

THOUGHT LEADERSHIP PROFILES

A CLOSER LOOK AT THE PEOPLE AND IDEAS THAT DRIVE MEANINGFUL CHANGE IN BUSINESS

SPOTLIGHT

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*about many aspects of health care for public release and private clients. He's a well-regarded, amusing presenter, and has delivered several keynote addresses. He publishes his analysis and opinions about health care online daily in *The Health Care Blog* (<http://www.thehealthcareblog.com>).*

*Matthew started his health care career conducting international health policy research at Stanford's Asia Pacific Research Center. At the Institute for the Future, the Menlo Park, CA think-tank, he led projects in healthcare financing, delivery and information technology. At Harris Interactive, the New York-based survey research firm, Matthew conducted two landmark survey research studies, *Computing in the Physician's Practice* and *The 10,000 Patients Study*. Most recently before returning to the consulting life, Matthew was Vice President, Strategy and Business Development at *i-Beacon.com*, an eHealth software company. He holds an MA in Political Science and an MS in Health Services Research from Stanford University.*

Q *According to McKinsey, health insurers will need to make the transition from wholesaler (B2B) to retailer (B2C) to survive in the new consumer-driven landscape. Any thoughts?*

A While there is some limited growth in the individual market, the vast majority of Americans get—and for the next five years will continue to get—their insurance at work. Health insurers sell to employers via an opaque relationship with benefits, and in general the small-group and individual end of the market is dealt with in a semi-dysfunctional relationship with brokers. Managing underwriting, pricing and network contracting have been the prized skills for insurers.

But there is no question that the market within group health care is changing. Employers of all sizes and wage levels are shifting risk slowly onto their employees. In most cases this doesn't change products much beyond changes in deductibles—although some of the consumer-driven plans have had success layering health coaching and accounting tools on top of their products. However, the change in the consumer that's being mirrored in the changes in the product is perhaps more important.

Pundits (including me) have been writing about the new consumer in health care for 15 years, and it appears that they're finally starting to get here. This is seen most in online activity in searching for health information, but also in huge demand for better service from health care as a whole. When Kevin Trudeau is on the NY Times best-seller list, you know there's something wrong with the marketing of conventional health care.

The next phase is consumers wanting control over their own health care information, and health insurers (and eventually providers) are going to have to provide it, and layer useful service over the top. At the moment WebMD Health is clearly the leader in providing that type of service to health insurers, but they're being quickly followed by a raft of technology companies filling all kinds of niches.

The challenge for health plans is that they're going to have to provide these "retail" services when their main sale is still "wholesale" to employers and via brokers. So the transition is not as much a change as an "add."

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Q *If the technology exists to collect, transport and protect patient data in electronic form, why isn't it happening, or happening faster?*

A Businesses make money by charging for a service, and either cutting margins on that service and increasing market share (e.g. Walmart), or delivering better service at a higher margin (e.g. Nordstroms). In both these cases knowing a lot more about your supply chain, business partners and processes and also about your customers helps your bottom line. Information technology has been a strategic weapon for successful companies in most industries.

In health care the nature of the incentives, put in place by Medicare, but with employer-based insurance companies following along, has been to encourage more piece-work on a fee-for-service basis. While external customers (employers and taxpayers) haven't insisted that their agents (CMS and insurers) reward their suppliers who do things differently, then there's no reason for change.

However, that change in incentives does appear to be coming. If instead of being paid for what they do piece-work, providers will get paid for their results or the "value" they add, then they'll start investing in the systems that track and improve their performance. Between CMS and the big insurers, a substantial number of provider organizations are now convinced that they have to adopt

digital records and improve processes, and are doing so. Assuming that plans and payers begin to reward them for those improved processes—what's being called pay-for-performance—this will be the first time that information technology provides a market advantage in health care. Then the rest of the industry will have to adopt it—with its attached "customer data disciplines"—or face a much bleaker future. But this remains at least a ten year process from now before most mainstream health care providers to be using what are already regarded as standard data processes in other businesses.

Q *What is the market factor that's most likely to blindsides the health insurance industry over the next 3-5 years?*

A Politics. I'm not a believer in the high likelihood of successful health care reform in the next Administration. But if a Democrat wins the White House (which looks likely 18 months out) and there is successful health care reform legislation—even one as "minor" as the Massachusetts system or the proposed changes in California—there will be tremendous dislocation to the current core operational business of health insurers.

Even if a "moderate" approach is taken (such as the Romney-type plan) insurers will have to get used to selling individual and small business products probably through a central

clearinghouse, with large restrictions on benefit-type, price and other product attributes. And of course it might be much more tightly regulated than that with strict community rating over all products. In that case, the business skills of understanding pricing will be less important than the care management skills required for improving member and provider performance.

Q *With healthcare costs and waistlines expanding at a rapid pace, what steps will need to be taken to either incent or coerce individuals to live healthier lifestyles?*

A The waistline issue is such a hard problem and so out of the control of either plans or providers that I don't think much can be done about it in the short term. On every measure (fat intake, activity level, hours watching TV, kids taking part in sport, etc) the numbers have been heading in the wrong direction for twenty years. And of course there's billions of dollars of advertising from corporate America pushing that ball downhill.

There is something that plans, providers and even employers can do. That's to focus on the cases with the greatest risk, and to employ those successful disease management techniques that have been shown to work—mainly very high intensive interventions amongst the stable chronically ill. Technology is

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making this cheaper and easier, and more needs to be done here.

But if plans are really interested in cutting costs—they need to do a better job of corralling their providers, reducing practice variation and concomitant wasteful care—as detailed by Jack Wennberg and his crew at Dartmouth. That’s a tough political job which, since the managed care backlash, insurers haven’t much wanted to do. However, the time is soon coming where someone has to start up at it again.

For the wider societal issues, perhaps there’s a lesson in what happened to smoking in California. A combination of strict laws, aggressive taxation, and social opprobrium has essentially eliminated a very addictive bad habit amongst large swathes of the population. Of course it’s taken 45 years so far and the process isn’t finished yet.

Q *Looking into your crystal ball, what are three predictions for the healthcare industry that might surprise or upset the status quo?*

A These aren’t predictions, so much as wild-cards that might cause huge change:

1) A really vicious recession. Health care costs have been going up as a share of the overall economy during an expansion. In a recession they’ll shoot up, and the cost issue may become so overwhelming for business and government that they’ll take drastic measures. Price controls?

Employers rich and poor dropping insurance? Single payer? Who knows what, but remember that the two biggest changes in recent decades have happened after a big recession (DRGs in the early 1980s, and managed care in the 1990s).

2) Some type of pandemic that overwhelms the health care system and society as a whole. Katrina showed that we’re not ready for a localized disaster. If some virulent strain of bird-flu, SARS, take your pick, killed say a million Americans and incapacitated the health care system nationwide, you’d likely see a societal reaction that would change America’s health care from a sick care system to one based more on public health and prevention.

3) Transparency and consumerism works. Many cynics, me included, think that CDHPs aren’t likely to have a great impact on the provider market. But if enough consumers are aggressive about chasing better experience in their health care services, and better outcomes, with their dollars, just maybe there’ll be that tipping point and providers en masse will be forced to react.

Q *What’s the most valuable piece of advice that you’d give to the CEO of large health plan or major healthcare provider?*

A From a short-term business perspective, stick to your knitting. What works now will still be your core business in 2010, and most likely in 2014 too. Keep putting the

systems into place that will enable you to enhance the focus of your business, such as better serving consumers’ information needs.

But also make sure that your organization remains flexible. Every CEO should know what their plan is for several different scenarios, including a relatively radical Federal health care reform effort à la 1994 actually passing, or a major IT player (Google?) taking on the role as the repository of all health data, and building financing products off that.

Finally, behave better. In recent years too many CEOs and organizations have taken advantage of the good times, and the lack of focus on health care from politicians and regulators. When there are daily stories in major newspapers about this plan pressure selling their customers or that provider dumping patients, it does have ramifications. People and eventually politicians notice. Just ask yourself: “Would my mother have been proud of what my company is doing?” If not, then perhaps you shouldn’t be doing it. ●