

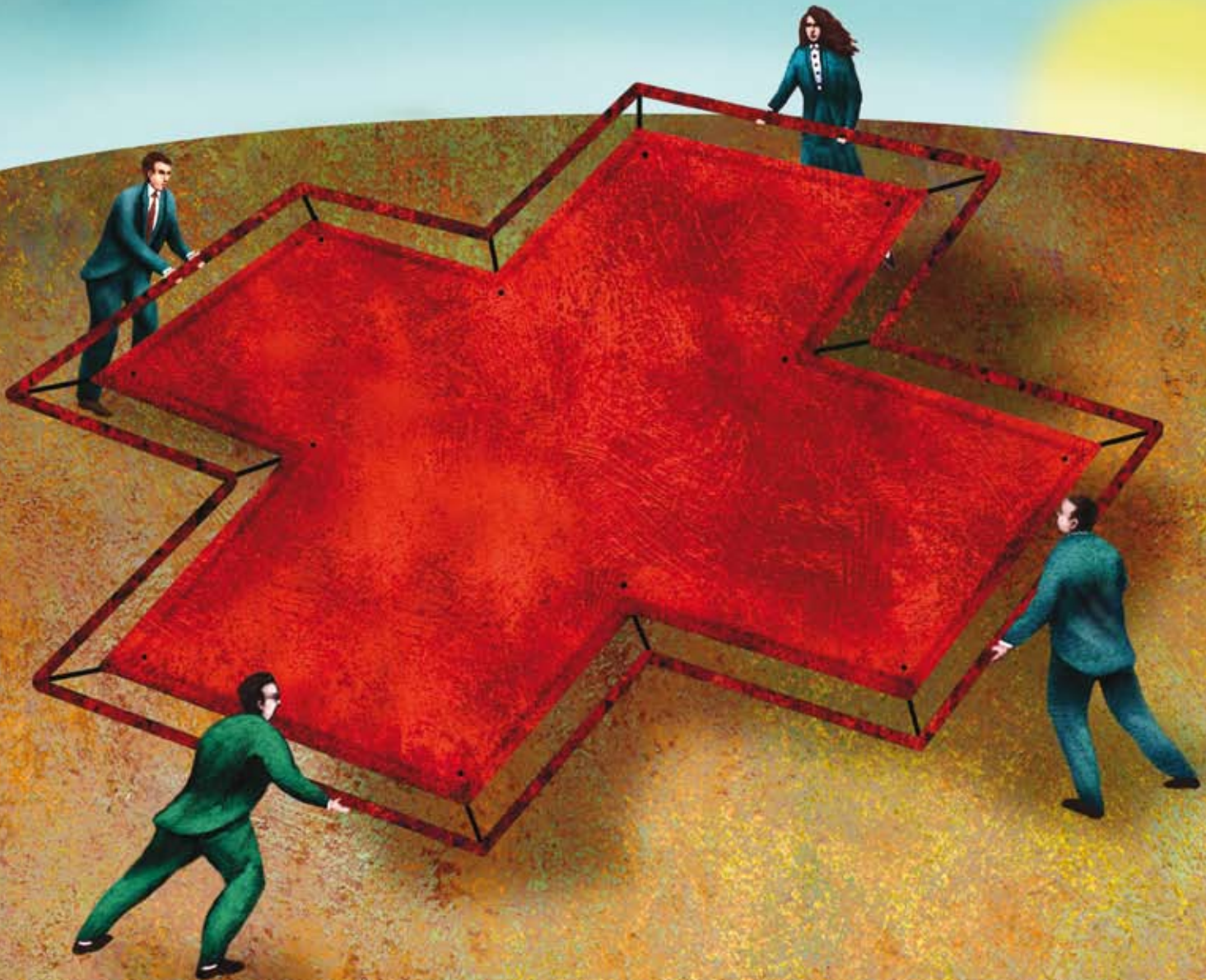
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Innovation, Diversification, and a Focus on Fundamentals

How Health Care Reform Will Change the Insurance Landscape



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How Health Care Reform Will Change the Insurance Landscape

Martin B. Silverstein, MD, Giridhar N. Rao, and Lori Spivey

July 2011

AT A GLANCE

A BCG study, based on a comprehensive survey of senior insurance executives, found that payers are responding to health care reform on several fronts.

COST IS KING: REDESIGNING THE OPERATING MODEL

More than 90 percent of the plans cited managing medical costs as a top priority; many are actively experimenting with provider reimbursement and collaboration models. Most plans are also taking aggressive steps to curb administrative costs.

THE EMERGING BATTLEGROUND: CAPTURING THE RETAIL CUSTOMER

Insurers are ramping up their growth efforts, but the cornerstone of the new retail-oriented market—the exchange—remains unnervingly abstract.

NEW FRONTIERS: DIVERSIFYING REVENUE STREAMS

Smaller plans are diversifying into new customer and product segments. Larger plans are moving beyond the core business by selling information and medical management services, testing the waters in foreign markets, and acquiring providers.

THE EVOLUTION OF THE PAYER LANDSCAPE

We expect the industry to assume a more sharply divided, barbell-shaped profile, with large plans at one end and smaller, niche plans at the other.

MORE THAN A YEAR after it was signed into law, the Patient Protection and Affordable Care Act is shaping up to be a mixed blessing for the health insurance industry. From 2011 to 2019, an estimated 26 million new customers will enter the market as a direct result of the law. Over the same period, the profit margins of insurers (taking into account a new premium fee but excluding all other taxes) could decline by more than 40 percent.

The change will be made all the more disruptive by the uncertainty surrounding the law. Many of the most significant rules have yet to be written. In addition, the act gives states tremendous latitude to develop their own strategies for ensuring that residents have access to “high-quality, affordable health care.” Insurers are likely to wind up dealing with radically different mandates from state to state. Muddying the picture further are the various state-led experiments to rein in Medicaid costs, along with the political forces and judicial reviews that could change how the act is implemented.

According to a recent BCG study, however, health insurers are looking past the uncertainty and moving ahead with initiatives designed to capture the upside of the changes while minimizing the pressure on profitability. (For more on the study, which was based on a comprehensive survey of U.S. health insurers, see the sidebar below.) Most companies are responding to the law by redoubling their

CANVASSING THE PAYER INDUSTRY

In March and April 2011, BCG surveyed or interviewed about 120 health-insurance executives. The executives represented 48 of the largest payers, including 9 national plans, 21 Blues, 9 regionals, and 9 other plans, most of which were focused-segment and integrated models. A focused-segment payer typically concentrates on just one or two customer segments, such as Medicaid or Medicare. An integrated model is based on the vertical integration of payer and provider.

The payers we surveyed provide health benefits to more than 160 million individuals, or about 65 percent of the total lives covered in the U.S. The survey was complemented by in-depth interviews on a variety of reform-related issues. We interviewed a broad range of executives, including CEOs and medical directors, as well as heads of marketing, IT, and operations.

efforts to improve business fundamentals, primarily by managing medical costs, curbing administrative costs, and capturing new customers. The act has also given them license to experiment with new and unconventional ways of addressing these perennial issues, while prompting some to diversify beyond the core.

Despite their proactive stance, payers still have significant hurdles to clear. Among other imperatives, they will need to transition from what has historically been a business-to-business model to a business-to-consumer model. The playing field will tilt steeply in favor of insurers that can provide low-cost products to retail customers. To achieve a cost position that can support such products, most insurers will need to shift from an adversarial to a collaborative relationship with providers, which is arguably the only way to change the trajectory of health care costs (for the better). Even then, however, the pressure on margins will be so great that almost all payers will need to continue searching for new revenue streams.

The playing field will tilt steeply in favor of insurers that can provide low-cost products to retail customers.

What will the rise of a low-cost, retail-oriented marketplace mean for the payer industry as a whole? The answer can be found not by looking at these companies as a monolithic group, but rather by understanding how each type of payer will respond to these imperatives given its relative strengths and capabilities.

Assessing the Impact of the Affordable Care Act

From 2011 to 2019, when all the elements of the Affordable Care Act go into effect, the total number of lives covered by health insurers is expected to increase by 49 million. Much of this growth—about 26 million new lives—will come as a direct result of the law. (See Exhibit 1.) The significant expansion of coverage, coupled with a steady rise in health care costs, has far-reaching implications for the health care system.

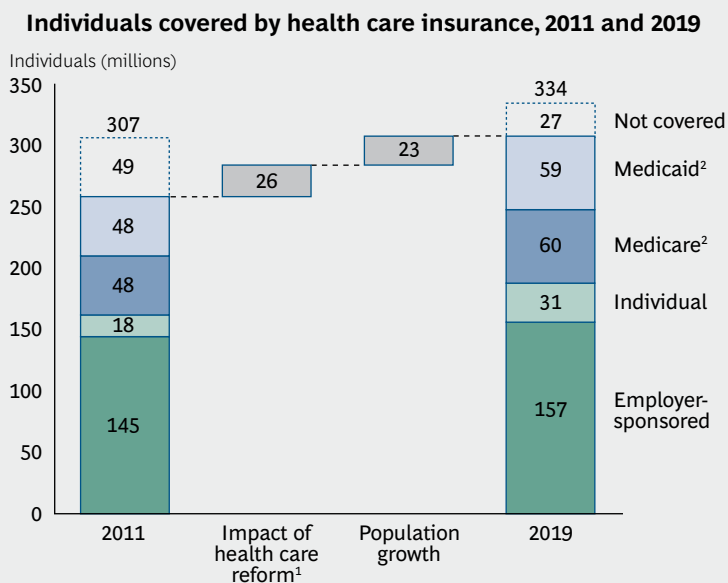
- The market for health insurance is expected to become much more retail oriented, for several reasons. First, we expect to see strong growth in the Medicare and Medicaid segments, both of which (and especially the former) have a retail bent. Second, the individual market and a significant portion of the small-group business will move to exchanges, creating a retail marketplace of some 30 million lives. Third, some analysts estimate that as many as 10 percent of employers may opt out of insurance altogether and instead provide financial incentives for employees to buy insurance via the exchanges; these are relatively conservative estimates—the actual opt-out rate could well be higher.
- The provider landscape will also undergo profound changes due to the growing emphasis on quality and outcomes. Hospitals are already anticipating a dramatic shift in reimbursement policies and are investing heavily in health care information technology (HCIT). HCIT capabilities can help providers make more-informed decisions about patient care, which is a critical step toward taking on the risk associated with outcomes-based arrangements. Many providers are also assessing whether and how to participate in Accountable Care Organization (ACO) pilots and medical home programs, in which a personal physician coordinates a patient's care. In addition, the provider landscape is

being transformed by an uptick in M&A activity. Hospitals have been acquiring physician practices in order to broaden their referral bases, participate as ACOs, assume risk for a larger population, and ultimately have a better handle on quality and outcomes. At the same time, private-equity firms have shown a growing interest in this sector.

As important as they are, these trends are overshadowed by changes in the economics of the health insurance industry—for better and for worse. We expect the industry’s revenues to more than double from 2011 to 2019, to about \$1.2 trillion. Over the same period, however, its profit margin (excluding all taxes other than a new premium fee) could decline from nearly 5 percent to slightly below 3 percent. Most of this decline—over two thirds—will come as a direct result of the new premium fee. The remainder will come from the relatively strong growth of less profitable segments. This estimate excludes other potential threats to margins, such as increased competition on exchanges and constraints imposed by the new medical loss ratio (MLR).

The impact of the fee, which is expected to rise to nearly 1.5 percent of revenues by 2019, will depend on the extent to which insurers pass this cost on to customers. A profit margin of less than 3 percent assumes that insurers pass on none of the fee. Payers are likely to shift at least some of the burden to their customers, but this approach is not without consequences. A rise in premiums may prompt some

EXHIBIT 1 | Health Care Reform Will Bring About 26 Million New Customers into the Market



Sources: BCG analysis; BCG survey of payer responses to the Affordable Care Act; BCG interviews.
Note: The sum of the segments may differ from the totals shown because of rounding. Medicaid lives include both fee for service (FFS) and Medicaid managed care. Medicare lives include both FFS and Medicare Advantage.
¹Includes about 4 million individuals who will be added to the population over this period and who would not have had coverage without health care reform.
²The Medicaid and Medicare categories together include about 7 million dual-eligible individuals.

employers to drop coverage for their employees or encourage larger employers to move from fully insured to self-insured. These actions would undermine the industry's revenues and profits.

One way or another, therefore, the fee could significantly dampen payer profits. Assuming, for the sake of simplicity, that payers pass none of the fee along to consumers, the industry's profit would grow from \$27 billion in 2011 to \$34 billion in 2019. (For more on how we derived these estimates, see the sidebar "Methodology.") This incremental gain—it amounts to average annual growth of only about 3 percent—stands in stark contrast to both the surge in new lives insured and the industry's track record of strong performance.

Our survey showed a wide variation in how different kinds of insurers are responding to reform. The strategies being pursued by nationals, for example, differ significantly from those being pursued by payers that are focused on a specific region ("regionals") or on a small number of customer segments ("focused-segment payers"). There were, however, several common themes.

First, executives are unbowed by the ambiguity surrounding the Affordable Care Act and are positioning their businesses to thrive in the new environment. Second, the strategies are, for the most part, focused on getting back to basics, albeit with a sense of urgency. "We are doing things we should have done all along," remarked one executive. "Reform is just forcing us to do them faster." Third, the disruption caused by health care reform has prompted some insurers to explore new and unconventional ways of improving performance or growing revenues.

The payers we surveyed are pursuing a range of initiatives to succeed in the post-reform environment. Among these initiatives, three broad imperatives are apparent. (See Exhibit 2.)

Insurers are pursuing new and unconventional ways of improving performance or growing revenues.

- *Redesign the operating model.* More than 90 percent of the plans in our survey cited managing medical costs as a top priority; many are actively experimenting with provider reimbursement and collaboration models. Most plans are also taking aggressive steps to curb administrative costs through alliances and outsourcing or by designing low-cost products for retail customers.
- *Capture the retail customer.* Insurers are ramping up their efforts to enhance their brands and reach new customers, but most are concerned about the lack of clarity surrounding exchanges. While virtually all plans are preparing to participate in exchanges, their approaches differ widely. Blue Cross Blue Shield plans ("Blues") and regional plans see their local share and brand as natural advantages. Nationals will participate selectively, but they generally view exchanges as a way to gain local share in what were the individual and small-group markets.
- *Diversify revenue streams.* Smaller plans are diversifying into new customer segments and insurance products, while larger plans are moving beyond the core business of health coverage by selling information and medical management services, testing the waters in foreign markets, and acquiring providers.

METHODOLOGY

Our projections of insurance coverage and industry profits were developed as a supplement to the primary goal of our study, which was to understand how payers are changing their business models in response to health care reform. Accordingly, the inputs to our model that generated these projections were based primarily on public sources.

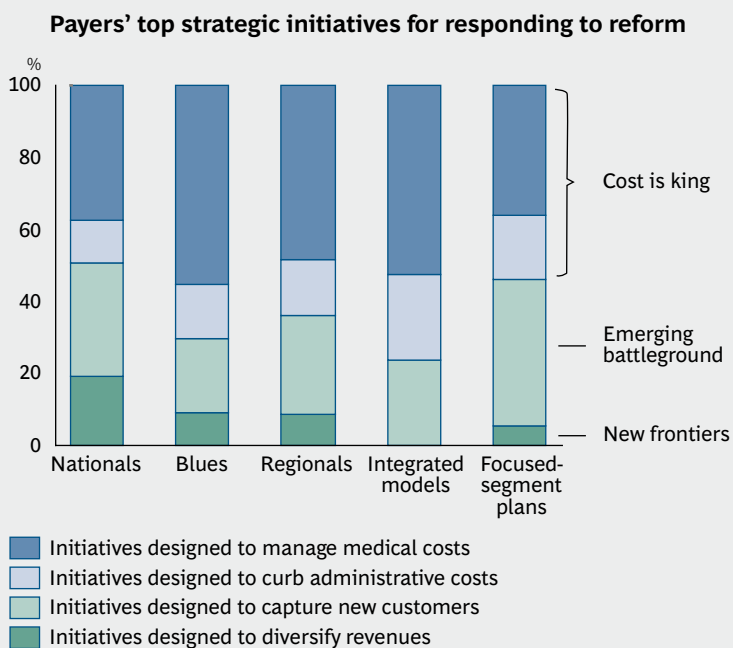
U.S. Census estimates were used for population projections and to understand sociodemographic factors (such as the distribution of the population as a percentage of the federal poverty level). Centers for Medicare and Medicaid Services (CMS) data were used as a baseline for Medicare and Medicaid program enrollment.

Coverage uptake rates were based on various sources, including the Urban Institute's Transfer Income Model (TRIM), the Congressional Budget Office (CBO), the *Current Population Survey*, and the Small Business Administration. In addition, data from the Medical Expenditure Panel Survey (MEPS), conducted by the Department of Health and Human Services, were used as a basis for rates of employees offered, eligible for, and accepting health insurance coverage by employer size.

Our projections of market growth, industry revenues, industry margins, and other reform-related developments, such as the market share of various distribution channels, were based on a set of assumptions about four key aspects of reform:

- **Employer Opt-In.** Projections of the number of people who will receive health insurance from an employer under reform were based on projections from the CBO, with some minor adjustments for expected population shifts among states, as well as on analysts' estimates.
- **Distribution Channels.** Projections for distribution channels were based on the National Federation of Independent Business's (NFIB) National Small Business Poll on purchasing health insurance, CBO estimates, and interviews with industry participants.
- **Individual Uptake.** Projections for the uptake of insurance in the individual market were based on expected price elasticity of demand within this market. Demand curves were based on published research into the impact of health insurance premiums and cost sharing in low-income populations¹ and on health insurance premium affordability and health insurance rates.²
- **Changes in Revenues and Costs.** Future industry revenues and costs were based on calculations of lives covered and were projected per member per month (PMPM) by product category. PMPM data were based on analyst estimates, including estimates from Barclays and Deutsche Bank, and interviews with industry experts. Medical costs were assumed to grow at a little over 6.5 percent annually.

EXHIBIT 2 | Most Plans Are Pursuing a Mix of Cost and Growth Initiatives



Sources: BCG survey of payer responses to the Affordable Care Act; BCG interviews.

Cost Is King: Redesigning the Operating Model

Recognizing that low-cost products will be pivotal to their success, many payers are taking a dual approach to transforming their cost structures. First, they are managing medical costs by redefining their relationships with providers and members. Second, they are lowering administrative costs by redesigning their processes, increasing automation, and pursuing other initiatives to improve efficiency.

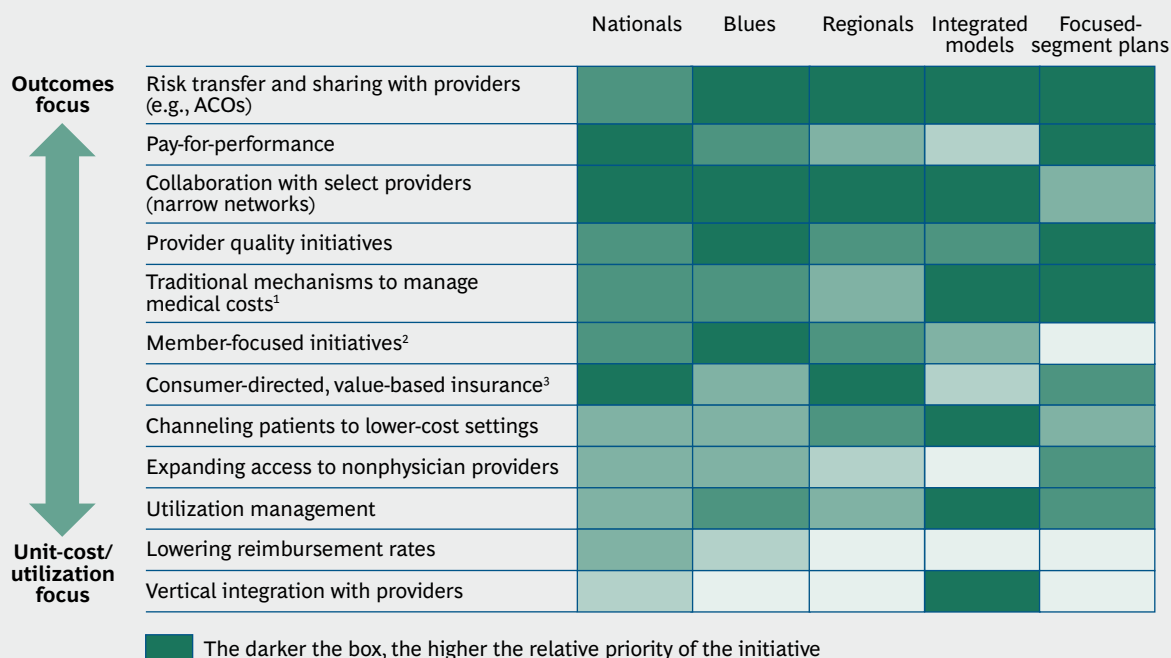
MANAGING MEDICAL COSTS

The insurance industry is pursuing a mix of initiatives to rein in medical costs. Some efforts, like lowering reimbursement rates, are fairly conventional. Others, particularly outcomes-based initiatives, border on the experimental.

For most plans, provider-focused initiatives are the key to managing medical costs. Payers have been experimenting with outcomes-based initiatives for years. Recently, many have begun accelerating their efforts, in part to become more competitive but also because outcomes-based arrangements have the potential to bend the cost curve. The degree to which payers are pursuing these initiatives varies widely. (See Exhibit 3.)

Blues and regional plans are relying on their deep provider relationships and strong positions in local markets to pursue quality initiatives or collaborative arrangements with providers—via medical homes and ACOs. Most are confident that their close ties with providers will give them a competitive edge. Compared with most other payers,

EXHIBIT 3 | Outcomes-Based Initiatives Are Critical to Managing Medical Costs



Sources: BCG survey of payer responses to the Affordable Care Act; BCG interviews.

¹Includes disease management.

²For example, providing direct support, including screenings and health coaching, for members to better manage their health.

³For example, structuring incentives for members to manage their health around preventive medicine, healthier lives, and improved compliance.

they have a better opportunity to shape these programs. At the same time, however, many are questioning how long they can sustain such an advantage, given that most plans will eventually gravitate toward similar arrangements.

Nationals are less interested than Blues and regional plans in outcomes-based efforts, at least in the short term. Only 40 percent of the nationals we surveyed have placed a priority on such initiatives, compared with around 70 percent of regionals, Blues, and integrated models. Most nationals believe that providers do not yet have the means to assume and manage the risk associated with outcomes-based arrangements. As a result, they are continuing with traditional efforts to manage medical costs. About 70 percent of nationals, however, are beginning to shift some risk to providers through their payment models—for example, by implementing pay-for-performance reimbursement schemes. Some nationals were hoping that the early ACO efforts would set the guidelines for such schemes. Given the complexity of the regulations, however, payers will need to work closely with providers to lay the groundwork for ACOs (and pay-for-performance reimbursement schemes) on a community-by-community basis.

Integrated models, which have even closer ties to providers, believe they have natural advantages—collaboration is an intrinsic part of the business model. Many are confident in their ability to capitalize on their strengths. As a result, integrated models are more interested in refining than in changing their approach to working with providers.

National plans are gearing up for exchanges by simplifying the customer experience and product portfolio.

Payers are also pursuing member-focused initiatives to manage medical costs.

Member-focused initiatives, which seek to modify behaviors that pose a risk to health, have been gaining prominence. Nearly 40 percent of Blues and more than 30 percent of regionals and nationals cited wellness initiatives as one of their top three priorities for responding to reform. They recognize that member-focused initiatives provide an important opportunity not only to control costs but also to strengthen relationships—a must in the emerging retail environment.

In sharp contrast, focused-segment plans, such as Medicaid-only payers, are managing medical costs almost solely by focusing on providers, not members. This is largely a function of their customer base. “My members have a hard time making ends meet,” said one executive at a focused-segment plan. “We do not want them to have the added burden of making the right choices.”

Lowering reimbursement rates is a double-edged sword. Nationals, unlike most other types of plan, seem likely to press ahead with efforts to negotiate better discounts from providers. In their estimate, the potential benefits, in terms of lower costs, outweigh the risk that tough negotiations might compromise efforts to collaborate with providers. Other plans—Blues, in particular—are more concerned about the downside and have not made lowering reimbursement rates a priority.

CURBING ADMINISTRATIVE COSTS

In addition to managing medical costs, payers have intensified their efforts to lower administrative costs. Over the past five years, for example, investments in technology have helped keep many payers’ administrative costs from rising—or at least from growing faster than enrollments or revenues. Most plans are now accelerating their efforts to increase automation. The most frequently cited goals were to increase auto-adjudication of claims—usually by 3 or 4 percentage points—and to use online portals to expand the range of self-service activities, such as eligibility checks, for both members and providers.

At the same time, the new MLR requirements, together with the expected decline in margins, are forcing almost all plans to consider more-aggressive or more-innovative strategies for controlling administrative costs.

- National plans, already at scale, are gearing up for exchanges by simplifying the customer experience and product portfolio—mainly by minimizing customization and increasing the number of self-service options. They are also redesigning their operating models to enable straight-through processing and greater automation. In addition, some are outsourcing or offshoring certain functions, such as provider services.
- Blues and regionals are lowering costs by building scale or outsourcing activities. Blues are building virtual scale through alliances, primarily within the Blue Cross Blue Shield system. Several Blues are outsourcing much of their technology-development work but are reluctant to let go of customer-facing activities. Lacking both scale and a national network of partner plans, regionals are being forced to consider more-aggressive business process outsourcing (BPO) options.

The Emerging Battleground: Capturing the Retail Customer

From the perspective of payers, the silver lining of health care reform is the influx of new customers, many of whom will enter the market via exchanges. Given their role as a gateway, exchanges have the potential to dramatically change the nature of competition by putting a much stronger emphasis on low-cost plans, restricted networks, and retail capabilities. The survey highlighted several trends in payers' response to the growth opportunity in general and to exchanges specifically.

Most insurers are priming their businesses to capture new customers. Seventy-three percent of insurers are planning to increase their marketing and sales capabilities in the near term, with a particular focus on direct-to-consumer marketing. Most have already begun to bolster their outreach efforts—across the payer industry, spending on digital media increased at an average annual rate of 22 percent over the last few years. In addition, health plans are beginning to segment consumers in order to craft highly tailored marketing campaigns, in some cases by experimenting with life stage marketing. They are also investing more in brand-building efforts. In a retail-oriented environment, marketing is likely to emerge as a critical source of competitive advantage, perhaps even on a par with being a low-cost producer.

The strategies for growth vary among the different types of plan. Given the expected growth in their core markets, more than half of focused-segment plans are preparing for the influx of new customers by increasing their penetration of existing segments, as are more than 40 percent of national plans—primarily those with a presence in the individual and Medicaid markets. Not surprisingly, more than 20 percent of Blues and regionals, which are likely to see their core business (small group) erode, are looking to expand into *new* customer segments. And despite the long-standing reluctance of many plans to return to government business, a majority of the executives we surveyed see Medicaid managed care and the individual exchange customer as growth opportunities. For some plans, this appears to be a defensive rather than an offensive strategy, designed to stem a potential loss of customers. Of course, all plans hope to improve their retention rates, but most acknowledge that intensifying competition will make this a challenge.

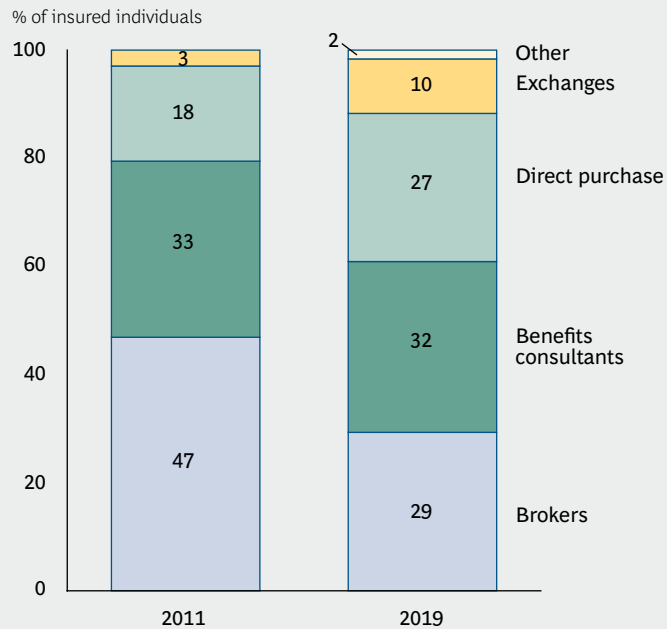
Distribution will undergo significant change. BCG estimates that the share of lives insured via brokers will drop from nearly half in 2011 to less than one-third by 2019, as more business is conducted directly or via exchanges. (See Exhibit 4.) Many Blues and regional plans are trying to find the right balance between investing in the broker channel, which generates the lion's share of their business today, and investing in new or increasingly important channels. One executive summarized the dilemma: "Brokers are why our brand is so strong. They've taken care of us, so we will take care of them. But we may have to cut their commissions to be able to invest in exchanges."

Despite their investments in growth, most insurers remain wary of exchanges. The cornerstone of the new retail-oriented market—the exchange—remains unnervingly abstract. Nearly all the executives we interviewed cited exchanges as their biggest concern, mainly because of the latitude states have to develop their own solutions. It is difficult, if not impossible, for insurers to develop comprehen-

Seventy-three percent of insurers are planning to increase their marketing and sales capabilities in the near term, with a particular focus on direct-to-consumer marketing.

EXHIBIT 4 | Brokers Will Account for a Declining Share of Customers

Market share of health insurance distribution channels as a percentage of insured individuals, 2011 and 2019



Sources: BCG survey of payer responses to the Affordable Care Act; BCG interviews.

sive strategies for participating in the exchanges without knowing more about how they will operate. Payers—and others in the industry—are likewise uncertain, or even skeptical, about the extent to which customers will embrace exchanges. “It will be an expensive pool of unhealthy lives,” remarked one survey participant, “and few will buy.” In addition, payers are concerned about the expected churn of customers between Medicaid and the exchanges. Projections show that more than 65 percent of people who are either Medicaid- or exchange-eligible will, at some point during a given 24-month period, shift from being Medicaid-eligible to being exchange-eligible, or vice versa, because of changes in income.³ This volatility could lead to gaps in coverage, particularly if consumers view the enrollment processes as too complicated. As a result, several plans are focusing on simplifying the member experience, especially around purchasing and enrolling.

But exchanges are impossible to ignore. Many insurers have taken a wait-and-see approach to participating in exchanges, but their basic strategies are already taking shape. Nationals will be compelled to compete in states where they have deep roots, such as California, Florida, Illinois, New York, and Pennsylvania. Beyond these markets, however, nationals are likely to cherry-pick the most attractive exchanges. Most are planning to leverage their low-cost operating models to develop affordable products geared specifically to exchanges. Some are reverse engineering existing products with a specific price tag in mind. Blues and regionals, on the other hand, feel obligated to participate in their states’ exchanges, not only out of a sense of duty but also because their success hinges on deep penetration in a single

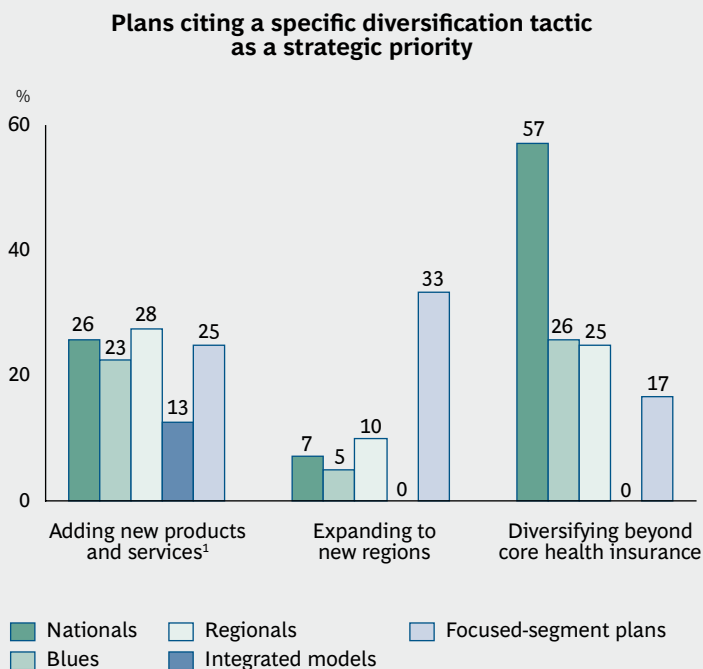
market. They are planning to leverage their local knowledge and established brands to capture exchange customers.

New Frontiers: Diversifying Revenue Streams

Health plans are pushing the boundaries of their businesses in an effort to increase revenues and alleviate some of the pressure on margins. Smaller plans are diversifying into new customer segments or insurance products (such as new stop-loss products for providers), while larger plans are venturing further afield.

Some payers are moving beyond their core health-insurance markets. Nearly 60 percent of nationals are interested in diversifying beyond the core business, in part because they have the capital to do so, along with the need to backfill eroding margins to satisfy investors. (See Exhibit 5.) Some have already ventured into international markets, and we expect others to begin exploring overseas options, as well. Nationals are also pushing the boundaries of their business models within the U.S. For example, Aetna acquired Medicity, a health IT infrastructure provider, to enhance its capabilities in health IT and health information exchanges. Others are seeking to generate new revenue streams by leveraging their core capabilities. Some nationals see an opportunity to help providers transition to an ACO model by providing information infrastructure, including measurement and reporting capabilities and risk management solutions. In addition, many plans, not just nationals, are designing holistic health and wellness services in order to become “health

EXHIBIT 5 | National Plans Are the Most Interested in Diversifying Beyond the Core



Sources: BCG survey of payer responses to the Affordable Care Act; BCG interviews.

¹Includes customization and bundling.

management” companies. Although such services dovetail with broader trends in health care, more work needs to be done to develop proven, effective strategies for engaging members and changing their behavior. Finally, plans in general have been experimenting with vertical integration, particularly over the past several months.

Reform will prompt payers to expand geographically, sometimes through

M&A. One-third of focused-segment plans want to expand geographically. Most are already active in either Medicaid or the individual business—two areas that are expected to grow significantly. As a result, they see multiple opportunities to push into new states. For example, Centene has moved into the Massachusetts Medicaid market through a subsidiary, CeltiCare. Entry strategies will vary from state to state, depending on growth rates and the current level of market concentration. In Texas and Florida, for instance, the number of people covered by Medicaid is expected to increase at an average compound annual rate of about 7 percent and 8 percent, respectively, from 2011 to 2019. Both markets are relatively fragmented, with the top three payers accounting for only about 40 percent of the Medicaid market. Plans that are looking to enter these markets would likely consider acquiring an incumbent.

Blues have a renewed sense of urgency to cooperate as a system in order to build virtual scale.

The Evolution of the Payer Landscape

The survey of health plan executives revealed an industry in motion. Payers are not only looking past the uncertainty surrounding reform but are moving ahead on more than one front. Most are gearing up for the new environment with a mix of cost and growth initiatives, as well as traditional and innovative strategies. By underscoring how much the responses among the different types of plans diverge, the survey provided important insights into how the landscape will evolve.

- *Nationals* are ahead of most other types of insurers when it comes to shoring up the core business, owing to their scale and capital. They are developing low-cost products and aggressively outsourcing operations. They have also placed significant bets on new products and services as well as on new markets. The successful national plan of the future is likely to be a diversified health-services company. It will leverage its extensive data and analytical capabilities as a source of competitive advantage, and its reach could well extend beyond the U.S. Some nationals are likely to be active acquirers.
- *Blues* are trying to leverage their deep local-market shares and strong relationships to collaborate with providers. While many Blues lack the scale of the nationals, they have a renewed sense of urgency to cooperate as a system in order to build virtual scale. The successful Blue plan of the future is likely to be part of such an alliance. It will differentiate itself with a strong portfolio of member-focused initiatives, along with innovative ways of working with providers to manage medical costs. Further consolidation among the Blues is difficult to predict, given local regulatory oversight.
- *Regionals* have some of the same advantages as Blues but lack their extensive network of sister plans. As a result, the successful regional plan of the future is likely to have a slimmed-down business model that relies heavily on two

capabilities. First, it needs to be an effective integrator, pulling together offerings from various partners to offer a superior member experience. Second, it needs to have a powerful sales and marketing engine. At the same time, we would not be surprised if some regionals merge with other regionals, or—in a nod to integrated models—become part of local delivery systems.

- *Integrated models*, as noted earlier, do not need to change their business model. The rest of the industry is rapidly moving toward their way of doing business. At the same time, they face significant constraints on their growth, including low levels of capital and relatively small footprints. The successful integrated plan of the future will find innovative ways to manage the insurance and medical risks of its population in order to consistently offer low-cost products.
- *Focused-segment payers*, given their penetration of the government (Medicaid or Medicare) and individual markets, are well positioned to capture new retail customers. As a result of their prime positions, some of these plans will be attractive to larger, better-capitalized plans seeking growth via M&A. The successful focused-segment plan of the future will be a retail machine that excels at attracting and retaining customers and is able to leverage its deep knowledge of customers to bend the cost curve.

Of course, theorizing about the pathway to success and actually following it are two different things, particularly in an industry known for trying to be all things to all people. A herd mentality—the convergence of payers on the same growth opportunities—simply cannot prevail in an era of diminished margins. To adapt their business models along the lines described above, many insurers will be forced to make difficult choices while continuing to push ahead with unconventional initiatives—in terms of managing medical costs, for example, or collaborating with providers.

As payers begin to recognize and respond to these imperatives, we expect the industry to assume a more sharply divided, barbell-shaped profile, with large plans at one end and smaller, niche plans at the other. The large plans—a mix of nationals, regionals, and Blues—are likely to be even larger, by virtue of their acquisitions and partnerships, and more diversified. At the other end of the spectrum, smaller, more nimble plans will exploit specialized product or customer niches. A sustained focus on innovation will be the common denominator among successful plans. Payers at either end of the spectrum will excel at developing new kinds of provider relationships, new revenue streams, and new products that appeal to the retail customer.

The payer industry entered the reform era with a fair amount of wind in its sails. Years of steady growth and strong performance have put most insurers in a position to invest in the capabilities and initiatives they need to thrive in the new environment. The survey suggests that few, if any, are complacent, and most are confident in their ability to adapt and win, despite the myriad challenges and complexities introduced by the Affordable Care Act.

We expect the industry to assume a more sharply divided, barbell-shaped profile, with large plans at one end and smaller, niche plans at the other.

NOTES

1. Leighton Ku and Teresa Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, Vol. 36, Winter 1999/2000.
2. Linda J. Blumberg, John Holahan, Jack Hadley, and Katharine Nordahl, "Setting a Standard of Affordability for Health Insurance Coverage," *Health Affairs*, Vol. 26, No. 4 (2007), <http://content.healthaffairs.org/content/26/4/w463.full.html>.
3. Benjamin D. Sommers and Sara Rosenbaum, "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges," *Health Affairs*, Vol. 30, No.2, 2011.

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