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Impact of the New Health Law on the Digital Health Industry - Health Insurers

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This month's newsletter is part 2 of a three-part series examining the new healthcare law's impact on the technology sector. This month, we focus on the health insurer side. In the final Issue, we will look into the medical device industry to analyze its exposure and upside under the new health law.

The Patient Protection and Affordable Care Act ("Affordable Care Act"), passed in the spring of 2010, has some favorable provisions for health insurers. The law, after its full enactment in 2014, will require near universal coverage, resulting in a net addition of 35-40 million members to the existing insured pool.

Private health insurers will benefit from enrolling low-risk populations, e.g., people who opt out of an employer-sponsored insurance plan due to belief that they are healthy. Premiums from these healthier members will help offset high claim costs from less healthy members and those with pre-existing conditions. For the latter, insurers previously could reject their coverage but no longer due to the new health law. Parks Associates believes that this provision, if enacted fully and precisely, will provide health insurers, collectively, with net financial gains. Gains for an individual insurer, however, will vary significantly based on their respective local market characteristics (health insurance coverage rates, demographics, competition, etc.).

A less obvious benefit from the new healthcare law comes from U.S. government's cut on Medicare spending. The spending cut is bad news for care providers but good news for private health insurers as reduction in government reimbursement rate will lessen pricing pressure for them as well. This benefit may translate into better operating margins.

There are several potential negative consequences as well. Along with the mandate on preexisting conditions, private health insurers will be under increasing pressure to cut

administrative expenses. A mandate in the new law requires them to maintain a minimum medical expense ratio. Another blow is the government's plan to phase out the Medicare Advantage program (MA), which will further erode their profitability.

However, the potential competition from a government-sponsored health insurance exchange market is another and potentially greater threat. Although the law will not create a government-run insurance program, private health insurers will still have to compete with quasi-government entities labeled as "co-ops" in the healthcare law. Government funds will subsidize their operation to offer affordable insurance to individuals.

Regarding the government healthcare programs Medicare and Medicaid, their funding over the next few years will be reduced or, at best, maintained at existing levels without increase. Medicare has over the past two decades tried numerous ways to slow growth in healthcare spending, but these efforts derailed due to demographic shifts or political pressure.

The more imminent crisis is on the Medicaid side. Over the last twenty years, Medicaid spending has increased 250%, placing significant financial burdens on state and federal governments. The economic recession further drained state resources, and the new health law will put the responsibility of covering the uninsured, after exhausting other means of insurance (private, co-ops), in the hands of state Medicaid programs (with federal matching funds). Budget hawks at both the federal and state level are threatening to resist such mandates, and in states like Texas and Florida, Republican-led legislatures are mulling strategies to opt out of Medicaid program completely. Twenty-six Republican-controlled states have filed lawsuits to challenge the health law's requirements of mandatory coverage as unconstitutional. Putting politics aside, a key motivation behind these moves is that state governments lack the resources to carry out the mandate. They probably will comply if the federal government provides the full funding, but that scenario would explode federal deficits through the roof, a result with dire financial and political consequences. As a result, the debates and lawsuits will continue regarding the funding of Medicaid programs, and the challenge to the healthcare law will ultimately end up before the Supreme Court.

Ostensibly these issues seem to have little to do with digital health technology adoption. The healthcare law has no mandate or incentive for health insurers to adopt new technologies. It will, instead, affect health insurers' financial positions and force them to stay competitive, which will in turn drive their interest in using technologies for the following purposes:

1. Reduce business churn through member engagement. Insurers will have to pay close attention to member churn over the next five years as competition increases. Today's health insurance market is fragmented at the national level but concentrated at the state/local level. The healthcare law may alter that with nationally available insurance plans through exchanges.
2. Grow revenues through alternative care models or business ventures. While health insurers' main business model will not change (i.e., collect insurance premiums, pay out claims and maximize profitability by actively managing utilization), they are looking for new growth areas. This is particularly true with integrated delivery networks or large, diversified health insurers such as UnitedHealth Group. UnitedHealth's Ingenix division is providing various clinical data-driven services to payers, providers, and drug companies. Its OptumHealth division goes further by offering various care services to 40 million Americans directly or through their physicians. These services include wellness programs, medical condition support, behavioral health programs, and medical record access that all use technology to support service delivery to end users.
3. Aggressively manage costs. The health law adds a tremendous amount of uncertainty to insurers' long-term business operations. With existing cost structures potentially falling out of line with future revenues, insurers will scrutinize their medical expenses

and administrative costs to accomplish both short- and long-term savings. These goals will result in potential investment in technology-driven products and services in the areas of wellness/disease prevention and chronic-care management.

For technology providers, they must market their solutions in a way that complements the business needs of the health insurer, which includes tailoring a message to individual divisions. Technology providers previously assumed that as long as they could demonstrate cost-saving benefits to payers, reimbursement money would follow. Market realities mercilessly crushed those expectations over the last several years.

In a series of 2008 interviews with private insurers' medical directors, Parks Associates discovered that the appeal of cost savings is secondary to payers in their reimbursement decisions. Although not explicitly stated, criteria such as the ability to drive revenue growth and enhance market competitiveness appeal more to payers.

Other factors also weigh against digital health technology providers. For example, they usually build their use cases on small-scale clinical trials, which weaken the conclusions of the ensuing cost-benefit analysis. In addition, private health insurers are notoriously short-sighted on technology investment due to their concerns about member churn (their beneficiaries regularly switch care plans every 2-3 years). As a result, these payers tend to perceive digital health technologies as costly investments with unattractive short-term return potential. Because of these gating factors, technology providers have failed to make much progress with private insurers in receiving direct reimbursement for their products or services during the last five years.

The situation with self-insured employers has been a little different. These employers are more concerned about healthcare costs and productivity loss due to chronic conditions and therefore are more motivated to invest in digital health technologies for both chronic care management and wellness services. Many have taken a cautious approach by conducting pilot programs on a small subset of their employees.

A few pilot programs could be used as templates for private payers, who have started to show a change of heart in the last eighteen months. Whereas the large health insurance companies effectively stonewalled the direct reimbursement model for digital health technologies during the last five years, resistance to reimbursement has started to thaw. More importantly, alternative care models and new services that health insurers have taken on will prompt them to look for technology-driven solutions.

Because of these new business needs, private health insurers have started to think hard where and how technologies can be integrated into their operations. Large health insurers are adding technology capabilities to complement their business expansion strategies. In the near term, private health insurers' digital health technology needs fall into the following categories:

1. Multiplatform communication tools to engage consumers. These tools include both online and mobile apps to let consumers access their information about health plan benefits, claim history, disease conditions, and preventive care options.
2. Chronic care management tools for their DM divisions to better manage patients' well-being by monitoring patient vital signs, track rehabilitation progress, and enhance medication compliance.
3. Wellness tools and applications that help individual consumers or employees reduce health risks and achieve a better balance of life and work.

About Parks Associates Digital Health Research

Parks Associates is an internationally recognized market research and consulting company specializing in emerging consumer technology products and services. Parks Associates envisions pervasive adoption of digital technology within the global health care system and a drastic transformation of how healthcare and wellness aids are delivered to consumers in the future.

Our research clarifies the opportunities and challenges for technology vendors, healthcare providers, and companies considering entering this changing market. Parks Associates' expertise includes new media, digital entertainment and gaming, home networks, Internet and television services, digital health, mobile applications and services, consumer electronics, and home control systems and security.

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Harry earned his MS degree in marketing research from the University of Texas at Arlington. He also holds an MBA degree in finance from Texas Christian University and a BA degree in international business from Guangdong University of Foreign Studies, P.R. China.

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