Leading Research

Sundar Subramanian
Gil Irwin
Curt Bailey

Post-Reform Calculus for Health Plans

Choosing a Business Model That Delivers the Right to Win

Contact Information

Chicago
Ashish Kaura
Principal
+1-312-578-4838
ashish.kaura@booz.com

New York
Gil Irwin
Senior Partner
+1-212-551-6548
gil.irwin@booz.com

Jack Topdjian
Partner
+1-212-551-6601
jack.topdjian@booz.com

Sundar Subramanian
Principal
+1-212-551-6651
sundar.subramanian@booz.com

San Francisco
Curt Bailey
Partner
+1-415-263-3701
curt.bailey@booz.com

Thom Bales
Principal
+1-415-627-3371
thom.bales@booz.com

Deepak Goyal
Principal
+1-415-627-4206
deepak.goyal@booz.com

EXECUTIVE SUMMARY

The Obama administration's sprawling healthcare reform law is redrawing the industry's landscape in the United States. Though opponents are working in the courts, in Congress, and in statehouses to repeal or curtail the legislation, it would be prudent to assume that many of its most important provisions will survive. Healthcare plans must recognize that they are at a historic crossroads and start to prepare for a radically different future in which no incumbent has a guaranteed right to win.

Unfocused and slow-footed plans will find the future inhospitable. They will no longer be able to use a scattershot approach to serve customer segments, "majoring" in some and "minoring" in others. Nor will they be able to rely on brand recognition and economies of scale to make up for operational inefficiencies and a business model that lacks coherence. Instead, they will have to adjust to a world in which strategic focus will be king, competition will be intense, and cost containment will be a never-ending imperative. To succeed, they will have to make painful choices about where to play, by understanding the needs of each customer segment and developing the precise capabilities to meet those needs. Four key ways to play are expected to emerge as competitive: a low-cost standard play, a custom administrative-services-only play, a medical value play, and a broader-services play.

To participate and win in multiple segments, a health plan will have to mix and match its capabilities to create a coherent company-wide model and deploy those capabilities with precision, segment by segment, in targeted geographic markets around the country. With profit pools shrinking, plans will also need to explore new sources of profits through diversification that is consistent with their company-wide model. This could include selling "best of breed" capabilities or services to other plans and offering new product lines to existing customers. Overall, the marching order for big incumbents will be to develop a coherent strategy that will make them nimbler and more relevant. The time to kick-start this strategy is now.

KEY FINDINGS

- The Obama administration's healthcare reform law is redrawing the industry landscape. Healthcare plans must recognize that they are at a historic crossroads and start to prepare for a radically different future in which no incumbent has a guaranteed right to win.
- Incumbents will no longer be able to use a scattershot approach to serve customer segments, "majoring" in some and "minoring" in others. Nor will they be able to rely on brand recognition and economies of scale to make up for operational inefficiencies and a business model that lacks coherence.
- To succeed, they must make painful choices about where to play, by understanding the needs of each customer segment and developing the precise capabilities to meet those needs. Four ways to play are expected to emerge: a low-cost standard play, a custom administrative-services-only play, a medical value play, and a broader-services play. In each, plans must raise the quality of products and services at the same time that they cut their overall costs.
- To participate in multiple segments, a plan must determine which capabilities are required "to win," mix and match those capabilities in a coherent, company-wide approach, and deploy them with precision, segment by segment, in targeted geographic markets.

NEW RULES FOR A CHANGING ENVIRONMENT

It is still the early days for the Obama administration's healthcare reform law. Only a few of its provisions have taken effect, and many of its most far-reaching changes aren't scheduled to kick in for several years, with questions swirling about their implementation and ultimate impact. Meanwhile, the future path of the law is clouded by court challenges and by efforts in the new Congress to repeal it or to deny funding for some of its key elements. Opponents at statehouses around the country are also working to weaken its provisions.

Yet despite all this uncertainty, it would be prudent to assume that much of the new law will remain intact and that health plans will soon be operating in a dramatically different environment. They need to start preparing for that new world now, in both thoughtful and assertive ways.

Eventually, this altered environment will reward health plans that use business models targeted to serve specific subscriber segments with specialized capabilities—and that are operating with the lowest costs. Those that follow that formula will claim a leadership role in a world that will punish unfocused and slow-footed incumbents, attract many lean newcomers, and make cost containment an ongoing necessity.

These conclusions are based on our extensive research in the wake of the passage last year of the Patient Protection and Affordable Care Act. We interviewed more than 70 health plan CEOs, policy experts, and regulators to develop broad-based perspectives on health reform and health insurance exchanges. We conducted surveys and focus group meetings to gather input from nearly 300 small and large employers and spoke at length with consumers in Massachusetts, where state health reform efforts have been ongoing for several years. We also conducted proprietary scenario modeling of payor economics for each of the major customer segments, using more than 60 variables, to analyze the impact on profitability of various ways to play.

Our research shows that one model will definitely not fit all in the new world of health reform—indeed, several winning models are likely to emerge. For a plan to choose the right one, or the right combination of several models working together in a coherent company-wide approach, it must have a deep understanding not only of the needs of the customer segments that it is targeting but also of its own core capabilities. These capabilities encompass everything from marketing and distribution, product standardization and/or customization, consumer engagement, and health and

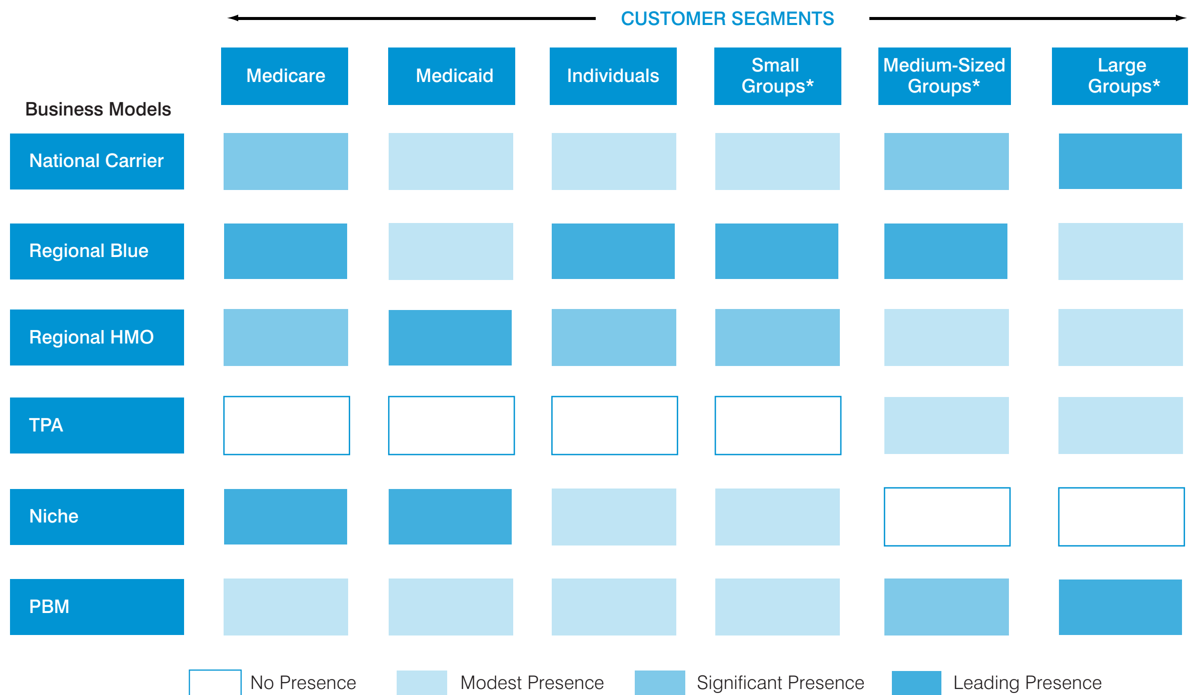
wellness tools to provider network management, payment systems, care delivery methods, and lean administration. It is unlikely, and probably impossible, that one company can be everything (that is, strong in all of these capabilities) to everybody (that is, play in all of the segments), given the divergent sets of needs and characteristics that will be the hallmark of the post-reform world.

The mandate to focus sharply on targeting core capabilities to specific customer segments is at odds with the approach currently used by most health plans, which have generally operated through one of six models: national carriers, regional Blue Cross and Blue Shield companies, regional HMOs, third-party administrators (TPAs), niche companies (Medicaid and/or Medicare), and pharmacy benefits management companies (PBMs). Most incumbents have tended to "major" or "minor" in various segments, often counting on their brand names and economies of scale to carry the day (*see Exhibit 1*). Many have even used vastly different platforms, processes, and organizational structures in their business units, with few if any attempts at integration and rationalization.

Given that the new law is attempting to redraw the entire landscape, none of the incumbents have a guaranteed right to win. And given that the emphasis in this new landscape will be on serving targeted segments with sharper, specialized capabilities, niche players and newcomers would seem to have a leg up in the looming race to claim a stake.

And yet, though the biggest incumbents face daunting challenges and the need to make difficult decisions about how they are structured and whom they serve, they are by no means out of the race. Indeed, because of their very size and their long experience with numerous customer segments, they may actually have the advantage if they move quickly to reorganize into leaner, more focused models.

Exhibit 1
Existing Models Tend to "Major" and "Minor" in Customer Segments



* Small groups have as many as 50 or 100 members, depending on the state; medium-sized have 51 or 101 to 1,000 members, depending on the state; large have more than 1,000 members.
Source: Booz & Company

WHY THE LANDSCAPE IS SHIFTING

Though many aspects of the future of healthcare in the United States are unclear, two areas of change seem fairly certain. The first is that the industry's existing business models will be severely challenged. The second is that a number of key strategic imperatives that were already in play because of ongoing market trends will now accelerate. Taken together, the changes in these two areas are altering the industry's dynamics in major ways, leading inevitably to a radically different landscape for health plans to operate on.

Growing Pressure on Existing Business Models

Assuming that court challenges and congressional and state opposition don't derail the reform law, we estimate that over the next five years it will provide coverage for 25 million people who now have no insurance, a significant portion of the uninsured population. The impact on health plans will be sharply felt.

To begin with, the huge increase in the number of insured will likely produce a near-term spike in demand for services. The healthcare system will struggle to quickly expand provider capacity. In the past, such hurried jumps in capacity have tended to send prices higher in many communities.

But this time around, health plans will face increased competition.

The huge increase in the number of insured due to the reform law will likely produce a near-term spike in demand for services.

They will come under immense pressure to reduce costs, especially in light of their damaged public image. At the same time, they will also come under tremendous pressure to improve quality.

The Accelerating Evolution of Key Strategic Imperatives

Four defining elements of the healthcare system have been evolving in recent years because of ongoing market trends. That evolution is now going to speed up. Health plans will find it increasingly necessary to get on the bandwagon by doing the following:

Shift to the retail market. This trend is certain to accelerate, thanks to the arrival and evolution of healthcare exchanges, a centerpiece of the new law. The exchanges, to be set up by the states in 2014, will serve as marketplaces for those who are not insured by their employers to shop for coverage at competitive rates. The exchanges will directly affect individuals, small groups (as many as 50 or 100 members, depending on the state), and, in some states, those covered by Medicaid. Because of implied price pressures, the exchange system will indirectly affect those covered by Medicare, medium-size groups (51 or 101 to 1,000 members, depending on the state), and large groups (more than 1,000 members).

Demonstrate medical value. The reform law does not directly address medical inflation and might actually add to it, at least in the short term, given the sudden demands that it will place on providers through expanded coverage. But to differentiate themselves, health plans will need to demonstrate their medical value to subscribers by improving the nature and quality of care and in the process reducing medical costs. They can do that by working with providers to develop new care delivery models, by introducing innovative payment methods and incentives, and by offering programs to promote consumer health and wellness.

Become lean. Apart from the push to control medical expenses is the need to reduce costs on the administrative side and to become more efficient. A lean operation will be essential to address affordability concerns at least partially and also to help keep a plan profitable in the face of severe rate and premium pressures.

Diversify core capabilities into new health-related or insurance offerings. Given the limited growth opportunities and increasing cost pressures that are shrinking the health insurance profit pools, the bigger plans need to look for new sources of revenue. This revenue can come from providing expertise to other plans or employers and from selling new products and services to existing customers.

FOUR FUTURE WAYS TO PLAY

The challenge facing health plans is enormous. They have to adapt their capabilities to the new realities of the marketplace, including widely divergent customer segments, while simultaneously reducing their overall operating costs. In this context, we see the emergence of three specialized ways to play and a form of diversification that involves selling broader services.

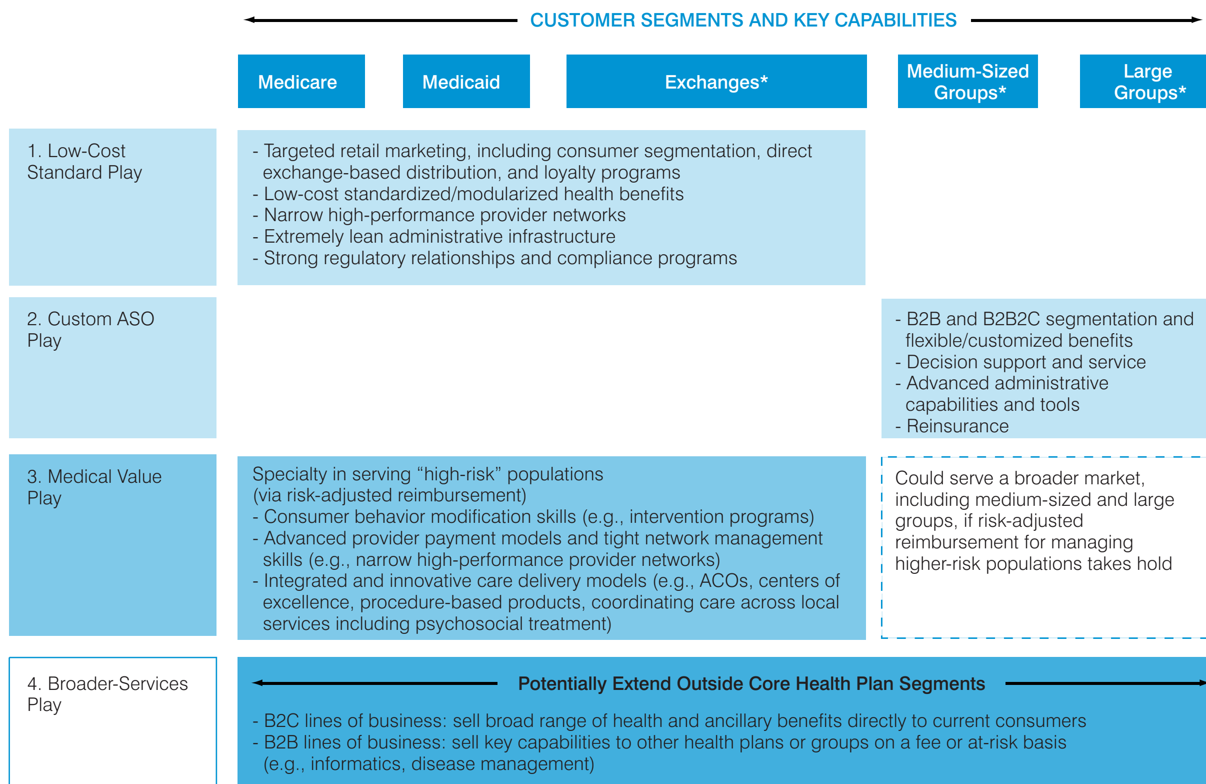
The three specialized plays, each targeting a discrete group of customer segments, are the low-cost standard play, the custom ASO (administrative services only) play, and the medical value play. Niche players and new entrants will likely be attracted to one of these three, although they may have a clear advantage over large incumbents only with the first one.

Large existing plans will presumably want to play in more than one of these specialized areas. Their success in doing so will depend on whether they can bundle their capabilities in different ways to serve different segments at the same time. The key will be in mixing and matching capabilities in a coherent, careful, and efficient manner.

Large incumbents will also need to explore the broader-services play, which opens up two new sources of revenue. The first is the sale of ancillary products and services to existing subscribers. The second is the sale of key capabilities to other health plans, which find themselves with gaps as they approach the segmented new market. Over time, niche players and new entrants that choose one or more of the specialized plays may also find it valuable to diversify in this way.

The common denominator for all three specialized approaches is the requirement that key capabilities align closely with the needs of each targeted consumer segment (*see Exhibit 2*).

Exhibit 2
The Four Future Ways to Play



* Exchanges include individuals and small groups (as many as 50 or 100 members, depending on the state); medium-sized groups have 51 or 101 to 1,000 members, depending on the state; large groups have more than 1,000 members.
Source: Booz & Company

Low-Cost Standard Play

This way to play will target individuals and small groups shopping for coverage at exchanges. It will also serve the Medicare segment and some parts of the Medicaid segment. Our modeling suggests that by 2016, when conditions will stabilize following the introduction of the health exchanges, companies aggressively pursuing the low-cost standard play could secure sustainable margins around 5 percent even in the face of premium reductions of about 8 percent. The leaders will achieve those margins by taking away market share from weaker players that cannot compete aggressively on price in these segments.

Key differentiators for this play include retail marketing capabilities targeted to the exchanges. A successful player will need to have a robust understanding of the impact of the new law on the targeted segments and of consumer behavior by subsegment. Loyalty programs, segmented product attributes, and direct distribution mechanisms are also critical.

Another hallmark is the ability to offer low-cost standardized and modular health benefits designed to meet the needs of most of the subsegments using the exchanges.

This play also calls for the ability to manage a narrow high-performing subnetwork of providers. Over time, this subnetwork can evolve into a payment model tied to patient outcomes instead of fixed fees, which are a staple of today's environment.

With so much emphasis on cost, players in this sector need to operate in an extremely lean way and to exploit cost reduction levers extensively, through everything from the promotion of Web-based self-service channels for information and billing to outsourcing and/or offshoring operations.

Also key is the development of strong relationships with government regulatory bodies, including the federal Department of Health and Human Services, state agencies, and departments of insurance. These relationships will serve as a conduit for health plans to offer their views on implementation of critical rules related to the reform law (such as risk adjustment) and to support rate increase negotiations.

Custom ASO Play

The custom administrative-services-only play targets the growing number of companies that are deciding to self-insure. Typically, only large employers have gone this route, assuming the direct risk for paying healthcare claims and hiring health plans to administer the coverage. With full-service plans expected to pass along higher costs stemming from the reform law, medium-sized employers are now seen as being open to joining the ASO market. Our modeling work suggests that by 2016, companies aggressively pursuing the custom ASO play could maintain margins around 4 percent and drive significant upticks in membership, thanks to this play's differentiated ability to offer targeted custom solutions while maintaining administrative scale.

To do well in this sector, an ASO company will, by definition, need very strong administrative capabilities. It will need to integrate "smart customization" techniques in its platform and processing architecture to achieve scale in operations while simultaneously providing customized service.

On the marketing side, it will need strong business-to-business (B2B) and business-to-business-to-consumer (B2B2C) capabilities, including highly customized benefits designs to meet group needs and the ability to market the brand through specialized distribution channels, including benefits consultants and brokers.

Also needed are decision support tools for plan sponsors and consumers and tailored "high touch" customer service with marketing tools and training to generate up-sell offers.

Sophisticated reinsurance capabilities will be essential as well. This feature will gain in importance as more midsized groups turn to self-insurance in order to control costs and will then need reinsurance safeguards.

Medical Value Play
This play directly targets the high-risk populations in the Medicare, Medicaid, and exchange segments. But it could apply more broadly, depending on the type and scale of medical value innovation that a company brings to the marketplace. The goal is to reduce medical costs for high-risk niche segments under a risk-adjusted reimbursement system.

The particular challenge affecting this play is to figure out how to change provider behavior and restructure care, given that providers tend to practice the same way across the range of plans they serve. What is needed is more transparency about the care they provide—and incentives to drive them to deliver high-quality outcomes at the lowest possible costs. Despite this challenge, we believe that plans that gain advantage with the medical value play can sustain margins in excess of 6 percent by 2016 even in the face of premium reductions on the order of 5 percent.

Key levers of differentiation for this play could be one or more of the following: tools for engaging consumers, provider payment systems, or innovative care delivery formats.

Consumer behavior modification skills that encompass prevention programs (such as vaccinations) as well as early detection and intervention programs (such as mammography screening) will be an emerging differentiator for some plans. Also involved are wellness offerings that improve employee productivity, reduce absenteeism, and influence other issues (including long-term disability) that affect health-related spending.

Plans in this sector will also start moving to advanced provider payment systems—such as pay for performance (P4P), global payments, and bundled case rates—that can be shown to reduce costs and to improve the quality of care by aligning incentives with outcomes.

Integrated care delivery will also emerge as a key differentiator for some plans. Such care includes tailored services from any of several available approaches, including accountable care organizations (ACOs), centers of excellence, procedure-based products, medical homes, and vertical integration (either broad or targeted provider ownership).

Broader-Services Play
As noted earlier, to expand their profit pools in new directions, the big incumbents will need to look for health-related “adjacencies” that fit well with their core strengths. The goal is to capture additional sources of revenue by offering product and service line extensions.

On the B2B front, this form of diversification includes selling “best of breed” capabilities or services to other health plans (though typically not to direct competitors) or to large employers that are self-insuring.

In terms of B2C expansion, the effort includes ancillary offerings that are outside the typical insured dollar flow. Some examples are dental, vision, and pharmacy products and services. These new offerings would be marketed to existing customers based on a deep understanding of their segmentation, needs, and purchase behavior.

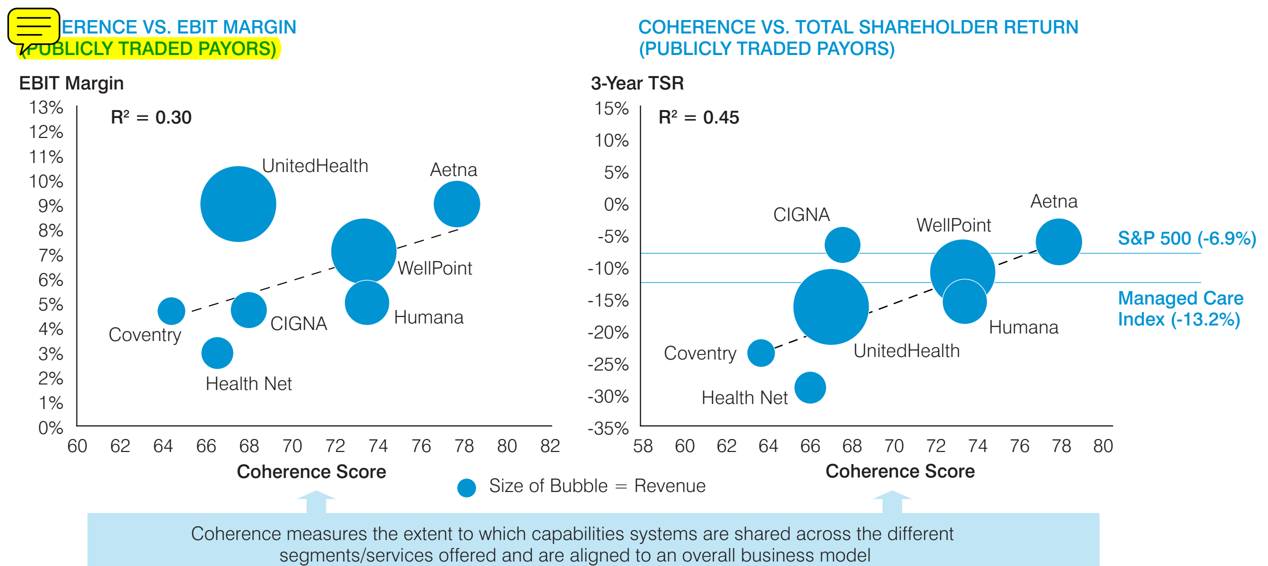
To expand their profit pools, the big incumbents will need to look for health-related “adjacencies” that fit well with their core strengths.

DESIGNING THE COMPANY-LEVEL BUSINESS MODEL

Given the different capabilities required to serve different segments, companies will now, more than ever, need to make tough choices about where they want to play. They need to figure out their "way to win" and settle on their future capabilities systems in order to have a coherent company-wide strategy.

"Coherence" is the operative word. Our research suggests that capabilities coherence has historically played a significant role in competitive advantage and financial results for health plans. Companies that can focus on a few key capabilities systems, leverage them repeatedly across target businesses, and satisfy customer needs for those businesses in a differentiated way are the most likely to create unique competitive advantage (*see Exhibit 3*).

Exhibit 3
Linking Capabilities Coherence to Competitive Advantage



Source: Bloomberg; company annual reports; Booz & Company

Looking ahead, large plans that are now in multiple segments should settle on a combination of capabilities that would maximize their coherence (*see Exhibit 4*). Overall, the marching order for big companies is to have a strategy that makes them nimbler and more relevant, by offering the right mix of products and services to targeted segments in targeted markets around the country.

Four Steps to Shaping a Company-Wide Model

To choose the right company-wide business model, health plans should follow a four-step process.

The first order of business is to make tough participation choices. As noted earlier, health plans have been able to participate broadly, if not always efficiently, primarily because of their ability to leverage a common brand and to realize economies of scale. Going forward, given the divergence of evolving needs, it will be very difficult to build out the new capabilities needed to compete across all segments in all geographic markets. Some plans may need to beef up areas of current participation that are relatively strong and sell or shutter areas that are now weak.

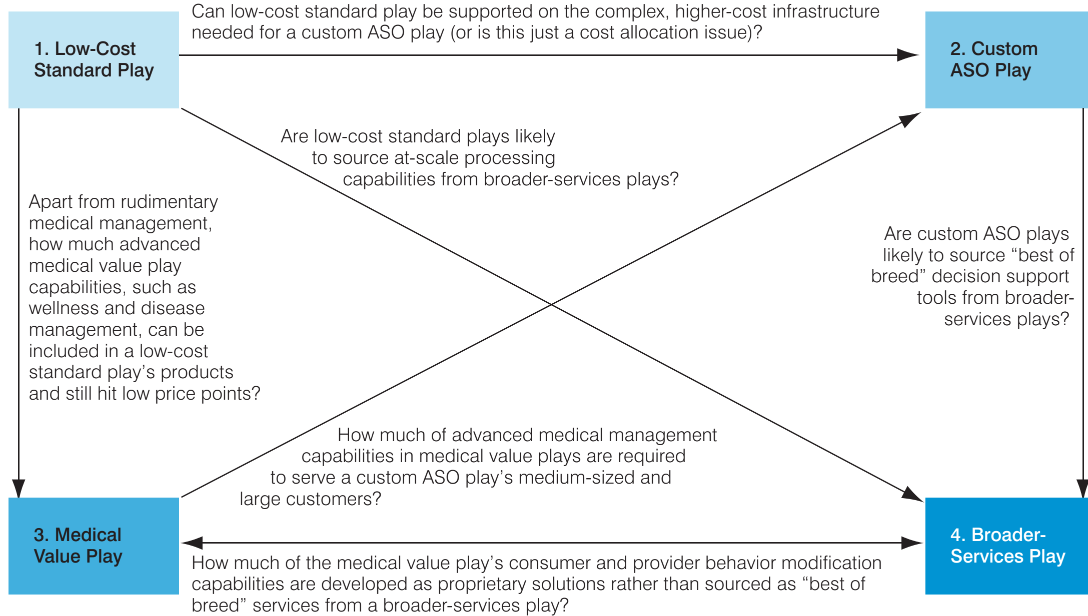
The second step is to define the way to win. It is essential to serve the target segments and geographic markets in a differentiated way (for example, by being the lowest-priced plan in a state's health exchange with the best brand and value in terms of benefits and network access).

The next step is to identify the target capabilities systems. As described earlier, these are the capabilities that support the chosen way to win and satisfy the needs of the target segments. To keep prices low, plans must rationalize their operating costs and investments, cutting back on discretionary expenses that don't focus on the essential capabilities linked to the way to win (*see Exhibit 5*).

Finally, it is important to assess the "option value" of these choices. Though the broad implications of healthcare reform are becoming clearer, significant uncertainty remains (for example, the design and evolution of the state healthcare exchanges are far from fixed). Choices that increase the "option value" of decisions down the road, allowing for more adaptability as the uncertainty resolves, should be seen as valuable in the strategic planning process.

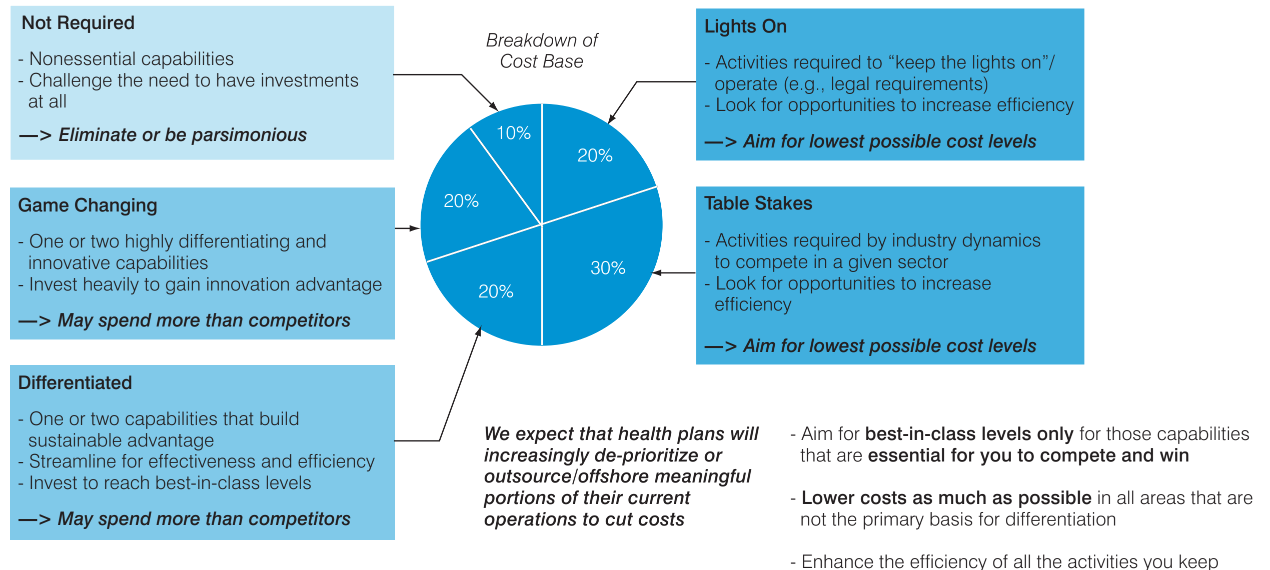
Going forward, it will be very difficult to build out the new capabilities needed to compete across all segments in all geographic markets.

Exhibit 4
How Each Way to Play Can Combine with the Others



Source: Booz & Company

Exhibit 5
Cutting Costs That Don't Support Essential Capabilities



Source: Booz & Company

Rewiring the Company
Once the target participation choices (segments and geographies) and capabilities systems have been broadly decided, the company has to be rewired to achieve its vision. This is no small matter and requires a programmatic transformation.

Capability gaps need to be filled systematically. Should the missing elements be developed internally, or could they be brought in from outside? If the latter, how should that be accomplished? Through M&A? Through arrangements with other plans that already have such skills?

Integrating these key capabilities into a cohesive operating model will not be trivial. Operating model components—such as process design, organizational structure, policy changes, data/technology systems, and metrics/key performance indicators—all need to be meshed with the chosen capabilities systems.

Finally, a systematic effort to change the organizational culture and behavior is central to achieving a health plan's new vision.

Handicapping the Players
Which of today's plans are better positioned than others to become the early winners in the three emerging specialty plays?

Low-cost standard play: Today's niche Medicaid players have the best "starting point" to focus exclusively on the exchange and Medicaid segments. A range of newcomers (other insurers, lean third-party administrators, online retailers) can also target these segments, but they may have to subcontract portions of the value chain through network rental arrangements and/or outsourced processing arrangements.

Custom ASO play: Today's national carriers have the best starting point—given the need for B2B marketing, member support tools, and customized design benefits and administrative platforms. They are less prone to direct attacks from new entrants or niche players, as traditional distribution channels for medium-sized and large group segments will continue to be dominant even after the introduction of the exchanges.

Medical value play: This play will be the most challenging for any plan to evolve into. Those that would seem to have a head start are plans that have begun to pilot payor–provider partnerships, companies that offer integrated health systems (such as Kaiser Permanente and Geisinger), and some niche companies. We could imagine Blue Cross Blue Shield plans, with their deep market penetration, having a head start. That said, health plans have not had any meaningful impact in affecting medical value on a large scale and this area will be a new undertaking for virtually the entire industry.

CONCLUSION

Clearly, one size does not fit all when it comes to choosing a business model for the new world of healthcare. Health plans will need to carefully evaluate their investment bets to uniquely maximize capabilities coherence by focusing on a few key capabilities systems, leveraging them repeatedly across the target businesses, and satisfying customer needs in a differentiated way.

This approach will be essential to create the kind of competitive advantage that can't easily be copied. For the right bets to be placed, the right choices have to be made about where to participate and with which capabilities. The company then must rewire itself to deliver those capabilities to the segments it will serve.

Health plans should begin innovating now toward defining and claiming their space in this new world, even amid the uncertainties that surround all the looming changes.

Plans that are slow to respond or, worse, adopt "wait and watch" strategies will begin to lose market share to their nimbler competitors. That said, while speed is of the essence, those that try to do too much too soon will squander limited resources and time and also come up short.

The winners will be those that make meaningful progress in building differentiated capabilities systems for the target segments that matter. Along the way, they will have implicitly maximized the coherence of their overall strategy. Such companies will stand to capture the bulk of the value that awaits in the future.

About the Authors

Sundar Subramanian is a principal with Booz & Company based in New York. He specializes in operations strategy and transformations in the healthcare industry and leads the firm's effort to apply capabilities-driven strategy to the development of operating models for health plans.

Gil Irwin is a senior partner with Booz & Company based in New York. He works with health, insurance, and capital markets clients, and specializes in the management and strategic use of information technology.

Curt Bailey is a partner with Booz & Company based in San Francisco. He specializes in operations strategy and transformative operations improvement programs for health insurers, ancillary carriers, health systems, pharmacies, and diagnostic companies.

The most recent list of our offices and affiliates, with addresses and telephone numbers, can be found on our website, **booz.com**.

Worldwide Offices

Asia
Beijing
Delhi
Hong Kong
Mumbai
Seoul
Shanghai
Taipei
Tokyo

Australia, New Zealand & Southeast Asia
Auckland
Bangkok
Brisbane
Canberra
Jakarta
Kuala Lumpur
Melbourne
Sydney

Europe
Amsterdam
Berlin
Copenhagen
Dublin
Düsseldorf
Frankfurt
Helsinki
Istanbul
London
Madrid
Milan
Moscow
Munich
Oslo
Paris
Rome
Stockholm
Stuttgart
Vienna
Warsaw
Zurich

Middle East
Abu Dhabi
Beirut
Cairo
Doha
Dubai
Riyadh

North America
Atlanta
Chicago
Cleveland
Dallas
DC
Detroit
Florham Park
Houston
Los Angeles
Mexico City
New York City
Parsippany
San Francisco

South America
Buenos Aires
Rio de Janeiro
Santiago
São Paulo

Booz & Company is a leading global management consulting firm, helping the world's top businesses, governments, and organizations. Our founder, Edwin Booz, defined the profession when he established the first management consulting firm in 1914.

Today, with more than 3,300 people in 60 offices around the world, we bring foresight and knowledge, deep functional expertise, and a practical approach to building capabilities and delivering real impact. We work closely with our clients to create and deliver essential advantage. The independent White Space report ranked Booz & Company #1 among consulting firms for "the best thought leadership" in 2010.

For our management magazine *strategy+business*, visit strategy-business.com.

Visit booz.com to learn more about Booz & Company.

©2011 Booz & Company Inc.