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2010 HEALTH INDUSTRY PERSPECTIVE

2009—Healthcare Reform Becomes Insurance Reform (Sort Of)

In last year's letter, we advised that healthcare reform in 2009 would be *the* issue, but that it would emerge as "more FDR-style relief than true structural change." We were mostly right, but sometimes for the wrong reasons. We underestimated the administration's commitment to the issue and its willingness to take on multiple, large-scale initiatives. However, what began as a major overhaul of the system devolved into a more limited-scope effort to aggressively expand coverage (without increasing deficits), ban or modify some long-standing insurance industry practices, and build key enablers for future waves of change.

The stimulus bill—the American Recovery and Reinvestment Act (ARRA)—got the ball rolling, as we had expected, with major funding to expand coverage through Medicaid, COBRA extensions, the State Children's Health Insurance Program (SCHIP), and the like, but it also included an unexpected nearly US$40 billion to jump-start the nation's future health information technology (HIT) base through electronic health records (EHRs), health information exchanges (HIEs), and other reform scaffolding. Then the administration signaled a full-court press on healthcare reform to be enacted in 2009. So far, so good. Then came the "summer of death panels."

Healthcare reform wasn't so much proposed by the administration as it escaped from multiple, messy legislative committee deliberations. As the political fighting ensued, it became clear that real structural change in health*care* was going to be impossible in this round. Trying to use reform as a lever for any substantive change on the demand side became a nonstarter when reimbursement for end-of-life counseling became "death panels" in the public debate. What survived are "comparative effectiveness research," aimed at standardizing prevention and treatment protocols, and a budget-balancing commitment to eliminate $500 billion in waste, fraud, and misuse in the Medicare program over the next 10 years, along with major cuts in Medicare Advantage. Beyond that, what remains of healthcare reform focuses mainly on expanding both coverage and subsidies, and reforming health insurance.

The Pillars of the First Wave of Reform

Healthcare reform may begin life as insurance reform, but the chances it will stop there are about zero. The current debate—and emerging legislation—should be viewed as the first of several "waves" of reform that will take place over the next five to 10 years. The intended and unintended consequences of these early efforts will drive future waves of change. We anticipate that the following features will be included in the final form of this wave of healthcare reform legislation, and the changes will lead to inescapable strategic implications for payors and providers.

- The individual and small-group markets for health insurance will be transformed—from today's highly concentrated state-by-state markets to state-by-state "exchanges" attracting many more competitors. Dismantling state-level health insurance regulation won't happen now, but it is clearly on the table for the next wave of change.

- Risk management at enrollment will change significantly with the ban on coverage denials due to preexisting conditions—assuming a relatively strong individual mandate for coverage. Spreading this risk more broadly and evenly (and blindly) through larger aggregations of individuals and small groups should ameliorate concerns about adverse selection.

- A public option—whether via trigger, opt-in, opt-out, discretely enacted, or in some other form—will become a reality, if not in this first wave, then in the next.

- Payment reform for providers will move from isolated experiments to a pervasive trend. For example, bundled payments for the full spectrum of care per episode or incremental reimbursement for care coordination through medical homes will move into the mainstream—en route to becoming the norm.

For better or worse, some aspects of care won't change anytime soon. Long-term care will remain the province predominantly of Medicaid. Dental care, apart from coverage for children, will not be addressed for the foreseeable future. Draconian supply-side constraints—the preferred approach of public health schemes in many other countries—will not be used, at least initially, as a back door to demand-side management. The absence of significant measures to actively manage demand, while perhaps inducing collective sighs of relief today, will loom large in future waves of reform.

Clearly, there are significant broad-based, secular issues involved in this first wave of reform—national fiscal policy chief among them. This wave will likely be deficit neutral, at least on paper. But reformers will still need to confront stark and unsustainable demand-side realities in subsequent waves of reform. For now, parochial healthcare issues such as access and coverage are the primary drivers of change.

2010—The End of the Beginning, and the Beginning of Big Change

As a result of what we expect from this wave of healthcare reform, both payors and providers have ample reason to make significant strategic changes, though payors will be under more immediate pressure. Longer term, when demand management must finally be confronted, providers will move to front and center. In fact, innovative plans and providers have a unique opportunity to begin now to work together on new models of care that have the potential to transform the delivery side of healthcare.

Implications and Strategies for Payors

Nothing short of a sea change awaits the payor sector of healthcare—no surprise, since this wave is, after all, healthcare *insurance* reform. Profit margins will be asymmetrically squeezed, operating paradigms will need to change, and capital formation and preservation will be key.

The distribution and structure of today's healthcare insurance book of business is the key to understanding the challenges that will face the industry's various competitors. The individual and small-group markets are a major source of profits for Blue Cross and Blue Shield plans, which generally dominate the segment. Their formidable distribution capability is a key advantage in their ability to win and keep these accounts. Larger groups served by the Blues are often multi-state, handled by their national accounts entity, and overwhelmingly self-insured—meaning profits on administrative services are thin, particularly for smaller plans that operate within a single state. With the advent of state-by-state insurance exchanges for the individual and small-group segments, the Blues will come under intense pricing pressure from "commercial" plans (mostly national and regional players such as Aetna and UnitedHealthcare), especially for the most profitable piece of their business.

Exchanges have the potential to change the game for the commercial players vis-à-vis the Blues. Not only are the profit margins attractive, but the exchanges introduce a structural change that will reduce the importance of the Blues' distribution advantage. The commercial plans will need to learn

new tricks to effectively compete in this expanding sector, but they are likely to prove rather nimble in pursuing these new opportunities. The exchanges will probably result in more Web-based sales, supported by mass marketing via TV, radio, print, and the Internet. Health insurance brokers will be challenged just to survive in this milieu.

To defend their book and ease margin pressures, the Blues are likely to analyze alternative operating models including downsizing their distribution network and lowering back-office costs. Whether by tradition or as a matter of political savvy, the Blues by and large have kept most of their back-office functions in-house—and in-state. Such loyalties will not be sustainable; at least some Blues will be forced to consider other options, including consolidating on a regional or national basis, outsourcing and offshoring, or selling back-office services to smaller competitors.

Product design will be a challenge for all players in the individual and small-group business. Absent large distribution networks and broker intermediation, and in the face of exchanges, more consumer-friendly product design will be increasingly important—and broad-scale customization will be less important. We expect comparable "tierings" to evolve across competitors—perhaps along the lines of silver, gold, and platinum. Given the retention of state regulation of healthcare insurance, these tiers may vary widely across the country, from bare bones in conservative states to more generous mandates elsewhere. Consumer-driven plans with high deductibles and health savings accounts will survive, but as underwriting options for these segments. Consumer-driven plans will continue to grow their share of the large-group/self-insured segment. Designing products to meet specific price points while simultaneously controlling costs will be critical to success for all insurers targeting this segment.

After nearly two years of investment hits to reserve balances, this pressing need to restructure operations, redesign products, and defend profit streams comes at a particularly inopportune time. Although the features of reform will be introduced in phases, we counsel payors to acknowledge this new world and to plan and act accordingly.

Other important issues remain in limbo for the moment, but payors can take some comfort from the likelihood that the most draconian scenarios appear to be off the table for this wave of reform. Various fees and taxes—however big or shortsighted—will fall equally on the plans, the carriers, and the sponsors, and hence will not be differential competitive factors. Further, any stampede to a public option by large employers appears unlikely—though it remains a

real future possibility if this wave doesn't result in reduced costs (or, at the least, a slowing of the rate of increase).

Providers Have Some Time, But Need to Change

A new era characterized by bundled payments and value for money is rapidly approaching; subsequent waves of healthcare reform will move providers aggressively in that direction. Already, the sector has been pursuing mostly appropriate strategies that will be in harmony with those goals. The biggest challenge for providers, though, may be envisioning the end game and defining their overarching strategies. A broader and more aggressive vision is needed.

Although demand-side controls are off the table for this wave of reform, the fact remains that both the *provision* of healthcare services and lifestyle choices by consumers, *not insurance,* drive the vast majority of healthcare expenditures. Providers are well-positioned to improve both of these leading factors but have yet to commit to the sort of change that could accomplish it. ARRA and some features of reform will help, but the sector must use such tools to advance an agenda of radically cutting cost, primarily through prevention and by reducing variability in treatments and outcomes.

The good news is that ARRA provided billions of dollars to supercharge the nation's development of EHRs and to promote seamless sharing of critical clinical information among providers, insurers, and patients. The reform package is also likely to further promote comparative effectiveness research programs to evaluate and recommend preferred prevention and treatment protocols for specific diseases. These two sets of tools are potentially powerful, but only if used as a means to an end. Ultimately, it's the meaningful interchange of information among healthcare stakeholders, potentially through HIEs, that will make the difference. And while government funding may jump-start HIEs, no one has yet articulated a sustainable business model that would support their long-term survival and stability. That said, almost all providers can and should take advantage of the incentives to aggressively implement HIT infrastructure and begin building HIEs—and take the government reimbursement for doing so.

For at least two decades, hospitals and health systems have pursued integration by acquiring practices and hiring physicians while simultaneously transforming the business side of medical practice. Such strategies will help ease the eventual transition to bundled payments and generally promote brand building and the development of centers of excellence.

But these integration strategies—even when combined with centers of excellence, EHRs, and treatment protocols—will be insufficient for turning the dial on costs. What is needed is a more dramatic inversion of the current approach to care, so that, say, 80 percent of care delivery becomes routinized and only the remaining 20 percent is customized.

Anticipating a transformed provider sector, several leading provider systems are offering what they term "strong-form" products. These products emphasize the use of "best care" pathways (evidence-based medicine, or EBM), combined with outstanding clinical talent and managerial oversight with respect to both patient care and cost. This approach also aligns well with "bundled" payments, eventually not just combining doctor and hospital bills but likely including indemnity-like payments (a specified dollar amount for a certain illness or episode, from diagnosis to rehabilitation) and maybe even evolving toward something akin to capitation.

Strong-form products, especially if developed in concert with forward-looking payors who are able to steer volume to their providers, could be a major force in reducing costs through the use of best-care protocols, which in turn would lead to dramatic reductions in variations in care and outcomes. In fact, plans that partner with innovative providers can help drive the move to EBM and strong-form products. This won't happen, of course, with a narrow vision of strong-form products as centers of excellence focused on a handful of high-profile, big-ticket treatments. The new approach, if it's to help more than a few well-positioned provider systems, must be expanded to nearly the full range of care and conditions. Only through a broad transformation is it possible to imagine a world with much lower costs, where the great majority of resources are brought to patients (and the market) via strong-form products.

The other key issue for providers is labor. While labor has been in short supply for years in nursing and the allied health professions, demand-side pressure is about to intensify as the first round of reform expands coverage. Millions of additional citizens will be looking for a family doctor (an improvement over the hospital emergency room), likely resulting in a near-term demand bubble to address existing conditions and semi-elective procedures (hernia repairs, colonoscopies, etc.). Investing in education—directly by establishing new schools or programs to train, or indirectly through scholarships with service-commitment strings attached—will be a high priority for hospitals and health systems. Investments in technology that can leverage the time and skills of clinicians also deserve serious attention. The jobs and the demand for care will be there, but little will result if we don't have the people to do the work.

The nation is taking its first steps on the healthcare reform journey, and the future is uncertain and scary. Whether it is a journey to a better place will depend more on actions by the healthcare industry than by debates in the political arena.

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