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Health Care Trends: Strategic Moves for a Successful Game Plan

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The rapid changes in the health care industry require a vision for the future and a commitment from payers and providers to stay informed and flexible.

The capacity to anticipate and adapt to change is essential to remaining competitive. A winning strategy requires the creative management of change to capitalize on the opportunities.

For the U. S. health care system, the following predictions are already being made for the year 2000:

- Health care expenditures will exceed $2 trillion.
- Medicare spending will reach $300 billion and Medicaid $175 billion.
- Integrated delivery systems will leave less than 20% of hospitals independent.
- Physician services will account for $400 billion with over 75% of MDs in groups.
- Home health care spending will be $50 billion.
- Managed care plans will enroll over 90% of all covered workers.
- Blue Cross Blue Shield will consolidate to fewer than 30 Plans.
- Uninsured Americans will reach 60 million.
- Americans age 50 and over will exceed 77 million – 28% of total population.

Integral to shaping the future of the changing health care marketplace are emerging trends among payers and providers. The actions and strategies implemented today will have profound implications for testing the predictions and staying in the game by the year 2000.

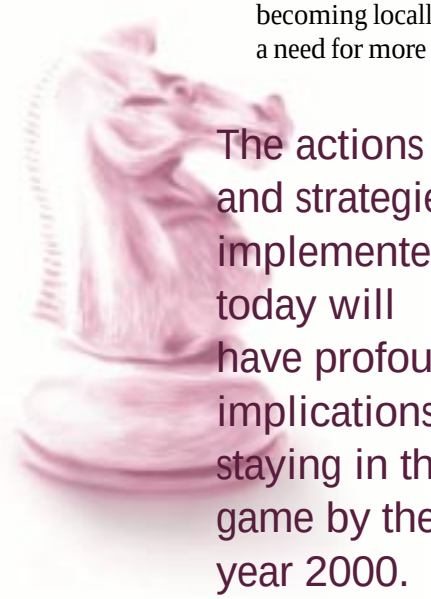
Payer Strategies

Managed care is a different business for payers than it was just two years ago. A new set of "best practices" is defining success and failure in today's insurance industry. Energies must now be directed toward market focus, product spectrum, information management, and provider networks, all of which are critical to the long term survival of payers.

Insurance industry leaders are emersed in a turbulent transition to managed care products, new business practices, and provider partnerships. Through contractual relationships, joint ventures, acquisitions and internal "start-up" initiatives, commercial carriers and Blues plans are investing significant resources to establish managed care market position. Change is being driven by traditional insurers losing market share to a new breed of competitor: an aggressive, fully-integrated managed care organization. As employers are exposed to managed care benefit designs and attractive market

prices, these new competitors emerge as tough rivals for traditional insurers.

Market Focus Strategies need to be designed for long term success, recognizing that health care is becoming locally focused. Managed care has created a need for more locally-based marketing and provider access strategies. Geographic target markets are integral to insurer's managed care initiatives. As product design becomes dependent on linkages to specific community health care providers, payers have begun to focus on gaining local market share versus traditional strategies of fragmented, multi-market national selling. In many instances, insurers are now targeting only a limited number of geographic areas for future growth and using formal market selection criteria (e.g., demographic indicators, provider access, regulatory climate). The process of aligning attractive markets and obtaining favorable provider relationships requires a delicate balance of an often broad array of options.



The actions and strategies implemented today will have profound implications for staying in the game by the year 2000.

In comparison, managed care organizations have always tailored development activities and operating assumptions to local market conditions. As a result, they have gained an important market advantage. Working under the premise that cost of service is driven by unit cost [price of service] times the number of units [utilization], these organizations contract or own local providers and refine pricing based on key market indicators (e.g., utilization and cost trends).

Product Spectrum Managed care continues to complicate market conditions, and in response to this challenge, insurance companies are re-examining their risk management practices, product portfolios and administrative services in order to keep pace.

The range of managed care product options (e.g., Managed Indemnity, PPO, EPO, HMO, POS) is increasing in terms of availability, awareness, and design sophistication. Traditionally, a payer's ability to manage up-front underwriting risk and pricing were the most critical component to a company's performance. Today, successful companies are shifting from traditional risk management to managing health care – arranging for delivery of cost-effective medical care and managing health outcomes in conjunction with a range of managed care financing and product options.

The ability to transform health care payer operations to changing market needs is also essential. Insurance and managed care administration must now be structured to address multiple market demands, including:

- Provider partner requirements
- Continuum of product offerings
- Clinical protocols
- Customer/distributor service
- Medical claims management
- Internal expense controls

Information Management An essential part of managed care operational integration is information systems. Next generation information technology is already available, and management is faced with the decisions concerning when and how to implement new, more efficient systems.

This technology issue involves the payer's capacity to generate reliable information to support pricing assumptions, utilization management criteria, business trend monitoring, and external requirements. Many traditional insurance companies do not have the information systems or managed care expertise to collect and analyze information needed to make an effective transition from indemnity insurance to managed care.

Conversely, managed care organizations have developed sophisticated approaches to data management. They are well ahead of commercial insurers in terms of information systems, which focus on cost controls, utilization and outcomes measures, disease specific care planning, and health promotion techniques.

Provider Networks The selection of managed care partners is another critical success factor as insurers lease networks or contract directly with hospitals, physicians, and ancillary care providers. Carriers may contract with as many as 30-50 different managed care vendors. The ability to manage

numerous suppliers and achieve consistent, effective performance yielding the value needed to financially support an insurer's bottom line is a formidable task. Proprietary selection and performance measures need to be applied to determine which provider partners deliver the most value. Strategic provider alliances will dictate future successes.

In addition to contract relationships, many payers are experimenting with managed care joint venture partnerships (e.g., Integrated Delivery Systems, Health Maintenance Organizations, Physician Organizations). However, few have perfected the process. While theoretically sound, these partnerships prove difficult when it comes to aligning market objectives and agreeing on financial structure. Regardless of the circumstances, provider partners must be vigorously scrutinized retrospectively and prospectively using detailed analysis to address such factors as market position and reputation, geographic coverage, customer base, service capacity, competitor relationships, payment arrangements, and cost/quality performance.

Provider Response

As health care purchasers continue to demand evidence that their benefit dollars are buying high quality health care at the lowest reasonable cost, managed care programs have become more prevalent and more aggressive. Across the country physicians and hospitals are facing a market transformation. Emerging issues include:

- Significant growth in managed care enrollment and sharp declines in fee-for-service.
- Emergence of integrated, risk bearing provider delivery networks.
- Reimbursement reductions by Medicare and Medicaid.
- Risk shifting using capitation, global budgeting or risk-based fee schedules.
- Payer demand for more predictable cost, improved access and utilization, better patient management and quality outcomes reporting.

Progressive provider leaders are developing responses to these market forces. Hospitals and physicians, independently and in partnership, are establishing spin-off corporate entities and strategic alliances to build their capacity to accept financial risk and manage care.

Hospitals Hospitals are experiencing a blurring of lines between payers and providers. Most hospitals across the country are operating far below an acceptable occupancy level. Indeed, inpatient utilization is falling dramatically. Nationally, 350 occupied bed days per thousand is now the average. Some markets are experiencing as few as 150 days/1000. Payer managed care programs are engaging in cut-throat strategies to shift financial risk. Hospitals find themselves making significant changes affecting their structure and longtime mission – changes that challenge the core of their organizational strength and relationships with both physicians and patients.

Stategic provider alliances will dictate future successes.

To fight back and help guarantee a steady stream of patients, many hospitals have organized into Integrated Delivery Systems (IDS). An IDS unites health care delivery and financing components necessary to provide a comprehensive continuum of medical services in a coordinated, accountable, and organizational structure. For many, IDSs have been the method to align hospitals and physicians into a cohesive unit to establish a competitive foothold in a local market and effectively pursue managed care risk contracts.

Ideally, IDSs form a "Community Health Care Management System" that integrates all aspects of patient care, horizontally and vertically, within a service delivery structure serving a geographically-defined population. In some instances however, intense competitive pressure among local hospitals has led to defensively-driven IDSs, formed as a reaction to market pressures and supported with little strategic focus. By moving too quickly to control development and capture payer market share, many hospitals have neglected to foster internal consensus and build a workable enterprise model between themselves and physician partners. As a result many Integrated Delivery Systems suffer structural problems with long term operating implications (e.g., imbalance of primary care and specialty

physicians, underestimated commitment of resources).

Physicians Physicians want to regain control in a managed care environment. Alarmed by their colleagues' dissatisfaction with managed care and concerned about their loss of clinical autonomy, physicians are developing their own networks and contracting organizations. California physicians have taken the lead in their movement for physician-driven managed care. But in other areas of the country, physicians have resisted managed care and are organizationally fragmented. Their desire to preserve a traditional style of independent practice, combined with a lack of experience managing patient care costs, makes many physicians wary of participating in pre-set payment programs. Nevertheless, physicians have begun to recognize the new paradigm and are taking action to develop physician-driven managed care organizations. Many physicians are seeking partners to help them retain autonomy, gain leverage and enhance medical practice management.

Several types of Physician Organizations have emerged to address changing market conditions. Physician Practice Management (PPM) companies are purchasing assets of dominant local medical practices. They provide corporate-based practice management services to control costs, direct managed care contracting, develop information linkages, and implement medical practice protocols. These companies have experienced rapid growth.

Managed Care Organizations such as Health Maintenance Organizations, commercial insurers, and hospital-based Integrated Delivery Systems are also purchasing physician practices. They can offer a lucrative opportunity for an acquired practice however, the result is a surrendering of independence and control to the parent company.

Finally, Management Service Organizations (MSO) are also gaining prominence and represent an alliance of independent or group medical practices in a geographically concentrated area that work together to create practice management efficiencies, establish risk contracting capabilities and increase marketing strength. Under a MSO structure there is routinely participation by physicians as equity shareholders and in an active governance role.

Integrated Delivery Systems and Physician Organizations are still evolving. None have enough market experience or patient volume to demonstrate effectiveness in delivering quality care in a cost effective and patient-centered manner. However, providers remain the ultimate source of health care services, and their longevity is assured, yet their role can change.

Future Success

Being successful in tomorrow's managed care marketplace need not put companies in jeoardy. It is a different game: HIPAA, POS, IDS, PPM. Yet, if internal controls and external relationships are in place, and a carefully crafted yet flexible strategy has been adopted, the next move will only bring management closer to success in the end game.

Health care payers and providers must work through today's challenges:

- Industry Consolidation
- Risk Management
- Regulatory Scrutiny
- Customer Satisfaction
- Managed Care
- Product Diversification
- Market Differentiation
- Information Technology

A carefully crafted strategy will bring management closer to success in the end game.

The capacity to manage continuous assessment of core business assumptions and maintain the corporate agility to execute informed, customer-focused decisions will separate winners and losers. Winners will sustain a competitive advantage and remain players in the 2000 health care game. Losers, and there will be many, will move into the next millennium as spectators. ■

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