Interesting Times Ahead: Payers’ Innovation in the Era of Healthcare Reform

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There is an old saying, attributed to the Chinese but never confirmed to be theirs, “May you live in interesting times.” Although this phrase is thought to be a curse, it is really more of a double entendre. It is also quite applicable to what health plans are currently experiencing. The Supreme Court’s upholding of the Affordable Care Act (ACA) as law and the reelection of President Obama have ensured that interesting times lie ahead for many entities, let alone health plans. In response to these interesting times, health plans have taken steps to confront challenges, redefine risks, and modulate their business model. This article provides my individual perspective on where we are going.

Business Agility

In confronting challenges, the key for health plans lies in business agility. Agility allows them to provide the internal resources to address the main aspects of the ACA law according to the various timetables put forth by the federal government and, specifically, the US Department of Health and Human Services. Health plans had already begun addressing the actuarial aspects of the ACA when they found themselves needing to prepare for medical loss ratio targets. Moving forward, plans have now made key assessments as to whether they will participate in various state health insurance exchanges and, if so, how will they market themselves to the millions of newly insured persons who will seek insurance coverage. This does not even take into account how plans will actually manage the health, or illness, of those newly insured millions for whom, of course, they are also planning.

As Ray Stata, the founder and current Chairman of the Board of Analog Devices, once said, “I came to the conclusion long ago that limits to innovation have less to do with technology or creativity than organizational agility. Inspired individuals can only do so much.” For payers, then, business agility will, by necessity, permeate the organization: it becomes inherent not only in marketing, but also in finance, clinical, business intelligence, and operations. As the late quality guru W. Edwards Deming opined, “It is not necessary to change. Survival is not mandatory.”

Redefining Risks

As a sidelight to survival, health plans also need to redefine risks. In the prereform era, payers had significant opportunity to mitigate financial risk, especially for their fully insured populations, and for their individual medical plan policies. (Self-funded groups have the ability to set their own parameters for coverage such that, in providing administrative services only, the payers followed the client’s intentions for coverage. Self-funded plans are also impacted by the ACA, but they are beyond the scope of this discussion.) In that era, health plans could decline to cover a group or an individual or could apply coverage rules to control losses (eg, preexisting clauses). Moreover, if a payer accepted a group or an individual and experienced significant financial losses, that payer could alleviate its risk through reinsurance or by raising rates on premiums.

The ACA eliminates the ability to decline an applicant, as well as the ability to rider medical conditions or apply preexisting limitation rules. Add that to the medical loss ratios mentioned above, and payers could find themselves in a vicious cycle of mounting losses, compounded with an inability to restrain them. Redefining risks, then, requires 2 key changes in a payer’s way of thinking—the first addresses philosophy, the second addresses operations.

Rethinking Health Insurance

Philosophically, health plans need to redefine themselves. Many health plans have already either done so or are in the process of doing so. UnitedHealthcare, for example, is “committed to the delivery of quality care and its continual improvement.” WellPoint strives to “improve the lives of the people we serve and the health of our communities.” Humana’s business decisions are geared toward improving “the health and well-being of
our members, our associates, the communities we serve, and our planet.” Of note, in these 3 examples, there is no mention of benefits or of cost. There is, however, specific mention of improving community health.

**Payer–Physician Relationships**

And that is where the second change comes in—payer relationships with physicians. The old adage that “all healthcare is local” certainly comes into play here. If the overarching goal for payers is to improve community health, then that starts with the physicians who deliver the care. The need for payers to redefine risk for themselves complements a new era in payer–physician relations, in which payers will allow physicians more flexibility to care for members/patients in exchange for physicians’ accepting accountability for the outcomes achieved. Every large payer is involved in some sort of arrangement with accountable care organizations (ACOs); Aetna even has an entire unit devoted to this concept. ACOs allow physicians to accept some modicum of risk in exchange for shared savings based on outcomes. Although ACOs may still be in their infancy, as they continue to proliferate, to some extent they will certainly serve as a vehicle for payers to redefine some of their own risk.

**Evolution of the Business Model**

In further meeting their new obligations for agility while redefining risks, payers will also need to modulate their business model. There are as many ways to change business models as there are models. Most of these entail using various levels of information, such as that found in medical/pharmacy claims, in demographics, or in health risk assessments. To that end, payers appear to be functioning, to some extent, as healthcare infomediaries—entities that profile consumer purchasing and utilization patterns and then customize services to meet that consumer’s needs.6

Payers are also tying in consumer/member utilization patterns with provider practice patterns in more sophisticated ways. Whereas in the past payers worked to automate the transactional nature of physician workflow through sites such as Availity, payers now use sites for health information exchange.7 Some payers have even taken the grander step of purchasing their own health information exchanges: UnitedHealthcare, Humana, and Aetna have advanced abilities to exchange information through their purchases of Axolotl, Certify Data Systems, and Medicity, respectively.

In addition, with a greater involvement in health information exchange, payers are engaged in broader analytics. While searching for where relationships in the data lead to prediction of diagnosis, utilization, or outcome, payers have taken “number crunching” to new levels.8 Moreover, to add even more numbers “to crunch,” a coming deluge of “big data” will continue to keep payers busy.9 As payers collect physical health information off of their members’ personal tracking devices, the possibilities for addressing payers’ concerns regarding cost, outcomes, and improving community health will promote further tweaking and adjustments in the business model. And as seen by payer purchases, among other examples, we can expect these business model adjustments to be made quickly.

**Common Goals Driving Innovation**

Even though I have provided a personal opinion on the challenges of agility, the redefinition of risk, and the need for business model evolution, I have hardly touched on major aspects of the ACA. Nevertheless, it is clear that when it comes to a payer perspective, we live in interesting times, indeed. Would our present “interesting times” define a coming crisis for health plans? I believe it would not. Many people ask if the Chinese symbol for “crisis” is made up of the symbols for “danger” and “opportunity,” as is often quoted. Literally, the answer is yes.10 However, from a pragmatic perspective, one can better define “crisis” as “opportunity in a time of danger.”

Are payers operating in a potentially dangerous period, given the unknowns and the uncertainty inherent in deadlines and commitments? We could say maybe. However, with the ingenuity they have shown as a function of their agility and business acumen, I believe that payers have and will continue to embrace what they do to achieve their ultimate and common goals of promoting financial security for their members, improved health for their populations, and a healthier way of life for the communities they serve.

**References**