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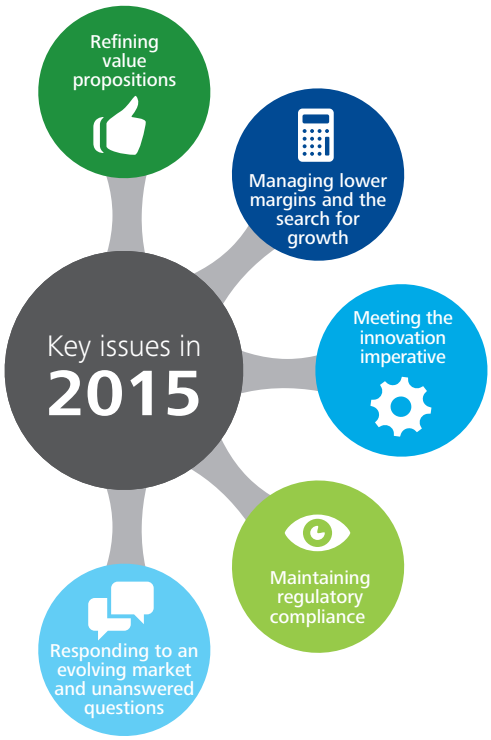
2015 health plans outlook United States

The U.S. health insurance sector is undergoing unprecedented regulatory, financial and competitive disruption. Players' roles are changing rapidly, and strategies that made health plans successful in the past will not suffice in the future.



- Overall healthcare spending growth has slowed – decreasing from 4.1% in 2012 to 3.6% in 2013. However, spending is expected to grow to nearly one-fifth of the U.S. economy by 2023.[1]
- Employers continue to shift costs to individuals and overall group coverage is on the decline.
- Commercial risk health plan enrollment continues to decrease, highlighting the attractiveness of non-risk products for many employers.[2]
- The number of Medicare beneficiaries enrolling in Medicare Advantage plans has continued to climb and Medicaid spending and enrollment is also on the rise.[3]
- 25% more health plans have signed on to offer products in 2015 in the health insurance marketplace.[4]
- Nearly two-thirds of employers with more than 50 employees are "likely or somewhat likely" to use private exchanges in the future and some companies agree that private exchanges will be a viable alternative to public exchanges.[5]

There may be some market-leading health plans (especially Blues) lacking disruptive competition that won't have to evolve as rapidly as plans in more dynamic markets. But most players are going to have to find new approaches to achieving growth, demonstrating value, developing products, embracing technology, engaging with consumers, and collaborating with providers.

Refining value propositions

Some key stakeholders view health plans as the middle man in the traditional health care marketplace model. Employers consolidate their purchasing through health plans, which contract with providers and deliver administrative services. That so-called middle man role is being challenged, and health plans are finding that they are under threat of disintermediation: some large employers are going directly to providers; some providers are forming their own insurance subsidiaries.

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1 NHE data: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html

2 *As A Rule, The Most Successful Man In Life Is He Who Has The Best Information*. CITI Research, January 2015

3 NHE data (http://kff.org/medicare/issue-brief/medicare-advantage-2014-spotlight-enrollment-market-update/) (http://kff.org/medicaid/issue-brief/implementing-the-aca-medicaid-spending-enrollment-growth-for-fy-2014-and-fy-2015/)

4 NHE data: (http://aspe.hhs.gov/health/reports/2015/premiumReport/healthPremium2015.pdf)

5 Deloitte 2013 Employer Survey http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/center-for-health-solutions-us-survey-of-employers-on-health-care-system.html

Meanwhile, other health care players are peeling off parts of the value chain, such as medical management, consumer engagement, and administrative functionally through cloud-based technology solutions.

Health plans are seeing increasing pressure to demonstrate value. In response, plans will need to develop strategies to align with providers under new payment arrangements (such as accountable care or value-based care [VBC]), even as old business models persist. In the traditional power struggle between providers and payers, providers are gaining leverage. Regaining balance will require greater collaborations and partnerships – between providers and plans and between plans and non-traditional players like niche technology companies.

Managing lower margins and the search for growth

U.S. health plans are generally expected to be operating in a lowered margin environment in 2015 and beyond. Some health plans — especially smaller ones — may not survive. Factors include pricing pressures, higher taxes and fees, rising medical costs, regulatory compliance costs, increased competition (from smaller players/start-ups non-traditional players), and general marketplace uncertainty. A changing patient mix is also impacting margins: More patients have coverage through Medicaid, which typically pays far less than commercial health plans, and further Medicaid & Medicare Advantage (MA) rate retrenchment is expected. Employers are shifting costs to individuals and overall group coverage is on the decline. Consumers, meanwhile, are becoming more price-sensitive as they face large deductibles and cost-sharing for services, including specialty pharmacy.

Amidst shifting opportunities and challenges, U.S. health plans in 2015 should clearly redefine and establish their value propositions in the new marketplace; create innovative, consumer-centric products and services; and relentlessly execute new sources of growth at home and abroad.

Lower margins and increasing costs are driving health plans to seek new sources of revenue and market growth. While traditional employer group insurance business is atrophying, significant new opportunities for growth are emerging, the result of increasing consumerism and health reform through the Affordable Care Act (ACA). Implementation of the ACA is proceeding despite ongoing political wrangling and efforts to roll back certain reform elements. Some eight million people used the marketplaces to take out policies during the initial 2013 enrollment period. Of these, 28 percent were 18-34 years old, the demographic needed if the system is to be sustainable.[6]

Obstacles and delays still threaten to undermine the ACA's key goals, which are to expand health insurance coverage from approximately 85 percent of the population to around 95 percent by 2019, and to slow the rise in health care costs.[7] In February 2014, for example, the federal government decided to delay the mandate for medium-sized companies to insure their employees until 2016, two years later than the original deadline.[8]

However, both government (Medicaid, Medicare, and dual eligibles) and commercial individual insurance enrollments are on the rise through public marketplaces, private exchanges, and off-exchange models. For example, 80 percent of employers with more than 50 employees are "likely or somewhat likely" to use private exchanges.[9]

Health plans that understand consumers' wants and needs, and are able to activate the right behaviors in the right consumers at the right time, will prevail and grow in the redefined, consumer-centric health care marketplace.

Integration along the value chain also presents opportunities for growth. Collaboration between health plans and providers to drive value-based care (VBC) and better health outcomes offers tremendous opportunities to expand and increase market share.

In addition, international expansion remains attractive, even though most health plans are still opportunistic in their global strategies.

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6 *Industry Report, Healthcare: United States*, The Economist Intelligence Unit, June 2014
7 Ibid
8 Ibid
9 *2013 Survey of U.S. Employers*, Deloitte Center for Health Solutions

Meeting the innovation imperative

Capitalizing on new opportunities in a shifting health care ecosystem, either at home or abroad, will require innovation. Health plans traditionally have not been known as innovators; however, those that can and do innovate — in the form of new products, better technologies, collaborative business models, and enjoyable consumer experiences — are likely to position themselves well for the future.

Health plans pursuing innovation should adopt a more encompassing definition of "product" to include provider networks, different financial arrangements, and consumer engagement models. They should also consider consumer-focused strategies to drive engagement (in shopping for health plans, selecting providers, taking care of their own health) and improve the customer experience — all of which can help increase health plans' value. Efficient, scalable, and rapidly deployable technology and sophisticated analytics will be key for health plans to bring innovative strategies and consumer experiences to life. Today's health plan technology is incapable of enabling the strategies needed for tomorrow's enterprise growth and margins; plans should make technology investments a strategic priority.

Innovation is about walls tumbling down and lines blurring — between providers and health plans, and within health plans' traditional organizational silos. Collaboration can help spark new products, services and business models across the entire health plan value chain.

Maintaining regulatory compliance

Health plans already operate in a highly regulated environment. As Medicare and Medicaid become bigger parts of companies' books of business, regulatory compliance will grow in cost and importance. In addition, ACA regulations extend through 2018 and changes/updates to existing regulations are anticipated, with unprecedented fines and penalties for non-compliance.

A new set of rating rules, a competitive environment, and ambiguity around enrollee populations are colliding to create unprecedented uncertainty for health plans in setting their premiums for the public health insurance marketplaces. The ACA established three programs — risk adjustment, risk corridors, and reinsurance — to address some of this uncertainty, but two of the programs will expire after 2016. The end of the risk corridors and reinsurance programs — coupled with growing health care utilization and higher costs due to the increasing annual, non-deductible fee on health plans – could make significant premium increases inevitable in the future. Additional uncertainties could raise premiums even more and affect pricing strategy. State and federal policies around rate reviews may limit a health plan's ability to obtain large premium increases, and rules about network standards could raise costs.

In another area of regulatory concern, safeguarding security and privacy is likely to become more challenging in the evolving health care environment. A rising data flow and number of organizations sharing sensitive information electronically escalates the risks of hacking and infection with malware and viruses. The Health Insurance Portability and Accountability Act (HIPAA) Omnibus Rule allows for significant fines for patient data breaches as well as organizational audits.[10] Yet, preventing all breaches is nearly impossible. Organizations can, however, mitigate cyber security and privacy risks with a secure, vigilant, and resilient security program that addresses both internal and external threats.[11]

Managing compliance, security, and privacy is an operational imperative. If they haven't already done so, health plans should establish a forum and governance process for risk-related decision-making and regulatory compliance. Components include assessing potential capability gaps, defining their vision and needs, securing adequate funding and trained staff, and developing appropriate implementation and remediation programs.

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[10] Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules Under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules; Final Rule, 78 Fed. Reg. 5566 (January 25, 2013) via http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf

[11] *Update: Privacy and security of protected health information*, Deloitte Center for Health Solutions, 2014

Responding to an evolving market and unanswered questions

As mentioned earlier, the much-hyped "rise of consumerism" is finally becoming a reality in the health care industry. The individual consumer insurance market is expected to grow in the coming years.[12] Most health plans are making strategic plans around this growth, investing heavily in building-out their retail IT infrastructures. There is also evidence of greater integration across the health care value chain — health plans entering the world of care delivery, providers starting insurance businesses, and new health plan-provider collaboration models. Meanwhile, non-traditional players are entering the marketplace; among these are niche technology vendors, private exchange players, and other disruptors. How and how quickly the U.S. health plan sector evolves is yet to be seen, and many important questions remain unanswered entering 2015:

- How will consumers react to increased out-of-pocket (OOP) requirements and constrained provider choice? Will the sector begin to see the early stages of another managed care backlash?
- How will VBC payment models take root (or not) in 2015? What will be the health plan role and impact on these new models?
- Will the Centers for Medicare and Medicaid Services continue to constrain MA payment rates, and will resulting premium and benefit impacts begin to dampen the MA enrollment growth bonanza?
- Will Medicaid expansion take hold in key Republican-controlled states?
- Will the dual eligible market take off in 2015?
- Will the next wave of major consolidation begin to take shape in 2015?

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[12] Congressional Budget Office, "Updated estimates of the effects of the insurance coverage provisions of the Affordable Care Act," April 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf