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Winning in Post-  
Reform Healthcare  
*What Insurers  
Can Do Today*



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**Contact Information**

**Chicago**

**Ashish Kaura**

Principal  
+1-312-578-4838  
ashish.kaura@booz.com

**New York**

**David G. Knott**

Partner  
+1-212-551-6541  
david.knott@booz.com

**San Francisco**

**Melanie Nallicheri**

Partner  
+1-415-263-3704  
melanie.nallicheri@booz.com

**Vishal Lall**

Principal  
+1-415-627-4212  
vishal.lall@booz.com

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## EXECUTIVE SUMMARY

*Since early 2009, the debate surrounding healthcare reform has occupied Congress and, arguably, the rest of the United States. Private insurers, who represent some of the primary stakeholders affected by legislative proposals, have spent considerable time and resources attempting to shape and influence the debate. At the same time, many insurers have felt severely constrained, even paralyzed, by the uncertainty the reform debate has created, and by the potential disruption to the insurance industry.*

As reform legislation comes closer to critical votes, insurers should start refining their long-term strategies to take advantage of potential opportunities and to mitigate potential risks and challenges in a post-reform world. Under any plausible scenario, the reforms will create a new set of winners and losers. Some insurers may already be better situated than others to win, given their current market position and book of business. But success will accrue to those insurers that can quickly seize the moment, mobilizing their resources and building the necessary capabilities to not only survive but succeed in post-reform healthcare.

Looking ahead, many insurers will find that post-reform success entails a reorientation of their business and a focus on four core strategic imperatives: refine “individual segment” strategies to target an expanded individual market; refresh strategies for dealing with government segments at both the federal level and the state level; strengthen administrative capabilities to serve and retain the new member base; and drive and demonstrate healthcare value by helping to reduce costs and enhance quality as long-term delivery system reform unfolds.

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## THE CRITICAL POINTS OF DEBATE

As the healthcare debate rages on, there is growing clarity and general agreement with respect to some elements of the ultimate reform environment. These include the likelihood of restrictions being placed on private insurance (for example, guaranteed coverage, standardized levels of benefits, and rating guidelines); expansion of Medicaid; and new national or state insurance exchanges (online mechanisms that will allow individuals and small businesses to compare and purchase healthcare plans). Although the strength of the legislation's carrots and sticks—the financial incentives designed to encourage individuals to enroll in a plan—is not yet clear, newcomers are projected to enter the market as individual healthcare insurance purchasers and through the expanded Medicaid program. According to Booz & Company estimates, with appropriately structured individual mandates, health insurance exchanges to provide access, and some migration from employer-sponsored insurance, the individual

segment is likely to increase by at least 25 percent and perhaps more than 100 percent, growing to a potential total of 35 million consumers (from 15 million today). In addition, the number of Medicaid enrollees could grow by as much as 40 percent as the eligible uninsured are absorbed into the expanded program.

In the meantime, a variety of other reform elements are still being debated, any of which would be disruptive for private health insurance. One major area of disagreement is potential sources of funding, which could include a surplus tax on the wealthy, taxes on high-premium insurance products, or annual stakeholder fees. Another significant issue for insurers is the proposed reform to Medicare Advantage payments. And two of the most critical open issues are the strength of individual mandates requiring consumers to purchase insurance and the structure of a potential government plan.

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A weakened individual mandate will present additional challenges to private insurers. The proposed legislation constrains insurers' ability to underwrite and requires them to accept all beneficiaries regardless of preexisting conditions. When the debate over healthcare reform began in earnest, insurers expected that these limitations would be counterbalanced by strong individual mandates, which would expand the insured pool in a balanced manner by pulling the healthy uninsured population into the system. Without such mandates, insurers would face increased financial challenges, espe-

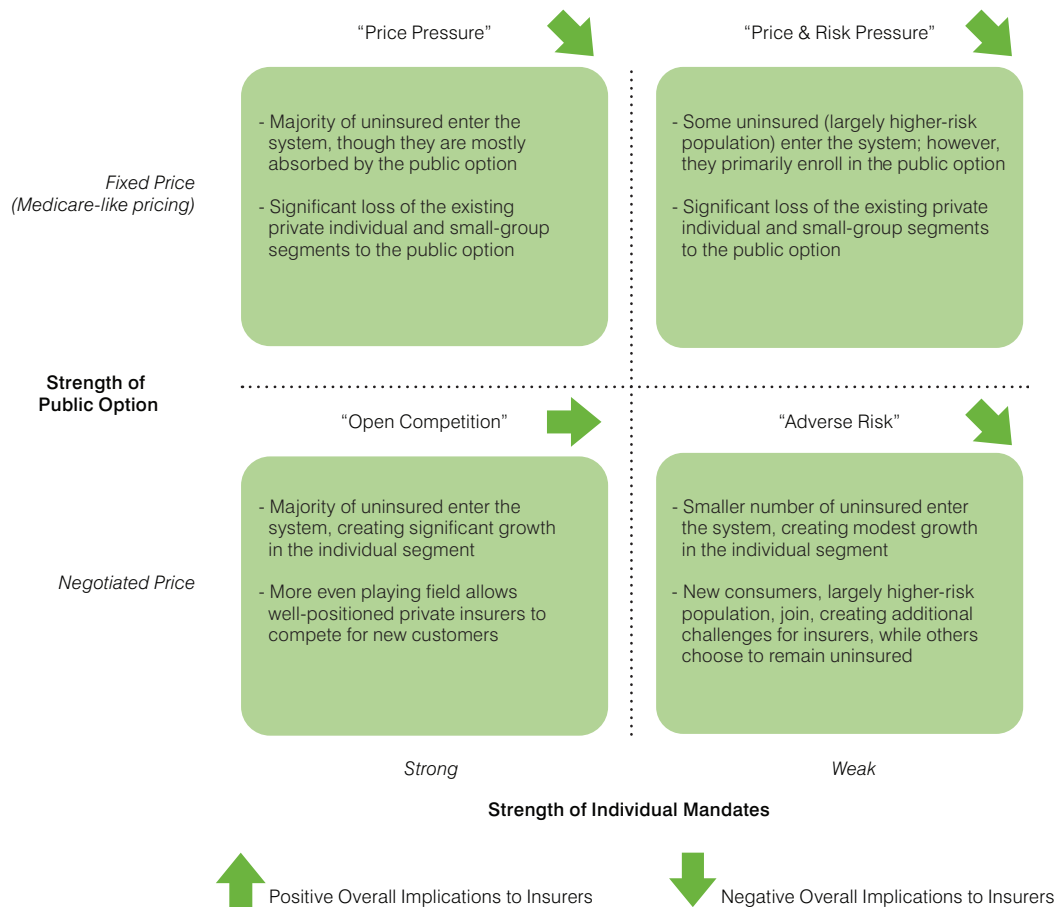
cially because high-risk individuals would be more likely than the healthiest ones to join the risk pool.

In addition, most private insurers have been gravely concerned about a full-scale public option. Indeed, the economic repercussions of a price-advantaged, Medicare-like public option could be significant for an insurer. Other alternatives under consideration would likely not create as large a disruption. For instance, one alternative public option would require the government to negotiate prices with healthcare providers, thus forcing it to compete on a level

playing field with private insurers, and making it more difficult for the government to gain a strong foothold in many markets. Likewise, state-based cooperatives, an approach proposed as an alternative to the public option, might struggle to compete, achieve sufficient scale, and gain access to capital.

With these two significant reform elements—the strength of individual mandates and the structure of a potential government plan—in mind, we can envision four potential reform scenarios (see Exhibit 1).

**Exhibit 1**  
**Potential Reform Scenarios**



Source: Booz & Company analysis

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Under these constraints, the best-case scenario for private insurers is likely a public option that requires public plans to negotiate with providers, coupled with strong individual mandates. Though still challenging for private insurers, this scenario would allow the stronger companies among them to compete on a more even playing field, while providing the right disincentives for the uninsured to remain outside the system.

The worst-case scenario for any insurer would be the establishment of a public option with Medicare-like pricing. An aggressively priced public plan could absorb most of the uninsured who choose to enter the system, while attracting current insured members from private plans—disrupting the ongoing business of private plans, especially those that are more exposed to individuals and small groups. That said, uncertainty with respect to the strength

of proposed individual mandates and potential consumer response to any mandate makes it unclear which individuals a mandate would bring into the market. A weakened individual mandate might limit the number of new members or attract only the highest-risk individuals to the system. If all high-risk individuals were attracted to an aggressively priced public option, it would leave the public option holding a disproportionate share of the highest-risk individual population.

Current insurers are not all equally vulnerable to these risks, because their existing business mixes and capabilities vary. For instance, insurers with a presence in the Medicaid business today are probably well positioned to benefit from that segment's projected growth. Similarly, insurers with a strong position in larger-sized groups, such as national private insurers, are less likely to be hurt by the individual market's

volatility or by a public option. Conversely, insurers that primarily cater to the individual and small-group market, although well positioned to take advantage of growth in these segments, are exposed to risks if these segments' margins shrink because of greater transparency requirements and increased competition within the context of new exchanges, especially with a public option.

Some leading insurers are already starting to lay the foundation for a post-reform world. They are developing the essential strategies and capabilities to mitigate risks and take advantage of emerging opportunities. However, many other insurers have been heavily focused on influencing the debate and have paid insufficient attention to scenario planning and preparing for concrete action.

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## SURE STEPS IN AN UNCERTAIN ENVIRONMENT

As the insurance industry moves toward a post-reform world, the sources of competitive advantage will shift dramatically. Scale and operating excellence will become more important as insurer margins are squeezed and capital becomes constrained. Retail capabilities, brand, and share of wallet will also become increasingly significant, especially as the industry moves toward a more individual-oriented marketplace. Finally, care management will become an even more important source of competitive advantage as consumers look for differentiated healthcare value. In order to get ahead of the competition and build the capabilities to succeed, insurers should focus on four core imperatives:

**1. Refine “individual segment” strategies to target an expanded individual market.** With up to 20 million new members entering the market, the shift toward a more

individual-oriented environment will accelerate. Insurers will need to invest in developing innovative consumer-centric capabilities and tools to cater to more sophisticated and informed consumers. However, some smaller insurers may decide to exit the individual market altogether, if mandates are weak and they do not have an advantaged position in that segment, in order to avoid the risk and focus on other core businesses.

To take advantage of the growing individual market, insurers will need to understand the role of insurance exchanges and evolving consumer needs. If exchanges exist, they will provide increased transparency and access for consumers. Within the exchange, insurance products will be grouped into a set of three or four standard tiers based on actuarial value for easier comparisons. Intermediation costs will be dramatically reduced as consumers bypass brokers. Ultimately, exchanges will shift the balance of power in favor of consumers, providing an array of choices and creating head-to-head competition among insurers. Consumers will benefit from lower switching costs, increased choice, and improved information upon which to base their decisions.

In response, insurers will need to deepen their retail capabilities and adopt a more sophisticated consumer lifetime value business model, similar to that in the financial-services industry. Moreover, insurers will need to reevaluate their consumer targeting strategies, while seeking ways to lower acquisition costs and increase retention of target segments. This will require a renewed focus on product cross-selling and on building consumer lifetime loyalty as a means of enhancing profitability, especially within the context of a transparent, price-competitive, exchange-driven marketplace.

Improved consumer understanding, novel segmentation approaches, and enhanced analytics are key capabilities that will be critical in the future to effectively target and attract individual sub-segments. Marketing and communication will need to differentiate products beyond price. Product innovation and new, leaner retail sales models, as well as value-added services for certain segments (such as guaranteed same-day appointments), will be required to cater to growing individual needs and more informed consumers. Indeed, leading insurers have already begun experimenting with different segmentation

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and product approaches, including investing in micro-segmentation and marketing analytics, modular product structure, and consumer decision-support tools.

**2. Refresh strategy for dealing with government segments.** With the growing role of government plans in healthcare, private insurers will need to consider their position and strategy in government lines of business. As millions of new Medicaid and Children's Health Insurance Program (CHIP) members enter the system, insurers with existing Medicaid capabilities may be well positioned to benefit from segment growth. However, they will need to accommodate the new population and better serve members, especially as other players seek to enter the segment. In contrast, insurers that are less exposed to the Medicaid segment should evaluate the benefits and challenges of entering this line of business in their particular market, and determine the investments and new capabilities

required to successfully compete for this segment.

Most insurers will need to closely reevaluate their Medicare Advantage (MA) strategy. If proposals to reduce MA benchmarks and change the payment structure are accepted, this book of business, which has provided an important share of profits for many insurers in past years, may rapidly become significantly less profitable. If it results in declining membership and reduced revenues, MA reform could raise serious questions about the segment's viability, potentially forcing some insurers to leave the program altogether, as they did after Congress constrained increases in payment rates in the Balanced Budget Act of 1997.

**3. Strengthen administrative capabilities to serve and retain the new member base.** After reform, the influx of the uninsured and the establishment of exchanges will create significant membership movement and switching. Along with

more stringent insurance provisions (such as minimum standard benefits and guaranteed issue) and increased transparency, the post-reform world will demand greater price competitiveness and value-added services from insurers.

Meanwhile, current legislative proposals include provisions aimed at reducing administrative costs, streamlining provider-payor transactions, and enabling effective information sharing. The U.S. Senate Finance Committee, for instance, is proposing to accelerate the adoption and implementation of standard rules for eligibility verification, claims status, payment or electronic funds transfer, and remittance advice. Insurers will be required to comply with standards or face a penalty. Indeed, as the industry heads toward a post-reform world, the need to significantly bring down costs while improving service levels across all segments will be more critical than ever for insurers.

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Moving forward, insurers will need to strengthen their administrative processes to both comply with regulations and effectively manage against increasing financial pressure. Reducing operational complexity and streamlining workflows, aspirations many insurers have pursued for some time, will be even more critical for unlocking greater administrative efficiency. Efficiency, in turn, will be essential to maintaining consumer satisfaction and loyalty. Customer service will play an ever-larger role in consumer retention, requiring insurers to use a greater variety and integration of service channels to better serve a growing number of more informed consumers. Today, leading insurers are already investing in new skills and tools to integrate their back-office processes and service channels. They are developing multiple views of member and product information to provide an enhanced level of consumer support, akin to the insight practices of other consumer-centric industries.

**4. Drive and demonstrate healthcare value.** No matter what the specifics of regulatory reform, insurers will need to start differentiating themselves beyond price and benefits, through medical value, quality, and service. Care management capabilities (e.g., disease management, health and wellness programs) will be an increasingly important source of leverage, not only to manage risk, but to successfully demonstrate value for consumers. Consumers will require and demand new, innovative healthcare management programs (e.g., online treatment programs, next-generation disease management tools, remote monitoring capabilities). In addition, effective clinical decision-support tools, guided by evidence-based medicine, will be needed to drive improved quality of care at the payor-provider interface. Moreover, with near-term demand likely to balloon rapidly thanks to expanded coverage, insurers can provide additional value by preventing potential service backlogs at providers (e.g., by providing consumers

with new tools to find primary care physicians with excess capacity, or offering remote care and telemedicine alternatives such as nurse lines, e-treatments, and e-visits).

More important, current reform discussions have focused primarily on increasing coverage and improving access (e.g., through mandates and exchanges), with less attention on truly bending the cost curve. As government and industry ultimately shift from today's focus on coverage expansion to longer-term delivery cost transformation, insurers will face more insistent demands to address medical costs and drive longer-term efforts to help transform the system. Indeed, some of the leading insurers are already focused on taking steps to restructure care delivery—introducing transformative provider payment models, piloting guideline-based reimbursement models, and launching innovative coordinated care models enabled by better use of information technology.

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## PLAN NOW FOR SUSTAINABLE SUCCESS

Even while reform elements are still being debated, health insurance leaders should recognize that change is imminent. The industry will face both significant opportunities and significant challenges. The time for influencing the debate may not be over, but political influence is only one small part of the effort that is needed. Insurers need to recognize that now is the time for action. They must begin preparing for likely changes; developing strategies to mitigate potential risks; and most important, building capabilities to help them take advantage of the significant opportunities on the horizon, either through organic growth or through acquisitions and consolidation.

As insurers look to build capabilities and prepare for reform, timing and capital constraints will be an important consideration. Between now and 2013, when most of the reform programs go into effect, health insurance leaders will need to determine the appropriate staging and sequencing of capability-building efforts. Starting points and investment phasing will likely vary on the basis of current capabilities and market position. Moreover, insurers will need to balance their capability-building efforts with capital preservation challenges. With limited capital, health plan CEOs

will need to choose where to invest and how to invest wisely, taking into account potential longer-term capital erosion. This may require plan leadership to make difficult but critical decisions regarding business and portfolio investments. Some insurers may decide to strengthen diversified lines of business to offset challenges in the core medical business; others may decide to divest relatively profitable, noncore businesses, in order to build their war chests for future investments. Ultimately, insurers will need to design a sequence of moves based on relative priorities and capital constraints, mindful of building the requisite capabilities beforehand, and in the order in which they will be needed.

Success, even survival, will require effectively taking advantage of the potential growth opportunities in a post-reform world. Unfortunately, not all insurers will rise to the challenge. Some will falter as a result of insufficient commitment and foresight; others from lack of scale, financial fortitude, or business readiness. Insurers that have the right foundational infrastructure and business capabilities, coupled with the leadership, agility, and resilience necessary to reorient their businesses, will be best positioned to win in a post-reform world.

## Methodology

The perspectives and recommendations in this paper are based on in-depth research and observations of the industry and of the debate that is about to thoroughly affect it. They are also based on a set of analyses and models developed at Booz & Company. These in turn are informed by primary research, analyses of analogous state-level reform initiatives, and in-depth discussions with a variety of key healthcare reform stakeholders. In evaluating potential reform implications for insurers, Booz & Company simulated potential membership shifts and the resulting changes in insurers' books of business.

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### ***About the Authors***

**David G. Knott** is a New York-based Booz & Company senior partner and leader of the firm's global health practice. He specializes in strategy programs within the health insurance industry.

**Melanie Nallicheri** is a Booz & Company partner based in San Francisco. She specializes in strategy development and transformative change across sectors in the healthcare industry.

**Vishal Lall** is a Booz & Company principal based in San Francisco. A member of the firm's global health practice, he specializes in strategy development for health-services clients.

**Ashish Kaura** is a Booz & Company principal based in Chicago. He specializes in the development of growth strategies and new business models in response to market discontinuities, for healthcare and health-services companies.

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