

TRANSFORMING YOUR BUSINESS IN AN ERA OF HEALTHCARE REFORM

Four Key Challenges to Payer Success in an Evolving and Competitive Environment

The evolving healthcare landscape has created a wealth of fresh opportunities for payers. There is a sense of urgency for payers in leadership roles to leverage technology and successfully transition to a value-driven healthcare system that rewards top performers and high quality standards. Passage of the Patient Protection and Affordable Care Act (PPACA) quickly changed many aspects of payers' business with higher costs, new oversight, more competition and a longer-term promise of millions of new members. Since healthcare insurance reform became law, opponents have vowed changes, if not its outright repeal. While it may be tempting to take as little action as possible and hope that the 2010 mid-term election or 2012 general election will make this all go away, the reality is that repeal is not a likely possibility.

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Although your business may be treading water in an ailing economy, it's time to start showing confidence toward the future. Many reforms have already been implemented, and payers that delay actions today put their futures at risk. New rules for grandfathered plans and appeals processes have already been implemented by the United States Department of Health and Human Services (HHS). Medical loss ratio (MLR) rules are nearly done. And, driven by new premium hikes well above prior years, the employer group selling environment in 2011 is expected to be more competitive than ever.

Given these realities, the time is right to reflect an opportunistic attitude on compliance and on succeeding in an era of healthcare reform. Launch new strategies to reduce healthcare costs, increase efficiencies, and improve care delivery. Be a leader, not a laggard left to stew in the politics of healthcare reform. The next 18 months may well be a make or break period for many payers. For those that seize the day and invest for the future, there are tremendous opportunities for competitive gains, regardless of the pace healthcare reform proceeds.

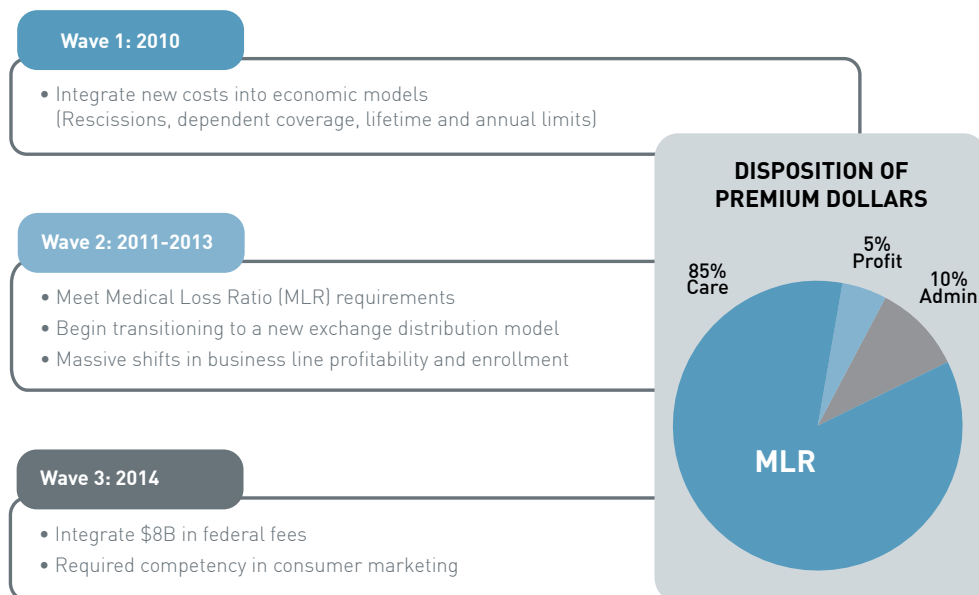
At its broadest level, TriZetto sees the impact of healthcare insurance reform affecting payers in three waves:

Wave 1 – 2010. In September, 2010, the first wave of new rules became effective, delivering an immediate bump to payers' cost structures. Expanded dependent coverage, plus new restrictions on annual and lifetime limits and rescissions have changed the game and the economics of providing insurance. While payers wrestle with revising their operating and cost structures and product offerings to make the math work, new rules and requirements such as grandfathering and appeals processes, are issued periodically from the HHS making course corrections necessary.

Wave 2 – 2011-2013. The greatest impact of the second wave is the new MLR requirement, effective January 1, 2011. MLR, alone, will drive further shifts in business line mixes and profit strategies. It will put additional pressure on economic models for the industry. During this wave, the transition to new exchange models will also begin, with a different competitive environment, highlighted by price transparency, and potentially significant price parity. Implementation of ICD-10 coding will greatly expand patient care data for intelligent risk management decisions.

Wave 3 – 2014. The third wave delivers yet another economic blow to the industry with \$8 billion in new taxes, promised to be offset by the addition of millions of new insured members. With insurance exchanges fully in effect, payers will need to have evolved into strong consumer marketing organizations, with the ability to compete on many additional differentiating purchase drivers, in addition to price.

THREE WAVES OF HEALTHCARE REFORM



Each of these waves bring operational and economic challenges for payers—and collectively require actions that payers must take right now to better ensure their survival and success in this new healthcare world.

Some leaders will have the foresight to view the turmoil of healthcare reform as an opportunity to create real and meaningful change. Payers are in a strong position to maximize the coordination of benefits and care for the healthcare consumer through the systematic application of processes, shared information and aligned incentives. TriZetto calls this vision Integrated Healthcare Management (IHM). IHM will facilitate much-needed communication, collaboration and efficiency in the healthcare system, and create a new era where all constituents can benefit.

The Four Key Challenges of Payer Success

To achieve success in this era of reform, payers need to address four key challenges that TriZetto believes will be essential to surviving and succeeding in a fiercely competitive reformed healthcare insurance marketplace:

- Comply with Reform
- Increase Administrative Efficiency
- Improve Cost and Quality of Care
- Compete to Win

Payers can address these challenges today by leveraging technology and systematically applying processes and shared information to drive efficiencies. In doing so, they may better compete with emerging competitors and move ahead of the pack to success. Let's take a look at each challenge in more detail.

Challenge 1: Comply with Reform

It is important to move quickly to address new regulations and associated costs being introduced into your economic models, including: eliminations of rescissions and lifetime/annual limits, expansion of dependent coverage, and first-dollar coverage of high-value preventative services. Over the next three years, payers will have to meet MLR requirements, begin transitioning to a new exchange distribution model, shift business line profitability and enrollment, and increase movement and influx of small business and individuals.

To help comply with these rapidly approaching requirements, payers need enterprise systems—including core administration and care and network management—that are scalable, highly flexible, and configurable to establish and vary benefits. Payers who focus on the ability to implement and change benefit designs quickly and efficiently may be able to comply more easily with healthcare reform and future requirements.

The industry is in the middle of converting to the ICD-10 diagnosis and treatment coding standard, which further complicates this compliance challenge. Payers that use technology to leverage rich 5010 and ICD-10 data will be able to drive administrative efficiency and accelerate care programs, helping meet demanding MLR thresholds. As savvy payers, you'll be able to identify and resolve issues faster and support more accurate trend, pricing, and reimbursement analyses—all leading to potential lower costs and better decision making.

Challenge 2: Increase Administrative Efficiency

This second challenge can make payers more efficient and help create sustainable economic models. Reform requirements taking effect in 2011 require at least 80 percent of insurance premiums be spent on direct patient care in individual or small-group plans (85 percent for large groups), or rebates must be paid the following year. Payers must take a hard look at how to reduce administrative overhead even further.

As an example, the new MLR requirements reduce current profit margins. Payers no longer have the flexibility to manage a portfolio of varied plans and business lines. Raising premium prices also will be difficult in the more competitive reform environment that kicks into high gear in 2011.

A solution is for payers to optimize administrative efficiencies to offset variances in patient care, stabilize the MLR and sustain economic values. Compliance to the MLR rules challenges payers to lower administrative costs through improved processes. Actions to take include streamlining enterprise systems to reduce administrative costs and re-examining outsourcing strategies.

When considering a core administration system

Payers need to identify what they need a system to support based on future business goals of the company. The system should be able to handle changes already planned, such as ICD-10 and healthcare reform mandates. It should also have the flexibility to meet new regulations quickly and to easily make value-based benefit changes.

Payers need to coordinate operations through system replacements and new solutions to automate “problem” processes to improve productivity, while keeping costs down. For example, a first step is to establish an efficient core administration system that streamlines processing and focuses on improving adjudication and first pass rates. Configurable business process automation features will be a key concept in claims adjudication.

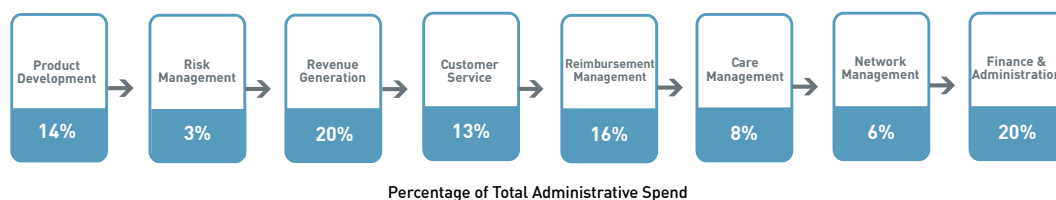
Care and network management also are key areas in which your enterprise systems should be highly efficient. These systems must automate administrative tasks and reduce manual configurations. For example, network management represents another area where automation and efficiency must be increased. Payers need to closely examine the contracting cycle where automated contract modeling and automated discovery of pricing variation can help avoid downstream manual intervention.

Efficiency gains are also possible by examining your outsourcing strategies and pursuing cost-effective solutions for business process outsourcing and technology management. Cost-effective offshore, onshore and blended models are available that can significantly lower your administrative costs across areas such as front-end services (mailroom, imaging, OCR/scanning and data processing), claims processing, enrollment and other business processes. In addition, application hosting and management services are tools you can use to help lower operating costs, reduce operational risk and accelerate time to market with new offerings.

Outsourcing Strategy

With the enormous pressure of healthcare reform and ICD-10 compliance challenging payers to increase their administrative efficiency and transform their businesses, the demand for Business Process outsourcing (BPO) services has never been greater. According to recent industry reports, 40 percent of payers plan to increase BPO usage to drive down their administrative costs and drive up their competitive differentiation.

PAYER ADMINISTRATIVE SPENDING



Challenge 3: Improve Cost and Quality of Care

Covering care for members comprises more than 80 percent of payers’ costs. Inefficiencies in the delivery of care provide the greatest opportunity for improvement. Only in the last five years have most payers truly begun to target cost and quality of care processes for significant systems improvement.

Now, healthcare reform legislation creates many new rules and programs to improve care quality and reduce individual consumers’ costs. Within the new, detailed MLR rules, allowance is made for the inclusion of quality improvement expenses in the cost of care portion of the MLR calculation. These provide financial incentives for payers and others to invest in activities and tools that improve care.

To do this requires a coordinated and systematic approach that aligns incentives to reward value instead of volume. The industry needs benefit designs that encourage members to make healthy lifestyle choices and avoid duplicate or unnecessary services. Providers need guidelines on analyzing performance to optimize incentives for improving quality care and patient satisfaction at lower costs. Both of these can be achieved through value-based strategies.

On the “demand” side for consumers, this involves developing value-based insurance design (VBID) plans. VBID is a strategy that incents individuals to use higher-value healthcare services and establishes financial barriers to potentially reduce the inadvertent use of lower value care choices.¹

On the “supply” side for clinicians, value-based provider reimbursement (VBR) strategies seek to use reimbursement as a lever to change the way providers deliver care, to improve quality, and to help ensure that patients receive effective care. Most forms of VBR involve shifting risk from payers to providers who, ideally, are better-positioned to manage risk. In particular, the Accountable Care Organizations (ACOs), payment bundling, and the patient-centered medical home take holistic approaches to risk. These approaches involve placing the right degree of risk in the hands of the party best able to manage it and giving that party support to manage the risk for value and results as well as for adherence to best practices and evidence-based medicine.

Move quickly to offer new programs

Beyond the regulatory mandates of reform, health plans should ensure core administration systems have the ability to allow them to move quickly to offer new programs that may come out of reform. Value-Based Benefit design and Value-Based Physician Reimbursement will take on many flavors and the core system must be nimble enough to offer these programs and make changes.

Although HHS has not yet created the specific rules or incentives for these approaches, many players across the healthcare industry are moving towards ACOs, ahead of any legislative rules or incentives. As rapidly as this market strategy is developing, it is critical for payers to find a game plan for ACO participation. There are two key avenues. The first is to leverage payers' important role in processing payments to develop new partnerships that extend their reach further across the revenue/payment cycle. At the same time, payers can leverage their expansions in care management activities to play a bigger role in the care delivery cycle.

The new MLR rules also provide encouragement for the application of predictive analytics and data-mining to care management. As a result, TriZetto anticipates significant growth in payers' development and improvement of processes to utilize new data for clinical risk modeling, identification and stratification, patient compliance monitoring, provider cost and utilization analysis and cohort studies.

Value-based strategies, new care delivery models and analytics provide opportunities for payers to wring significant waste and duplication out of the system, and engage patients to improve health and wellness. Payers are well positioned to lead change that will have a dramatic impact on the long-term shape of the industry.

Smart payers will lead the market by engaging in innovative, value-based strategies. It's important to look at a strategic agenda and determine the capabilities that will get you through the transitional period of the next few years and put you in a strong position to survive long-term transformation of the healthcare system.

Challenge 4: Compete to Win

Become a retail expert who stands out from the crowd by leveraging your brand, improving your experience for prospects and customers, and being transparent. Build customer loyalty by designing smart products that add value and meet changing needs.

Leveraging technology to achieve competitive differentiation is an excellent recipe for success in building relations with customers seeking long-term marketing strategies. Developing this approach can:

- Attract and retain customer interest
- Increase transactional efficiencies
- Engage constituents

Reform is leading us into a retail health market with innovative products and stiff competitors. Challenges for a piece of the healthcare dollar could emerge from supplemental insurers such as Geico or Aflac, financial groups like Fidelity, large discount stores like Wal-Mart, and social networking media, such as Google, Yahoo! and Twitter.

In this new competitive arena, payers will need to find innovative and cost-effective ways to acquire new business from the individual market. When the PPACA takes full effect in 2014, payers will vie for millions of new insured individuals expected to come into the market due to the reform legislation. Much of that will happen through the 50 new state-run insurance exchanges, which will be built over the next three years. The result will be dramatically increased price transparency—and probably substantial price parity—between commercial insurers' offerings. That pricing uniformity will put greater emphasis on other competitive differentiators and purchase decision drivers such as service and reputation.

To fully appreciate the affect of this, we can look at just one sub-segment of that large pool of individuals. The reform legislation's new requirement for all Americans to have health insurance, combined with the elimination of nearly all rescissions, is expected to bring a flood of new twenty-somethings into the market. But, most payers have had little experience talking to this younger audience and are a long way from being "plugged-in" to the social media channels where our millennial generation spends its time.

A significant evolution toward retail products is a certainty. To compete in this retail environment, payers may need to create a single, integrated system that can automatically carry the customer from enrollment at the exchange to ID-card generation and post-sale service. Multi-payer architectures will likely be needed to integrate case installation and policy administration.

In addition, new product development will be critical in helping payers compete and move beyond their traditional roles as administrators and provide the unique value of highly coordinated benefits and care. Payers can begin to orchestrate the interactions among key constituents—members, employers, brokers and providers—and deliver new tools and information that enable them to conduct transactions, interact with one another, and carry out their roles with increasing efficiency.

Conclusion—Winners Will Move Quickly

The passage of reform has set a course for a long, challenging journey to a transformed national model of integrated patient care. It's important for payers to take quick actions to navigate successfully through the sea-change of activity rolling through a system that will expand health benefits to millions of more Americans over the next four years. While it's easy to concentrate on the negatives, healthcare reform provides an opportunity to thrive for those payers who move quickly to invest in technologies that enable compliance, administrative efficiency, and improve the cost and quality of care, to enhance their competitiveness.

Solutions are available today to help payers address each challenge. TriZetto's industry-leading core administration, advanced care and network management, and innovative constituent solutions can work independently to deliver superior capabilities—or as an integrated platform to share information and better align incentives among constituents. TriZetto software and services are scalable and flexible for payers of all sizes, to help drive administrative efficiency and improve the cost and quality of care.

It's time to move ahead as you work to comply with reform, but also drive administrative efficiencies, improve cost and quality of care, and compete to win in the new market paradigm. Payers who forge ahead and take action on these four challenges will be well-positioned to survive healthcare reform, outpace their competitors and benefit from real solutions that drive more value in healthcare.

Changing expectations of constituents in a retail environment

It is becoming more and more important for payers to provide transparency to member and provider constituents. A solution-oriented integration via Web services is increasingly important as is the ability to deliver required data in different ways—real-time liability calculations based on the member's actual benefit status as an example.

PAYER CHALLENGES IN A REFORM ERA

Challenge	Payer Requirements	Solution Opportunities
Comply with Reform	<ul style="list-style-type: none"> Move quickly to address compliance issues Comply with ICD-10 and 5010 standards to boost administrative efficiency 	Enterprise Systems (Core, Care, Network Management) ICD-10
Increase Administrative Efficiency	<ul style="list-style-type: none"> Streamline operations to reduce administrative costs Optimize management processes 	Enterprise Systems (Core, Care, Network Management) Business Process Outsourcing Application Hosting
Improve Cost and Quality of Care	<ul style="list-style-type: none"> Strengthen models to assure MLR compliance Align incentives to improve quality 	Care & Network Management Value-Based Solutions
Compete to Win	<ul style="list-style-type: none"> Achieve competitive differentiation with integrated technology 	Enterprise Systems (Core, Care, Network Management) Constituent Solutions

Powering Integrated Healthcare Management®

Integrated Healthcare Management is the systematic application of processes and shared information to optimize the coordination of benefits and care and maximize the value of every healthcare dollar spent. It is fueled by the convergence of core benefit administration, care management and constituent engagement. The intersection of these competencies enables payers to leverage data to more systematically stratify, engage and reward constituents, and personalize interactions with them in order to motivate healthy behaviors, increase the effectiveness of treatments, reduce the cost of care and drive better results. TriZetto has invested in a long-term architectural approach to bring core, care and constituent capabilities together, and enable payers to help them achieve the vision of Integrated Healthcare Management.

About TriZetto

Founded in 1997, TriZetto is the leading privately held healthcare information technology company to the healthcare payer industry, with its technology touching half of the U.S. insured population. TriZetto's vision for the industry—Integrated Healthcare Management—is the optimized coordination of benefits and care for healthcare consumers to improve the value of every healthcare dollar spent. The company's offerings include enterprise and component software, hosting, outsourcing services and consulting that help payers implement and optimize their operations and minimize the risk of bringing to market new products that drive competitive differentiation.

To learn more about how TriZetto can leverage integrated management technology to improve efficiencies, drive profits, and be competitive in a value-driven health reform landscape, call 1-800-569-1222 or visit www.trizetto.com.

ⁱ Variations on the definition of value-based insurance design can be found in these leading white papers: "Value-based Insurance Design Landscape Digest." Fendrick July 2009. Available at: <http://www.sph.umich.edu/vbidcenter>

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