CHANGE HEALTHCARE

White Paper

The 8th Annual Industry Pulse Report

A national survey of leading health plans and other healthcare stakeholders commissioned and conducted by the HealthCare Executive Group and Change Healthcare

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Abbreviations and Definitions

For the purposes of this white paper, the terms below have the following meanings:

ACA
Affordable Care Act

Bundled payment (see also "Episode of care")
A negotiated lump-sum payment for a treatment and/or procedure that might exclude certain elements of the episode of care, such as certain specialists, rehab services, or pharmaceuticals.

Capitation
A payment model where a physician or group are paid a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

Distribution Channels
The avenues through which healthcare consumers buy health insurance.

Episode of care (see also "Bundled payment")
A care episode that includes the CPT codes for all parts of care for a treatment and/or procedure, from the first appointment through the last treatment or medication dispensed.

Gainsharing
A payment model where direct payment by hospitals to physicians is based on care quality improvement and efficient inpatient performance.

Gamification
Adding games or game-like elements to a process to increase participation and engagement.

HDHP
High-deductible health plan

Health Plan
Same as "Payer."

Hospital
Same as "Provider."

Navigators
An unbiased individual or organization trained to help consumers, small businesses and their employees evaluate healthcare marketplace coverage options, and complete eligibility and enrollment forms.

Non-Governmental Organization (NGO)
A non-profit, citizen-based group that functions independently of government.

Patient-Centered Medical Home
A program from the National Committee for Quality Assurance (NCQA) designed to optimize outcomes by building better relationships between patients and clinical care teams.

Payer
A health insurer/health plan that finances or reimburses the cost of health services.

Abbreviations and Definitions

Pay-for-coordination
A payment model where primary care providers, specialists, and other care providers are incentivized to coordinate care to help plan members manage a unified care plan that reduces redundancy.

Pay-for-performance
A payment model that incentivizes payment and clinical performance, using measures such as bonus payments for preventive care, for meeting baseline quality indicators, and more.

PPACA
Patient Protection & Affordable Care Act

Profit sharing
A payment model where direct payment by hospitals to care team members is based on overall increases in hospital profitability.

Provider
A hospital or hospital system that provides healthcare services to patients. For clarity, this paper does not refer to clinicians as providers.

Reference pricing
A payment model with defined contribution health benefits, where plan sponsors pay a fixed amount or limit contributions toward the cost of specific health care services. Health plan members pay the difference if a more costly provider or service is used.

Risk sharing
A payment model where providers and payers enter into an agreement where they are collectively responsible for the total expense of a given patient population.

Social determinants of health
The social structures and economic systems responsible for many health inequities. These include social and physical environments, health services, and other structural and societal factors.

VBC
Value-based care

VBP
Value-based payment

VBR
Value-based reimbursement

Executive Summary

Annual national survey identifies what payers and other healthcare stakeholders see as the top challenges facing the industry, and as well as greatest opportunities for positive change.

For the past eight years, Change Healthcare has commissioned an online survey in an effort to determine and report on the "pulse" of the healthcare industry. This latest survey, fielded online in late 2017 and published in the first quarter of 2018 in partnership with the HealthCare Executive Group (HCEG), looks not only at marketplace challenges, trends, opportunities, and investments payers report, but also contrasts those findings to what was reported in past Industry Pulse surveys.

This edition's survey was open to more than 2,000 Change Healthcare customers, which includes leading national and regional payers of all sizes; members of the HealthCare Executive Group; and members of the Health Plan Alliance. Additionally, we received survey responses from healthcare leaders across the provider, vendor, government, and academic spaces. In all, 52% of respondents were at the President, Vice President, and C-suite levels.

While there are many insights and take-aways in this report, a few stand out:

- **Social determinants of health transcended buzzword status**, with more than 80% of respondents already taking steps to promote value-based healthcare by addressing the social needs of their members.
- **High-deductible health plans are not converting passive patients into active healthcare consumers.** In fact, they seem to be having the opposite effect–spurring more care avoidance than shopping. But respondents are having success with other approaches that are detailed in the report.
- **Mobile/digital health adoption is not just about functionality and interoperability,** but more about trust, with nearly 50% of respondents indicating that digital health tools are not more widely embraced due to security and privacy concerns.
- **Industry attention has turned to blockchain, artificial intelligence, robotic process automation, and other advanced technologies,** but 63% of respondents pointed to clinical data integration as a leading factor supporting administrative cost efficiencies.
- **Healthcare is transitioning from negative to positive incentives to influence consumer behavior** faster than most expect. Payers are also taking aggressive steps to advance value-based care, and crack the code to successful consumer engagement.

Armed with these and other fresh insights from the 2018 Industry Pulse survey, stakeholders can better understand the shared challenges and opportunities facing industry peers, see what's hot and what's not, know what's working and what's floundering, and strengthen their sense of where the industry is truly heading as it faces the coming year.

ChangeHealthcare.com/2018Results

How Change Healthcare Can Help

As one of the largest, independent healthcare technology companies in the United States, Change Healthcare is inspiring a better healthcare system. We are a key catalyst of value-based healthcare, working alongside our customers and partners to help accelerate the journey toward improved lives and healthier communities.

Our solutions enable improved efficiencies and insights for major stakeholders across healthcare, including commercial and governmental payers, employers, hospitals, physicians and other providers, laboratories, and consumers.

We champion improvement, before, after and in-between care episodes, striving to provide a visible measure of quality and value. Our solutions add value across three distinct areas—Software and Analytics, Technology Enabled Services, and Network Solutions—by helping payers, providers, and consumers improve the full spectrum of healthcare.

For Payers	For Providers	For Consumers
Payment accuracy	Revenue and financial risk management	Access to personal health information
Consumer and member engagement	Patient access	Engagement with providers
Network management	Support for clinically appropriate care	Electronic payments
Transition to value-based payment	Claims and payment management	Tools to help evaluate healthcare choices based on quality, cost, and convenience
Claims payment management	Optimize diagnostic and clinical data	
Support for clinically appropriate care	Imaging, workflow and extended care	

Change Healthcare's Industry Profile At a Glance

5,500
Hospitals

800,000
Physicians

2,100
Payer Connections

$2.0 Trillion
Healthcare Claims

130,000
Dentists

600
Laboratories

1 in 5
US Patent Records

12 Billion
Healthcare Transactions

Please visit our website for more information about how Change Healthcare can collaborate with your organization to accelerate the journey to a better healthcare system.

About Change Healthcare Consulting Services

Publication of the annual Industry Pulse Survey is a service of Change Healthcare Consulting Services.

Change Healthcare Consulting Services is comprised of a dedicated team of 46 experienced, diverse, passionate, and creative team members with a shared vision: Enabling smarter healthcare.

We are dedicated to making it simpler for payers and providers to engage with an evolving and complex healthcare system by helping them cut through complexity and make better decisions, chart a clear path forward, "see around corners" to stay ahead of shifting market dynamics and eliminate inefficiencies.

We work collaboratively with our clients to define new strategies and bring them to life, unlocking the opportunities created by change across six consulting areas:

- Healthcare consumerism
- Value-based healthcare
- Population health
- Government programs
- Process and system modernization
- Analytics and insights

Please visit us on the web for more information about how Change Healthcare Consulting Services can help your organization bring its major initiatives to life to enable smarter healthcare.

Research Background and Methodology

Survey, Screening Criteria, and Data Collection

Respondent demographics

Data collected Oct. 16 - Nov. 24, 2017

Figure 1: Respondent demographics

The Industry Pulse is an annual healthcare industry survey designed to provide directional insight on opportunities, challenges, and trends facing the healthcare market. The research focuses on payer organizations, but includes the perspectives of other industry stakeholders such as provider organizations and vendors.

Developed in partnership with the HealthCare Executive Group (HCEG), this is the 8th annual Industry Pulse survey. It mirrors the HCEG Top 10 priorities list compiled by HCEG members during their Annual Forum.

The national research sample draws from more than 2,000 Change Healthcare customers, including leading national and regional payers; nearly 40 HCEG members; and 50 Health Plan Alliance members.

The researchers targeted the leaders of these organizations, 52% of whom are at the President, Vice President, and C-suite levels.

Consumer Engagement Strategies

How does your organization engage healthcare consumers to better understand their wants and needs?

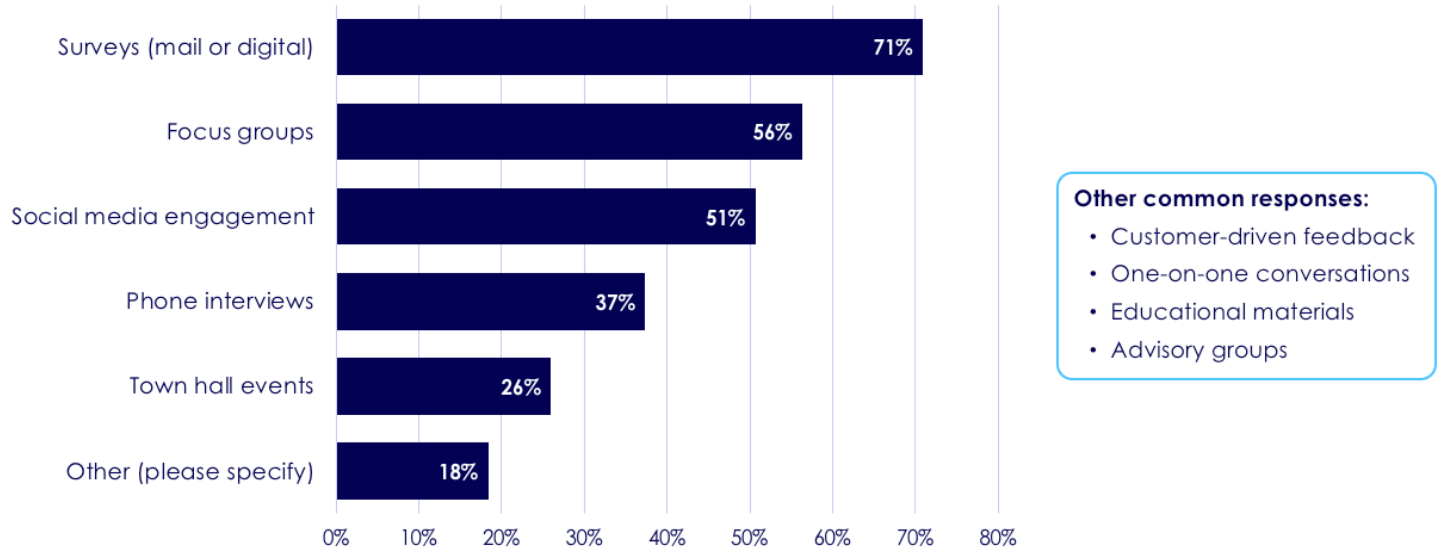


Figure 2: Consumer engagement

We asked healthcare leaders what strategies their organizations are using to connect with and engage healthcare consumers.

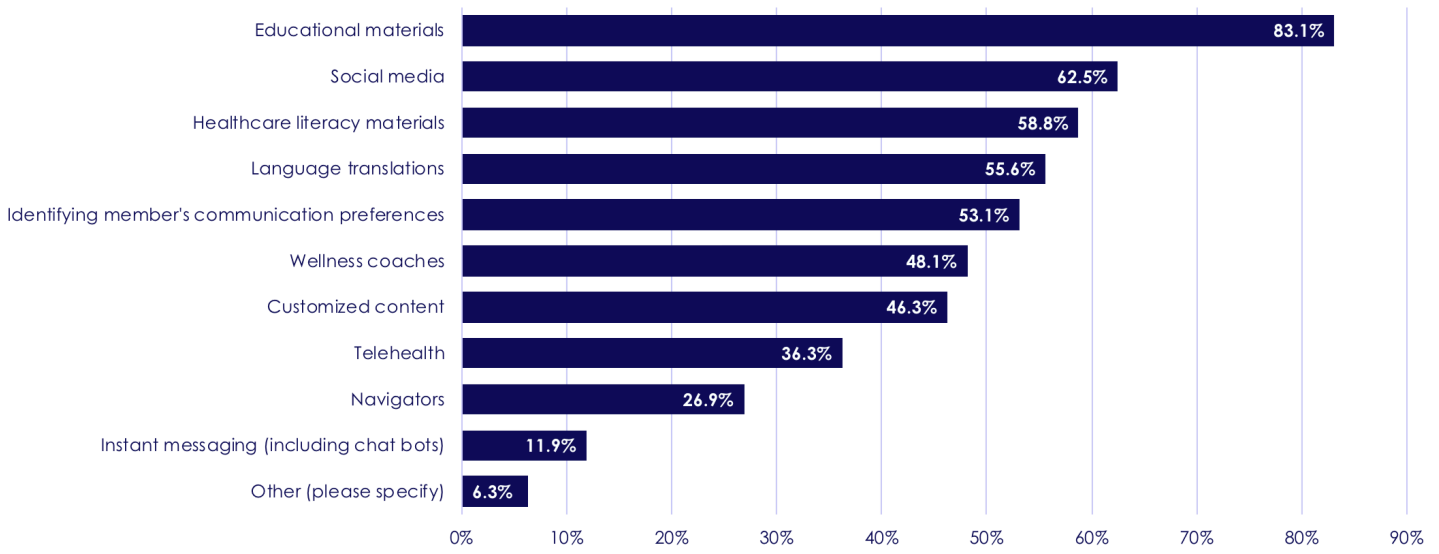
While just over half (51%) of respondents now use social media as an engagement channel, traditional market research methods such as surveys (71%) and focus groups (56%) remain dominant.

About a quarter (26%) of participants engage with consumers on a more intimate level, using "Town hall" style events, while 37% use telephone interviews to determine what consumers think about their healthcare choices.

Note that many of these approaches are opt-in, which can be problematic. For example, a survey is lost in the mail, discarded or ignored; is poorly designed; reaches consumers in the wrong context or at the wrong time (e.g., arrives right after the consumer receives a large medical bill); or only those most-pleased or most-displeased respond, etc.

Consumer Engagement Tactics

How does your organization leverage marketing to enhance member engagement?



Response Count: percentages will total over 100%

Figure 3: Consumer engagement tactics

We asked respondents how they are using marketing to enhance member engagement.

Few would argue that listening to healthcare consumers is not a cornerstone to a successful engagement strategy. Equally important, however, is persuading consumers to become active participants in their own healthcare.

Asked how they are pursuing these complementary goals, the most common method mentioned, by 83% of survey participants, was creating and distributing educational materials.

A majority of participants also said they are using social media (62.5%) to promote and socialize their consumer engagement materials. What are they promoting? Most are developing and promoting healthcare literacy materials (58.8%), and translating that engagement content into other languages (55.6%) to maximize relevance.

The majority are identifying and, ostensibly responding to members' communications preferences (53.2%) to help give consumers what they want when they want it.

Techniques in the minority include the use of wellness coaches (48%), telehealth (36%), navigators (26.9%), and instant messaging (11.9%).

It should be noted that, as an emerging technology, telehealth has made significant inroads relative to older techniques, with over a third of respondents now using it. Likewise, as questions around privacy and security are addressed, and advancements in AI and machine learning make chat bots smarter, instant messaging might not be coming up from behind for long.

What is the best approach for turning passive patients into active healthcare consumers?

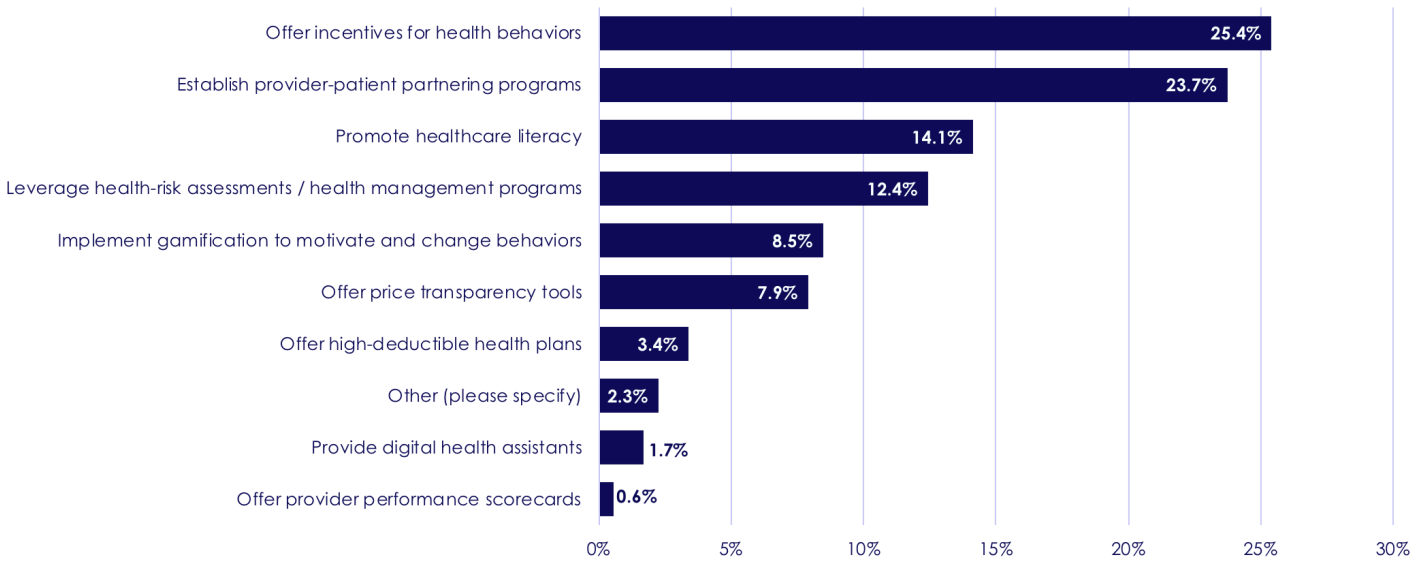


Figure 4: Changing consumer behavior

We asked survey respondents to name "the single best method" for changing consumer behavior, rather than choosing or rating several methods.

Contrary to popular belief, respondents report high-deductible health plans aren't the best way to turn passive patients into active healthcare consumers. A meager 3.4% of respondents identified high-deductible health plans as the best approach for doing so.

This bucks the theory about these plans giving patients "skin in the game." Instead, high-deductible plans may lead to care avoidance rather than fostering shopping and price-comparison behaviors.

But the tools for engaging patients and incentivizing them, and helping them understand healthcare, are often not very good. Consumers need quick, convenient access to accurate price and quality information they can understand—which is rarely the case.

The largest block of survey participants (25.4%) report incentives are the key to encouraging engaged, positive health behavior. This makes sense considering the psychology of positive versus negative reinforcement. Incentives also tend to be aligned with factors such as diet and exercise, which consumers have far more control over than figuring out the optimal cost of a hospital procedure.

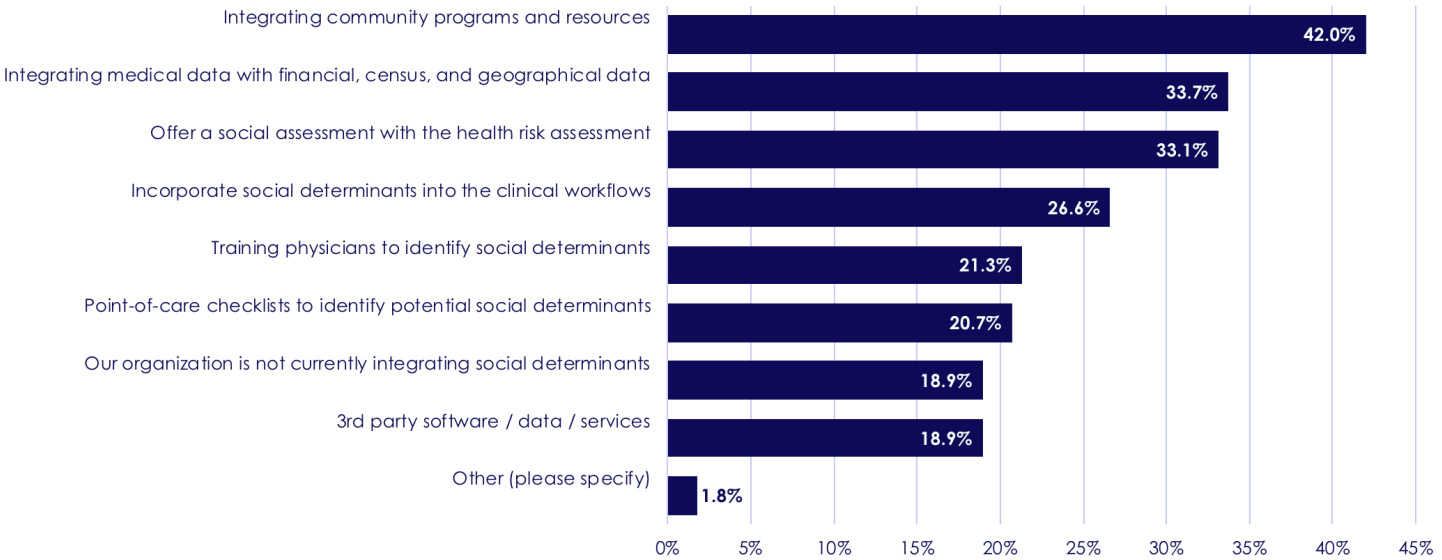
Changing Consumer Behavior

While high-deductible health plans seek to make consumers feel the pain of failing to control healthcare costs, incentives reward them for demonstrating they are making progress toward improving their health. Incentives can take many forms, including lower premiums or other bonuses for behaviors such as participating in an exercise program.

After incentives, the next most popular choice, cited by 23.7% of respondents, was establishing patient-provider partnerships. This falls into the general category of taking positive steps to engage with healthcare consumers.

Other approaches that ranked above high-deductible health plans include promoting healthcare literacy (14.1%), leveraging health risk management/health management programs (12.4%), using gamification software (8.5%), and offering price transparency tools (7.9%).

How is your organization integrating social determinants of health into your population health programs?



Response Count: percentages will total over 100%

Figure 5: Integrating social determinants of health

We asked how respondents' organizations were integrating social determinants into their population health programs.

The issue of social determinants of health has become part of every conversation around improving care quality while lowering costs. This concept recognizes that not every healthcare problem can be addressed with a prescription pad or a hospital procedure.

For example, an elderly patient's health might suffer because they lack access to transportation. This leads to missed doctor's appointments, an inability to get to therapy or the pharmacy for prescriptions, and so on.

In a value-based model that emphasizes promoting health over delivery of medical services, healthcare organizations have an incentive to consider providing transportation, helping patients identify or secure affordable transport, coordinating ride sharing, or other potentially effective solutions for such cases.

Other programs in this category include helping plan members gain regular access to healthy meals and health management counseling as opposed to treating illnesses (obesity, diabetes, etc.) related to a poor diet or bad dietary habits. Financial support, including utility bill reductions and housing assistance is also available. These solutions can help reduce stress related to financial worries and potentially enable a patient to divert funds to help cover healthcare related expenses.

Integrating Social Determinants of Health

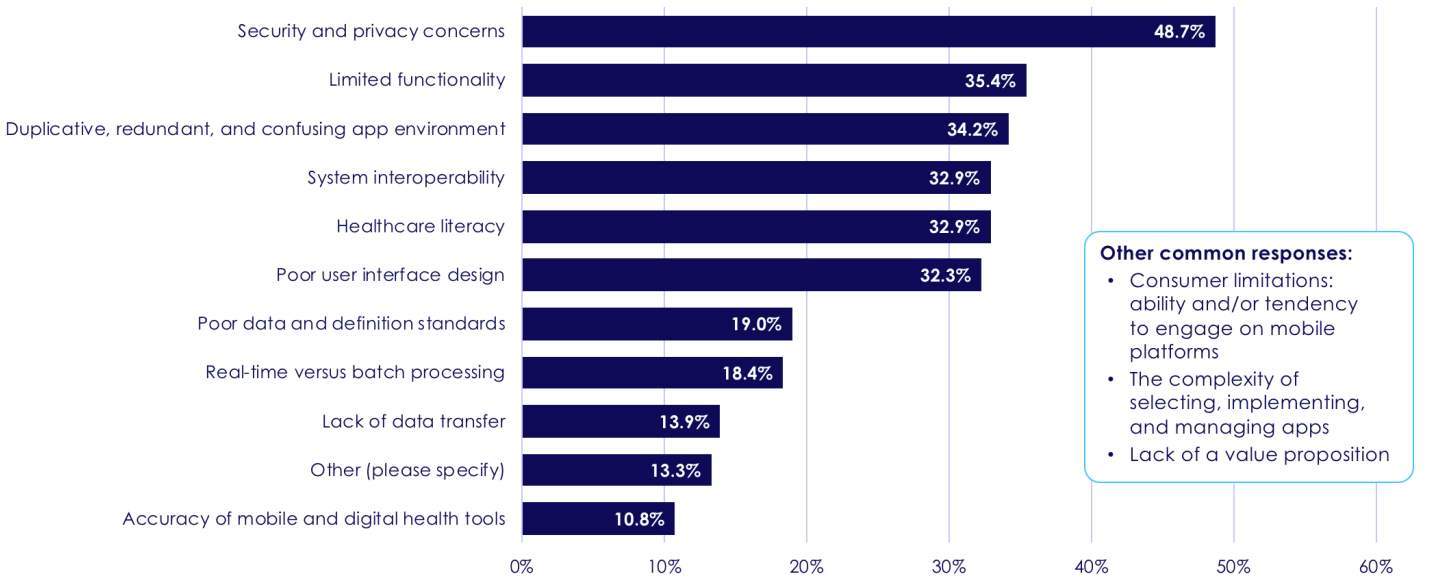
Healthcare organizations are clearly responding. The overwhelming majority of survey respondents report their organizations have started integrating social determinants of health. The results show a variety of strategies being employed, with 42% including community programs and resources; 33.7% integrating medical data with financial, census, and geographic data to better understand their patient populations; and 33.1% offering social assessments with health risk assessments.

Fewer organizations are going further still and incorporating social determinants into the clinical workflow (26.6%), training physicians to identify social determinants (21.3%), and/or using point-of-care checklists to identify potential social determinants (20.7%). Taken as a whole, nearly 70% of these organizations are integrating social determinants directly into clinical processes.

A minority of organizations surveyed (18.9%) report they are not integrating social determinants into their programs, underscoring the strength of this trend among respondents.

Factors Limiting Use of Mobile and Digital Health

What has limited the widespread consumer adoption of mobile and digital health tools?



Response Count: percentages will total over 100%

Figure 6: Factors Limiting use of mobile and digital health

We asked stakeholders what, if anything, has limited more widespread adoption of consumer mobile and digital health tools.

Healthcare leaders continue to be disappointed by weak consumer adoption of mobile and digital health tools. Few would be surprised to see security and privacy emphasized as major factors for this, and this was pointed to by nearly half of survey participants (48.7%).

Compounding these concerns are regulations around patient data privacy and security, which make it challenging if not impossible to provide transparency; easy data exchange, access, and sharing; and an exceptional end-user experience.

Indeed, outgrowths of security, privacy, and regulatory challenges were cited among the top gating factors holding back consumer adoption of digital and mobile health tools. These include limited functionality (35.4%), interoperability (34.2%), poor user experience (32.3%), batch processing requirements (18.4%), and lack of data transfer (13.9%).

What do you feel is the impact of the following mobile health technologies on healthcare?

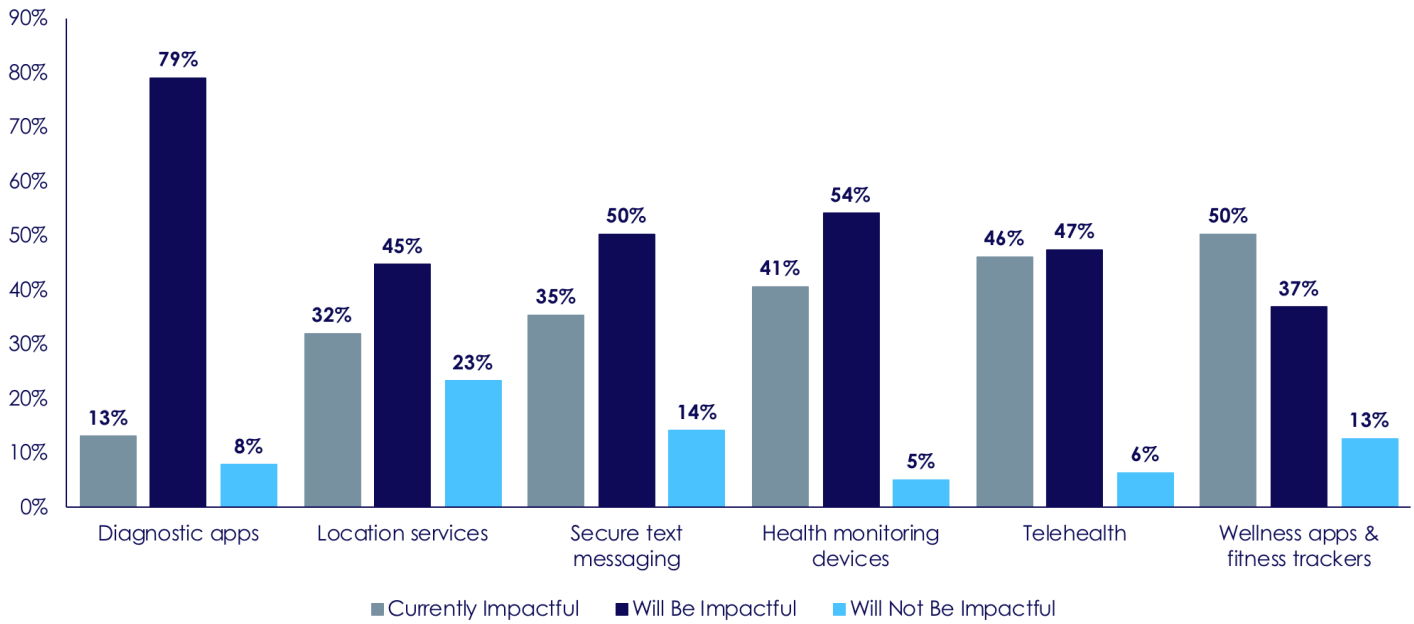


Figure 7: Impact of mobile technologies

We asked respondents to rank the impact of mobile applications on healthcare. Nearly 80% of respondents believe diagnostic apps have the greatest potential to transform healthcare in the future.

This optimism arises from a belief that mobile technologies will continue to improve their ability to help patients self-diagnose, and help patients determine whether they should engage a medical professional—either in the real world or via telehealth (which itself could be integrated into the diagnostic function).

That said, relatively few respondents (13%) ranked diagnostic apps as having much of an impact today. In that regard, a full half (50%) of respondents say wellness apps and fitness trackers are influencing health behaviors today, with 37% believing that impact will increase over time.

Health monitoring devices are a close second on asserted impact (41%), and over half of participants (54%) expect these devices to become more significant in coming years, as mobile sensors and their analytics software continues to improve.

What are the primary value-based reimbursement models used at your organization?

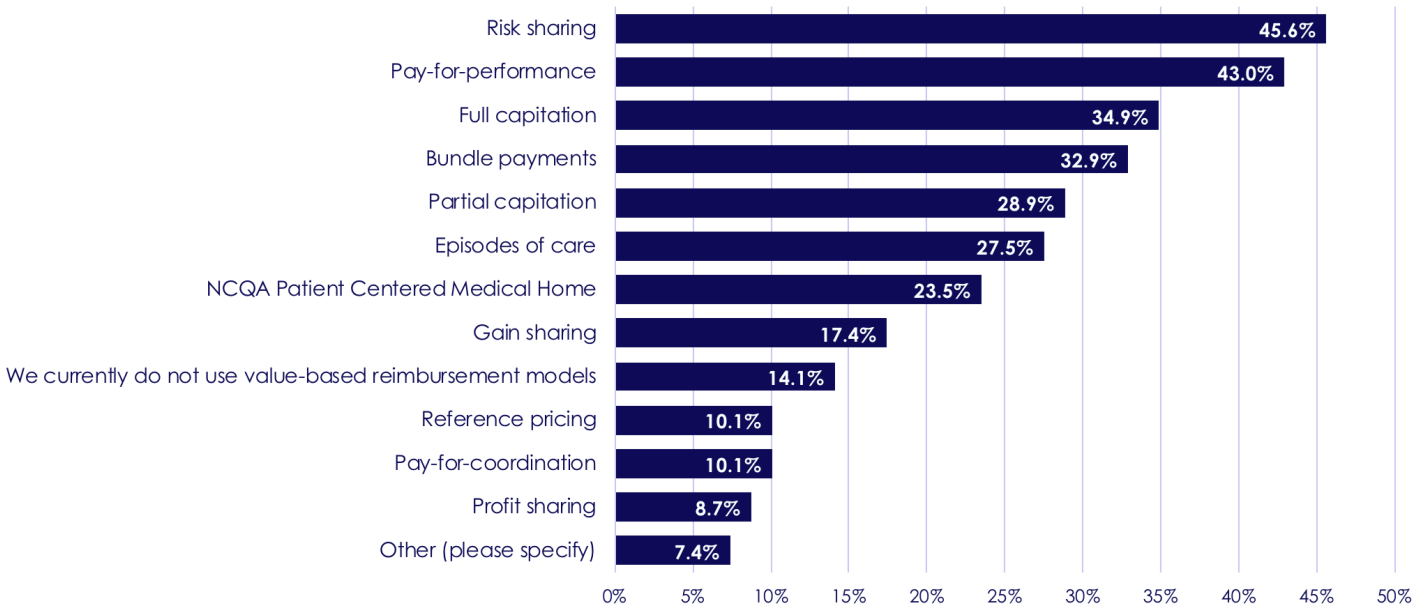


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Figure 8: Value-based reimbursement models in use

Which of the following value-based reimbursement models do you feel will be most effective at delivering performance-based care within the next three (3) years?

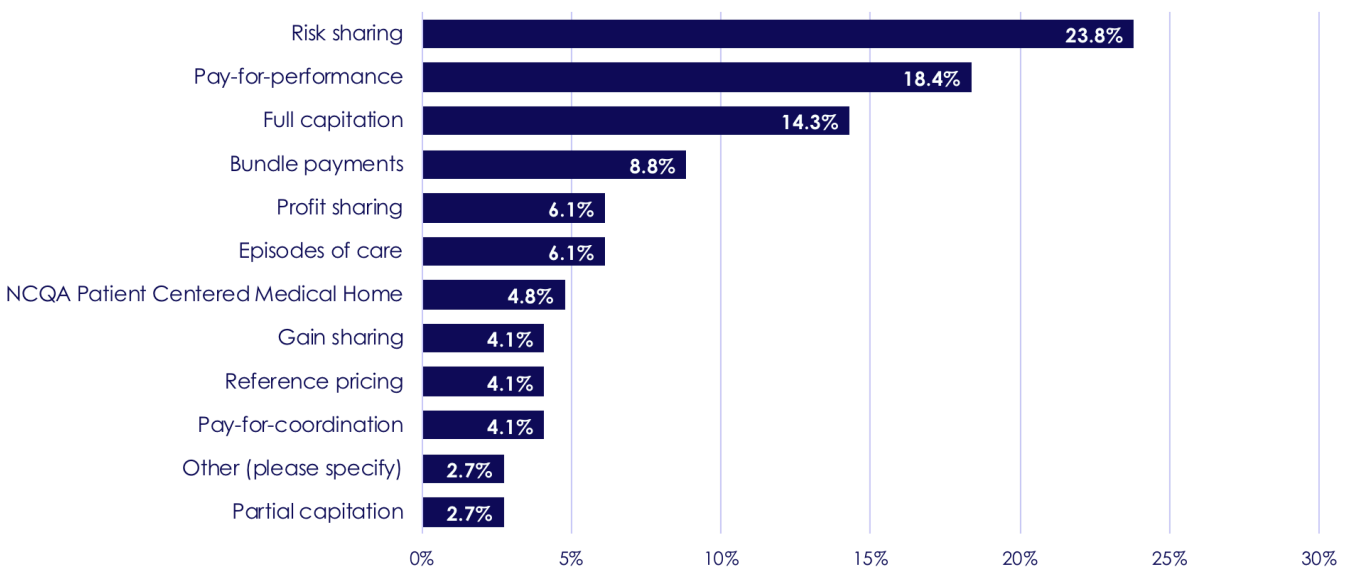

Figure 9: Most effective value-based reimbursement models

Use of Value-Based Reimbursement

VBR models in use vs. predicted effectiveness

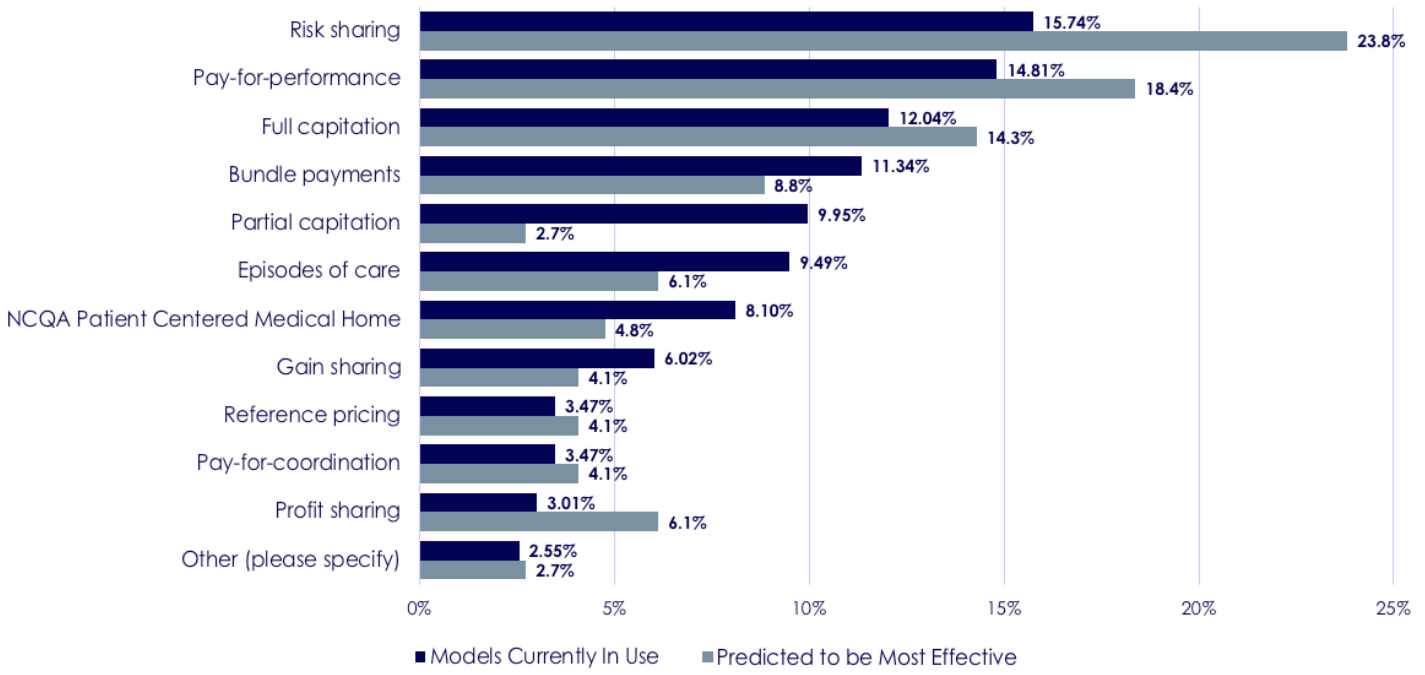

Figure 10: Value-based reimbursement models in use vs. predicted effectiveness

Understanding the state of, and progress on, value-based reimbursement is crucial to all stakeholders. We asked respondents about the alternative payment models currently employed by their organization, and then asked which model they believed would be "most effective" in the next three years.

Risk-sharing arrangements, such as accountable care organizations, stood out on both fronts, with 45.6% currently using them and 23.8% predicting they will be the most effective over the next three years. Pay-for-performance arrangements is a close second in terms of adoption, with 43% of respondents using them, and 18.4% predicting optimal efficacy by 2020.

Rounding out the top three: Health plans also believe full capitation will be among the most-used VBR models by 2020, and it is now in use at 34.9% of respondents. Conversely, partial capitation, a VBR model now used by 28.9% of respondents, is likely to fade, as it is predicted to be effective by only 2.7% going forward.

Remaining models were seen as viable through 2020 by under 10% of respondents, and fewer organizations (again, under 10%) are making use of those models today.

Barriers to Value-Based Reimbursement

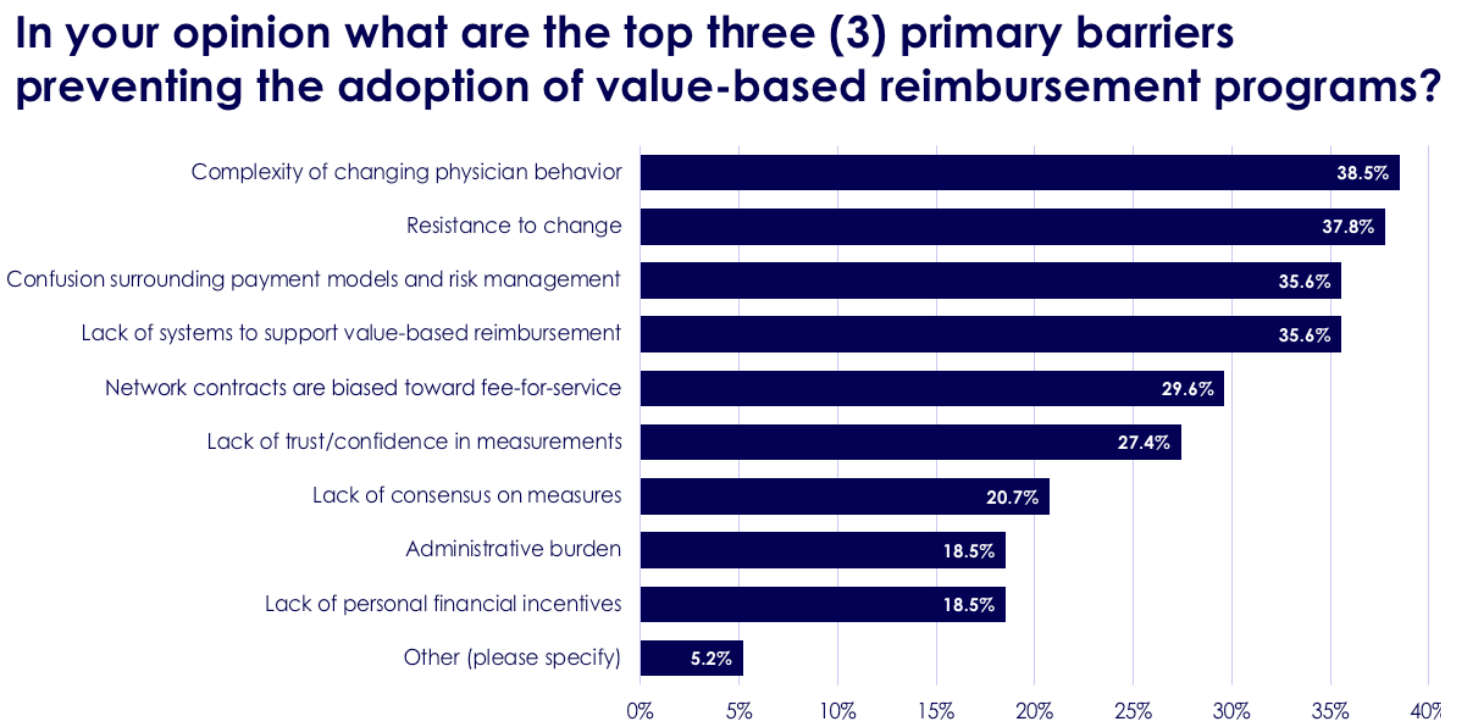

Figure 11: Barriers to value-based reimbursement

We asked healthcare leaders what they see as the top three barriers impeding successful adoption of value-based reimbursement programs.

Perhaps not surprisingly, lack of healthcare IT systems to support VBR was cited by 35.6% of respondents—making it a top factor. But the other top obstacles all involved human factors, such as changing physician behavior (38.5%), resistance to change (37.8%), and confusion surrounding payment models and risk management (35.6%).

Confusion about VBR models should be no surprise. A lack of consensus in Washington, coupled with myriad state VBR initiatives, has created some level of uncertainty among healthcare stakeholders in the government markets.

Despite that, the commercial markets appear to be forging ahead, with several new VBR initiatives and progress reports announced by major health plans of late. In particular, the data analysis technologies required for effective VBR programs at scale, especially related to bundled payment and care episodes, are starting to have a significant impact.

Impact of Clinical and Data Analytics

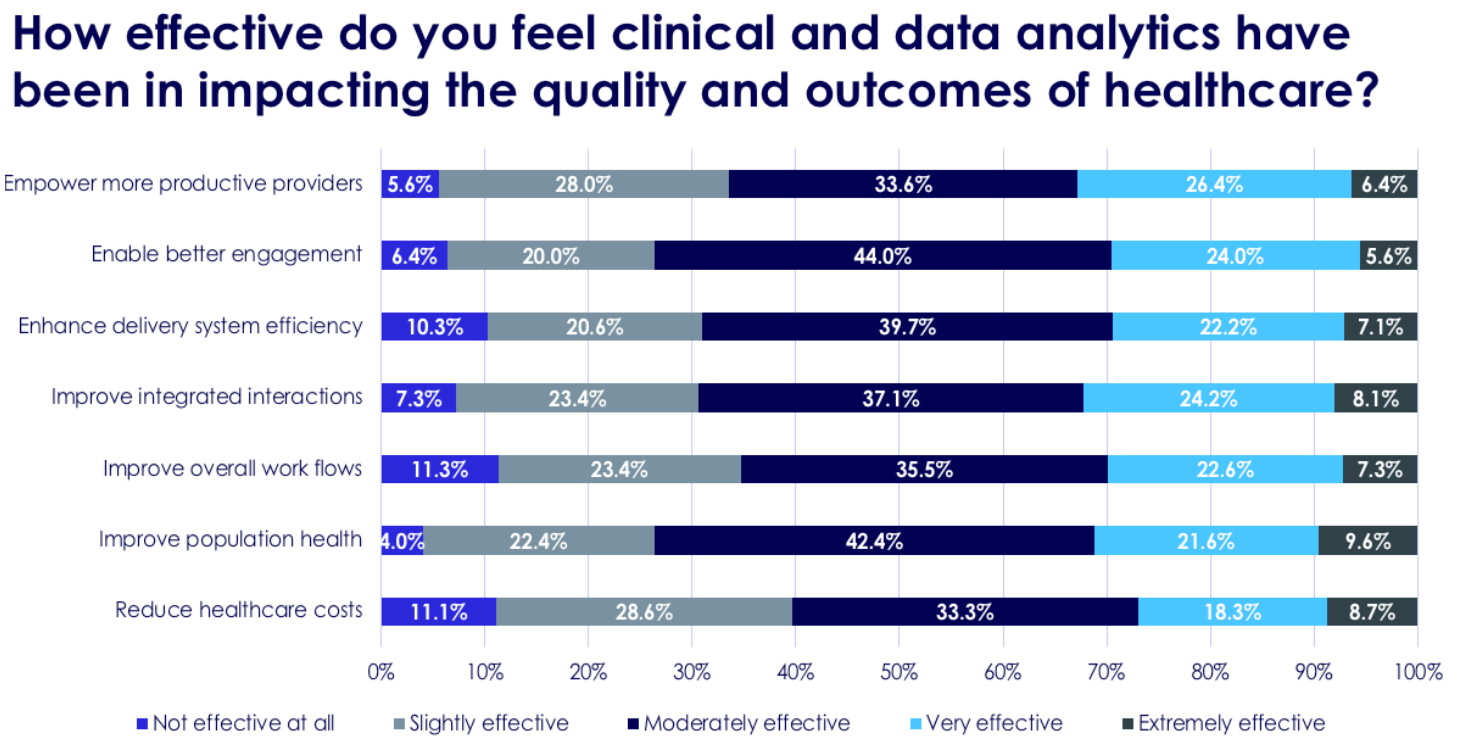

Figure 12: Impact of clinical and data analytics (2017)

Impact of Clinical and Data Analytics

2017 vs. 2016 comparison

How effective do you feel clinical and data analytics have been in impacting the quality and outcomes of healthcare?

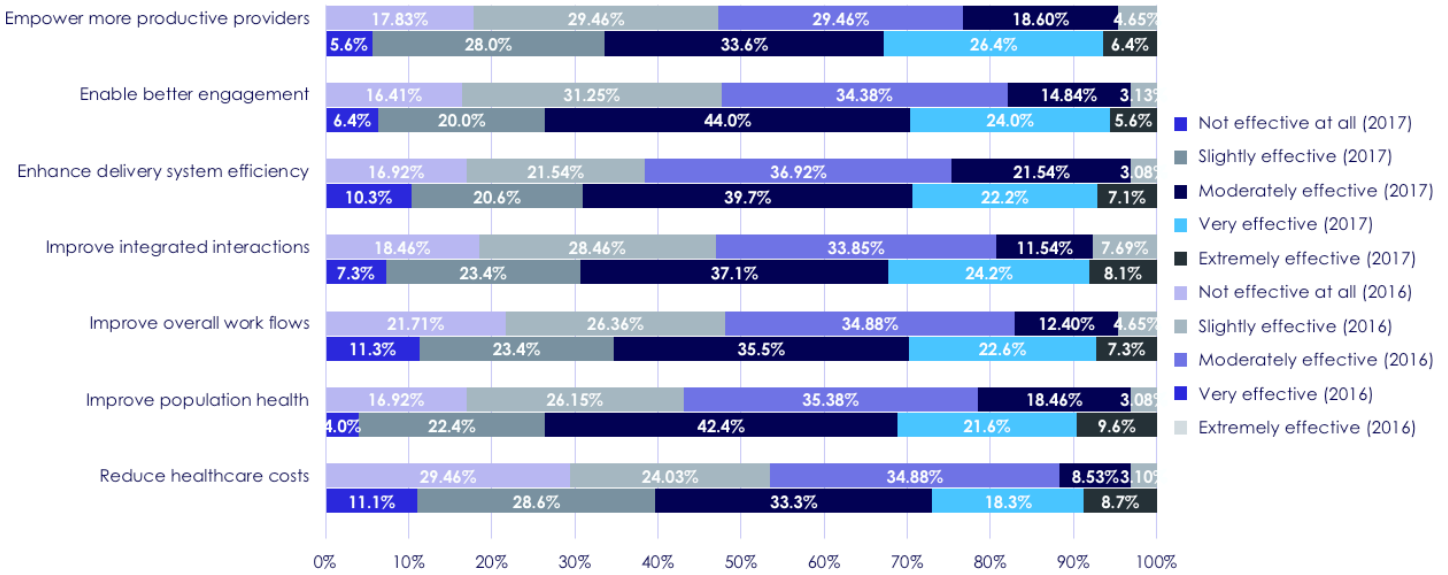

Figure 13: Impact of clinical and data analytics (2017 vs. 2016)

In 2016 and again in 2017, we asked respondents what impact clinical and data analytics have had on care quality and clinical outcomes.

The charts above reflect the impact clinical and data analytics are having on a variety of goals in 2017, including improving population health and reducing healthcare costs. The significance of these results, and the progress (or lack thereof) that healthcare organizations have made over the past 12 months becomes clear when juxtaposed with 2016's responses.

One trend is immediately apparent: Healthcare is getting better at using clinical and data analytics. The portion of respondents who rated analytics "very effective" or "extremely effective" in achieving various goals is larger in every case. Moreover, those characterizing analytics as "not effective at all" contracted proportionately.

That said, the most common perception is that analytics technologies are "moderately effective." That could reflect the state or age of the tools, the skill set of the healthcare users, or some combination of both. Still, these are encouraging signs that payers and providers are pressing on and figuring out how capitalize on their vast data sets to generate positive results for both consumers and their organizations.

Technologies Improving Administrative Efficiency

Which technologies are leading to significant administrative cost efficiencies?

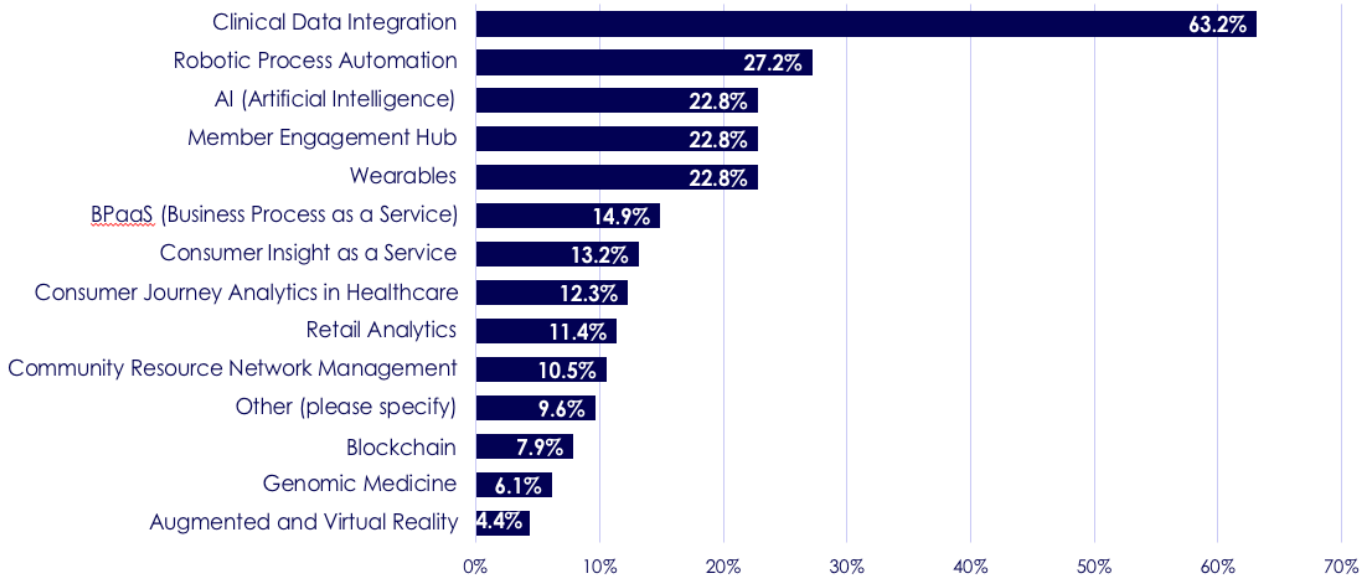

Figure 14: Technologies improving administrative efficiency

We asked respondents which technologies are leading to significant administrative cost efficiencies.

Buzzworthy technologies—like augmented/virtual reality (4.4%) and artificial intelligence (22.8%)—as well as transformative technologies such as blockchain (7.9%) and analytics (11.4% combined) appeared on the list this year. But the runaway leader was clinical data integration, with 63.2% of respondents saying it drives significant cost efficiencies.

Indeed, improving integration between financial, clinical, and systems data for administration and payment of care was also cited as a prerequisite for many of the other technologies posited in this question. For example, analytics, AI, and blockchain are most effective when they have access to complete data sets.

In the #2 slot for helping organizations achieve administrative savings was robotic process automation (27.2%). This refers to the automation of routine processes, such as front-end electronic claims processing, automation of the re-adjudication process, and updates and maintenance to provider data records. Tied in third place at 22.8% each are artificial intelligence, member engagement hubs, and wearable tech.

Technologies Improving Administrative Efficiency

We also can't help but note that blockchain, the distributed data management technology associated with Bitcoin and other cryptocurrencies, has made an initial showing, with an impressive 8% of respondents saying it is leading to administrative cost savings.

While healthcare applications of blockchain at scale are only now emerging, potential uses include the secure sharing of electronic medical records and claims data, real-time transparency into transaction statuses, and more.

Genomic medicine also makes a showing, cited by 6.1% of respondents, for its significant potential to allow patients to received personalized (e.g., precision) treatment, improving care quality while eliminating waste in healthcare delivery.

Financial impact of the ACA *(over the past 3 years)*

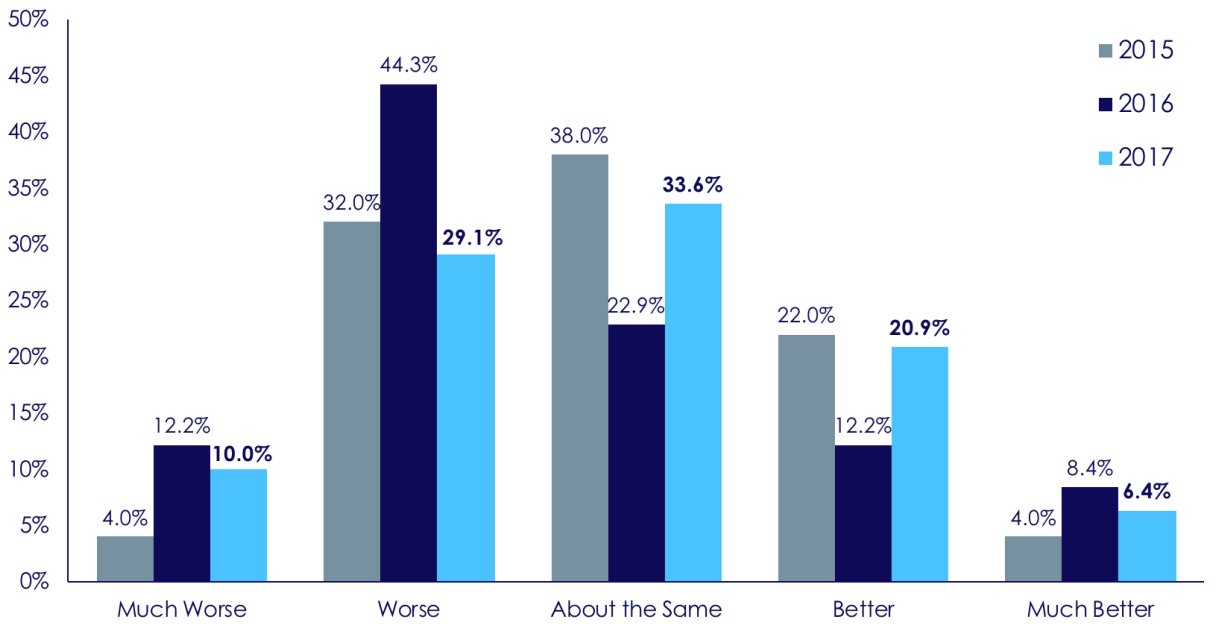

Figure 15: Impact of the ACA year-over-year

We first asked payers and other healthcare stakeholders about the financial impact of the patient Protection and Affordable Care Act (a.k.a. the "ACA") in 2015. We queried this topic again in 2016 and 2017.

This year as in years past, the responses revealed a majority negative (39.1%) or neutral (33.6%) impact. Only 25.3% of respondents feel the ACA has had a positive impact on healthcare.

Note that the survey closed in November 2017, before passage of the GOP tax bill that eliminated the ACA's individual mandate requiring citizens to obtain healthcare coverage.

Payer vs. provider – financial impact of the ACA

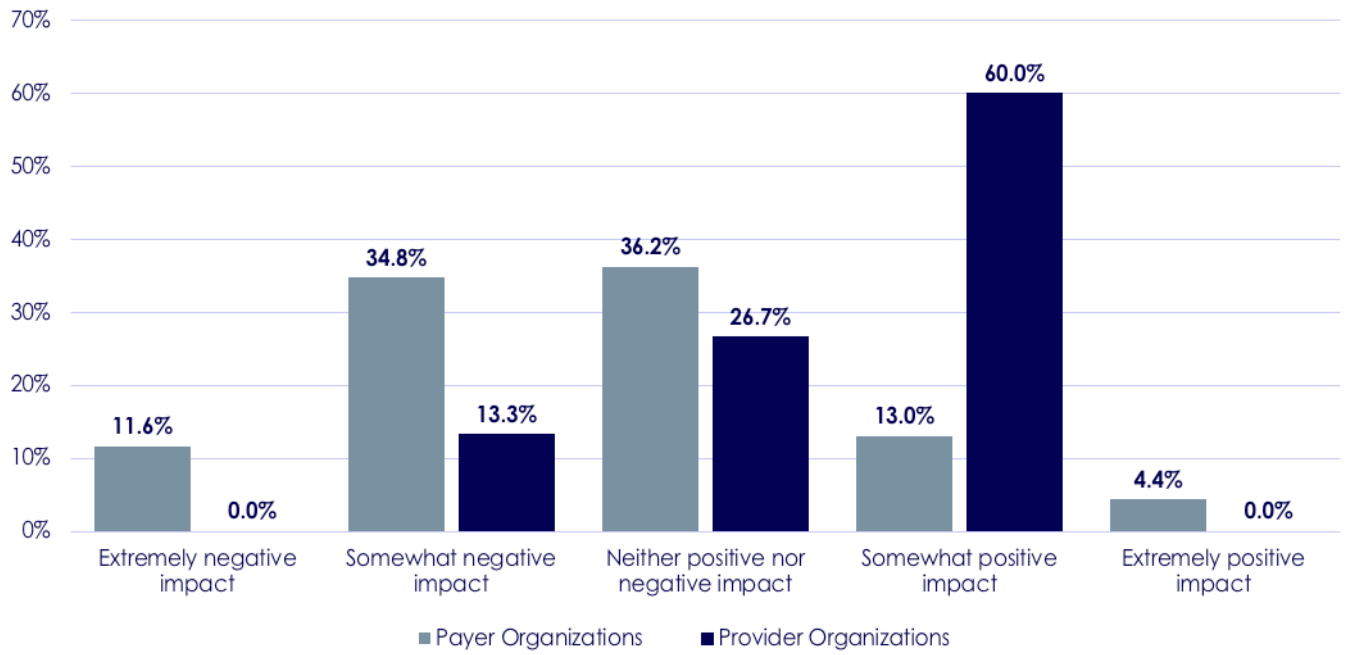

Figure 16: Financial impact of the ACA, payer vs. provider

Slicing the data to contrast payer and provider responses reveals that provider organizations are far more likely to see the ACA as having "somewhat positive impact" (60%) vs. payers (13%). This makes sense given providers benefit from seeing more patients who did not have healthcare coverage before the advent of the ACA.

Conversely, 82.6% of payers view the ACA as having no impact (36.2%) or a negative impact (46.4%) on finances. A stark minority of payers report an extremely positive (4.4%) or somewhat positive (13%) financial impact from the ACA.

Payer Line of Business Growth

Line of business growth: *Payer survey respondents*

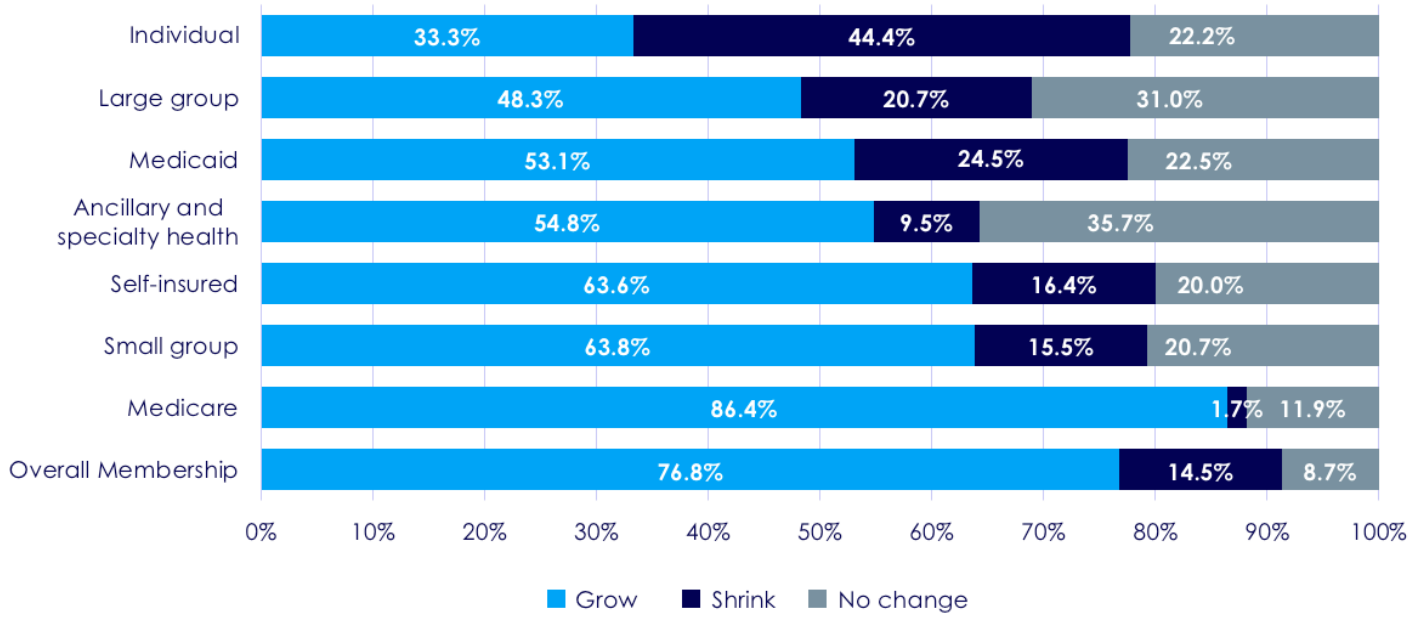

Figure 17: Payer line of business growth

We asked payers to project line of business growth over the next year. Overall, payers expect to see strong membership growth across 6 of 7 market segments, with Medicare (86.4%) leading the pack.

The exception: The individual market. The Affordable Care Act propelled growth of the individual market since it was signed into law in 2010. But while the Industry Pulse survey was in the field, the advertising budget used to promote annual enrollment was cut 90%. Spending on NGOs that help consumers find a health plan was also reduced.

And there was ample discussion in the media about the possibility of the individual mandate being repealed as part of what was then the proposed Republican tax plan (indeed, it was repealed as part of the Tax Cuts and Jobs Act of 2017).

As a result, 44% of payers now believe the individual market will shrink. Surprisingly, however, a majority of payers (55.5%) still expect the market to remain stable (22.2%) or even grow (33.3%).

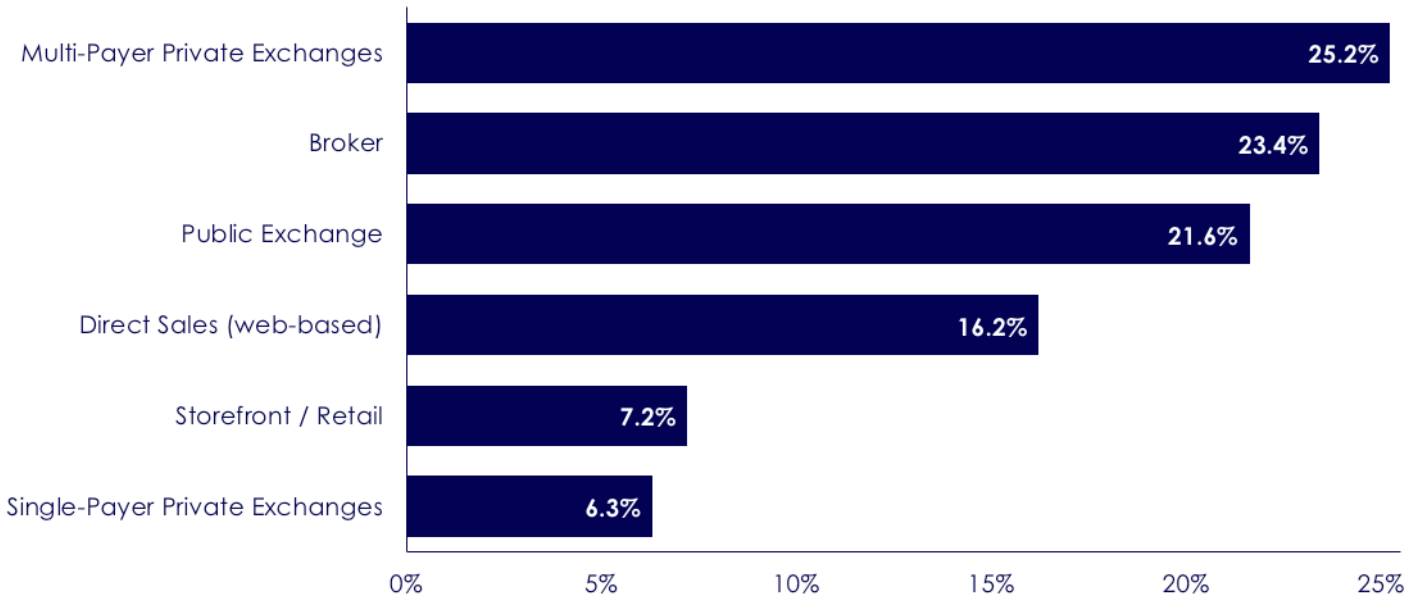

Figure 18: Distribution channel productivity by 2020

Distribution Channel Productivity

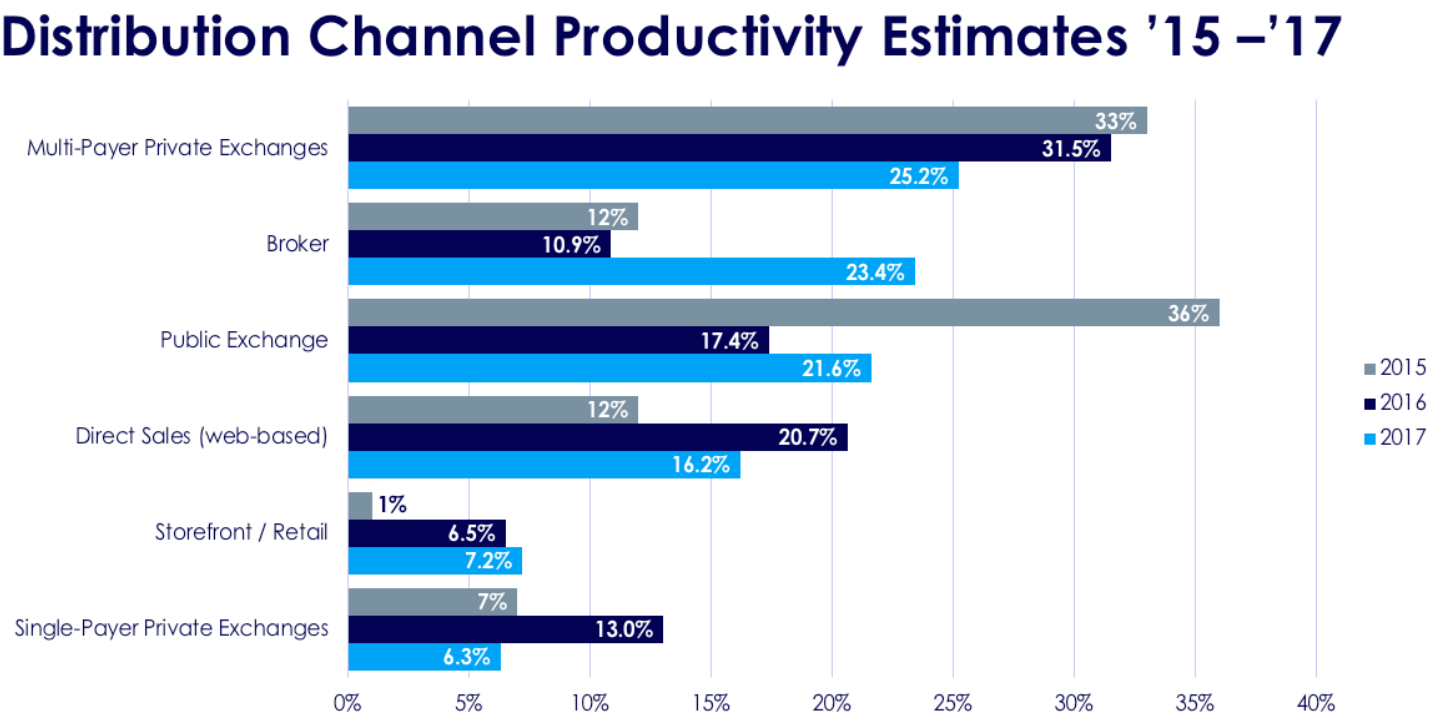

Figure 19: Distribution channel productivity estimates, 2015-2017

We asked payers to project what will be the most productive distribution channels for health insurance customers by 2020. We also compared their responses to those collected in previous years' Industry Pulse surveys.

This question became relevant with the advent of the ACA marketplaces. Suddenly millions of Americans had access to a new way of shopping for health insurance. Survey responses were somewhat erratic year-over-year as expectations around the public exchanges evolved in a turbulent political environment.

Cuts in the budget for ACA marketing and healthcare navigator programs added to the uncertainty. As a result, compared to 2015, this year's survey saw noteworthy dips in respondents' confidence in multi-payer private exchanges (from 33% to 25.2%) and public exchanges (36% to 21.6%) as productive channels, although public exchanges did uptick from 17.4% in 2016 to 21.4% in 2017.

Moreover, 23.4% of 2017's respondents—the highest since 2015—see brokers as a top channel because they can close the gap created by the cuts to the healthcare navigator program. Brokers also don't have the same restrictions as navigators. Brokers can receive commissions, charge for services, and offer plan recommendations based on the client's situation, potentially giving consumers a more personalized approach.

Critical Issues 2010-2017

Year over year trends

2017	2016	2015	2014	2013	2012	2011	2010
Critical							
• **Privacy & Security** • **Customer Service** • Membership Retention • **Clinical & Data Analytics**	• Customer Service • Privacy & Security • Clinical & Data Analytics • Risk Management	• Customer service • Data analytics • Privacy & security • Membership retention	• Customer service • Membership retention • Membership growth • Regulatory compliance • Data analytics	• Member retention • Customer service • Regulatory Compliance • Membership Growth • Provider Networking & Contracting	• Member retention • Member growth • Customer service	• Member retention • Automation & performance optimization • Member growth	• Member retention • Regulatory/ mandate compliance • Health care reform compliance
Important							
• Regulatory/ Compliance • Membership Growth • Tech limitations & System integrations • Risk Management	• Member Retention • Provider Network & Contracting • Regulatory/ Compliance • Payment Integrity • Vendor Relationships	• Vendor Relationships • Brand & Marketing • Product benefit design • Provider Networking & contracting	• Product benefit design • Payment integrity • Brand, marketing, communications	• Private HIX • Public HIX • Risk Management • Payment Integrity	• Claims accuracy and recovery • Risk management • Product benefit design	• Regulatory/ mandate compliance • Customer service • Claims accuracy & recovery • Product design	•Automation & process optimization •Product design
Lower Priority							
• Automation • Payment integrity • Provider network & contracting	• Tech Limitations • Branding, marketing & sales	• Payment integrity	• Risk mgmt. • Privacy & security	• Brand, marketing, & communications • Product benefit design	• Privacy & security • New sales channels	• Privacy and security • Risk mgmt.	• Customer Service • Risk Mgmt. • Claims accuracy and recovery

Survey data collected Oct-Nov each calendar year

Figure 20: Critical issues, 2010-2017

Each year we ask respondents to share their list of the issues they are facing or dealing with. They're asked to rank them as Critical, Important, or Lower Priority. The Industry Pulse has been collecting this data since 2010.

This year we have compiled all eight years of Industry Pulse responses into a single chart to reveal how concerns evolved over time. For example, a top 2010 concern was member retention, and it remains so today.

But in 2017, healthcare IT concerns around privacy, security, and clinical & data analytics have knocked issues such as regulatory compliance and membership growth out of the top box.

Overall, this year's respondents ranked the following issues as significant for the 2018 year ahead. They're listed here from critical to low priority, as follows:

1. Privacy & Security
2. Customer Service
3. Membership Retention
4. Clinical & Data Analytics
5. Regulatory/Compliance
6. Membership Growth
7. Tech Limitations & System Integrations
8. Risk Management
9. Automation
10. Payment Integrity
11. Provider Network & Contracting

Opportunities

As identified by our respondents

Data and Clinical Analytics

"Increase and improvement in analytics to improve approach to quality care and efficiencies"

"More complete and comprehensive health data integrated with other social determinants of health"

Value-Based Care

"Advance our payment models with health systems to better engage and support physicians"

"Significant growth & savings around alternative clinical delivery models"

Market Growth Opportunities

"Better economy should result in stronger commercial opportunities"

"Growth in Medicare and special-need populations"

IT System Consolidation

"Real-time systems which can connect seamlessly to other solution components in the ecosystem"

"Reducing redundant IT"

"Change out care management platform and extend its utility creating better care management"

Figure 21: Opportunities

Challenges

As identified by our respondents

Government Policy & Regulation

"Regulatory chaos - the political divide is devastating"

"Fluid government regulations, uncertainty on ACA, single payor regulations"

"Uncertainty caused by politics in D.C."

"Uncertainty in federal and state policy"

The ACA

"Defining our priorities for On-Marketplace (ACA) individual enrollment"

"Uncertainty of the future of ACA/subsidies and the significant membership losses that could result from repeal or defunding"

Medicare and Medicaid

"Section 1115 waiver and Medicaid ACO"

"Changes in Medicaid payment models"

"Decrease in Medicaid membership due to anticipated reform"

"ACA changes and public health funding uncertainties"

Technology and Resourcing

"Hiring the right kind of resources, i.e. a correct blend of business and technology"

"Technology changes impacting administrative expense pressures"

"Technology keeping pace with needs"

"Antiquated technology platform needs to be replaced"

Figure 22: Challenges

We asked panelists what they see as their primary opportunities and challenges for 2018. These were posed as two open-ended questions. We then consolidated and organized their responses into the two figures above.

On the opportunity side, responses were consistent with years past, with value-based care and market growth opportunities cited as major opportunities. It's also not surprising to see data and clinical analytics noted as an opportunity, given the rapid maturation and accelerating adoption of these tools in both payer and provider organizations. Still, it's the early days for analytics—which makes it, as the survey shows, both a critical priority and huge opportunity.

The consolidation and enhancement of IT systems is also a significant opportunity. Healthcare delivery and reimbursement have changed dramatically since the 1990s—yet many organizations continue to use information systems that are out of step with today's requirements.

These old systems increasingly can't meet the automation, interoperability, and data processing demands of today's healthcare market. Adoption of contemporary technology is essential for healthcare organizations to compete in an industry that's transforming rapidly, including value-based care, price-and-quality transparency, improved collaboration, optimized patient experience, advanced cybersecurity, and more.

Regarding challenges: This year respondents expect government and regulatory issues to dominate. Healthcare leaders are concerned about the difficulty of making and executing plans amidst regulatory uncertainty, knowing that small to seismic changes could occur at any time.

While Washington played a central and early role in stimulating VBR interest and activity, the transition from volume to value in care delivery now has its own momentum. Still, given the lack of consensus in D.C., healthcare leaders who continue to see VBR as an opportunity must take leadership roles in terms of innovating new payment programs.

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