strategy+business

ONLINE OCTOBER 22, 2013

Are Health Insurers Ready to Care for New Consumers?

BY JOYJIT SAHA CHOUDHURY AND JENNIFER YAGGY

This article was originally published by Booz & Company.

Are Health Insurers Ready to Care for New Consumers?

by Joyjit Saha Choudhury and Jennifer Yaggy

The centerpiece of the Affordable Care Act (ACA)—the creation of online health insurance marketplaces known as exchanges—launched this month, enabling individuals and families to purchase more affordable health coverage. In anticipation of this development, health insurers have been working steadily over the past several years to design products, healthcare provider networks, and processes to support an increased demand from new consumers. But most health insurers haven't given a lot of thought to how they're going to actually *manage* the previously uninsured population's specific needs.

Now is the time for these companies to pay attention, because the issue of formulating specific offerings for these new consumers will soon have a big impact on health insurers' financial health. The people buying coverage on the new exchanges are likely to be different than most health insurers' current members, who have been receiving insurance under an employer's plan. The uninsured probably haven't had regular preventive care. They're also twice as likely to have mental health issues as insured people, and many have undiagnosed chronic conditions such as asthma and diabetes.

In the health exchanges launched by the federal government, there will be little room for insurers to bear unexpected medical costs: The markets are expected to provide low margins as consumers shop for the best value in plans across many insurance companies. Some health insurers have decided to sit on the sidelines of the health exchanges in the near term and not take on this risk. Others, such as various Blue Cross Blue Shield insurance companies, are jumping in.

So what can health insurers do to be successful in this market? We believe new models of care are required to manage the risks and address the care needs of this unique population. Based on Booz & Company's research of dozens of care models, particularly for complex populations, healthcare is best managed in a holistic way. Insurers should design models of care that incorporate traditional providers as well as community organizations and public agencies; coordinate healthcare across primary-care physicians, specialists, and patients; and carefully design incentives for both providers and consumers. We see certain healthcare organizations innovating in some of these areas, but few companies have addressed all the issues.

Insurers can find a cautionary tale in the healthcare reform effort in Massachusetts in 2007, and the implementation of its online exchange—the Connector—which was a model for the ACA. Fewer young, healthy people purchased coverage on the Connector than expected due to low initial penalties for individuals and low subsidies for certain income levels. The exchange population was much older and sicker than insurers had

Joyjit Saha Choudhury
joyjit.sahachoudhury@booz.com
is a partner with Booz & Company based in New York. He co-leads the firm's medical value management practice.

Jennifer Yaggy
jennifer.yaggy@booz.com
is a principal with Booz & Company based in New York. She specializes in government healthcare programs and medical value management.

expected, resulting in medical costs that were 40 percent higher than they had anticipated. Massachusetts insurers lost significant amounts of money and had to negotiate with the state for price increases, some pulling out of the Connector, at least temporarily. Some of these dynamics have been addressed in the ACA, but others may not have been—for example, the ACA's individual mandate penalty is only US$95 per adult or 1 percent of family income in 2014.

Care models for the exchange population should consider the population's demographic characteristics, health status, previous sources of coverage, and should include:

- Health risk assessments and initial check-ups to identify patients' health conditions before significant claims are incurred
- Convenient access to low-cost healthcare, such as after-hours or weekend preventive and urgent care, and telehealth visits
- Transition support as consumers change plans, with continuity of providers, transition of care histories and care plans, and support for consumers as they navigate through the changes
- Ways to reduce likely near-term costs, given the expected short tenure of membership: shifting care to higher-value settings—from ERs to urgent care centers or telehealth visits—through consumer education and incentives, and increased emphasis on managing chronic conditions to prevent acute episodes
- Utilization of existing community support mechanisms such as community health fairs and local substance abuse programs to improve efficacy of health interventions
- Careful management of ROI of care management efforts given likely consumer turnover and tight margins

As more consumers sign up for health plans through the exchanges during the next few months, more health insurers will need to learn how to best manage care for these individuals. The effort will include trying to understand the new population's needs, designing and implementing all necessary care model components, and determining how to best put them into action across their organizations. This is no small task, but it will be critical to developing a sustainable consumer business in 2014 and beyond. +

strategy+business magazine
is published by PwC Strategy& Inc.
To subscribe, visit strategy-business.com
or call 1-855-869-4862.

For more information about Strategy&,
visit www.strategyand.pwc.com

- strategy-business.com
- facebook.com/strategybusiness
- http://twitter.com/stratandbiz

101 Park Ave., 18th Floor, New York, NY 10178

pwc | strategy&
Formerly Booz & Company