We all know the trends. Our nation’s health is declining and our healthcare costs are rising. 20% of patients account for 80% of healthcare dollars,¹ and the Center for Medicare and Medicaid Services estimates healthcare spending to account for 20% of GDP by 2025.² In the face of these trends, the entire U.S. healthcare industry is under tremendous pressure to reduce healthcare costs while improving health outcomes.

In order to understand how these threats are impacting health insurers, Willow Research and PNC Healthcare undertook a large-scale study with payer executives. Through qualitative and quantitative research nationwide, we examined the challenges that payers face, what they are doing to address those challenges, and how they are preparing for the future.

Our research finds that payers are proactively reimagining themselves for a different — and even more influential — role in a rapidly evolving healthcare landscape.
This article reports the results of our quantitative study of payer executives, supplemented by insights and verbatim comments from the qualitative research.

In this paper, we look at:
• The biggest challenges facing payers today
• What payers are doing to address the cost problem
• How they are coping with ACA uncertainty
• How payers are reimagining themselves for the future

This is the second of three white papers on the state of the healthcare industry. The first, “Hospitals in Transformation,” focused on how providers are navigating the tumultuous healthcare climate. The third will look at employers: their commitment to continued health benefits and how they’re adapting to contain rising costs.

**Payers Are Leveraging Their Assets and Hedging Their Bets**

Payers find themselves in a unique position. Yes, rising healthcare costs and Affordable Care Act (ACA) uncertainty are challenges that need to be addressed, but many payers find themselves well-situated to play a central role in solving healthcare’s thorniest problems. They aren’t experiencing the solvency danger facing hospitals and health systems, and beyond financial stability, they have two powerful resources at their disposal: 1) direct relationships with both members and providers; and 2) vast oceans of data from both sides. If they can harness those assets effectively — and they are certainly trying to — they stand to both improve the health of their members and slow the ever-increasing costs of healthcare. In the process, they are starting to evolve beyond their traditional function as claims-denier and fees-processor, and possibly even beyond their perceived role as the antagonist in the healthcare drama.

Aside from leveraging their core assets to reduce costs, many payers believe that there are long-term threats to their business (both marketplace and regulatory) and are mitigating their risk through investment, diversification and innovation.

However, just because they’re poised for success doesn’t mean the path forward will be easy. Payers are not entirely confident that their initiatives will succeed, citing struggles with member engagement, provider buy-in and data integration.

Yet, our research finds that payers are betting on the future: taking advantage of their relationships and strength in analytics, with the hope of improving outcomes, reducing costs and, ultimately, being at the center of the eventual solution.
The Biggest Challenges

Far and away, payer executives say their biggest challenges are costs and ACA uncertainty. But, about half of payers are also struggling with systems integration, aligning incentives with their providers, and consumer engagement and education. And, a substantial minority of payers are threatened by some of the changes happening among providers today — providers entering the payer space and provider consolidation. Importantly, just one in three payers sees the rise in employer self-insurance as a significant threat to their business.

Rising healthcare costs isn’t just a payer problem; it’s an everybody problem.

— Executive Director/CEO, Payer, National

Payer executives blame rising healthcare costs on a number of factors but place the most culpability on the high cost of pharmaceuticals (general and specialty) and the rise in chronic health conditions (e.g., diabetes, obesity, cardiovascular disease).

A substantial minority also fault the high cost of medical devices, therapies and equipment. Relatively few payers blame the high cost of healthcare on overbuilding of hospitals, or bloated administrative costs or salaries on the provider side.

HOW ARE PAYERS ADDRESSING THE COST PROBLEM?

Analytics: First, payers are leveraging their core capabilities in analytics to identify and target high-risk, high-cost members, shape provider behavior, and move the needle on population health.

Members: To encourage healthier behavior and prevent chronic disease — a major driver of high healthcare costs — payers are working to promote member responsibility for their own health through several initiatives, including wellness programs, consumer education and digital health / telemedicine.

Providers: On the provider side, payers are attempting to align financial incentives and foster greater collaboration with hospitals and health systems through value-based care initiatives, narrow networks and other payer-provider programs.

We’re constantly looking at ourselves, our policies, procedures, and how we can improve in the organization, technology, product offerings, improving our customer service, improving our member engagement, consumer engagement programs, health and wellness, collaborations with different organizations, provider collaboration — those are all the areas that we’ve been working on that I think are key to survival.

— Marketing Director, Payer, Midwest
Analytics: A Core Payer Asset

When asked about recent trends and opportunities, many payer executives discuss data analytics / predictive analytics. No longer relegated to IT or finance, clinical and financial data are coming together in payer organizations to a powerful end. Whether it be for predicting high-risk patients, reducing readmissions, managing pharmaceutical costs, or targeting participants for wellness programs, payers are crunching data in every way imaginable to achieve the primary aims of the Affordable Care Act (ACA) — improving outcomes and reducing costs.

The vast majority of payers are currently using — or planning to use — predictive analytics to identify and target high-risk patients, influence provider behavior, and guide their reimbursement strategies with providers. While still a majority, fewer payers are currently using or planning to use analytics to select network partners or providers.

There’s a huge fundamental shift in having “Data” seen as a separate asset and not an extension of health IT. Data, like sunshine, is the core source of energy for business. Data analytics are being applied to every aspect of the health enterprise operations today. Data and the associated analytics are being used to prevent readmissions, predict diseases, improve efficiency and invent the future of life and health. Data is the fuel for all businesses. Health and Life Science organizations must re-engineer their entire transaction-based processes by harnessing the power of data and analytics to deliver value, population health and improved quality of life. The challenge we all face is applying data smarter, securing and protecting and figuring out how to monetize the use of data all along the continuum of life.

— Douglas Goldstein, @eFuturist

Challenges with Analytics

While payers are investing heavily in analytics and are continuing to expand its use, predictive analytics has its challenges. Providers can be resistant to data output, particularly when it pertains to their own outcomes or performance metrics, and, as we saw in our recent study of hospital executives (“Hospitals in Transformation”), disparate systems often impede the integration and comparability of data.

Payers also struggle with determining the right data-based interventions to impact population health. It can take time to see ROI on any interventions, which is further complicated by the frequent turnover in plan members. And, last but not least, patients, particularly high-risk ones, often resist changing their behavior, even though it will improve their health outcomes.

Member Initiatives

Of all their major initiatives today, payers are both most committed to and making the most progress on their member initiatives (e.g., wellness / incentive programs, consumer engagement / education, and even digital health / telemedicine).
While committed to partnering with providers, less progress is being made on this front, perhaps due to some resistance from the providers, which we discuss in greater detail below.

Payers have been hard at work developing consumer engagement and education initiatives. In response to consumer demand and in an effort to engage their members, nearly all payers are emphasizing customer service and have set up an online member portal with a physician finder tool. Most payers are also focusing on consumer education around health benefits and costs, offering telemedicine (e.g., virtual office visits with physicians), establishing coordinated care teams, and developing mobile apps for members. Online cost estimators for pharmaceuticals and medical services are also in the pipeline.

Payers have embraced apps to further engage their members. Among payers who have set up mobile apps for their members, the vast majority enable members to access their health insurance portal through the app and to participate in the payer’s wellness/incentive programs. Expanded use of mobile apps for monitoring patient health and virtual office visits are also in the works.

**Challenges with Member Initiatives**

Although payers are attempting to engage their members on multiple fronts, they cannot go about it on their own. Payers view provider collaboration as critical to certain member engagement initiatives. Payers say that it is difficult to get consumers to take responsibility for their own health, especially without provider intervention. Some payers have established their own case managers to work directly with members but have found it more effective to work through case managers on the provider side.

Trust is a major challenge for the health insurance industry today. Indeed, in PNC Healthcare’s 2015 study of patients, when consumers were asked to rate their confidence in different healthcare institutions, commercial insurance companies ranked at the very bottom, right alongside pharmaceutical companies. Many consumers reported the belief that commercial health insurance providers put their own profits above patient care.

Payer executives recognize that consumers do not trust health insurance companies and certainly do not want their insurance company interfering in their relationship with their doctor or dictating their treatment and medication options. As a result, it is difficult for payers to drive behavioral change that promotes wellness (and therefore, cost savings) on their own. Payer-provider collaboration and goal alignment among patients, providers and payers will be essential for success.

**Provider Collaboration Is Critical**

Fully-integrated delivery networks like Kaiser and Geisinger are held up as the gold standard in the industry because they fully align incentives between payers and providers.

I think those that are in the best position to thrive are integrated systems that have sophisticated capabilities to do population health, be able to influence the consumer, and hold on to those members for 3–5 years.

– Payer Executive, Integrated Delivery Network

However, most payers are focusing more on aligning incentives and collaborating with providers through ACOs, patient-centered medical homes and other value-based care initiatives, rather than consolidating with payers to establish integrated delivery systems. In fact, nearly half of the payer executives we spoke with say that their organization is very committed to payer-provider collaboration, while just one in five say that they are very committed to payer-provider consolidation.

Payers are undertaking a number of different value-based care initiatives with providers. The overwhelming majority of payers have already developed or are planning to develop payer contracts that incentivize their providers on cost and quality. The majority of payers are also establishing Accountable Care Organizations (ACOs) and setting up capitated payments and bundled payment structures. While not as pervasive, a majority of payers also plan to get involved in patient-centered medical homes, with one-third of payers already doing so.

**Adoption of Member-Focused Initiatives**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Total Adoption</th>
<th>Currently Doing</th>
<th>Not Currently, but Planning To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emphasizing customer service</td>
<td>93%</td>
<td>88%</td>
<td>5%</td>
</tr>
<tr>
<td>Online physician finder tool</td>
<td>90</td>
<td>82</td>
<td>8</td>
</tr>
<tr>
<td>Online member portal</td>
<td>90</td>
<td>78</td>
<td>12</td>
</tr>
<tr>
<td>Focusing on consumer education around health benefits and costs</td>
<td>90</td>
<td>70</td>
<td>20</td>
</tr>
<tr>
<td>Coordinated care teams and case managers</td>
<td>86</td>
<td>66</td>
<td>20</td>
</tr>
<tr>
<td>Telemedicine (e.g., virtual office visits)</td>
<td>86</td>
<td>56</td>
<td>30</td>
</tr>
<tr>
<td>Providing mobile apps for our members</td>
<td>83</td>
<td>59</td>
<td>24</td>
</tr>
<tr>
<td>Online patient cost estimator for pharmaceuticals</td>
<td>75</td>
<td>48</td>
<td>27</td>
</tr>
<tr>
<td>Online patient cost estimator for medical services</td>
<td>74</td>
<td>50</td>
<td>25</td>
</tr>
</tbody>
</table>
Despite making the shift to value-based care, payers are not totally convinced the move will succeed in its aims. Only one in four payers are very confident that the shift to value-based care will actually improve healthcare outcomes, while only one in five are very confident that it will reduce healthcare costs.

**Challenges with Provider Collaboration**

Further, while committed to provider collaboration, payers explain that they face resistance from providers who do not always buy into their recommendations. In the past, the two have had an antagonistic relationship, and that history may hinder their ability to partner today.

Payers believe that providers resent insurance companies intruding on their domain and are not always receptive to financial risk-sharing models that payers might propose (e.g., value-based care payments). These health insurance executives also say that providers resist the changes to their practices and pricing models required for inclusion in a narrow network and also distrust payers’ value-based care analytics pertaining to quality and performance measures.

52% of payers report provider alignment/buy-in to be quite challenging when it comes to executing value-based care initiatives.

However, in our recent study of hospital executives, we found that providers today are both committed to and making progress on value-based care initiatives, suggesting that the long-term tension between payers and providers represents the real threat to their successful collaboration.

**Impact of the Affordable Care Act on the Payer Organization**

<table>
<thead>
<tr>
<th>Covered Lives</th>
<th>Operates in Medicaid Expansion States</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1M (N=36)</td>
<td>1M-9.9M (N=37)</td>
</tr>
<tr>
<td>Positive</td>
<td>33%</td>
</tr>
<tr>
<td>Neutral / little impact</td>
<td>22</td>
</tr>
<tr>
<td>Negative</td>
<td>44</td>
</tr>
</tbody>
</table>

**HOW ARE PAYERS COPING WITH ACA UNCERTAINTY?**

**The Impact of the Affordable Care Act on Payers Has Been Decidedly Mixed**

Nearly half of payer executives say that the ACA has been a net positive for their organization, while one-third say that the impact has been negative. Just one in five say the ACA has had no impact on their business.

Larger payer organizations are more likely to say that they have benefited from the ACA, while smaller payers are more likely to have felt a negative impact. Payers who operate in Medicaid expansion states have benefited more from the ACA than those who operate in states that didn’t expand.

**The Uncertain Future of the ACA Poses a Real Challenge to Payers**

Regardless of how it has impacted their organization, the effort to repeal and replace the Affordable Care Act is creating considerable uncertainty for payers, who don’t know what to expect in terms of future reimbursement rates, cost-sharing subsidies, covered lives and taxes.

Payer executives expressed tremendous frustration with the regulatory uncertainty and with the politicization of healthcare and say that they are stymied by their inability to forecast their risks and determine what types of plans to offer and to whom.

Yet, payers are not simply sitting and waiting for Congress to decide on the future of the ACA. While some payers are delaying large capital expenditures (e.g., technology infrastructure), as a group they continue to move forward on many of their long-term initiatives, including those engendered by the ACA.

In the short term, payers are raising their rates. Most payers have increased their premiums across the board in 2018, particularly for members with group and individual insurance.
The challenges in planning are particularly acute for payers who have made a commitment to being on the exchange, or individual market. Nearly four in ten were on the exchange in 2017. Some opted out of the exchange for 2018 because of the uncertainty. Among those who were on the exchange in 2017, two-thirds remained on the exchange in 2018, while one-third exited the exchange in at least some markets. Payers who have exited the exchange or plan to do so explain that they just didn’t get the ROI from participating in it.

**Mixed Feelings About the ACA**

On the one hand, payers want people to have health insurance and support the idea of universal coverage, which they feel the ACA accomplished. On the other hand, they say that the ACA did not sufficiently address the cost side of the equation, making it untenable in the long term.

When asked how well the Affordable Care Act has delivered against each of its primary goals, payer executives credit the ACA for advancing the goals of expanding access to healthcare and protecting patients against arbitrary actions by insurance companies, but say the ACA has only made moderate progress on its third aim: cost reduction.

**What Do Payers Want in ACA Reform?**

While critical of some aspects of the ACA, most payers prefer to see improvements and reform, rather than a wholesale repeal and replacement of the legislation.

Payer executives were asked whether they favor or oppose specific proposed changes to the Affordable Care Act. They are heavily in favor of stronger regulation of prescription drug costs and also support raising the contribution limit on health savings accounts in order to increase consumer responsibility.

> I think there’s an understanding that we don’t want to go backwards and waste what we’ve done. We’d like to improve upon it and fix it moving forward.

– Executive Director / CEO, Payer, National

On the other hand, payers are largely opposed to removing the essential health benefit requirement and rolling back Medicaid expansion.

More than anything, payers want healthcare to be more affordable. When asked to identify one thing they would want to see in a new healthcare bill if they had a seat at the table, payer executives most frequently discuss the desire to find a way to lower healthcare costs / make healthcare more affordable.
Our ultimate goal is affordable healthcare as much as possible for everyone. We can see ourselves growing and competing. We think that affordable healthcare is where we need to be, and we think we can get there using the networks we’re creating and the payment models we’re working on right now.

– VP Treasury Services, Payer, Northeast

REIMAGINING THE FUTURE FOR PAYERS

Ultimately, payers are trying to make the shift from middleman to active change agent. They believe that their core strength in data analytics makes them uniquely suited to facilitate improved outcomes and cost reduction among members and providers.

Nine in ten payer executives (91%) express confidence in their organization’s ability to survive in the foreseeable future. At the same time, more than eight in ten payers (83%) agree that the role of health insurance companies is changing, and the payer of tomorrow will look different from the payer of today.

Payers also recognize the potential threats that loom ahead, including continued rising costs and potential regulatory upheaval. Indeed, one in five payer executives believe the U.S. is heading toward a single payer system.

There is general consensus that the payer of tomorrow will not be the same as the payer of yesterday, and payers are actively positioning themselves for a different role in the future. Some are building up their capacity in data analytics and population health, while others are strengthening their customer service and still others are focused on innovation and technology. In fact, many are doing all of the above.

Payers believe that their core assets make them uniquely suited to be of continued service to both members and providers, and they are reimagining their businesses in order to remain vital for the long haul.

Well, hold onto your hats. All of the major health plans have said to me, ‘We are not going to be the traditional insurer 10 years from now. We want to be a wellness company; we want to be a healthcare company, and whether that means we’re buying providers, or ancillary services, partnering with CVS or some of these other wellness programs... That’s where the real opportunity is. How do we grow our business ‘cause it’s not going to be ‘business as usual.’

– Deanne Kasim, Managing Partner, Santesys Solutions.
IN CONCLUSION
The pressures on the healthcare industry today represent both a challenge and an opportunity for payers. With their strength in analytics and their direct relationships with members and providers, payers are well-positioned to play a central and active role in shaping the new landscape.

However, historically, commercial payers have had an uneasy relationship, at best, with consumers and providers. It is somewhat ironic that payers today are working to repair these same relationships as a means to reinvent themselves.

Whether payers can actually improve their reputation or reverse the tide on cost and outcomes remains to be seen. These are universal and complex problems, and payers certainly can’t solve them alone. At a minimum, meaningful results will depend on goal alignment and willing participation of members and providers.

Nevertheless, in this research, we see that payers are positioning themselves to be central to a new healthcare landscape that engages payers, providers and consumers toward a common cause: driving wellness to reduce costs.

“If we’re going to lower total cost of care, it’s by engaging the consumer. It’s by engaging the provider. It’s by having the infrastructure and the analytics. It’s by scalability, which is going to come from health information technology, and it’s going to come from alignment of incentives. They all work together.”
– Payer Executive, Integrated Delivery Network

About This Study
PNC Healthcare and Willow Research examined the trends and challenges in healthcare today from the perspective of payers.

The Payer Study began with a qualitative phase, conducted from June through August 2017. This phase included secondary research and in-depth interviews with more than 20 healthcare experts and payer executives around the country.

The quantitative phase that followed was based on interviews with a national sample of 101 health insurance company executives representing payers of all sizes (i.e., covered lives), geographic reach (i.e., national, regional and local) and annual revenues. Respondents are C-suite executives, presidents, vice-presidents and directors who are involved in setting strategy for their organization. Online interviews were conducted from November to December 2017.

ABOUT THE AUTHORS
Jean Hippert
PNC Healthcare
jean.hippert@pnc.com

As senior vice president of strategy and business development for PNC Healthcare, Jean Hippert is responsible for increasing the presence and awareness of the group nationally, especially as a thought leader in subjects integral to the healthcare revenue cycle. She holds a bachelor of arts degree from Mary Washington University and is a participating member of Health Care Financial Management Association and Women Business Leaders of Healthcare Foundation.

Sara Parikh
Willow Research
sara@willowresearch.com

Sara Parikh is president and owner of Willow Research, LLC, a market research and consulting firm that designs and conducts original studies of consumers and professionals. She has 30 years of experience in research design, analysis and consulting. She holds a doctorate and a master of arts in sociology from the University of Illinois at Chicago, and a bachelor of arts in political science from the University of Wisconsin–Madison.
The article you read was prepared for general information purposes only and is not intended as legal, tax or accounting advice or as recommendations to engage in any specific transaction, including with respect to any securities of PNC, and does not purport to be comprehensive. Under no circumstances should any information contained in this article be used or considered as an offer or commitment, or a solicitation of an offer or commitment, to participate in any particular transaction or strategy. Any reliance upon any such information is solely and exclusively at your own risk. Please consult your own counsel, accountant or other advisor regarding your specific situation. Neither PNC Bank nor any other subsidiary of The PNC Financial Services Group, Inc. will be responsible for any consequences of reliance upon any opinion or statement contained here, or any omission. The opinions expressed in this article are not necessarily the opinions of PNC Bank or any of its affiliates, directors, officers or employees.

PNC is a registered service mark of The PNC Financial Services Group, Inc. (“PNC”). Banking and lending products and services, bank deposit products, and treasury management services, including, but not limited to, services for healthcare providers and payers, are provided by PNC Bank, National Association, a wholly-owned subsidiary of PNC and Member FDIC.

©2018 The PNC Financial Services Group, Inc. All rights reserved.