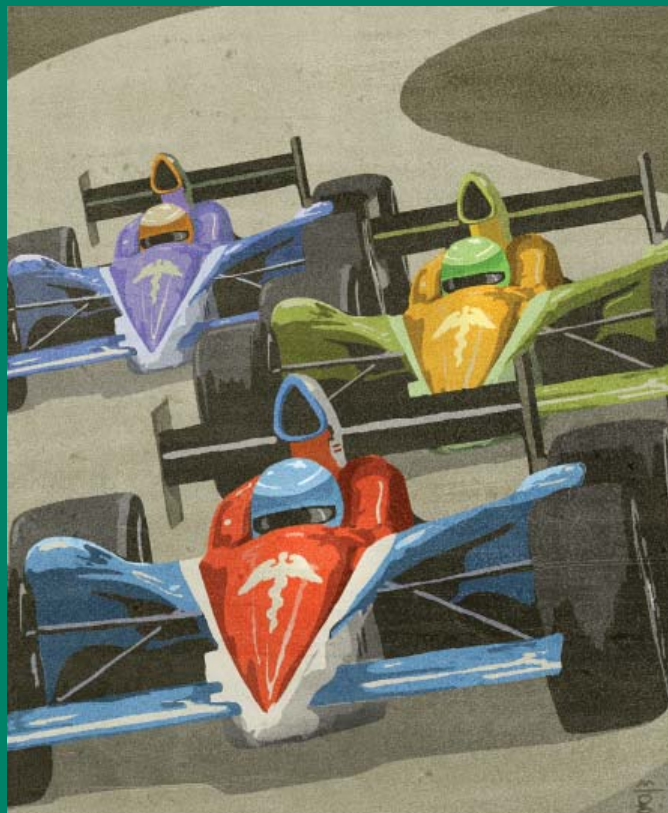


FOCUS

THE EMERGING WORLD OF MEDICAL MANAGEMENT II

Competitive Strategy and the Future of Medical Management



THE BOSTON CONSULTING GROUP

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Competitive Strategy and the Future of Medical Management

To contain medical costs, health insurers are looking with increasing interest toward medical management as a solution; and they are implementing the various techniques, old and new, that it offers. Different types of insurers, according to their particular strengths, are backing different strategies for medical management. The large nationwide insurers, for instance, can exploit their scale advantage by pursuing a strategy aimed at engaging their members more deeply in managing their own health. By contrast, some regional insurers are striving to strategically transform the quality and cost-effectiveness of health care at the point of delivery. They are drawing on their greater knowledge of local networks to educate and influence the providers they recommend and reimburse.

In this Focus report—the second in a three-part series—The Boston Consulting Group evaluates the uncertainties that surround these strategies and suggests possible refinements. The previous report reviewed the evolution of medical management in general and dis-

cussed the basis for and details of the individual strategies. In the third and final report, we will examine how the new approaches to medical management will affect other stakeholders in health care, notably care providers and the pharmaceutical industry.

Competing for Supremacy—Perhaps for Survival

The future of health care in the United States will be determined largely by whether and how insurers—hereafter referred to as *health plans*—successfully deploy medical-management strategies. If all goes well, a distinctly more powerful and effective market for health services will emerge. If the strategies fail, however, the health care system will almost certainly be subjected to politically mandated reform and all the risks that such intervention implies.

Health plans will have to prove very quickly that they are on the right track. The public is losing patience with the current health-care system. Too many of the system's supposed beneficiaries feel let down—the

victims of inadequate coverage, fragmented delivery, and high-price, low-quality care. The health plans, using their accumulation of capabilities and influence in medical management, can break the old patterns and create a new balance of quality and cost. The system can be transformed within the current, largely private model. But it's a race against time.

Warming Up at the Starting Line

For health plans, it's also a race against one another. In the first report of this series, we identified the three main segments of private health insurance—*nationals*, *transformational regionals*, and *reinforcing regionals*—and described the models of medical management that they are building. (A fourth segment, the *locals*, is not really relevant to the questions under consideration in this report.) The models differ fundamentally in their broad vision for health care. For the nationals, the key factor is the patients: these plans seek to motivate patients to become more effective consumers of health care and custodians of their own health. For the transformational

regionals, the future depends on the providers: these plans aim to improve the performance of the system by actively working with providers to transform the quality and cost-effectiveness of health care. For the reinforcing regionals, the future depends on a broad national resolution of the key impediments to affordable and available health care: the reinforcing regionals' strategy is not to change the system but to work within a changing system to reinforce current thrusts in medical management. Each segment must persuade the market of the merits of its vision, and the segment that first achieves a critical mass of acceptance will likely emerge as the overall winner.

Of course, these models are somewhat stylized. Any individual health plan—whether regional, national, or ill-defined—might pursue a blend of these strategies, customized to reflect its unique history, capabilities, and focus.

For each of the rival models, distinctive uncertainties threaten to slow progress. Some of these uncertainties are intrinsic to the strategies, while others may be extrinsic, based on the unpredictable responses of employers, providers, or the government. One of the intrinsic uncertainties is simply the fallibility of various medical-management techniques. Even techniques that are now in their third generation are far from fail-safe. For example, as a way of aligning consumer incentives, the current use of value-based insurance designs—which evolved from consumer-directed plans, which themselves had evolved from high-

deductible plans—still seems far from perfected.¹

The task is further complicated by unfamiliar competitive forces. For one thing, large employers are experimenting with their own models of medical management, and in the process, they are creating an array of direct vendor relationships—carve-out relationships—that threaten to sharply reduce the role of health plans. For another, various vendors and providers are seizing new opportunities to create value. Even entirely new entrants, mostly from the world of technology and information management, are lining up to join the race to deploy medical management.

Negotiating Straightaways and Hairpin Turns

The way that each health plan deals with these and other critical challenges will determine its competitive success. We explore each strategy in turn.

The Nationals. The nationals rely heavily on scale for their competitive advantage and on improvements in consumer engagement and decision making for their medical-management strategy. So they are intent on maximizing access to data and then channeling those data to consumers. Here lie the roots of the three major challenges facing the nationals.

First, the unwieldy plethora of information needs to be integrated before it can be properly exploited. Second, the consumers have to be won over; although they are crucial to the strategy, they remain skeptical

of it and distrustful of the health plans. Third, the consumer-oriented strategy also suits some niche vendors particularly well, so the nationals have a host of new rivals snapping at their heels.

Integrating the Data. The nationals are investing more and more heavily in building complex analytics to support medical interventions and in developing highly coordinated methods to engage patients. But these formidable capabilities remain underpowered unless the nationals also optimize data integration. That's no easy task, given that the data to be integrated are now of many and varied types: not just the streams of claims data, but also all lab results, images, patient-generated data, and more complex reports from providers. To integrate all such data sets will take extremely sophisticated and flexible systems.

To compound the difficulties, many of the nationals have been expanding their capabilities by acquiring vendors—only to confront the awkward reality that each vendor has its own systems, its own way of doing things, and often its own ongoing external-client list. What's more, many clients that are large employers have their own array of vendors and wish to retain some of those vendors and integrate them into their overall insurance program.

1. Value-based insurance designs offer members a reduction on copayments for high-value preventive services and medicines (statins, for example, rather than antihistamines). These designs seek to increase compliance and improve clinical outcomes, thereby reducing costs over the long term.

Building Consumer Trust. Once this rich set of integrated data emerges, the nationals must use it to activate consumers to make decisions that result in cost-effective care. The trouble is that in many cases, consumers distrust their health plan. They perceive a conflict between the health plan's concern for patients and its role as steward of the employer's resources. Or, more bluntly, consumers suspect that their health plan sometimes trades off patients' health interests in order to save money for the employer—the health plan's client—or directly for the health plan itself. To overcome this distrust, the nationals are pursuing a multipronged strategy.

First, they are emphasizing the interests they hold in common with consumers and are realigning incentives accordingly. For example, some health plans are sharing their savings with patients through reward programs—programs that offer rewards for healthy behaviors. Some are also visibly increasing their expenses, by providing preventive care, for instance. Of course, they make these investments with the aim of effecting savings in the long run.

Second, the nationals are striving to create greater transparency. No longer do their perspectives on appropriate care emerge from a “black box.” Now the nationals are publicizing the rules and data that underlie their quality rankings of providers and are also working to use Web-based personal health records (PHRs) as a way of sharing information with patients to help them evaluate any health advice they have received.

Finally, they are offering the consumer access to impartial third-party advisors. The nationals seek out independent vendors whose economics are in no way tied to the type of care they recommend, and contract with those vendors to

The nationals are creating openings for nontraditional competitors to enter the race.

discuss treatment options and health advice with patients. Some of these vendors are becoming formidable health-care brands themselves, and the health plans are “borrowing” their power in order to impress or reassure their members.

Competing with New Entrants. By championing a consumer-oriented model of medical management, the nationals are creating openings for nontraditional competitors to enter the race—and these competitors may be excellently positioned to exploit the opportunities. Prominent among these strategic free riders, as they might be called, are the following types of players:

◇ *Technology companies such as IBM and Microsoft.* These companies possess powerful capabilities in the crucial area of data integration; they can be perceived as relatively neutral by the various health-care stakeholders; and they could appeal to large clients by offering to service data integration needs beyond the health context as well.

◇ *Independent vendors of medical-management services, such as disease management companies.* Some of these vendors, in their specific niches or even across them, have scale that rivals that of the nationals; some may have even more experience in influencing consumer behavior.²

◇ *Players that operate outside the health care space and that potentially command a high level of consumer trust.* On the one hand, Internet search companies such as Google could step into the credibility gap and offer consumers increasingly detailed and reliable health-care advice—or at least navigation to such advice. On the other hand, financial services companies such as Vanguard could tap into their already strong asset-management relationships with consumers.

It is plausible that, alone or in combination, those strategic free riders could chisel off enough business to weaken the nationals' chances of winning the race or capturing the full value of their model. It is also plausible that the nationals might choose to team with them in order to achieve transformation faster, albeit at the cost of having to share the prize.

The Transformational Regionals.

The transformational regionals enjoy a greater intimacy with providers

2. Healthways, for example, provides wellness and disease management services for some 27 million members: compare that with Aetna's roughly 16 million medical members and WellPoint's roughly 35 million medical members.

and are devoting considerable energy to improving the balance between quality and cost in the provider system. Consequently, they are armored against nontraditional competitors that lack their provider orientation. But they are not armored against the providers, of course.

Providers are notoriously autonomous, and they remain suspicious of health plans in many regions. They are also loath to engage with the patients of one health plan in a specified way while engaging with patients of another health plan in a different way. For the transformational regionals to vindicate their strategy, they have to succeed in four very challenging tasks: creating a standard definition of quality that the providers will agree on, building information channels so that they can monitor providers' performance, developing incentives that are appealing enough to encourage providers to change their ways, and capturing an appropriate reward from the resulting changes.

Creating Standards and Measures of Quality. No fully satisfactory system has yet been found for setting quality standards and measuring the performance of providers. While measures and standards do exist in certain areas of certain specialties, they are conspicuously lacking in others. (See Exhibit 1, page 5.) Their absence is not without reason: It is difficult to develop a shared framework. Doctors disagree with doctors, health plans disagree with doctors, health plans surely disagree with one another (just witness the variety of drug formularies), and doctors are

skeptical of health plans' motives in seeking to set standards.³

Even when definitions and standards are generally agreed on, objective measures may be lacking. Zero-tolerance hand hygiene, for instance, is universally acknowledged to be good medical practice, but measuring compliance levels is impractical.

Moreover, because health plans derive their quality-of-care information primarily from reimbursement claims, the transformational regionals cannot easily conduct a rigorous dialogue with providers about their clinical decisions.⁴

In light of the complexity of the task, the potential impact, and the variety of stakeholders involved, a national "standards industry"—that is, a large organizational apparatus for driving standards—has developed, with organizations such as the National Quality Forum and the Ambulatory Care Quality Alliance gaining momentum. (See Exhibit 2, page 6.)

Although they may find such organizations helpful, the transformational regionals cannot rely on them to drive the regional agenda or to help gain a competitive advantage. Instead, they must continue independently to make quick progress and win the buy-in of the providers they deal with. The Massachusetts Health Quality Partners is an encouraging example of what can be done. This organization has successfully fostered collaboration among payers and providers by regularly measuring and publicizing the quality of clinical care and patient-provider communication.

Building Information Channels. Once a critical mass of standards and measures is finally in place, the health plans will have to evaluate the providers' performance against those standards and measures. To do so, the health plans will need access to more finely grained clinical information. Paper records of a patient's medical history are still widely used, but sharing them is costly, and staying consistent with privacy requirements is awkward.

Consequently, more attention is now being paid to creating interoperable electronic health records (EHRs) that can support greater transparency and IT-driven decisions. Some success in this regard has been registered by regional health-information organizations such as the Indiana Health Information Exchange and the Massachusetts eHealth Collaborative. Elsewhere,

3. According to a recent survey by the Massachusetts Medical Society, for instance, only 4 percent of Massachusetts physicians agreed that public-reporting or pay-for-performance quality measures were "useful," while 43 percent disagreed; 23 percent of respondents said that the measures were "somewhat useful," and 30 percent said they did not know whether they were useful or not.

4. For want of such dialogue, disagreements between health plans and physicians over measuring and reporting performance can become public information. In 2006, for example, a Blue Shield plan in the Pacific Northwest voluntarily halted the launch of a new tiered-network product when several local providers engaged in a lawsuit challenging the validity of the quality assessments, asserting that they were based on flawed methodology and data. Also, in 2007, the New York State attorney general's office began investigating the physician-ranking programs of six major health plans and subsequently announced that some of the plans had agreed to make modifications.

Exhibit 1. Standards and Measures Are Evolving at Different Rates Across Medical Specialties and Services

	Standards and measures of clinical care ¹	Standards and measures of patient experience ²	Standards and measures of efficiency ³
Primary care			
◊ Adult	Healthcare Effectiveness Data and Information Set, Ambulatory Care Quality Alliance	Massachusetts Health Quality Partners	
◊ Pediatric	Healthcare Effectiveness Data and Information Set	Massachusetts Health Quality Partners	
Internal subspecialties			
◊ Allergies and immunology			
◊ Cardiology	American College of Cardiology, Ambulatory Care Quality Alliance, Physician Consortium for Performance Improvement		
◊ Endocrinology	Healthcare Effectiveness Data and Information Set, Ambulatory Care Quality Alliance, National Committee for Quality Assurance		
◊ Gastroenterology	Blue Cross and Blue Shield Association (bariatric care standards)		
◊ Hematology			
◊ Infectious diseases			
◊ Nephrology			
◊ Oncology			
◊ Pulmonology	Healthcare Effectiveness Data and Information Set, Ambulatory Care Quality Alliance		
◊ Rheumatology	Physician Consortium for Performance Improvement		
Surgery			
◊ General	Agency for Healthcare Research and Quality, Centers for Medicare & Medicaid Services, Ambulatory Care Quality Alliance		
◊ Cardiac	Centers for Medicare & Medicaid Services, Society of Thoracic Surgeons		
◊ Colorectal			
◊ Neurologic			
◊ Orthopedic	Physician Consortium for Performance Improvement		
◊ Plastic			
Other specialties			
◊ Anesthesiology			
◊ Emergency care			
◊ Neurology	Physician Consortium for Performance Improvement		
◊ Nuclear medicine	Physician Consortium for Performance Improvement		
◊ Obstetrics and gynecology	Healthcare Effectiveness Data and Information Set, Agency for Healthcare Research and Quality		
◊ Ophthalmology	Physician Consortium for Performance Improvement		
◊ Otorhinolaryngology (ear, nose, and throat)			
◊ Psychiatry	Healthcare Effectiveness Data and Information Set		
◊ Urology			
Facilities			
◊ Outpatient	Centers for Medicare & Medicaid Services		
◊ Inpatient	Agency for Healthcare Research and Quality, National Quality Forum	Hospital Consumer Assessment of Healthcare Providers and Systems	
◊ Long-term care			
Ancillary care			

Some process measures
 Some outcome measures
 Targeted regional data
 Open (uncertain timing)

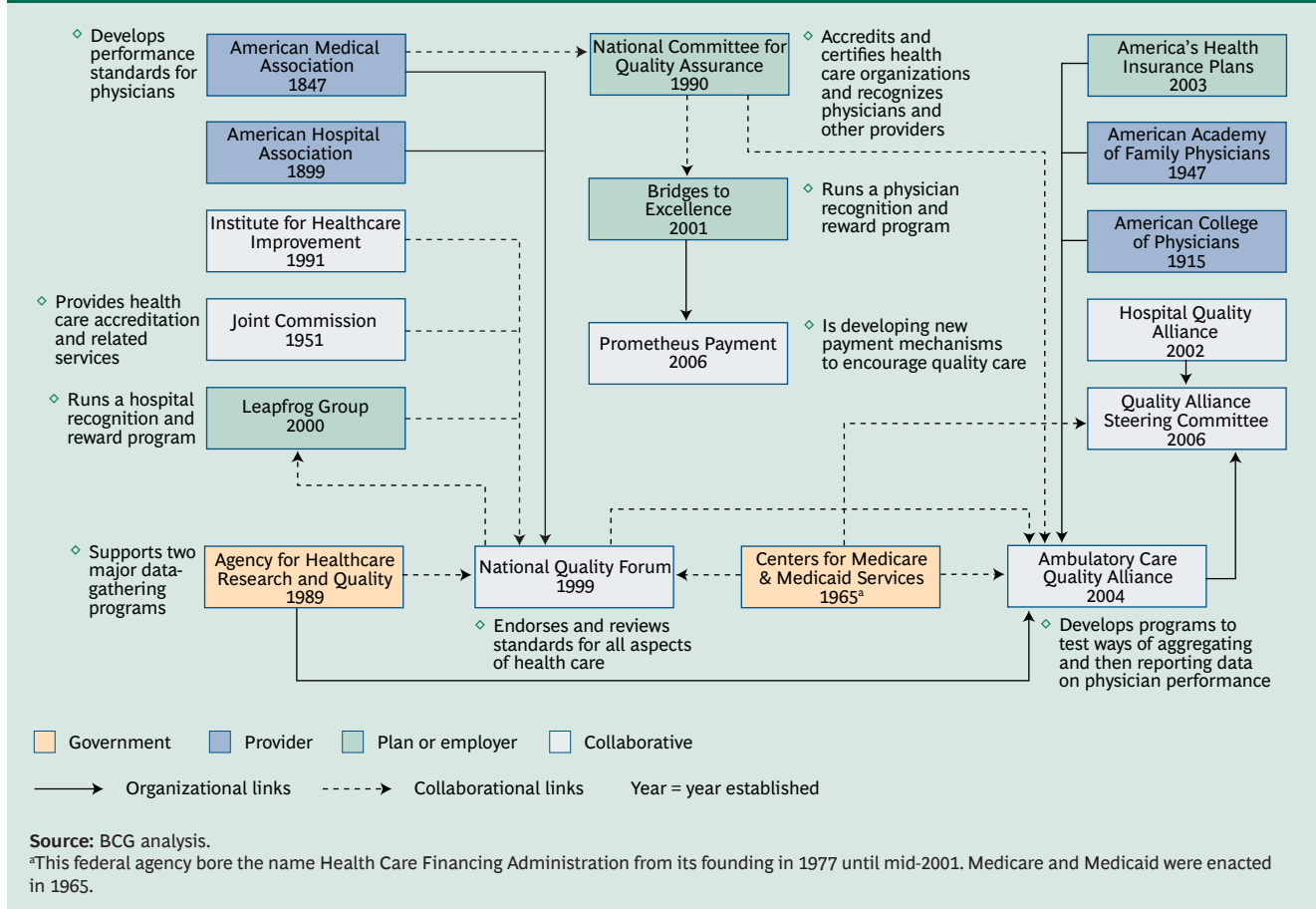
Sources: National Committee for Quality Assurance; Centers for Medicare & Medicaid Services; Agency for Healthcare Research and Quality; Massachusetts Health Quality Partners.

¹These address the way that the delivery of care conforms with medical guidelines.

²These address the way that the delivery of care is received by patients and the way that patients can actively participate in their care.

³These address the delivery of quality care using a minimum of resources.

Exhibit 2. A National Quality Industry Is Emerging



however, progress remains very slow, and the strategic uncertainties persist. Can the interoperable EHR model be rolled out and sustained? And where there are issues about collaboration and privacy, can they be resolved in each region?

Developing Incentives to Change. It's not enough for the transformational regionals to identify the high-quality providers and direct patients to them. Those providers will soon reach full capacity. So the incentives have to be sufficient to ensure that a large proportion of providers change

their behaviors and improve the quality of their care. A more far-reaching pay-for-performance system is needed.

The current payment structure is mainly a pay-for-procedure model, and it has the weight of Medicare practice behind it. True enough, pay for performance is gaining ground in the bonus schemes of individual health plans, but for most providers, the schemes of any one health plan represent marginal economics and therefore have little appeal when measured against the high volume of

patients from Medicare and other health plans. Moreover, the current pay-for-performance schemes tend to be better at encouraging underused treatments than at discouraging overused treatments. That is, it is much easier to get providers to agree to rectify underutilization or misutilization than to combat overutilization. No effective way around this distorting effect has yet been identified.

Capturing an Appropriate Reward. Payer-driven transformation is a costly endeavor. In bankrolling it, the

transformational regionals hope to benefit not only by bringing about higher-quality health care for their members but also by increasing their membership numbers.

There's a problem, however: if underperforming providers are indeed transformed, they will begin practicing higher-quality medicine for *all* their patients—those covered by the national health plans as well as those covered by the transformational regionals themselves. Employers will have no reason to prefer contracting with their local transformational regional; in fact, they may actively opt against doing so. They could find that most transformational regionals—burdened by the costs of transformation—have become more expensive than their rivals. In sum, the danger is that the transformational regionals will bear most of the transformation costs without capturing a corresponding reward in the market. They will need help from providers—and recognition from employers—to make the strategy succeed.

The Reinforcing Regionals. The strategy of the reinforcing regionals is one of preserving current options. Its underlying assumption is that system transformation—whether focused on consumers or providers—cannot be driven or fully exploited by any one stakeholder group. Instead, it can come only from broad-based national collaborations, such as the various elements of the national quality industry described in Exhibit 2. The reinforcing regionals therefore seek to ensure their position irrespective of how the national environment evolves. They

do this by investing in existing competitive advantages. They strive to forge closer ties with providers, for example.

They seek tactical ways of improving local operating systems—by promot-

The reinforcing regionals work with vendors rather than invest lavishly in internal capabilities.

ing an e-prescribing program, say, or launching a public-health initiative on a specific widespread disease such as diabetes. They seek to reinforce their intimacy with the local community and with the market niches that are least attracted to provider- or consumer-oriented transformation strategies. For example, the reinforcing regionals help install nurses in provider clinics to ease the administrative burden, and design health insurance products that meet the needs of small employers. They also seek to minimize risk, opting to work with vendors rather than investing lavishly in internal capabilities.

The big danger, of course, is that by pursuing the risk-reducing strategy, they might get left behind and find themselves unable to catch up with the bolder policies of their competitors. What if the nationals or transformational regionals do in fact establish a workable model for medical management and duly capture advantage from it? A play-it-safe strategy is not necessarily a safe bet.

Gaining a Sustainable Lead in the Race

Given all the uncertainty surrounding their strategies, the three rival health-plan segments need to plan shrewdly. There are several measures that they can take to draw ahead of the competition and then sustain their lead in the race.

The Nationals. The nationals will aim to accelerate the pace of product innovation, expand the scope of consumer choice, and promote the national standards agenda.

Accelerating the Pace of Product Innovation. Because the nationals' strategy does not require them to engage closely with providers or any other well-organized sets of stakeholders, it should allow a rapid advance to viable products. The nationals have already shown their ability to advance in this way and drive innovation in health care. Consider how swiftly their member-engagement strategies have developed—from single-condition disease management to a whole-person strategy that incorporates comorbidities to a total-population approach focused on addressing diseases early. The nationals can claim to be the leaders in “getting something done” in health care, and if they continue to innovate so flexibly, they can reinforce that positioning. In particular, they should increasingly supplement their traditional products with consumer-oriented approaches such as value-based designs and decision support tools for patients.

Expanding the Scope of Consumer Choice. The nationals' focus on

changing consumer behavior creates an interesting dynamic. The more scope that consumers have for making choices that influence medical costs, the more the nationals can influence medical outcomes. And typically, the scope for making cost-lowering decisions is greater when a condition is less severe. If a person is diagnosed as being prediabetic, for example, his or her options to manage the disease are much greater than those of a person with severe diabetes.

Obviously, health plans can minimize their costs by engaging patients early in the disease cycle—or ideally, before the disease even emerges—and by changing the patients’ behaviors before treatment becomes necessary. There is a balancing act involved, of course, although it is not a particularly tricky one: the nationals must make sure that the costs of conducting a program of early engagement with a broad population are in fact going to be lower than the costs of treating individuals who have a more advanced form of the condition.

Even when dealing with cases involving severe conditions, the nationals have tools for encouraging and empowering consumers to engage more in their own care. For example, many patients who have a chronic physical ailment may also suffer from associated behavioral disorders, notably depression, that inhibit them from managing their own care optimally. By offering access to counseling or fuller psychological support, the health plans can help such patients participate more effectively in their own care.

Promoting the National Standards Agenda. The nationals should press hard for national standards and transparency. By ensuring that these concerns are addressed countrywide, the nationals will hinder the transformational regionals in their efforts to

The transformational regionals should work to reinforce the patient-provider relationship.

drive a regional quality agenda and achieve differentiation.

The Transformational Regionals.

To take the lead, the transformational regionals should take a wide range of measures.

Creating Solutions for Treating High-Cost Diseases. The trick for the transformational regionals is to create differentiation in areas in which the nationals are at a disadvantage. These include areas in which providers have the most scope for decision making—areas that rely on clinical judgment rather than on standardized protocols—as well as areas in which the costs can be very great, such as oncology and various rare conditions that require specialty pharmaceuticals. In all such areas, the nationals’ scale advantage has little influence over a provider’s individual decisions, and the transformational regionals can seize the initiative by working closely with influential providers to identify aspects of care that could be standardized and made more cost-effective.

Facilitating Access to Providers. In contrast to the nationals’ emphasis on putting consumers more in charge of their own health, the transformational regionals should work to reinforce the patient-provider relationship and defend the role of the provider in the care of even the relatively healthy. To this end, they should strive to make providers more accessible.

The transformational regionals have a myriad of techniques at their disposal. At the simpler end of the scale, they can improve the ways that patients make appointments and can help patients and doctors engage online. With slightly more effort, they can reinvigorate primary care or preventive care.

For example, they can arrange regular physical checkups for patients; they can coach physicians in techniques for sharing information and clinical suggestions with patients; and they can promote the “medical home” model, in which a primary-care physician, or a team of physicians, takes on the responsibility of coordinating a patient’s care across the provider system.

Finding Creative Ways to Increase Visibility Among Providers. For most providers, any one regional health plan remains dwarfed by Medicare. To gain greater visibility, therefore, health plans should collaborate more with other regional stakeholders. The Integrated Healthcare Association in California is an example of such an alliance. Collaborating health plans can develop a uniform approach to pay for performance, reduce mixed signals about priorities for improving

the system, and use a common list of recommended providers. Collaborative models could also be used to spread the costs of transformation across multiple stakeholders.

Exploring More Aggressive Pricing. Because the transformational regionals have a far better feel for local market trends and the likely effect that transformation efforts may have on provider behavior, they are in a far better position to fine-tune pricing in line with that potential impact. They might even be able to offer employers guarantees on future pricing and providers' performance levels.

Supporting Targeted Entry by Nontraditional Players. Nontraditional entrants into health care are far more threatening to the nationals and their consumer-oriented strategy than to regional health plans, which have such close ties with providers. The transformational regionals might opt to educate and even collaborate actively with Microsoft, Google, and other IT and search-oriented companies. In doing so, they would hamper the nationals and gain some powerful allies that have complementary offerings for the market. Imagine if a transformational regional could tell its members that patients' decision making would now be actively supported by a brand such as Google.

Encouraging Client Carve-Outs. The transformational regionals might also openly encourage large employers to carve out portions of medical management. The theory is that the employers would concentrate on the more consumer-oriented aspects of

medical management, such as disease management. They would leave untouched those components of health plan activity that the transformational regionals are particularly expert in and eager to retain—for example, contracting with providers and engaging with them on the care delivered to specific types of patients. Such an approach would, in theory, not only frustrate any attempts by the nationals to sell integrated strategies but also lure employers into doing more business with the transformational regionals.

The Reinforcing Regionals. These health plans will gain an advantage by taking a segmented approach to the market, forming close ties with leading vendors, and joining collaborative initiatives.

Taking a Segmented Approach to the Market. Being more pragmatic and smaller in scale, the reinforcing regionals have the advantage of flexibility and nimbleness. They don't need—and would be ill-advised—to compete in segments in which the nationals and transformational regionals excel. Instead, they should identify the segments least likely to be attracted by the value proposition that the other two types of health plan put forward—small employers, notably—and then exploit those segments with a carefully tailored offering. Such a conscientiously segmented approach to the market would give the reinforcing regionals a further advantage, improving their predictions of the way their market dynamics might evolve if either the nationals or the transformational regionals begin to take the lead.

Forming Close Ties with Leading Vendors. A second strategic strand is to seek out partnerships with emerging vendors of medical-management services. Such vendors are typically looking to grow and would likely be more open to a creative arrangement with smaller payers. If their joint array of capabilities is broad enough, the reinforcing regionals could, in some circumstances, take on the nationals head to head.

Joining Collaborative Initiatives. The reinforcing regionals should participate—modestly—in collaborative efforts aimed at transforming health care provision in the region. “Modestly” is the keyword here. Involvement should be deep enough to keep tabs on regional developments, but not so deep as to require costly investments or jeopardize relationships with providers should the transformational efforts create conflict.

Betting on the Outcome

In depicting the future landscape of medical management, this report has relied on broad brushstrokes and stark contrasts to differentiate the various types of health plans and to highlight conflicts and trends. In reality, of course, the distinctions are not clear-cut. All three health-plan segments have their particular mix of assets, targeted employer clients, provider structures, and serious competitors. And those unique profiles will greatly influence the way that the specific medical-management strategies are shaped. So each type of health plan will regularly adopt the tactics of the other types.

That said, the fundamental strategic challenges and choices still apply. The outcome of the race remains radically unpredictable because the rival strategies are not only highly complex in their own right but also subject to the vagaries of stakeholder reactions. The only certainty is that the winning strategy will be supremely well executed.

How would a betting person view the race? The nationals are clearly in a good position to create value, but they cannot expect to capture it unless they succeed in restoring consumer trust and influencing consumer behavior. Even if they win the race, the nationals might find that much of the value is being siphoned off by partners or even rivals.

The transformational regionals are in a good position to reverse or slow the trend of rising health-care costs,

thanks to their intimacy with providers and hence their potential to influence them. But this influence—and even the missionary zeal of those health plans—might not be enough to transform the system. Or else, the cost of transformation might be too high for the market to stomach.

The reinforcing regionals, though poised to benefit should either the national or the transformational-regional paradigm take hold, could quickly be marginalized if vendors or the transformational regionals manage to expand their share substantially.

If only both of those paradigms could take hold, the entire health-care system would get a real boost. The nationals' emphasis on wellness and changed behavior among consumers—before they enter the provider system—could redraw the

trajectory of health care costs and associated productivity. At the same time, the transformational regionals' efforts to fundamentally and systematically improve provider performance—once consumers do enter the provider system—could dramatically reduce the incidence of low-quality care and its associated costs.

In the meantime, the hope is that competitive markets will keep fueling all these change agendas and continue driving reform throughout the health care system. Complex changes will be made in health care—in behaviors and structures alike—and most of the stakeholders will adjust to them. If the health plans are to influence the shape of these changes, they themselves need to change. They appear to have made a good start.



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