GUIDE

Health Plans:

Your Guide to Leveraging Trends in the Post-Reform Consumer Marketplace

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Looking for technology to make things faster and simpler

Introduction

With over five years into the Affordable Care Act (ACA), healthcare reform continues to transform the benefits landscape at a very rapid pace. It has created a fast-changing environment, causing many industry players to move at a hectic pace to implement new provisions, keep healthcare costs down, create infrastructure to support new reporting requirements, and develop new payer, provider and care delivery models.

While originally for health plans, the ACA may have initially affected them by leveling the playing field in certain respects through such requirements as the standardization of benefits, guarantee issue, and limited pricing mechanisms. However, they have not only experienced all the changes noted above, but have also seen changes in the types of plans people are choosing, how they are enrolling for coverage, their expectations once on the plan, and the what, when and how they want communication from their health plan.

Over the last 15 years many health plans have done B-to-B and B-to-C marketing ever since consumers started purchasing insurance online. But healthcare reform has catapulted these end-users to the forefront, and health plans are now talking directly to them, even when a broker or employer is part of the equation. That means they're putting more energy into health literacy initiatives (e.g. making their member materials easier-to-understand) and exploring new ways to attract and educate the large number of uninsured people seeking coverage (e.g. partnering with a health insurance exchange or redesigning their website).

Healthcare reform continues to transform the benefits landscape at a very rapid pace

The reason being that consumers and enrolled members are a little savvier than perhaps five years ago. Now, many have high deductible health plans and health savings accounts, and are looking for technology to make things faster and simpler. Their expectations are growing once on the plan within the digital and service realms. Yet, they also want more transparency in terms of price, coverage, details, and claims processing times. They want to know what benefits they have and how to make the most of them.

This is true for participants in both the group and individual markets. Employer-sponsored coverage, while once dominated by HMO, PPO, and POS type plans, has seen a steady shift toward more consumer-directed plans, including HSAs. 58% of individuals with an HSA-eligible HDHP opened an HSA, according to the EBRI/Greenwald & Associations Consumer Engagement in Health Care Survey. About 32 % of companies are now only offering HDHPs.

Employers have also begun to adopt a defined contribution approach to employee benefits, including their health coverage options. Concerned about maintaining predictable benefit costs, employees are provided by a fixed dollar amount to purchase employer-sponsored plans and other benefit options, which are then offered through a private exchange. The American Health Policy Institute (AHPI) surveyed chief human resource officers (CHROs) who are responsible for their companies' healthcare benefits and found this trend will probably continue, as 77% said they were either considering or had considered private exchanges. Furthermore, they remarked that the top three healthcare options they are considering in the future are consumer-directed healthcare plans, private exchanges, and public exchanges.

Consumer **Trends**

It's time to put the consumer squarely in the center of every healthcare executive's conversation when it comes to his or her organization's future strategy. Benefit surveys are indicating that consumers want more information, more convenience, and better service. And like the old adage goes "there's strength in numbers", they now have the volume to be heard loud and clear.

A February article in hhnmag.com looks at how Consumerism Hits Healthcare and the impending impact this has on the future of healthcare organizations. To get healthcare organizations on track, they offer this overview with five key points that executives should further develop within their organizations.

TOP 5 HEALTHCARE EXECUTIVE CONSUMER STRATEGY POINTS

1. **Identify the type of consumer your healthcare system serves and what they value** - People own an HSA but make no contributions or withdrawals. Do they know they have an account? Do they know the basics? Is it possible they're expecting an employer to provide a contribution?

2. **Develop and execute your consumer experience strategy** - Don't wait until patients arrive; figure out and plan to meet their expectations. Some may be looking for a quick fix, other patients may want a lifelong partner for continuum of care.

3. **Evaluate the best metrics to use to track your progress** - To effectively meet your consumers' needs, measure the things that are important that impact their choices and experiences.

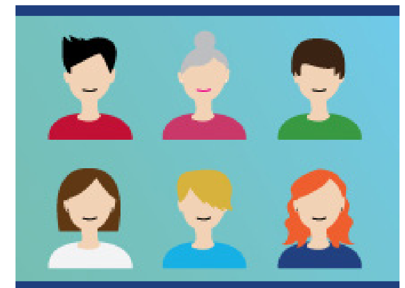
4. **Select a consumer champion within your organization** - You need someone who is looking at every department to ensure that the consumer experience is consistent and the vision is being clearly communicated to employees and members.

5. **Allocate appropriate resources** - Creating and executing your consumer experience will require important investment decisions that should be geared toward meeting your consumer goals.

TODAY'S HEALTHCARE CONSUMERS

Every person in the U.S. healthcare system wears a number of hats: they're shoppers, insurance policy holders, payers, patients, and maybe even medical savers or investors. But at the heart, they're consumers. Healthcare organizations and professionals want to attract, influence, engage, and help them. Health plans design products to meet their coverage needs, agents customize services to help them make informed choices, and providers personalize treatment plans to keep them healthy.

But healthcare consumers aren't all alike. It's important to identify the types of consumers your organization serves and understand there isn't a one-size-fits-all approach to connecting with them. Some consumers want to be actively involved in their healthcare - they want to dig into information and use the tools at their disposal to make personal medical decisions. Others are comfortable taking a more traditional approach, defaulting to the advice of experts like physicians and insurance brokers, for example, when faced with a treatment or coverage decision. Everyone is at a different place along the continuum of change-readiness, and some people are more willing than others to identify as a fully-engaged healthcare consumer.



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In Rising Consumerism: Winning the Hearts and Minds of Health Care Consumers, Deloitte breaks healthcare marketplace consumers into six segments:

1. **Casual and cautious** (34%) - Not engaged, no current need, cost-conscious
2. **Content and compliant** (22%) - Happy with physician, hospital, and health plan, trusting and follows care plans
3. **Online and onboard** (17%) - Online learner, happy with care but interested in alternatives and technologies
4. **Sick and savvy** (14%) - Consumes considerable healthcare services and products, partners with physician to make treatment decisions
5. **Out and about** (9%) - Independent, prefers alternatives, wants to customize services
6. **Shop and save** (4%) - Active, seeks options and switches for value, saves for future health costs

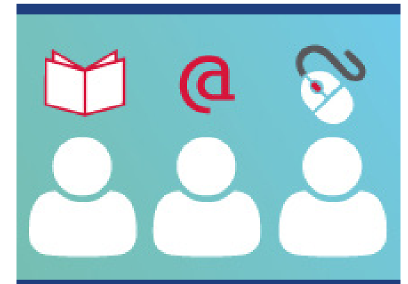
MAKING SENSE OF THE 6 TYPES

It's clear that each individual navigates the marketplace a little differently. But why? What affects people's coverage and care decisions? What affects their behaviors? What impacts how they prioritize their needs? There isn't a definitive list of characteristics or a formula for determining what "type" of healthcare consumer a person may be, but we can glean insights from Deloitte's segmentation in an effort to better understand what makes each person unique. Let's take a look at some of the factors that go into the mix.

WILLINGNESS TO FACE CHANGE

The healthcare marketplace has rapidly changed since the introduction of the ACA. People hear about healthcare reform from their employers, politicians, newscasters, family members, and neighbors. A great deal of uncertainty and even controversy surrounds the various reform issues, and that can lead some to "go with the flow" or simply choose to "see what happens." Some people don't like change; they're not ready to engage, and nothing has inspired them to sit up and take action. It's challenging to reach those who are change-averse, and health plans may simply have to wait for the opportunity for these individuals to seek out support - when they're ready. Or, they can employ a strategy that puts employers or brokers in the position to communicate with them.

> Health plans are on the leading edge of trying to help consumers get comfortable with coverage terms



KNOWLEDGE OF HEALTHCARE TOPICS

With healthcare becoming a more consumer-oriented marketplace, people's level of proficiency with (or lack thereof) healthcare concepts and behaviors are coming to light. Health literacy has become a significant concern, and health plans are on the leading edge of trying to help consumers get comfortable with coverage terms and concepts so it's easier for them to engage and get more involved with coverage and treatment decisions.

COMPLEXITY OF PERSONAL HEALTHCARE SITUATION

This is where a person's health status, age, life-stage, and history of care utilization may come into play. An individual who is well versed in the medical system and has experience traversing the healthcare "process" has a good basis for knowledgably comparing prices and treatments - and demonstrating consumer behavior. But just because a person has high utilization of medical services, don't assume they're more interested in participating in the management of their healthcare. The number of choices they need to make may overwhelm them, so they're willing to let their providers (including their insurance company) handle the details. In this case, their clinicians may be the right people to engage them.

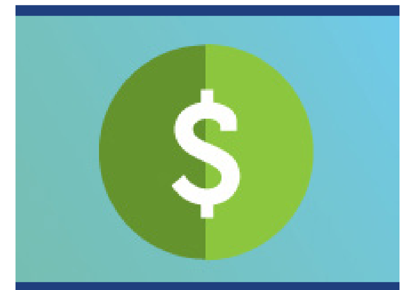
COMFORT WITH TECHNOLOGY

Consumers who do research and shop online for products and services outside of the medical realm are usually more comfortable going through the same process for healthcare. Technology has made it simple and convenient for consumers to connect and communicate with their healthcare partners and providers, making web-based tools an important part of a health plan's customer engagement strategy. People who are less inclined to do the work online can engage - perhaps a little less efficiently - through face-to-face and telephonic consultation.

PRICE SENSITIVITY

Costs are a leading driver of consumer behavior in the healthcare industry. Today's health plans are introducing new cost-sharing mechanisms, including higher deductibles, to provide additional price points for consumers who need to keep their monthly costs down. Health plans have made it very easy for consumers to compare plans based on price, and offer readily accessible online tools shoppers can use, and it makes sense that people who are motivated to save money will take advantage of these tools. Additionally, more consumers with health savings accounts are learning how to maximize their medical savings and save on taxes through savvy investing.

Health plans tap into these insights to know their customers better and become more adept at personalizing their value propositions for different people. Individuals can help drive their various strategies for attracting consumers, helping them make informed decisions, and making the most of their coverage.



Costs are the leading driver of consumer behavior in the healthcare industry

The key objectives in member communications today are to personalize and engage, not only to encourage their participation but also to improve their health. Since the market for new potential customers spans generations, income ranges, education levels, and life stages, health plans have any number of target markets to serve with their messages, and a lot of work goes into understanding these consumer segments: what they need in a health plan, how they want to be reached, and what kind of support they require. Health plans will keep learning to operate with a consumer "mindset" and put the tools and processes in place to manage new sales and marketing programs, not the mention the technology required to keep the cogs turning.

SPECIAL SECTION: MILLENNIAL HEALTHCARE CONSUMERS

Young adults ages 18-34, commonly called "young invincibles," are a critical part of the economic equation defining today's uninsured population. Their participation, in adequate numbers, is needed to stabilize the market because as younger and generally healthier consumers, their premium dollars can help offset the healthcare costs of older participants.

But even before the ACA, young adults were a large portion of the country's uninsured population. Whether they lost dependent status on their

parents' plan or their first real-world employer didn't offer healthcare insurance, they may have found individual coverage too expensive or felt a sense of not "needing" coverage. This is still true, post-reform. Federal and state governments, as well as health plans, continue to be challenged by this market segment—they are highly sought-after consumers and will remain the subject of much analysis into the future.

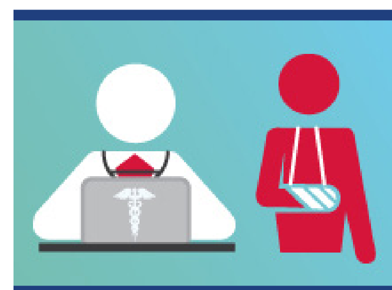
The demographics of the newly insured are already proving interesting as 6 million young adults have gained coverage since the implementation of healthcare reform. This makes Millennials the largest of any age group to have gained coverage thus far. The challenge for health plans will be to learn all they can from these brand new members in a relatively short amount of time.

This is good news for health plans as younger people are often healthy and simply use less healthcare services. Since health plans have to contend with the health insurance tax (expected to be about $11 billion and spread around health insurance companies for payment in 2015) and the transitional reinsurance program (set at $44 per covered employee) to help stabilize premiums in the individual market, they need volume on their plans and younger members tend to cost them less.

Young adults are upwardly mobile, and their life changes often go hand-in-hand with financial changes. They might get married, have children, buy a home, start a business—all events that often spark a need for insurance and financial products, especially if they're losing dependent status on their parents' healthcare plans.

Yet many young consumers face a steep learning curve. They need extra help assessing their healthcare and financial needs. They may not be familiar with health insurance concepts and terminology, and they may not understand how saving for healthcare today will help them tomorrow.

That's why health plans will need to consider how to appropriately reach and engage members through the innovated use of technology and a renewed/redesigned customer service approach that emphasizes transparency and clear communication. Here's a snapshot of five components that health plans need to consider for keeping the attention of younger people and developing more effective healthcare member interactions for everyone:



Many young consumers face a steep learning curve

1. **Use technology wisely** - Show plan and price comparisons and create mobile apps that improve speed and easiness for typical plan activities
2. **Provide benefit plan transparency** - Show members how to use their plans
3. **Create customer engagement** - Provide ways for members to connect with physicians via telemedicine or become more interested in wellness activities
4. **Invest in creating thoughtful, targeted member mommunication** - Members who have certain conditions should receive timely and consistent information specific to them
5. **Provide clear communication at a 6th grade reading level** - Be a trusted source of information and increase members' health literacy

Trends In Technology

From benefits administration technology to mobile technology and everything in-between, health plans are implementing tech solutions to streamline processes, communicate more effectively with members and healthcare partners, and manage and deliver benefits.

Health plans working with technology vendors, including those partnering with them to manage ACA compliance, will have more opportunities to collect data and learn how to effectively leverage it across the organization. Technology can give health plans a competitive edge in this day and age, especially when the technology makes it easier for people to get the care they need at the right time, in the right place, and at the right price.

BIG DATA

When it comes to understanding buyers and designing the plans and services they want, health plans need data—and lots of it. "Big data" is a hot topic across all industries, and healthcare is no exception. The ability to derive actionable insights from data is changing the way business is done. Health plans are using data to uncover trends and provide personalized service. Member or process-generated data can and should be used to help save costs, better communicate, or operate more effectively. It has already made an impact on how health plans have structured prescription drug formularies, for example, and has uncovered opportunities to engage at-risk members with new disease management programs.

What's more, an article from the Institute for HealthCare Consumerism, *The Consumerization of Healthcare: What Patient Experience Means to Our Future*, suggests that healthcare organizations collect data beyond the usual and customary to get a better sense of a person's preferences and habits so they can serve them with more personalized solutions. For instance, if health plans can collect information such as member name preference, communication preference (mode of contact, time), language preference, payments preference, and even caregiver preference, each insured can be delivered a more customized experience. Ultimately, a more customized experience may lead to better health outcomes.

"Big data" is a hot topic across all industries, and healthcare is no exception

ADMINISTRATION TECHNOLOGY

Administration technology is helping health plans and employees offer easy-to-use consumer-directed health plans and deliver benefits using a defined contribution strategy, and it's helping people manage their healthcare funds. Web-based and mobile technology is changing service models. As healthcare consumers, health plan members turn to their mobile devices to access symptom checkers and savings calculators, to perform a provider search or price check, or to explore plan benefit or self-service options. Health plans need to understand that the outlay of money for technology will empower members with the tools that will boost their engagement and help them to make good choices—and those are cornerstones of healthcare consumerism.

While taking steps to improve members' experience with their coverage and services, delivering value, and building loyalty, health plans will also seek to gain market share in a competitive marketplace with the healthcare solutions people are out there shopping for today.

PAYMENT TECHNOLOGY

Technology is making a significant impact on healthcare payment reform, especially in the consumer healthcare-spending arena. Service providers are introducing solutions to help people take better control over their transactions—and make sense of the big picture of their healthcare spending. By integrating data furnished by providers, financial institutions, and health plans, these patient-facing tools enable people to track what they owe, manage available funds, and even make payments to providers.

Consumers are getting access to web-based resources that put them in a more direct relationship with healthcare partners. Providers and health plans are "plugging into" these tools and expanding their capabilities, making their payment processes deliver a retail-like experience. This touches almost every stage in the payment process, from confirming eligibility to invoicing and receiving electronic payments.

These patient healthcare payment solutions are meeting consumer expectations in much the same way as those leveraged by banks, utilities companies, and travel websites. People can manage their personal banking and cable television subscriptions online—and make secure payments for any number of services—so as they continue to become more involved in their healthcare decisions and payments, they're turning toward similar service models.

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MHEALTH

A growing number of health plans are entering the sphere of Mobile Health, or mHealth, to communicate and engage with customers. By offering healthcare engagement tools for people to use on their mobile devices, health plans make it easy for members to manage their policies and participate in healthy lifestyle activities anytime, anywhere—even on-the-go.

Results from the 2013 Employee Benefit Research Institute/Greenwald & Associates Consumer Engagement in Health Care Survey showed that 70% of the adult population with private health insurance had used a smartphone within the last year and 50% had used a tablet. Of these,

- 24-34% used an app for nutrition information
- 22-29% used an app for general health information
- 22-29% used an app for exercise programs
- 19-26% used an app for weight management or diets

They also used apps to research prescription drug and medical care prices, contact their health plan's customer service, check medical-claims history, see HSA/HRA balances, look up providers' hours, or make an appointment.

Yet, in Robert Half Technology's recent mobile technology survey of 2,300 U.S. CIOs, the healthcare services industry had the greatest percentage of respondents (36%) reporting that their organization has no mobile technology strategy. They lag behind the business services and retail industries, with 65% and 63% of respondents, respectively, using a blend of apps and mobile-friendly web pages.

Health plans now need to conduct their own research with their members to develop an mHealth strategy as it appears more healthcare consumers will surely want mobile technology to enhance management of their medical care. We expect more healthcare organizations will develop mHealth strategies to meet customer expectations and remain competitive with the major players—namely the large, national health insurers who have already made mobile health a business priority.

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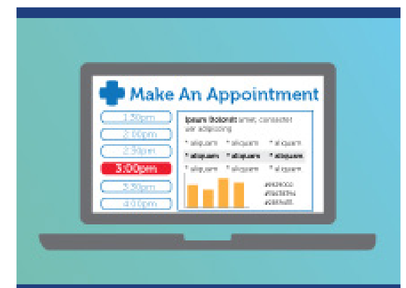


SPECIAL SECTION: GETTING STARTED WITH MHEALTH

What does mHealth look like? For some health plans, it's simply a mobile version of their website. For others, it's an app that's downloaded and installed on a member's device. Some carriers utilize a combination of tools—a mobile website plus one or more apps designed for specific functions. From an IT development standpoint, the easiest first step needs be to create a mobile website that provides visitors with an easy-to-navigate user interface. This is essential now due to Google's April 2015 announcement that it gives higher ranking to mobile-friendly websites. Then, when resources are available, a customized app (or suite of apps) can be developed to serve members' more customized needs.

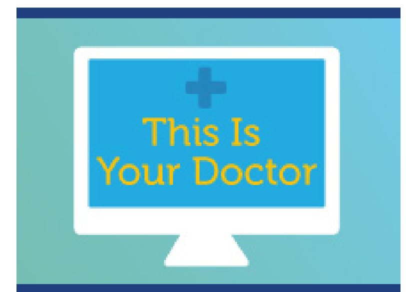
"WHAT DO OUR CUSTOMERS WANT?"

Health plan members have the most important voice in the development of tools, whether they are offered on the primary website, the mobile site, or as a stand-alone app. There is an almost endless list of services health plans can provide, and their offerings will depend on members' needs. People with traditional health plans may benefit most from policy, self-service tools, while those whose health plans include a savings account component or a wellness program may require a more robust set of tools.

Here is a list of various resources health plans can make available to members using mobile technology:

- **Member services** - view ID cards, review deductibles, check account balances, and submit claims
- **Healthcare management** - set up preventive care alerts, access medical records, order Rx refills, record health and fitness goals, and track medications and immunizations
- **Decision-making** - shop for plans, search for providers, and compare prescription drug costs
- **Medical support** - contact a Registered Nurse, manage pregnancy, and access triage service
- **Social integration** - share health-related content and rate physicians

For health plans, a foray into mHealth signifies a shift toward a more customer or patient-centric operating model; it also makes conducting business faster, easier, and smarter for members as well as employees.



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Future Trends

TREND 1 – ACCOUNTABLE CARE ORGANIZATIONS

Health plans looking toward the future need to consider a world that includes new payment models that move beyond the traditional fee-for-service. Payment reform is on the horizon as various pilot programs such as accountable care organizations (ACOs) are currently being tested under the Affordable Care Act. These new payment models that are resulting from healthcare reform are being considered so as to improve the economic and clinical value of the services that are provided to consumers.

Healthcare organizations understand that in this new ACA environment they need to find ways to reduce unnecessary costs and improve patient outcomes. A recent article in Healthcare Financial Management titled, *Payment Reform: A Primer for Taking on Risk*, explores the new realities of the healthcare system that include a willingness by all those involved to collaborate on reengineering care delivery.

For health plans, the article notes two basic steps: defining the population for which it is assuming risk and defining the services that it will deliver to the target population. A population can be defined in many ways, typically some of the characteristics include geography, demographics and even medical conditions. Once healthcare organizations identify what kind of population they have, then they can determine the at-risk services they will need to cover for that group.

Often, a high-priority population is identified first, such as those with chronic conditions, who will benefit from improved care coordination immediately. The range of services needed for this group will need to be clearly defined. This may require working with external partners to deliver certain aspects of care. These providers will need to be brought under the risk-base contract as well to make a new bundle payment system for this population work.

These are really the first steps for healthcare organizations looking to develop the capabilities and infrastructure necessary to start a new bundled payment model. The next steps involve defining the cost and quality of care that can lead to the real rethinking of care delivery. As ultimately wanted, a bundled payment model structured around population health management will hopefully produce two important ACA goals, better care at lower costs.

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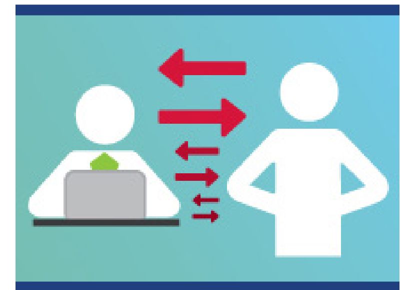
TREND 2 – TELEHEALTH SERVICES

The influx of new members from the exchanges, the individual mandate, and the employer mandate will increase the demand for services. Yet, over a quarter of the practicing physicians are age 60 and older, according the Association of American Medical Colleges, and ready to retire or may be unwilling to invest in the new technological requirements of the ACA.

Telehealth services help answer the challenge of less physicians. This is one of the fastest adopted healthcare services ever introduced by the industry. That's because people want to do their healthcare the way they do everything else in their lives, especially the younger generations.

A recent article in Hospital & Health Networks discusses the three modalities of telehealth services that healthcare organizations are implementing.

- **Real time** - This is probably what most people think of when they hear telehealth. It's live video conferencing during which the patient and the doctor communicate. Primary care physicians, specialists, psychiatrists, and other healthcare professionals all use this method.
- **Store & forward** - Patients take or have stored on their mobile device images, video, audio, and clinical data that they transmit securely to a provider for later analysis. This mode of telehealth services is often used in teledermatology and telepathology
- **Remote monitoring** - Patients with chronic diseases such as diabetes or asthma are connected to sensors that feed data to an external monitoring center where healthcare professionals remotely monitor them. Telehealth allows providers, doctor offices, hospitals and other health organizations to provide more care without needing more locations. The technology is here to use virtual care, now it's time for the reimagining of operation workflows and the re-engineering of providers' and clinicians' workdays to include online time via smartphones, tablets, computers or video screens. Health plans need to consider how to support physicians in the use of telehealth services to help meet the needs of their members.



Telehealth services help answer the challenge of less physicians

TREND 3 – PRIVATE HEALTHCARE EXCHANGES

Health plans looking to grow in the group market need to carefully consider the value of private exchanges in this marketplace and consider developing their own exchange or partnering to become part of one. A recent report by Accenture found that enrollment numbers in private health exchanges have grown to 6 million in 2015, which is double last year's number of 3 million. Accenture also estimates that private exchanges will have 40 million people enrolled as of 2018. The reason being, they offer employers several advantages:

- The ability to provide uniform coverage for employees regardless of location (something that only PPOs could do before)
- Help them avoid the "Cadillac tax" set to take effect in 2018
- Reduce HR workloads by lessening plan administration
- Provide budget transparency
- Help them avoid the "pay-or-play" penalty by offering minimum essential coverage that is affordable
- Provide more health plan options to increase employee satisfaction with more individualized alternatives

Public exchange enrollment numbers are equally impressive, which have positively affected the individual market. In 2015, nearly 11.7 million people have purchased plans through public marketplace, double last year's numbers. Projected growth by the HHS estimates that in 2016, 24 million people will enroll, providing a window of opportunity for health plans to attract new consumers.

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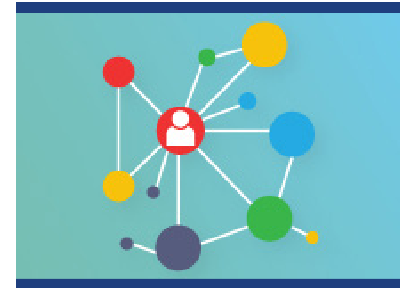

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About the Healthcare Trends Institute

The Healthcare Trends Institute is an educational platform to help employers, third-party administrators, health plans, brokers, banks, payroll providers, consumers, and other stakeholders keep up with the rapidly changing healthcare benefits industry. It covers a range of topics related to the administration and management of healthcare benefits. To ensure all content and programs achieve the highest level of quality and relevancy, the Institute is guided by an Editorial Advisory Board comprised of subject-matter experts that represent diverse aspects and perspectives within the healthcare benefits industry. More information is available at www.healthcaretrendsinstitute.org

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