Total cost management for payors

How to raise medical value and lower administrative costs
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U.S. healthcare payors have come under tremendous pressure to strike a difficult balance: control rapidly rising medical expenses to make healthcare more accessible, while also constraining operating expenses to maintain margins. In an effort to remain both competitive and profitable, many payors mistakenly assume they have to focus their improvement efforts on either medical or administrative costs. We challenge the notion that these two categories are mutually exclusive. Rather, payors have a number of levers they can pull to optimize both medical and operating expenses and thus achieve better healthcare outcomes at lower costs. Moreover, payors can make smarter choices about which levers to pull.

In this report, we present a consumer-centric medical value transformation framework that shows how health plans can address these dual objectives. By applying the framework, they can reduce both medical and administrative costs simultaneously as they transform their middle-office operations (care management, quality management, and provider networks) to become more effective and efficient. In turn, the freed resources can be reinvested to build the capabilities needed to thrive in the new healthcare environment, such as population segmentation, innovative care models, and savvier network design.
In the past several years, a confluence of forces — including healthcare reforms, emerging new competitors, and consumerization among patients — has created a far more challenging environment for U.S. health insurers. As a result, they now face a difficult balancing act between controlling rapidly rising medical expenses to make healthcare more accessible, and constraining operating expenses to maintain margins.

Our work with large national and regional payors suggests that many of them, in an effort to remain both competitive and profitable, mistakenly assume they have to focus their improvement efforts on either medical or administrative costs. With this supposedly unavoidable trade-off in mind, payors have established “strong-form” care models that channel extensive resources into utilization, case, and disease management functions charged with attacking medical expenses, which constitute the majority of total costs.

The problem with this approach is that the resulting efforts to reduce medical spend and administrative costs have raised middle-office costs. For example, payors staffed extensive utilization, case, and disease management functions to support timely prior authorizations and utilization tracking, resulting in oversized middle-office functions with a low return on investment (ROI). Similarly, most payors’ quality management and network operations functions have evolved to include activities that are no longer needed for effective operations (such as the use of obsolete quality metrics and unnecessary prior authorization requirements). This has led to uncoordinated efforts to balance medical costs, administrative expenses, and quality.

What’s needed is a more strategic approach — one that cuts the costs of traditional middle-office programs by focusing on ROI. Using such an approach, payors can then reinvest cost savings in capabilities that support segment-specific care models and high-performing, value-based provider networks. This is essential for driving the deeper cost transformation necessary for payors to survive and thrive in an increasingly challenging landscape.
Reduce administrative costs and relieve capacity

In this report, we present a consumer-centric medical value transformation framework (see Exhibit 1). The framework shows how payors can achieve medical and administrative cost management goals simultaneously as they transform their middle-office operations (utilization, case, and disease management; quality management; and network operations) to become more effective and efficient. Our analysis suggests that payors that adopt this framework can create medical value by reducing administrative and medical costs in the current environment. As a result, they free up resources to invest in needed future-state capabilities, such as population segmentation, innovative care models, and network design for high performance.

Exhibit 1
The consumer-centric medical value transformation framework

Current state

- Utilization management
- Disease management
- Case management
- Quality management
- Network operations

Future state

Goals: Improved quality of care and patient experience at lower cost

- Population segmentation
- Care models
- “High-performing” and “value-based” networks

1. Reduce administrative costs and relieve capacity
2. Reduce medical costs by focusing on ROI through released capacity
3. Reinvest savings in future capabilities

Source: Strategy& analysis
This approach emphasizes three elements that are critical for maximizing the ROI of payor activities: effectiveness, efficiency, and organizational alignment (see Exhibit 2).

**Effectiveness**

Our analysis of and experience with small and large payors suggest that this more focused approach to care management activities, including utilization management, will enable companies to reduce operating expenses by 30 percent to 60 percent. As an example of the need for sharper focus, we benchmarked utilization management operations across five national and regional payors and found that almost 80 percent of procedure codes have a negative ROI, with 38 percent of codes being approved 100 percent of the time (see Exhibit 3, next page).

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**Exhibit 2**

Maximizing ROI in payor activities

<table>
<thead>
<tr>
<th>Improvement levers</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Effectiveness</strong></td>
<td>Removing activities that have an unsatisfactory ROI (e.g., below a certain threshold)</td>
</tr>
<tr>
<td><strong>Efficiency</strong></td>
<td>Improving the efficiency of the remaining activities around three primary levers:</td>
</tr>
<tr>
<td></td>
<td>– Process/system redesign and automation</td>
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<tr>
<td></td>
<td>– Staff productivity</td>
</tr>
<tr>
<td></td>
<td>– Work-force management (WFM)</td>
</tr>
<tr>
<td><strong>Organizational alignment</strong></td>
<td>Improving the organizational alignment through spans and layers and organizational restructuring</td>
</tr>
</tbody>
</table>

Source: Strategy& analysis
Exhibit 3
ROI for procedure codes in select treatment areas

79% of all codes have ROI <1

Aggregate ROI breakdown*

Respiratory, cardiovascular, hemic, and lymphatic system
Musculoskeletal system
Digestive system
Urinary, genitals, maternity care, and delivery system
Endocrine, nervous, eye and ocular adnexa, auditory system
Anesthesia services
Integumentary system
Evaluation and management services
Miscellaneous
Radiology services
Pathology and laboratory services

* Only codes with >10 cases were used

Note: Numbers may be rounded.

Source: Strategy benchmark analysis across five health plans
To maximize operational savings in utilization management, payors need to deploy a rigorous ROI-based approach to decide which activities to cut and which to keep or add. Examples include current procedural terminology (CPT) category ROI, medical savings, and provider ROI. After analyzing these criteria, payors can choose the best options for reducing operational costs, such as dropping CPT codes from prior authorization lists, minimizing plan-member touch points, automating processes, and improving the execution of specific processes (for example, by beefing up training and making pay-code reviews more consistent). This ROI-focused approach can also be applied just as effectively to inpatient case management and disease management functions.

**Efficiency**

In parallel with becoming more ROI-driven about their activities, health plans can also achieve significant operating savings by enhancing workforce productivity and efficiency. The middle office in many organizations is excessively staffed for labor-intensive, multistage processes that are tracked through self-reporting, which makes work effort and time allocation difficult to measure.

These and other challenges result in costly labor inefficiency, including idle resources. In response, insurers need to align the staff to work patterns and volumes as well as reduce staffing waste. Achieving scale by sharing resources across multiskilled and multi-process operations can help, as can analyzing data on production and resource utilization (both real-time and historical). Our benchmarks analysis across five plans found that there is a potential savings of 10 to 15 percent in managing shrink (nonproductive time away from the desk) and idle time (time when the operator is at the desk but not engaged in a work activity).¹

**Organizational alignment**

As payor organizations grow, staffing and management ratios, spans of control, and reporting layers grow more complicated. Simplifying these by benchmarking industry best practices will free up further savings, as will restructuring the organization to align with more effective and efficient operations, such as standardizing staffing ratios across markets and functions.
Reduce medical costs by focusing on ROI through released capacity

As the clinical capacity is released through reduction in operating expenses, some of it can be redirected to focus on improving the ROI of the remaining programs. This can be done by identifying incremental opportunities across the current programs that will increase medical cost savings. For example, within the utilization management operations, claims analytics can uncover procedure codes that can potentially yield positive ROI if they are added to the prior authorization list. Similarly, by improving the quality of referrals from utilization to case and disease management, plans can achieve a better ROI for some of the existing utilization management operations.

Another lever to reduce medical costs in the near term is to reengineer the existing clinical review processes, many of which are ineffective in evaluating the medical necessity of the procedure due to a lack of training or coordination among the clinical staff.

While these interventions to improve medical expenses are not strategic or transformative, they can uncover financial savings that can be directed toward the more strategic, population-based models of care.
Segment members and build population management capabilities

The dirty little secret of healthcare is that most of the costs and needs are concentrated — roughly 5 percent of the population accounts for 50 percent of spending. And 20 percent of the population controls 80 percent (see Exhibit 4, next page). The needs among that 20 percent are unique and varied. Our research of more than 20 models across the country reveals three key imperatives to increase medical value.

Medical value lever 1: Population segmentation

A holistic approach to improving plan members’ health will enable payors (as well as providers) to reduce medical expenses while also achieving valuable economies of scale. To adopt this approach, health plans must segment healthcare consumers. The goal of population segmentation is to design the most suitable care management model for each segment. Possible segmentation criteria include attitude (how proactive a plan member is in managing his or her health and accessing healthcare resources), health condition (relatively well versus dealing with serious chronic disease), and care setting (patient home, hospital, or assisted-living facility, for example). A critical capability for this kind of segmentation is consumer analytics and predictive modeling, which can match the most effective types of care and outreach to specific patient segments.

As part of this effort, health plans can use predictive modeling to better classify plan members’ current and future needs and preferences across the scope of interactions they experience. Examples of such interactions include “attract and enroll,” “advise and engage,” “flip members to relevant programs and services,” and “help and support.” Armed with such understanding, payors can design comprehensive interaction models tailored to each segment.

To get the most benefit from population segmentation, plans need to use value as the fundamental criterion. That is, instead of the traditional approach of focusing efforts on specific service or code categories, they need to understand which segments have the
biggest impact on costs. That way, they can design a model that meets the needs of different segments. For example, insurers can help high-need plan members take a more active role in managing their health, by providing greater access to resources through more numerous touch points. Meanwhile, the plans can engage with the rest of the population through lower-cost self-service mechanisms.

**Medical value lever 2: Integrated care models**

In driving medical value, coordination among the various stakeholders is critical. Managing the highest-cost populations, in particular, requires a tightly integrated effort across all constituents — including patients, their doctors and other providers or caregivers, and payors. Indeed, our research into two dozen care models nationwide revealed that the most successful models have five defining components: (1) integrated care coordination, (2) care collaborators, (3) payor and provider engagement and outreach to consumers, (4) use of digital technology and informatics, and (5) the right incentives. Care models that have these components can be tailored to each population segment the payor has identified. For example, the whole-person care model that Strategy& developed aims to help payors manage the most costly populations effectively (see Exhibit 5, next page).

To support their chosen care models, plans must establish the right management capabilities. These include understanding and controlling...
the forces affecting utilization management value, which vary considerably across providers and CPT codes.

**Medical value lever 3:**

**High-performing, value-based provider networks**

Developing high-performing, value-based provider networks will help payors operationalize their chosen care models for each population segment. A number of payors have tried to define narrow or tiered...
networks aimed at containing rising medical expenses. However, that approach is not comprehensive enough. By “high-performing,” we mean networks that optimize quality, economics, and consumer preferences to deliver desired value to plan members.

Similarly, by “value-based,” we mean networks with risk-based arrangements that create a wider range of strategic choices for payors to use to address rising medical costs. Given the increasing number of accountable care organizations — and the medical costs flowing through these networks — value-based arrangements (VBAs) are key to the next generation of managed care. These arrangements enable payors to move away from the fee-for-service (FFS) model through risk sharing with healthcare providers. Examples of new VBA models include FFS plus bonus, FFS plus gain share, FFS plus partial capitation, budget plus partial capitation, and global capitation plus payor-owned.

However, though many plans have some form of VBA model in place, some have not fully mobilized the capabilities needed to extract maximum value from the arrangement. Our experience suggests that payors can lower overall costs while also improving quality of care by applying the following practices:

- **Make sure VBAs support the payor’s strategies.** For example, VBA models that support a payor’s affordability strategy will focus on reducing medical and administrative costs.

- **Define VBA archetypes.** Create a manageable set of VBA archetypes — categories of arrangement types — that the payor will support in the market. Define the benefits and trade-offs of each archetype.

- **Segment the market.** Develop a prioritized list of geographies and providers in the market that are ready to adopt a VBA.

- **Pair VBA archetypes to market segments and providers.** Assign each archetype to the right prioritized segment and provider.

- **Develop capabilities.** Develop capabilities that enable targeted contracting with providers and successful achievement of mutual goals. Examples of such capabilities include the right governance model, care delivery, information technology, and administrative skills.

By adopting a true value-based contracting approach, some plans have been able to reduce medical expenses by as much as 15 percent.
Next steps for payors

How insurers navigate the new healthcare landscape in the next three to five years will spell the difference between success and failure. The single-minded, simplistic approach to cost savings that health plans have long relied on will not be sufficient. Instead, payors will need to transform their cost structure to reduce both medical and operational expenses — in ways that deliver greater value to healthcare consumers while also strengthening plans’ bottom line.

Forward-looking payors willing to overhaul their business models will be able to create entirely new models swiftly — investing only in activities needed to support those models, and thereby achieving a lower administrative cost structure at the outset. By contrast, incumbents struggling with legacy approaches must overcome any gravitational pull toward the past and transform now — or face the possibility of being left behind by newer players as well as their more progressive peers. To avoid this fate, incumbents can take the following steps:

• Aggressively cut the administrative costs of middle-office activities by weeding out those with low ROI, and relieve capacity.
• Reinvest the capacity in programs that can generate a higher ROI in the current environment.
• Develop a future-state operating model — one that enables the company to achieve its goals for medical and operating expenses.

Transforming a plan’s cost structure through such actions requires extensive coordination and strong change management leadership. Yet health plans cannot afford to shy away from the work. Their profitability — and their very survival — hangs in the balance.
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Endnotes

1 Sundar Subramanian, Gil Irwin, George Svoboda, and Christoph Dankert, “Go lean or go home: How health plans can better manage their workforce,” Strategy&, June 2014.