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Thrive or Survive? Will New Health Plan IT Needs Spur Vendor Consolidation?

by Geoffrey B. Baker

Advances in information technology, the rise of consumer-driven healthcare, and the need for ROI-driven medical management, have created new payer requirements for purchasing technology. Today, health plans are deploying technology solutions that support a seamless, integrated care management process for patients. This represents a break from past practice, where payers generally sought to build on legacy systems by purchasing separate modules for referral management or stand-alone, case management software.

With medical costs rising 15% annually, payers are eager to reduce medical costs by carefully managing the utilization of at-risk patient populations. Consequently, many health plans have developed integrated care management programs which unify separate, "siloed" medical management programs, including outsourced disease and population health management.

Integrated care management programs rely on directing patients to different levels of assistance based on their individual health needs. They encourage patient self-care through coaching and education, monitor patient progress against evidence-based guidelines, reduce practice variability, and keep physicians informed to maximize patient compliance. Take, for example, a motivated patient with a stable, chronic condition like diabetes. Using self-help tools such as personalized education materials and Internet-based content, the patient's condition can be managed at a cost of $200 per year versus $1,500 per year for nurse-based intervention.

Integrated care management requires technologies that integrate data, automate care management, and provide actionable information. While these technologies take a variety of forms, they often have as a foundation enabling components such as enterprise content management, enterprise application integration, customer relationship management, business rules, and business intelligence. A robust, care management information technology (CMIT) system then builds upon this foundation to provide end-user applications such as predictive modeling, automated care workflow systems, and outcomes reporting.

The use of these technologies enables care managers to improve their productivity by identifying and stratifying high-risk patients for intervention purposes; managing co-morbid patients across multiple medical management programs; evaluating the cost-effectiveness of disease management programs; and coaching and educating patients so they can effectively navigate the healthcare system.

Early reports from health plans show that these programs can produce significant savings. Our firm recently conducted a survey of 40 plans and software vendors and found a $3.30 pmpm (per member, per month) net saving from using an integrated care management program with advanced CMIT applications for commercial populations. This figure compares favorably with net savings of $1.50 pmpm, a benchmark for judging traditional disease management programs.

When applied to hundreds of thousands of patients, the savings can be substantial. An effective CMIT system and integrated care program can produce a 1-3% reduction in the overall medical cost ratio; this translates into tens of millions of dollars in savings for a large health plan or self-insured employer.

While CMIT can produce big dividends for plans, the investment cost for software vendors is significant and must be weighed against the market opportunity.

Currently, there are just 250 large regional and national health plans and that number. In contrast, there are some 5,000 hospitals and some 600,000 practicing physicians. Total IT spending by health plans and payers in 2001 was $5.3 billion, versus about $22 billion spent by hospitals, physicians and other care providers. When the care and disease management IT market for payers is separated out, it totals just $800 million.

On the bright side, payer spending on CMIT is expanding at a 12-14% combined annual growth rate. This is desirable enough to attract the interest of major players, including several Fortune 100 companies. It is important to note that in an $800 million market, garnering even a 1% market share translates into $8 million in sales.

Still, the payer market is finite with a large number of vendors. If software vendors cannot 1) address payer requirements with best-of-breed solutions, or 2) partner with others to offer robust, integrated solutions, consolidation will result. We project that during the next five years, the total number of CMIT vendors serving the payer market will shrink from 35 to fewer than 15. Examples of where consolidation will occur in the payer CMIT market include predictive modeling, care workflow systems, and business intelligence /decision support.

For payers, the primary goal will be seamless integration. They will seek care management information systems that can collect, integrate and share data among patients, physicians, outside disease management vendors and internal legacy systems. On a basic level, this data integration includes transforming administrative information (e.g. from claims and prescriptions) into episode of care groupings and clinical measures. At a more advanced level, integration means incorporating non-administrative data, such as patient health risk assessment information.

The most advanced level of integration involves linking disparate external and internal systems. To solve this problem, payers are investing broadly in enterprise application integration (EAI) and evaluating specific technologies such as Simple Object Access Protocol (SOAP). SOAP is a promising XML-based protocol that dramatically reduces the cost of custom interfaces between disparate systems by permitting communication among multiple enterprise applications in a decentralized and distributed environment.

The emerging “gold standard” for payers is to connect these fragmented data points and deliver patient health records that all clinical stakeholders can access. This might include, in some cases, access by specific patients and community physicians. For example, care managers could collect non-administrative data such as lab results and vital statistics from the patient’s health record or physician’s patient registry without having to contact the patient or physician for additional information. In addition, an enterprise-based patient health record improves nurse productivity by enabling coordination of care for patients with co-morbid conditions across several intervention programs.

During the next five years we will see tremendous advances in both medical devices and health information systems. If we can harness even a fraction of the potential of these exciting technologies, we will greatly improve the accuracy and timeliness of health information, improve the lives of millions of patients, and reduce run-away medical expense trends.

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