Evaluating Payer Adoption of Digital Health Solutions

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Insights from the US Market

Payer coverage is heavily dominated by six large health plans, however, plan innovation and new entrants are changing the landscape.

Key trends:

- The six largest health plans in the U.S. cover nearly half of the country’s population

- Medicare Advantage has grown rapidly, covering 34% of all Medicare beneficiaries today, and is projected to grow to 45-55% of Medicare enrollees by 2025

- Medicare Advantage has grown in popularity and stoked payor innovation due to its capitated model and focus on value-based care delivery
Payer models vary based on unique characteristics, incentives, and business models of each risk bearing organization (1 of 2)

**LARGE NATIONALS**
- Primarily public companies with member counts from 15-40M and $42B+ in revenues
- Multiple lines of insurance business - e.g. MA, Medicaid, Employer, etc.
- Sweet spot has historically been large employers with national footprints, but LOB is declining
- Active with vertical M&A: looking to diversify and chase profit pools
- Many also have third-party administrator business lines to expand services for employee benefits (self-insured employers)

**THE BLUES**
- Oldest payer group consisting of 36 groups working independently; maintain a non-profit status
- Operate in every state to various degrees; seen as having a local flavor
- Historically viewed as tech/strategy laggards but innovation and venture arms are changing this perception
- Typically rated highly across key performance measurements (e.g., AR, claims resolution) and have high member satisfaction

**INDEPENDENT MANAGED CARE**
- Plans that contract directly with state medicaid or federal Medicare programs to deliver comprehensive services to enrollees
- More than 2/5 of Medicaid beneficiaries and 1/5 of Medicare beneficiaries were covered by managed care plans in 2019
- The majority of managed Medicaid and Medicare beneficiaries are managed by the large nationals
- Consolidation is occurring across independent plans and also driven by the large national players

**INTEGRATED MANAGED CARE**
- Multibillion-dollar organizations with multimillion lives covered, also delivering care
- Horizontal and vertical integration creates a closed-loop system for patient care - a model many systems are trying to replicate in the new VBC world
- Pre-paid revenue through premiums
- Often have advanced IT systems with full integrated EMR's.
Payer models vary based on unique characteristics, incentives, and business models of each risk bearing organization (2 of 2)

**SMALL SEMI-LOCAL INSURERS**
- Typically small and privately-held
- Focus on addressing a local market with a deeper understanding of small employers
- Often partner with a local integrated care delivery system to create exclusive networks
- Typically have a stronger focus on member experience and preventative health
- Becoming less active on the individual market

**SELF-INSURED EMPLOYERS**
- Employers that bear the financial risk of healthcare beneficiaries (employees), but often contract with third-party administrators to process claims and provide customer service support
- Structure enables customization to meet the specific health needs of an individual workforce and are only subject to regulation under federal law
- 61% of covered workers in the US are enrolled in self-funded plans

**NEXT-GEN PAYERS**
- Typically technology and/or data driven
- Focus on reinventing some combination of the member experience, plan design, provider network development, and/or internal processes
- Frequently target Medicare Advantage plans as a path for rapid growth
Fundamental Payer Challenges and the Digital Opportunity

1. Increased competition
2. Regulatory pressure
3. Controlling costs
4. Impact of consumerism
5. Infrastructure updates
Increased competition

- **New entrants**: New digital-native payers are acquiring market share and challenging the value propositions of traditional insurers; big tech companies are equally interested in such large value pools.

- **Expansion and Consolidation**: Insurers of all sizes are attempting to gain scale through M&A, creating more concentrated markets and encouraging competition; many market players are shifting to public-sector payment structures, where having the capacity to compete is important.

- **ASOs / Employer Sponsored Plans**: The trend toward self-funded plans (ASO) continues to appeal to smaller employers; plans are trying to maintain relevancy by updating administrative services and offering new types of insurance to help manage risk.

Regulatory pressure

- **Cost Pressures**: Health plans are not allowed to deny coverage or charge higher premiums based on health status; at least 80% of premiums must be spent on medical losses while the other 20% is divided between administrative losses and profit.

- **Reimbursement Changes**: CMS continues to introduce regulation around risk adjustment and STARS measures for Medicare as well as reimbursement qualifications, which impacts the capabilities required for data collection, validation, and reporting.

- **Government Policies**: U.S. political parties have varying views on healthcare spending and reform, requiring health plans to stay constantly informed on proposed and enacted changes in coverage; most recently, the current administration has focused on pulling back the ACA, price transparency, and the proposal of significant budget cuts for Medicaid programs.

Controlling costs

- **Payer Spend**: Payers are shifting how healthcare spend is managed in an effort to control costs that continue to raise faster than the rate of inflation (e.g., narrow networks, utilization management, new actuarial models).

- **Transition to Value Based Care**: Shifting to value-based contracts, new metrics, and new transparency tools and requirements requires payers to operate under different incentives and with different partners than in previous years.
Growing impact of consumerism

- **Consumerism**: Members are demanding greater transparency and personalized, customer-centric experiences as they have grown accustomed to in other parts of their lives.

- **Shifting Views on Value**: As members bear more financial responsibility for their own healthcare, individuals are transforming into payers who are searching for the lowest cost, best value, and highest level of convenience.

- **Employer Expectations**: Employers who are bearing more medical risk are seeking new ways to engage their employees to increases utilization of inexpensive, high-value services, driving down overall healthcare spend.

Outdated IT Infrastructure

- **Digital Laggards**: Traditionally, payers and many other stakeholders in the healthcare industry have been slow to adopt and effectively integrate new information technologies, including artificial intelligence and automation.

- **Proliferation of Data**: Payers, similar to other stakeholders across the ecosystem, are faced with new sources of data and must identify ways to effectively capture, aggregate, structure, analyze, and share this information in ways that lead to better outcomes and optimized processes.

- **Threat of Big Technology Players**: Large technology companies such as Amazon, Facebook, and Microsoft are all investing in the healthcare space, with the potential to utilize their core capabilities to disrupt the market (e.g., medical data management, care management, payments) and drive significant change.
### HealthXL Market Map of Digital Solutions that can help tackle these fundamental challenges

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<th>EDUCATION / ENGAGEMENT</th>
<th>EXAMPLES</th>
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<td>• Health coaching • Member rewards and incentives • Enhanced communication</td>
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<th>SCREENING &amp; DIAGNOSTICS SOLUTIONS</th>
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<td>• Remote screening platforms • Treatment pathways • Triage tools</td>
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<th>DIGITAL ACCESS &amp; DELIVERY OF CARE</th>
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<td>• Telemedicine • Care provider navigation tools • Personal health concierge • Virtual care delivery and remote monitoring</td>
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<tr>
<th>CARE MANAGEMENT &amp; COMMUNICATION</th>
<th>EXAMPLES</th>
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<td>• Social Integration and Connections • Communities • Complementary Health Services (e.g., nutrition, travel)</td>
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<th>CORE INSURANCE SERVICES</th>
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<td>• Financial Coaching • Coverage / network navigation</td>
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<th>ADMINISTRATIVE FOCUSED SOLUTIONS</th>
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<td>• Underwriting</td>
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Improved Member Satisfaction
Increased Efficiency & Lower Costs
Better Member Health Outcomes
Higher Quality Member Data

CHALLENGES
#1 Increased competition
#2 Regulatory pressure
#3 Controlling costs
#4 Impact of consumerism
#5 Infrastructure updates

MODALITIES OF ENGAGEMENT
- Partner with a digital health solution or services provider through a pilot or commercial contract
- Acquire or invest in companies that are developing digital health solutions and capabilities
- Develop and deploy digital health solutions using internal resources

DIGITAL HEALTH SOLUTIONS

Improved Member Satisfaction
- Increased member touchpoints
- Improved end-to-end experience
- Higher rates of engagement
- Member growth and reduced attrition

Increased Efficiency & Lower Costs
- Increased claims processing efficiencies
- Reduced member acquisition costs
- Lower admin costs
- Medical cost savings

Better Member Health Outcomes
- Reduction in wasteful healthcare utilization
- Improvements in health quality measures
- Improved patient reported outcomes

Higher Quality Member Data
- Better data aggregation and standardization
- More robust bi-directional information exchange
- Expanded generation of real-world patient and outcomes data

Modalities of Engagement for Impact
HealthXL Maturity Framework | Pillars of Assessment

- Investment & Partnerships
- Strategy & Vision
- Outcomes & Impact
- Resources & Support
- Culture & Leadership
Survey Results Here