

Embedding churn  
intelligence to protect  
revenue and drive  
healthcare payer growth

## Table of contents

|  |    |
|--|----|
| Introduction   | 3  |
| Churn drivers across the value chain                                 | 3  |
| Enabling the GUARD framework: HCLTech's integrated solution approach | 7  |
| Tracking the success of the churn reduction program                  | 10 |
| Conclusion   | 11 |
| References   | 11 |

## Introduction

Member churn has emerged as one of the most critical and persistent challenges for healthcare payers today. Recent regulatory and policy shifts—including **One Big Beautiful Bill**-driven changes to subsidy structures, benefit designs and cost-sharing mechanics—combined with tighter margin controls across Medicare Advantage and ACA marketplaces have conspired to significantly amplify the revenue impact of every lost member. Healthcare payers who fail to anticipate and address the underlying drivers of member attrition risk will lose not only membership, but also margin, market share and trust.

The scale of the challenge is undeniable. Medicare Advantage annual churn now averages **10%–12%** with as many as **one in six members switching plans during recent enrollment periods** (CMS; Commonwealth Fund; MedPAC). In the group market, annual employer churn ranges between **12%–22%**, with even modest attrition among large employer groups resulting in outsized revenue loss (McKinsey; Mercer). Across segments, retaining an existing member typically costs **\$100–\$300 per year** compared to **\$500–\$1,500 to acquire** a new one, making churn reduction one of the highest-return levers available to healthcare payers (McKinsey; Bain). At scale, a **1%–2% improvement** in retention can preserve tens to hundreds of millions of dollars in annual revenue for mid-to-large plans (McKinsey).

Traditional reactive approaches to churn that focus on narrow enrollment windows or post-disengagement outreach are no longer sufficient. Healthcare payers must build a cohesive, AI- and data-driven capability that enables them to **predict** attrition risk early, **engage** members and employer groups with timely and personalized interventions and **retain** them through consistent value delivery across the member lifecycle.

This whitepaper introduces a comprehensive AI-led framework for reducing member churn. It outlines how healthcare payers can move from fragmented retention efforts to an integrated, enterprise-level strategy that protects revenue, strengthens loyalty and supports sustainable growth in an increasingly regulated and competitive market.

## Churn drivers across the value chain

Although churn typically surfaces during enrollment or renewal, the underlying drivers and root causes are embedded much earlier in the member lifecycle. Treating churn as an episodic enrollment issue obscures these structural causes, undermining the effectiveness of retention efforts.

A value-chain lens enables healthcare payers to identify where churn risk originates, how it compounds over time and which levers have the greatest impact on retention.

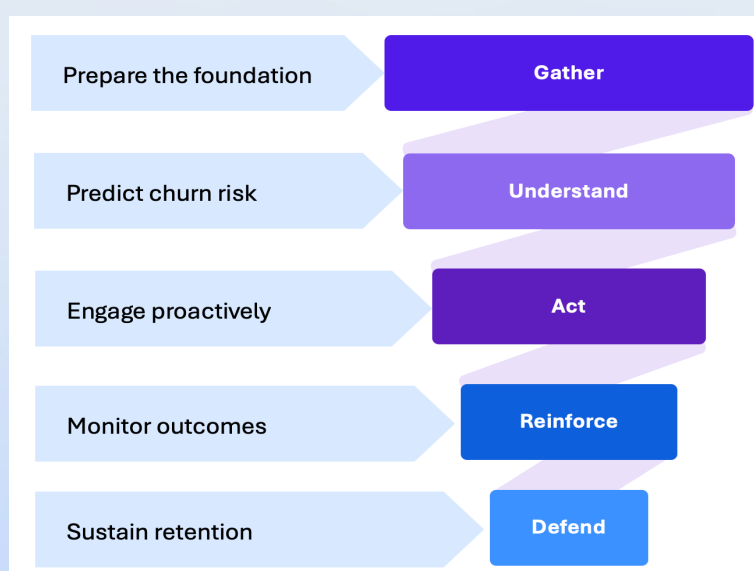


## Key drivers of member churn across payer functions

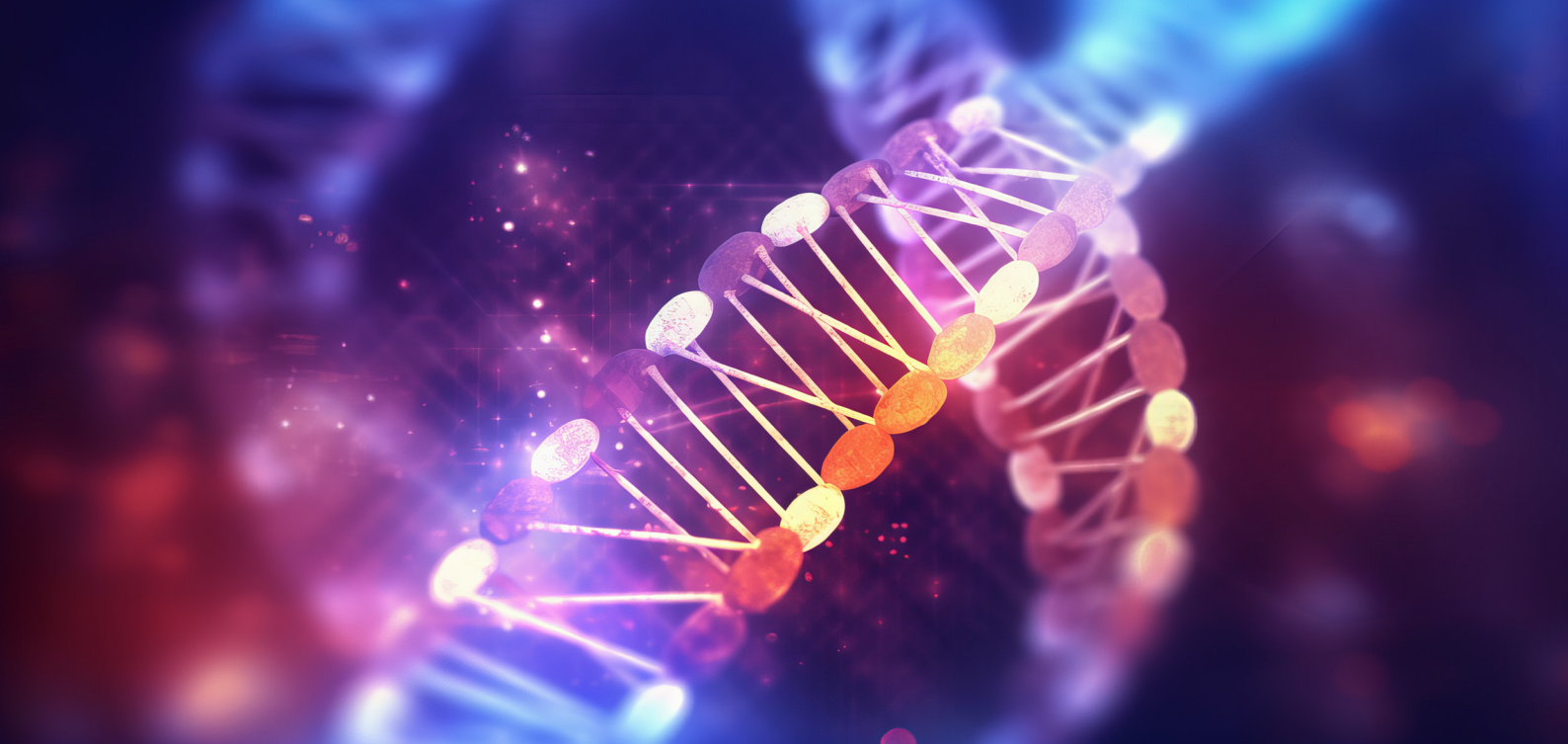
| Payer value chain               | Primary churn drivers                   | Churn risk intensity | Early warning signals                          |
|---------------------------------|---|----------------------|--|
| Sales and marketing             | Broker steering toward competitors      | 8                    | Broker inactivity, competitor mentions         |
|                                 | Misaligned broker incentives            | 7                    | Late renewals, declining broker engagement     |
|                                 | Over-promising during sales             | 6                    | Post-enrollment complaints, benefit confusion  |
| Enrollment and billing          | Complex enrollment experience           | 7                    | Enrollment abandonment, high early call volume |
|                                 | Billing errors and premium inaccuracies | 9                    | Multiple billing inquiries, grievances         |
|                                 | Loss or change in subsidy eligibility   | 10                   | Coverage downgrades, payment delays            |
| Provider management             | Narrow networks                         | 9                    | Increased out-of-network usage                 |
|                                 | Provider terminations                   | 8                    | PCP/specialist change requests                 |
|                                 | Inaccurate provider directories         | 7                    | Provider detail inquiries, access grievances   |
| Benefits and product management | Premium increases                       | 9                    | Rising OOP costs, price sensitivity inquiries  |
|                                 | Benefit gaps (dental, vision, wellness) | 7                    | Declining benefit utilization                  |
|                                 | Cost-sharing complexity                 | 8                    | Benefit clarification calls                    |
| Claims and financials           | Claims denials or delays                | 8                    | Repeated claim status inquiries                |
|                                 | High member cost responsibility         | 9                    | Appeals, payment disputes                      |
|                                 | Lack of cost transparency               | 7                    | Unexpected bill complaints                     |
| Medical management              | Poor care coordination                  | 7                    | ED overuse, care gaps                          |
|                                 | Delayed or denied authorizations        | 8                    | Appeals, provider escalation                   |
|                                 | Low preventive care engagement          | 6                    | Missed preventive services                     |
| Customer service                | Slow issue resolution                   | 8                    | Repeat calls, unresolved tickets               |
|                                 | Inconsistent service quality            | 7                    | Declining CSAT/NPS                             |
|                                 | Poor grievance handling                 | 9                    | Escalations, regulatory complaints             |

## HCLTech's GUARD framework: A systematic approach to reducing member churn

Reducing member churn in today's healthcare payer landscape requires a fundamental shift from reactive retention tactics to a proactive, enterprise-wide operating model. Churn is no longer driven by a single factor or confined to enrollment periods; it is the cumulative result of pricing pressure, network access, service experience, regulatory changes and competitive intensity across the member lifecycle. To address this complexity, healthcare payers need a structured framework that embeds churn management into everyday operations.



The **GUARD Framework** provides a systematic, repeatable approach to protecting revenue and strengthening member loyalty. It integrates data, AI, analytics, engagement and governance into a closed-loop model that enables healthcare payers to continuously identify risk, intervene at the right moment and institutionalize retention as a core business capability.



### **Gather: Building the churn intelligence foundation**

Effective churn reduction begins with a robust and trusted data foundation. Churn signals are scattered across the payer value chain, often residing in disconnected systems and owned by different functions. The Gather stage focuses on unifying the data (both internal and external) to create a single, enterprise view of data required to identify at churn risk.

Key activities include integrating enrollment, eligibility, billing, claims, provider network, medical management, customer service and broker data, alongside external market data sets such as competitor pricing, subsidy eligibility changes, regulatory updates and socioeconomic indicators. Data is standardized, cleansed and governed to ensure consistency across lines of business and geographies.

### **Understand: Anticipating churn risk before it materializes**

Once the foundation is in place, advanced data science techniques (AI/ML) are applied to understand churn risk in depth. Rather than relying on lagging indicators such as historical disenrollment, the Understand stage focuses on forward-looking intelligence that answers three critical questions: who is at risk, when churn is most likely and why it may occur.

This includes predictive churn scoring, lifetime value assessment to quantify financial impact, timing models to identify high-risk windows and behavioral analysis to surface early warning signals such as billing delays, utilization anomalies or rising grievances. Together, these insights create a prioritized view of churn exposure across members, employer groups and broker channels.

### **Act: Executing targeted, timely interventions**

The Act stage translates churn intelligence into targeted, personalized interventions that address the specific drivers of attrition. Operations teams servicing members across the business functions are supported with clear insights, next-best actions and playbooks aligned to churn drivers and risk intensity. By embedding engagement into existing sales, service and care workflows, healthcare payers ensure that retention becomes proactive and consistent rather than episodic.

| Business area                               | Stakeholders   | Interventions  |
|---|--|--|
| <b>Sales and marketing</b>                  | <ul style="list-style-type: none"> <li>• Sales teams</li> <li>• Account executives</li> <li>• Broker managers</li> </ul>         | <ul style="list-style-type: none"> <li>• Proactive outreach to high-risk employer groups or members ahead of renewal windows</li> <li>• Plan comparison and benefit realignment discussions for at-risk segments</li> <li>• Broker re-engagement when reduced broker activity or migration risk is detected</li> <li>• Targeted renewal messaging informed by predicted price sensitivity and benefit gaps</li> <li>• Strengthen social media driven engagement for younger, digitally native member segments</li> </ul> |
| <b>Enrollment and billing</b>               | <ul style="list-style-type: none"> <li>• Enrollment operations</li> <li>• Billing teams</li> <li>• Finance operations</li> </ul> | <ul style="list-style-type: none"> <li>• Early identification and resolution of premium billing issues or payment delays</li> <li>• Proactive communication for subsidy changes, eligibility shifts or contribution updates</li> <li>• Guided support for plan changes, downgrades or coverage transitions to prevent hard churn</li> <li>• Automated alerts for enrollment discrepancies or coverage gaps</li> </ul>  |
| <b>Provider management</b>                  | <ul style="list-style-type: none"> <li>• Network management, provider relations teams</li> </ul>                                 | <ul style="list-style-type: none"> <li>• Proactive communication when provider terminations or network changes impact at-risk members</li> <li>• Directed navigation to in-network alternatives for members with high out-of-network utilization</li> <li>• Provider directory accuracy validation and rapid correction workflows</li> <li>• Targeted network adequacy actions for geographies or specialties linked to churn risk</li> </ul>  |
| <b>Benefits and product management</b>      | <ul style="list-style-type: none"> <li>• Product managers</li> <li>• Actuarial and pricing teams</li> </ul>                      | <ul style="list-style-type: none"> <li>• Benefit education and cost-sharing transparency for high-risk members or groups</li> <li>• Early identification of coverage gaps influencing churn</li> <li>• Scenario modeling to assess impact of pricing or benefit adjustments on retention</li> </ul>  |
| <b>Claims and financial operations</b>      | <ul style="list-style-type: none"> <li>• Claims operations</li> <li>• Finance teams</li> </ul>                                   | <ul style="list-style-type: none"> <li>• Accelerated resolution of high-impact claims issues linked to churn risk</li> <li>• Proactive outreach on denied or delayed claims for high-value or high-risk members</li> <li>• Pattern detection of recurring claims disputes triggering grievances or appeals</li> <li>• Automation of corrective actions to reduce repeat billing or claims errors</li> </ul>  |
| <b>Medical management (um / cm)</b>         | <ul style="list-style-type: none"> <li>• Utilization management teams</li> <li>• Care management teams</li> </ul>                | <ul style="list-style-type: none"> <li>• Early outreach for members experiencing repeated prior authorization denials</li> <li>• Care coordination support for members with fragmented care or frequent transitions</li> <li>• Proactive case management for high-risk clinical cohorts correlated with churn</li> </ul>   |
| <b>Customer service</b>                     | <ul style="list-style-type: none"> <li>• Contact center agents</li> <li>• Service supervisors</li> </ul>                         | <ul style="list-style-type: none"> <li>• Priority routing of high-risk members to experienced service agents</li> <li>• Guided next-best-action support during calls based on churn drivers</li> <li>• Proactive outbound calls triggered by negative sentiment or repeat contacts</li> <li>• Post-interaction follow-ups to confirm resolution and rebuild trust</li> </ul>   |
| <b>Executive and operational governance</b> | <ul style="list-style-type: none"> <li>• Payer leadership</li> <li>• Operations heads</li> </ul>                                 | <ul style="list-style-type: none"> <li>• Cross-functional churn review forums using shared dashboards and KPIs</li> <li>• Performance tracking of intervention effectiveness and ROI</li> <li>• Incentive alignment to retention outcomes across teams</li> <li>• Continuous refinement of playbooks based on observed churn patterns</li> </ul>   |

## **Reinforce: Monitoring outcomes and driving continuous improvement**

The Reinforce stage focuses on measuring outcomes, learning from interventions and strengthening performance over time. Key metrics such as churn rates, renewal outcomes, grievance trends, engagement effectiveness and retention ROI are monitored continuously.

Feedback loops ensure that insights from real-world outcomes are continuously fed back into predictive models and ongoing engagement strategies. This allows healthcare payers to refine risk thresholds, improve intervention targeting through constant personalized touchpoints and adapt to changing market or regulatory conditions.

Reinforcement also includes performance transparency, ensuring that teams understand how their actions influence retention outcomes.

## **Defend: Institutionalizing retention as a core capability**

The final stage of the GUARD framework focuses on sustainability. Defend ensures that churn reduction is embedded into governance, operating models and accountability structures, rather than treated as a temporary program.

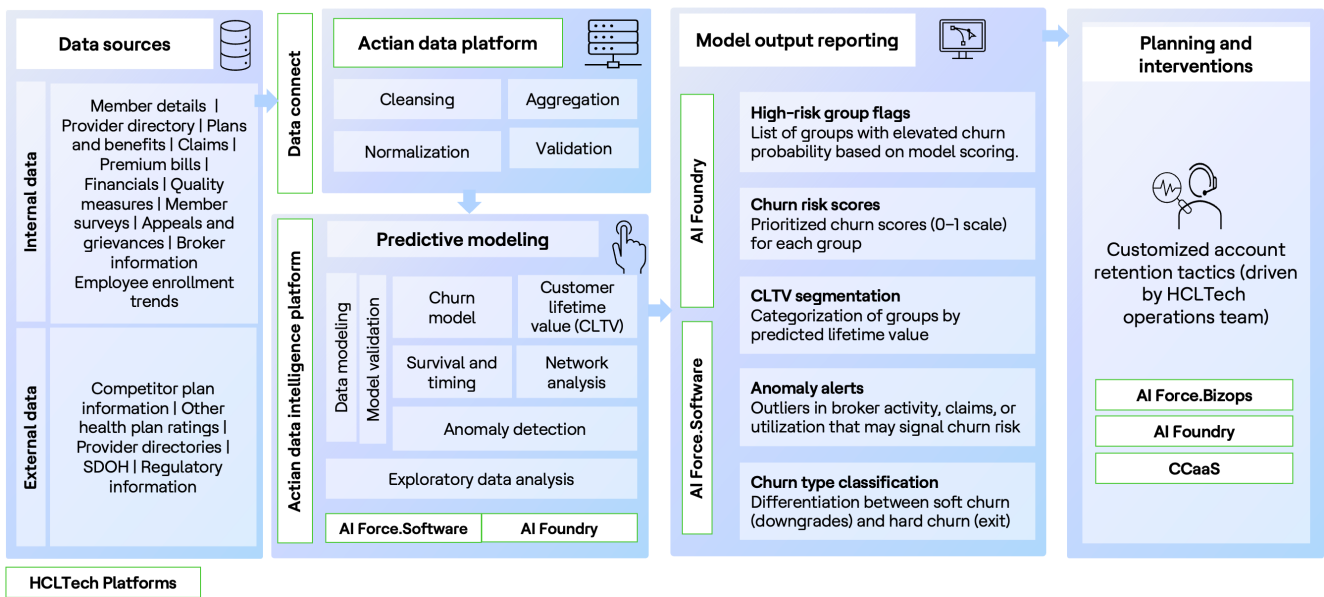
This includes formalizing retention ownership across functions, aligning incentives to retention outcomes and integrating churn metrics into executive dashboards and planning cycles. Over time, healthcare payers build organizational muscle memory around retention, enabling them to respond quickly to emerging risks and competitive threats.

By institutionalizing churn management, payers move from defending against attrition to actively protecting and growing the value of their membership base.

# **Enabling the GUARD framework: HCLTech's integrated solution approach**

Operationalizing the GUARD framework at scale requires more than isolated tools or analytics models. Healthcare payers need an integrated enterprise solution that connects data, intelligence and execution across the payer value chain. We enable enterprise-scale churn reduction through an integrated solution architecture that combines data platforms, AI/ML intelligence, automation and customer engagement technologies. Together, these solutions transform fragmented churn signals into actionable intelligence and embed retention directly into payer operations.

## Integrated data, AI and operations solution for churn management



**Action data solutions:** AI-led enterprise data and metadata foundation for intelligent churn analytics

At the core of the solution architecture is **HCLTech's Action Data Platform**, which provides an **AI-led data and metadata management foundation** for churn intelligence. Beyond traditional data ingestion and integration, Actian enables intelligent metadata-driven ingestion, integration and governance of structured and semi-structured data across the payer ecosystem, including member demographics, enrollment and eligibility, benefits, claims, billing and financials, quality measures, grievances, broker activity and enrollment trends. External datasets such as competitor plan information, provider directories, SDOH indicators and regulatory data are seamlessly incorporated to enrich churn analysis.

Action's data capabilities extend to cleansing, normalization, validation and aggregation, ensuring that downstream analytics and AI models operate on trusted, analytics-ready data. By consolidating disparate data sources into a governed enterprise layer, Actian eliminates data silos and enables a consistent view of churn risk across lines of business. A key differentiator is Actian's ability to establish an **enterprise knowledge graph** that links entities. By maintaining semantic relationships across the entities, the platform enables a richer, context-aware understanding of churn drivers.

### HCLTech's AI Force software and AI Foundry: Advanced analytics, AI/ML and Agentic AI

HCLTech leverages our proprietary **AI Force software** and **AI Foundry** to deliver advanced AI/ML capabilities on top of the enterprise data foundation. AI Foundry provides industry-aligned modeling and orchestration capabilities used to develop and operationalize churn propensity models, customer lifetime value (CLTV) models, survival and timing analysis, anomaly detection and churn type classification. These models generate prioritized churn risk scores, high-risk flags, segmentation outputs and early warning alerts.

AI Force software accelerates the development and deployment of these capabilities through GenAI-enabled SDLC automation, enabling faster model iteration, explainability and scalability. Together, these platforms support Agentic AI orchestration, allowing predictive insights to be continuously refreshed and contextualized as new data signals emerge.



### **AI Force BizOps: Operationalizing retention at scale**

Predictive insight alone does not reduce churn without execution. **AI Force BizOps** operationalizes churn intelligence by embedding it directly into payer workflows. It translates model outputs from AI Foundry to actionable work items, guided playbooks and decision support for frontline teams. Within AI Force BizOps, a coordinated set of AI agents work together to translate churn signals into consistent, role-specific actions across sales, service, care management and account management teams.

**Workflow automation agents** monitor prioritized churn risk outputs and automatically generate work items, route cases and trigger playbooks based on predefined policies and real-time context. **Knowledge agents** surface relevant policies, benefit information, historical interactions and resolution guidance at the point of action, ensuring frontline teams have the right information when engaging members or employer groups. Decision agents apply next-best-action logic—combining churn risk, member value, timing and operational constraints to recommend the most effective intervention for each scenario. **Correspondence agents** automate and personalize member and employer communications across channels, ensuring timely, compliant messaging aligned to churn risk and lifecycle events, while capturing response and sentiment signals to continuously refine engagement strategies.

This approach ensures that retention actions, such as proactive outreach, service recovery, broker engagement and renewal support are timely, consistent and aligned to churn risk and customer value.

### **CCaaS: Intelligent customer engagement and service automation**

HCLTech's **Contact Center as a Service (CCaaS)** capabilities enhance customer engagement across inbound and outbound channels. CCaaS enables conversational AI, intelligent call routing, automated outbound campaigns, call summarization, sentiment analysis and real-time agent assist. These capabilities allow healthcare payers to proactively engage members and employer groups showing early signs of churn, while also improving service quality and consistency.

Insights from customer interactions, such as sentiment shifts, repeated complaints and escalation patterns, are fed back into the analytics layer, strengthening churn prediction and intervention effectiveness.

Together, Actian data solutions, AI Force software, AI Foundry, AI Force BizOps and CCaaS form an integrated, closed-loop architecture that enables the GUARD framework in practice. This solution-led approach allows healthcare payers to move beyond reactive churn management and build a scalable, enterprise-grade retention capability that protects revenue, improves member experience and adapts to evolving regulatory and market conditions.



## Tracking the success of the churn reduction program

Healthcare payers must move beyond retrospective reporting and establish a performance management approach that links predictive insight, operational interventions and financial outcomes. Tracking success requires a combination of leading indicators, lagging results and continuous feedback loops embedded into business operations. A structured KPI framework enables consistent measurement across the payer value chain. Typical metrics include:

**Churn rate and renewal rate**, segmented by product, geography, broker and risk tier

**Revenue at risk vs. revenue retained**, aligned to CLTV

**Intervention effectiveness**, measured through uplift in renewal probability or churn reduction post-intervention

**Grievance and appeal trends**, including repeat issues and resolution time

**Customer experience indicators**, such as CSAT, NPS and sentiment trends

**Operational metrics**, including intervention cycle time, automation rates and agent productivity

HCLTech's solution helps to surface these KPIs at regular intervals and tailor them by stakeholder groups to ensure accountability.

## Conclusion

Member churn has emerged as one of the most material risks to healthcare payer growth and profitability. Rising affordability pressures, regulatory changes, network disruption and heightened consumer expectations have fundamentally changed how and why members leave. In this environment, churn is no longer a downstream outcome to be managed at renewal—it is a continuous, enterprise-wide challenge that must be addressed proactively across the payer value chain.

Together, the GUARD framework and HCLTech’s integrated solution architecture offer healthcare payers a differentiated path to reducing member churn by combining AI-led prediction, agentic execution and embedded governance into a single, closed-loop operating model. By unifying churn intelligence on an enterprise data foundation and translating insights into automated, role-specific interventions across the payer value chain, this approach enables retention to move from a reactive, siloed effort to a scalable, accountable business capability. Tracking success through a robust performance management model ensures that churn reduction delivers tangible business value. When measured across retention outcomes, financial impact, operational effectiveness and member experience, the program becomes self-reinforcing—continuously improving through feedback, governance and executive oversight.

With the GUARD framework and HCLTech’s integrated AI solution approach, payers can quickly transform their member churn management from a tactical into a strategic, enterprise-level capability.

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