



## Five Macro Trends Driving Healthcare Industry Investment in 2011... and Beyond

Though healthcare reform remains a matter of political debate at the national and state levels, we have identified five broad industry trends that should hold true regardless of political maneuvers. These trends and their implications will strongly influence where and how healthcare ecosystem participants will invest business development and technology dollars this year and into 2012.

### 1 Trend 1: The Public-Sectorization of Healthcare in the U.S.

Government involvement and influence in health insurance markets and healthcare delivery is expanding dramatically. The Patient Protection and Affordable Care Act introduced sweeping provisions that will have a significant impact during the next 10 years and beyond.

The Patient Protection and Affordable Care Act affects all industry segments to varying degrees. While shifts in the political environment will affect healthcare reform's evolution and implementation, the overall impact of the act will be a significant increase in the government's role over all aspects of healthcare. It will influence supply and demand equilibrium within the healthcare system while driving significant changes in that system, including:

- **Health benefit exchanges.** Exchanges in each state are to be in place by 2014, with all participants offering four standard benefits packages. Insurance markets could be transformed as new business moves to these exchanges,

which could become an Orbitz or Travelocity model for healthcare. With the commoditization of insurance products, health plans on the exchanges will differentiate themselves through such measures as price, service, quality and breadth of network.

- **Minimum medical loss ratios (MLRs).** In a mandate to reduce administrative expenses, reform has reset MLRs to 85% for the large group market and 80% for the small group and individual markets. If unable to meet the MLR requirements, plans must refund a portion of premium dollars to members. Many individual and small-market plans are not meeting the new required MLRs. Doing so will require revamped cost structures.
- **Millions of new members.** Health reform will result in 32 million more Americans having insurance coverage. Individual membership will increase dramatically, from 11 million today to nearly 20 million, post-reform.
- **Medicaid expansion and growth.** Medicaid recipients will increase by more than 16 million new members. Revenue is likely to increase for Medicaid health plans, but margins on this new business will be low.
- **Medicare Advantage challenges.** Cuts in Medicare Advantage reimbursements will strain plan profitability and drive some plans out of this business. Medicare Advantage plans have about 11 million members today; post-reform, that number could decrease by 15%.



- **Accountable care organizations (ACOs).** These encompass a spectrum of models involving physicians, hospitals, payers and vendors, under a basic premise of sharing risks and rewards based on patient outcomes.
- **Administrative simplification.** If efficiencies are gained, these could be significant for both providers and plans. Yet implementation will be expensive and difficult, coinciding with ICD-10 remediation efforts and expenditures.
- **Risk adjustment in individual and small group commercial markets.** Insurers with higher risk will receive additional payments; those with lower risk will pay a penalty. These adjustments could have dramatic operational, revenue and profit implications for health plans.
- **Outcomes- and quality-based reimbursement.** The Patient-Centered Outcomes Research Institute, the CMS Innovation Center and the Independent Payment Advisory Board all share the mission of driving down cost trends and rewarding quality.

#### Cognizant's Perspective

Reform will reduce overall health industry profits. Only the most efficient plans will survive. Increased pressures on profitability will drive plans toward economies of scale, so consolidation and M&A activity among health plans and providers will intensify. Successful insurers will shift their attention from group to individual plans.

Remediating systems and applications to support new business requirements will require significant expense and may change technology roadmaps and timelines. Administrative simplification will transform basic trading partner interactions between plans and providers.

We will see renewed interest in transformation, outsourcing and/or virtualization of business processes and functions to drive efficiency and maintain profitability. Managed-care expertise will win the day as reform renews the business case for innovation centered on the core principles of managed care: improving quality, access, efficiency, patient centeredness, safety and cost containment.

## 2 Trend 2: Redistributing Accountability and Risk Across Payers, Providers and Consumers

Shifting risk from payers to providers and from groups to individuals is reshaping accountability and delivery models. New delivery models include ACOs and the Patient-Centered Medical Home. Financial risk is also shifting from health plans to providers, convergent with a move from episodic to continuous care. Related new reimbursement models and capitation are emerging, such as pay for performance, outcomes-based contracts, global pricing strategies and risk-based capitation.

A major question is how widespread and successful the adoption of ACOs will be. The Affordable Care Act includes a new Medicare shared savings program, to launch in 2012, that "promotes accountability for patient populations and coordinates items and services ... and encourages investment in infrastructure and redesigned care processes for high-quality and efficient service delivery." Many of the organizations that want to qualify as ACOs under the Medicare shared savings program have already begun preparations to do so.

Business models will change with ACOs. Expect new partnerships, acquisitions and/or mergers among healthcare payers and provider organizations by year's end. Another profound question is whether the advent of ACOs could mark the beginning of the end for today's health insurers by allowing employers to contract directly with providers for medical services, care management, wellness programs and cost control. ACOs also could have an impact on prescribing patterns.

The critical question is which entities will have the ultimate control within the ACO model. Developments to watch include the timing of payer investments in provider delivery models, as well as shifts among biopharma and life sciences companies, from pure vendor models to partnering with providers.

Accountability and insurance risk are shifting from groups to individuals. Member accountability is growing and being built into product designs such as value-based benefits. Value-based benefits encourage and reward members for such behaviors as appropriate use of high-value services, including certain prescription drugs and preventive services; healthy living, including quitting smoking and/or increasing

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exercise; and selecting high-performance providers who follow evidence-based treatment guidelines.

Incentives for members can include rewards, reduced premiums, adjustments to deductible and co-pay levels, as well as contributions to fund-based plans, such as a health savings account.

### Cognizant's Perspective

Providers and payers will focus on ACO planning in 2011 and begin implementation later this year and into 2012. The biggest challenges for ACOs will be managing patient populations, including retaining members and encouraging them to adopt healthy behaviors and make smart medical choices. If ACOs succeed, fee-for-service models will decline, and capitation-like payments could become the norm. The role of health plans as “infomediaries” will increase. As traditional insurance functions are delegated to ACO-like entities, plans will need to refocus on new value propositions.

ACOs will invest in clinical decision support and business intelligence tools to provide actionable information and alerts to support care management. The right infrastructure will be critical to ensure sustainability. Payers will leverage their infrastructure and technology investments to gain entrance to the ACO market. ACOs will need to invest in or partner for such services as customer relationship management and revenue cycle management and analytics capabilities and tools. “As a service” models and ACO-in-the-cloud offerings will emerge and gain traction in 2012.

Health organizations have new opportunities to work together to share financial risks and rewards. Combining the care management experience of providers, the analytics and risk management of payers and the outreach experience of the biopharma/life sciences industry will enable the creation of new entities among traditional players as ACOs grow.

### 3 Trend 3: Standardization, Commoditization and Transparency

Several forces are rapidly accelerating the standardization and commoditization of core processes across the health plan industry:

- **Industry-wide data and transaction standards adoption.** This not only enables greater interoperability, but it also increases process portability and automation.

- **The widespread acceptance and adoption of standardized, evidence-based medical care guidelines,** or EBM, for an expanding set of medical conditions. Evidence-based medical care guidelines are speeding the standardization and commoditization of components of the care management value chain, including predictive modeling, health risk assessment, stratification, quality reporting and outcomes measurement.
- **The regulation and standardization of health insurance products,** occurring as the industry migrates away from its traditional business-to-business focus on group insurance purchasing models, toward retail and business-to-consumer models for individuals making purchases via public health insurance exchanges.
- **Commoditization of product development, underwriting and rate quoting processes.** These trends will dramatically accelerate, fueled by the combination of standardized products and premium price transparency.
- **Increasing quality, cost and efficiency transparency** among providers. These views into provider results are available through performance networks, report cards and Web services such as Subimo, HealthGrades, etc.
- **Regulatory agencies and industry groups** accelerating, governing and institutionalizing transparency and standardization. Influencers include the Patient Centered Outcome Reimbursement Institute; CMS Innovation Center; the Independent Payment Advisory Board; and the Comparative Effectiveness Research Institute.

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### Cognizant's Perspective

Standardization and commoditization of processes will lead to increased virtualization in tandem with delocalization and disaggregation across the value chain. As standards expand beyond administrative data and business functions to encompass clinical activities, we will see the rapid emergence of software as a service (SaaS), platform as a service (PaaS) and knowledge as a service (KaaS) offerings in the market. The business case for health information exchanges will become clearer because the value of conductivity and data exchange will increase with the use of standardized data sets, clinical pathways, outcomes measurement, etc.

As these trends continue, health plans and health industry vendors can leverage lessons learned from the financial industry, namely that

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as processes were commoditized, a plethora of new solutions, products and services emerged. Health plans will be driven to distinguish themselves based on service, brand and quality.

Standardization, commoditization and transparency also will contribute to the creation of the IT-enabled economy. Those stakeholders who can quickly exploit automation and business

solution opportunities will be best positioned for accelerated growth in the coming decade.

#### **4 Trend 4: Emergence of Cloud Solutions and “Anything as a Service” Business Models**

Rapidly evolving technology – including mobility, social computing, broadband and cloud-based computing models – are enabling corporate IT to transition to a new architecture. However, the healthcare industry’s flexibility to adapt to a quickly changing environment is significantly

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hampered by heavy on-premise, often customized, CRM and RCM implementations.

The emerging technologies with the greatest disruptive capacity in 2011 and beyond include cloud computing and telemedicine/tele-health. In addition, healthcare “unwired,” or new business models delivering

care anywhere, will rise, aided by the proliferation of mobile health applications to collect and send vital signs from wireless and wired remote patient and personal health monitoring devices.

The combined healthcare reform factors of new customers, revamped costs and improved medical loss ratio performance will drive healthcare payers to new technology models that promise greater flexibility and cost control. These include virtualization of processes (the

“anywhere, anytime worker”) and business models (anything as a service), concurrent with a decreased emphasis on asset ownership and increased reliance on third-party specialists.

Healthcare payer technology vendors have been active in acquiring or partnering to position core applications as BPO platforms (and vice versa, with BPO players investing in platforms), while large vendors are renewing BPO investments and strategies to meet surging market interest.

#### **Cognizant’s Perspective**

Most providers will explore IT as a service this year and next. Electronic health records as a service will attract particular attention because timelines for American Recovery and Reinvestment Act (ARRA) implementations are growing short, and the majority of U.S. physician practices have five or fewer providers and little to no in-house IT capability.

The proliferation of telepresence and wireless and wired mobile health applications will significantly change how patients, providers and care managers interact. For example, millennials, who have essentially been raised using the Internet, mobile devices and social networking tools, will expect to interact with the healthcare ecosystem in the same way that they interact with all of their other service providers: through Web sites and portals, via e-mail, using smartphone and tablet PC applications.

Healthcare stakeholders will turn to cloud computing solutions to address concerns about scalability, availability and security. Mobile devices and consumer connectivity will create new security challenges for CIOs. Virtual ACO solutions will proliferate to provide necessary technology to these new entities. Expect “ACO in a box” offerings from IT consultancies, as well as software vendors.

Cloud-based platforms and new IT as a service models will fundamentally change the software, service and hardware business equations and create opportunities for new players to enter the industry. For example, cloud technology, combined with advances in mobility and telepresence solutions, will create new unwired business models capable of providing care anywhere. This will allow new entrants to leapfrog brick-and-mortar and go directly to virtual integrated models of care delivery.

## 5 Trend 5: Consolidation, Diversification and Collaboration

Lines will blur between provider and payer sectors as they formulate post-reform strategies. Players throughout the health industry have new opportunities to combine their expertise, sharing financial risks and rewards as they develop new solutions.

These activities include business portfolio realignment, with companies expanding services beyond their core offerings. This includes leveraging existing assets and capabilities in international markets. It also involves the expansion of service lines, with health plans offering disease management or case management services, claims processing services and/or business and IT consulting services. Health organizations are acquiring software companies for revenue growth and service expansion, along the care continuum.

This activity could traverse unlikely terrain, as suppliers buy providers, health plans team up with providers, and pharma and life sciences companies enter more service markets along the care pathway.

Transaction activity in all health sectors is on an upward trend that will continue throughout the year. Mergers and acquisitions will bond familiar industry names, as well as unfamiliar entities, as organizations fill their strategic gaps.

### Cognizant's Perspective

Vertical market mergers and acquisitions will

dominate the healthcare market into 2012. Health plans and stakeholders that can accommodate new business models effectively and rapidly will be rewarded. Agility will drive sustainability and profitability. Integration competencies will be paramount. Payers and other health industry stakeholders will need to be proficient at quickly launching and absorbing new lines of business. Services will expand; for example, health plans will offer new disease management/case management services or IT services to create new revenue channels.

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Healthcare payers will acquire technologies and software companies to develop new revenue sources. More health plans will differentiate themselves based on their solutions and outcomes, enabled by technology and application ownership. Payers will acquire provider technology platforms and applications to speed up vertical integration, further blurring the lines between payers and providers. Plans will tap existing IT assets and cost centers to drive new revenue opportunities, including those in international markets.

Adaptive, agile health plan business models that can accommodate accelerated transformation through rapid-cycle change management, innovation and virtualization will be best positioned for post-reform opportunities.

## About the Authors

*Bill Shea is an Assistant Vice President within Cognizant Business Consulting's Healthcare Practice. He can be reached at [William.Shea@cognizant.com](mailto:William.Shea@cognizant.com).*

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### World Headquarters

500 Frank W. Burr Blvd.  
Teaneck, NJ 07666 USA  
Phone: +1 201 801 0233  
Fax: +1 201 801 0243  
Toll Free: +1 888 937 3277  
Email: [inquiry@cognizant.com](mailto:inquiry@cognizant.com)

### European Headquarters

Haymarket House  
28-29 Haymarket  
London SW1Y 4SP UK  
Phone: +44 (0) 20 7321 4888  
Fax: +44 (0) 20 7321 4890  
Email: [infouk@cognizant.com](mailto:infouk@cognizant.com)

### India Operations Headquarters

#5/535, Old Mahabalipuram Road  
Okkiyam Pettai, Thoraiakkam  
Chennai, 600 096 India  
Phone: +91 (0) 44 4209 6000  
Fax: +91 (0) 44 4209 6060  
Email: [inquiryindia@cognizant.com](mailto:inquiryindia@cognizant.com)