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# The Changing Healthcare Landscape

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Imminent Market  
Forces and the  
Transformation  
Opportunity

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A Bulletin from  
HealthScape Advisors

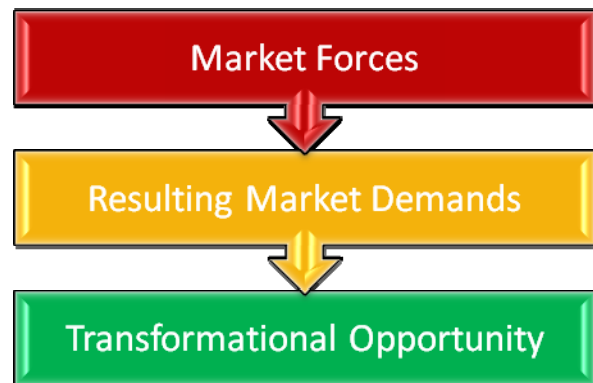
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## Abstract

The health care reform debate continues its winding path. If the Federal government fails to implement nationwide reform, states will likely fill the void with a patchwork of home-grown solutions. However, to date, the reforms considered at the Federal and state levels consistently fail to address the fundamental issue all health plan executives know will drive the future success of their organization: long term cost containment. Even if the current legislative efforts fail, the focus on unsustainable cost trend of healthcare and inequitable access ensures that several key market forces will drive changes that require health plans to compete on fundamentally different dimensions.

In this bulletin we assess the cumulative impact of four significant issues facing the industry. The intertwined nature of these issues creates certain forces that will likely drastically alter the landscape and role of health plans in the future. We believe that in the end, a health plan's position in this new landscape may largely be driven by its speed to move beyond the threats these issues pose to the opportunities that may be at hand. The four most widely recognized market forces facing plans in the near future will drive the new landscape: *failings of the current reimbursement model; underwriting implications of community rating and other regulatory "insurance reforms"; transparency of price and quality measures; and health information technology changes.*

These market forces have been studied extensively independently, yet thorough analysis of their interrelationship has been relatively lacking. The collective effect of these emerging forces will spur demand for new services and solutions and will afford health plans the opportunity to achieve long-term cost containment thereby sustaining their competitive position. There will be significant challenges in leveraging this transformation; this white paper addresses how health plans can begin the transformational process.



The issues facing health care today are not new. Contrary to current political rhetoric, health plans have not caused this predicament. Rather, dominant fee-for-service (FFS) reimbursement models have been perpetuated by fragmented care-delivery and the slow adoption of certain enabling technologies. Yet, this can and must change to meet the market's current demands.

**Health care will change more in the next three to five years than any other period over the last forty years. This rapid, unprecedented change creates a brief window of opportunity for health plans that are willing to act boldly and remake themselves to compete in the dramatically altered future landscape. Forward-looking health plans that deliver differentiated value to their partners and prioritize member wellness will dominate the future market.**

### ***Market Forces in U.S. Health Care***

***The Broken Fee-for-Service Model*** – Health care reimbursement in the U.S. is often accurately referred to as a “sick-care system.” Providers get paid to perform services; payment has less to do with improving patient wellness and more to do with the number of services rendered. Health plans have tried to address this by “discounting” services, but this has only resulted in delivering more services and high-cost procedures that often do not provide any improvement to health outcomes. This failing FFS system has resulted in health insurance premiums rising 131% during the last ten years<sup>i</sup>.

If health plans cannot replace this model, relentless government intervention in this marketplace will continue to grow over time. Massachusetts provides a potential window to the future. Despite its recent insurance reform efforts, Massachusetts has experienced

continuing acceleration to the growth in health care costs driving the state to consider a statewide global payment system<sup>ii</sup>. The recent Massachusetts race for the vacated Senate seat is clear evidence that, in the end, cost-containment and affordability is at least as important, if not more so, than universal coverage for most consumers.

***Underwriting Implications of Community Rating or Other Forms of Pricing Restrictions*** – Today's insurance underwriting for small groups and individuals will most assuredly undergo change. If Federal insurance reform does not occur, most states will likely step in with a populist approach to “protecting” consumers through pricing controls. As a result, the future will bring some form of guaranteed issue and new prescribed pricing constructs that largely ignore the underlying claims experience of members that are purchasing insurance.

As community rating and other regulatory constructs drive risk management away from groups' and individuals' experiences, health plans must find other means to manage the profitably and competitiveness of their business. As health plans are constrained from “re-rating” a high-cost group, they must turn to product-design techniques combined with integrated clinical and network solutions that promote member health, as well as evidence-based methods of lowering the cost of care provided.

***Price and Quality Transparency Through Exchanges or Other Means*** – Federal and/or state legislative reforms, as they unfold over the next several years, will likely drive some group and individual business through insurance “exchanges” or other forms of transparent comparative market place. Exchanges normally lead to highly standardized product structures

that can be easily compared across competing companies. As insurance price and quality transparency is created by such platforms, “spread sheeting” will accelerate the need for clinical health and network solutions that deliver more affordable prices to the market.

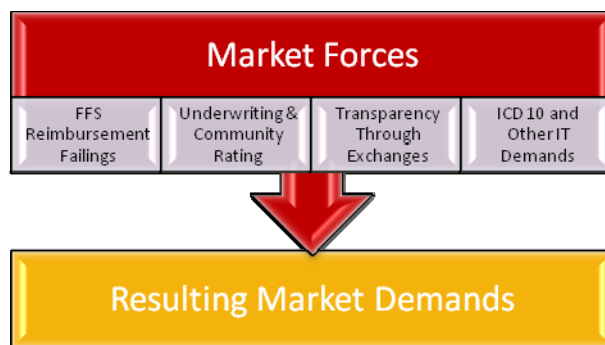
**Technology will Enable the Transformation –**

New health information management tools such as Electronic Medical Records (EMRs), Personal Health Records (PHRs) and ICD-10 will enable an organization to expedite total population health management, integrated network management solutions and reimbursement transformation. Deploying these strategies will help plans transform their operating model.

ICD -10 provides a perfect example of how health plans should plan strategically to re-position for the new healthcare landscape. Most IT specialists agree that the complicated ICD-10 transition will make Y2K appear easy<sup>iii</sup>. Nevertheless, many question whether this will be a game-changing tool for transformation. Some parties will treat ICD-10 as an IT remediation issue first and a business issue second. Others will focus first on the richness and speed of the available clinical information to then transform medical management and risk adjusted reimbursement models.

The US significantly lags in adopting EMR technologies with an adoption rate of less than 50% in comparison to 90%+ adoption rates in most advanced industrialized nations<sup>iv</sup>. In addition, technology that helps collect and share critical patient data in PHR is evolving rapidly. As technology adoption accelerates in the U.S. through Federal incentives, health management and collaborative care will advance rapidly.

These modern health information tools will enable rapid improvement in wellness, disease management and evidence based medical care to create a new era in health management. Plans must be creative in deploying their capital toward information management while leveraging the capabilities of health exchanges and other collaborative efforts to share health information to improve quality and efficiency. Plans must also re-evaluate their partnering relationships with providers, members, and employers to effectively deploy these tools throughout the care continuum via an integrated approach.



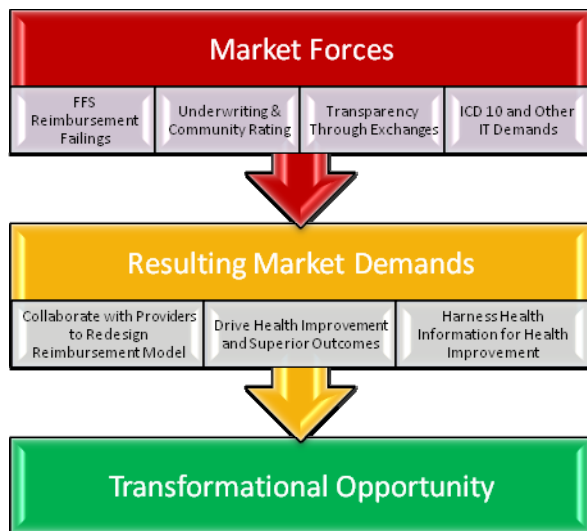
**Market Demands Driven by These Interrelated Market Forces**

Reducing costs by emphasizing long-term member health will be the key differentiator of successful plans. To replace today’s broken FFS model, health plans will be tasked to deliver customized reimbursement models and techniques. Plans that focus too heavily on legacy functions will be left behind in this transformative period.

Distribution of individual and small-group products through transparent insurance exchanges or other comparative platforms will allow plans with *true* integrated health management programs to flourish, while slow adopters will be unable to maintain competitive

prices and will suffer declining enrollment that may be irreversible. Increased price-sensitivity for all product offerings will drive change faster than ever seen before.

In this new price-sensitive market, employers and consumers will demand that plans incorporate clinical information tools and techniques to drive advanced health management and integrated reimbursement models. Plans must promote quality performance and healthy outcomes, not merely control the raw volume of services. It is critical that plans use the fastest and most effective means of obtaining, aggregating and disseminating critical information to reduce medical spend for its member population.



### ***The Health Plan Transformed***

The renewed urgency to contain costs creates great opportunities to learn from and avoid past failings. Whether integrating new technologies or implementing performance-based payment methods, health plans and providers are beginning to recognize that future success lies in rebuilding trust between providers and plans to collaboratively work towards the ultimate

goal of cost effective population health improvement.

The market views the old model of controlling the cost of services as inadequate. Today, successful plans will encourage fewer services through sophisticated consumer engagement and provider incentives to drive better long-term health. Additionally, for certain high-risk populations, the focus will shift to coordinating and deploying historically underutilized preventive and wellness services combined with continual reinforcement of lifestyle changes through the primary care channel to improve health and reduce cost. Better integrated primary care programs and reward mechanisms are the centerpiece of a model that promotes long-term health and wellness.

**The fragmented nature of our healthcare system best situates health plans to achieve the goal of long-term cost containment.** Plans are connected to all players in the system including patients, families, employers and all providers in the continuum. They also control the majority of the financial incentives and disincentives needed to drive rapid change. As such, health plans can gather and aggregate information beyond medical encounters and disseminate it via appropriate platforms to improve members’ health and reduce medical-treatment costs.

Leading health plans are moving from “insurance carriers” to “health and wellness organizations.” Increased investment in wellness and lifestyle management, chronic care condition management and advanced direct-to-consumer delivery through provider-segment partners are table stakes in the new healthcare competitive landscape.

Reimbursement change will culminate in the successful adoption of global payment structures which align cost and quality for health systems. However, historic failings of capitation will not allow the realization of this solution overnight. Plans must work with their providers to evolve reimbursement techniques from today's FFS model. This strategic migration will likely begin with incentive, disincentive and reporting mechanisms to align behaviors with the ultimate goal of health improvement and cost reduction. Over the longer term, providers will begin to accept the concept of partial or full capitation as they gain comfort with global population-cost behavior, improved risk-adjustment techniques, advanced pay-for-performance models and quality measurements which protect both providers and consumers from undue risk. These capitation models may take the form of Medical Homes or Accountable Care Organizations. This evolutionary process will create "win-win" structures over time that not only align incentives, but will also integrate vital care for patients, thereby improving both health status and outcomes.

This market-driven solution will achieve superior results to any model driven by the government and consumers and employers will embrace the new roll of the health plans that serve them.

### ***Barriers to Transformation***

***Change must happen locally*** –The variability in local care-delivery models across geographies is tremendous. Rural versus urban or academic medical centers versus other acute-care centers are just two examples. Nevertheless, diverse local models are so widely accepted in the U.S. that their inconsistencies are often glossed over when assessing system-wide medical cost containment.

The path to a system-wide solution in the U.S. lies in these hundreds if not thousands of local systems. Getting any provider to adopt a given approach is the single biggest challenge in achieving the transformation, so there cannot be a one-size-fits-all approach. Yet all plans should be prioritizing several imperatives:

- Capitalize on their intimate knowledge of each local health system and collaboratively work with providers to move to an integrated solution.
- Analyze each local market to create a customized, staged path to success.
- Redesign all interactions with providers to reduce administrative cost.
- Change incentive/disincentive structures to manage the health of the plan's population.
- Ensure integration and coordination of care across the provider spectrum with minimal administrative burden.

This can be difficult to achieve in most localities. The health reform debate has brought much attention to the few truly integrated models. However, on a system-wide basis, successful, integrated care is the exception not the rule; they cover a small portion of the population and have evolved over decades. The U.S. is running short on time and does not want to force providers to convert universally to a centrally-owned and -controlled model such as these integrated systems.

***Understanding Provider Finances*** - Plans have the potential to be the catalyst to guide providers through this change by becoming a partner in improving the provider operating model as it relates to both revenues and costs.

On the revenue front, the conventional wisdom is to pay for quality. However, based on the recent results of Medicare pilot programs, many now believe that pay-for-performance based on quality measures is not adequate unless it is taken out of the FFS environment.<sup>v</sup>

Advancement in risk-adjustment capabilities is creating reasonable methods to migrate to universal payments that reward performance without creating significant insurance risk for the provider. These holistic models reward the provider continuum for reducing overall medical costs by improving patients' health.

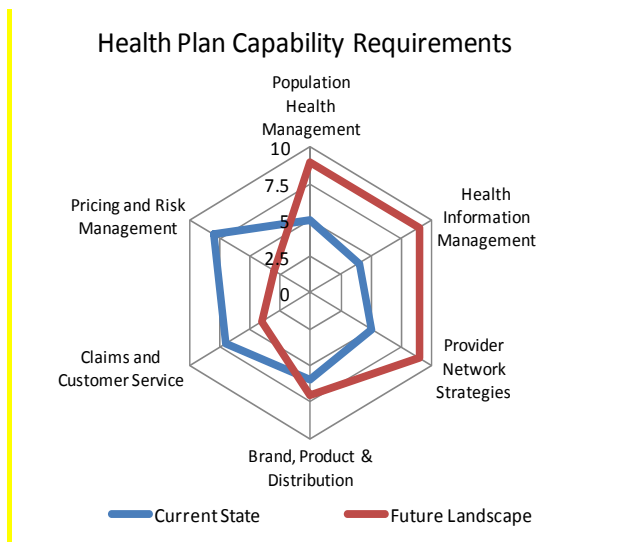
ICD-10 will further enhance a plan's ability to account for risk and measure outcomes. These types of changes will advance how patient health improvement is measured.

Universal payment adoption is complex and will not happen overnight; it will evolve over time via a careful partnership between the plan and provider. Plans must consider interim alternatives to expand providers' revenue if service-based payments are curtailed. For example, plans may reconsider their role in disease management and wellness processes by transitioning certain clinical management responsibilities to the primary care community. This increases a provider's revenue base and improves the patient's adherence levels. Furthermore, even if a provider declines risk-adjusted capitation, plans must measure the cost and health of members treated by the primary care physician and incent them accordingly. In specialty and acute care, the plan can "reward" the adoption of clinical pathways and other evidence based medicine techniques.

On the cost side, payors and providers alike must focus on reducing overall cost through improved population health and outcomes while simultaneously streamlining administrative functions. Unfortunately, providers' revenue-cycle experts and the related payor focus on FFS reductions have created enormous administrative loads on both sides that hinder such objectives. Global reimbursement structures could be a quick fix, and the administrative cost savings of these approaches may speed adoption of those techniques. However, it is unrealistic to believe that providers will adopt these structures overnight. Plans must consider interim steps and continually re-evaluate administrative activities and prioritize those that support efficient population health improvement to achieve speed to market.

Implementing the newest administrative tools can be a catalyst for change. For example, all inpatient and outpatient contracts will need to be re-contracted as a result of the ICD-10 conversion, which is a unique opportunity to move to new reimbursement structures that better align incentives while lowering administrative costs for everyone.

***Transformation Starts Within*** – Health plans have typically focused on reducing costs through comprehensive FFS claims systems and accurately setting prices for its customers. Yet the successful plan of the future must migrate its business model to holistic solutions that draw upon a global understanding of medical management, contracting, operations, actuarial, and information management. Competitive plans will emphasize collaboration between these disciplines through mutual collection and analysis of health information with members, delivery system partners and human capital.



### ***Optimizing the System-wide Use of Health Information***

Health plans historically created value by aggregating the flow of money to create significant purchasing power for their customers. In the new era, value – and population wellness, for that matter - will be driven by capitalizing on information. Understanding a patient’s health over time is essential for improving disease management and population health programs for the 10% share of the population that drives over 60% of total spend. For most localities, the health plan is the repository of the broadest data set available to monitor and manage the long term health of patients. Technology advancements such as ICD-10 will make this data set even richer. Other IT developments will collect, transmit and share timelier, ongoing health status information. Similarly, the adoption of EMR is critical to delivering efficient care, particularly in an un-integrated health system. Leveraging these tools combined with the health plan’s control over the incentive and disincentive framework for both the provider and the patient allows for the alignment of all parties’ interests to capitalize on robust and timely information to improve and maintain health of the plan’s members.

To reduce costs via these information systems, the successful plan must take several steps to create a central nervous system of strategic transformation:

- Begin to shift its information management efforts from claims processing to health management.
- Facilitate connectivity and standardization initiatives between itself and all constituents including providers, members and their families, employers and regulators.
- Incorporate its health information strategy into every aspect of its business from provider contracting to medical management to product design.
- Offer incentives to gather health and medical data and deliver that information to the right place at the right time.

### ***The Clear Road Ahead***

Due to market forces facing the industry, health plans must transform or consolidate. The magnitude and speed of change during the next three to five years will certainly drive which path organizations take. Certainly, the capital required for major transformations will cause many to consolidate, and Third-Party Administrators (“TPAs”) will likely be the most severely impacted. As population health and other medical-cost-containment methods create a competitive environment, self insured groups will seek new solutions to constrain medical costs, and the TPA model of discounted FFS networks and low administrative costs will no longer be viable.

Large, national plans have the scale and capital to implement solutions that collect, aggregate and distribute the data required to integrate processes and improve member health. They also have more localities from which to pilot, evaluate and refine their strategies.

Conversely, regional plans (particularly not-for-profits) have better provider relations and are more nimble and responsive to local market needs. For decades, the local nature of healthcare in the U.S. has allowed these plans to survive, thrive and compete and the same will likely ring true in the new era. The trust and cooperation required to achieve population health improvement through reimbursement restructuring will likely favor the local, regional plans. Furthermore, such plans can quickly organize themselves for rapid deployment of products, thereby making themselves quite competitive. Finally, to address scale issues that large national plans do not face, regional plans will likely form partnerships with non-competing entities to spread the investment to a larger base of members.

***Strategic elements in the transformation process*** - Health plans should consider several elements to succeed throughout this process:

- Create organization-wide commitment to transformation as the centerpiece of the long-term strategic plan.
- Recognize that it will be difficult to get providers to change, mandating a collaborative and staged approach throughout the transformation.
- Develop and deploy comprehensive local-network reimbursement solutions that continually evolve to create mutually beneficial outcomes for plans, providers and patients.
- Build or acquire broad health management capabilities to create and maintain long term member health.
- Consider joint ventures in areas requiring significant capital investment to speed deployment and spread the cost to a larger membership base.
- Position the organization as the transparent health information hub for all participants in the health system.

***Creating an Infrastructure for Change*** - Indeed, the transformation process could be disruptive, which is why it will require commitment from senior management to move past the safety of the status quo. As such, organizations must assemble a “transformation team” comprised of senior professionals in networks, medical management, information systems, sales, actuarial, product design, operations and legal. This will foster the development of creative and practical solutions to overcome historic internal and external barriers to success. Even so, transformation will require resourceful and customized approaches in relatively uncharted waters. Therefore, plans must use new analytical tools and conceptual frameworks to help achieve system-wide cost reductions.

This discipline will allow the plan to collaborate with providers, health systems and employer groups to create customized, local solutions to incent patients and providers to improve member health to avoid treatment costs, reduce the cost of required treatment and

thereby reduce the overall system costs. Plans must also address the urgency of market demands while recognizing that transformation will not be created overnight; it will evolve as plans and providers capitalize on the continual advancement of health information capabilities and management techniques. Plans must create a long-term vision and break down the process into achievable stages over the next five years. Then they can employ a disciplined and relentless pursuit of each stage of transformation with long-term success in mind.

Health plans that urgently execute on these few vital dimensions will realize a long-term sustainable advantage. In the end, successful

plans will be those that act with speed, organizational alignment, refinement-through-experimentation, flexibility, creativity, and focus. They will continually evolve their relationships with providers to keep members healthier and treat medical issues cost-effectively to achieve superior outcomes. The competitive nature of the health insurance industry holds the key to the U.S. solving the issue that is now seen as the greatest threat to our long-term economic health. If successful, the industry will not only survive, it will thrive, and at the same time position the U.S. economy to compete from a position of superiority.

## **ABOUT HEALTHSCAPE ADVISORS**

HealthScape Advisors LLC is comprised of experienced consultants who assist healthcare organizations in navigating the changing industry landscape and transforming their businesses to deliver sustainable market value. With particular focus on health plan operations, claim reimbursement, government health programs, regulatory and compliance requirements, disputes and investigations and business acquisitions and integration, the firm offers clients across the United States exceptional analytical skills, objective and fact-based thinking and innovative problem solving.

## **ABOUT THE AUTHORS**

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Arjun is a managing director and founder of HealthScape Advisors. He has more than 15 years experience helping healthcare clients with performance improvement, regulatory concerns, government programs, and disputes and investigations. Arjun's work is concentrated on helping firms strategically align themselves in the ever changing healthcare industry. As part of this work, Arjun is actively involved in assisting his clients navigate through the current Healthcare Reform landscape. Previously, Arjun served as a managing director of a publicly traded consulting company and, prior to that was a partner at Arthur Andersen.

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John has advised healthcare clients for nearly 15 years on business growth, profitability improvement and risk mitigation assignments. John has been actively involve in advising clients on how their business will be impacted by the current market forces and executing strategies to prepare his clients for the future environment. He began his consulting career at Arthur Andersen, and then became managing director at a publically traded consulting company until he co-founded HealthScape Advisors.

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Kyle is a managing director at HealthScape Advisors. For more than 15 years, Kyle Stern has worked exclusively in the healthcare industry. His broad range of experience serving in corporate leadership, as well as in a consulting capacity, provides him with the unique ability to anticipate and meet the ever-expanding needs of healthcare clients. Prior to founding HealthScape Advisors, Mr. Stern served as chief financial officer of UnitedHealth Specialty Benefits and as chief financial officer for a subsidiary of Sierra Health Services. Prior to Sierra, he worked at Arthur Andersen.

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### Steve Young

With more than 20 years of healthcare experience, Steve Young, managing director of HealthScape Advisors, has supported clients in virtually every segment of the healthcare industry, with a particular focus on the managed care and pharmaceutical segments. Before founding HealthScape Advisors, Mr. Young served as managing director of a large consultancy, where he led the company's efforts for the health plan and pharmaceutical industry segments. He also served as partner of Arthur Andersen earlier in his career.

Mr. Young earned his Bachelor's in Accountancy from Northern Illinois University. He is a licensed CPA in the state of Illinois. Steve is a member of the American Institute of Certified Public Accountants, the Illinois CPA Society, American Health Lawyers Association and an Associate member of the ABA.

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<sup>i</sup> Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009

<sup>ii</sup> See "Recommendations of the Special Commission on the Health Care Payment System" dated July 16, 2009.

<sup>iii</sup> "Implementing ICD-10" by Lori Becks, RHIA, and Sheri Poe Bernard, CPC published by Ingenix, 2003

<sup>iv</sup> See Exhibit 2 of "A Survey of Primary Care Physicians in Eleven Countries, 2009: Perspectives On Care, Costs And Experiences" by Cathy Schoen, Robin Osborn, Michelle M. Doty, David Squires, Jordon Peugh and Sandra Applebaum

<sup>v</sup> MedPac, Report to Congress: Improving Incentives in the Medicare Program, June 2009, Chapter 2.