

Health Care Reform Is Real. And Luck Favors the Prepared.

With the passage of the Affordable Health Care for America Act in the House on November 7, 2009, the nation witnessed the most historic health care events of our generation. The five-vote margin was surprisingly thin and serves as a barometer for the tough road ahead to passage of health care reform. As attention turns to the Senate, where vote margins are even tighter, expect the debate to reach a boiling point only to be exceeded by one of the most contentious House-Senate conference committee negotiations ever seen. While the timeline for passage may not meet the President's expectation of a year-end Rose Garden signing ceremony, we continue to believe it is very likely health care reform will become a reality by the next State of the Union address in late January 2010.

Sweeping change to this country's health care system and almost \$900 billion in new expenditures translates into a massive opportunity – but here, as always, luck will favor the prepared. With 25 to 35 million uninsured individuals set to gain access to health insurance coverage, forward thinking health plans need to swiftly execute an action plan. An early 2010 passage means a regulatory structure will be built in 2011-2012, with 2013 set for implementation of the program. That makes the next two years a critical time, much like during the early days of Medicare Advantage and Part D.

Acting early to gain in-market learning and establish a track record in the under-65 individual medical market will become a huge advantage. Competition within the new health insurance exchanges will revolve around commoditized offerings. Potential sponsors must be aware that this will be a price fight and a Year-One land grab extraordinaire, much like Medicare Part D. The lions' share of enrollment will accrue to the low cost plans. Success in the exchanges will require acute price sensitivity, strong brand, differentiated value features, and superior customer service. Operationally, health plan success factors will focus on administrative efficiency, comprehensive care management, adaptable technology, and diversified, cost-effective distribution channels with emphasis on sales over the Internet.

With many traditional risk management tools such as accept/reject medical underwriting and pre-existing condition exclusions no longer applicable, the playing field will become more level. Small and regional plans should not think they have to surrender this opportunity to mega-national plans. Strong local physician and hospital relationships structured around a collaborative payer-provider business model can be powerful leverage and enable smaller players to compete effectively against industry giants. However, caution will have to be exercised. There's a lot of unmet demand among today's uninsured population. Many will be seeing health coverage for the first time... others have either been rejected for coverage or are paying exorbitant premiums. One recent study found approximately 12.6 million adults applying for individual medical insurance either had their premiums rated-up, medical conditions excluded, or were flat-out denied coverage. Under reform, these consumers will be entering the market seeking health care services, not just insurance. Millions of new policyholders with uncontrolled chronic illness will present unprecedented challenges in care management for the first several years of the program. This highlights plans' need for a strong actuarial function to predict and manage cost of care, an aptitude in managing risk adjustment data collection and reporting, and aggressive medical management capabilities. All-in-all, community-based health plans can see resurgence under reform if they are prepared to act early.

Experience will also count as health plans define their health reform business plan. If Year One (2013) creates the ultimate price fight and land grab, then having claims experience in the under-65 individual market upon which to base bids could be a game-changer. That means getting started immediately and not taking a wait-and-see approach. Going forward, the regulatory framework and operational infrastructure will closely mirror Medicare Advantage (MA) and Prescription Drug Plans (PDP). Plans that have mastered Medicare's rules of engagement will certainly have a competitive edge—managing the regulatory maze, maintaining nimble product development capabilities, and well-honed individual-based marketing, sales and enrollment capacity. Expect to see these MA and PDP plans jump into the under-65 marketplace to leverage the roadmap they've refined over the past few years.

Of course, the Medicare market won't go untouched as Medicare cuts make up approximately one half of the financing for health reform. ***But let's be clear, health care reform does NOT mean the end of Medicare Advantage!*** The House phase-down approach to parity with Medicare fee-for-service for Medicare Advantage is likely to prevail, as opposed to the competitive bidding process proposed in the Senate bill. While not lethal to the industry – remember, Medicare plans were paid at 95 percent of fee-for-service in the 1990s and plenty were profitable – these cuts will have a significant impact. Expect to see an acceleration of MA and PDP plan consolidation. The bulk of exits will come from low membership plans, especially Special Needs Plans, where the lack of economies of scale can't sustain margins, and plans with borderline executive commitment to the senior market. Plans staying in the MA and PDP market for the long-haul need to confirm that the core “blocking and tackling” value chain components that have made them successful, remain current, compliant, and are thriving: revenue and enrollment management, member services, claims processing, chronic care management, provider network engagement, and senior-focused marketing and sales.

Even as some components of the House bill are negotiated away as the process continues, there are enough far-reaching changes to impact every citizen, every provider and every health plan: insurance exchanges, expanded Medicaid programs, Medicare reimbursement adjustments, individual and employer mandates, increased taxes, and a broad array of “adds & extras” (e.g., wellness and Long Term Care insurance incentives, PDP “doughnut hole” phase-out, age/sex premium restrictions).

With the health care reform end game in sight, now is the time to for health plans, providers, pharmaceutical companies and insurance service organizations to ask tough, introspective questions and make informed decisions about how to ***reform-proof*** strategic business plans. Many of those saying “let's wait to see the final legislation that comes out of Washington” are likely to fall behind their competition. Playing catch-up in such a complex environment is not easy. Survivors must anticipate change and react quickly in a reformed health care marketplace—“By failing to prepare, you are preparing to fail.”

DON'T MISS Gorman Health Group's executive briefing webinar and audio series on health care reform. To receive alerts, please send your contact information to ghg@gormanhealthgroup.com.

About Gorman Health Group (www.gormanhealthgroup.com)

The premier Medicare, health insurance and federal programs consultancy provides thought leadership, strategic insight and business solutions to the private sector. By leveraging extensive subject matter expertise and in-market learning, a team of former health plan executives and seasoned regulators brings clients the vision, technical acumen, and operational savvy to excel in competitive markets.