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Predicts 2016: U.S. Healthcare Payers Are Challenged to Become Digital Health Payers

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Analyst(s): Robert H. Booz, Jeff Cribbs, Constance Sjoquist

Healthcare payers are faced with unprecedented regulatory mandates, cost constraints and customer engagement challenges. As the digital wave crashes over the payers, Gartner predicts they will face greater challenges around how to support new ways for consumers to seek, manage and pay for care.

Key Findings

- The demands on healthcare payers to innovate and redefine their value proposition are more acute now because of continued uncertainty about their future in the more regulated future.
- As consumers become more adept at managing their own health information, including the use of remote sensory devices, healthcare payers must strive to integrate broader data sources from both within and outside of the organization.
- Capitalization constraints and an inability to manage medical risk on new entrants to the healthcare payer space, whether from traditional models with new operations or payer provider convergent efforts, will not be successful.

Recommendations

Healthcare payer CIOs:

- Change the view of what constitutes how medical payments are made with a new generation of payment for anticipated care not just delivered or intended-to-be-delivered services.
- Make sure the information to which you want your members to have access is consumable to both payer-owned and third-party applications and devices.
- Reach out to the leaders of subrogation and coordination of benefits areas to integrate the Internet of Things as it relates to determinations of medical liability and medical necessity. This can involve the development of new bridges between different technology attributes, some of which may exist outside of the organization.

- Build better financial analysis support systems that recognize price competition is not sustainable unless significant savings can be realized by better medical management and administrative cost limits. New entrants cannot sustain underpricing to gain market share.

Strategic Planning Assumptions

By 2018, 25% of consumers will use a virtual assistant as a first consult in making medical decisions.

By 2018, "precision payment" will replace value-based contracting as the bleeding edge of payment reform.

By 2018, Internet of Things data will be admitted as case support in 20% of worker compensation medical or injury determinations.

By 2018, 75% of the healthcare plans newly licensed between 2013 and 2018 will fail.

By 2018, the role of payers as fiscal intermediaries will transition to a business model defined by broad information integration.

Analysis

What You Need to Know

The U.S. healthcare system is transforming rapidly with the adoption of the Affordable Care Act (ACA) and its many provisions. Seemingly at opposite ends of transformation, both the ACA and the shift from analog to digital business are challenging the U.S. healthcare system to discover new methods of conducting business. Payers are trying to develop new customer relationships and stronger bonds with the provider community. Healthcare payer CIOs must increase their influence within the enterprise, while still keeping their budgets in line. A key part of the challenge of becoming a digital payer will be discovering new methods of operations that integrate the greater flexibility of data analysis with more sources of data.

Healthcare payers have been moving forward with changing their medical loss ratios to a standard mandated by the government. In doing so, they have also met with greater efficiency in their administrative operations. This transition to a more effective healthcare economy is based on a model that is still largely retrospectively reimbursed. That is, payment is based on services that have been delivered with a traditional view toward paying based on past practice. The future of healthcare, however, is based on an economic model that rewards positive changes in healthcare status. This requires new ways of assessing and paying for risk. It also requires IT systems that are predictive, rather than reactive.

The emergence of new technologies also challenges healthcare payers. Digital business, which combines virtual business moments into a consolidated, immediate point of view of the user of the healthcare system, is decreasing the turnaround time on business operations. What was once a

weekly batch cycle is now an immediate response. Sales cycles move from annual enrollment to continuous monthly open enrollment. There is the need for quicker responses to consumer needs. It is necessary that healthcare payers lead the way in digitizing their day-to-day operations, an essential step toward the digital payer. The digital payer is, however, a much bigger proposition that involves the changing of standard operating methodologies to embrace a new way of doing business. This new way of doing business embraces technologies that are agile and react and even proactively predict and respond, to change market positions.

Healthcare payers that fail to transform to meet these new market conditions are likely to become irrelevant quickly. Gartner sees the need for complete revision of the way they do business in a very short three to five years. CIOs of these healthcare payers will be required to create new technology solutions for both existing business problems and soon-to-emerge digital payer challenges. We believe that payers and their CIOs will be challenged in ways that go beyond challenges created from the ACA.

One of the foremost changes that payers need to understand is how their IT organizations need to keep calm and go to bimodal. The bimodal organization has a set of attributes rooted in the legacy operations and maintenance of IT as they have traditionally existed. It also has a series of attributes related to agility and speed to market. While these two are not mutually exclusive, they are different enough that organizations can often struggle in determining the right way to go. In a digital world, speed to market and the ability to be agile and accept new business challenges are sources of market differentiation. We believe that day-to-day, traditional IT operations will enhance the organization and its administrative cost structure as well. CIOs must comfortably adapt to both the traditional and the agile as part of their day-to-day operations. Payer CIOs need to be willing to eliminate costly and ineffective legacy technologies that will not support future IT needs.

Gartner presents the following predictions for health payers and changes in the overall healthcare market.

Strategic Planning Assumptions

Strategic Planning Assumption: By 2018, 25% of consumers will use a virtual assistant as a first consult in making medical decisions.

Analysis by: Constance Sjoquist

Key Findings:

- Over 40% of consumers are dissatisfied with the communications they receive from payers, and 34% of consumers switch to another payer each year.
- Usage of next-generation self-service technology, such as smart machines and virtual personal assistants, will improve customer engagement and service issues.
- Eighty-four percent of payer decision makers viewed creating a comprehensive strategy for digital technologies — mobile, social, smart devices — as highly important.

Market Implications:

Healthcare payers continue to respond to the rise of the consumer as the purchaser and decision maker of health benefits and services by adopting digital solutions to guide and inform members along their health shopping and utilization journey. Payers are enabling mobile apps, click-to-chat customer support applications and online decision tools in an attempt to support and keep consumers loyal to their brand.

Yet consumers remain dissatisfied with the communications they get from payers (over 40%, according to an EY study) and switch insurers year over year at a rate of 34% (according to McKinsey & Co.). Younger consumers, in particular, are less loyal to brands, are price-sensitive and are willing to switch to payers who are easiest to do business with. They are a subset of a growing consumer population — one that is increasingly digitally focused, omnichannel and seeking out smart technologies to learn about, make decisions about, and with which to monitor healthcare and costs. Consumers seeking more proactive notifications and interactions than they are getting today from their health insurer will adopt the use of third-party mobile apps and online health tools to inform and advise them on their health decisions.

Gartner predicts that, in the next five years, 25% of consumers will use a smart virtual personal assistant (SVPA) from a nonpayer entity to help them proactively manage their healthcare and costs. SVPAs will blend the best of smart app technologies, smart advisors and virtual private assistants to collect, analyze and predict consumers' health needs. With opt-in allowance and personalization settings, SVPAs will utilize a consumer's demographic, social, behavioral, purchasing, payment and health data to remind, recommend and complete tasks on their behalf. SVPAs will amalgamate data from the consumer's larger health ecosystem, including data from payers, providers, care management vendors and the consumer's online footprint, as well as from other smart technologies, such as wearables (e.g., Fitbit or Apple Watch), medical devices (e.g., implants and medical monitors) and smart appliances.

Some definitions:

- **Smart apps** use hyperpersonalized mobile app experiences, services and knowledge extraction to increase personal and commercial information about consumers. Digital information is continuously collected about users so that the payer can proactively offer new products and services based on pattern recognition and other machine-learning approaches.
- **Smart advisors** (such as IBM Watson) are a class of smart machines that advises users about the state of operations, makes recommendations on the best decisions to make and/or gives the best answers to their questions.
- **Virtual private assistants** (such as Google's scheduling assistant) observe user content and behavior, and then build and maintain data models from which they draw inferences about people, content and contexts and predict users' needs.

Expect sophisticated and highly customized SVPAs to enter the healthcare market. As consumers bear increased responsibility for health costs and care decisions, they will seek out SVPAs that:

- Permit access to their personal electronic medical records.

- Collect and leverage their personal data from wearables, the Internet of Things and medical devices.
- Provide information and recommendations on health and wellness options.
- Offer exercise and diet regimens, and help them manage chronic conditions through treatment protocols and medication reminders.
- Capture more detailed health histories and give more sophisticated and personalized assistance.

Healthcare payers cannot expect to create a comprehensive and meaningful SVPA on their own. Since a high percentage of consumers switch plans each year, payers will need to prepare their data and IT to support SVPA providers that have the most influence on their members' healthcare decisions. At the same time, payers will need to beef up their smart technology capabilities and offerings to address customers' desire to embrace these technologies and to increase customers' satisfaction and loyalty.

Recommendations:

- Create data and information sharing links with the ecosystem of vendors that are likely to support or provide SVPA-like solutions to members and prospects.
- Be sensitive to consumer privacy, and give a fair exchange of value between access to user data and its eventual use in their experiences.
- Prioritize privacy and data policies in your customer relationship management, engagement and recommendation solutions.
- Offer personal assistance (schedule appointments, set reminders, check stocks, etc.) as a component of your mobile and online consumer applications.
- Embrace and interface with smart technologies (such as Fitbits, wearables and medical implants) that collect and utilize consumer health data and preferences.

Related Research:

"Virtual Personal Assistant Use Is Growing, but Usage Functions Are Still Limited"

"IT Strategists Must Prepare for the Rise of Virtual Personal Assistants in the Workplace"

"Hype Cycle for Smart Machines, 2015"

Strategic Planning Assumption: By 2018, "precision payment" will replace value-based contracting as the bleeding edge of payment reform.

Analysis by: Robert H. Booz, Jeff Cribbs

Key Findings:

- Precision medicine will fundamentally alter the institutions, vendor community, processes and technologies used in the payer industry to establish medical policy, authorize services and complete medical necessity review.
- As precision medicine gains traction in the delivery of care over the next 10 years, it will be necessary to develop a parallel in the financing of healthcare — precision payment.
- The gradual change from retrospective reimbursement mechanisms, typified by fee-for-service "reimbursement" and concurrent payment systems in value-based care, will move to prospective payment specific to a member's current and future medical needs.

Market Implications:

In 2015, precision medicine was added to "Hype Cycle for Healthcare Provider Applications, Analytics and Systems, 2015." It is defined as "an emerging approach for disease diagnosis, treatment and prevention that takes into account individual variability in genes, physiology, anatomy, environment and lifestyle." It was positioned as an embryonic, but transformational technology that will require 10 or more years to reach mainstream adoption among provider organizations. For providers, it offers a greater opportunity for personalized care integrating information specific to patients' clinical profiles, as well as their environmental and behavioral reality. This can include genomic test results and other unique identifiers from which care providers can design these individually specific diagnosis and treatment programs. It can equally include data collected from the Internet of Things that provides the real-world context for treatment decisions. It also includes the use of cognitive analytics embedded in "smart machine healthcare sages" that will give the assistance that providers need to assemble and interpret this deluge of information.

This presents both a challenge and opportunity for payers. As precision medicine gains traction, what we currently classify into thousands of disease and degeneration states will increase by orders of magnitude. The prevention and treatment of these states will similarly explode. Healthcare payers will find their processes and technologies for establishing medical policy, conducting claims billing, and managing utilization, pricing and payment inadequate to respond to new demands for clear medical care management that is unique to the individual.

As precision medicine takes hold, the direct relationship between medical services rendered and payment methodology becomes a bit more difficult to determine. Precision medicine, if combined with a new payer competency in precision payment, offers a new way of provisioning care that is appropriate to the individual, of high quality and financially effective. Treatments that are not necessary, are not aligned with the goals of the patient or that can cause unforeseen harm are diminished. Furthermore, the individual response to these improved healthcare delivery mechanisms is more attuned to a longer-term positive outcome. This offers payers an improved financial situation that is more specific to the individual.

With this, a move toward prospective payment based on cognitive skills, predictive testing (such as genomics) and intended medical outcomes all come together as a new way of delivering medical care. For payers, this will mean revision of existing payment mechanisms to make the gap between intended payment and services more closely linked. Precision medicine is still in the aspirational

phase of its development. It is conceptually a superior way of managing the care delivery side of medical care. Precision payment, on the other hand, is a reinforcing methodology that will facilitate the move to precision medicine by accurately evaluating the medical services that are both delivered and to be avoided. Both are in their infancy. We do, however, believe that precision medicine and precision payment are tied to each other in order to achieve the systemic changes that will improve the overall health and economics of the medical system.

Recommendations:

Healthcare payer CIOs should:

- Change their application's definition of what constitutes payment with methodologies addressing a new generation of payment for care delivered or intended to be delivered at a patient-specific level.
- Understand the efforts and adoption of precision medicine among the most utilized provider facilities in your provider network.
- Move the digital payer concept forward via advising business partners of the new methodologies of care prediction and delivery appropriate to precision medicine.

Related Research:

"Transitioning to Value-Based Care: A Technology Maturity Model for U.S. Healthcare Provider Organizations"

"The Emergence of Precision Algorithms in Healthcare"

Strategic Planning Assumption: By 2018, Internet of Things data will be admitted as case support in 20% of worker compensation medical or injury determinations.

Analysis by: Robert H. Booz

Key Findings:

- Healthcare payers will be more observant of services that might be considered as compensable by a third party, increasing subrogation information requests.
- Payer CIOs will be challenged to help put into place processes and procedures that will determine appropriate use of the Internet of Things to establish medical need on a real-time basis.

Market Implications:

The Internet of Things creates opportunities for healthcare payers to increase the speed of discovery of medically related compensable liability coverage impacting the accuracy of payment methodologies. The reporting capabilities of the Internet of Things give an immediacy to services

that might be considered by other insurance, such as workers' compensation. This creates the business opportunity for payers to have precise claims payment calculations using sources of information not traditionally considered by the insurance industry.

Health insurance is a fast payer ahead of any comprehensive determination of liability and workers' compensable payment. That is, the time between the date of service, date of receipt of the claim and final adjudication (including payment) is of relatively short duration — measured in days, not weeks or months. For many healthcare providers, the short duration offsets what is often payment below the billed amount. Determination of other liability, subrogation and related claims takes longer periods of time to adjudicate. Primary coverage must be determined services and must be reconciled to the diagnosis and procedures. Litigation may also be involved. There is a trade-off for providers between a faster, but lower payment versus a higher, but longer duration between care and payment. Health insurance companies are, therefore, concerned that services will be billed to it rather than the appropriate other liability insurance in place. Internet of Things technologies can help to alleviate any difference between compensable claims versus medical claims.

Robust reporting of medical conditions, as determined by real-time sensors, makes the determination of other liability much more possible. Moreover, the intelligent sensor, a physician, may also be incentivized by a rapid payment scenario in which the health insurer has greater leverage over a property and casualty insurance company because it has more information about the service. With that in mind, payers can increase their throughput rate with greater accuracy through the use of the Internet of Things.

The intervening adjudication step of comparing a reported diagnosis code to medical services delivered would be eliminated. The speed of the payment process would result in higher customer satisfaction rates.

Data collection is far more comprehensive and potentially more accurate in an Internet of Things world. This information can provide greater accuracy with which claims can be adjudicated. In the end, sensor-based systems can provide faster and more accurate determinations of claim policy. Technology will be able to augment human-based decision-making processes for greater consistency in a faster business environment.

Recommendations:

- Investigate the current state of sensor technology as it relates to determinations of medical liability and medical necessity. This can involve the development of new bridges between different technology attributes, some of which may exist outside of the organization.
- Work with business partners in creating appropriate determinations of liability to streamline transactional processes. This moves the organization from a strictly analog world to one in which there is greater data availability through digital designs.

Related Research:

"The Practicalities of Implementing IoT"

"How to Manage All Your IoT Endpoints"

Strategic Planning Assumption: By 2018, 75% of the healthcare plans newly licensed between 2013 and 2018 will fail.

Analysis by: Robert H. Booz

Key Findings:

- The ACA created funding for new market entrants to emerge. These cooperatives energetically pursued the public-exchange-based markets.
- Healthcare providers have assumed greater responsibility for insurance-style products, whether licensed and regulated health plans or risk-bearing entities, such as accountable care organizations and self-insurance networks.
- Creating and managing healthcare payer organizations is a complex process that integrates financial duties, care management activities and regulatory oversight; combining these capabilities requires experienced healthcare professionals.
- Significant member education and medical management are key elements of success.

Market Implications:

As the drive for new markets takes place, non-payer-based organizations are seeing the health payer market as a possible area of expansion. In some cases, this is a repackaging of capabilities that are largely identical to traditional insurance, but at different levels of service. It is a matter of understanding how and why organizations need to enter the market, and exploiting perceived gaps in product diversity and consumer appeal.

New market entrants over the past five years have been facilitated by funding from the ACA. The consumer-operated-and-run insurance companies, called co-ops and funded by the federal government, have been expected to be new competition for traditional health insurance companies. This early experiment in creating a different market has had mixed success. According to the inspector general of the U.S. Department of Health and Human Services (HHS), most enrolled fewer members than budgeted. He reported that all but one of the 23 co-ops lost money in 2014. As of this writing, some 10 co-ops have gone out of business. The attrition rate is high, and the market for these new entrants remains cloudy. The lesson here is that to try experiments in health insurance, you have to be big enough to be unprofitable for a while. Underpricing the market to gain share is not sustainable without significant reserves.

Gartner expects this trend of high attrition rate of co-ops in particular will have a significant dampening effect on other new entrants into the traditional health insurance marketplace. This will have multiple side effects for technology in the healthcare payer space. It will limit the market for new installations of products and services to these new health plans. There will be fewer vendors that can look to add products and services to the market space. Essentially, it will decrease their market opportunity.

One potential area of growth is the expansion of health insurance capabilities by existing healthcare providers. Whether these are licensed entities that compete directly with health insurance companies on their own terms or unlicensed, but risk-bearing organizations such as accountable care organizations or provider networks that accept consolidated payments, the end lesson is that there will be some competition from nontraditional sources that can be considered as new entrants' vertical integration between payer and provider has been shown to be successful (for example, Geisinger Health System, Kaiser Permanente, UPMC and SelectHealth) when there is significant overlap in the member/patient population. Significant member education and medical management are key elements of success.

Healthcare markets may not be able to support multiple, from-the-ground-up entrants to the market, will have positive organic growth, but also growth through merger and acquisition activities. Mergers and acquisitions create two baseline situations. First, the combined IT staffs are usually larger than are necessary for the new combined entity. Second, it will cut the prospective market for health insurance vendors. Taken together, we believe that the failure rate of new entrants, either due to the high cost of entry into the market or the combined buying power of larger entities lowering the cost and therefore requiring increased efficiency. Payer market consolidation can result in vendors trying to solidify their position in the face of a smaller number of prospective clients.

Recommendations:

Healthcare payer CIOs:

- Recognize that price competition is not sustainable unless significant savings can be realized by better utilization and administrative cost limits. New entrants cannot sustain underpricing to gain market share.
- Build IT strategic plans that are more agile in order to create competition on services and capabilities at market-competitive pricing. It is not just about price; service must also be integrated.
- Select technology vendors and business process outsourcing (BPO) partners that offer advanced capabilities to compete in a new market environment.

Strategic Planning Assumption: By 2018, the role of payers as fiscal intermediaries will transition to a business model defined by broad information integration.

Analysis by: Robert H. Booz

Key Findings:

- Healthcare payers have achieved initial competitive advantage and cost savings through leveraging technology for transaction-based processes.
- Growing availability of diverse data available both from within the payer through better analytics and outside of the payer from sources like the Internet of Things can be leveraged to create new value propositions.

- Information integration across payers, providers and others is essential to successfully managing costs, quality and access of healthcare services.

Market Implications:

Healthcare payers have long played the role of fiscal intermediary. The payer, for the payment of a premium, accepts and manages medical risk for an enrolled population. This acceptance of medical risk is then accompanied by payments to individuals or organizations for medical services. At its heart, this is a financially based, transaction-oriented model. Accordingly, it has been sufficient to fund industry growth through rising premiums, coupled with closely controlling administrative and medical expenses.

As the payment for healthcare services becomes value-based to organized medical delivery systems working to achieve quality outcomes, the value-add that was once created by health insurers in controlling costs is less important than bringing together the data needed to control those costs. Care management, risk analysis and underwriting, and claims administration are increasingly assumed as core competencies adding little economic value to the healthcare equation. With this, the healthcare payer must transition its value proposition to one that is less economically based and more knowledge-based.

The knowledge-based organization integrates technology with increased sources and uses of data to create a new value proposition. Drawing conclusions from an array of information gathered from both providers and the Internet of Things, healthcare payers will use their access to many data points from many sources to integrate information in ways that their fiscal intermediary predecessors could only dream of. The challenge for payers with this new opportunity will be to monetize the value of the information they gather. This can be through the containment of medical costs, the improvement of cost transparency and increasing customer satisfaction. With all of these attributes, payers can become stronger advocates for better healthcare while simultaneously measuring that healthcare expenditure.

As payers compete in the market based on information, their traditional business model must change to become information integrators. This creates a scenario in which they can capture from new sources of information data points that give new analyses and insights. Healthcare payers that rely on an enhanced fiscal intermediary position, utilizing better technologies, will be well-positioned to become the kind of information integrators that have a sustainable business value proposition.

Payers are actively pursuing technology not just as a competency, but also as a new product category. Led by such companies as UnitedHealth Group, with its Optum, and Aetna, with its Medicity products, payers will become more technology vendors than straight claims processors.

A big challenge for healthcare payers will involve the ability to adequately staff their IT departments with individuals skilled in the areas that demand agility and speed of change. Information analytics, big data and the cloud are all attributes that are, and will continue to be, in high demand. That said, skill sets in the traditional side of the business maintaining legacy applications will also be in demand as the retirements of long-term personnel cannot be replaced with individuals who are

either interested in or able to maintain legacy applications. This creates a near-term storm for payer CIOs as they look to manage a new type of IT responsibility for their organization.

Recommendations:

Healthcare payer CIOs:

- Create new staffing plans that reflect both the current personnel needs and succession plans for IT departments consistent with a strategic view of new technology needs. Include a clearer understanding of what applications need to be retired for logistics reasons.
- Increase funding for areas of data integration and management. Include cloud-based activities because access to new data information flows will come from nontraditional sources.
- Increase training and certification requirements to provide a steady stream of capable employees with the right mix of agile IT skills. Establish partnerships with colleges and universities for new talent and new BPO relationships for legacy applications.

A Look Back

In response to your requests, we are taking a look back at some key predictions from previous years. We have intentionally selected predictions from opposite ends of the scale — one where we were wholly or largely on target, as well as one we missed.

On Target: 2011 Prediction — By 2015, payers' transaction-focused business models will be insufficient for the postreform environment, requiring fundamental IT changes.

The transformation of healthcare payers has begun. Stage 1 of that process, moving away from transactions as a differentiator in the market, is typified by organizations that see BPO as a strategic, rather than tactical, goal. Interest in BPO is increasing and payers are utilizing vendors to provide what were once exclusive activities by a health plan. Additionally, the data needs of payers are expanding as their CIOs are charged with increasing their organizations' data footprint. We see this prediction as the initial stage of a much larger change in the way healthcare payers deal with the market.

Missed: 2013 Prediction — By 2016, 60% of health insureds will know in advance the procedure price and provider quality rating of shoppable medical services.

If only it were true. In 2013, there was a steady stream of announcements and technology investment that pointed toward a healthcare system where prices for medical services were readily available to the consumer seeking care. Anecdotal evidence suggests that the availability of pricing data has played out just as Gartner expected. Unfortunately, availability of pricing data does not equate to increased consumer knowledge — and consumer adoption of transparency tools has been painfully low. Gartner set out the path to remediation in our 2014 research, "Payer CIOs Must Enable the Next Generation of Medical Shopping Transparency," but, in 2013, we clearly missed on this prediction.

Gartner Recommended Reading

Some documents may not be available as part of your current Gartner subscription.

"A Digital World Requires Becoming a Digital Healthcare Payer"

"Virtual Personal Assistant Use Is Growing, but Usage Functions Are Still Limited"

"Hype Cycle for Smart Machines, 2015"

"Payer CIOs Must Enable the Next Generation of Medical Shopping Transparency"

"Hype Cycle for Healthcare Provider Applications, Analytics and Systems, 2015"

"Healthcare Payer Market Consolidation Brings CIOs to the Forefront of the Merger Team"

More on This Topic

This is part of an in-depth collection of research. See the collection:

- Predicts 2016: Algorithms Take Digital Business to the Next Level

GARTNER HEADQUARTERS

Corporate Headquarters
56 Top Gallant Road
Stamford, CT 06902-7700
USA
+1 203 964 0096

Regional Headquarters
AUSTRALIA
BRAZIL
JAPAN
UNITED KINGDOM

For a complete list of worldwide locations,
visit http://www.gartner.com/technology/about.jsp