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insight

Seismic Shifts in the Health/Wealth Landscape

An upheaval in the financial services and healthcare industries is creating $40 billion in new opportunities

By Aamer Baig, Andrew Rocklin, and Srinivas Velamoor

Everyone knows that the healthcare system and many people nearing retirement are in trouble. But despite the unsettled rumblings and dire forecasts that permeate media coverage of these topics, most major market participants recognize that it's the wealthiest generation in U.S. history that is retiring and that healthcare spending in the United States is about twice the size of the entire Canadian economy.

Such geologically large flows of supply and demand are creating seismic shifts in the landscape of the financial services and healthcare industries. Market leaders are already staking out their positions in this new ground. Our analysis shows that there is at least $40 billion in play over the next five years.

The new landscape is exceedingly complex. Traversing this virgin territory will be challenging. Based on multiple research efforts, thousands of data points, dozens of interviews, and our in-depth work with leaders in the field, we have constructed a comprehensive topography of a new health/wealth market. This combined view is essential for profitable navigation.

Furthermore, we have designed a readiness diagnostic so any firm can assess where it should stake its claims in this new territory, and how ready it is to begin that journey. Based on our analysis, we predict that in this elaborate domain, generic strategies will fail, but well crafted plans with the right navigational tools and persistent execution can win.

Uncharted Territory

Mounting costs and unfunded retirement liabilities have dominated the national health care debate and rightly so. Healthcare costs are expected to exceed $4 trillion by 2016, and nearly a third of the baby boomer population has few or no retirement assets. However, it is the unlikely confluence of landmark policy developments, technology advances, and the rise of consumerism that is spurring the healthcare and financial services industries to explore new ground in their search for growth.

The fault lines between these two industries are rapidly converging. This phenomenon is creating what Diamond Management & Technology Consultants calls the "health/wealth market." Banks, health plans, technology infrastructure providers, and other firms that have focused on their traditional domains now must consider how they will respond to the demands of consumers and employers for a seamless healthcare experience—from saving and paying for care to making informed decisions about treatment alternatives. We conservatively estimate that convergence will create seven key opportunities that generate more than $40 billion in aggregate revenue over the next five years.

Like the uncharted waters of medieval maps that noted "here be dragons," the health/wealth market is unexplored territory for many companies. However, some courageous innovators are already actively re-positioning themselves to capture some of that revenue. Banks are forging partnerships with claims processors. Health insurers have chartered banks. Well known financial services brands and payment providers are becoming healthcare financiers. There's a race for ownership and control of the customer health/wealth experience. Companies reluctant to explore this new terrain risk irrelevance.

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Five Powerful Forces Are Reshaping the Landscape

Like the unstoppable tectonic stresses that give rise to earthquakes and irreversibly recast the earth's landscape, five key forces are reshaping the way consumers and employers buy healthcare services. These seismic shifts are already creating promising new business opportunities. To appreciate the size and scale of those opportunities it is first useful to understand what is driving them.

Rising healthcare costs are sending industry players on a quest for innovative and disruptive solutions. The nation spent approximately $2 trillion or 16 percent of GDP on healthcare in 2005. With an aging population, skyrocketing administrative costs, and other factors at play, healthcare spending is expected to exceed $4.1 trillion by 2016, according to a Jan. 2007 forecast by the Centers for Medicare and Medicaid Services. Since 2000, the cost of health insurance has increased by 87 percent compared to cumulative wage growth of 20 percent and cumulative inflation of 18 percent during the same period, the Kaiser Foundation reported in 2006.

Consumers and employers will seek innovative ways to cope with looming unfunded pension liabilities. The Government Accountability Office (GAO) reports that 33 percent of the Baby Boom generation have no retirement assets and among those who do, their total holdings (median savings: $45,900) are relatively small. The GAO also notes participation in defined benefits plans decreased from 80 percent to 33 percent between 1985 and 2003 whereas participation in defined contribution plans has increased to 51 percent, placing far greater responsibility on individuals for their retirement security. Using current projections from a Social Security Administration's Board of Trustees May 2006 report, when today's 31 year-olds retire, Social Security will only be able to pay 74 percent of scheduled benefits.

Five Powerful Forces Reshaping Healthcare Services

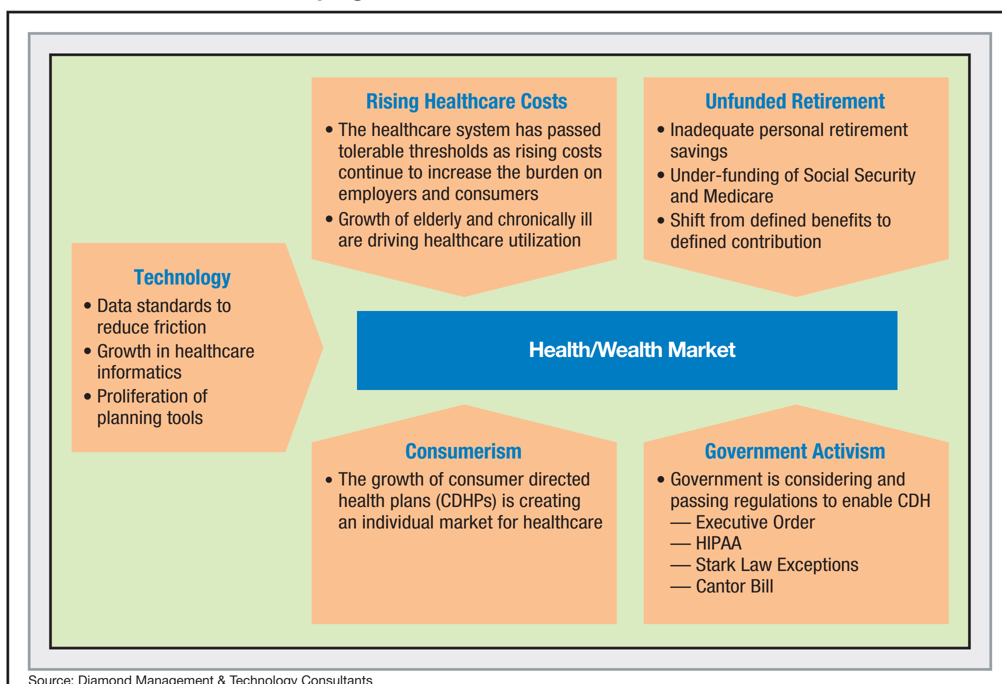


Figure 1

Technology will eventually transform the way consumers, employers, providers and financial services firms interact with the healthcare system. The healthcare industry generally acknowledges that there is plenty of room for improvement. Healthcare providers are slowly but inexorably defining and applying common data standards, fully recognizing that their performance will depend on the ability to share data among multiple participants with varying levels of IT sophistication. At the same time, a variety of well-intentioned standard-setting organizations are trying to enable interoperability for sharing clinical data by establishing healthcare data standards.

Government policies at the Federal and State levels are another force to be reckoned with in a new world of consumer-directed healthcare. Public policy efforts in recent years have focused on four key areas: 1) increasing access; 2) reducing costs; 3) enabling the exchange of data about quality of care and price transparency; and 4) improving safety and efficiency. The consequences of trying to achieve these goals have already been far-reaching. For example, Washington's support for health savings accounts (HSAs) has created a significant opportunity for financial services firms. (Diamond's whitepaper, "Seizing the HSA Opportunity," details how HSAs are driving the redistribution of tens of billions of dollars across the healthcare and financial services industries.)

Combined with emerging data standards, the Health Insurance Portability and Accountability Act (HIPPA), and a renewed focus on safety and efficiency, we are witnessing accelerated growth of electronic health records. New exceptions to the 2001 Stark Amendment and anti-kickback rules make it easier for hospitals to help fund their physicians' technology investments. This likely will fuel the growth of e-prescribing and electronic medical records.

Consumerism is another powerful force that must be considered when surveying the health/wealth landscape. Employers in particular are promoting a migration toward consumer-directed health plans. Although these products will not dominate the health insurance market in the near term, their impact in the short term is striking. Participation in HSA-qualified high deductible health plans tripled from 2005 to 2006. By the end of 2006, according to ISI, there were 3.5 million HSA accounts opening the door for companies to introduce a range of products that help increasingly accountable consumers become better empowered to manage their own health and wealth needs.

Navigating a New Route

Consumers and employers aren't willing to stand still. With the ground shifting under their feet they are demanding a way out of the morass of complexity associated with the current healthcare system. Navigating a new route will require tighter integration of healthcare and financial services.

Traditional healthcare and financial services firms are being forced to expand outside their traditional boundaries. For example, the major card companies have created debit cards linked to HSAs to adjudicate payment for healthcare services. Aetna acquired ActiveHealth Management, a disease management company with physician-written proprietary algorithms that sort through medical claim, laboratory, pharmacy and member information to anticipate care needs and communicate with physicians and members. JP MorganChase's acquisition of Fisacure highlights their focus on automating healthcare payments to increase efficiency in the claims reimbursement process.

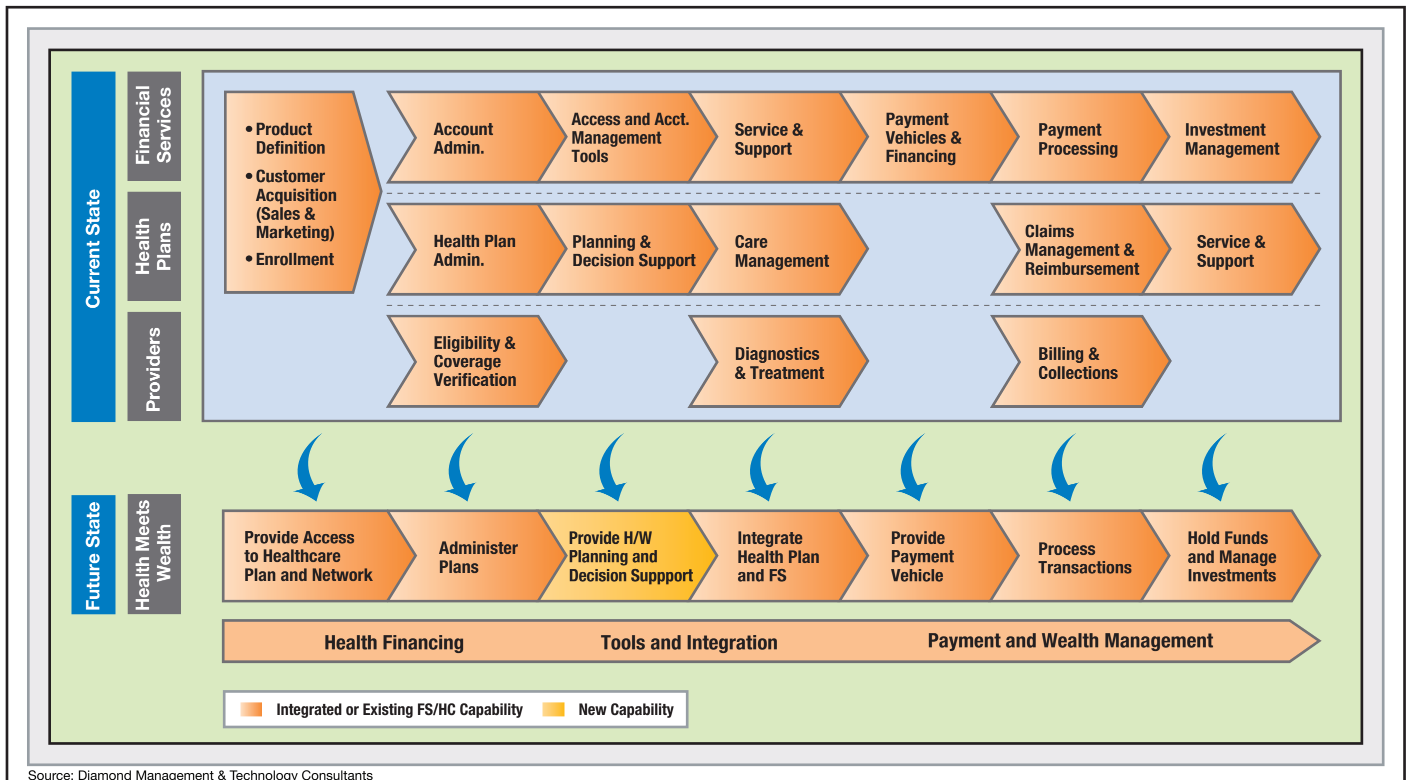
Survival and success in this new environment depends on thoughtful decisions about the role each company wants to play. Broadly speaking, there are three strategic options: 1) specialization, 2) experience integration, and 3) adjacency expansion.

Specialization

Some participants will opt for a focused strategy; becoming a dominant, differentiated leader in a particular category such as healthcare coverage and management, healthcare payments, or decision support tools. Those with significant scale, efficiencies, expertise, or market access in a narrow area may be best positioned to maintain market leadership.

This in no way implies that those companies that take this path can travel alone. Quite the contrary, they will need to expand their strategic and operational capabilities. As we see today, financial service providers of

Emerging Value Chain



Source: Diamond Management & Technology Consultants

Figure 2

reimbursement accounts (FSAs, HRAs, HSAs, and the like) are partnering with health plans to offer their products during employee enrollment windows. On the back-end, efforts are being made to enable multi-purse payments so that a patient can present a membership card at the time of care and have the appropriate funds designated from the health plan or the patient's reimbursement or personal account.

The risks of taking this tack include losing control over other aspects of the customer relationship, and displacement by new competitors or those entering the market from adjacent positions in the value chain. Recognizing the importance of services delivered from those adjacencies, successful participants will focus partnering efforts to ensure tight integration of their service with partners that provide complementary services.

Experience Integration

The objective of this strategy is to play an integral, profitable role in guiding customers along a path filled with new health/wealth opportunities. From an employer or employee perspective, this means engaging in a new customer experience; one where the information they exchange with service providers from the plan and product selection process, into enrollment, and throughout their use of health and financial products, remains available and integral to their decisions and service experience.

Competitors in this space today include benefit managers and technology solutions providers that are trying to cobble together an integrated customer experience. In addition, health plans and financial services companies are betting that their versions of complementary products will improve experience integration. Individual and small group buyers may accept incremental integration improvements but more sophisticated purchasers will demand seamlessly integrated best-of-breed capabilities.

Deep technology skills and expertise in cross-platform integration are critical skills for success with this strategy. Delivering on the promise of experience integration requires the ability to integrate information while maintaining consistency in quality, access, and interaction across the value chain. This means going beyond loose connections of systems and interoperability. It requires investing in information and service delivery platforms that transcend multiple partners across industries.

In addition, companies pursuing this strategy must be adept at picking the right partners and maintaining win/win relationships to bring profitable long-term solutions to the market.

Adjacency Expansion

Within the health/wealth market aggressive companies with an appetite for major growth (or at great risk of disintermediation) may consider their own adjacency expansion strategy—adding new capabilities in house rather than partnering with complementary providers. The objective of this strategy is to provide a comprehensive suite of services that are closely related in the eyes of the customer, but may not have traditionally been located under the same roof.

On the healthcare side, several health insurance companies have chartered their own banks and are among the leaders in HSA assets under management (e.g., Blue Cross Bank, Exante from UnitedHealth).

Similarly, financial services organizations are expanding their involvement in healthcare beyond providing traditional treasury and lockbox services. They are getting involved in B2B healthcare payments, delivery of Explanation of Benefits (EOBs), reconciling medical claims and payments, and providing factoring and receivables financing services (e.g., Bank of America acquiring HealthLogic).

For many large healthcare and financial services companies pursuing this strategy will lead down a path of mergers and acquisitions. These firms are adding complementary capabilities and targeting relatively new technology-driven firms that have evolved in the last 2-5 years to fill gaps in the current offerings of healthcare providers, health plans, card companies, or banks. Success in those initiatives can be elusive without a deeper understanding of the new market, without looking deep inside the target firm to understand their real (vs. marketed) capabilities, and without understanding how the target firm could fit with the acquiring firm's technology and operational platforms.

What Lies Ahead: The $40 Billion Opportunity

Diamond has carefully studied the health/wealth landscape and charted seven specific consumer and employer needs that will generate an aggregate $40 billion worth of demand for new products and services over the next five years. Some of these opportunities offer companies a chance to repurpose their existing assets. All of them will require firms to reconsider the boundaries of their current organization, reevaluate their target customer base, or rethink their business model. But with five-year revenue potential in the billions, the journey can be well worth it.

Integration and Infrastructure: $10.4 billion opportunity

Consumers, employees and employers are frustrated with cumbersome processes for enrolling in consumer directed health plans, spending their healthcare-related dollars, and navigating the fragmented healthcare system. Driving this frustration are the growth of high-deductible and defined contribution health plans and excessive friction in the healthcare system. However, these problems open the door to $10.4 billion of opportunity for a new breed of "benefits value managers" and "health IT platform providers."

Diamond believes that as the options for plans and benefits coverage increase, more consumers and covered employees will demand optimal value from their benefit investments. This will create tremendous demand for Benefits Value Managers who can integrate benefits administration and help customers manage an increasing array of custodial accounts such as HSAs, FSAs, and HRAs. We expect that in many cases companies will choose to outsource this administrative function.

The complexity associated with managing insurance claims, paying for care through a custodial account, getting medical advice and receiving care is also driving a pressing need for "Health IT Platform Providers" that can integrate information

Health/Wealth Opportunities

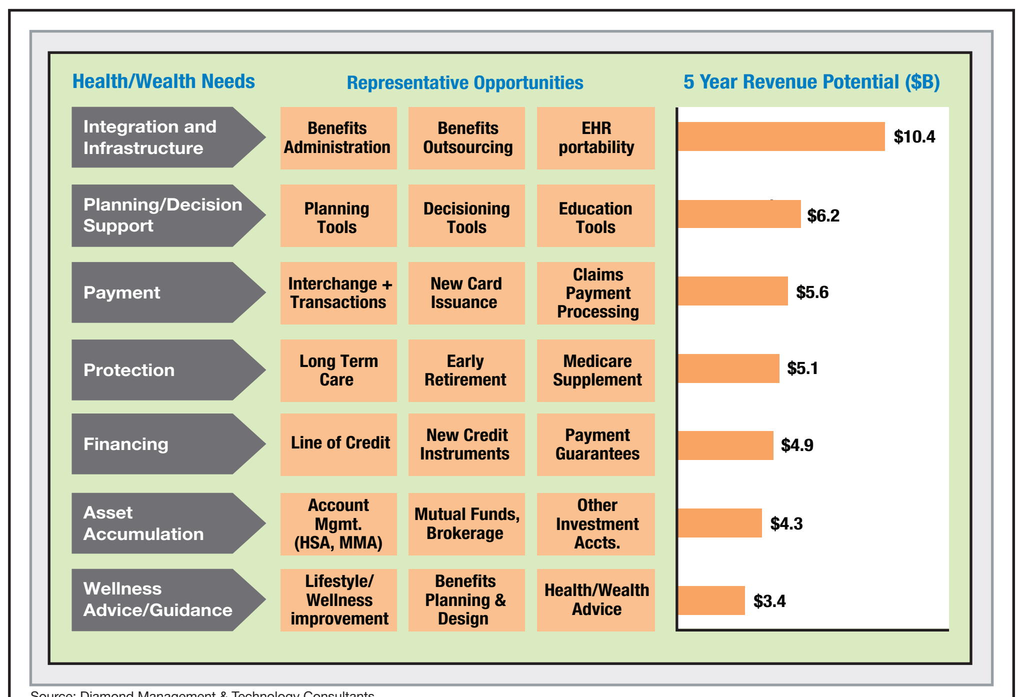


Figure 3

from multiple partners to provide a single point of access and a single, consolidated view of a patient's expanded health/wealth profile.

That problem can be addressed by providing interoperable health information platforms that enable the smooth transfer of information from electronic health records to hospitals, insurance companies, banks, radiology labs, pharmacies and other stakeholders while ensuring security and privacy. Successful Health IT Platform Providers will establish partnership strategies that enable multi-party interactions. In the near term, they must be able to work seamlessly across multiple partners' information systems—often proprietary and only occasionally standardized. In the long term, integrators must have the market strength and presence to define standards that will be widely adopted, or have the flexibility to respond to emerging standards.

Planning/Decision Support: $6.2 billion opportunity

Access to Trusted Health/Wealth Advice

Making decisions about coverage and benefits, choosing generic or branded drugs, the efficacy of treatment alternatives, and how to pay for healthcare products and services can be a daunting problem for many consumers. Confusion creates problems for employers, too, when the burden falls on them to provide trusted health/wealth advice to their employees.

What's needed are a host of educational, planning, and decision support tools that can help guide consumers towards the right health choices. Diamond estimates that meeting this need will foster demand for $6.2 billion worth of health/wealth advice over the next five years.

On the demand side, consumers are looking for help in four key areas: 1) clinical decision support and financial planning tools; 2) patient-centric healthcare cost, quality and treatment option comparison tools; 3) health plan comparison tools; and 4) health-related pre- and post-retirement savings advice and health expense budgeting tools.

From the supply side, driving this market in large part is ownership of the patient relationship. Many health plans want to strengthen their customer relationships by helping their members make informed health/wealth decisions. Financial services companies are also expanding their capabilities with the aim of becoming trusted advisors on matters pertaining to paying and saving for healthcare costs.

Competing in this space will require sophisticated advisory capabilities. Influencing consumer behavior will take commitment and creativity. Aggregating historical data about pricing and service quality and turning it into usable information is both a policy and a technology challenge. And because healthcare is a world of specialization, evolution, and jargon, competitors in this space must be able to counter this complexity by codifying information that consumers can actually use to make informed decisions.

Payments: $5.6 billion opportunity

A New Breed of Health Payment Processors

Consumer directed health plans and their associated HSA services may be growing in popularity but they are far from consumer- or provider-friendly. There are two primary problems. The lack of integration between enrollment activities forces employees to juggle the time-consuming process of joining a CDHP and then—independently—making complex HSA investment decisions. Once they're finally in a plan, there's little integration at the point of service. Providers are waiting longer for payment from patients with HSA accounts. According to some estimates the uncollectible portion of payments is two to three times greater for CDHP/HSA customers than it is for patients in more traditional programs.

The Health Payment Processor who can provide an integrated, efficient claims processing platform for enabling transactions among health plans, providers, employees and consumers has the opportunity to capture a share of an incremental revenue opportunity Diamond estimates as $5.6 billion over the next five years.[1]

The revenue opportunity from issuance and administration of HSA-linked debit cards and other new payment vehicles represents an attractive growth sector for the payments industry. Companies have started to explore other payments opportunities as well, including 1) eligibility verification services; 2) electronic claims submission/aggregation; and 3) payer-to-provider payments and electronic delivery of remittance advice/EOBs.

[1] Transaction processing in this context refers to the integration of claims processing and payments infrastructure under a single healthcare value chain as first illustrated by Diamond in an article in the Journal of Payments Strategy and Systems, "What are the Implications of Health Savings Accounts for the US Payments Business?" Oct. 2006.

What will drive success? First, a strategy must help reduce provider bad debt and shorten payment timeframes. Real-time eligibility information and claims authorization and alternative payment forms to cover payments at the point of service are critical. The second priority is lowering administrative costs by streamlining and automating claims processes and by efficiently capturing all the information required for reporting.

Protection: $5.1 billion opportunity

Financial Health Protectors to the Rescue for an Aging Population

The need for supplemental healthcare coverage at retirement is well documented within the industry but not well understood by millions of consumers. Between 1988 and 2006 the share of large employers offering retiree health benefits declined from 66 percent to 35 percent. Eighty percent of employers expect to increase retiree premiums in 2007. This decline in employer benefits is forcing retirees to face significant challenges in finding affordable coverage in the individual market. Medicare and Medicaid typically only cover around 60 percent of the typical expenses incurred by folks older than 65 years of age.

Providing supplemental insurance to help consumers manage the risks of unforeseen life events after retirement is becoming an increasingly attractive proposition. Diamond estimates that this market will represent a $5.1 billion incremental revenue opportunity over the next five years.

Meeting this demand will require companies to invest in educating younger consumers and pre-retirees on the value of purchasing such products when they can be underwritten at lower prices. They need to create an advantage by bundling healthcare planning alternatives with long-term financial and retirement decisions. And they need to offer a portfolio of easily understood, complementary products, including supplemental insurance, that is priced and packaged to compete more effectively against alternative, near-term investments.

Financing: $4.9 billion opportunity

Helping Consumers Most in Need Bridge the Obligation Gap

As consumers shoulder more of the financial burden of healthcare costs, the need for products and services to help them fulfill their obligations, and to help providers reduce their bad debt, will surely increase.

Diamond estimates that the demand for help from consumers and healthcare providers will present a $4.9 billion opportunity over the next five years. Financial services firms, including banks, card issuers, and credit unions, are starting to offer health-specific lines of credit, special bridge loans, new credit instruments, and payment guarantees. These products can help consumers with their near-term obligations until they can accumulate adequate assets in an HSA and other custodial account. Furthermore, they can help providers collect payment in a timely manner.

The drivers behind these opportunities are clear. Consumer out-of-pocket health care costs increased almost 6 percent in 2005 and are expected to exceed $1,000 per capita by 2010, according to The Centers for Medicare and Medicaid Services. The average annual out-of-pocket obligation for HSA-linked high-deductible health plans tends to be much higher ($3,190 for an individual and $6,350 for a family plan). Among low- and middle-income families carrying health care-related debt, the average credit debt was significantly higher (46 percent) than in those households without medical expenses, thus increasing the creditor's risk exposure.

While the opportunity in healthcare financing may be significant, firms must pursue opportunities only after carefully understanding the impact of additional healthcare related credit risk. Finally, healthcare credit requires a thoughtful and consumer-oriented approach to policies and practices around billing and collections to ensure that the firm's broader consumer brand image and reputation are not impacted.

Asset Accumulation: $4.3 billion opportunity

The Emergence of Health/Wealth Cultivators

The problem of unfunded medical liabilities is expected to worsen as healthcare costs rise and employers shift from defined benefits to defined contribution models. Already, every 30 seconds someone in the U.S. files for bankruptcy in the aftermath of a serious health problem, according to a 2006 study conducted by Harvard University researchers.

Diamond estimates that there is a $4.3 billion incremental revenue opportunity for "health/wealth cultivators" who can help consumers manage their healthcare dollars and meet their financial obligations. Value-added services such as funds management, brokerage, and investment services will generate significant revenue opportunities as HSA contribution limits rise in 2010 and enrollees accumulate assets beyond deductible requirements (from $1,200 currently to $5000).

The HSA Phenomenon

Diamond estimated in 2004 that health savings accounts would represent a tremendous growth opportunity for financial services institutions. Recent reports indicate that our short-term projections weren't off by much and our estimates regarding account and asset growth for 2010 appear right on track. Several market factors—employer investment in consumer education, state tax deductibility, enrollment among jumbo employers, an increase in contribution limits and compliance requirements—are moderating the rate of growth of accounts and assets under management. Overall, however, we still see steady progress in the development of the projected $3.5 billion HSA opportunity we sized back in 2004.

The latest ISI report, released in Jan., 2007, pegged the 2006 HSA enrollment number at nearly 3.5 million accounts, exceeding our initial projections by a million. Also identified in the report were total assets under management, approximately $5.1 billion, which was nearly identical to our initial projections for 2006.

Actual HSA growth exceeded our expectations primarily due to high enrollment among the previously uninsured, comprising nearly 27 percent of new enrollees, and an increasing preference among employers to offer HDHPs linked to HSAs versus HRAs. We conservatively estimated that HSA-linked HDHPs would comprise 40 percent of the nearly 6 million CDHPs in play by 2006, with the remaining accounts linked to HRAs. Actual numbers suggest that HSA-linked HDHPs are growing at a faster rate than HRA-linked HDHPs and comprise nearly 50 percent of the current CDHP enrollment.

Average account balances of $1,206 lagged our projections by approximately $700, primarily due to contribution limit constraints associated with late-stage HSA enrollment and poor HSA enrollment and investment levels among eligible HDHP plan participants. According to the Jan. 2007 ISI study, average deposits are approximately $1,900 or less. They are growing rapidly within accounts open for more than a year but only $1,090 for accounts that are less than a year old. This represents less than 50 percent of the average deductible for single coverage. Additional studies conducted by AHIP and AIS in 2006 revealed that less than 50-60 percent of eligible HDHP plan participants actually enrolled in HSAs.

Although interest in CDHPs and HSAs remains high among employers and independent consumers alike, future growth expectations must be tempered to reflect the current lack of investment in integrated enrollment and consumer/employee education. Although 22-25 percent of all employers are expected to offer HSAs within the next year, their level of investment in benefits design and employee education has been poor. According to a 2006 GAO report on CDHPs, 90 percent of employers offering CDHPs do so in parallel with traditional PPO plans without the appropriate financial incentives or plan differentiation required to modify behavior. A recent AON survey indicated that nearly 66 percent of employees do not enroll in HDHPs due to a fear of high deductibles/out-of-pocket expenses. Clarifying the value proposition of triple tax advantaged HSAs and HDHP coverage levels vis-à-vis traditional plans would help alleviate such concerns among employees and drive future adoption.

Adjusting for these challenges, our updated projections place 2010 HSA enrollment at approximately 15 million accounts, nearly 5 million fewer than previously anticipated. Similarly, total assets under management are likely to be lower than previously anticipated at approximately $65 billion by 2010.

Nonetheless, HSAs are fast becoming a stay-in-business proposition for most banks and thrifts. As more consumers adopt HSAs, those accounts become a critical lever for financial institutions seeking to maintain profitable long-term relationships. In fact, the number of banks offering HSAs has more than tripled since the end of 2005. Approximately 1,100 financial institutions now offer HSAs (including federally chartered savings institutions, credit unions and community banks). The top five players, Exante, HSA Bank, JP Morgan Chase, Mellon, and Wells Fargo still account for nearly 25 percent of all HSA accounts and assets under management

As all these players migrate towards integrated enrollment, better customer service, and near real-time payment adjudication, the key success factors for HSA growth remain the same: targeting the right consumers, making the requisite infrastructure investments, and shifting the focus from transaction fees to longer-term asset management opportunities.

Two solutions are already gaining traction in the marketplace. One is advisory and planning services with a personalized view of financing needs and assets that incorporate health care in the investment equation such as Humana's Family Health Budget. The other is asset accumulation vehicles such as retirement and money market accounts, HSAs, HRAs, FSAs. Competitors in this arena are numerous, ranging from Exante and Wells Fargo, to Fidelity and Vanguard.

Driving the demand for these services is the need for clearly understood, practical, and targeted investment alternatives. Providing tiered levels of customer service, and by adding health/wealth information in concert with more traditional financial planning advice, can improve consumer adoption and greater profitability for financial services firms. In addition, companies need to consider and deliver the appropriate set of tools (both online and via more traditional sales channels) to help consumers make the appropriate choices.

Wellness Advice: $3.4 billion opportunity

Health Coaches Can Help Halt Runaway Spending

One obvious way of curbing runaway healthcare costs is to create a healthier population. Obvious, but far from easy. Diamond estimates that the cost of unhealthy behavior (lack of exercise, tobacco use, substance abuse, a lack of preventive care, and non-compliance with prescription medication, among others) exceeds $350 billion a year. For example, Unum Provident notes that obesity-related disabilities cost employers an average of $8,720 per claimant/per year in wage indemnity.

The demand among employers to get their employees to adopt healthier lifestyles is creating an important and profitable role for wellness program managers who can foster lifestyle improvements. Diamond estimates that this demand will spark a $3.4 billion market for wellness program designers, behavior modification programs, and wellness platform vendors over the next five years.

At first glance competing in this space may appear to be a stretch for many traditional healthcare and financial services firms. Convincing employees and other consumers to change unhealthy behaviors is no easy matter. Companies must be prepared to invest in a long-term effort and have the analytical skills to track progress in changing behaviors. Wellness program managers must be attuned to the unique characteristics of each client's employee base, know what behaviors to focus on, and how to structure the most effective set of rewards and disincentives. They will also need deep skills in managing partnerships with reward providers, national fitness center chains, and other third-party service providers, and in integrating their services into the broader health/wealth value chain.

Staking Your Claim

Because the opportunities in the health/wealth marketplace are enormous, it might be tempting to seize as much new territory as possible. However, even the largest players, with the greatest appetite for growth, will come away from the health/wealth marketplace dissatisfied unless they evaluate opportunities against seven key dimensions:

Strategy

Building consensus around the organization's future role in the health/wealth value chain is essential and will require significant internal and external analysis.

For example, a leading investment and benefits management firm developed a multi-year strategy and roadmap for capturing new revenue opportunities that are emerging as employers seek to reduce benefits expenses and employees look for guidance in making healthcare decisions. Various market opportunities were sized and validated. A rigorous framework was applied to determine the attractiveness of those opportunities across multiple dimensions. The management team clearly identified a business model and set of product offerings that could conservatively generate more than $1 billion in new revenue over five years. In addition, the company had a detailed action plan for developing the capabilities required to capture that revenue.

The kinds of questions raised in a strategic planning exercise might include:

- *How would a new role in the health/wealth value chain advance our corporate objectives?*
- *What role should we play?*
- *What specific problems can we address for our customers?*
- *Which customer segments offer the greatest profit potential, be they consumers, employers, health plans, or providers?*

Health/Wealth Readiness Framework

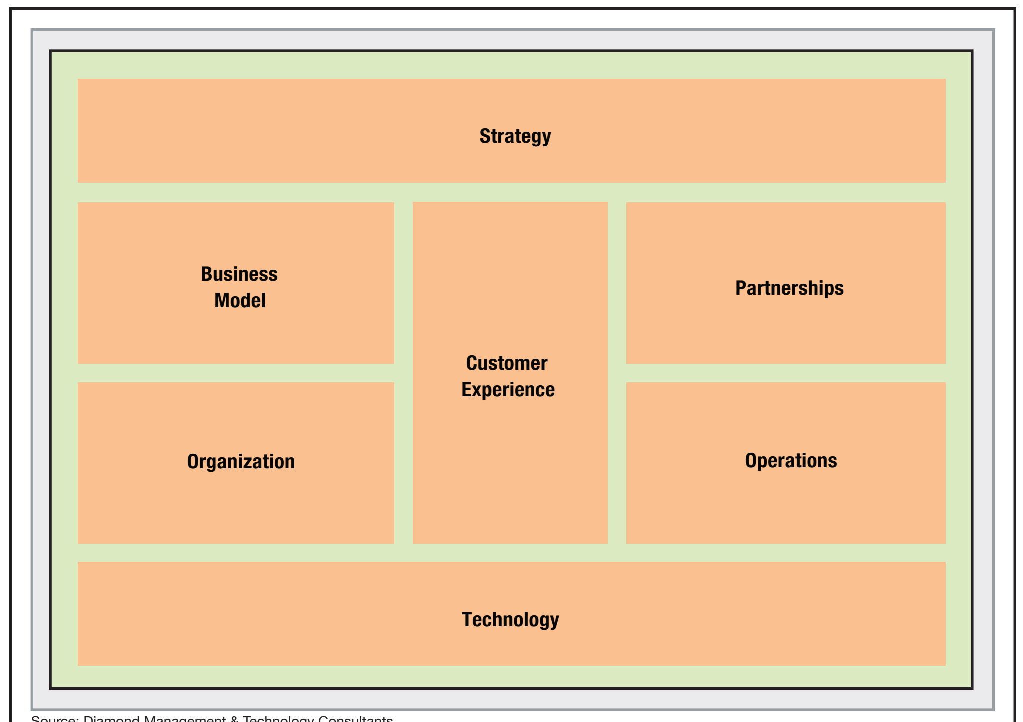


Figure 4

- *Who will we be competing against?*
- *How big is the opportunity for us? Should we strive for a dominant position?*
- *Are our current capabilities sufficient to reach our objectives?*

Business Model

Actually executing a new health/wealth strategy requires an additional level of detailed analysis, a business plan including financial pro-formas, and a blueprint for execution that describes precisely how the organization can generate revenue and earn market share.

That work can be done quickly. In less than three months, a national consumer marketing firm built a business plan to capitalize on opportunities created by HSAs. The project team defined a precise value proposition and created a high-level business model to monetize the most promising opportunities. With revenue and operating cost estimates in place, the team then crafted a roadmap with a development timeline, action plan, and an organizational plan for operations and governance.

In building a business model questions must be answered on both the revenue and cost sides of the equation:

- *What's the size of the addressable market, and how much of that market can the organization realistically hope to capture?*
- *What specific products and services can the organization bring to market?*
- *Have various pricing models and elasticity assumptions been tested to ensure accurate revenue projections?*
- *What capital investments are required as the price of entry?*
- *What operating costs will be incurred in delivering products and services? How might investment requirements change as the market matures?*

Customer Experience

The most successful health/wealth services will offer an experience that consumers embrace. An optimal customer experience can engender loyalty that leads to profitable, long-term relationships.

Recognizing this, a leading national insurance firm defined a multi-channel customer experience roadmap to support their new consumerism strategy. Depending on a particular organization's intent, that work might include integrating retirement and healthcare planning and decision support tools; linking tools with third-party healthcare providers and sources of health information and financial forecasts; producing customer-specific integrated health/wealth statements; or enabling real-time eligibility verification and claims adjudication.

Questions companies should be asking about improving the customer experience include:

- *Which touchpoints warrant the greatest investment and attention?*
- *What are the market's current expectations and pain points and how are they evolving?*
- *What will an enhanced customer experience look like?*
- *How will those touchpoints be seamlessly integrated with other products or services, including those which might reside outside the organization's domain?*

Partnership Alternatives

Even the largest organizations will have to consider partnerships to provide the integrated health/wealth experiences customers demand. This requires a coordinated approach to evaluating, selecting, and managing various models and relationships.

Partnering is not an instinctive act; getting it right takes time, effort and the right intent. For example, a leading investment and benefit management firm developed a health/wealth strategy that was contingent on partnering successfully with a significant number of health plans. The process included identifying the key areas where collaboration was required and evaluating alternative approaches towards integrating the strengths of the firm and its health plan partners. In addition, the project detailed all the technology, channel and operational implications. The company now has a detailed implementation roadmap that it is using to establish partnerships and seize an important market opportunity.

The primary considerations in building a partnership strategy include:

- *Is the purpose of the partnership strategy to gain market access or add new capabilities?*
- *Is a near-term relationship sufficient or is a longer-term commitment required?*
- *Is a collection of loose partnerships appropriate or is there leverage to be gained by creating tight partnerships?*
- *Can exclusive partnerships create differentiated services and a competitive advantage?*
- *In terms of partnership management, is a vendor relationship sufficient or would other governance and relationship models mitigate risks and provide more potential upside?*

Leadership and Organization

Because the health/wealth market is a product of convergence, Diamond recommends that the leadership team be comprised of expertise in financial services and healthcare markets, product development, marketing, and consumer behavior.

That leadership team needs to answer some key questions, including:

- *Does the team have the necessary authority across traditional organizational boundaries?*
- *What's the best approach to achieve organizational alignment with health/wealth initiatives—grouping similar products or projects or perhaps integrating various competencies?*
- *How will we focus our efforts? Is a high risk/high reward "big bang" initiative required or should we build a portfolio of options, starting small, going to market quickly, and preparing to scale our early successes?*

Operations

Since many of the integrated health/wealth opportunities are virgin territory for healthcare and financial institutions (even those with HSA and CDHP offerings today) an objective assessment of current operations and how they might support future initiatives is critical.

A leading national health plan, for example, had been early to the market with HSAs but knew they could do better. The company took a fresh look at improving the contribution process and its enrollment capabilities. Detailed requirements for enhancing their business operation were defined and thorny operational and IT issues across the enterprise were surfaced and resolved. That effort dramatically and cost-effectively improved the customer experience.

Operational questions that deserve particular attention include:

- *How will new health/wealth initiatives impact other key operational areas, such as increasing the volume of customer service calls?*
- *Have we designed new operational processes with flexibility and incremental improvements in mind?*
- *Do we have a global sourcing strategy to efficiently expand (or contract) capacity as market conditions change?*

Technology

Health/wealth opportunities are highly dependent on information and technology. To ensure that new initiatives are helped rather than hindered by IT, it is essential that a company have a roadmap leading to new capabilities and even a lower total cost of ownership of IT assets. The scope of that initiative will vary in size, based on a variety of factors, but the best technology roadmap will be flexible enough to adjust IT investments consistent with changes to the business model, organizational strategy, and operational requirements.

A leading provider of consumer-driven health/wealth services (HSAs, HRAs, and FSAs) wanted to move from an employer-focused model to a consumerism model and add a variety of new technology-enabled capabilities. That effort required a new integration architecture and linking the company's new products with a major financial institution and a debit card vendor. The company's legacy payer claims systems and PBM are now incorporated into a single claims payment process. Member enrollment has increased four-fold in three years.

Questions management should be prepared to answer include:

- *What are the potential impacts of new initiatives on our current technology architecture and organization?*
- *What gaps in infrastructure, architecture, applications, and capabilities do we need to address immediately?*
- *What future state architecture should we strive for to support the larger strategy (e.g., partnership integration, service, and transaction processing strategies)?*

Conclusion

The magnitude of the upheaval underway in the U.S. healthcare system is significant. For many healthcare and financial services firms the traditional path to profitable growth will be irreversibly altered. But this upheaval will also create new routes that lead to new opportunities.

The executives that successfully lead their organizations on this journey will set a clear strategic course. Their companies will be well equipped with the necessary business model, organization, operational capabilities, and technology. If they can't make the journey alone, they will align with like-minded partners who share their quest. And they will be guided by the North Star of customer experience, always headed towards that shore where profitable, long-term customers are waiting for a better way of managing their wealth and their health.

About Diamond

Diamond (NASDAQ: DTPI) is a management and technology consulting firm. Recognizing that information and technology shape market dynamics, Diamond's small teams of experts work across functional and organizational boundaries to improve growth and profitability. Since the greatest value in a strategy, and its highest risk, resides in its implementation, Diamond also provides proven execution capabilities. We deliver three critical elements to every project: fact-based objectivity, spirited collaboration, and sustainable results. To learn more visit www.diamondconsultants.com.

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