Manage the Challenges of Health Care Reform

Regulatory change brings new market forces and competition, but health insurance plans can come out ahead with advanced customer intelligence and engagement strategies.

Insights from a webinar sponsored by SAS

Featuring:
SAS and HealthScape Advisors
There’s nothing like major regulatory reform to throw a little upheaval into an industry.

Remember the Telecommunications Act of 1996? This law enabled any communications business to compete in any market against any other – and completely redefined the competitive environment. Ditto for the airline industry after the Airline Deregulation Act of 1978, which removed government control over fares, routes and entry of new airlines into commercial aviation. And for the financial services industry after the Financial Services Modernization Act of 1999, which eliminated restrictions on the integration of banking, insurance and stock trading.

The business models and market dynamics of all three industries were dramatically overhauled by regulatory change. Now health insurance companies in the US are facing the same as a result of the Patient Protection and Affordable Care Act of 2010, which seeks to ensure affordable health care coverage for everyone.

A key provision of the act calls for the creation of health insurance “exchanges,” or marketplaces, where people not covered through their employers could shop for health insurance. The hope is that this new system for buying health insurance will create more competition among health insurers and plans – thereby lowering health insurance prices while providing more people with access to affordable health care. The individual mandate – coupled with subsidies and penalties – is intended to ensure a more level playing field by bringing more entrants into the market.

Health care reform will likely bring some profound changes to the business model for insurance companies. For instance:

- Individuals will probably represent a much larger percentage of the overall market. These individuals will shop for coverage based on a wide variety of criteria – price being paramount – but there may also be huge opportunities for health plans to create new types of value that lead to new purchase patterns.

- Traditional actuarial and underwriting mechanisms will become largely obsolete in the new marketplace, as rating processes and methodologies are dramatically overhauled.

- Although the state agencies that run the exchanges will not be able to dictate premiums or specific plan designs, they can remove an insurance company from an exchange if it doesn’t think the company is playing fair and in the best interests of the exchange.

In short, the act injects some consumer-level competition in a marketplace that has traditionally been more focused on employer groups, with their pools of enrollees, rather than individuals. For many reasons, the transition to this post-reform environment will be tumultuous.
How can health insurance companies navigate this change? Can they take advantage of customer relationship management strategies that have worked so well for other industries that have also been through regulatory change? That was the topic of a May 2011 webcast sponsored by SAS. In the hour-long webcast:

- **Arjun Aggarwal**, Managing Director of the consulting company HealthScape Advisors, talked about new issues health insurance plans will have to address under health care reform.

- **Leigh Nichols**, Senior Solutions Architect at SAS, presented customer-centric strategies that have proven successful for other industries and could be applied in health insurance.

Health care reform and other market pressures are shifting the health care industry to a more consumer-driven or retail model. Facing a new competitive scene, health insurance companies can learn a lot from other industries that have experienced profound regulatory change: financial services, telecommunications and the airlines. For these industries, data integration and advanced analytics have been key to creating sophisticated consumer engagement strategies that win in a dramatically altered environment.

**How Big a Market Shift Are We Talking About?**

How many people are we talking about? The answer depends on whom you ask. There is a lot of uncertainty about how the market will shape up. When the act was first passed, the Congressional Budget Office estimated the marketplace for exchanges could be about 26 million people. After an extensive study conducted in 2010, the Rand Corporation places its estimate at 67 million.\(^1\) That’s a pretty big spread.

“There have been a number of studies published that estimate the size of this population, said Aggarwal. “As you can imagine, there is a lot of uncertainty about the scope of folks who are going to enroll in the exchange.” Aggarwal pointed to four factors that explain why a credible number is so hard to come by:

- **Will everyone be required to have health care coverage?** There is litigation pending around the individual mandate, a component of the act that requires individuals to purchase health insurance and threatens financial penalties for those who don’t. If this provision is removed, the scope of the population will drop dramatically.

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• **What mix of customers will the exchanges attract?** A big concern is that if the exchanges only attract higher-risk individuals, it will end up being a high-cost option; as a result, small to midsized groups may be unwilling to drop coverage and force their employees into the market.

• **Will employers and employees rethink coverage as an inherent benefit of employment?** Today, most employees and their employers perceive that an employer-provided health benefit is a key part of the total compensation package. That could change. Employees might start to perceive that the benefit they can get from the exchange is equal to, if not richer than, what they would get from their employers.

That shift in attitude could encourage employers to stop providing health care insurance on their own – perhaps increasing salaries a bit to compensate, and encouraging employees to move onto the exchange. How long will it take for this mind shift to occur? No one is really sure.

• **Will large groups shift to the exchanges?** Since the penalties are modest, might larger employers choose to stop offering coverage, and provide funds to allow their employees to purchase coverage individually on an exchange?

It could make dollars and sense for large groups, Aggarwal said. “In 2010, the then governor of Tennessee wrote an editorial piece in the *Wall Street Journal* where he opined that it may benefit the state of Tennessee to move all its state employees onto the exchange as it would save the state a considerable amount of money, even if the state were to pay the current penalties.”

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**The Shift to a More Consumer-Driven Business Model**

Whatever the answers to these questions, one thing remains clear: Health insurance companies will face a new form of competition that will force them to behave more like their counterparts in other product and service industries, said Nichols. “The basic premise behind the regulatory changes in telecommunications, financial services and the airline industry was to benefit the consumer by creating a competitive marketplace full of consumer choices and options. From a business perspective though, this meant fierce competition for companies that in the past really hadn’t had to compete.

“New competitive marketplaces drove business in those industries to do two things,” said Nichols. “First, they had to become more efficient in controlling the cost side of the equation. Second, they had to become very efficient in winning the right customers against the competition.”
Nichols described some winning strategies from other industries that could have relevance for health insurance plans:

**Develop package bundles for targeted segments of the customer base.** Instead of offering a one-size-fits-all offer to everyone, consider the unique attributes of a customer segment and develop a product that fits.

But be prepared to find out more than you thought you knew. When Nissan first introduced its Xterra SUV, the company targeted the rugged outdoors type. However, the best response to the Xterra came from soccer moms. Go figure. “Digging in and understanding that consumer base was very important for ongoing sales of that particular product package,” said Nichols.

**Reward loyalty.** “When I think about service loyalty programs, I automatically think about the frequent flyer programs that have been developed by the airlines in an attempt to get, grow and keep a portion of their customer base so they have a source of repeatable service and income,” said Nichols.

Insurance plans don’t want to promote higher consumption of the health care services, but there are other ways to reward loyalty, perhaps taking leads from the auto insurance industry. Premium credits, extended payment plans, membership in wellness or incentive programs … plan designers can find ways to add to perceived value for their long-term beneficiaries.

**Be inventive with pricing and value.** “Think of all the credit cards that are out there; they come with a variety of perks, such as airline miles or points for every dollar spent, and they come in a vast range of interest rate options,” said Nichols. “What if the financial institution could integrate low-interest rate credit cards with an asset management program, to build wealth management programs for its best customers?”

For health insurance companies, this concept translates into designing plans that provide the right value to identified customer segments. Understanding customers enables an insurer to design plans that are relevant to its needs. For example:

- **Tight or broad networks?** A young, ‘invincible’ population might be completely satisfied with a small network convenient to where they live or work, whereas those with chronic conditions might want a broad network that allows them to see the specialist of their choice,” said Aggarwal. Individuals who alternate between Medicaid and the health exchange will expect to have access to the same providers under either program.

- **Self service or full service?** Is the plan going to attract a Web-savvy, tech-savvy population that is satisfied with limited service because they can help themselves online, or a population that is going to want a lot of personal interaction?
• Basic or value-added? Will the niche be to offer an attractively priced option that meets the minimum standard requirement, or to provide value-added services that enhance the offering? For example, some plans may want to attract a population with more expendable income, so they might consider developing concierge services or even separate outpatient facilities that are only available to members wishing to pay more out of pocket for the value derived.

• Which tier for which segment? Bronze, silver, gold and platinum plans will have different cost levels and benefits. How will these tiers be defined, and which types of product should be promoted for which type of potential beneficiary?

All of these decisions offer opportunities to tailor the product to the customer – so insurers can differentiate themselves in a more competitive field.

It All Depends on Customer Insight

“The key to driving all of these ideas to fruition is to identify the right consumer and the right offer at the right time, all accomplished by taking a full view of the customer across the enterprise, and then optimizing the investment in the consumer across all touch points,” said Nichols. “If we assume that all consumers are the same, or if we only view a sliver of the data that’s available to us in trying to analyze the consumer base, we can totally miss the mark because consumers are not all the same.”

Nichols provided an example of this lesson learned the hard way. In the 1990s, mass marketing was the norm, and a telecom company offered a $20 gift certificate to anyone adding a new landline phone. “Many people chose to add the new landline, got the certificate, and then promptly canceled the landline,” Nichols recalled. “In the days of landline services, this meant two trips to the location to install it and then uninstall it, resulting in a very expensive endeavor with no real return on investment – a total misallocation of resources. Even though there may have been a high response, making it look like a very effective marketing program, the desired result of growing the customer base and deepening the presence within that customer base was not achieved.

“It became apparent very quickly that more targeted communication was important in achieving desired results. In order to be more targeted, one has to truly understand the personalities of the various consumer segments, and that starts with data.

“There are so many rich data sources available to us today – and since computing capability has grown so enormously over the years, as well as the ability to look at lots of data from different sources and different types of data – this process of gaining deep customer insight is not nearly as difficult as it was back in the ’90s.”
It is time for the health insurance industry to capitalize on the possibilities, said Aggarwal. “Health plans need to become much more proficient in using data to understand customers and prospective customers, because the characteristics of the beneficiaries in this marketplace are going to be very diverse. Some will be very healthy; others will have chronic conditions. Some may be entering the marketplace having just come off Medicaid and are therefore receiving a higher percent subsidy on their premiums, while others may have earned just enough to fall under the subsidies and are paying 100 percent of the premiums each time.

“Each of these categories would have different needs, different desires and different ways to look at the marketplace. It is therefore important to really try to uncover their preferences, so we can develop products, services and engagement models that target these segments appropriately.”

Aggarwal recommended that insurance companies look deeper into the sources of available data to build comprehensive population profiles. “Health plans have spent a lot of money developing data warehouses, but those data warehouses focus primarily on claims data. Next-generation data warehouses need to integrate data from disparate sources – not just claims and service information, but also information from sales and marketing functions, the health management function, EMR and EHR data, as well as other points of interaction with the beneficiary.

“The data must be both comprehensive and comprehensible. It must include not only proprietary data that comes out of the in-house systems, but also third-party sources, such as credit card information, data from online channels (transactions, website use, social media interactions text), demographics, psychographics, wealth, credit information and more. We need to be able to pull all of this information together to gain much more sophisticated insights about customers, their needs, and what is going to attract them to the health plan and to stay with the health plan for the long term.”

This is a closed-loop process of continual improvement, Nichols added. “The most evolved state an enterprise can achieve is to use all the relevant data sources that are available across the enterprise and from third parties and vendors, and then feeding that back into a continual learning process, adding more data, getting deeper insights into that consumer base, and then being able to test out even more ways of engagement to determine what works best, and then continually feeding that data back in for ongoing learning.”
From Insight to Action

Assuming the organization has built wonderful, comprehensive profiles of existing and potential customer populations – and segmented these populations by meaningful similarities – it now has the intelligence to answer critical operational questions about customer engagement and risk management.

What’s the best way to engage with customer groups to drive the desired behaviors?

“To effectively compete in this new marketplace, health plans must apply the same customer-focused engagement principles as other industries,” said Aggarwal. “We need to develop and rapidly test products and services, such as value-based products, to laser in on populations that are likely to respond to engagement. This needs to be an iterative process. We need to understand what works with individual beneficiaries, what gets them excited, and what is going to keep them engaged with us.

“With health care exchanges effectively eliminating the employer as the middleman, there is a unique opportunity to create long-term relationships with these beneficiaries.” In addition to reducing churn, long-term relationships can reduce costs, because the insurance company is in a better position to create wellness and care management strategies that will reduce a beneficiary’s overall health care costs.

What is the risk profile of the population … really?

Under the Patient Protection and Affordable Care Act, coverage cannot be denied, even on the basis of pre-existing conditions, and health status cannot be considered in pricing – only fairly narrow bands for age and other factors. Underwriting will effectively be replaced by risk adjustment: the transfer of funds from insurers who have lower risk populations to those who have higher risk populations. The hope is that there will be no negative financial impact for a health plan for attracting a high-risk population.

Risk adjustment exists today and is used on a limited basis. It exists in the Medicare Advantage world, the Medicare Prescription Drug Plan (PDP) world, in some Medicaid states as well as the Massachusetts Health Connector.

“The one critical difference for risk adjustment under health reform, as opposed to Medicare currently, is that in Medicare Part A, the risk adjustment is additive in nature,” said Aggarwal. “if you have a high-risk score, you get paid additional money from the federal government. Under health care reform, it is very different. On a state by state basis, risk adjustment will result in a transfer of money from plans with low documented risk scores to those with high risk scores. Risk adjustment creates an unusual new competitive dynamic among competing plans.
“While it is unclear what the final outcomes of the risk adjustment models are going to be, it is fairly clear that these models will combine demographic as well as diagnosis information. Member attributes can drive drastically different risk scores, and consequently payments, to health plans. As a result, revenue will be driven by the ability of health plans to obtain current, accurate and complete diagnosis information – and to do it as early as possible.”

Aggarwal presented a chart showing the life cycle of a beneficiary’s interaction with the health system, progressing from having a risk for a chronic condition to reaching the onset of the disease, resulting in physician visits, which lead to prescriptions, which can lead to inpatient care, and then to a maintenance phase.

Historically, the health plan didn’t get diagnosis information until the beneficiary entered an outpatient or inpatient setting, because physicians don’t always provide this information on claims data, Aggarwal said. “Health plans need to identify the patient’s diagnosis information earlier in the life cycle. In addition to helping identify the diagnosis earlier and getting a more accurate risk score, it enables the health plan to put the beneficiary into a more appropriate care management plan, which ultimately reduces the overall cost of care.”

The revenue implications of underreporting risk scores are significant, said Aggarwal, who presented a typical example: a 22-year-old male who has a very low risk score of 0.22. If the health plan did a better job understanding the beneficiary as an individual, it might know that the 22-year-old male is a diabetic and has asthma, as well as a minor dermatologic condition. When you factor in those diagnoses, the risk score jumps to 2.8, a twelvefold differential to the health plan for the same member. Which risk score would you want used to calculate your risk adjustment payment?

**Closing Thoughts**

We have seen this type of regulatory-driven market transformation before: in 1978 with the airlines, in 1996 with the phone companies, and in 1999 with the financial services industry. In all cases, fierce competition emerged. The survivors learned how to appeal to the consumer’s perception of value. The winners figured out how to identify new opportunities and create new perceptions of value.

They integrated data from multiple, diverse sources, applied analytics and optimization techniques to the data, and generated unique customer insights that guided more effective decisions and actions. Nichols presented some compelling successes that should make health insurance plans take notice:

- A large North American financial services provider was struggling with multiple products and multiple contact channels, all being managed independently and sometimes in conflict with each other. The institution used analytics and optimization to determine the right product offers and the right channel, while still managing resources and budgets – and gained an ROI of well over 100 percent as well as a significant competitive edge.
A telecommunications company that had multiple, disparate data sources in different functional areas found a way to integrate all of that information – plus demographic, psychographic and credit data from third parties – to create a 360-degree view of its customer base. Working with a more comprehensive view, it overhauled sales and marketing efforts, transforming from product-based to enterprisewide strategies – and saw a 250 percent increase in its close rate.

“Regulatory changes are driving shifts in the way we do business,” said Aggarwal. “The business is clearly changing from being product-focused to being consumer-focused. That means we need to be able to engage the customer, and to do that successfully, we need to first understand the consumer population. Once we understand the population, we need to be able to drive the right message at the right time through the right channel to deliver the right product at the right price. And once we do that, we need to measure our results. Are we doing this successfully or not? And if we are not, what do we need to change to sustain a continuous learning curve over time?”

Health care reform doesn’t reduce the potential market; it just redistributes it to those who compete better. Some insurance plans will lose business, but that means others will gain. The winners will be the ones that capitalize on data integration, advanced analytics and optimization to seize the opportunities that come with open competition.

About the Presenters

Arjun Aggarwal
Founder and Managing Director, HealthScape Advisors
Arjun Aggarwal advises health plans, managed care organizations and third-party administrators on a variety of performance improvement, financial, operational, investigations, disputes and regulatory topics. In particular, Aggarwal focuses on helping clients develop a strategic position to respond to the changes in the marketplace.

Leigh Nichols
Senior Solutions Architect, SAS
Leigh Nichols has more than 20 years’ experience in consulting and management with companies like First Data, Peoplesoft, Fair Isaac and most recently SAS – helping customers apply advanced analytics to solve real-world business challenges such as acquisition, retention, loyalty and segmentation.

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Arjun Aggarwal,
Managing Director, HealthScape Advisors
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