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THE EMERGING WORLD OF MEDICAL MANAGEMENT I

New Levers and New Strategic Choices

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New Levers and New Strategic Choices

As medical costs continue their seemingly inexorable rise, health care insurers are taking a fresh look at the central technique for containing them: medical management. But today's approaches are far more sophisticated than those of the 1990s. They extend beyond case, utilization, and disease management to include alternative payment mechanisms, performance-based bonuses to providers, incentives that reward patients for healthy choices, and greater transparency about provider performance and cost. So insurers are having to make some shrewd strategic choices.

In this Focus report—the first in a three-part series—The Boston Consulting Group reviews the various strategies that different types of insurers are adopting. In the second report, we will evaluate the uncertainties that surround those strategies and their implications for the various types of insurers. Finally, in the third report, we will examine how the new approaches to medical management will have an impact on other stakeholders in health care—doctors, hospitals, pharmacies, and manufacturers, notably the pharmaceutical industry.

Adjusting to a Changing Landscape

Driven by increasing anxiety in the market over the rising costs of health care, medical management is evolving rapidly at U.S. insurers. After being treated as an "extra wheel" for many years, it is evolving into a central strategic engine of competitive advantage. Very broadly, medical management seeks to contain the costs and improve the quality of health care by informing the decision-making processes, changing the behaviors, and enhancing the care choices of physicians, other providers, and patients. (See Exhibit 1, on page 2, for a summary of the components of medical management.)

In recent years, leading health-care insurers (hereafter called *health plans*) have begun not only to dramatically expand their capabilities in medical management but also to deploy them in a far more integrated way. This twofold development creates a new dimension in which health plans can compete.

To survey this changing landscape, The Boston Consulting Group earlier this year interviewed chief medical officers (CMOs) of 18 health plans. These health plans represent the full spectrum of size and geography and, in total, provide coverage for about 100 million lives—the bulk of the commercially insured lives in the United States.

The CMOs expressed a common view of the long-term future and promise of medical management, but they differed considerably on the best approaches toward realizing that promise. Health plans are taking a variety of distinct routes toward a more integrated and effective health-care sys-

tem—and each is racing the others to shape the market to its own advantage.

Drawing on our interviews with the CMOs, this report examines the changes under way in medical management and discusses the importance of those changes, the recent evolution in the field, the strategic bets that result, and the critical issues that will determine success or failure for the health plans placing those bets.

Reclaiming Center Stage

Following a lengthy period of strategic irrelevance, medical management has only recently returned to the main agenda of most U.S. health plans. When managed care rose to prominence in the 1980s, health plans created powerful tools to control costs: tightly managed benefit designs, narrow networks of care providers, primary-care "gatekeepers" with

Exhibit 1. Medical Management Includes Many Different Components That Affect Plan Members Throughout Their Life Cycle

Benefit design	• Define benefits covered under the plan and the conditions for coverage, such as prior certification • Set rules for obtaining access to providers and for the extent to which members must share in the costs of their own care
Member management	• Educate members on plan benefits • Educate and offer incentives to members about healthy-living choices • Collect data that help assess members' health risks and determine which programs would serve members
Behavior modification	• Identify targets for interventions, such as members who smoke or don't exercise • Recruit members into programs that encourage them to alter unhealthy lifestyles
Demand management	• Offer guidance on the most cost-effective courses of action • Promote targeted use of the provider system, such as visits to primary-care physicians rather than specialists • Identify and promote appropriate utilization opportunities and address gaps in care
Network management	• Contract with providers to create networks for members • Promote provider and patient awareness of the quality and cost of components in the network • Steer members to higher-performing providers
Utilization and component management	• Encourage providers to use evidence-based medicine • Identify and pursue opportunities to reduce unnecessary and costly utilization of particular types of care
Case management	• Optimally manage and coordinate care for patients who have complex and catastrophic medical conditions
Disease management	• Identify members with costly chronic conditions and support them in managing those conditions • Collaborate with providers by sharing information on member programs and patients' engagement in those programs, and by advising the providers on potential interventions
Quality management	• Assess providers' performance, identify gaps in their performance, and make recommendations for improvement • Deploy incentives—such as pay-for-performance programs and tiered networks—that encourage providers to improve quality

Source: BCG analysis.

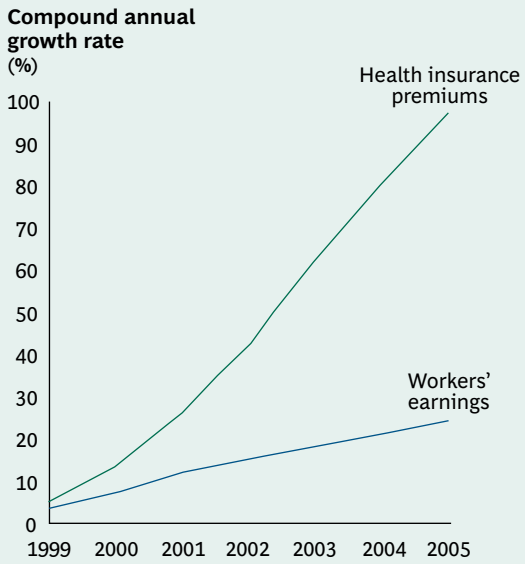
incentives to control patients' access to services, and formidable hurdles for reimbursement approval. These tools, effective as they were at containing increases in medical costs, were also perceived as intrusive, and they diminished patients' trust. In the mid- to late 1990s, the market shifted its focus back to greater choice and access for patients—effectively neutralizing or even stripping away the strongest tools of medical management.

In the new era, health plans found new ways to compete: building administrative scale through acquisitions, offering portfolios of new business models and benefit designs that were more open, and investing aggressively in IT. A flurry of repositioning followed, creating the highly segmented world of health plans that we know today. There are three broad categories of health plans: the *nationals*—a handful of giant, typically for-profit, publicly owned players such as United Healthcare and Aetna; the *regionals*—a larger number of midsize players such as the for-profit Health Net and the nonprofit Blue Cross and Blue Shield of Florida; and a dwindling group of *locals*—smaller, localized players focused mainly on providing benefits under health maintenance organizations (HMOs), delivering niche products, and serving special segments.[1] In addition, a growing assortment of vendors—outcomes management players such as Healthways and pharmacy benefit managers such as CVS Caremark—offer selected capabilities in medical management as a way of enabling health plans, especially smaller ones, to "rent" scale and be competitive on a cost basis.

In this changed landscape, medical management is again becoming a strategic lever in light of three broad developments. First, even though consolidation among health plans is still playing out, strategies designed to capture administrative scale have already begun to yield diminishing returns. With the nationals fully exploiting their scale and smaller plans tapping vendor relationships and alliances to remain competitive, health plans must look elsewhere for competitive advantage. Consequently, they are shifting their emphasis toward managing the business's medical component—where 85 percent of their costs lie.

Second, the relentless growth in medical costs and health insurance premiums has become a top concern of payers of all kinds—private employers and the government alike. (See Exhibit 2.) Squeezed by competitive pressures in their industries, employers are increasingly economizing by taking up medical-management options, even at the risk of employee dissatisfaction. For instance, they are turning to cost sharing with employees, changing the benefits structure for retirees, and investing in behavior modification programs. A further boost and incentive for medical management comes from the Medicare Modernization Act, which is opening up a broad new market for cost-effective health plans.

Exhibit 2. Between 1999 and 2005, Health Insurance Costs Grew About 70 Percent Faster than Labor Costs



Sources: Kaiser Family Foundation and the Health Research and Educational Trust, *Employer Health Benefits Survey,* 2006; Health Insurance Association of America; Centers for Medicare & Medicaid Services, *National Health Expenditure Data,* 2006, cms.hhs.gov/nationalhealthexpenddata; BCG analysis.

1. In this Focus, we use the term *national* to refer to any of the major health plans that have many millions of members, a significant presence in many locations including major metropolitan areas, a branded national network of providers, and a breadth of programs and capabilities for serving nationwide employers.

We use the term *regional* to refer to any health plan that has more than 1 million members and thus represents a leading presence in a broad but specified geographic area such as a multistate region, an entire state, or a portion of a large state. Typically, regional plans also carry multiple product lines, such as preferred provider organizations, HMOs, and point-of-service offerings.

We use the term *local* to refer to any health plan that has fewer than 1 million members and is thus too small to support multiple lines or represent a leading presence beyond a narrow geographic area such as a portion of a state.

Third, the market is becoming more aware that the quality of medical care is very uneven, varying significantly across locations and providers, and consequently that employees in some areas are underserved and that some employer dollars are being poorly spent.[2] Employers are therefore asking their health plans to become more effective as care-purchasing agents.

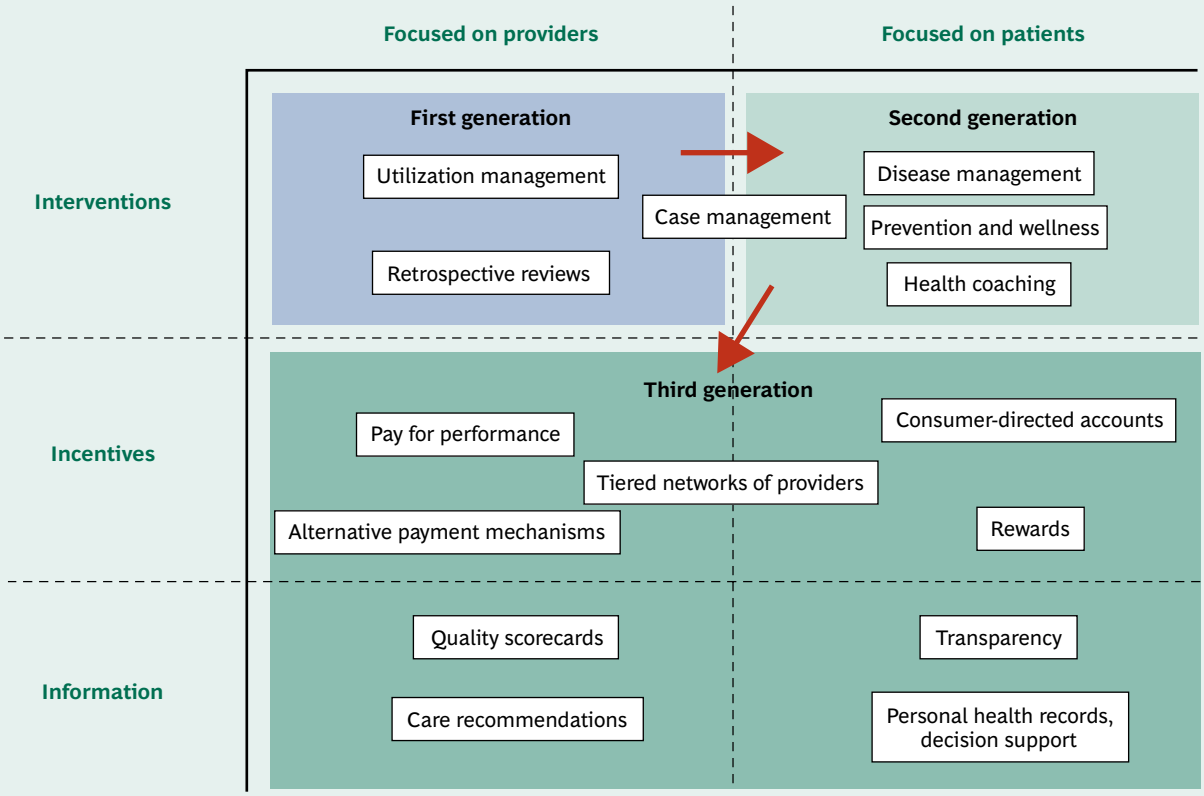
To address these developments, medical-management executives are once again assuming a prominent role within their health plans, only to find themselves facing challenges dramatically more complicated than those that they faced during the 1990s. That's because health plans—which now have to serve a more complex base of clients buying a more complex array of products—have to outperform a proliferation of like-minded competitors.

Adopting New Approaches

Medical-management executives have not been sitting idle. Over the years, they have continued to expand their tool kit, and today's portfolio of medical-management tools is the culmination of three generations of innovation. (See Exhibit 3.)

2. The following are among the influential publications that highlight this phenomenon: Institute of Medicine, *To Err Is Human: Building a Safer Health System,* ed. Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson (Washington: National Academies Press, 2000); Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington: National Academies Press, 2001); The Center for the Evaluative Clinical Sciences, Dartmouth Medical School, *The Dartmouth Atlas of Health Care,* ed. John E. Wennberg et al. (Chicago: American Hospital Publishing, 1996); and a Rand Health study by Elizabeth A. McGlynn et al., "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* 349 (2003): 1866–68.

Exhibit 3. Capabilities in Medical Management Have Evolved to Incorporate Third-Generation Tools



Source: BCG analysis.

The first-generation tools, which consist of direct interventions with *providers,* include prior authorization and precertification for procedures and hospitalizations, utilization reviews, and case management that coordinates care for complex treatments that span diseases and providers. Although those tools were established in the early days of medical management, they are currently attracting renewed interest. Today's marketplace is amenable to making new tradeoffs between choice and cost: tiered networks are emerging, for example, offering the lowest insurance copayments for the most cost-effective options. Similarly, utilization management is being applied more rigorously in the costliest areas—limiting, for example, the use of imaging and more tightly managing the use of specialty drugs.

Building on the success of provider-focused interventions, health plans crafted a second generation of tools focused on direct interventions with *patients.* To support those interventions, health plans drew on their own data to help get an integrated view of patients' health and derive new predictive analytics. The evolution of such capabilities continues, as we see in the expansion of disease management beyond chronically ill patients into "total population management." New tools that engage patients in person, such as health coaching and peer-to-peer programs in disease management, were also added to the tool kit.

Even though the first two generations of tools used expensive monitoring and direct engagement to manage medical choices, the health care system continued to suffer from rapidly escalating costs and variable quality. So a third generation of tools has emerged, with a much broader scope, improving the decision making of providers and patients by reshaping the system in which they operate. Ultimately, this third generation of tools shifts away from interventions and instead deploys incentives and information flows.

Under this new form of medical management, providers are rewarded not just for treating a high number of patients but also for treating patients *skillfully.* Similarly, patients are now given greater incentives—financial incentives—to adopt healthier behaviors. And finally, both patients and providers, by being better informed, are encouraged to use health care resources more appropriately.

Many of the third-generation tools are still prototypes. Those already being piloted or operated include patient reward programs; differential copayments; pay-for-performance programs, which award bonuses to providers who deliver high-quality care; and personal health records, which allow patients to keep track of their medical histories and share the information with providers.

Integrating at Many Levels for Optimal Medical Management

When they are running optimally, medical-management approaches collect the right information, convey it at the right point of intervention to the right decision maker—provider, patient, or payer—and offer effective incentives for making the right care decisions. The key to achieving this ideal is *integration.*

Most CMOs we interviewed agreed that the faster and better a health plan achieves such integration, the greater its competitive advantage in managing costs and quality—but there was little agreement on a precise definition of integration. In our interviews, we found that CMOs were using the term in at least three different senses: integrating data, integrating functions, and integrating health care delivery.

Integrating Data. The old, compartmentalized programs in medical management are reaching the limits of efficiency, and the differences between best-of-breed performance and the market average in a standalone program are shrinking. In the view of some CMOs, the next layer of value can emerge only from a different paradigm—one in which the program and the underlying data sets are integrated to develop more customized, coordinated approaches for reaching each individual member. Health plans hold enormous amounts of information about patients and providers. Most of

it is derived from claims, but patient information can also include some clinical data from labs and pharmacies, as well as self-reported data such as health risk assessments. Health plans that fully integrate those data by means of sophisticated analytics can identify gaps in a patient's care, identify optimal points for medical intervention, and segment the member base by risk.

In addition, such data integration can offer patients and providers better insight into what's at stake: the advantages of taking a differential diagnostic test for diabetes, for example. Some health plans, lacking capabilities for or interest in conducting this sort of integration in-house, will opt to rely on vendors. Others will want to move far beyond claims information, integrating detailed clinical information that will directly influence the practice of medicine. Most are working to promote the sharing of electronic health records among providers.

Integrating Functions. To create the incentives and information that third-generation tools rely on, health plans must align medical-management approaches with functions that have traditionally operated as silos, notably network design and product design. These functions determine a plan's approved providers and set copayments and coverage decisions, respectively. By integrating the functions with medical management, health plans might spur providers—through pay-for-performance programs or tiered networks—into becoming more cost-effective. And by tailoring various incentives, they might inspire patients to pursue healthier lifestyles.

Integrating Health Care Delivery. Historically, when reaching out to patients through direct interventions, health plans would ignore or circumvent providers. But some health plans today are looking for ways to enhance and leverage the power of the trusted provider-patient dialogue as part of their medical-management agenda. For example, they may now push to ensure that a patient's disease-management counseling is tightly coordinated with his or her primary-care physician.

Different CMOs value these three types of integration differently—and their evaluations drive their competitive strategies. Suppose, for example, that a CMO believes that health plans can—by overcoming patients' mistrust—significantly influence patients' decision making on such matters as adopting healthy behaviors and choosing between very different therapies. And suppose this same CMO believes that such decision making is the most effective way of containing medical costs. In such a case, he or she would invest in building an integrated view of patients' data—incorporating claims and lab data—to drive a very targeted deployment of coordinated capabilities for engaging patients and managing their conditions.

Now suppose that another CMO believes that health plans can significantly influence providers and, perhaps, even overcome the dominating influence of the Centers for Medicare & Medicaid Services (CMS) in defining operating practice. And suppose this CMO also believes that changing the way providers operate presents the highest-value opportunity. In this case, he or she would concentrate more on promoting the integration of clinical data through the sharing of electronic health records. The CMO would also place a heavy emphasis on integrating the network-contracting function with incentive schemes such as pay-for-performance programs, thereby ensuring alignment with medical-management objectives.

Despite all the rich actuarial data that health plans capture about their members, uncertainty persists regarding the current and future value of implementing various types of medical-management capabilities—even disease management and wellness programs—and, hence, the optimal form of integration. In the absence of a clear answer, CMOs can only place strategic bets.

Making the Leap from Parity to Competitive Differentiation

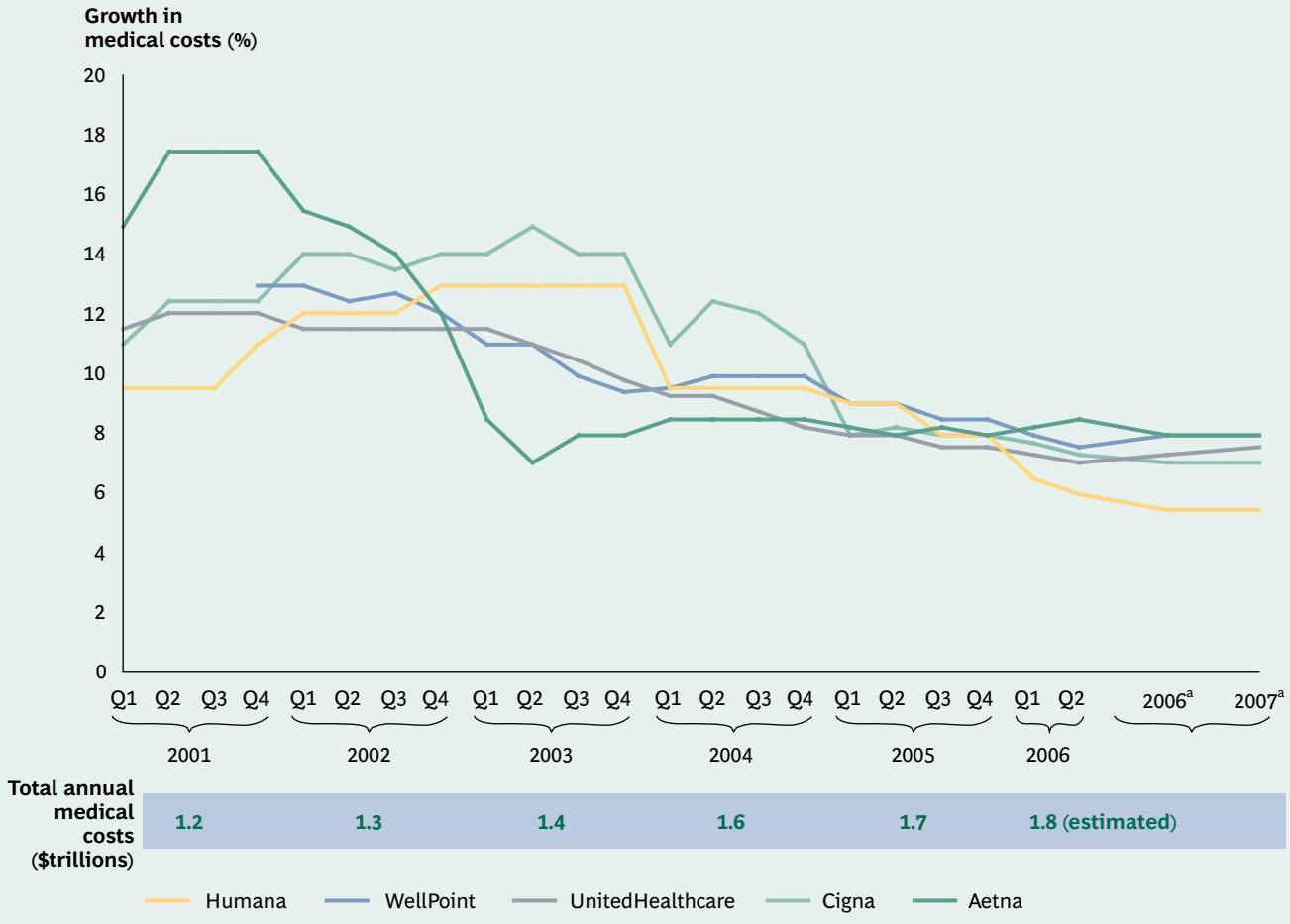
Superficially, at least, health plans often appear to offer very similar portfolios of medical-management capabilities. With every CMO being asked to contain growth in medical costs in an effective and differentiated way, intense competition is quickly

eroding any gains made by individual plans. (See Exhibit 4.) Furthermore, the community of brokers and benefits consultants is continually raising the table stakes for competition. In order to bid realistically for new business, health plans must maintain a broad array of capabilities so that they can "check the box" for each item on a long and ever-growing list of required offerings.

Beneath this apparent similarity, however, medical-management strategists differ widely on how best to meet the challenges of controlling medical costs and ensuring high quality. They grapple with the fundamentals that have shaped competition over the last decade: scale, regional share, product mix, and customer mix. Here we present a broad outline of the perspectives held by the different types of leading multiproduct health plans.

National Plans. At the nationals, CMOs operate on two key assumptions. First, they generally assume that the best way to manage medical costs is by improving patients' decision making. Second, they assume that health plans, even if they cannot access all the clinical data generated by providers, remain best positioned to serve as the core integrators of

Exhibit 4. Cost Increases Are Converging at Private U.S. Health Plans



Sources: Bear Stearns, *Managed Care: Outlook and Model Book,* March 2006; Lehman Brothers, *2007 Managed Care Guidebook,* January 2007; Centers for Medicare & Medicaid Services, *National Health Expenditure Data,* 2006, cms.hhs.gov/nationalhealthexpenddata.
[a]Estimates are based on data from Lehman Brothers.

health information. These two assumptions frame their strategy for optimizing information flows to members: seeking more effective ways to exploit the largely claims-based information they possess and gaining broader access to clinical information. Indeed, the ready availability of clinical information is becoming a major source of competitive advantage.

Overall, this strategy is aligned with the underlying operating model of the nationals, which possess scale, can afford the large IT investments required to integrate data, and can—at least in principle—engage consumers directly to empower them and gain their trust. But the operating model limits the nationals as well, because it keeps them from commanding a large enough share of individual markets to capture the attention of local providers. As a result, the nationals often can't engage or influence providers in differentiated or powerful ways, and they must either match the activities of other health plans or focus on reaching a specific set of providers such as narrow networks.

As part of their overarching strategy, the nationals are expanding the types of patient data they collect and fully integrating them. They are also insourcing critical capabilities that they had previously outsourced or lacked, such as pharmacy benefit management, specialty pharmacy programs, disease management, and behavior modification.

In addition, the nationals are concentrating intently on the third-generation tools in medical management—specifically on providing incentives and information on the patient side. They are therefore investing heavily in information delivery and plan design and in programs that create transparency on costs and quality. Tools such as personal health records can be invaluable for keeping patients informed about their health needs, and simple, standard benchmarks on quality can help steer patients to the most cost-effective providers. On the provider side, the nationals are striving to relay to providers more information about patients and recommended treatment regimes, thereby hoping to reduce inappropriately denied claims and improve the effectiveness of care.

Regional Plans. Unlike the nationals, the regionals lack the scale to undertake comparably major investments in IT systems. But they enjoy greater local market share and, in many cases, the legacy of shared success with providers. Both of those competitive advantages foster significantly closer relationships with physicians, hospitals, and other providers, which in turn make the regionals more sensitive to the providers' concerns and better positioned to persuade them to embrace improvements to the general health-care system.

Our interviews also revealed a clear division among the health plans, and we identified two distinct segments: *transformational regionals* and *reinforcing regionals.* Transformational regionals are health plans that actively work with providers to improve the broad performance of the health care system. By contrast, reinforcing regionals are not inclined to invest heavily or accept substantial business risk in order to transform the system; instead, they seem intent on working within the existing system to *reinforce* their first- and second-generation medical-management capabilities.

At the transformational regionals, providers are the key. In our interviews, the CMOs of these plans conceded that health care can, as the nationals contend, be improved by influencing patients' decision making. But they insisted that patients are influenced best when they are reached through a trusted doctor-patient relationship and also that it is the provider that has the most influence when it comes to transforming the health care system. At the same time, these CMOs told us that they were acutely conscious of the current gaps in quality among providers, and they doubted the ability of lower-quality providers to "transform" themselves unaided. They therefore questioned the efficacy of levers such as network tiering and transparency on provider performance, which are designed to drive volume to higher-quality providers. Although these levers expose quality gaps, they fail to address them. The reality, the CMOs explained, is that provider systems in their regions may simply be too fragmented to improve significantly. Or because higher-quality providers may already be working at full capacity, patients cannot navigate to them anyway.

Given their mindset, transformational regionals engage closely with providers on ways to improve care, placing an emphasis on building the third-generation medical-management capabilities that target providers. These joint efforts include helping to make clinical information transparent by engaging different stakeholders to collaborate on electronic health records. Such efforts are geared toward reducing inefficiencies and medical errors, and they enable providers to share best practices at a level of granularity that is clinically meaningful. In addition, the transformational regionals are exploring new payment structures that encourage improved performance and reward providers that deliver it. Such approaches would not diminish the health plans' collaborative engagement with providers in the way that tiered networks would, nor would they diminish transparency on quality for patients.

Because they concentrate on improving the quality of care delivered by providers, transformational regionals may appear altruistic. But competitive logic is at work here. Often they compete with niche players such as HMOs or integrated delivery systems, which have access to more tools for controlling costs. Transformational regionals can neutralize the competitive advantage of those rivals by improving the performance of all providers. Similarly, when competing with the nationals, transformational regionals can seek to overcome scale advantage by dramatically improving the cost-effectiveness and quality of the health care delivered by providers and tightening the network of relationships within their market.

The transformational regionals are well aware that they must keep pace with the nationals or, at the very least, defend against encroachments into their local markets. To succeed, they must therefore offer flexibility by giving employers the option of customized programs. They must also invest selectively to develop internal capabilities in medical management and must contract with vendors to supplement their capabilities, especially in services where scale is important.

Reinforcing regionals, by contrast, are typically smaller than their transformational counterparts and have correspondingly more modest ambitions. The CMOs of reinforcing regionals told us that they don't believe that a transformation of the health care system can be driven at the regional level. Or at least they don't believe that the health plans themselves have the scale or market share to drive that transformation. Instead, they believe that in light of the CMS's dominant role in shaping health care, improved medical care can be brought about only through efforts that engage all health-care stakeholders and span the entire United States.

What's more, the reinforcing regionals, many of which operate in more fragmented markets or have second-tier positioning, would not gain much by investing in systemwide improvement within their regions. Those that serve very few nationwide employers face almost no competitive threat from the nationals.

Their interest lies less in transforming the system than in reinforcing their current medical-management approaches, and they concentrate on the third form of integration—integrating health care delivery. That means that they seek to integrate providers into disease management programs, for example, and install health plan nurses in provider offices. If they invest at all in improving the quality of the overall health-care system, they tend to favor collaborative endeavors that target specific diseases. Their limited investments mirror the limited returns that they expect to realize from improvements in system quality.

Shifting from Managing Trends to Managing Strategic Uncertainty

How well the various health plans fare over the next five to seven years will be determined largely by the medical-management strategies they adopt now and the resulting investments they make. Of course, substantial uncertainties and open questions still hover over those strategies. We highlight the most critical unknowns below. Each one of these areas of uncertainty will influence the ulti-

mate success of the strategies and the health plans themselves.

- How accountable will patients be for their own care? How extensive a role will consumer-directed benefit designs play? If the impact of empowering consumers to make decisions about their health care is limited or ephemeral, the strategy of the nationals to contain the growth of health care costs might prove ineffectual, and the regionals will therefore find it easier to maintain parity or secure advantage.

- Can the transformational regionals really succeed in transforming the health care system? If they can and do, will they find ways to capture the full benefits deriving from their efforts, or will they have to share the benefits with the other payers in the system, including their competitors? Suppose that they do succeed in their transformational goal but don't succeed in creating a lower medical-cost trend relative to their competitors. They could then find that the competitors had gained the advantage by having invested in other capabilities, such as consumer empowerment, that can be deployed on top of the transformed system.

- Will the improved quality of health care slow the rise of medical costs? If so, over what time frame? Timing is critical in determining the reaction of employers. If, for example, costs continue to grow quickly, employers might seek ways to fundamentally shift the market. They might lean toward consumer-directed models or models with high deductibles. Or they might promote regulatory change. No matter which direction they choose, most likely it would be the nationals that benefit. If, on the other hand, the growth in medical costs is slowed successfully, employers would probably seek less disruptive solutions, and it would be the transformational regionals that benefit because their medical-management strategies depend less on changing patients' behaviors.

- To what extent will national stakeholder collaborations and public-sector initiatives change the landscape in which health plans operate? Specifically, how soon might we see results from national initiatives to improve quality and promote the use of IT in health care delivery? The more progress is made on a national level, the less effective the transformational regionals will be in their attempts to achieve differentiated gains in their service areas—and the more effective the nationals will be in empowering consumers.

- How will the capabilities of medical-management vendors evolve? Will they provide services that allow the regionals to maintain some parity with the nationals? Will medical-management vendors, through carve-out relationships with employers, increasingly compete with health plans, much as they do in the category of pharmacy benefit management? Over the past five years, these vendors have broadened their skill sets considerably. In many cases, in fact, they are more than just holding their own against the nationals: their capabilities are at the leading edge of the market. If the pace at which vendors develop their skills should stall or the number of vendors decline, however, the nationals will leverage their scale and pull ahead.

Because the uncertainties are interdependent and because employers' preferences are so crucial, health plans find themselves in a race to demonstrate effectiveness, shape employer preferences for benefit designs and types of health insurance partners, and bring about significant slowing in the increase of medical costs. Success will hinge not only on placing bold bets but also on executing effectively in the chosen areas of medical management. By managing the multiple drivers of costs and quality and by minimizing the risks, health plans stand their best chance of effecting a favorable outcome.

Still, no matter how prepared and flexible the health plans are or how confidently they place their bets, the only certainty for them is uncertainty, all the more so in such a fast-changing environment.

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