Optum

Advisory Services

Health plan executive insights for 2023 and beyond

Three themes emerged in our latest CEO study: Rising consumer expectations, government influence and labor shortages.

Forward

At Optum®, we're eager to understand our clients' perspectives on the market challenges they're facing today, and the challenges that are unique to their enterprises. We believe there is no better way to cement this understanding than speaking with leaders firsthand.

This study reflects more than 20 conversations we personally conducted with our partners from national health plans, community health plans and international health plans.

We probed leaders on how they are thinking or investing in the following topical areas:

- Alternative modalities
- Transparency/interoperability
- New concepts in network design
- High-cost therapeutics
- Regulatory and compliance

As we engaged with the leadership teams of these diverse health plans, three themes emerged.

Theme 1

Rising complexity, competition and consumer expectations

p. 3

The transition to value- and outcomes-based care continues to be a top priority for health plan leaders. But it's approached differently within the context of the ongoing COVID-19 pandemic and increasing consumer preferences and demands.

Theme 2

Escalating influence of government in health care

p. 6

Plans monitor the pipeline of regulations, and they largely struggle to interpret, plan and comply with mandates. Regardless of size, plans are increasingly investing time and energy to stay compliant while understanding the future impact of key initiatives, such as interoperability and cost transparency.

Theme 3

Economic pressure and labor shortages

p. 8

With rising costs, economic pressures and fears of an impending recession, leaders are feeling the pressures of the "great resignation." Acute labor shortages, especially for front-line workers, continue to strain the delivery system. Health plans cannot ignore this since providers drive patient outcomes.

The following study summarizes collective and individual insights from these interviews. Our team is committed to using our partners' insights to guide our strategy to generate more client value and develop innovative solutions to help health plans achieve better outcomes, better patient and provider satisfaction and overall greater impact to their membership.

Theme 1

Rising complexity, competition and consumer expectations

Rising complexity, competition and consumer expectations are forcing health plans to improve provider relationships to create better patient outcomes. Plans are turning to both traditional and non-traditional care providers as partners to push forward the quadruple aim.

In our interviews, most respondents' priorities are:

- Expanding value-based care
- Implementing new concepts in network design
- Using alternative modalities to improve outcomes

Leaders are steadfast in expanding value-based contracts with providers. These arrangements not only create growth incentives for the providers but create savings opportunities for health plans. The transition to value is incredibility difficult for providers, and health plans are beginning to partner with provider systems to manage and grow their value-based presence and relationships.

Humana and UnitedHealthcare are offering providers online tools and reports that allow providers to compare performance to their peers. Other plans support providers in generating and accessing data, as well as strategically advising providers on best practices and managing the transition. While the support is well-intended, providers' competing priorities of caring for patients and managing their practice makes progress slow and limits positive results.

Partnering for a whole-person approach

In addition to traditional value-based care expansion and support, health plans are attempting to address whole-person care through partnering with non-traditional providers. Some leaders mentioned the integration of community-based organizations (CBOs) into their value-based care models. CBOs could be local nonprofit entities such as churches, social-service groups or health care agencies.

In some cases, insurers directly contract with CBOs. Or CBOs can be incorporated into shared savings arrangements with both the provider and a managed care organization – incentivizing them to receive a share in savings in the total cost of care. One health plan is contracting with a local food pantry to close food insecurity gaps.

States are pushing the adoption of non-traditional providers, too. In Pennsylvania, the state is requiring its Medicaid MCOs to incorporate CBOs into moderate and high-risk value-based arrangements, as an effort to address social determinants of health. Outside the state of Pennsylvania, health plans believe that the expansion of contracts with CBOs will better drive outcomes for patients.

Insurers recognize that the transition to value is gradual, but leaders continue to see the multi-year initiatives as a key driver of outcomes and member satisfaction.

Telehealth and alternative modalities

Outside of provider partnerships, plans continue to leverage alternative modalities to achieve the quadruple aim. Not surprisingly, telehealth is at the forefront of leaders' minds when discussing alternative sites of care. Recently, 88% of consumers say that they had telehealth services at some point since the pandemic began. In one survey, 83% of providers offered virtual services compared to only 13% prior to the pandemic.

"Our challenge is how do we keep people out of the hospital, even behavioral, or if they're going to have surgery. How can I keep them out of inpatient and treat them outpatient and virtual soup-to-nuts?"

– Health plan leader

Expanding the role of the provider

In addition to telehealth, plans are pivoting to outpatient, skilled nursing facilities and in-home care more frequently than prior to the COVID-19 pandemic. Not only do patients prefer the more convenient locations, but the upside is also evident for health systems that are struggling to meet patient demand. As utilization shifts toward alternative locations, plans are considering doulas, or caregivers, to be primary providers of care, even including them as in-network options.

"We believe there's an opportunity to create more targeted care programs that are less about us doing case management, but actually connecting the dots in the health care system with services in a person's community."

– Health plan leader

Networks designed to create stickiness

While not a new trend, health plans continue to use network design to achieve goals: attract more members, reduce costs or create high-value partnerships. While other industries are expanding consumer choices, network leaders are taking an alternate approach. Instead, health plans are creating focused and targeted networks to create member steerage and improve the experiences. Plans are branding the care experience as a single experience – blurring the lines between provider and health plan from the consumer perspective.

The increase in demand for mental health care, driven by COVID-19, laid the foundation to the increasingly important aspect of whole-person health. Plans are working to integrate this holistic approach into the network and benefit structure. Some risk-taking plans take delegated risk for behaviorally challenged, high-cost members. Other plans are expanding ancillary benefits in addition to behavioral, such as vision and dental, to create stickiness and attract members. The expansion of and specific focus on behavioral health care as in-network services continues to enable plans to attract and serve all patients from a holistic perspective.

"We brand the experience, build a product and a network design that drives high levels of steerage into that facility. Knowing if that care system has 80% or 90% of the care coming through from our members, that continuity creates a far more efficient system, as well as higher satisfaction from that member along the way in their overall experience."

– Health plan leader

Virtual-first considerations

Leaders discussed the potential attractiveness of a virtual-first plan and network. An outcome of the COVID-19 pandemic, a virtual-first approach uses remote or digital engagement as the default care delivery method whenever appropriate to quickly provide care. While plans continue to expand virtual-first networks, it's unclear if the outcomes and results are truly reducing costs and improving experiences.

Health plans continue to lean on provider relationships to drive member outcomes in targeted ways: value-based care expansion, network design and through alternative sites of care. As the partnership deepens, the context surrounding the relationship continues to complicate with new government regulations and mandates.

UnitedHealthcare and Optum recently co-launched NavigateNOW, which incorporates a virtual care team to triage the call and provide the level of care required, including an as-needed handoff or referral to in-person "last mile" care (e.g., exams, lab work, diagnostics). With 2023 plans to expand, and backed by large amounts of capital funding, UnitedHealthcare provides members an easy-access entry point to care at their convenience.

Theme 2

Escalating influence of government in health care

Following the transition of presidential power and the ongoing nature of the COVID-19 pandemic, we expect to see the government play a more involved role in the administration and coverage of health care services. We believe some government policies prevent general optimization for health plans. Plans continuously advocate for the modernization or abolition of such policies.

In contrast, the government also passes futuristic, idealistic regulations and policies that push plans into the future on aggressive timelines. Plans struggle to comply, fund or partner with providers to manage these changes.

Health plan leaders continue to think about Medicare Advantage and the expanding population of senior citizens taking up a larger portion of plans' memberships. Pre-pandemic, virtual care for Medicare members was relatively limited, with about 100 services administered through telehealth, such as office visits, preventative screenings and mental health services. And utilization was extremely low, with less than 1% of Medicare beneficiaries using telehealth services in 2016.

What's expiring, what's expanding?

Because of the pandemic, services have expanded due to the multiple rounds of COVID-19 regulations. But these telehealth measures within these rulings are temporary — and will expire. For example, according to the 2021 Consolidated Appropriations Act, permanent coverage for telehealth services for diagnosis, evaluation or treatment of mental health disorders exists after the COVID-19 public health emergency officially ends. This includes in-home visits and audio-only visits. But members are required to have an in-person follow-up visit within six months of the telehealth visit. This is difficult to comply with from the member perspective, and often unnecessary, creating waste in the system.

On the other hand, leaders are focused on new initiatives that are laying the foundation for the future of the health care system, such as interoperability, cost transparency or high-cost therapeutics. These are a few examples of areas where leaders continue to contemplate their approaches to innovative policies.

Looking ahead

When leaders spoke about interoperability and cost transparency, it wasn't that they disagreed with the focus and objective. They voiced concerns that this regulation would confuse rather than empower the consumer. Leading plans want to optimize their strategy to make the compliance more valuable to the organization.

The challenge with cost transparency is not generating the machine-readable file. It's getting members to understand the output — translating it into something customer facing is incredibly difficult. Leaders believe the return on investment for interoperability and cost transparency are still many years away.

As more expensive drugs receive approvals and hit the U.S. market, plans are bracing for their cost and utilization. Employer clients report specialty drugs account for 60% or more of their total drug spending. We probed leaders on how they are preparing to offer high-cost treatments to their members, and their responses varied.

Leading health plans with investment dollars are seeking outside help (such as actuarial consulting) to predict the likelihood of utilization for these medications on their membership and to better understand the financial impact. Lagging health plans or smaller community plans struggle to understand the pipeline and actuarial impact of the medications. But even the leading plans are waiting to understand how the retrospective risk adjustment will reimburse plans for these costs.

We heard from a provider-sponsored health plan that brought on fewer than 10 HIV patients from a competitor. These members, while few in number, meaningfully impacted the overall health plan spend significantly. We expect costly treatments will continue to consume leadership time and energy in the coming years.

> "There are a lot of draws or comparisons to other industries that are trying to be pulled into health care, and much of that is how we get the consumer more engaged at the center and control of their own of decision-making through data and information similar to other industries. This is one trend that we expect to continue [in the future]."
>
> — Health plan leader

Theme 3

Economic pressure and labor shortages

The tight labor market has impacts broader than human capital teams. With rising costs, economic pressures and continued workforce shortages, health plans are forced to do more with less. In our conversations, leaders highlighted that the workforce shortages – in health plan and provider organizations – are incredibly difficult to manage. Optimistically, leaders see the challenges as the catalyst to push strategic priorities forward.

Getting creative

Leading employers and health plans recognize that their current staff are invaluable, with institutional knowledge and deep industry experience. As such, some leaders are putting their money where their mouth is in terms of attracting and retaining talent. Leaders shared that they've have deployed 50% salary increases or invested $50 million to attract employees. To lure recruits, employers are getting creative with benefit packages. We have seen employers offer a four-day work week or $0 premiums for employees and families. If plans cannot afford salary increases, they are finding other ways to attract and retain talent.

In the absence of resources, plans are accelerating operating model modernization. For example, a leading provider-sponsored health plan leader said the workforce shortages forced them to deploy cross-functional teams. Plans also push innovation agendas that aim to remove human intervention.

Advancements in automation, machine learning and natural language processing accelerates technological processes and lowers costs. This shift has also enabled a more flexible model with remote staff, relocating employees to other states or leveraging offshore staff. With staff shortages, plans are also increasingly leaning on partnerships – staffing, consulting or outsourcing to complete initiatives.

Health plan leaders insisted they are not ignoring the existing provider shortages. Pre-COVID-19 provider shortages were exasperated by burnout, distress and retirement. The continuous shift to in-home care highlights a rising shortage of low-paid health care workers such as home health aides, nurse assistants or caregivers. As health systems struggle to staff, they hire temporary travel nurses to fill the gaps. This is an expensive solution that fills an immediate need but does not fix the long-term problem.

Some experts think the "great resignation" is behind us. We want to believe this is the case. What we do know is that the decisions plans are making today will impact members, consumers and employees for years to come.

Conclusion

In a market that feels incredibly urgent, plans aggressively pursue growth. It seems like the gaps across the large nationals to community health plans continues to widen, especially in our current acquisition-driven environment. At Optum, we serve a spectrum of health plans: from challenged health plans barely meeting margins, to strategic plans creating and driving next-generation member-centricity. In between these two personas are the cautious health plans, the managed, and the collaborative – all at various stages in the health plan maturity model.

On any given challenge or initiative, like the shift to in-home care or the prediction of high-cost prescriptions, a health plan could be in any of these categories – from challenged to strategic. We believe the key is to understand where you fall on the maturity model as a leader. We encourage leaders to continuously evaluate whether they have the resources (time, money, talent) to pursue a strategy, project or growth opportunity. We encourage plans to carefully assess each decision and their own strengths and weaknesses to ultimately create better outcomes, create a better provider experience and lower the total cost of care for all health care customers.

Optum

optum.com