

# MANAGED CARE

## OUTLOOK

The Insider's Business Briefing on Managed Healthcare

ASPEN PUBLISHERS

Electronically reprinted from Volume 21, Number 2 • January 15, 2008

## Predictions for the Health Care Payer Market for 2008: The Rise of Integrated Health Care Management

*By Jeff Margolis*

As we begin 2008, the health care industry is entering a new era of integrated health care management — the systematic application of processes and shared information to optimize the coordination of benefits and care for the health care consumer.

Payers are ideally positioned to lead the way toward this new model, and the move is already getting started within some of the more innovative organizations. These payers are implementing systems and processes that drive the convergence of core administration, care management, and constituent-engagement approaches through interactivity, information, and incentives.

Multiple powerful forces, all of which will intensify in 2008, are prompting this. For example, growing demands for improved coordination and quality of care require that payers gain a comprehensive view of individual members, share this with providers in a timely way, communicate more directly with members, positioning them as informed consumers. Clearly, this necessitates the integration of systems and related processes that support core administration, care management, and communication among all relevant constituents in the health care supply chain.

Meanwhile, competition with financial services organizations is intensifying, heightening the need for payers to implement systems that differentiate their ability to serve the whole person, as opposed to focusing on transactions.

Other trends also will change the landscape in the year ahead. The push for universal health care coverage will present complex demands to state governments as well as the commercial payer organizations that provide coverage to residents. Ubiquitous access to the Internet promises to play a catalyzing role in health care — as it has in other industries — and will lead some payers into new territory in 2008. As they seek to guide the health care dialog, some organizations are likely to establish virtual communities that connect consumers with each other, with their providers, and with the content that consumers need, when they need it.

All these eventualities will impose significantly increased demands on payer organizations and their information technology (IT) systems, which were designed largely just to execute transactions. Increasingly, these systems will be counted upon not only to provide a comprehensive view of each member's health care benefits, health history, and health status but also to support innovative new programs in disease management and health and wellness. Extensive system integration and, with it, the ability to share comprehensive administrative and clinical data in real time with providers and others involved in member care will prove essential to success in this rapidly changing market.

As both this new era and the New Year get under way, here are six predictions regarding the challenges and changes that lie ahead. Integrated health care management will play a major part in helping payers meet these.

**1. The variety of supplemental benefits and support services (for example, disease management) will increase in consumer retail health care, creating new information integration challenges to “visualize” the entire person.**

To control their own health care expenditures, employer groups have increased employee out-of-pocket costs and, in some cases, hired disease management companies to work with employees who have chronic conditions or predictive risk factors. Basic benefits offered by health plans that contain higher deductibles open the door for a cadre of supplemental benefits and discounting arrangements that can “fill the gaps.” A potential consequence is that today, no single entity, except the consumer, has a comprehensive view of the individual’s health status and history. That contributes to waste, redundancy, and ineffective care.

If payers are to facilitate collaboration and coordination of care across all the entities involved in member care, they will need to arm members with easy-to-use tools — for example, personal health records — that enable these various entities to gain a comprehensive view of the member. Without this, collaboration among constituents and optimized coordination of care cannot effectively be attained.

**2. State-based universal programs targeted at the uninsured population will be hindered by ineffective enrollment and population management systems, providing an opportunity for commercial payers to demonstrate and apply robust administrative and care management capabilities in a visible and positive manner.**

The move by Massachusetts to require that all residents obtain health insurance coverage is gaining adherents in other states; however, the states will encounter serious challenges in implementing and administering these complex programs. The states will find that they cannot meet these challenges without access to integrated-systems capabilities similar to those of private health care payers.

Without highly efficient systems, identifying, enrolling, and tracking uninsured populations will be difficult at best. Some residents will not wish to be identified by the government; some will be less than eager to pay premiums (even if they are subsidized); and many will move in and out of jobs, creating complex eligibility-verification challenges for states and employers.

At least as significant are the challenges associated with care management, as many newly insured

Americans will require extensive services, not to mention extensive help navigating the complex health care system.

Although these are daunting challenges, they also present opportunities. Payers will have a chance to demonstrate that they have the people, processes, and technologies to meet consumer needs efficiently and cost-effectively and that they can serve as advocates for — and partners of — consumers.

**3. Social networking constructs will rapidly infiltrate health care, providing challenges and opportunities for payers to directly participate in and influence dialogs with and among consumers.**

The number of specialized online groups that focus on health and medical topics is increasing rapidly, in parallel with the overall growth of social media. Largely because of the proliferation of these virtual communities, millions of consumers today have public or semi-private forums in which to discuss medical care, providers, and health plans. Consumers also can rapidly amass information — accurate or not — about topics of personal relevance and make important decisions about health benefits and care on the basis of this information.

The question for payers is whether and how to help shape and direct the online health care dialog by providing and organizing content and interacting with consumers in these virtual communities. Both the challenges and the opportunities are considerable.

**4. A significant portion of the U.S. health care industry will go “back to the future” toward a primary care (*i.e.*, medical home) and multi-specialty model, causing health plans to construct better methods of channeling technology-enabled information to consumers in coordination with their provider networks.**

The American College of Physicians and other professional organizations have expressed strong support for the advanced medical home model, which would entail greater coordination of care in the interests of reducing waste, promoting evidence-based care, improving management of chronic conditions, and delivering preventive services.

In this model, primary care physicians, general practitioners, and internists would play a coordinating role in managing member care — somewhat akin to the role these providers played in the heyday of the health maintenance organization (HMO). The medical home model,

however, is not intended to mark a return to highly restrictive forms of managed care; rather, it “entails a central resource (the Advanced Medical Home) with a competent team, including a physician specialist in complex, chronic care management, and coordination and active involvement by informed patients,” according to an American College of Physicians monograph on this topic.

Payers with integrated systems will be well-positioned to support the coordinating role of front-line practitioners and, at the same time, ensure that consumers receive the information they need in order to make informed decisions about benefits and care.

**5. Physician reimbursement for patient engagement beyond traditional office visits will accelerate, creating new types of “transactions” (for example, health coaching and adherence to evidence-based protocols) that must be managed as benefits, adjudicated, and paid.**

The traditional system of provider reimbursements was built to accommodate basic transactions such as office visits, lab tests, pharmacy use, and inpatient/outpatient procedures. In the recent past, some payers have begun to reimburse providers for telephonic and Web-based transactions. Although these new transaction types meet consumer and provider demand for convenience, payers will need to go a step further.

To ensure that transactions of all varieties — whether office visits, hospitalizations, e-visits, or emails — conform to evidence-based protocols, payers will need to establish integrated payment systems that enable them to pay for the services themselves while also incenting providers to adhere to evidence-based protocols.

**6. The battleground to become the trusted health care ally of the consumer will intensify among health plans and financial institutions; neither will meaningfully prevail, although services branding will drive persistency.**

As consumer-oriented products continue to reach the health care market, payers and financial institutions are vying to become the consumer’s trusted health care ally. At the highest level, the battle is futile. No matter how hard they try, neither health plans nor financial institutions will win the undying loyalty and trust of consumers. In health matters, consumers listen first and foremost to their physicians.

What payers and financial institutions can hope to win is consumer persistency; *i.e.*, the willingness of the consumer to stay with a particular familiar brand because switching to another would be inconvenient and because there is a perception of quality associated with the brand. By providing good service, payers and financial institutions stand to boost persistency, even if they do little or nothing to boost the highest levels of trust and loyalty.

That said, payers are in a better position to drive persistency through branding because, having started down the road to integrated health care management, many of these organizations are in a better position to offer to the consumer a comprehensive picture of his or her financial and medical information in a single snapshot. ■

Jeff Margolis is chairman and chief executive officer of The TriZetto Group Inc., a health care software and services company whose payer technology touches nearly half of the U.S. insured population. Mr. Margolis founded TriZetto in 1997.



The TriZetto Group, Inc.  
 Corporate Office  
 567 San Nicolas Drive  
 Suite 360  
 Newport Beach, CA 92660  
 1-800-569-1222