

Health Insurance Exchanges Change Game

Healthcare reform forces insurers to modernize their IT infrastructure and business processes, says health IT exec.

BY NEIL VERSEL



With new rules requiring that large-group health insurers limit spending on administrative functions to no more than 15% of premium revenue—20% for individual and small-group plans—payers have a stark choice: raise their premiums or become more efficient. Successful insurance companies will choose the latter path by fundamentally rethinking how they attract new members and process claims, according to one technology vendor.

Health plans at their core are transaction processors, noted Dan Spirek, chief strategy and marketing officer of The TriZetto Group, a Greenwood Village, Colo.-based vendor of healthcare management software. “They’ve spent the last few years incrementally improving [on] the status quo,” Spirek said in an interview with *InformationWeek Healthcare*. But with health reform, greater provider adoption of electronic health records, and the transition to ANSI X-12 version 5010 transactions and ICD-10 code sets, they have to accelerate their efforts.

“It’s almost like Y2K in that they have to look at their

entire IT infrastructure,” Spirek said.

TriZetto is among the companies mentioned in a recent IDC report, “Business Strategy: Care is the New Core—Healthcare Payer Top 10 for Health Management in the Reform Decade.” That document said that healthcare reform, competition for new customers, and a need to cut operating expenses would drive health insurers to change their business models in the coming years.

“It’s not really a new imperative, but it becomes a doubly important imperative,” Spirek said. Raising premiums is less of an option than it used to be because the market will become more competitive between now and 2014, when the Patient Protection and Affordable Care Act [PPACA] fully phases in health insurance exchanges. Already, Spirek said, there has been a migration toward Medicare Advantage and Medicaid managed care, which are more consumer-oriented than employer-based insurance, in that members choose the insurance carrier.

There is more of a sense of urgency with the coming

InformationWeek Healthcare

advent of health insurance exchanges, since participants likely will buy on cost and because there will be new methods of marketing and distributing health insurance, mostly enabled by technology. “If you’re not ready, you could have your lunch eaten,” Spirek said.

“The basic realization is that you can’t spend your way out of reform,” Spirek explained. “You’ve got to attack the cost of care or you’re not going to be in the game.”

According to Spirek, payers have three levels of IT systems: core administrative (enrolling, paying claims, customer service); care management and population management; and connecting constituents to information. When the PPACA passed in early 2010, TriZetto surveyed its customers. Insurers that had invested in new technology across those categories were three times more profitable than those that had not, and their medical-loss ratios were better, Spirek said. “The more they invested in technology, the better they did,” he added.



Spirek said the trend now is toward outsourcing, something that payers historically have avoided, in part because the largest insurers have tended to be rather tight with state officials who saw them as job creators. “There was no burning platform,” Spirek said. Now, the 15% and 20% requirements have changed that.



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