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by Sundar Subramanian and Joyjit Saha Choudhury

The market just keeps getting more competitive for U.S. health plans that cover Medicare Advantage (MA) patients. Most recently, the February 21 Advance Notice from the Centers for Medicaid and Medicare Services (CMS) implied a proposed reimbursement cut for MA patients of approximately 4 to 5 percent. That follows a 2014 reduction of about 4 percent.

Taken together, these cuts are consistent with a recent article we published about actions initiated through the Affordable Care Act to bring private MA costs down to Medicare fee-for-service (FFS) benchmark levels. This year's announcement indicates that the end state may be slightly better than expected, due to positive trends in fee-for-service costs. Looking ahead, cuts are expected to moderate in 2016 and beyond.

More broadly, these measures are the government's attempt to control the expanding health cost inflation plaguing the United States. Yet every cloud brings a silver lining, and the current challenges could be a tremendous growth opportunity for health plans that are "fit" enough to survive them.

As baby boomers retire, the number of people eligible for Medicare is expected to grow by some 3 percent a year, and we think growth will slightly exceed that rate. That's only half the story though. Given current constraints in the market, we expect that many unfocused and low-quality plans will either be acquired or exit the MA business, particularly small and mid-size payors. The emerging winners—those that gobble up the membership of the exiting plans—will fall into two categories: (1) larger players that can leverage their scale as an antidote to smaller margins, and (2) regional plans that have deep local provider relationships, which can give them a significant cost advantage in both medical care and administration.

In fact, the current dynamics in Medicare are effectively a preview of what will soon affect health insurers in all segments. We predict healthcare will continue to accelerate toward a "survival of the fittest" model in which three critical factors will separate the winners from the losers.

1. Innovation in the way that patients receive care. Success in MA might sound obvious. Payors need to control the total cost of care, maintain high quality scores, and assess risk accurately. Getting there, however, is a much tougher proposition, requiring that plans substantially increase their engagements with both consumers and care providers.

A stratified approach will be critical, as health insurers focus on those members that accrue disproportionate costs and adopt a "whole person care model" approach to help them better manage their health. In our research of leading care models across the country,

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we found that true population management involves five key areas that effectively influence consumer behavior and reduce avoidable medical costs. These dimensions include:

• an effective care coordinator that deals directly with the patient, integrates multidisciplinary teams, and develops personalized care plans;

• a supporting multidisciplinary healthcare team;

• care collaborators that are nonmedical entities, such as community groups and home aides that provide for the personal care needs;

• strong informatics that help plans identify and share actionable information; and

• incentive structures that align the different participants in the system, especially the providers.

The incentive component is critical and needs to happen through risk-sharing or value-based arrangements with providers. For these to be effective, payors must focus on providers that can create the most value. Payors must also ensure that arrangements are financially meaningful to all parties, and offer critical infrastructure support, such as analytics, care coordinators, and other features that can improve outcomes for patients.

For example, WellPoint's Caremore plans focused their efforts on the highest-cost populations—the frail and ill—and used multidisciplinary care teams to engage these populations. The result: Per capita costs are now 15 percent lower than the overall Medicare population, coupled with four-star quality ratings in California.

2. Using data-driven analytics to select markets and design consumer-centric products. Every U.S. county is unique—differing in terms of reimbursement levels, competitive dynamics, provider readiness for risk sharing and value-based arrangements, and consumer preferences, to name just a few factors. Sophisticated payors can sift through this data to prioritize counties based on the factors that truly impact their margins. In this new world, two factors are becoming critical. First, with the shift to value-based contracts, plans must understand provider readiness and their own ability to enable them at a local level. Second, payors need to quantify their local strengths as they relate to weaker competitors. Many smaller plans are expected to exit markets, and aggressive moves by top players can provide the needed push to rapidly gain the share that other plans will leave behind.

Beyond market selection, payors must understand consumer preferences in order to more effectively design each benefit and experience component (such as copays and network preferences). This is a very different approach to health insurance. Compared to other industries—such as consumer packaged goods manufacturers—health plans still lag in their understanding of consumer preferences and the corresponding implications on their product portfolio and margins.

But new tools are emerging to help. For instance, certain analytics tools allow payors to combine consumer preference research, risk analysis, and profit forecasts to help build and test products in a simulated market. Some of these tools rely on sophisticated techniques such as conjoint analysis, which consumer industries already use extensively. While this will be a big shift, the plans that use these tools effectively will be able to more analytically understand consumer preferences and make fact-based decisions that increase profitability.

3. Building a continuous improvement culture to enhance both compliance and quality. The third

factor is the way that the current objectives of many payors—such as achieving four-star ratings in the CMS Star system, complying with federal regulations, and reducing costs—will soon become table stakes. As a result, plans need to stop attempting the across-the-board cuts or improvements of yesterday and instead ruthlessly focus on optimizing the processes that have the highest impact on quality and compliance.

Leading insurers are already adopting this approach. For example, call-center effectiveness typically supports both quality and compliance goals, and we are seeing average performance for these measures improve above four-star thresholds. With lags in reporting, it is imperative that plans systematically work to improve their star ratings and enhance their operational compliance to ensure that they see the benefits by 2016.

Across all three of these factors, it's easy to spot the payors that are most threatened: those that offer low-quality services and/or unfocused strategies and investment approaches. In a "survival of the fittest" environment, their only viable choice will be to exit the market. Yet we think that some players have the attributes needed to thrive: local plans with deep provider relationships, and large insurers with scale. For these plans, the continued cuts in Medicare reimbursement present a growth opportunity—provided they take the necessary measures to seize it. ✚

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