

# Insurance

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### INDUSTRY TRENDS

## Predictions of the Evolving Healthcare Landscape

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Neil Armstrong once said, "Science has not yet mastered prophecy. We predict too much for the next year and yet far too little for the next 10." With this in mind, each year I develop a set of predictions for the healthcare industry that isn't necessarily for just the next year, but for anywhere from one to five years in the future. While the timeline varies for these predictions, one constant is my conviction that the U.S. healthcare industry is up to the challenge of improving the delivery of benefits and care in our country.

### **Prediction 1: EMRs Are Not the Be-All in Delivering Evidence-Based Medicine Guidelines**

I believe that evidence-based management (EBM) guidelines will begin to be distributed in two distinct ways. Integrated delivery network health plan models, such as Kaiser's, will rely primarily on clinical electronic medical record (EMR)-based rules, while virtual network health plan models, such as most of the Blues, Aetna, United and others — comprising some 80% of the market — will rely primarily on health-plan-assisted distribution.

In an integrated delivery network model, hospitals and most office facilities function as one entity, and the health insurance overlays that entity. Provider and payer are integrated under the auspices of one organization. In this model, it makes sense that the information that helps keep one healthy or treat one's illness comes through a clinical-based EMR or similar type instrument. However, about 80 percent of people in the United States see their primary care doctor in one office, get blood work in an independent lab, see a specialist in another, separate medical practice, and pick up prescriptions at yet another location — a virtual network model. In this case, the one entity with a view across all the disparate providers of care is the health plan.

Health plans have software tools that can distribute information in the form of what we at TriZetto call a "healthcare itinerary," helping both the consumer and the physician get the right information at the right time to make the most informed decisions about one's care. Therefore, watch for payer-based information technology, not provider EMRs, to distribute EBM guidelines to clinicians treating most Americans.

With the health plan at the center of the predominant virtual network model, and with its rich repository of digital information about the consumer's care across multiple physicians and facilities, we'll see two approaches emerge to help improve clinical outcomes and the quality of care: value-based reimbursement and value-based benefits. Value-based reimbursement rewards physicians for practicing and following EBM guidelines in the care of their patients. Value-based benefits remove the financial barriers to managing one's health, adjusting the consumer's co-pay or co-insurance to incent the individual to effectively stabilize and even improve chronic conditions, in accordance with EBM. Taken together, these two approaches align incentives for the consumer and physician, enabled by the central position and coordinating role of payer organizations in virtual networks.

### **Prediction 2: Payer-Populated PHRs Emerge as an Accelerating Complement to EMRs and EHRs**

With payers as the primary coordinators of health information distribution within virtual networks, payer-populated personal health records (PHRs), which were previously rejected by providers and academicians as "containing only administrative data," will become recognized as efficiently complementary to EMRs and electronic health

records (EHRs) and enter the mainstream of consumer and ambulatory provider interaction.

Because care providers of all types must submit claims for reimbursement, health plans have a uniquely comprehensive view of the consumer's history of care across disaggregated healthcare settings. These claims contain rich, already digital healthcare data about diagnoses, dates of service, places of service and treating physicians — data that is ready, today, to pre-populate PHRs. This wide, though not necessarily deep source of healthcare information can be provided prior to or at the point of service to give the treating physician a broad record of the consumer's health history, or "health resume," at the physician's own practice and at other clinical settings. This payer-based PHR spares the doctor and patient the redundant paperwork regarding eligibility and health history that is otherwise required at check-in. It's easy to see how such a resource will improve the efficiency of many types of office visits. Even without detailed clinical information, the PHR tells the physician exactly what happened when, whom to call or where to search for additional information that will help treat the patient in the best way possible.

### **Prediction 3: Can't We All Just Get Along? A New, Win-Win Relationship for Payers and Providers**

As a member of a hospital board, I've learned from experience that providers and private healthcare payers have long engaged in an adversarial relationship, fueled by protracted, often acrimonious negotiations over network provider reimbursement rates. Notwithstanding the ebb and flow of healthcare reform, there remains the prospect of a broader government role and hence of broader noncompetitive pricing. To contain the potential impact of expanded government, noncompetitive pricing in U.S. healthcare, private health plans and providers of all types — hospitals, physicians and even labs and testing centers — will enter into a new era of win-win supply chain partnerships. Providers will realize that while private payers negotiate hard on reimbursement rates, they are considerably better payers than federal and state governments are for Medicare and Medicaid. It will become abundantly apparent that private payers pay and reimburse at rates that compensate for shortfalls in reimbursement by government. Providers will determine that it is in their best interest to work out cooperative value-based compensation arrangements with private health plans. Likewise, private payers, greatly concerned about the prospect of losing market share to government, will be motivated to negotiate more flexibly with providers on terms of reimbursement.

### **Prediction 4: Concrete Jungles and Rolling Hills: Geographical Health Plan Segmentation**

As health plans grapple with traditional product lines, they'll also develop more and more nuanced methods to deliver better organized systems of benefits and care, based on the consumer's geographic location. This new methodology differs from how health plans currently think about segmentation, which is generally along product lines. Instead, we'll begin to see differences in effective health

plan models for dense urban, suburban and rural geographies, and in turn more refined categories of payer market segmentation across all commercial and government program product lines. If we consider the integrated delivery systems discussed earlier, such as Kaiser's, it's important to note that these systems function best where there's a critical mass population. Conversely, virtual networks function best in less-dense suburban and even rural areas, so payers must consider different, innovative ways to leverage information technology to deliver high-quality healthcare services across great distances. Further, the winners among health plans serving suburban and rural segments will distance themselves from the also-rans by using information technology to efficiently distribute benefits and care information to geographically dispersed consumers, providers, employers and brokers to optimize clinical outcomes and cost management.

### **Prediction 5: Payer Care Management Will Improve Public Health and Public Image**

I believe that, despite federal and state budgetary downshifts in reimbursements, private, Medicaid and Medicare health plan programs that embrace the chronically ill, programs for the frail and elderly with rigorous care management and social-support programs will succeed financially while helping create a more positive public image for payers.

The Medicare and Medicaid populations encompass some of the most needy and medically complex individuals in our population. In the past, health plans that serve these populations may have tended to employ traditional care-management methods: focusing more on identifying the "sickest of the sick" and trying to minimize associated costs, while focusing less on the rest of the membership.

The leading Medicare and Medicaid health plans today are turning that model on its head. These payer organizations recognize the diversity in health status within these populations as well as the diversity in education, communication preferences and the overall ability to comply with treatment recommendations. Increasingly, payers will do three things that improve both public health and their own public image: 1) create benefit plans tailored to the unique healthcare needs and preferences of each individual, 2) provide information to the consumer and provider that helps identify evidence-based care that is most appropriate for the patient's medical needs, and 3) align the provider's reimbursement with the delivery of evidence-based diagnosis and treatment. The combination of these three actions by health plans will bring together the right information at the right place and time for the physician and patient to make the best medical decision and minimize unwarranted variation in care. Additionally, health plans will provide social support for those who are chronically ill, frail or elderly. For example, one payer may provide a taxi ride to the doctor for the Medicare member who lacks transportation, a second may send a dietician to a co-morbid Medicaid patient to assist in preparing nutritious meals, and a third health plan may provide bilingual

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support for the consumer who wants to comply with her doctor's instructions but faces a language barrier. Thusly will private, Medicare and Medicaid programs reduce healthcare costs, succeed financially and improve their image in the public's eye.

### **Prediction 6: Defining Quality: What Really Matters, and to Whom?**

My last prediction is really a rehash of a few predictions from years prior, but it's an issue that should remain top-of-mind for the industry now and for years to come. While early efforts at qualitative provider transparency for value-based care will be academically and clinically oriented, providers and plans will learn that consumers have their own definitions of quality that are simple and understandable for lay people. The smartest clinicians and academicians are hard at work researching, developing and refining best practices, evidence-based guidelines and measurable outcomes for treating those with low, medium and high health risks —people spanning the health continuum. And this important, essential work must continue. That said, most consumers have an often different set of metrics in evaluating their healthcare experience, their level of satisfaction. Was I able to schedule a timely appointment with the specialist I needed? How long did I have to wait in the waiting room, then in the treatment room? Did I have to fill out forms with information I'd shared previously? Did my doctor know about my outpatient visit to the hospital last month, or did I have to tell him? Was the doctor's office able to tell me how much various treatment options would

cost? Were they able to tell me what my office visit would cost me under my high-deductible health plan? It's important that we, as an industry, step out of our shoes as payers and physicians and tune in to how consumers measure satisfaction. While we know much about the clinical, actuarial and more, much of what we know may resonate little with the mainstream population.

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