

Health Plans

Achieving High Performance in Uncertain Times

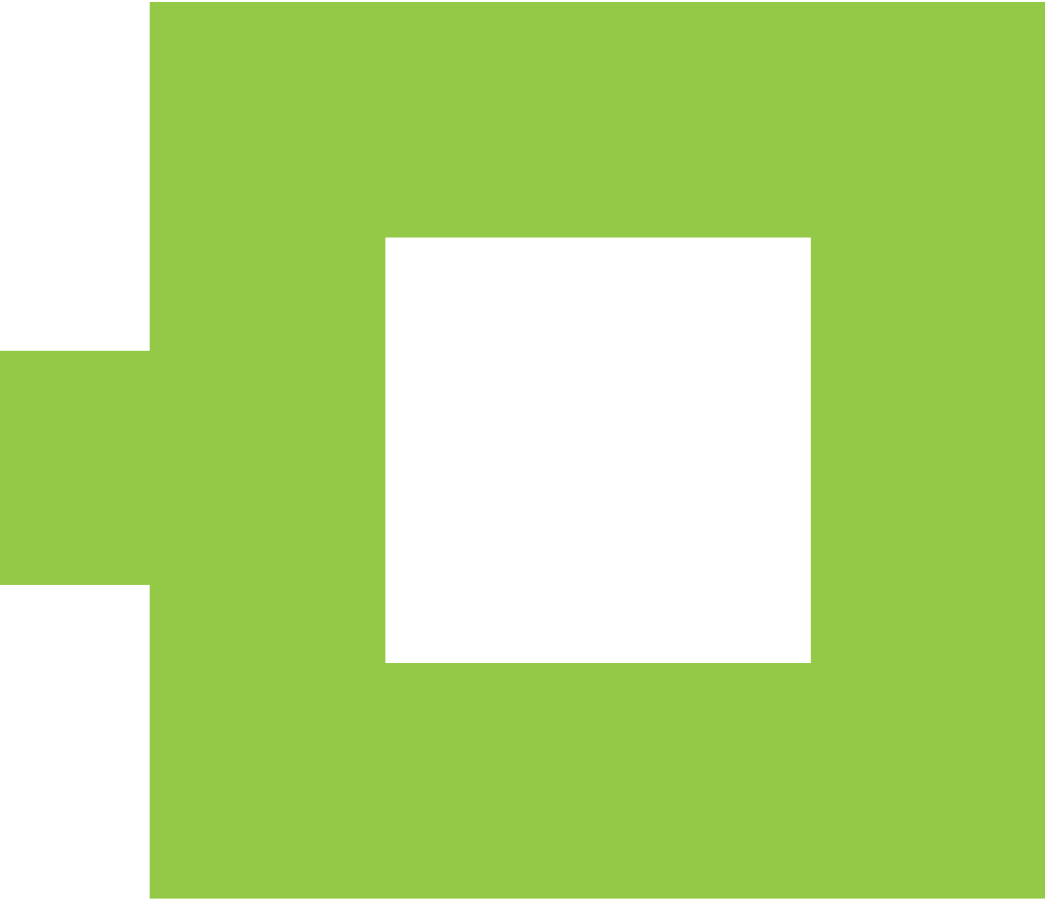
>
accenture

Innovation
Center for
Health



• Consulting • Technology • Outsourcing





Already experiencing several quarters of an unfavorable underwriting cycle, health plans today face a period of greater uncertainty even than the initial transition to managed care 20 years ago.

Accenture sees significant opportunities for health plans to act now and improve their performance.

According to the US Bureau of Statistics, the number of unemployed persons has risen about 6 million over the past 12 months. With millions of American workers filing jobless claims, the traditional market for health plans is shrinking as employers cover fewer workers. Small employers will continue to demand lower-cost plan options or they will have to drop coverage altogether. Increasingly, larger and self-insured groups will come to their insurers and ask for reductions in administrative service fees. Further, as President Obama follows through on his campaign promises related to Medicare Advantage, premiums to private insurers for Medicare beneficiaries will be reduced to help fund health care reform.

All the news is not bad however. As traditional markets and reimbursement levels weaken, the prospect of universal coverage opens up a possible new market of up to 46 million new customers, the majority of whom are likely to be covered via private health plans. This unprecedented opportunity for growth exceeds the market opportunity created when Medicare Part D was introduced.

But capturing the new market of the uninsured will require different strategies and robust retail capabilities that many health plans are not ready to provide. This new market segment brings with it unique utilization behaviors and health care needs that will require health plans to develop specific strategies to engage these consumers.

Passage of the economic stimulus package adds further uncertainty to the health plan environment. National investment in the implementation of health information technologies, like electronic medical records and health information exchanges, will change the way health care is delivered over a period of many years. In the interim, health plans need to address the current uncertainties. Accenture sees significant opportunities for health plans to act now and improve their performance. Reducing their administrative and medical costs in the near term can help them meet their current market challenges and also help to fund investment to develop the capabilities required to win in a changing market.

Figure 1. Administrative Cost Performance Indicators

Metric	Bottom Quartile Performance	Top Quartile Performance
Revenue Dollars Per Sales Administrative Dollar Spent	\$23.28	\$62.72
Provider Services Administrative Cost Per Member Per Month	\$1.17	\$.59
Members Per Enrollment Full-Time Equivalent	7,317	11,236
Percentage of Inpatient Claims Auto-adjudicated	53.4%	68%
Member Service Cost Per Phone Inquiry	\$11.38	\$6.56
Finance Administrative Cost Per Member Per Month	\$.75	\$.48
Total Selling, General & Administrative Costs Per Member Per Month	\$33.27	\$21.98

Administrative cost performance

In the health insurance industry, administrative costs are commonly measured as a percentage of the overall premium cost. The increasing incidence of chronic conditions, combined with new, sophisticated treatments and drug therapies have driven double-digit increases in the cost of care. Unfortunately the administrative cost ratio has largely kept up with that high rate of inflation instead of tracking more logically to the consumer or producer price indices. Not only does this administrative cost creep contribute to the affordability problem, it has also left health plans with higher fixed cost structures as the economy turned sharply downward.

Accenture's most recent High Performance Metrics study of US health plans compared results for more than 700 performance measures at 10 high-performance health plans, including both blue plans and commercial plans. The results of that study demonstrated a wide variation in health plans' ability to manage administrative costs, with at least a 25 percent gap between leading and lagging performers in cost and efficiency metrics across each operational area. The variability is clear evidence that high-performance health plans can achieve lower administrative cost structures (see Figure 1).

Accenture recommends a two-track effort to drive medical savings in the near term, where an organization's care management team focuses on utilization while the claims team works to identify and address the root causes of overpayment leakage.

Health plans can meet the challenges of these uncertain times and counter the trend in administrative costs by focusing their efforts on driving out costs and creating a more variable cost structure. A more variable cost structure will enable them to shift resources from lagging products and segments to those that are growing. Health plans need to:

- Take a hard look at their cost structure from end to end, with the goal of systematically taking out 10 to 20 percent of costs.
- Recommit themselves to driving gains in productivity across every part of the company. To establish a culture of continuous and measured productivity gain, health plans need to institute a program geared to identify, engineer, measure and force productivity improvements in every single department.

- Pursue greater agility in their operating model through investments to cross-train human resources and simplify supporting technologies.

- Continue to look for ways to reduce costs and improve productivity by implementing shared services, consolidating operations and outsourcing.

With a relentless focus on driving out administrative costs and making cost structures more variable, leading payers can create market advantage and position themselves for growth.

Reduce medical cost trend

Ongoing medical cost inflation, the current position in the underwriting cycle and downward pressures on commercial membership all combine to add further urgency to managing near-term

medical costs. With large-scale, government-subsidized investment in health information technologies through the federal stimulus package, the potential to capture medical cost savings and improve the quality of care has never looked brighter. But those advances will take years to accomplish, and health plans need to act aggressively to find and achieve more medical cost savings now.

The High Performance Metrics study also showed a high degree of variability in fundamental medical cost containment areas. For example:

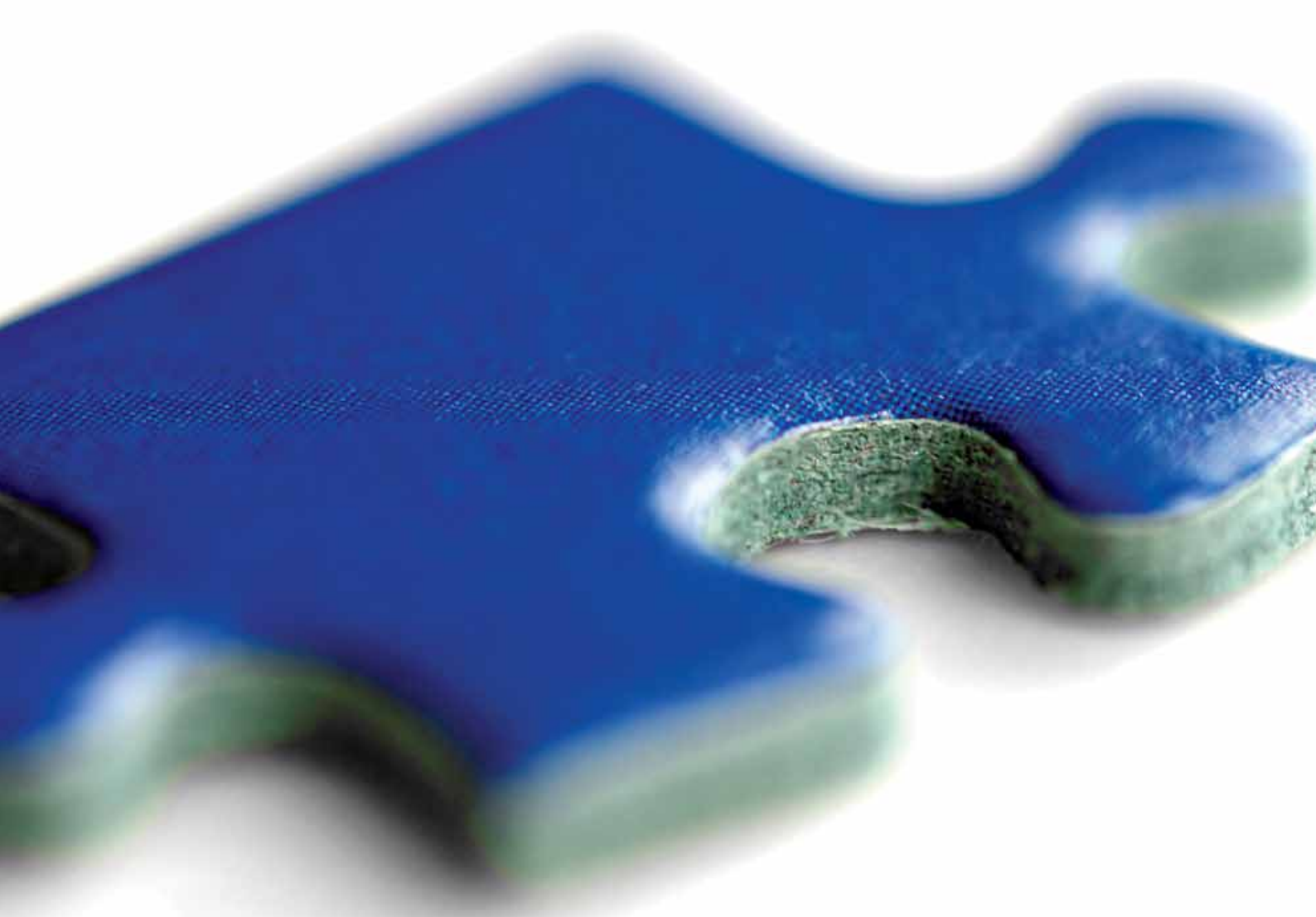
- The number of acute care inpatient days per 1,000 commercial members between the bottom and top quartiles was 295 versus 195.

- The number of emergency room visits per 1,000 commercial members between the bottom and top quartiles was 232 versus 153.

- The number of inpatient stays lasting 15 days or more per 1,000 commercial members between bottom and top quartiles was 2.77 versus 1.73.

This variability is clear evidence that high performance health plans can achieve lower medical cost structures when they focus clinical resources on high impact functions that support timeline management of utilization and focus on addressing gaps in care that impact clinical outcomes.

These are areas in which health plans can move the needle now, without waiting for structural changes in the industry and the advent of digitized medical records. Accenture recommends a two-track effort to drive medical savings in the near term, where an organization's care management team focuses on utilization while the claims team works to identify and address the root causes of overpayment leakage.



Health plan care management teams can deliver tactical savings by sharpening their ability to apply a data-driven approach to identify and act on specific pockets of overuse and misuse of the medical delivery system. Using data to be more focused on high-impact areas will allow staff to address more of the population. Across client engagements, Accenture has helped clients achieve 3 to 5 percent per member per month medical cost savings by pulling on the following levers:

- Focus on unnecessary admissions. Use data to identify inpatient admission types with the highest occurrence of readmissions within 30 days and create post-discharge programs focused on care coordination to prevent readmissions. Identify admission types that are appropriate for an observation versus admission and create processes to manage based on this distinction when admission is requested.

- Analyze performance on managing length of stay and unnecessary inpatient days. Use data to identify admission types with the highest variance to industry standards and focus concurrent review efforts on reducing length of stay through more aggressive discharge planning.

- Initiate case management processes more quickly to capitalize on high-impact opportunities, such as the use of high-cost specialty drug management.

- Increase the percentage of the population managed through condition/disease-management programs by better applying models of clinical and non-clinical staff and multichannel engagement methods.

In parallel with tactical care management efforts, claims teams can redouble efforts to identify, recover and prevent

overpaid claims. Over the past 10 years, a number of Medicare/Medicaid studies have shown claims overpayment as a result of fraud, abuse and errors. And, across more than a dozen client engagements, Accenture has helped achieve savings of between 1 to 2 percent of annual claims cost by focusing on administrative errors that lead to claims leakage. Some common errors are paying duplicate claims, failing to recognize coordination of benefits and difficulty in applying complex Medicare reimbursement models. Health plans can uncover the savings by creating specialized, high-energy teams and initiatives that:

- Reassess all current internal cost-containment measures undertaken by the claims department and outside vendors to ensure all types of overpayments are being addressed for all claim populations.

The high-performance businesses will be able to demonstrate their impact and be accountable for delivering value through their care management and cost containment programs.

- Apply data analytics and business analyst skills to increase the detection of overpaid claims. Current efforts in this area tend not to be treated as a top-priority activity.
- Focus on moving from recovery to prevention. Continued use of outsourced recovery vendors increases provider friction while failing to fix the root causes of the overpayments.

The high-performance businesses will be able to demonstrate their impact and be accountable for delivering value through their care management and cost containment programs. Through focused efforts to control both utilization and claims leakage, health plans can capture significant medical cost savings in the near term to meet current uncertainty and provide funds to invest in longer-term growth and development of strategic capabilities.

Develop capabilities for a potentially large, new market

As mechanisms for covering the uninsured are devised, health plans will need capital and also the agility to respond to the new market. While the timing and structure are not yet certain, the potential of universal coverage offers health plans a tremendous opportunity to expand their business, but only if they are prepared to serve a different set of populations.

Depending on how universal coverage is rolled out, health plans are likely to face a direct sell of up to 25 to 30 million new prospects out of the overall uninsured population of 46 million. The remaining portion of the uninsured is likely to obtain coverage through Medicare, Medicaid, or the Children's Health Insurance Program. This new addressable market will come with a

widely varying set of needs and circumstances, from lower income, chronically ill consumers to wealthy, healthy consumers who previously have exhibited little interest in purchasing health insurance. Customer segments among these newly insured will likely be far more diverse than health plans currently address in their employer-based coverage market.

The initial winners of market share will likely be those businesses that invest in and execute on the required capabilities.



Success in this market will require a variety of different capabilities in both the front and back offices:

Direct-to-consumer sales capabilities—Health plans will need to master how to attract, engage, sell and retain consumers who will be making decisions on an individual basis. The winners in this new market will be those businesses that develop the tools, systems, channels, processes and people to understand the behaviors of each customer segment and sell directly to the new health plan consumers. Well-scripted consumer experiences will be required across a variety of subpopulations of health, age, lifestyle, attitudes and economic status. Few health plans have a mature capability in direct-to-consumer sales and retention. The leaders are likely to be those that have developed robust new competencies.

Administrative processing capabilities—To process the new plan memberships gained through universal coverage, health plans will likely need a variety of new or enhanced administrative capabilities. For example, most health plan operations are oriented toward group billing and single-payment accounts receivable reconciliation. But given the likely approaches outlined in leading reform proposals, health plans will need to build more complex enrollment and billing capabilities. There are likely to be multiple entities that are billed and collected from—to capture the premium revenue, between one or more government entities and the insured consumer. Also, under the Obama plan, enrollment and eligibility verification may come through a centralized national health insurance exchange. These potentially complex models differ from today's employer-driven enrollment and billing framework.

We expect that eventual universal coverage will look a lot like the Medicare Part D launch, where significant new capabilities had to be built in a short time to capture a large new market quickly. Further, the initial winners of market share, will likely be those businesses that invest in and execute on the required capabilities, thereby creating a foundation for securing long-term franchise and market share. The top-10 Medicare Part D plans captured 85.2 percent of the enrollment during the initial year of 2006 and still hold 80.7 percent market share four years later in 2009. Solid execution during the initial launch proved to drive lasting, multi-billion dollar growth. For those health plans ready to take advantage of it, universal coverage may present a similar opportunity.

Conclusion

Unprecedented uncertainty in the health plan industry creates threats and opportunities for leaders. Despite obstacles, health plans can achieve high performance. The baseline step for all health plans is to fully reexamine their administrative and medical costs to drive significant near-term savings. Improving administrative and medical cost performance will enable health plans to compete in the present while investing for the future. Health care reform is likely to open up the largest untapped domestic market ever, but it will require capital and

new capabilities to capture the opportunity. These are uncertain times for sure, but the high-performance health plans of the future will be those that both aggressively address the near-term cost challenges and at the same time proactively invest to be well positioned to gain significant share from the emerging growth opportunities.

About the Accenture Institute for Health & Public Service Value

The Accenture Institute for Health & Public Service Value is dedicated to promoting high performance in the health care sector and in public service delivery, policy-making and governance. Through research and development initiatives, the Institute aims to help health care and public service organizations deliver better social, economic and health outcomes for the people they serve. Its home page is www.accenture.com/healthpublicservicevalue.

About the Accenture Innovation Center for Health

The Accenture Innovation Center for Health provides innovative resources and recommended actions for achieving high performance in the health care industry. The Center, part of the Accenture Institute for Health & Public Service Value, produces industry-leading white papers and hosts engaging client workshops and roundtable discussions. The Accenture Innovation Center for Health, combined with Accenture's deep health industry experience, offers exceptional reach, speed and flexibility to help clients achieve high performance. Its home page is www.accenture.com/innovationcenterforhealth.

About Accenture

Accenture is a global management consulting, technology services and outsourcing company. Combining unparalleled experience, comprehensive capabilities across all industries and business functions, and extensive research on the world's most successful companies, Accenture collaborates with clients to help them become high-performance businesses and governments. With approximately 177,000 people serving clients in more than 120 countries, the company generated net revenues of US \$21.58 billion for the fiscal year ended August 31, 2009. Its home page is www.accenture.com.



High performance. Delivered.

To find out more, please contact:

Nicholas Howell, Partner
+1 310 426 5774
nicholas.f.howell@accenture.com

Richard Birhanzel, Partner
+1 612 277 5020
richard.f.birhanzel@accenture.com

Kimberley Mentzer, Partner
+1 703 947 2360
kimberley.o.mentzer@accenture.com

Russell Nash, Partner
+1 310 426 5265
russell.k.nash@accenture.com

Copyright © 2009 Accenture
All rights reserved.

Accenture, its logo, and
High Performance Delivered
are trademarks of Accenture.

