



Health insurance industry trends

What is the outlook for US health plans in 2017?

Rob LaFrentz: What's the outlook for health plans in 2017? What trends are on the horizon during these uncertain times, and what opportunities exist moving forward? Greg Scott is Deloitte's national leader of the health plans practice. He has more than 27 years of industry experience as a management consultant, insurance company executive, and government official. I had the chance to talk to Greg and we started with the biggest news for our country this year, Donald Trump winning the election.

Greg: I'm actually glad that you started with an elections question. I wasn't sure as we looked at the upcoming health plan landscape for 2017 whether we would start off with the elections or inevitably get to it later in the conversation, but another exciting year, perhaps like the one we had in 2010 when the Affordable Care Act was debated and enacted.

We expect that political change will be the number one trend that our clients, which are generally health insurance companies, managed care plans, pharmacy benefit managers, and a variety of other companies that we include under the moniker of health plan. Political change and disruption, market disruption prompted by political change is likely to be the number one issue not just on January 1, obviously before the January 20 inauguration Day and probably too early in the year to have anything approaching an understanding of what sort of statutory and regulatory change from Washington DC will come to health plans. But we think it's going to be a period of uncertainty and flux throughout the year, even if there is bold action.

Rob LaFrentz: Okay, well that said, and knowing that the landscape is very vague, can you talk about some trends that you see coming forward in 2017?

Gregory Scott: Issue number one is clearly affordability. I think I saw this more in 2016 than I did in 2015, but as we speak with opinion leaders in the health care industry, when we speak to the CEOs of

our major health plan clients; there's clearly been even a shift in terminology towards focusing on the affordability of health care generally, the affordability of health insurance premiums, health insurance deductibles and other cost-sharing requirements.

Throughout most of my career we have focused on costs; we would talk about cost being the issue. And I think it's more than a semantic transition when we say that, as an industry, as individual health plans, as individual leaders in American health care, we're now focused on affordability: not just what something costs, but whether families can afford those costs, whether individuals can meet the monthly premium payment requirements and pay for the copays and deductibles when they go to the doctor, when they go to the hospital. The share of the burden of American health care, the costs of American health care, that has shifted over recent years to the consumers, is really amazing.

And you can look at it in different ways. You can say that [health care now costs 2X, in 2016](#), what a family would have devoted out of their disposable income for health care in 1996. You can say that the burden of deductibles – that is, the amount that an insured individual or family pays out of pocket before insurance coverage really kicks in – that the costs that consumers bear for [deductibles has risen three times faster](#) than the portion of consumer spending that's covered by insurance, over the past decade.

And I could stay here all day with more statistics that just clearly shine a spotlight on the fact that we're asking consumers to pay more out of pocket, to be more sensitized to decisions that they make about what sort of services to obtain when from what sort of provider in what sort of set of care, under what sort of arrangement. So the role of the consumer has expanded dramatically. And it is probably the single biggest issue that we face under that broad umbrella trend of affordability.

But it's not just consumers. It's a national issue. As a nation, we devote 18 percent of our gross domestic product to health care spending. That's basically twice the rate that nations that we compete with economically, whether in Europe or Asia – and nations vary dramatically in percentage of GDP that they devote to health care. But suffice it to say that nobody's close to the amount of spending, as a percent of overall national wealth and income – nobody's close to what the United States spends. And we think that by 2025, the percent of GDP devoted to health care will be 20 percent.

And the numbers just keep growing. As America ages, as health care continues to cost more than most other consumer goods and services, generally speaking, health care grows – has in recent history – at one and a half to two times the general rate of inflation as measured by the consumer price index. So health care spending, in the eyes of some, crowds out other potential uses of our national capital and our national income.

Our employers believe that their competitiveness in the increasingly global economy is challenged. We have state governments struggling with the costs of covering not just Medicaid beneficiaries, but state active employees, state retirees. Every purchaser of health care services and health insurance in the United States is grappling with the issue of cost, and that's why we think affordability's number one.

Rob LaFrentz: So how can health plans prepare in a system that's shifting from volume to value?

Gregory Scott: Well, the good news is that shift has been accelerating. I think many of us have been looking at the shift from traditional fee-for-service medicine, where doctors get paid based on patients that show up and receive certain services for which insurance companies and patients have cost responsibility through the claims process – same thing with hospitals; same thing with prescription drug costs. We've been billing and paying for services and products in the US health economy on a piecemeal, by-the-drink basis for many years. And, as you noted, we're shifting mightily towards more of a value-based model here. We still have a ways to go.

But under the leadership of the US Department of Health and Human Services, as well as employers in health plans and others, who have long seen a flaw – a basic, fundamental, structural flaw in the US health care system, in which clinicians and manufacturers and others get paid on a service and product basis – we are seeing a shift. And when we say "value," that's a small word that has some pretty big denotations and connotations. So value is a combination of price and quality of outcomes. So we are seeing health plans playing leadership roles in working through new arrangements with hospitals, with integrated delivery systems, with physician groups.

So health plans in many ways – and I would say health plans together with the Medicare program of the federal government – have really been blazing the trail in developing new payment models, new contractual arrangements, new collaborations, new ways to enable clinicians to think about value, to assess value, to focus on what's

the best thing for this patient at this particular time. So we're excited about this trend.

There's some recent federal legislation called MACRA. MACRA is one of those sleeper pieces of legislation and regulations that have recently been published in final form from the Centers for Medicare and Medicaid Services. They are implementing this major statutory milestone from 2015, which replaced basically the way that clinicians get paid under the Medicare Part B Physician Fee Schedule – MACRA overhauls the way physicians in America will get paid from the largest single payer in US health care, the federal Medicare program.

And it's all about encouraging physicians to enter into value-based arrangements. The law has lots of incentives. The law has lots of penalties. So there are carrots; there are sticks. There is a time horizon where, year over year, individual clinicians need to make progress and demonstrate results in the value of the services that they provide, that they arrange for, that they are involved in. And MACRA is a game changer that maybe hasn't received all the press attention or even industry attention that it warrants. But it could be that 2017 is the year that MACRA turns into the really visible game changer we think it will be instead of just the acronym that everybody's not even sure what it means.

Rob LaFrentz: I know Deloitte recently published a research study of US consumers that identified a number of factors that matter most to health care consumers. How will this trend play out in 2017?

Gregory Scott: I think that was a fascinating piece of research. Our health plan practice, in conjunction with our Center for Health Solutions, conducted some pretty creative market research that really went through painstaking detail in trying to identify and then define and categorize and then evaluate the importance of all sorts of interactions that consumers have with the health care system.

We came up with 64 interactions that we thought were important to understand. And I don't think it will come as a surprise to many listeners, and certainly to many health plan executives, that consumers placed primary importance, primary priority on the interactions that they have with health care providers.

It is not that health care consumers are not interested in member service, call it interactions with health plans or the kind of mobile applications that increasingly health insurance companies are providing to their members. Or how claims are paid and provider directories are published. All those insurance interactions are important. It's just that they're not viewed, through the eyes of the consumers that we interviewed – they're not nearly as important as a category of interactions that we like to call "Personalized interactions between consumers and their providers."

So the implications for our clients are, number one, to recognize the preeminent priority of consumer – or I guess we could call them "patients" in this setting, right? – patient-to-provider – particularly patient-to-physician interactions. And health plans, in addition to making themselves and their processes easier to do business with

for consumers – making claim payments more accurate, more timely, less painful; having customer call centers and internet self-service capabilities that more quickly and accurately and helpfully address consumer – in this case, member inquiries – and help them answer their questions.

These are all important things, but health plans also need to find ways to sort of grease the skids, sort of reduce the friction in the interactions that their members have when they show up in a clinic, in an emergency room, in a physician's office, in an urgent care center, in a pharmacy. We could go on.

So health plans, as some of the more technologically savvy stakeholders in the US health care system, really have some opportunities to sort of ease some of the interactions that are most important to their members, consumers, who are really focused on providers who understand who they are; personalizing interactions, have data at the fingertips, and generally are ready, willing, and able to have more productive encounters between physicians and the consumers who are the members of our health plans.

Rob LaFrentz: So, as consumerism takes hold in 2017, what opportunities exist for health plans when it comes to advancing information technology?

Gregory Scott: Well, I think there are a raft of those. Before I get into some of the technology-specific, let's just take a step back. A few minutes ago we were discussing affordability and I shared some statistics about how much more responsibility individuals and families bear for the overall cost of health care.

I was speaking with a health plan CEO recently about the big upcoming trends, and one of them was obviously the one you just raised, consumerism. And he said, "We have lots of opportunities to increase the ability of consumers to be prudent shoppers and to make the right decisions regarding their health care and the cost of the care." He said, "But we've gotten to the point now where we've probably fixed an issue that we've been talking about for years. So for years many experts in the US health care system have been talking about the need to have more consumers get more skin in the game so that they're more sensitive to the decisions they make, the prices they pay, etcetera." This CEO, who's also a physician, said, "We've solved that problem. Consumers now have skin in the game. But the problem is you can't put more skin in the game if you don't have any skin left."

His point was that we've already increased the price sensitivity of consumers so dramatically that we probably can't address many more of the costs and affordability challenges just by raising deductibles, by raising copays, by making consumers more responsible for a greater proportion of the overall health care costs. There are certainly many segments of population that're responsible for more cost than they can probably pay for. They simply don't have the bank accounts; they don't have the cash in their wallet.

So with that overarching perspective, there are lots of things that

health plans are beginning to do, innovations that they are taking to market to provide some technical and technology enablement of some of the consumer shopping experience. We have a long way to go though. There are probably more price transparency mobile apps than there are available sources of reliable pricing data that these apps, no matter how well they run on someone's phone – no matter how cool the app is, if there is not reliable data – retail pharmacies, prescription drug manufacturers, hospitals, outpatient clinics, ambulatory surgical centers, physician offices, etcetera – if we don't have good, comparable pricing data on services and sources of services, it doesn't matter how cool the apps are.

So I actually think we're to a point where we don't have issues with the information technology; we have issues with the underlying data, which is not yet sufficiently available; it's not yet of consistent quality; it's not of real-time or even near-time timeliness. And the list of data concerns goes on. So in some ways, in addition to doing kind of the cool tools work that not just health plans, but all sorts of technology vendors and provider systems and pharma manufacturers – everybody's been developing cool tools.

But at the same time – I don't want to stem the flow of new capabilities to anybody's smartphone, including my own. But we need to pour at least as much effort on sort of the plumbing and the foundational data structures that are really the single biggest heavy lift we need to do in order to make a true comparison shopping experience a reality, and where we begin to see US health care be the sort of consumer experience and consumer set of possibilities that we see in all sorts of other industries where consumers, based on their day-to-day experience, have expectations of how they'll be able to buy cars, how they'll be able to buy all sorts of consumer goods, how they'll be able to shop for air fares and go on vacations. Almost every other sector of the US economy has been transformed by technology, particularly in consumer technology, more so than the US health care system has.

And while we've made a good down payment in recent years, we have lots of work to do. And health plans will continue to play a leading role in trying to break through some of the barriers.

Rob LaFrentz: Are there any emerging technologies that could be a game changer.

Gregory Scott: Well, I think we have several of them that could be a game changer. But I do think that blockchain, which is an emerging technology with distributed ledgers and smart contracts – I think most people when they think of blockchain think of the cryptocurrency Bitcoin. But I'd like people to take a broader view of the potential of this new technology. I think it could be truly a game changer.

Blockchain could change the way that we contract between providers and health plans, the way that we track payments, the way that we provide customer service, the way that we underwrite our insurance products, the way that we calculate and convey pricing. I mean, there's just 20 or 30 fundamental processes of the health insurance business model that could be transformed by blockchain.

So I'm going to put that at the top of the list, even though it's going to take a few years, for certain, for this to reach anything approaching a tipping point. But I do think that 2017 could be a step function more meaningful than the very early progress that we saw in 2016. So I'm gonna make that point number one.

But point number 1A would be really automating some of the complexity of health insurance basic business processes. Whether it's through robotics and automation – we have ways now of automating all sorts of processes and interactions and communications that could be a game changer. The health insurance business has, over many decades, grown into one of the most complex businesses in terms of business rules of any sector in any industry you can think of. But we do have the tools now, the algorithms, the machine learning, the cognitive automation, the artificial intelligence – there are many buzzwords that could be applied here; but I don't think the buzzy-ness of those words should distract us from the real potential of automating one of the most manual industries left at least in the service industry.

Rob LaFrentz: So, what role can health plans play in the changing regulatory landscape in 2017?

Gregory Scott: I think health plans don't need to be convinced about the importance of engaging in the political and regulatory discourse that is already upon us. I think health plans get mixed reviews, in recent years, for effectively communicating what they do, how they do it, why it makes a difference, what the value is, what the cost is, and certainly I think the complexity of the overall health care system and the role of health plans, health insurance companies, in that system. The complexity requires some degree of education, and certainly of informing the political debates that have already started.

So repeal and replace of the Affordable Care Act involves a multitude of decisions. And I would venture to say that there are more insights and more objective data available from the US health plan industry than any other sector in our US system of health care.

So I'm confident that my clients will, as individual companies as well as companies that find common voice through various industry and trade associations – it's time for them to, in addition to doing the great work they do with their businesses in their communities every day – they're going to have to spend some time in Washington, D.C., in 50 state governments and the District of Columbia, and they're going to need to engage again the way that they engaged in 2008, 2009, early 2010, to inform what's clearly going to be some new directions in US health care.

Health plans are incredibly important to the debate, and I'm confident that if they participate the way they should and can, that we'll have a better repeal-and-replace than we otherwise would.

Rob LaFrentz: Let's talk about some opportunities of growth. What areas are you looking at for growth in 2017?

Gregory Scott: Many of the opportunities that we see for US health plans, as we look forward to 2017, really involve diversifying their products, their services, their business models. We have talked about value-based care. And that general category of opportunities for health plans to work with providers in different ways, not just signing network contracts with hospitals and physicians and clinics and the like, not just paying their claims, not just having provider relations call centers answer the inevitable inquiries from physician billing offices, but rather, really becoming collaborative, really sharing data in ways that we haven't before, bringing some of the in-house expertise of health insurance companies to their ecosystem partners, particularly providers.

So, bringing actuarial science, bringing big data, bringing analytics solutions, bringing all sorts of technology-enabled and expert-human-capital-enabled business capabilities to providers who often don't have all the human resources as well as the data and technology resources that health plans have. That's just one example of sort of opening the aperture and thinking well outside the legacy transaction processing roles of a health plan, where health plans have been viewed, with some justification, as sort of the administrative middleman in the midst of lots of processes of the US health care system. But health plans finding more value-added roles.

So I do think that health plans have been maybe a well-guarded secret of the US health care system for a lot years. And now the more open architectures of American business, and in particular the way that hospitals are teaming with health plans, the sort of talent, the sorta capabilities that health plans can bring to both the opportunities and challenges that providers face – it's a game changer.

Rob LaFrentz: For more on trends impacting the entire life sciences and health care ecosystem, visit www.deloitte.com/us/lshc-outlooks, and follow @DeloitteHealth on Twitter.

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