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OVERCOMING GROWTH IMPEDIMENTS DURING UNCERTAIN TIMES

AUDIO TRANSCRIPT

Host: Hello and welcome to today's webinar, **Intelligent Payer: Overcoming Growth Impediments During Uncertain Times.** Before we get started, I'd like to review a few housekeeping details. Today's webinar is being recorded and an online archive of today's event will be available a few days after the session. If you have trouble seeing the slides at any time during the presentation, please press F5 to refresh your screen. You may ask a question at any time during the presentation by typing your question into the Q&A box located on the right side of your screen and pressing enter. And finally, I'd like to remind you of AHIP’s antitrust statement and ask that you reference it in the handout section at the bottom of your screen. The antitrust statement prohibits us from discussing competitively sensitive information.

We're very fortunate to have with us today Ms. Sonal Kathuria and Mr. Rick Stewart. Sonal is Accenture's strategy and performance growth lead for health. Her focus area is the convergence of healthcare delivery and financing to address issues impacting affordability and outcomes. With more than 20 years of healthcare consulting and industry experience, she has helped design and implement new care models, innovative payment approaches, provider collaborations, and cross sector collaborations to address issues of healthcare value across population segments.

Rick leads Accenture's North America payer clinical innovation practice, which specializes in approaches to drive clinical outcomes, reduce medical and operating costs and capture quality-based revenues. For more than 25 years, Rick has worked with large for-profit and not-for-profit payer, provider and government health organizations to improve the quality, effectiveness and efficiency with which healthcare is delivered in North America. At this time, I would like to turn the floor over to the speakers.

Sonal Kathuria: Thank you. Good afternoon. Welcome to the session. We appreciate you spending your afternoon, or for some, lunch hour with us. Today we'll talk about how health plans can overcome growth impediments in these times of pandemic, where there's so much uncertainty. We're going to be spending 45 minutes with you. Our agenda for today and what we would like to cover over the next 45 minutes is, first, baselining on what are the uncertainties driven by COVID-19 and how will that determine the future in terms of impact on health plans? The MLRs may be looking good for now. We would like to frame these uncertainties to how it's the right time for plans to evaluate the health of their financial organization or performance so they can reinvest in growth and then we will wrap up with priorities for the new future or the new normal. That's our agenda for today. And, we obviously want to start with what's been the impact of COVID. And what toll COVID has led to in terms of conundrum of health plans and uncertainties driving forward.

The first one obviously has been the impact of unemployment on employer-sponsored insurance. The uncertainty question here is given the numbers, where are we going to settle for the rest of the year? What's next year going to look like, and how far and how deep will this go? We have created a model to evaluate the impact of unemployment on employer-sponsored insurance and the commercial landscape at a market level. And we'll share some thoughts on that in a second. The next question and the next uncertainty is around the demand for medical procedures and healthcare utilization going forward. We all saw when COVID was declared a pandemic, that there was immediately a 60% to 80% reduction in deferrable utilization. These included elective surgeries, provider visits and actual chronic care visits. And now that we're slowly beginning to see the stopping of log down in some markets, some of that utilization is creeping up. But the question every health plan actuary is asking themselves is how much of that will come back and will we ever be at pre-COVID levels? Or, what would be the impact of utilization on continued peaks of the pandemic over 2020 and 2021?

The third point, obviously, and this is interesting to see at a time when nearly every sector of the US economy finds themselves under massive economic pressure. The parents are actually doing better financially than when the crisis began. But the key of talking about deferred utilization, in combination with employer-sponsored insurances, is what's the outlook for 2021 and beyond going to look like? The uncertainty here is it's really fraught with threats in the next 18 months, which may have profound structural implications for the pair economics.

Obviously, the silver lining of this is the rise of digital care delivery adoption and virtual visits. The obvious question is how long will that last? The exponential rise of telemedicine that we saw going from a base of a few hundred basis points to almost 10 X. So where would that end up? And Rick

will hit on that a little bit. And last is the way we work. It has become very clear with the pandemic that the fundamental ways we work have changed from office to virtual. Now with digital, how will that get impacted forever? Let's hit on these one by one and discuss some implications.

The first impact that I mentioned, and the uncertainties are on unemployment, on employer- sponsored insurance, and then the eventual impact on profit pools. Many experts anticipate significant disruption in the health insurance space. And we think there's a nuance understanding of key trends at work, and then likely market shifts that this will drive.

First of all, we believe the market will shrink, but it will shrink unevenly. This is a chart coming out of a model that we developed at Accenture. We forecasted the model based on several inputs and outputs. Obviously the key being the impact of unemployment scenario on commercial group insurance and what we saw and we modeled out is that, when you think about commercial group insurance, every 1% increase in unemployment could lead to almost 2 million lives, commercial lives that could be displaced. And when you start peeling the onion a little bit, and going back to my uneven point, what's clear here is that the small business is disproportionately impacted- with that 35% of the newly unemployed coming from businesses or employers that are under 50. And then 60% perhaps coming from those that are under 500. And then the unevenness is further assessed when you look at industries such as hospitality, travel, hotels, restaurants, where that impact has been on unemployment and the lockdown more profound.

Now what's going to happen to these populations if they lose coverage where they're going to go. A majority of them would unfortunately go to Medicaid and that number goes anywhere from about 40% to 50%. A smaller slice of that would go to AHCA or individual coverage and then the rest will potentially become uninsured. This is a big impact and there's some disturbing trends we're seeing where most recently the unemployment is not coming from furloughs, but it's also from new cases on unemployment requests so where folks may not be seeing growth in those industries or markets. That's a very important factor when we look at the impact of COVID on health insurance.

Let's ask a little poll here and get a little interactive with everybody. The first question- we would love to hear from you and you all come from some various organizations- is how concerned is your organization with the impact of unemployment on commercial group insurance? Is your organization very concerned, somewhat concerned or not concerned at all?

Let's take a minute or two to see what responses we come up with. They would like to publish the poll now. Maybe we're having some technical difficulties. I can see the results on here. Rick, are you able to see them?

Rick Stewart: Yes, I am. It looks like...Forty percent of your organizations are very concerned.

Sonal Kathuria: All right. Rick, let's have you talk about the utilization impact.

Rick Stewart: Thanks, Sonal. Obviously there are many different scenarios here in terms of how COVID responds going forward that are going to have a big bearing on utilization and on costs. And I'm sure most of your organizations are modeling at least one of these scenarios. Probably, you're modeling many of the scenarios.

Frankly, as an industry right now, we're doing a little bit of sophisticated guessing in order to think about what is going to happen. As we move into the fall, will it get worse? And there's going to be differences coming in. It sounds like there are many different variations geographically that are going to happen. If you're somewhere like Wyoming, the scenario one where the flatten curve may end up persisting. If you're somewhere like Florida, there's a good chance that there's a prolonged period where COVID is present. And I think a lot of places are going to see cyclical outbreaks and that's going to have different ramifications from a use and a cost perspective. And it's going to change how we as consumers… it's going to change our ability and our motivation in how we seek preventative care, in how we seek episodic, ambulatory care and certainly in how we seek urgent care. Even in some situations how we seek emergent care and thinking through how we model that is going to be important.

Now, one thing that will have a large bearing on what that does to use and cost is virtual care. And those of you that attended the AHIP Institute a few weeks ago, even though there is much debate and disagreement across a number of topics, one of the topics I think there was almost unanimous agreement on was that virtual care is here to stay. We've hit a point where, not only have consumers begun to accept virtual visits, there are situations where there's almost an expectation of virtual care. And that's going to have a bearing on how we think about utilization going forward. It’s going to have a bearing on how we think about product structure going forward and what things get covered. We think that even though there's been a necessary spike as things were shut down, as things begin to reopen and we get to whatever our new normal looks like, we think we're going to land somewhere around one in three visits being done virtually. I've seen some models where the numbers are lower. I've seen some where it's more than 50%. I think where we're landing is around one in three. And there's a number of variables that are going to influence that.

There are things like reimbursement policy and rate parity. We've had several payer organizations, including CMS, come out, leaning towards, or, making more declarative statements around, we're going to have rate parity for an office visit and a virtual visit.

There are other organizations that are still kind of playing a wait and see, and we may do parity for primary care. We may do some percentage of an office visit for specialty care. I think where things land will have a big impact on provider behavior. Other variables include telemedicine access. A lot of people are doing this for the first time.

Thinking through the platforms that we now have being able to scale those, industrialize it so they can handle the scale that we're talking about going forward. There's some work that's going to need to be done there and there's going to be some growing pains.

From an individual consumer standpoint, there is a training component. If you've never done it, and you're doing it for the first time, how do I log in? How do I respond when I have questions? How do I connect devices to be able to capture clinical data? There's going to be probably some kind of a cottage industry of either payers are going to develop this, or there's going to be third parties coming up to install, train, educate, maintain devices that are going to be used for virtual health.

And I think the other piece is around the data. How do we make sure that the data that's needed gets into the hands of the provider having the virtual interaction? And how do we make sure that data captured in that interaction securely and accurately flows through to all the different places and people that need to see it?

Another variable here is going to be provider network paradigm. We think there's going to be a fairly substantial modification to how payers look at provider networks. Think about this. If you're a geographically centered health plan, now, all of a sudden, you don't have geography so much as a barrier.I know there's some licensure things that need to be worked through, but as virtual care proliferates and we get to a one in three, we think some of those licensure barriers may be lifted.

And if that's the case, think of the power of being able to leverage centers of excellence, whether that's cancer care through MD Anderson, cardiac care through Cleveland Clinic. And there are some startups in the space that are based on providing virtual specialty care help. One of the ones I am interested in is Aura oncology being able to provide virtual oncology specialists. That's going to make some interesting changes to the paradigm of how we look at the provider network. And then lastly, the ease of use and the convenience factor. It's worth very much monitoring if consumer preference stays on virtual health and for which types of procedures, for which geographies and demographics, etc.

Those are all kind of influences we see to the modeling that all of you are surely doing to think through what's use and cost going to look like. I do want to queue up another poll question if we could. For your organization, where do you believe, or where does your organization believe the new normal will land, as a percentage of overall provider visits? Is that going to be returning to pre-COVID levels, which is more like less than 5%? Is it going to be between 6% and 25%? Is it going to be slightly under half, between a quarter and a half? Or is it going to be 40% or greater?

And for some of you, your organizations could still be modeling and haven't landed on something. That's perfectly fine. For others, your organization may be doing it, but you may be unaware. We'd like to understand that as well. So, if we could activate the poll, please.

Sonal Kathuria: Rick, as the poll is coming up, it would also be nice to talk about-- is utilization ever going to come back, at least in the foreseeable 12 to 18 months, to pre-COVID levels? I would love to share our points of views on that.

Rick Stewart: Now, that's a very good point. What we're seeing among our clients is that there are some elective procedures that likely will come back. We no longer think there's going to be a bubble. It's likely going to be probably more of a ramp that goes into 2021. There are some elective procedures and certainly a lot of the ambulatory care, and unfortunately some of the preventive care, that probably is not going to come back. It's just going to be kind of forfeited. And then the next cycle, people will evaluate if this is something I'm now comfortable going into the office for, or I can now do remotely.

It looks like our poll is published now. And the lion's share of the vote is for somewhere... it looks like most people think it's going to be less than a quarter going forward. The next highest is going to be somewhere between 26% and 40%. Very few, as we probably expect, are thinking it's going to be less than 5%. And a few think it's going to be greater.

Sonal Kathuria: That makes sense. The bar is pretty low between 6 to 25 or 26 to 40; it's a small change.

Let's be honest. What Rick and I have been sharing so far is that were at mixed messages, right? MLR is down. Growth is down. Would that really even out over time? This is our take. But the prospect of administrative pressure in a year, which is marked by massive medical cost reductions, might seem kind of counterintuitive. But this is the likely reality in the absence of, let's say a significant government intervention, that may try to stabilize enrollment. We feel that there's so much else to be done in terms of stabilizing the country, and the industries, and probably every other industry that, this is going to be a question mark. We believe that health plans need to act now to drive performance and really start thinking about it from a restructuring standpoint.

And we would think that based on some of the membership numbers that I was sharing earlier, that payers may endure an operating margin pressure depending on their mix. What's the mix between commercial fully insured and self-insured? And also, if you look at your Medicaid and government book of business, that there could be operating margin pressure, as much as 10% to 25%. Now, obviously that would be higher for ASO and a little different for small groups. And in addition, the local and regional plans are probably going to suffer a larger share of the volume than national or large group plans, given the density that they have in a particular market within commercial.

What we've done here is we've laid out a few ways to think about performance and I would start from left to right. Smart spend- preparing now for a leaner cost base. What we mean by smart spend is that it's really your nonmember expenses, your third-party expenses. You can get to it quickly by stopping. Stopping things are non-strategic spend or looking at your procurement process. And what we've typically seen is if you

really want to get to a rapid recovery or some kind of rapid performance, you could see an impact of working on this particular opportunity, as low as three months. You know, depending on the type of payers, this can typically be a large spend of payer spend. You'll be surprised. For a 1 million life plan, they could be spending 200 million into this category.

The second step -the key question- is around building a smart organization. What we're seeing now with COVID; I mentioned the silver lining before is the rise of digital or the rise of automation, and people working virtually, etc. It really pushes the payers to think about what can they do now to focus on building a smart organization or different ways of working. And these different ways of working can really come from all areas. How do you use data? How do you use intelligence? How do you use digital? How do you redesign their process, or reimagine their process through these costs? When we used to talk about cost takeout and health plans 10 years ago, we'd just talk about benchmarking. Now, it's really rethinking the way you do your business. Benchmarking is something most health plans have become very smart on and most business functions started doing this more continuously. But if you really want to rethink cost and look at potentially using this time to take 10% to 30% cost out, look at labor expenses with a smart organization mindset. I'll spend a little bit more time on what that means.

The next couple levers, we go into medical cost. We believe that now is the time to leapfrog into medical management improvements and telemedicine virtual capabilities that Rick was talking about. COVID-19 presents payers with what I would call a once in a lifetime opportunity. This is a good time. Next six months, we'll get pairs of free pass to really look at the medical costs and shut down unsatisfactory programs, care management interventions or build new ones and experiment with fresh capabilities. One example I like using- how do you take this time to usher telephonic medical management programs for the new era of care? That's the way to rethink about it. Any comments on three or smart utilization rate before I walk us through four and five?

Rick Stewart: I get that most of you are probably in organizations where you're having a pretty favorable position right now, when it comes to utilization and costs. But the fact remains, there's still waste in the medical delivery system. Many care management programs are continuing to either fail to drive tangible results or driving dubious results. Those are things that are going to persist and as the utilization comes back, you want to have those things in place. Taking this opportunity to put fixes in place for those now is really important, particularly around the waste of medical spend, because that is something that can be addressed and getting to the point where you're recognizing value fairly quickly.

Sonal Kathuria: That's right. And then obvious things, which Rick already touched on a little bit before so I won't go deep into it, but it's really reimagining

the network contracts- smart networks with an eye towards long-term value because I talked about the healthcare industry being unlike, or at least health plans right now, are unlike any other industry, but many providers need cash in the near term. And this is a good time, perhaps to strike deals that in a sense, disincentivize volume-driven medicine and better align incentives or accelerate value with care in the future.

And then last but not the least, let's take this time to reimagine growth and aggressively acquire and integrate if possible. And again, when I use the word acquire and integrate, this is not just about premium revenue, it's also about non-premium revenue. Peer provider collaboration, investing in care delivery assets, investment in data analytics to externalize and become that data consolidators, which payers unlike anybody else in the healthcare community, especially if they have market density to be able to leverage, to enable better care and make it more affordable. That's sort of the glide path of thinking about healthcare costs and performance in general, both on the admin side as well as on the medical cost side.

The next part really has to say, when you look at admin performance in general, and I spent some time talking about smart spend, and I mentioned this word smart organization, and I also shared that there's never been a better time to rethink and apply to the future because you have some downtime right now.

The common framework here is let’s start thinking about how do you design an intelligent enterprise or a smart organization where you manage both spend, which I mentioned earlier calling it the norm labor expenses, as well as the labor expenses.
And when I mentioned the word smart organization, the philosophy we like using, which works really well if you are a large complicated health plan, with the infrastructure of your front office, middle office and back office starting with zero based mindset, which is asking the question- “What's the right work we should be doing?” What’s the right process to do that work? Is it virtual? Should it be onsite? Should it be offshore? Should we look at outsourcing arrangements? And then what's the organization to enable that work? How do I need to repivot my operating structure to do that?

And then one question that I'm hearing a lot of from some of our clients asking and really taking time to hone in on is- what are my right talent needs in the future? Especially now that part of my talent is working virtually. Some of the talents, I may have to start having them born on site. And, how do you do that with a shift to AI and applied analytics and intelligence? We believe organizations can dramatically shift the pyramid of work. AI is used in a very small level of healthcare right now. The power of using data analytics to automate processes and enhance or augment human decision making…rethinking your organization, rethinking where you're spending most of their money, rethinking that transaction can really work in there.

And so that's the way of thinking about performance improvement. Then, I started talking about applied intelligence and what changes performance improvement and enabled growth topics have been talking about so far is using data digital and process reengineering to rethink business. And what we have seen is from many of our clients that are taking either an organization-wide approach, a scaled approach of AI, or a very social-based approach, they can apply automation, analytics and applied intelligence to processes organizations that can standardize and innovate business processes.

When you look at this kind of framework, foundation to automation, there are only two things that I would like to call out. What I'm trying to build upon is how nature of the work is changing. Some of the leading health plans are already using automation as a first step. Automation on its own will not deliver exponential outcomes. There is a tremendous opportunity to look across the value chain --from what do you do to go sell a product, to market it and build it, to design the network, to do the medical management, to process the claims, to service the experience, and then also all the backend finance and billing- is that data is available at scale to be engineered and analyze the value chain. And if you can use that data to really inform your process engineering, you can really drive exponential improvement in a lot of your automated processes. And then on top of that, machine learning can do that more exponentially as you build on that...year one, year, two, year three, year four.

That's the thought process here. Didn't want to be complicated, but at the same time, really want to highlight this because again, the silver lining with COVID has been the rise of data and digital. Rick, why don't I hand it over to you now to start talking about- what does it mean if I've been listening to this conversation now for about 35 minutes? What does it mean if I'm not clear on how can I get started?

Rick Stewart: Sure. Thanks, Sonal. We like to think of this in kind of three tranches. There are some things to be done that have an immediate impact. I'll speak to some of the medical costs ones and then maybe I'll turn it back to you to talk about some of the administrative ones.

One of the things that we continue to see among the health plans we work at is medical dollars that are kind of flying out the window because there is misalignment between the policies that exist and how those policies get administered, whether it's through the authorization process, the claims process, the appeals process.

And there are things that typically don't get picked up on through the payment integrity vendors. And the nice thing about being able to solve for those is once you plug the leak, you start recognizing the value very quickly. That becomes a good, fairly rapid way to generate some financial value. Same thing with utilization controls. What we typically see is this could be an administrative play or a medical cost play, frankly, because, most health plans

have utilization controls in place where it's actually costing them more to administer than the value that they're getting in return. Being able to identify those, quantify those, get the data to back that up. You can make some cautious decisions on do we choose to eliminate that control or somehow automate it further. And then by the same token, often we see health plans that are missing utilization controls that are effective with others, that they can add to their list. So, being smart about how you use we see as a rapid performance improvement.

And then lastly, use your data; take advantage of that data to understand where am I trending higher than I would have expected from a use or a cost perspective, and how can I put in place rapid campaigns to go after that? There are some metrics that take a longer time to move, but there are other things like readmission prevention, observation status, medication adherence, that if you are armed with the information and can find the people very quickly, those are metrics that you can put straight forward campaigns in place to go out and reduce. Things like that that can be done rapidly.

When you think of your care models, obviously this is one that has a little longer lead time to get to the savings, but it also has a fairly large scale attached to it, which is, take your traditional care management model and really evaluate- am I clear on what I'm trying to do? Am I clear on the metric I'm trying to move and are the actions that I'm taking aligned with that metric? Are the people that I'm identifying aligned with doing the actions to be able to get that end business result? Oftentimes we see, especially with complex case management programs, where health plans have some sort of predictive model that's a predictor of future use and costs, that doesn't necessarily go to the level of here's exactly why this use and cost is happening. Getting that clarity to... I'm trying to reduce ER visits. I'm trying to prevent a readmission. I'm trying to avoid duplicative services. Having that in mind, and then you're having your care managers be able to be measured on their effectiveness on specifically getting to that business impact that can have a big effect on the value of your care management program.

I think in the interest of time, I'll skip to the last bullet on that section around reducing demand because that was probably raising some eyebrows. This could be a product play. And I want to caveat this with in no way, can you put out products that are going to dissuade people or prevent people from accessing care, but what you can do is understand- who are my preferred members? Who do I really most want to be part of my health plan? What are their attributes? What do they value? And how can I build my products, my sales strategy, my marketing strategy around those values? United Healthcare is brilliant at this. If you look at how they attack the Medicare market, they have advertising that specifically targets a 68 year old in a rowboat with his grandkids and the text over top is talking about

how thankful he is that he talked to his health coach and how he now gets his medications through mail order. They do a really good job of targeting their specific target population.

If you think about things going forward, social determinants of health has almost eclipsed buzzword status to the point where you can ask 10 people what they think it means, and you'll get 12 different answers. I think the key here is understanding those social barriers and being able to incorporate it in two ways. Number one: how you use the data as you identify people that need to have some kind of an action, how you use it to prioritize those people, and then in the interaction itself, arming your care managers with that social determinant information is really powerful. If I'm calling someone who is at risk for readmission, and I know that there is a housing barrier, I'm going to have different tactics that I take going into that conversation. And I'm going to mine for things, during that interaction, that are going to be very impactful. Thinking through those types of things as you reimagine your different care programs is important. Sonal, let me turn it over to you to talk through some of the admin pieces.

Sonal Kathuria: Thank you, Rick. So hopefully my phone's better. And thank you for walking us through this. The bottom line on admin is very similar to the path that we walked through for the medical. The rapid part is how do you take off or look at non-mission critical spend and right size your consumption there?

Like I said earlier, you could do that within three to six months and then the heavy work is really rethinking operating models. And by the way, you can start with these three lenses sequentially, or it can happen anywhere on this glide path. And the rethinking operating model, looking at IT and subsets, and what needs to go above the line or below the line, that may take anywhere from six to 12 months again, in terms of realizing value. And then the reimagine the new future, the build obviously can happen sooner, but that's where you start putting yourself in a sustainable three year journey that completely changes the way you think about how you fund care, how do you operate as a business, and then how do you really think about growth. Again, the idea between this being that you're using the value coming out of this to reinvest in growth.

Rick, does it make sense to get into the last and final poll?

Rick Stewart: That sounds good. If we can queue up the next poll...As you think about your organization's priorities over the next 12 months, and obviously these are going to be things where everybody's thinking about probably all of them, but if there is an emphasis, that's what we're trying to understand through this poll question. Is it to reduce admin spend whether that's labor spend or non-labor spend, any of the admin components of cost? If it's reducing medical spend? If it is growing top-line revenue? Or is it the emphasis really on all of the above equally? So if we could activate the poll, please.

Looks like we're just to the end here. So again, the poll is: select the priorities your organization is most focused on over the next 12 months. 44%, by far the highest answer here, was all of the above equally between reducing administrative spend, reducing medical spend and growing top line revenue. Pretty even distribution across producing medical spend and growing top line revenue. And 12% responding with reducing admin spend.

Sonal Kathuria: Interesting. So really a pivotal time in healthcare on the payer side. Well, let's go to the last section now. Obviously, we spent a lot of time talking about performance improvement and how you think about administrative improvement. How do you think about building smart organizations and then medical costs to get ahead of the curve, given the time and the shift in the care model, etc. Now we do this again to fuel or reinvest in growth because we said the growth is challenged. And first of all, there is a method to how you approach it. What we're seeing with many of our clients and working with some of them is we recommend that you do a detailed membership and economic simulation and scenario planning to understand likely market at risk. And pinpoint which customers are at risk so you try to either retain them or you try to come up with different negotiation strategy and become very proactive because it's much easier to try to do that than spending on the customer acquisition of a member that you may lose or lose forever. The second thing that can enable you to make it actionable around prioritizing customers at risk is equipping sales and marketing to capture them. Again, depending on the type of group and the type of channel and how you innovate, there is a lot that can be done. If you have actually changed business and do direct to digital marketing capabilities and drive growth and retention through that, or using your traditional broker channels and making them smarter about the information that you're learning with your data analytics and step one, and enabling that to proactively capture or retain that membership.

We already talked about product innovation, and we cannot not stress this enough, that there is a fundamental disruption and an opportunity to really focus on both product and network innovation and how can you rethink product. That the product is not only always about the insured. It's also about the uninsured and the underinsured. Does a product have to be a one year site go. What could you do for those that can't pay the premium rates now? Or they may only have line of sight to pay premiums for three months. How do you make that product more affordable? And then how do you design an enabling network to support that or the type of services, both core and value added, to enable that.

And then, I mentioned this before and you have to aggressively acquire, integrate. Again, acquisition and integration should not just be about other plans. Obviously, there's opportunity. Evaluate that, but it could be around care assets or other

businesses that may also reflect you to both leverage your scale in the organization, your community, your brand, in terms of both premium and non-premium revenue.

That's the part on growth and recovery. We really want to be able to bring it all together now and say what is the glide path to grow amid uncertainty- the framework, obviously, the now, next and new future. As health plans experience what I may say brisk tailwinds this year, they may be tempted not to take much needed actions we outlined here. But in light of how quickly the winds could change as a result of our unemployment, our economic condition, potentially the impact of that on the downstream enrollment shifts, and cost pressures from employers, and government programs, it's essential not to give into that tailwind inertia. We also believe that companies that take early and aggressive action will put themselves in a much better situation. Bringing it all together for now, focus on smart spend. Focus on smart organization. Rick, do you want to do this together in terms of medical costs? In terms of next to new future- obviously taking a very strategic view of your organization, both in terms of cost restructuring, thinking about smart organization, your network stress points, and then looking at the growth. Rick, what else would you add to this?

Rick Stewart: Well, I do think, and we've had a couple of questions come in about this. I do want to emphasize in the now, the managing out of the wasted medical spend. How do you recommend identifying that medical waste? This is where you need to put your data to work. We've been very big proponents of data-led efforts in this space. You're looking at things like- do I have system constraints or configuration errors that are causing things to be done differently than I'm expecting them to be done? Are there exceptions that I have made to my processes that I never went back and corrected? Using your data and, there is a hypothesis, analysis validation in sizing that goes on with that. It's things like if I'm authorizing at a certain level of complexity and the claim comes in at a higher level of complexity, what does my policy say I do relative to paying that claim? If I have time constraints on when somebody notifies me of admission or, when they request authorization for a service, at what point do I cut off the ability to do retrospectively? It's those types of scenarios where the policy is clear, and the administration is not per the policy that you're testing against, to find those areas. And like I say, we've seen a number of organizations where there's three, four, five dollars PM PM going out the door in just wasted spent for that.

Sonal Kathuria: There's a similar question around the admin expenses and where the health plans have found excess or non-mission critical spend. And obviously an easy way to look at this is your non-labor expenses and within that, your non-labor expenses, your procurement and strategic spend. And again, doing apples to apples comparison, are you getting the same rates across your other businesses for the things that you're outsourcing or using other third party partners for? What is non-strategic? What is strategic?

How much is travel? How much are events and other sponsorships and others? Those are some quick takes and obviously the harder stuff in the operations becomes you've got to prioritize where the majority of your spend is, where the majority of P&L is going. And if you start looking at things like claims and calls, and for example, in calls, why do call centers still exist? Can we turn them into only good calls where your transactional calls happen digitally? Now, how many of you guys listening to this have ever called Amazon or are even able to at least find the phone number for Amazon? Turning your call centers into the next generation of omnichannel engagement, where most of the transactions happen digital and it happens when you want at any given time, and then human when you really need it. And, we have seen and worked with healthcare organizations, other industries, where you can take back 30% - 40% cost volume out. Again, maybe different ways to address both non-labor and labor spent.

We're going to flip to the Q&A. And I'm scrolling through and seeing what other questions there are.

Rick Stewart: We’ve had one come in. The question is, are you seeing health plans use AI to improve cost structure and how are some of those ways and how?

Sonal Kathuria: That's a great question because we spend time talking about it. When you think about health plans, they're all at very different levels of maturity of using AI. But some of our, what I would call leader plans using applied intelligence to, again, purposefully go into large places of spend. Going into claims and seeing what parts of claims can be automated, looking at utilization management. How could you use rules and applied intelligence to further automate UM? Obviously, the other big spend around benefit configuration. Clients are saying what can I do to do this more seamlessly. Why do I have to touch every benefit out there to configure? Can I have a common configuration, and can I drive more standardization in my products that I sell and maintain and configure so I can take those costs out? They're logical areas of maturity where we're seeing this. Finance is another place where you could look at the finance organization and use finance data and AI to digitize the financial planning and forecasting methods and keep the workforce focused on really specialized. How do you take the journey? If only 2% of your business today is using AI, how do you create a path where that 2% can become 10, 20, 30 over the next five years. This is the type of journey that many of our health plans are looking to take to essentially digitize themselves and turn themselves into more of an intelligent enterprise.

Rick Stewart: Great. Thanks, Sonal. Next question is regarding the rapid performance actions. How quickly are you seeing health plans get to a point where they are actually realizing the savings? This would be the time from start; I'm assuming it's time to start until time until the dollars are actually hitting your bottom line. I think as I described in

the discussion, a lot of the wasted dollars are driven off of things that are relatively straightforward fixes. They're either retraining. They are perhaps making some slight changes to system configuration. In some cases, there's a notification to your providers that you're going to begin enforcing a policy you have in place. What we tend to see is these are time to value-certainly same year and sometimes as much as six months start to finish. The long pole in the tent really tends to be being able to run the data to validate the issue, size the issue and decide is this something I want to take an action on. And once you make that decision, taking the action is relatively straightforward.

Sonal Kathuria: That's right. And a lot of times clients get stuck on what's a labor action decision versus non-labor. Typically, we see the actions are more impactful early on for non-labor and that's a great place to start. Well, great. I know we're closing on the top of the hour and I will hand it back to our host.

Host: To our speakers. Thank you for that great presentation and for sharing your thoughts. Thank you to the audience for participating in today's webinar. This concludes today's presentation. Thank you again and enjoy the rest of your day.

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