The Impact of Healthcare Reform on Payers’ Products, Provider Reimbursement, and Member Engagement

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The Healthcare Reform Act—officially called the Patient Protection and Affordable Care Act (PPACA)—institutes sweeping changes across all healthcare stakeholders, including payers, providers, and plan members. In fact, the amount of change required by the PPACA is so extensive, distilling all the changes down and accounting for their impact is a serious challenge for the industry as a whole. However, if we focus on the apparent macro changes that affect payers—an increase in competition for the group market, an increase in overall access, and new regulations on expense caps for medical costs—a rational set of assumptions becomes apparent for predicting the direct impact on stakeholders. The implementation of these changes will cause payers to:

1. Develop new products and provider networks that are aligned based on the benefit structure and the needs of the covered population; these tailored, personalized products and provider networks will enable payers to more effectively serve their customers’ needs
2. Design new provider-reimbursement models that shift methodology from paying for individual services to reimbursing for improved member health and wellness, the latter being driven by provider performance, quality measurement, and member outcomes
3. Create new provider- and member-engagement strategies that enable greater information sharing and transparency for improved decision support
4. Implement/redesign internal payer processes to further drive down administrative costs.

Although some reform requirements have enactment dates as far as 2018, we consider reform a complete overhaul of the healthcare system, necessitating a phased approach to ensure success. Payers, providers, and plan members need to begin preparing for these changes, because the changes will affect the traditional stakeholder relationships we take part in today.

Greater Differentiation for Payer Products

The needs of plan members vary across the spectrum of benefit designs—some need only preventive health benefits, whereas others require preventive and catastrophic coverage levels. The PPACA will drive approximately 32 million more members into the healthcare system. Some of these new members will fall into traditional lines of business for a payer; however, estimates by the Congressional Budget Office and PriceWaterhouseCoopers predict that these members will drive expansion in the individual market.

The government-mandated healthcare exchanges, stipulated by the PPACA, are poised to be the principal avenue for competition within the individual market. The benefit structures will be defined by the government, so the area for differentiation from the payer’s perspective will be on price, the member’s experience, and compatibility of the network with the plan member’s needs.

In addition, as the individual insurance market increases, the group insurance market is estimated to decrease by 3 million members. This potential decrease in the member population, coupled with increased payer dependence on the profitability experience in the group market, will cause increased competition for the valued group customer. Continued emphasis on differentiation by product and network, furthered by benefit designs that align with a group’s individual healthcare needs, will drive success in this area of the payer market.

Redefining Provider-Reimbursement Models

Along with membership population changes, the regulatory change that excludes payers from denying coverage, combined with the change that institutes new spending caps on medical costs, is already beginning to drive innovation in provider-reimbursement methodologies.

Traditional fee-for-service (FFS) reimbursement methodologies do not enable payers to optimally manage new member populations with fluctuating/nonpredictable risk profiles, and they do not account for physician/provider performance and quality programs.
The Massachusetts Attorney General’s 2010 report, *Examination of Health Care Cost Trends and Cost Drivers*, provides evidence supporting the need for changes in the reimbursement model. The report relates substantial evidence that nonstandard and non–quality-based provider contracts are a major contributor to rising healthcare costs. The emergence of provider reimbursement models based on episodic and global payments is likely in reaction to these developments. These reimbursement models will not completely eliminate the FFS model, but they enable hybrid pricing models that combine FFS payments with reimbursement payments for the delivery of reliable evidence-based care.

**Changing Payer-to-Provider-to-Member Engagement Models**

Although these reimbursement and product changes are derivative in nature, stemming from changes in multiple parts of the PPACA, the anticipated payer-to-provider-to-member engagement changes are primarily driven by the PPACA’s call for improved collaboration and information-sharing among all stakeholders. The PPACA reignites the focus on how to increase the clinical collaboration between payers and providers and how to better engage members to improve their healthcare decisions.

The healthcare marketplace has shown movement in this direction via patient-centered medical home pilot projects and other team-based delivery programs. Such programs intend to facilitate evidence-based medicine and coordination between the care-delivery team and the particular member’s care program.

These types of collaborative care environments, in conjunction with the American Reinvestment and Recovery Act, are fueling a new round of payer investment in point-of-service tools, such as electronic medical records, e-prescribing, and e-laboratory order entry systems. These assets between payers and providers are needed to facilitate the exchange and analysis of clinical information by all parties to better serve members and improve their overall health status.

The member’s interactions with their providers and payers will also take on a new dynamic. With the rise of an individual market and a likely acceleration of payer products like health savings accounts, members will share a greater amount of financial responsibility for the care services provided. In line with this greater financial responsibility, payers and providers will need to be able to provide quality and cost information to members in a more seamless and transparent fashion to improve member decision-making capability.

**Conclusion**

As a result of increased competition, expanded access, and amplified cost-containment pressures caused by the Reform Act, payers will need to change their operational DNA to achieve product differentiation, administrative and medical cost-containment, and quality-based relationships with their provider networks. Changes in the payer industry will have a ripple effect, driving all stakeholders toward taking the evolutionary steps necessary for successful operation in the overhauled healthcare delivery system of tomorrow.

**References**