making this construct lucrative for payers and providers alike.

However, the journey for payviders has not been smooth, and they encounter challenges such as low profitability, the need for high technology investment, and scalability issues. A BPaaS model is well-positioned to tackle these challenges without putting pressure on payviders' expenses. Exhibit 12 highlights the prominent issues that payviders face and explains how a BPaaS solution can address them.

EXHIBIT 12

Challenges that payviders face and the benefits of BPaaS

Source: Everest Group (2021)

Challenge	Payvider issue	How BPaaS can help
Challenge #1 Low profitability	• Most payviders struggle with profitability • According to an analysis by the Robert Wood Johnson Foundation (RWJF) in 2017, of the 42 Provider-Sponsored Health Plans (PSHPs) founded in 2010, only four were profitable as of 2015	• BPaaS reduces the total cost of ownership for payviders by shifting from a capital expenditure model to an operating expenditure model • It increases profitability by reducing the operating cost and improving metrics such as quality, which positively impact the top line
Challenge #2 Need for process and technology improvement	• Payers and providers work on different workflows and platforms, such as EHRs, RCM platforms, and claims management systems • The presence of multiple systems makes it difficult for payviders to share data and feedback among different systems and drives heavy investments to optimize these processes	• BPaaS provides significant technology leverage by combining modern platforms and services • Processes across the RCM and payer value chain, such as billing, claims processing, and payment reconciliation, are ripe for BPaaS • A BPaaS vendor with strong domain and industry knowledge, and technology capabilities across the payer and RCM value chains can provide exponential value to a payvider
Challenge #3 Need for scalability	• Barring most large payviders, many have not achieved significant scale in terms of members enrolled • The RWJF analysis highlighted that as of September 2016, only four PSHPs of the 42 created since 2010 had between 50,000 and 100,000 insured enrollees, while the rest had less than 50,000 • This lack of scale, coupled with a high capital investment to improve processes and technology, prevents payviders from achieving economies of scale	• BPaaS solutions are quicker to deploy and do not involve a high lag time, enabling the payvider to scale quickly • The pay-as-you-go pricing model of a BPaaS solution avoids heavy investments from payviders and helps them scale at a low cost

Adoption by buyer size

Across industries, small and midsized buyers have demonstrated higher BPaaS adoption than larger organizations. The trend is similar for the healthcare payer market, where small and midsized health plans account for almost three-quarters of the BPaaS market, as shown in the exhibit below. Smaller health plans are typically more open to digital transformation, as they operate on thinner margins, and, hence, it is vital for them to achieve maximum operational efficiency to survive in the industry. They do not have the operational or technological expertise to overhaul their processes in-house, resulting in higher affinity to BPaaS.

EXHIBIT 13

BPaaS adoption by buyer size; % of commercial payers[2] adopting BPaaS

Source: Everest Group (2021)

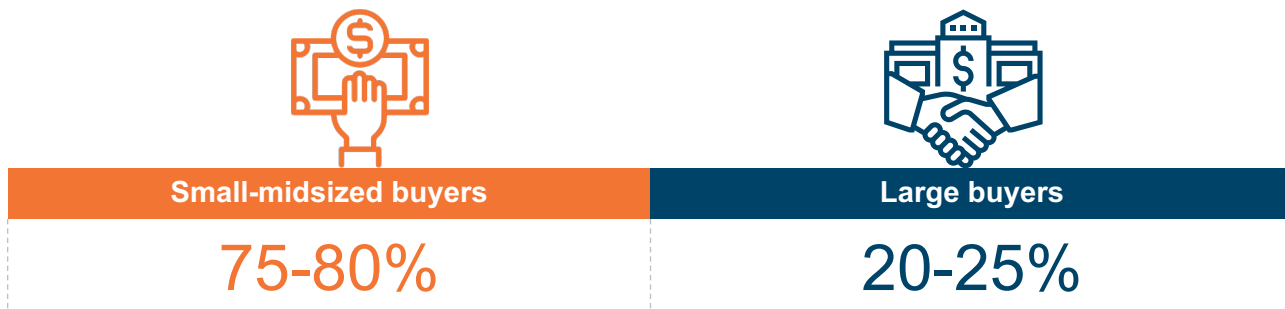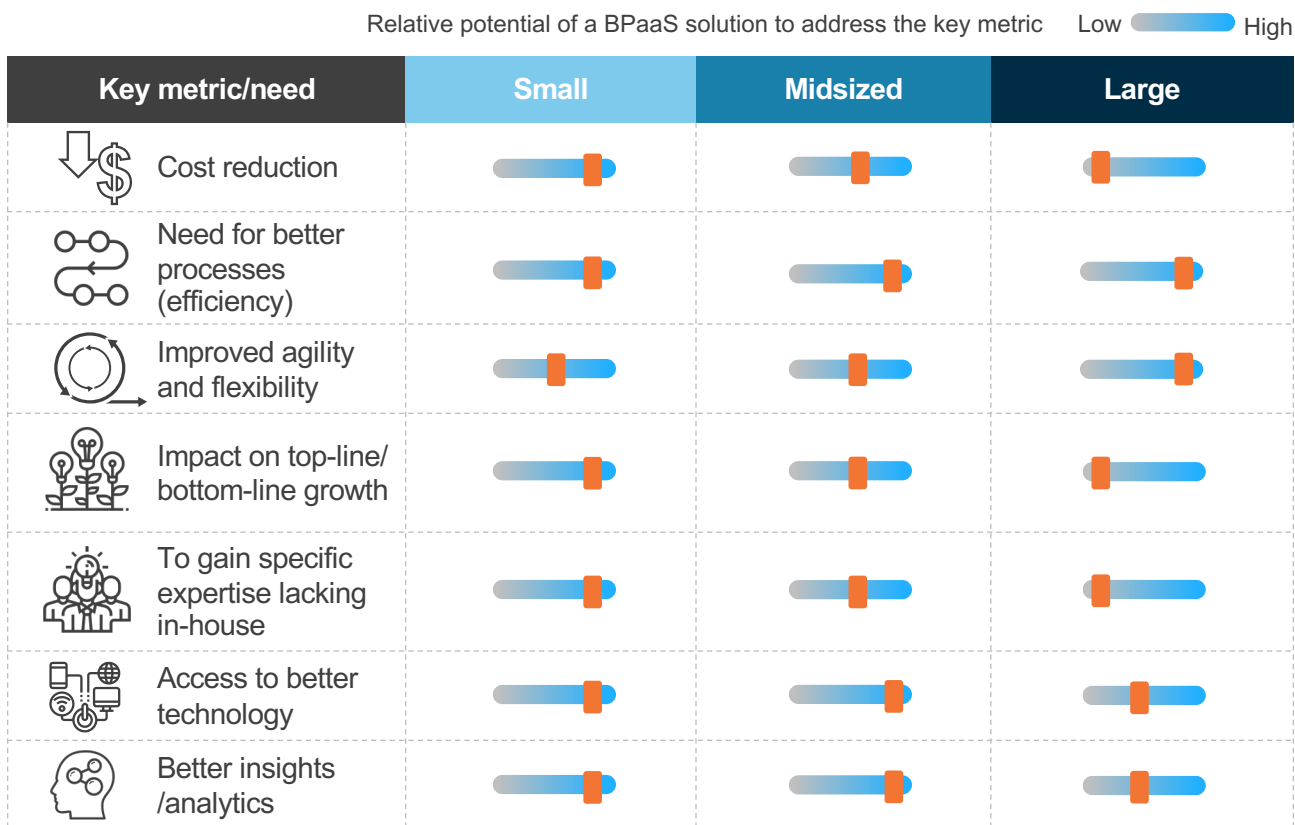| Small-midsized buyers	Large buyers
75-80%	20-25%

Exhibit 14 shows the value addition that a BPaaS solution can bring for health plans of different sizes across different metrics.

EXHIBIT 14

Potential of a BPaaS solution to address key metrics/needs of a health plan

Source: Everest Group (2021)

Relative potential of a BPaaS solution to address the key metric   Low ▬▬ High

Key metric/need	Small	Midsized	Large
Cost reduction	High	Medium	Low
Need for better processes (efficiency)	Medium-high	High	High
Improved agility and flexibility	Low-medium	Medium-high	High
Impact on top-line/bottom-line growth	Medium	Medium	Low-medium
To gain specific expertise lacking in-house	Medium	Medium	Low
Access to better technology	High	Medium-high	Medium
Better insights/analytics	High	Medium	Medium

As evident from the table, BPaaS has immense potential to address all the key metrics, both traditional and modern, for smaller and midsized health plans. However, this in no way implies that BPaaS does not offer tangible benefits for larger health plans. While larger health plans typically leverage service providers for tactical administrative processes, they can achieve significant cost savings and process efficiencies by using BPaaS. The larger health plans are keeping a close watch on the developments, and higher adoption is expected in the medium to long term, as BPaaS solutions mature and more successful use cases emerge in the market.

Adoption by value chain function

The payer value chain encompasses a range of processes, including administrative ones, such as claims management, network management, and member enrollment, as well as core care processes such as case management, care coordination, and utilization management. The administrative processes are largely transactional in nature and were the earliest use cases for traditional BPS outsourcing.

By extension, BPaaS has found initial adoption among these administrative processes, which include the following examples:

- A major US health plan recently signed a deal with a healthcare BPS service provider to leverage its BPaaS solution across the full spectrum of claims management, from claims ingestion and validation to adjudication and payments
- A midsized health plan used BPaaS to automate the claims process and encounter processes
- One of the largest Blues plans used BPaaS to increase its Medicare Advantage membership. It leveraged BPaaS to meet CMS' compliance requirements and increase its MA plan's STAR ratings

A key takeaway that emerges from these use cases is that while BPaaS adoption among administrative process is picking up, most payers have not unlocked the full potential of BPaaS by integrating it across the value chain. Even for administrative processes that leverage BPaaS, payers are not adopting BPaaS across the full spectrum of processes. For instance, achieving higher enrollment in MA plans would mean deploying BPaaS and optimizing processes across the value chain, including member engagement, risk adjustment, and STAR ratings support. However, there are limited examples of payers doing this. Also, more than 80% of a health plan's spend comprises the medical cost, which is generally overlooked, as it is considered to be core to the business. However, this medical cost can be checked through BPaaS, and, in fact, the potential to create a breakthrough via BPaaS is immense by focusing on both administrative and medical costs.

The member engagement process can also be significantly improved by basing interaction with members on a combination of administrative and clinical data. Access to clinical data can enable a health plan to send care reminders to a member inquiring about their health plan. Intervention at the right time can help reduce the cost of care for healthcare payers, while improving the overall experience for the member. A better member experience helps improve plans' STAR ratings, which in turn increase enrollment, all the while reducing the cost of operations. In fact, according to a research by Everest Group, payers can achieve significant savings through a comprehensive sourcing model that addresses both administrative and medical costs.

Some payers have realized the potential of BPaaS in addressing these care processes, and initial case studies for BPaaS to address medical costs are emerging, including:

- A large Blues plan that wanted to improve its member engagement and cost metrics used BPaaS in combination with analytics to improve its health risk assessment process. Analytics enabled the health plan to segregate members based on their utilization, while BPaaS allowed access to scalable and domain-rich resources that could proactively engage with members, improve member engagement and health outcomes, and reduce costs

- A large health plan optimized its utilization management and care coordination processes by using a cloud-based BPaaS solution to connect data from disparate data sources and automate workflows. Automating workflows helped the health plan eliminate manual case and utilization management processes

BPaaS adoption is likely to increase further as many new use cases, especially in growing areas such as population health management and care coordination, emerge. Exhibit 15 depicts the current and future use cases for BPaaS deployment.

EXHIBIT 15

BPaaS use cases and adoption by value chain process

Source: Everest Group (2021)

Future potential of BPaaS ● Low ● Medium ● High
Current adoption of BPaaS ● Low ● Medium ● High

Product development	Member engagement	Network management	Care management	Claims management	Risk & compliance
Plan development	Enrollment and eligibility	Provider management	Disease management	Initial claims processing	Risk adjustment
Channel management (agent/broker network)	Handling of endorsements and renewals	Provider credentialing	Utilization management	Claims review and investigation (adjudication)	HEDIS and Star ratings support
	Risk identification and assessment	Provider contract management	Population Health Management (PHM)	Claims disbursements	Internal/external reporting
	Records management and HIX support	Support for PBMs and TPAs		Fraud detection and management	
	Billing and collections	Records management		Claims litigation; recovery/subrogation	

Best practices for a successful BPaaS deployment

While BPaaS provides additional value to health plans, the adoption or amenability of a BPaaS solution varies by payer and process. The decision to opt for BPaaS is an important one for payers, and various factors can affect the potential success of a BPaaS implementation. Everest Group has classified these factors into two categories – process-specific factors and organization-specific factors. **Process-specific factors** depend on the processes being considered in terms of BPaaS deployment; payers should readily adopt a BPaaS solution if the process is non-core and undergoes frequent volume fluctuations, such as claims processing or member enrollment. **Organization-specific factors** are reflective of the broader organization's characteristics, such as size, financial position, and overall objectives. For instance, a payer should opt for BPaaS if the organization is operating on legacy platforms and reeling under the inefficiencies of a siloed IT and operations model. Small and midsized organizations should also consider BPaaS, which would enable them to match the digital initiatives of larger payers without undertaking equivalent capital overheads.
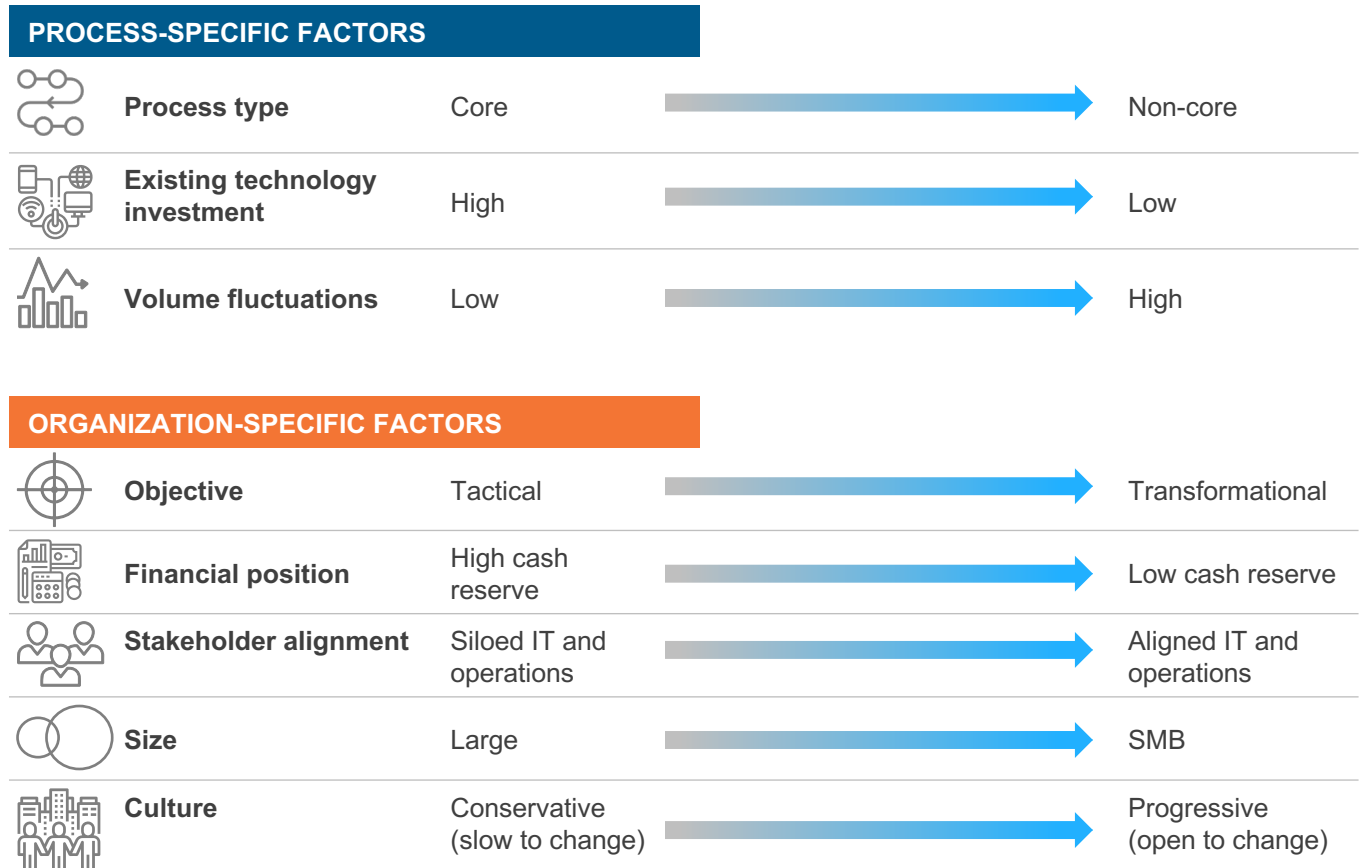
Exhibit 16 illustrates the various factors that determine a health plan's decision to adopt BPaaS.

EXHIBIT 16

BPaaS adoption framework for health plans

Source: Everest Group (2021)

Increasing likelihood of BPaaS adoption: Low ➡ High

PROCESS-SPECIFIC FACTORS		
Process type	Core	Non-core
Existing technology investment	High	Low
Volume fluctuations	Low	High

ORGANIZATION-SPECIFIC FACTORS		
Objective	Tactical	Transformational
Financial position	High cash reserve	Low cash reserve
Stakeholder alignment	Siloed IT and operations	Aligned IT and operations
Size	Large	SMB
Culture	Conservative (slow to change)	Progressive (open to change)

This is a bare-minimum checklist to assist payers in decision-making vis-à-vis BPaaS. As the industry evolves, payers' sourcing considerations are likely to evolve and impact these factors. For instance, as mentioned earlier, if the core processes are shifted to a BPaaS model, the potential for improved outcomes and cost savings increases significantly. Hence, as the BPaaS model matures, its adoption can be positively co-related with how core the process is.

A three-pronged approach to BPaaS deployment

Determining the organization's readiness for BPaaS is just the first step toward a successful BPaaS deployment, which essentially involves a three-pronged approach – business case creation, service provider selection, and risk management, as showcased in Exhibit 17.

EXHIBIT 17

Three-pronged approach to BPaaS deployment

Source: Everest Group (2021)

Business case creation	Service provider selection	Risk management
What is the business case for adoption, including the segment / functional area to choose for BPaaS implementation?	How should the payer evaluate/select the right solution and provider?	How can risks be reduced during implementation /adoption?

Business case creation: This is the first step in any BPaaS deployment. A payer should start by identifying the process or functional area that should be shifted to BPaaS. Process selection is influenced by many factors, and payers can use the framework in Exhibit 16 to make this decision. Next, the payer should create a holistic business case that evaluates the key metrics for the business process, such as cost savings, quality improvements, faster speed-to-market, access to a domain-rich talent pool, and increased member satisfaction

Service provider selection: Once the business case is created, a payer needs to select the right service provider. This is arguably the single most critical decision in the whole process. Hence, a payer should evaluate service providers very rigorously on the following parameters, as the success of any BPaaS implementation rests on the service provider:

- Experience in similar deployments with similar clients: While the need of each payer is different, a service provider that has already done similar implementation for a similar enterprise would be able to leverage valuable learnings and best practices for the payer
- Capabilities across the technology stack: BPaaS is a platform-led modernization for the health plan. Hence, a sound understanding of the underlying platforms goes a long way in identifying process

inefficiencies and addressing them. Some service providers own the technology stack themselves, while others partner with core administrative platforms to provide BPaaS

- Human capital: BPaaS is an interplay of business process services, technology, and platforms. A strong service provider should also be able to provide an industry domain-rich scalable talent pool that can reduce costs, improve process quality, and enhance outcomes

- Coverage across the value chain: Depending on the business case, a payer would want to assess service providers' capabilities in providing end-to-end services. For a payvider health plan, a service provider with capabilities and industry knowledge across both payer and provider value chains could provide immense value

- Mode of delivery: BPaaS solutions are delivered in various ways in the market. A payer should check if it wants the BPaaS solution to be deployed on the client environment, public cloud, private cloud, or a hybrid cloud and select a service provider accordingly

Risk management: Once the service provider is finalized, the last step for the payer is to minimize risks when deploying the solution. This involves taking into account:

- Security considerations: The payer should conduct a thorough due diligence of the service provider's security standards

- Change management: As with any new deployment, change management is bound to be a concern. The payer should engage a majority of shareholders during the transition and assign clearly defined roles for efficient delivery

Conclusion

The healthcare industry has evolved by leaps and bounds in the past few years. Increasing consumerism, shift to value-based care, and the rise of digital health have all changed the way payers function. Consequently, payers' sourcing considerations have also evolved, and the traditional BPS outsourcing model is rapidly giving way to a platform-led BPaaS model, which has ushered in benefits such as reduced cost of ownership, access to better technology and human capital, and the promise of digital transformation at a lower cost.

Consequently, BPaaS adoption is rising rapidly, though it is not uniform across buyers and varies based on the buyer or process characteristics. Small and midsized payers have shown higher affinity to the BPaaS model. In terms of plan types, Medicare Advantage, Managed Medicaid, and payviders have emerged as ripe business cases. From a process standpoint, BPaaS has found most adoption across administrative processes such as claims management. However, payers are gradually realizing the potential of BPaaS in addressing medical costs and in processes such as care management, population health management, and utilization management.

To realize the full potential of BPaaS, payers need to consider it strategically. The decision to shift to a BPaaS model from a traditional BPS model is an important one, and payers should follow a systematic approach in deploying BPaaS. It involves determining the organization's readiness for BPaaS and creating a business case, selecting the right partner in the journey, and managing risks during the implementation. All things considered, the future of BPaaS looks promising, and it seems set to become the next frontier in business process outsourcing for payers.

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