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The pitfalls that can prevent health plans from achieving their goals in 2021

A follow-up to an Optum study

OPTUM ADVISORY SERVICES

FOREWARD

In late 2020, Optum experts in the payer space conducted more than 30 interviews with senior leaders of health plans. The respondents represented a broad array of perspectives, including community plans, provider-sponsored plans, Blues and large national plans.

The leaders we interviewed generally agreed on the centrality of these major themes:

- Payers must work harder to bend the cost trend to increase affordability.
- They must grow and scale existing offerings, operations and product lines, and reinvent their relationships with providers to drive better care outcomes and reduce administrative burden.
- They seek to create an Amazon-like member experience in which care happens when, where and how members need it.
- They endeavor to build out a digital foundation to power the entire ecosystem — from front-end consumer engagement to back-end claims processing.

Payers must aggressively tackle these priorities to maintain or grow membership, drive better care outcomes, and make the health system work better for everyone. But there are undetected risks associated with pursuing each of these priorities. Throughout the interviews, while leaders didn't explicitly mention them, several potential pitfalls emerged that could derail these larger efforts. In this white paper, we explore these challenges and strategies to overcome them.

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INTRODUCTION

The pitfalls we observe are based on in-depth conversations with health plan leaders, proprietary industry data and experiences working daily with health plan executives.

The U.S. health care system is a trillion-dollar industry that sometimes seems immovable and unchangeable. It can be a challenge to observe the latent risks in health care. But there are gaps in the system, often identified and filled by new market entrants boasting millions in funding.

There are four primary areas that payers may be overlooking:

PITFALL 1

Reliance on value-based care models to reduce total cost of care

PITFALL 2

Lack of alignment of payer and provider strategic priorities

PITFALL 3

Underestimating the focus and investment required to enhance the member experience

PITFALL 4

Overall fragility of the health care ecosystem

Health plan leaders must acknowledge and address these pitfalls to achieve their goals and truly bend the cost trend to make health care accessible and affordable for all.

PITFALL 1

Reliance on value-based care models to reduce total cost of care

Payers are too reliant on the success of value-based payment models being the solution to rising health care costs. More must be done to reduce the cost and increase affordability.

With value-based care (VBC) models, providers get paid based on the value and quality of the care they deliver. The intent is to cause a fundamental shift toward well-care and improving the overall health of a patient before the need for episodic care. Provider groups' willingness and ability to adopt the VBC model is a challenge and can be time-consuming. For their part, payers are interested in shifting the incentives and behaviors of providers and members alike.

Toward the end of 2019, **86% of United States physicians remained in fee-for-service (FFS) arrangements.** Top barriers included the lack of resources such as adequate staffing models to fully fulfill the parameters of VBC infrastructure.[1] Providers may lack primary care physicians, nurses and pharmacists. Providers also cited additional challenges with interoperability and data exchanges.

Further, the transition to VBC is expensive and time-consuming for groups. According to UnitedHealth Group CEO Dave Wichmann, it may take providers up to three years to fully transition.[2] It can be daunting for physicians to invest in a long and expensive process.

Last, **the average age of providers in the U.S. is over 50**,[3] implying that physicians may be unwilling to change payment models in the later years of their careers. These combined headwinds lead us to believe that the transition to value-based care has and will continue to be an uphill battle for providers.

But is the transition to VBC significantly slowing the growth rate of health care costs in America? The accountable care organization (ACO) model incentivizes and measures provider performance based on quality metrics. To date, adoption of the ACO model has seen slow growth since the origination of government-sponsored ACOs in 2012. The models are shown to cut costs through preventive care, sometimes into the billions of dollars.[4] **Yet, the National Health Expenditure in the U.S. continues to rise and is expected to reach $6.2 trillion by 2028.** This indicates that even though the transition to value-based payment models is a priority for plan leaders, it may not slow the overall growth rate of health care costs nearly as much as payers expect.

Payers should not abandon value-based care or slow the pace of adoption. But they should push for models that don't simply redistribute payment without reducing overall health care spend.

One approach is to ensure value-based arrangements have enough downside risk. Payment should not be a forgone conclusion. Instead, payment is provided when providers meet agreed-upon standards and document behaviors. Second, consumers must play a role in the transition to value. Their behavior and willingness to take responsibility for their own health care needs to play an important role. Without their contributions, value-based care will not reduce trend or slow the cost curve.

1. Dorr L. The top 5 barriers to value-based care. *Managed Healthcare Executive.* Nov. 13, 2019. Accessed Dec. 4, 2020.
2. King R. UnitedHealth Group CEO: Pandemic pushes providers to take more serious look at shift to value. FierceHealthcare. Sept. 11, 2020. Accessed Dec. 4, 2020.
3. Michas F. Distribution of U.S. physicians by age group in 2018. Statista. Aug. 27, 2020. Accessed Dec. 4, 2020.
4. Business Wire. Humana Medicare Advantage members benefit from improved health outcomes, preventive care and an estimated $4 billion in reduced costs through value-based care. Oct. 7, 2020. Accessed Dec. 4, 2020.

PITFALL 2

Lack of alignment of payer and provider strategic priorities

Payer-provider collaboration is a key priority for respondents. Yet in the interviews, health plan leaders seldom mentioned deliberate alignment of payer and provider priorities.

These leaders believe payers are responsible for getting "closer" to providers to enable better care outcomes. Health plan leaders also discussed initiatives to reduce administrative burden on providers and align on incentive structures that are win-win scenarios.

Our question is: Do payers truly understand what providers want? We believe the potential risk lies in misunderstanding provider priorities. Payer and provider priorities need to tie closely together. Yet many health plan leaders are executing initiatives without explicitly including the strategic priorities of provider groups into their business plans. Payers should address this potential hurdle to avoid driving toward different goals and creating additional misunderstanding within the health care system.

It's no secret that COVID-19 heightened the financial strain on physicians. **The American Hospital Association estimates hospitals lost $200 billion between March and June 2020.** This forced hospitals to either furlough or lay off thousands of employees.[5] Margins were already small pre-COVID-19. To keep hospital systems afloat, some physicians may delay shifting to value-based payment models or even withdraw from existing programs to focus on rebuilding financial stability within their practices.

For example, one potential instance of misalignment between payers and providers is the future of virtual or telehealth payment. COVID-19 led to a massive increase in telehealth visits, enabled when the Centers for Medicare & Medicaid Services (CMS) relaxed regulations on virtual or telehealth visits.[6] The regulation allowed providers to bill for telehealth visits at the same rate as in-person visits. Some payer leaders believe that associated expenses for telehealth visits are lower than in-person visits and that telehealth visits should be reimbursed at a lower rate. Providers, on the other hand, argue that the cost of a visit (telehealth or in-person) will not simply disappear with the increase of telehealth utilization. Payers and providers must be flexible and ultimately support and comply with the final CMS telehealth reimbursement models in order to enable more accessible, affordable care to the members and patients.

$200B

amount hospitals lost between March and June 2020, estimated by the American Hospital Association

5. Optum. How value-based care became vital for survival. September 2020. Accessed Dec. 4, 2020.
6. CMS. Trump Administration makes sweeping regulatory changes to help U.S. healthcare system address COVID-19 patient surge. March 30, 2020. Accessed Dec. 4, 2020.

PITFALL 3

Underestimating the focus and investment required to enhance the member experience

Many payers may be underestimating the effort and investment required to facilitate an Amazon-inspired member experience. A better member experience is part of the Quadruple Aim, yet it's not always treated as a priority. More than ever before, payers and providers can drive meaningful and quantifiable change in consumer perception of their health plan.

Optum® Advisory Services (OAS) believes that payers must transform their thinking to prioritize member experience. They must substantially invest to create innovative solutions that directly address the voice of the customer to improve member experience and engagement.

The payer leaders discussed meeting members how, when and where they want to engage. Health plans continually survey members to ensure there is voice-of-the-customer data. But payers underestimate the amount of effort and investment required to leverage that data to enable a world-class member experience.

Initiatives to improve member engagement include convenient, simple and targeted member experiences. For example:

- AI chat bots
- Easy-to-use mobile apps
- Integrating data between provider and payer systems

OAS questions whether these efforts will impact member engagement in ways that benefit the member and the health plan. Or will the improvements miss the mark for members?

According to this year's HealthSparq "2020 Annual Consumer Sentiment Benchmark Study," almost half of consumers do not trust their health insurance company.[7] We know that consumers are frustrated with health care challenges — from rising premiums, to the price of prescription drugs to surprise billing. Members are tired and are demanding change. They want improvement, and they want it now. This pitfall should be addressed quickly, and with leadership's full attention.

To achieve a high-quality, frictionless member experience, health plan leaders must emulate the practices of Amazon. For example, while Amazon may work with a plethora of suppliers, they take on the risk of the product quality and accountability for the entire consumer experience. They are more than an intermediary. Health plans should apply the same principles to take responsibility for a full end-to-end member experience. Even though providers may own most interactions with members, plans have an opportunity to play the role of consumer advocate.

7. HealthSparq. 2020 Annual Consumer Sentiment Benchmark Study. Accessed Dec. 4, 2020.

PITFALL 4

The overall fragility of the health care ecosystem

COVID-19 highlighted the fragility and interdependency of the health care system. Payers need to simultaneously address existing challenges and implement innovative new offerings.

The financial structure of the health care system is in an unbalanced state. Payers entered the pandemic in a healthy financial position, with profitability at a 10-year high[8] and expecting increases due to delayed elective procedures and associated low medical loss ratios (MLR). Provider groups, on the other hand, are receiving loans from the government or pre-payments from payers to keep practices open.

COVID-19 also highlighted operational challenges that will need to be addressed. The life-threatening lack of personal protective equipment (PPE) during the peak of the pandemic or the unacceptable delays in testing illustrate how the system is unable to adequately respond to a pandemic. Supply-chain issues experienced during COVID-19 cannot be forgotten as payers drive to push new innovations to the market.

Another example is the lack of medical equipment needed for a successful telehealth visit. Not all members own a blood pressure sleeve, a scale and other necessary tools. Payers have an opportunity to use purchasing power to fill a gap that may be a hurdle in implementing telemedicine across populations and socio-economic groups. We heard that health plans are charging ahead with innovative priorities. But we urge leaders to heed the lessons of COVID-19.

8. Everest Group. Healthcare Payer State of the Market: Trends, service provider performance in 2019, outlook for 2020. Feb. 2020. Accessed Dec. 4, 2020.

CONCLUSION

Focusing on affordability, growth, member experience and enhancing provider relationships are important goals for most health plans. Yet several potential pitfalls could compromise leaders' ability to achieve them.

First, while payers should continue to pursue the transition to value, they should take steps to ensure it meaningfully reduces the total cost of care. This means facilitating greater downside risk for providers and greater consumer engagement.

Next, leaders must deliberately align their priorities to those of providers, just as providers ought to align priorities to payers. The financial viability of high-performing providers is critical, as is their ability to care for patients in convenient, cost-effective ways such virtual visits.

While most health plan leaders would identify enhancing the member experience as a priority, few have sufficiently focused and invested in it. The right investments in digital and consumer engagement are no longer nice to have. They are table stakes for health plans that wish to remain competitive.

Finally, health plans do not operate in a vacuum and are part of the larger health care ecosystem. The impact of COVID-19 has demonstrated just how fragile it is. However, plans have an opportunity to bolster it through innovative new offerings.

> If potential pitfalls are unaddressed, payers may experience a declining Net Promoter Score® (NPS), higher costs and lack of relevancy in their market. But when addressed, payers will achieve their strategic goals and win the competitive advance they seek.

WHY OPTUM ADVISORY SERVICES?

With breadth of industry knowledge and depth of experience, Optum Advisory Services is uniquely positioned to offer comprehensive services that can not only help you deal with COVID-19 issues, but also support you across a wide range of interconnected strategic and operational domains. We bring together incomparable data and analytics with years of experience in both consulting and on the front lines of health care. Our team of consultants is ready to help you design your organizational response to the current environment and enable a secure future.

MEET OUR EXPERTS

The following Optum executives participated in discussions with our health plan clients and worked to develop insights within this study:

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