

Where Are Health Plans Heading in 2009? America's Health Insurance Plans (AHIP) Annual Conference Review A Summary June, 2009

Once again, we attended America's Health Insurance Plan's (AHIP) annual convention to get an assessment of where one of the past "drivers" of this industry is heading. This year's event was held in San Diego and you could probably guess the main topic of discussion.

Last year there was some mild talk about the possibility of health care reform, but nobody thought much would become of it. Most didn't really expect much (if any) government interest in taking on health care as an issue considering everything else that was going on. We were in the middle of all of the elections and everybody was throwing around ideas about a lot of things; most of the time without much thought or details behind them. We were dealing with escalating gas prices so our energy policy discussions were rising on the agenda. The wars in Iraq and Afghanistan were still out there. We were just a short time away from the collapse of our first financial institution that proved to be the beginning of the economic event we're experiencing today. The health care discussions were actually pretty general and involved technology needs, value-based purchasing, wellness/prevention, and others; but the thought of a major reform of our system looked like it was way off in the distance. There was no sense of urgency.

The following provides some of the primary themes that were discussed at AHIP 2009. We tried to provide a brief review of the key topics we heard to give you with an idea of where the health plan/payer market may be heading. (You can check out our blog at <http://www.collaborationhealthcare.blogspot.com> for some of our daily thoughts and comments from the conference.)

Without a doubt, health care reform was the primary topic on the minds of the health plans this year. The debate is about to become intense and proposals are now being developed and floated in Congress. Very soon we're going to start to see the direction the health care system is going to take. And, hearing how we're going to pay for it.

As usual, we tried to stay out of the politics as much as we could here. That said, we will continue to maintain our position that "something needs to change" so we may be biased in that regard. Continuing to operate with the status quo is not an option. As several of the speakers on both sides of the discussion stated at the conference, "our current health care system is both morally and economically unsustainable". We've always said it's going to be up to all of the stakeholders working together better than in the past to successfully change a system that needs to change. It looks like now is the time.

The Main Issue At The Conference- Health Care Reform

Many stakeholders are justifiably concerned with the shape health care reform will take when it arrives. As has occurred in each debate about health care in this country for the past 100 years, the major question is boiling down to the right balance between allowing a private market to operate, and injecting public direction in delivering and financing health care services to our citizens. Everyone agrees that the current model is broken- but the issue is going to boil down to what combination of the two will work to fix what we have today. And next, how are we going to pay for it.

While there are many issues that need to be addressed, one of the decisive is focused on the need or desire to include or not include a "public option" into our overall delivery structure. Just to be fair, there are valid and compelling arguments on both sides of this issue. One side argues for more competition and providing a safety-net for those falling through the cracks; the other side argues against any more government intervention and especially against government-created competition in a system that should be dictated by the free market. And, we also have to figure out how to pay for it either way.

Regardless of the final outcome, this debate is going to influence the business strategies of all stakeholders as it evolves. The discussions that will be taking place will hopefully result in changes in the relationships and interactions between the different players regardless of the inclusion of a public option or not-- the current fragmented approach just simply no longer works and needs to change.

You can already see some of the changes in relationships occurring. Nancy Neilsen M.D. President of the American Medical Association, and Tom Priselac, Chairman of the American Hospital Association addressed the health plan participants in a keynote session on the closing day. We doubt whether this would have happened in the past. We were encouraged by their frequent use of the word “collaboration” as a means to define the relationships that will be expected in the future. Regardless of the initial motivation, these groups have recognized that working together is more likely to achieve win/win results than working in silos or isolation as has been the operating method of the past. Don’t get us wrong, the organizations are not “buddies for life” or singing Kumbayah around the campfire. But, it’s a start. The effort shows that when different groups focus on a common mission and goal, some good things can happen.

Some Other Themes

Deal With Access and Cost Together- Not Separate

Somewhat related to the reform discussion was the continued emphasis on the need to focus both on access as well as cost when discussing any health care policies and potential solutions. Massachusetts is another perfect example of a program that tried to focus on half of it (access; which has been very successful) while neglecting the methods to address costs up-front. The Massachusetts model is struggling financially and is going to take some work to fix it. Before we hold up Massachusetts as an example we may want to replicate nationally, we’ll need to make sure we’ve got the cost component side of the equation addressed as well.

Comparative Effectiveness Research

Evidence-based, comparative effectiveness, best-practices, outcomes measurement, and value-based were all terms used repeatedly regarding the clinical results expected of the health care system. Most of these terms were bantered-about last year but this year they received a higher level of attention. We expect the policies and processes that are going to be put in place to focus much more directly on “what works and what’s the cost?” Reimbursement strategies and care delivery structures will begin to shift from the current fee-for-service methods to methods that are much more focused on outcomes and results- and the services that have demonstrated their value will be getting the attention. All of this discussion was wrapped around the evolving concepts of Medical Homes, Health Homes, Accountable Delivery Systems, Health Coops, etc. as methods of delivering care in the future. Things are going to be a little different than they are today.

Determining “value” is going to be the name of the game. And, defining value creates a significant challenge for many stakeholders in the system today. If services don’t have a quantifiable value, they probably won’t be at the table in this reform discussion.

Health, Wellness, and Prevention

There is a general consensus that our health care system needs to change from the current “disease model” to one of wellness, consumerism, and prevention. We’ve heard this for the past few years at this conference, but this year (once again) there seemed to be more serious discussion about its application in a new health care paradigm. This change in focus will require a huge cultural shift not only for the consumers but for virtually all stakeholders participating in our health care system today. We’re going to need to develop some new models. There was a lot of discussion concerning the use of incentives and other methods to direct the behaviors of consumers-and there was some fascinating lessons shared on how to communicate with consumers in the first place. With such a large percentage of our total health care costs related to lifestyle-behaviors, our system has got to figure out a way to get consumers engaged, and become part of the solution. We’re getting there- but have a long ways to go.

Technology

It’s safe to say that the technological vision of the health care industry is to become paperless and electronic. At least that’s the vision- here again; we have a long ways to go.

Deloitte’s Center for Health Solutions presented an idea arguing that until we have the technological platform throughout the health care industry to allow a diverse group of stakeholders to communicate together, share information, and transact business, many of the other wants and needs we’ve identified may have to wait. How can we integrate, if we can’t even share information?

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Most of the “buzz” in technology has been centered around using Electronic Medical Records for collecting data and sharing clinical information but the technology segment is also facing other pretty significant “transactional challenges” (CPT coding, HIPAA 5010) that will take time and resources. (Great career opportunities in Health Care IT)

Suffice it to say, health plans and payers are going to be looking for any innovations or ideas that will squeeze inefficiency out of the system we have today. The challenge is going to continue to be to try to get a monstrous, independent, and fragmented system talking the same language so we only have to go through this once.

Wrap-Up

Within the next few weeks we’re going to start to see some of the initial proposals to re-design the health care system in this country. We all know it needs to happen, as what we have today simply doesn’t work and is not sustainable over the long-term. Regardless of including a “public plan” in the mix or not (which will likely be the primary debate as well as how to pay for it all); the focus of the industry in 2009 will be on a few fundamental but very complex areas that need to be addressed:

1. Redesigning the delivery of health care models to focus on outcomes, results, and performance (away from the traditional fee-for-service models).
2. Defining, measuring, and delivering value for the health care services provided
3. Moving from a “sickness system” to a wellness/prevention focus
4. Creating a common technology structure to improve efficiency, communication, and interaction between multiple stakeholders
5. Getting the consumer- the individual- engaged in the system
6. Figuring out we pay for it? (Big, Big, Big, Issue)

As we stated at the beginning, we also see the relationships between stakeholders changing dramatically as a result of the process. Health plans will be working more closely with provider groups, provider groups more closely with employers, and everyone focusing more directly on the individual health care consumer. This has been needed for a long time. Assessing, developing, and maintaining these relationships will be a key component for participating in the health care system that will be evolving. We saw it starting with the AMA and AHA participation in a health plan event this year. We are hoping to see collaboration and expanded relationships continue to spread throughout the health care landscape to the many other segments that exist.

That’s what collaboration is all about- but you have to be at the table in the first place in order to collaborate with the rest.