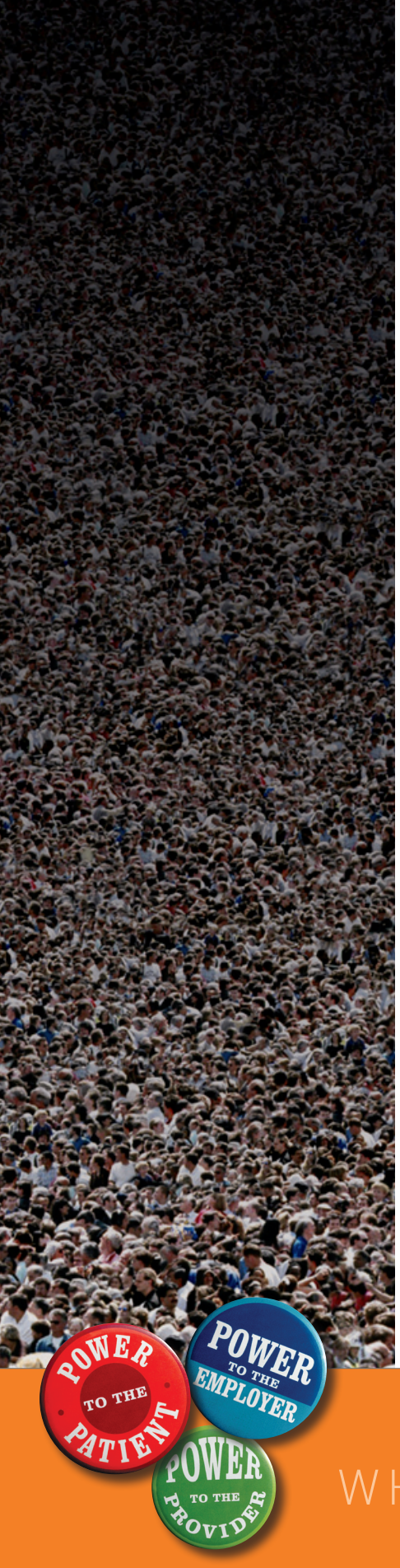

Integrated Healthcare Management:

Powering A New Era of Healthcare

Integrated Healthcare Management is the systematic application of processes and shared information to optimize the coordination of benefits and care for the healthcare consumer.

WHITE PAPER

TRIZETTO®
Powering Integrated Healthcare Management™

Contents

Healthcare in the United States faces challenges of cost, quality, consistency and availability of coverage. A variety of factors has created a growing affordability crisis that impacts the providers of care, the health insurance companies that pay the bills, the employers and government entities that purchase most medical coverage, and consumers, who find themselves paying more out of pocket than ever before. Faced with continually rising costs, consumers are paying more and receiving less in benefits, employers are shifting costs, and providers are at greater risk for carrying bad debt.

The question is why? And what can be done?

Constituents in the healthcare supply chain—consumers, providers, purchasers—are disconnected from one another, and their incentives are misaligned. Healthcare information does not flow easily among them, and they sometimes work at cross purposes. This fragmentation has fostered tremendous inefficiency and waste.

Moreover, many Americans are becoming increasingly unhealthy. The care environment is characterized by unacceptable levels of practice variation. Incentives for consumers to adopt healthy behaviors, and for providers to optimize care, are not adequate. These complex challenges have helped create our healthcare affordability crisis.

TriZetto views this crisis as an opportunity to create real and meaningful change. What we call Integrated Healthcare Management (IHM) will address the affordability crisis by systematically delivering health benefits designed to encourage better health and care delivery, while providing participants with the knowledge and incentives necessary to drive change. IHM will facilitate much-needed communication, collaboration, discipline and efficiency in the healthcare system, and create a new era where all participants can benefit.

TriZetto believes that payers are ideally positioned to lead the way toward IHM. With the use of the right information technology and processes, payers can help drive industry transformation by systematically coordinating the flow of core benefit, care management and constituent information across the system. By personalizing this information, payers can make it more relevant and meaningful for each constituent. Finally, by building incentives into the system, payers can also help drive positive behavior. Bringing together technology, personalized constituent information, and aligned incentives will give payers the power to significantly improve the quality of care, and reduce costs.

In the past decade the payer industry has invested billions in improving administrative efficiency. Payers have increasingly engaged in the management of chronic disease. More recently, they have focused on more effectively engaging constituents, particularly consumers. However, transformation will not result from a piecemeal approach. It is the convergence of the systems, information and processes that support core benefit administration, care management and constituent engagement that will fuel IHM.

The greater the convergence, the more value payers will be able to create for their constituents. IHM gives payers a way to leverage the wealth of information they hold and to capitalize on their position—as the organizations engaged with consumers, care providers and employers—at the center of the healthcare supply chain.

This white paper will outline the key challenges facing the industry, define IHM and explain how it works, how it is different from today's approach, and why payers have the opportunity to lead. Additionally we will discuss some basic steps payers can take to begin the journey of transformation.

IHM is the key to transforming and improving the way our healthcare system functions—to the benefit of every constituent. We believe that IHM can help payers:

- Design benefits tailored to individual needs
- Enable constituents to collaborate and engage on healthcare decisions, so they can make better choices and receive or provide better care
- Share knowledge by making information about treatment choices, costs and quality and options "transparent" to constituents across the entire system
- Align behaviors and incentives across consumers, providers and employers

A Healthcare Affordability Crisis

Our healthcare problem is not caused by spending too little. The U.S. spends a larger share of gross domestic product on healthcare than other industrial nations – currently estimated at 16 percent GDP and growing to near 20 percent by 2016. But inefficiencies in our system prevent us from receiving full value for the dollars spent.

A growing gap between escalating medical care costs and the amount of employee health insurance coverage employers can afford to buy is producing a healthcare affordability crisis. (See figure 1) Employers struggle to offer attractive health benefits and compete in the global economy. Virtually all Americans are paying more for their share of coverage and care. It's no wonder that healthcare has become a top U.S. political issue.

"Healthcare is politicized as a crisis in the United States, but is a very solvable problem. There is enough money being spent in the U.S. healthcare system to provide every U.S. citizen with a reasonable level of care. What we need to do is eliminate the inefficiencies in the system."

– Jeff Margolis, Founder and CEO of TriZetto

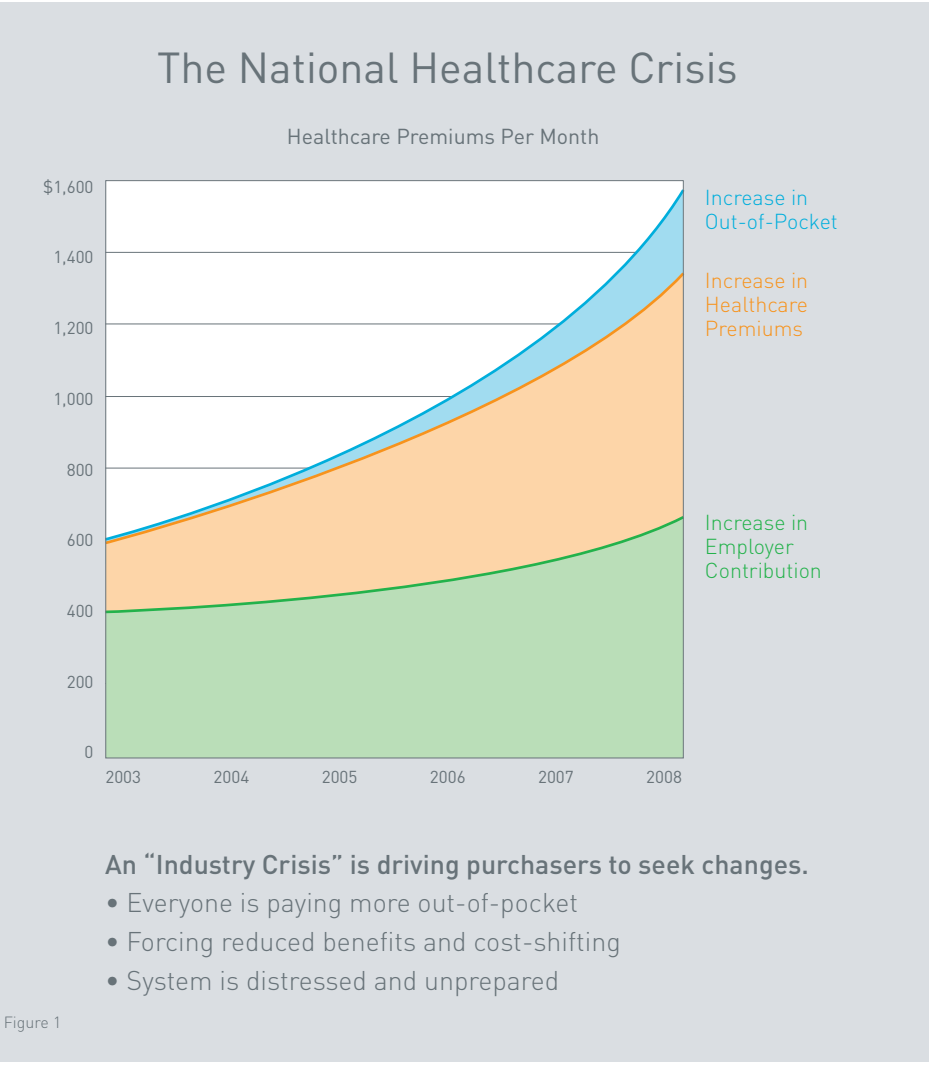

Figure 1

Among the root causes of this affordability crisis are unhealthy lifestyles, an aging population and a payment system that separates healthcare consumers from knowledge or concern about what their lifestyle and care choices really cost. (See figure 2) These problems are compounded by a medical delivery system characterized by high degrees of variation in practices, redundancy in procedures and tests and compensation based on production, not results. Yet these ills are not terminal.

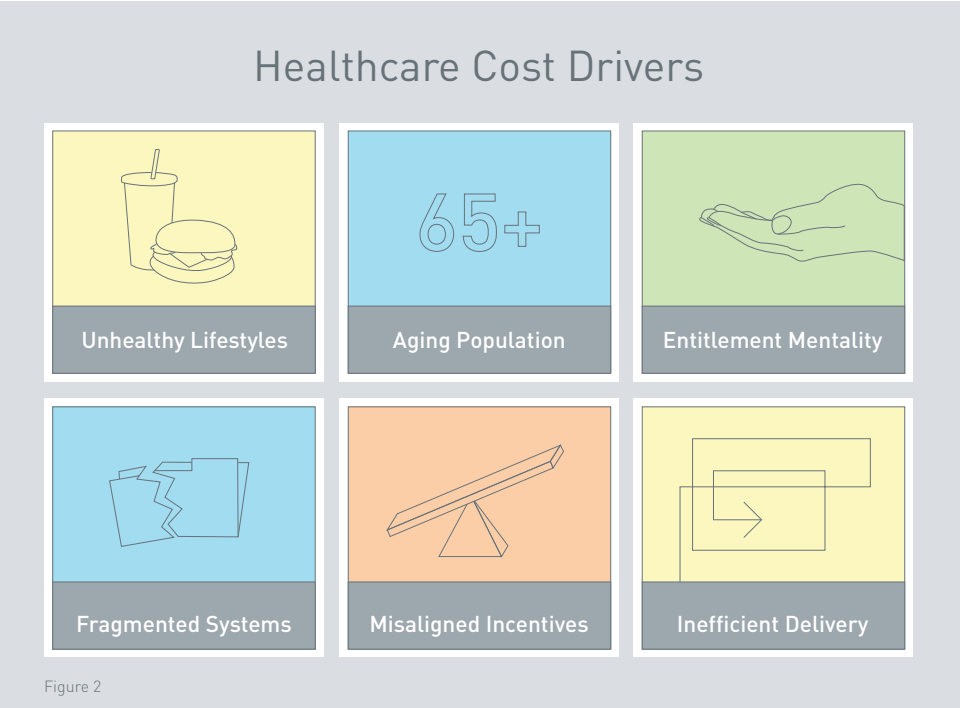

Figure 2

Health System Challenge: Fragmented Processes, Islands of Information

Across the healthcare system, constituents share the need for accurate and complete health and financial information. Consumers, healthcare providers and payers each hold key information, but the flow of information among these constituents is often limited and fragmented.

Though payers have a wealth of information about benefit plans, fund management, provider contracts, care management rules and increasingly, consumer information, their ability to act on such information has been limited by operational and technological 'silos.' (See figure 3) The systems, business processes and information flows in payer organizations have traditionally been disconnected, with little integration across the functions that design and sell health insurance products, that service the products, and that coordinate the care of the patients. The payer silos exist in three key functional areas:

Core Benefit Administration. Core systems that support payers' day to day functions and administrative efficiency have been fundamental for payers, and they have honed their capabilities to a fine edge. As financial administrators, payers have focused on improving their efficiency in claims processing and operations and driving down administrative costs, which represent 10 percent to 12 percent of the health benefit dollar. As they made gains in this area, payers also began to focus on the greater potential for savings in care management.

Care Management. Care Management includes systems that support the usage cost of care via utilization, case, disease and population management. Additionally, network management systems, which focus on the unit cost of care, drive more effective network contract modeling and pricing. In the past 5 years, many payers have begun to strategically invest in care and network management systems. They are focused on reducing the 90 percent of spending related to the delivery of care by lowering utilization and unit costs, proactively managing chronic conditions and expanding emphasis on health and wellness. Consumers with an overweight problem, for instance, may be encouraged to join exercise or weight loss programs—or pay more for healthcare coverage.

Constituent Engagement. Constituent engagement entails providing the right information, in the desired format at the right time, to consumers, providers and employers. The goal of constituent engagement is to create an efficient dialogue between constituents and the payer as well as amongst the constituents themselves. Over the past few years, many payers have focused on better understanding the consumers' preferences and needs, and engaging them in a healthcare dialogue. Only an enlightened few, however, have expanded their focus to include the important roles of other constituents, like the provider and employer.

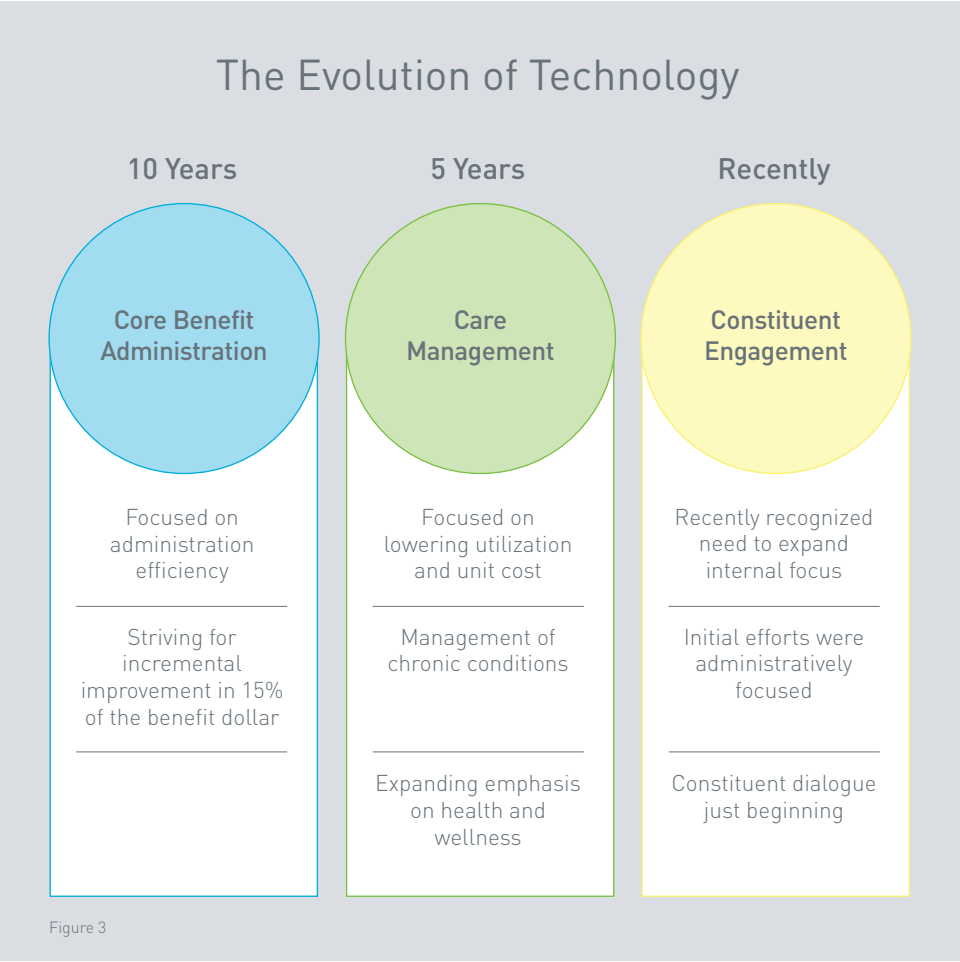

Figure 3

Though healthcare information still does not flow easily between these payer functional areas or between constituents, such as between doctors and patients, payers are well positioned to improve this situation.

"We have to remember that not everything in healthcare is broken today," said Margolis. "A lot of things are going right. We have core administrative technologies that keep track of benefits and help match up consumers to the health plans that make sense for them. We have a growing body of information about evidence-based medicine. We're getting better as an industry."

To move ahead from here, payers need to leverage the investments they have already made and add strategic new capabilities that will enable them to use the rich data at their command in a more systematic, integrated and automated way than they have up to now. Then they can connect and integrate those functional and informational silos, unlock the valuable data and experience they already possess, and engage with all participants in the healthcare system.

The Next Frontier: Integrated Healthcare Management

Today sweeping technological changes such as the Internet and wireless communication are creating new opportunities to connect people with the information they need when they need it. Other industries are far ashead of healthcare. And it's here we'll find a cure for the healthcare affordability crisis.

In a world transformed by IHM, healthcare constituents—consumers, providers, and purchasers—will share information, incentives and interactions to create optimal outcomes for the consumer: the best healthcare available based upon the individual's benefit plan. By building a new level of data sharing and collaboration among the constituents, IHM promises to foster new efficiency and effectiveness across the breadth of healthcare.

The need to solve the affordability crisis is driving the redefinition of "healthcare coverage." This redefinition is critical to achieving IHM. Forward-thinking payers are looking at new ways to partner with their employer customers by designing benefits that are not only customized for their unique business and employee needs, but also incorporate care management and integrated incentive programs. These plans may even include multi-year contracts that have clearly articulated cost reduction goals. (See figure 4)

TriZetto defines Integrated Healthcare Management as *the systematic application of processes and shared information to optimize the coordination of benefits and care for the healthcare consumer.* This is the key to transforming the way we pay for and manage healthcare.

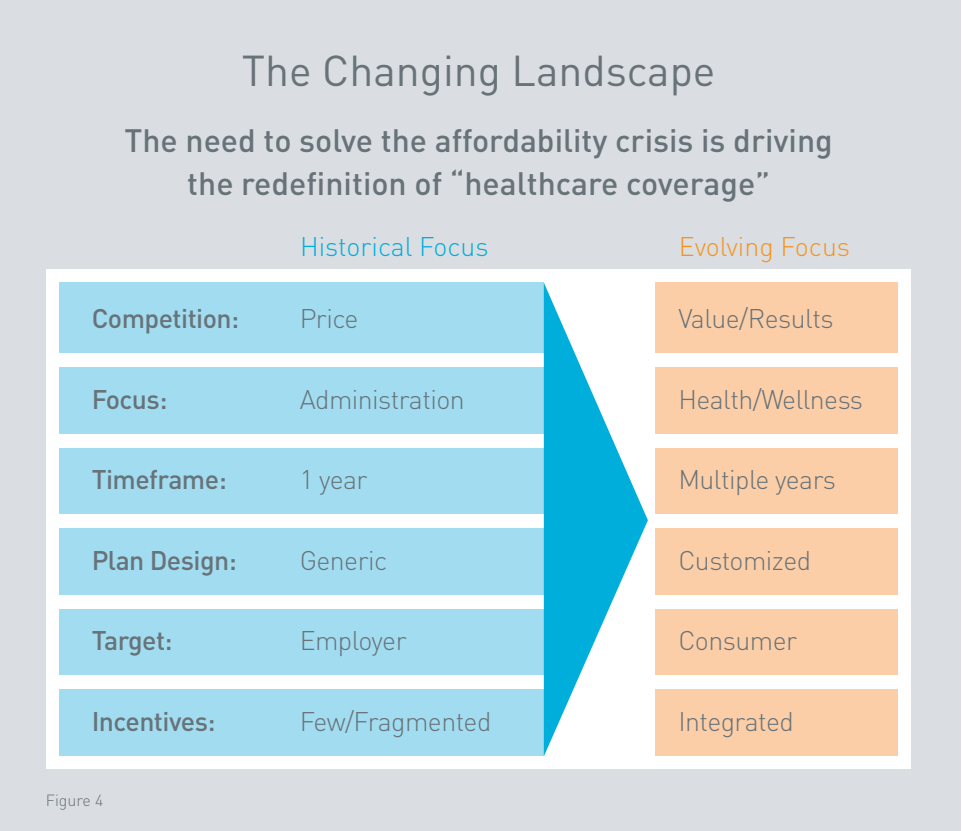

Figure 4

"The promise of IHM is to help payers fundamentally redefine the health benefit product," said Dan Spirek, Chief Solutions Officer for TriZetto. "It's the ability to bring completely new products to employers and individuals—products that are different at their core than traditional insurance products, that have the systematic ability to positively influence constituent behavior, drive lower costs and therefore be more competitive over time."

"The promise of IHM is to help payers fundamentally redefine the health benefit product."

– Dan Spirek, Chief Solutions Officer at TriZetto

So, how does the world look different with IHM? As demonstrated in the chart below, the evolution toward IHM touches all aspects of payers' business, impacting how they design products, manage health programs and share information.

Making the evolution to IHM requires that payers employ technology solutions and an information architecture that sustains their role—as the organizers of transactions and information—at the center of the healthcare supply chain. The solution must consider the interactions, information and incentives across constituents, and ultimately support the consumer's increasing direct involvement in decision making about such questions as cost, quality and personal health status. Payers that understand the diverse needs of their members, provider and employers, and offer products and services that align with their lives and needs will "win" in the market. (See figure 5) They will do so by enabling those constituents themselves to win.

Benefits for All Constituents

The proper coordination of benefits and care for the consumer requires the successful interaction of consumers, payers, employers and healthcare providers. Each of these groups has their own systems processes, which have operated largely in uncoordinated silos in the past.

By systematically informing, engaging and motivating all constituents in the healthcare system in this way, IHM has the potential to improve the system for each participant.

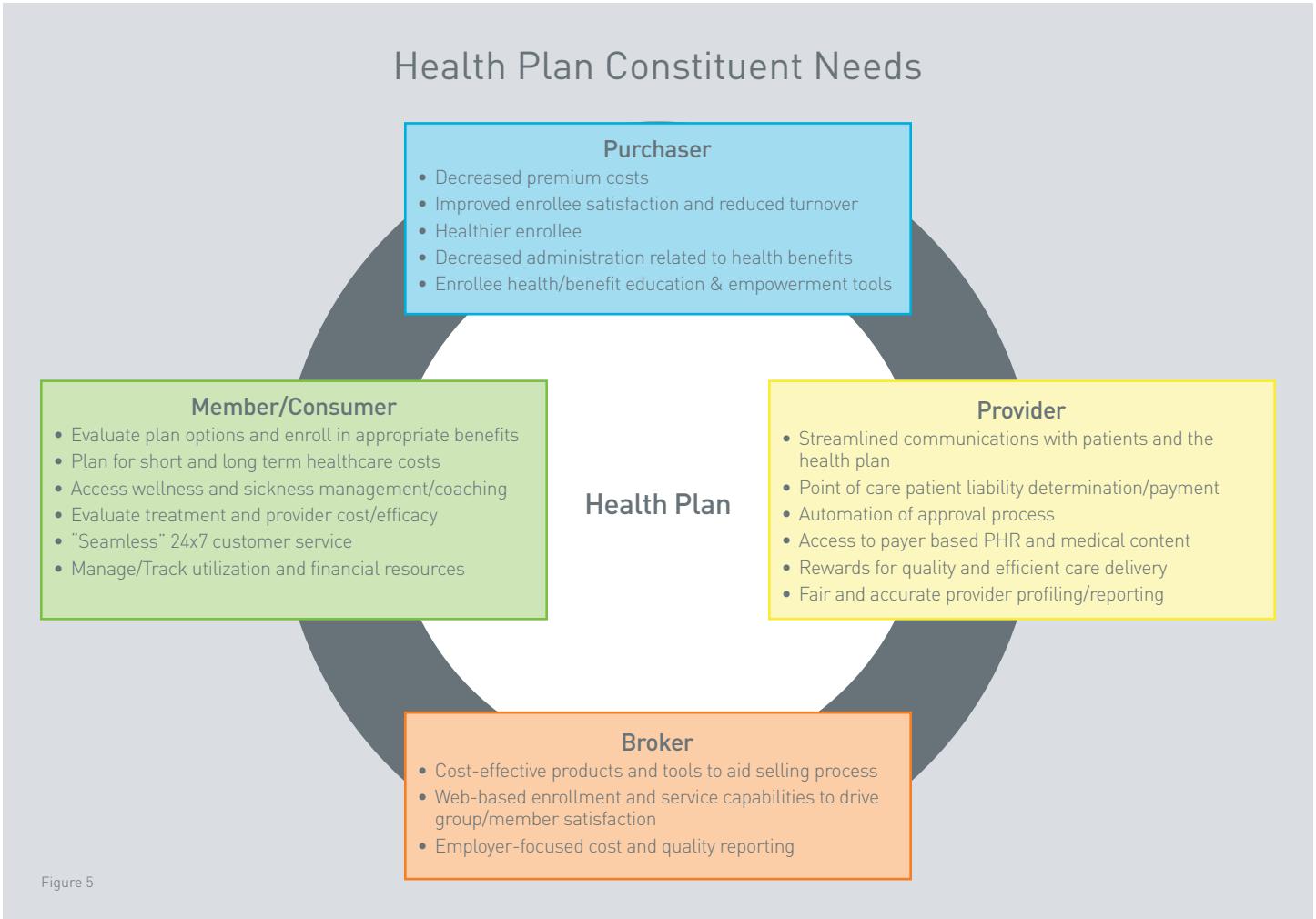

Figure 5

Members will have new opportunity to become fully informed and engaged in managing their own health and care. They will have both the incentive and opportunity to become "world-class patients," and will receive positive reinforcement for their good health decisions. With enhanced access to information on services, quality and cost, consumers will be able to make consumer-directed healthcare work. Because members will be more accountable for their healthcare costs, they will better understand the cost implications of their lifestyle and treatment choices. Greater transparency will help ensure more accurate and safer treatments and better outcomes. And all will benefit as waste is driven out of the healthcare system.

Providers will have better information about the patient's health, with incentives to provide effective, safe and cost-efficient care. The patients they see will be better informed and ready to engage in serious and positive dialogue about their health. Because they have the opportunity to engage with patients both in the office and through the Web and other electronic channels, providers will be able to develop deeper relationships and more holistic knowledge of the patient's health situation. And they will have a better understanding of the patient's covered benefits and the treatment protocols recommended by the health insurer. Improved point-of-service payment technology will help ensure they receive full payment, faster and easier.

Purchasers will be able to offer benefit packages better tailored to the needs of their business and employees—healthcare benefits that provide a competitive advantage in hiring and retention. By embracing IHM, payers can provide new access to programs that help employees and their families manage their illnesses, improve their health and spend more productive time on the job. Because waste will be driven out of healthcare, health benefits will be more affordable for employers.

Payers will maintain their position at the center of the supply chain. For them, the transition toward IHM will unlock the full value of the care data they hold today. With rapid access to information on patient status, billing and reimbursement, they will be able to reduce errors and operate more efficiently, at lower cost. Managing information and providing counseling and incentives to consumers and providers will help payers build closer relationships and greater loyalty among these key constituents. By designing benefit and incentive programs that will drive desired results and accountability, they will be able to help consumers improve their health, help providers to practice better medicine, reward healthy people and good providers, and deliver better results—and lower costs—for the employers who pay the bills.

Convergence of Core, Care and Constituent Information Fuels IHM

To create the shared information and aligned incentives necessary to deliver these benefits, payers must drive the convergence of core benefit administration, care management and constituent engagement. Integrated Healthcare Management is fueled by the convergence of these three key competencies. (See figure 6) Where these competencies intersect a powerful opportunity is born, enabling payers to leverage data to more systematically stratify, engage and reward constituents and personalize interactions with them in order to motivate healthy behaviors, increase the effectiveness of treatments, reduce the cost of care and drive better results.

With Integrated Healthcare Management, payers can expand their core administrative capabilities to enable more advanced benefit designs and provider contracts that give consumers and care givers incentives to drive desired behavior and accountability. They can expand their care management capabilities to provide consumers and care givers access to both generalized information about health, wellness and treatments, as well as individualized information about health status and healthcare provider performance. And they can engage consumers, providers and employers in consistent and energetic interaction with one another in the drive for more efficient care and better outcomes.

"Though nascent, payers are starting to have a dialogue with members and their doctors about their attitudes and beliefs, and what their preferences are for how they want to consume information and make decisions. That information in silos is of some value, however, it is more powerful when it can be combined and overlaid with care and core information, including protocols for how patients should be treated. So it's not just about identifying the diabetic. It is about understanding the diabetic, the preferences and practices of their doctors, and predicting the best way to communicate with them and encourage them to do what's desirable. The same approach and understanding applies to other constituents. It's this convergence of data that creates a fundamentally new system."

– Dan Spirek, Chief Solutions Officer at TriZetto

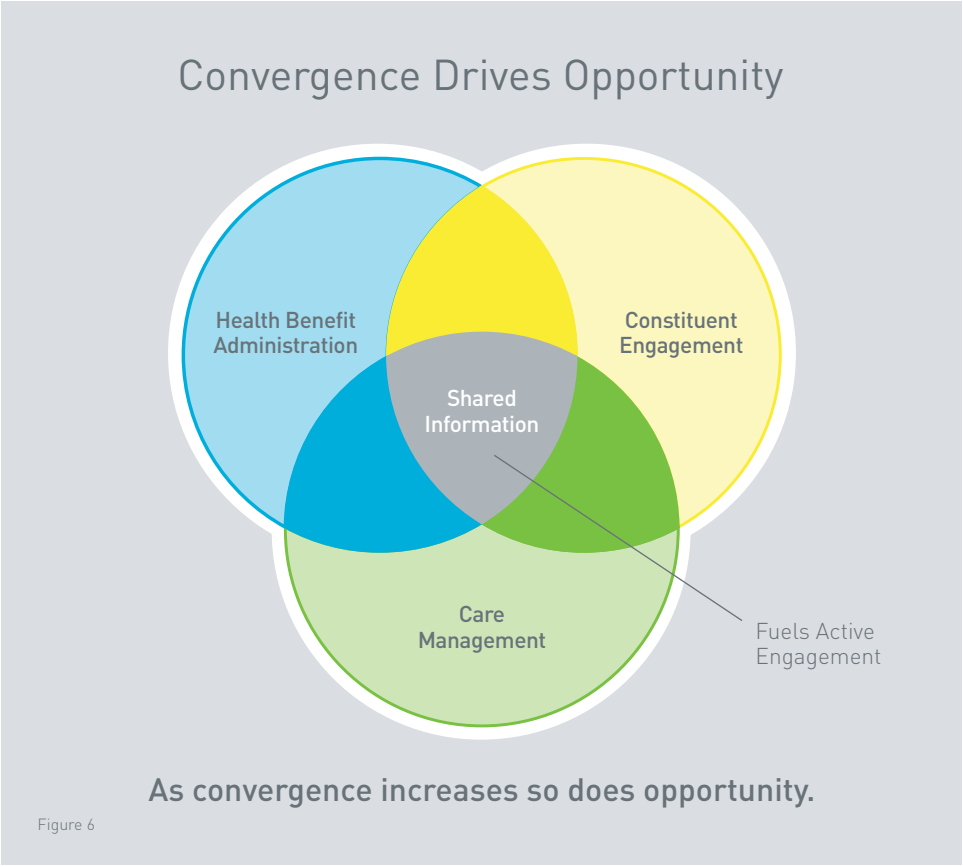

Figure 6

To support this level of information sharing and engagement, IHM requires information transparency—the unfettered availability of accurate and relevant information to be used by constituents in the healthcare supply chain. Payers who embrace a broader transparency strategy will be better able to connect islands of unconnected, inconsistent information. Transparency isn't just about quality and cost, and it doesn't apply exclusively to the consumer or provider. Each participant in the healthcare dialogue needs a clear idea of his or her role.

Ultimately, transparency is about changing behavior. Payers must continue to take a leadership role by providing broad and deep transparency and decision support solutions and orchestrating and aligning interactions and transactions across all constituents, and in particular, the consumer.

As the zone of convergence and information sharing expands, opportunities for interaction and collaboration among participants in the healthcare supply chain will increase. More people will be better informed about their health and their choices, and better prepared to make the best health decisions.

Engaging Millions, One at a Time

Personalization will be vital in making IHM succeed. Individual consumers will be asked to take an active role in managing their personal health and treatment options, and provide the personalized information they need to make decisions. Providers of care too will be engaged individually regarding treatments. Such individualized, focused attention is expected in the doctor's office, but multiply that individual patient or provider by thousands or millions. How can payers support personalized interaction and information for such vast numbers without creating a huge new cost center?

The answer is to automate the processes of categorizing and communicating with consumers and providers. IHM will require a systematic approach that uses technology solutions to deliver the tools and information that consumers and providers need to interact effectively with one another and with the health plan. Communications over multiple channels, tailored to the preference of each individual, will be key.

So how does IHM work? Payers can take four key steps that leverage the converged core, care and constituent information: (See figure 7)

- **Stratify:** First, they organize or stratify constituents according to certain common characteristics. For consumers, for instance, those characteristics could include gender, age and past health history—all information that payers currently track.
- **Personalize:** This information can be further personalized with preferences and attitudes contributed by the individual consumer, giving them what they need, when they need it, and in the way they want to receive it.
- **Engage:** Next, payers engage with that consumer regarding their health situation and needs and involve them in a two-way interaction.
- **Reward:** Finally, provide incentives (rewards) to elicit the kinds of behaviors that will provide the best outcome for the consumer, while optimizing the use of resources

This approach can be used to guide engagements and interactions not only with consumers, but with providers and employers as well.

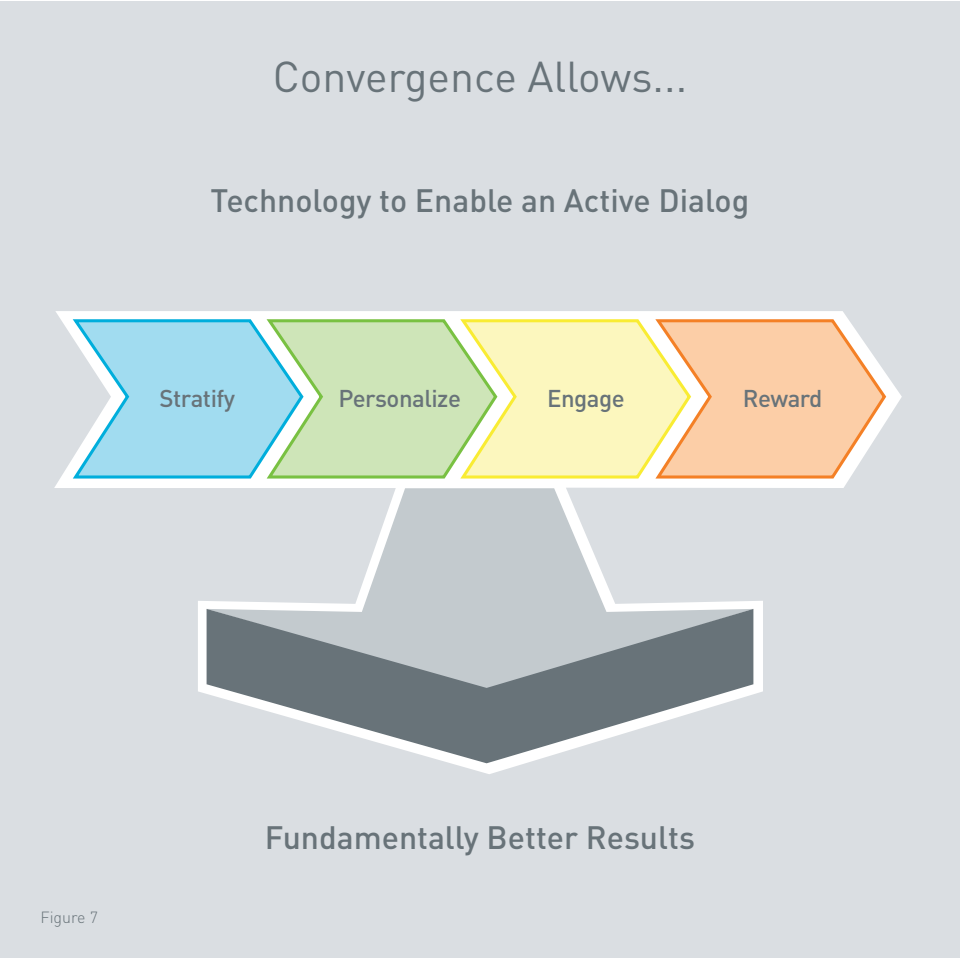

Figure 7

"The Web is a channel—but there are many channels. Print media, broadcast media, active outreach that's people based. There'll be intelligent automated outreach with integrated telephony and smart call centers. It's not the Web, *per se,* that's going to drive. The changes in IHM are founded in how to use the rich data contained in payer systems to help drive customized, more personalized outreach to the constituents, with incentives and mechanisms to support the behavior you want."

– Dan Spirek, Chief Solutions Officer at TriZetto

IHM is fueled by the convergence of three key technology competencies.

- **Core Benefit Administration** to automate business processes and enhance efficiency, to provide the flexibility to administer diverse plan designs, integrate with third-party solutions, and adapt rapidly to change
- **Care Management** to support enhanced communications, increase collaboration with members and care providers, and improve cost and quality of care
- **Constituent Engagement** to foster successful interactions with members, providers, employers, and brokers by providing the relevant tools and information they need, when they need it

Getting to IHM

Payers are ideally positioned to lead the way toward this new model, as they are the organizers of both benefits and care. They touch all key constituents. While a person may interact with a number of different physicians, care facilities and pharmacies over the course of a year, he or she typically has only one health plan. With comprehensive data about all those interactions, payers already possess much of the system foundation for Integrated Healthcare Management.

Achieving IHM and solving the affordability crisis will impose significant demands on payer organizations and their IT systems, which were designed largely to execute transactions. Increasingly, these systems will be counted upon to provide a comprehensive view of each constituent and to support such diverse and critical functions as quality improvement and care management. At the same time, IHM will enable payers to make new use and extract new value from data they already own.

"What's critical to the notion of Integrated Healthcare Management from a technology standpoint is that we're finding more effective ways to systemically use the information we've had for a long time," said TriZetto's Spirek.

"Payers will have to evolve from administrative companies to life-long health and wellness managers," he said. "The member can no longer just be defined as an ID card or enrollment form that has to be processed, or a phone call that has to be measured. Payers will need to expand how they interact with consumers and how they measure success. And this is true for their relationship with employers and providers. There's a real opportunity to drive cost savings in the care piece of the equation. If payers can figure out how to do this, it will give them a compelling competitive advantage."

TriZetto is Powering IHM

TriZetto is the only company that is 100 percent committed to sustaining payers as the organizers of the healthcare system. TriZetto has the largest customer base in the industry, providing products and services to 360 payer customers, including more than 60 percent of Blue Cross Blue Shield plans, and more than 135 million consumers. Building upon its premier position in core administrative capabilities, over the past five years TriZetto has pioneered the next generation of care management and provider network technologies, while introducing a unique and innovative approach to engaging all players in the healthcare supply chain through our integrated constituent model.

TriZetto has invested more than $1 billion in the evolution of its integrated platform technologies. In the past seven years the company has invested $300 million in research and development to bring together these assets and conduct the research and development to begin making IHM a reality.

The industry is full of point solutions for each of these competencies, but TriZetto has uniquely invested in a long-term architectural approach to bring these capabilities together. TriZetto's solutions in each of these disciplines are market leading individually and, when deployed together, they are unbeatable. The convergence of these deep capabilities makes TriZetto the only solutions provider capable of enabling payers to achieve the vision of IHM. Where these competencies intersect, a powerful opportunity is born, uniquely enabling payers to more systematically stratify, engage, and reward constituents and personalize interactions in order to shape healthy behaviors, increase the effectiveness of treatments, reduce the cost of care, and fundamentally drive better results.

"TriZetto will help payers be successful," Margolis said, "by focusing on solutions that help them with core administration, with the cost and quality of care, and helping them also enhance their ability to grow and retain membership. In providing tools for each of those functions, we will make sure that these tools are integrated in terms of how a constituent experiences them.

"As TriZetto focuses on its mission of delivering solutions that enhance revenue, drive administrative efficiency and improve the cost and quality of care for plan members, we will power integrated health care management for payers."

Overview of TriZetto Solutions — "Powerful Independently, Unbeatable Together"

Core Benefit Administration

TriZetto offers two leading core administration solutions:

- **Facets®** is a comprehensive, flexible, scalable, production-proven, enterprise-wide core administration solution for healthcare payers. Facets provides a functionally rich set of modules that allow healthcare payers to meet their comprehensive business requirements—across claims processing, claims re-pricing, capitation/risk fund accounting, premium billing, provider network management, group/membership administration, referral management, hospital and medical pre-authorization, case management, customer service, and electronic data interchange.
- **QNXT™** is a comprehensive, flexible enterprise-wide core administration solution. The QNXT system is a patented, open platform designed based upon a Service Oriented Architecture employing Web services (.NET, XML, and Simple Object Access Protocol or SOAP). QNXT provides a broad set of functionality to healthcare payers to meet their business requirements utilizing a thin client Web-based user interface. QNXT core functionality includes: claims processing, claims re-pricing, capitation/risk fund management, premium billing, provider network management, group/membership administration, referral management, hospital and medical pre-authorization, case management, customer service, and electronic data interchange.

Care Management

TriZetto offers two solutions that address payers' need to improve the cost and quality of care:

- **CareAdvance Enterprise® (CAE)** is a secure, Web-based communication platform for advanced care management that facilitates case, utilization, disease, and population management. The CAE application enables payers to partner with members in shaping care decisions to maintain personal health and wellness and to improve communication among members, their providers, and the health plan. This advanced care management application reduces the administrative costs of communicating with members; leverages all available data in support of timely interventions by care managers; and increases member satisfaction and employer retention. The TriZetto Personal CareAdvance® (PCA) application, the personal health management module of CAE, supports the creation and maintenance of individualized online health records for members. This helps the payer's staff manage campaigns related to population and disease management programs.
- **TriZetto® NetworX Suite™** is a group of software applications that provide complete automation of contract modeling and execution, claims pricing, and all aspects of advanced network management. TriZetto® NetworX Modeler™ allows the payer to precisely model and project the financial implications of contracts during negotiations. TriZetto® NetworX Pricer™ automates claims pricing, increasing the speed, accuracy, and efficiency of provider contract administration, regardless of the number or complexity of contracts.

Constituent Web Solutions

TriZetto Constituent Web Solutions provide 24x7 access to critical information for all constituents, helping payers exchange information and conduct business online with key constituents, including providers, members, employers and brokers. (See figure 8) Complex processes can be completed efficiently and quickly in real time. Constituents experience a seamless, centralized approach to many standard activities, including plan comparison, enrollment, billing, self-service, claims and fund account management, health management campaigns, treatment cost comparison, real-time patient liability determination and claims adjudication at the point of service, and the ability to keep track of their health and benefit status through personalized health account statements.

Constituent Web Solutions

Member Web Solutions	
Benefit Cost Modeler	Member Benefit Profile
Treatment Cost Navigator	Personal CareAdvance
Member Enrollment	MHB Finance
Member Service	Professional Services

Employer Web Solutions	Broker Web Solutions	Provider Web Solutions
Employer Service	Broker Service	Provider POS Direct
Employer Enrollment	Broker Enrollment	Provider Service
Employer Bill	Broker Bill	CareAdvance Provider
Professional Services	Professional Services	Professional Services

Figure 8

Used independently, TriZetto's core, care and constituent enterprise systems are powerful enablers. When used together, they deliver the only integrated enterprise technology platform in the market today.

A key to TriZetto's success is our ability to provide complementary services in addition to our market-leading software solutions, which include:

Hosting Services

TriZetto offers a comprehensive hosting solution that works for health plans of all sizes. TriZetto Hosting Services include best-practice implementation, and management and support of TriZetto's products as well as the third-party applications with which these systems interface. Standard packages include monitoring and reporting of customers' equipment, telecommunications, network services and disaster recovery. Also included is the management of daily batch scheduling, reporting, and interfaces to business-critical third-party applications.

Business Process Outsourcing

To complement our software hosting services, TriZetto provides health plans and benefits administrators with transaction processing services for typical back office functions, including claims, billing, and enrollment. Customers typically outsource to TriZetto for the following reasons: to improve or maintain service, for more predictable costs, to take advantage of our larger scale, to reduce risk through our performance guarantees, to gain access to our technical and healthcare business expertise, to increase speed-to-market, to ensure business continuity, and to become HIPAA compliant.

Professional Services

TriZetto Professional Services ensure effective deployment of retail solutions through best-practice business processes, making payers more competitive faster. TriZetto's services are focused on helping payers define and build a platform that maps to their short- and long-term deployment strategies. TriZetto offers assessment and planning, process engineering and implementation services that can assist from strategy to execution. TriZetto Professional Services help payers optimize their investment in retail solutions and meet the evolving needs of the retail market.

For More Information

For more information about how TriZetto can help enhance revenue growth, drive administrative efficiency and improve the cost and quality of care, please call TriZetto at 1-800-569-1222 or visit www.trizetto.com.

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