10-103
July 13, 2010

Conexia: Entering the U.S. Market

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"So, where do we go from here?" asked Luis Navas.

Sitting in the Buenos Aires office of Conexia, a leading Argentinean IT services company that provided insurance claims solutions for the healthcare industry, Navas, the CEO, was continuing a long series of discussions with his partners Sebastian Letemendia, COO, and Alfredo Semeniuk, Director of Sales. On this particular day in mid-January 2010, they had just walked out of the final presentation given by a team of students from MIT Sloan's Global Entrepreneurship Lab (G-Lab), who had been helping Conexia devise a U.S. market entry strategy for its Real-Time Adjudication (RTA) solution.

As Conexia's senior management had anticipated, entering the U.S. market posed a wide variety of challenges. In addition to the lack of brand awareness for Conexia's RTA product and the disjointed claims processes followed by U.S. health insurance companies, the U.S. healthcare market was going through a number of regulatory changes. Thinking back to a series of discussions with the G-Lab team, Letemendia said, "I knew it would not be easy. But I still believe we can provide value to U.S. customers." Navas agreed: "Considering our long-term growth goals, entering the U.S. market is a necessary step for Conexia. But in light of the challenges ahead, is it the step we should take now?"

Real-Time Adjudication (RTA) of Medical Insurance Claims

Real-time claims adjudication was an IT solution which allowed health insurance companies (typically called payers) to pre-authorize medical services before they were rendered by doctors (providers). Traditionally, claims were submitted after the provider treated patients, leaving both patient and provider financially uncertain: patients about how much they would ultimately be

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responsible for paying and providers about how much they would be paid by the insurance company. RTA solutions enabled providers to know in advance which services were covered by a patient's insurance plan, the correct amount for the patient's co-payment—the portion of the treatment cost the patient was responsible for paying—and how much the providers would be paid for services rendered. Given that claims were processed in real-time, payers paid providers more quickly. The RTA process flow (which is also depicted in **Exhibit 1**) entailed four steps:

1. A healthcare payer negotiated and agreed beforehand with providers on the prices of specific medical services.
2. Patients who subscribed to the payer were provided with a magnetic strip ID card. When a patient visited a physician, the administrative staff swiped the ID card through a card reader, thereby automatically entering data into the system.
3. Using pre-established business rules, the system approved (or denied) the medical services intended by the provider, based on the patient's diagnosis, and indicated any co-payment and deductibles that the patient was responsible for.
4. The patient paid the amount he/she was responsible for prior to leaving the provider's office.

RTA customers were the healthcare payers, since they "owned" the claims processing systems and managed the data (e.g., different plans and payment rates) that fed into an RTA system. Additionally, they had the financial resources to implement an RTA system, which electronically connected to thousands of data capture points in providers' offices. **Figure 1** describes ways in which RTA benefited payers, providers and patients.

Figure 1 Benefits of Real Time Adjudication to the Healthcare Value Chain

Stakeholder	RTA Benefits
Payers	• Real-time information regarding accrued expenses • Ability to identify abnormal consumption patterns (fraud and misuse) and deny payment in real-time, leading to lower medical costs • Administrative savings due to reduction of paper claims • Potential savings due to decreased number of pended claims • Improved provider and patient satisfaction
Providers	• Certainty regarding payment for services rendered • Shortened accounts receivable cycle, leading to improved cash flow • Potential for reduced administrative costs
Patients	• Certainty about cost of medical services (eliminating stress about unexpected charges after receiving treatment)

Source: Casewriters and Conexia marketing materials.

Conexia

Originally a division of IMPSAT, a leading Argentinean telecommunications firm and a subsidiary of IMPSA, Conexia was bought out in 2003 by Navas, who was just completing a 10-year stint with IMPSA in China, and his partner. Upon taking over the newly formed company and relocating back to his country of birth, Navas focused on the RTA market. Despite the general economic turmoil that beset Argentina in the early 2000s, Navas persevered and the company grew rapidly. In its first five years, Conexia's revenues grew by an average of 36% annually to over US$2.5 million. (See **Exhibits 2** and **3** for income statement and profit margins and **Exhibit 4** for revenue and earnings projections through 2012.) By 2008, with 130-plus employees, Conexia was the RTA market leader in Argentina, serving over 20 insurers, with a total of 4 million beneficiaries, and over 10,000 provider data capture points. (See **Exhibit 5** for capsule biographies of Conexia's key executives.)

Conexia, a company associated with the Endeavor network of high impact companies and which was ISO 9001 and CMMI Level 3 certified, sold its RTA solution as Software-as-a-Service (SaaS), meaning that it was delivered over the Internet in a subscription-based manner. In addition to the software, Conexia offered providers a set of services, including infrastructure installation, which ranged from card readers for the magnetic cards issued to patients, to a phone-based or credit card-like point-of-sale (POS) system. By 2009, the company was in the process of developing business intelligence/analytics tools for payers so that they could analyze various internal financial results as well as customer usage trends.

Introduced in Argentina in the early 2000s, Conexia's RTA solution initially received a cool reception. Payers were hesitant to make the necessary IT investments and changes to their systems and processes. However, some of the large, government-run *Obras Sociales* (similar to state-run Medicaid programs in United States) embraced RTA's ability to computerize membership verification, as well as claims submission and adjudication from both provider offices and pharmacies. Up until the late 1990s, payers in Argentina had operated on a purely paper-based system. When a patient visited a provider, the provider verified the patient's insurance "membership" in a printed directory published periodically by the payer. After treating a patient, providers filled out a paper claim and submitted it to the payer by fax. Similarly, when a patient visited a pharmacy to buy medication, the pharmacy followed the same eligibility verification and claim submission process. Users considered this system highly labor-intensive, time-consuming, and inefficient.

Once Argentinean payers started seeing the benefits that these early adopters were getting—several reported a 10% decrease in administrative costs and a 5% decrease in medical costs—the adoption of RTA picked up rapidly. (**Exhibit 6** provides information on pricing and savings for Conexia's RTA.) Payers saw RTA's electronic platform not only as a tool to improve relationships with provider networks and pharmacies through faster payments, but also as an opportunity to streamline their claims systems and yield substantial savings.

The reasons for Conexia's success in its home market went beyond the value provided by the RTA product itself. Conexia's sales team, headed by Navas, was experienced in the relationship-driven selling approach in Argentina, and skilled in navigating the political process of selling to *Obras Sociales*. Its ability to claim large, influential government payers as clients helped Conexia's sales efforts in its home market. In addition, Conexia differentiated iteself from its domestic competitors by focusing solely on the healthcare insurance market and providing a highly service-oriented approach. Conexia's clients believed that the company had strong brand awareness in the RTA space.

By the late 2000s, facing a saturated domestic market, Navas began looking beyond Argentina for growth opportunities. Although the Brazilian and Mexican markets were of interest, Navas knew that in order to fulfill his vision of building a multinational, publicly traded company, Conexia would have to have a presence in the U.S. market. The question Navas and his partners faced, and the question that Endeavor helped them sponsor a G-Lab team to solve, was whether the U.S. market was ready for Conexia.

The U.S. Healthcare IT Market

Industry Overview

In early 2010, the U.S. healthcare industry was in a state of flux. Nearly $50 billion of President Obama's stimulus bill had been set aside for the HITECH Act to support the modernization of the healthcare system through the adoption of electronic medical records. In addition, all healthcare providers had until October 2013 to transition from the 9th version of the International Statistical Classification of Diseases and Related Health Problems (ICD-9), a system of codes characterizing patient diagnoses used in the claims process, to the updated ICD-10 version. Beyond the impact of the stimulus package and regulatory changes, healthcare reform in the way of mandatory universal health insurance was being debated in the U.S. Congress. No one in the healthcare value chain knew what to expect from the proposed $1.2 trillion, 2,000-page healthcare bill.

Alongside regulatory reform, several new market trends were emerging. The first was the growing popularity of High Deductible Health Plans (HDHPs) as a way to reduce consumer costs. Subscribers to these plans paid a higher share of treatment costs in exchange for lower premiums. A second trend was the rise of telemedicine and e-prescribing, both enabled by ever-improving communications technology.

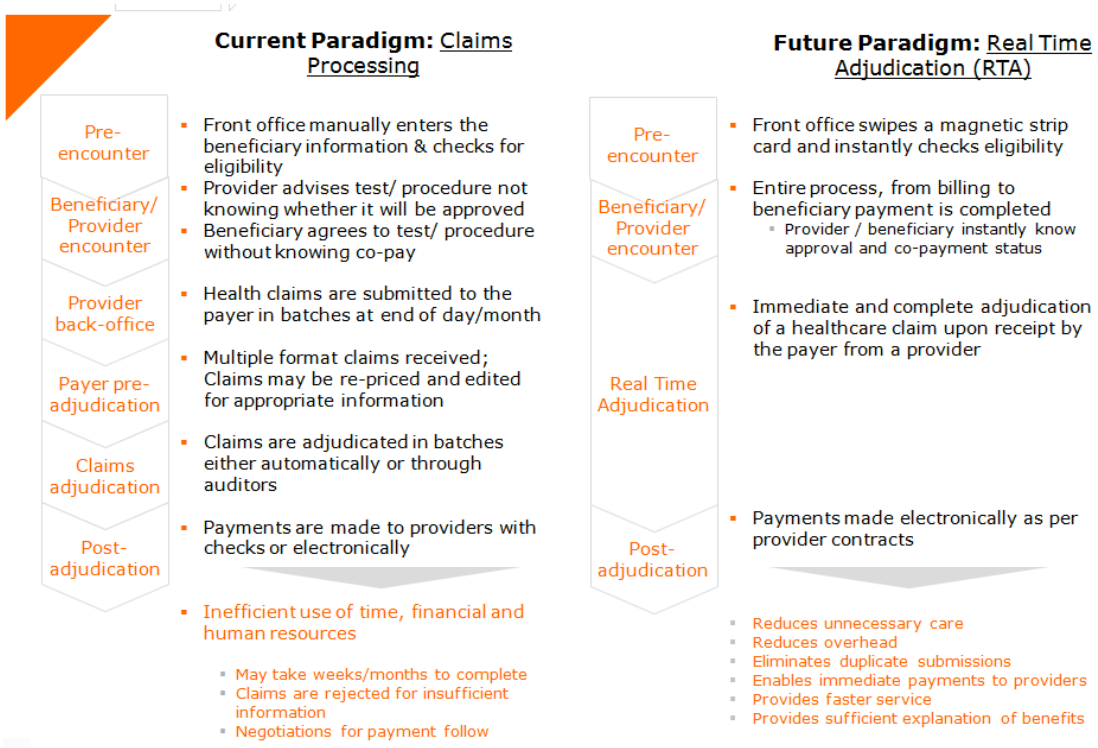
Overall, the U.S. healthcare industry was at an inflection point and great uncertainty existed due to the HITECH act, regulatory shifts, impending healthcare reform, and market trends. The majority of these changes were focused on overhauling the healthcare system, and many targeted improvements in healthcare IT specifically. Navas thought that introducing RTA would be a good fit with the general environment of change. As the CIO of one private insurer noted, "RTA is a concept that has

been around for a while, but now interest is growing due to the current environment where everyone is considering overhauling their entire systems. This might be a logical component of their upgrades."

Payment System

In the United States, when patients visited a healthcare provider to receive medical care, they had to provide proof of their medical coverage, assuming they were insured. Based on a patient's insurance plan, the physician's office would collect a co-payment, and the patient received care. Following the visit, the provider's staff recorded the specific services that were provided and their associated fees, known as a medical claim, into either a paper-based or electronic format. These claims were then submitted in batches to healthcare payers—both private insurance companies and government-run Medicaid programs—to request payment. The payer then processed these claims and paid physicians based on their payment policies. If any portion of a bill remained unpaid (e.g., if a certain treatment was only partially covered by a patient's health plan), the physician would then send a bill to the patient and attempt to collect the balance. **Figure 2** illustrates the difference between the U.S. healthcare claims adjudication processes in 2010 and RTA.

Figure 2 Current U.S. Healthcare Claims Processes versus RTA



Source: Casewriters and Conexia marketing materials.

In general, the U.S. healthcare claim process was widely viewed as complex and inefficient. The lack of real-time information, and the complexity and variety of data formats used by each payer, imposed a heavy administrative burden on providers and payers alike. Some providers employed medical coders to write up claims using industry-specific nomenclature. (Every medical procedure had an associated medical code specified in the ICD-9 or ICD-10 standard.) Additionally, because providers had no way of knowing a patient's exact insurance coverage at the time of treatment, they often performed treatments that were not covered, or charged the wrong co-payment. Meanwhile, insurers incurred high administrative costs from the time-consuming process of reviewing and auditing claims to assure that unnecessary payments were not made. If a claim was found to contain mistakes or requested payment for services that were not covered, it was "pended" by the payer; resolving such issues with providers could take months.

One of the ways that providers dealt with this complexity was to use healthcare claims clearinghouses. These organizations reviewed every claim before it was submitted, identified errors or incomplete information, and provided other value-added services for providers (e.g., generating claims reports as a way to analyze trends, helping providers track status of claims, etc.) in return for a small percentage of each claim they processed. They acted as an interface between the payer and provider, submitting claims electronically to the payer and sending back claims adjudication information to the provider, thereby minimizing the need for providers to deal with the IT challenges of submitting claims electronically to multiple payers. These clearinghouses ranged from relatively small, regional operations to very large, nationwide operations that worked with thousands of providers.

The multitude of steps and delays in the U.S. claims adjudication process contributed to long payment cycles of up to 60 days, which was highly undesirable from the provider's perspective. In the end, providers were often left trying to collect from patients whatever amount insurance companies didn't pay long after the treatments were provided, a process that yielded only a small percentage of fees owed. Paper-based claims processing, a small fraction of U.S. billing, further increased the time and administrative costs burden to both providers and payers.

Prospects for RTA in the United States

Although healthcare IT in the United States was one of the most advanced in the world, RTA had yet to gain traction. While most medical claims were submitted electronically, the vast majority of payers adjudicated them in a batched, offline manner. A handful of payers had adopted online systems to allow physicians to enter data in order to verify a particular patient's eligibility and obtain a "real-time estimate" of the anticipated payment. However, in contrast to true RTA, these systems did not complete the claim submission and adjudication process in real time. According to a number of payer organizations, despite the growing adoption of real-time systems, overall awareness of the potential for RTA among payers was low. Nonetheless, when RTA was explained to them, heads of IT at both private insurers and state-run Medicaid programs did see three potential benefits. First, the payment

period would be shortened, which would increase providers' cash flow. Second, administrative overhead would be reduced due to a decrease in claim inquiries and re-submissions. Third, RTA systems purportedly reduced fraud and/or overuse by providers and subscribers, though its impact could not be measured directly.

However, both providers and payers raised several concerns. Implementing RTA solutions would require the payers to make substantial capital outlays, estimated in the millions of dollars. On top of this, whereas providers benefited from a shortened accounts receivable cycle, payers' cashflows would be negatively impacted by a corresponding shorter accounts payable period. In addition, the way in which physician offices were organized in the United States posed another challenge. Physician offices typically separated back-office and front-office functions. The front office typically dealt with customers, collected co-pays, managed scheduling and other administrative tasks. The back office typically wrote up claims, interfaced with payers and followed up with customers on outstanding payments. Adopting an RTA system would require significant changes in provider workflow (i.e., physicians or front office personnel would now be responsible for entering and coding claims). Finally, unlike the Argentinean market, the U.S. payer market was heavily fragmented. There were a few large payers, clearinghouses and provider networks, but none of them accounted for a significant share of their respective markets, and each of them had many small- and medium-sized competitors.

Existing Competitive Landscape

Although the RTA market in the United States was still in its infancy, there were a number of companies that were providing subsets of RTA solutions to U.S. payers. These competitors included large system integrators (SI), healthcare financials-focused IT companies and RTA focused start-ups. (See **Figure 3**.)

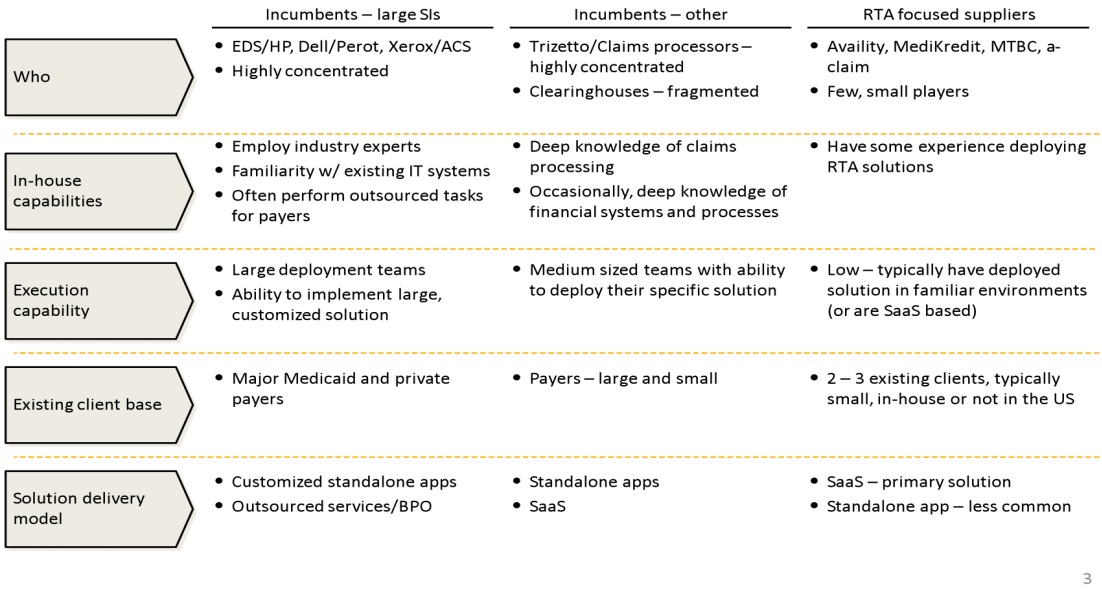
Systems Integrators (SIs) Systems integrators, including HP-EDS, Dell-Perot Systems and Xerox-ACS, were typically full-service IT companies that offered application development and outsourcing services. They operated across a wide variety of industries and had tens of thousands of employees. Many SIs had deeply entrenched relationships with some of the larger private and public payers, since they had either developed their IT systems or helped run those systems. Although most SIs did not have a "pre-packaged" RTA solution, they had the ability to build highly customized solutions catering to the exact needs of a customer.

Healthcare Financials-focused IT Companies Firms like Trizetto, ZirMed, Allscripts, and Ingenux offered a variety of revenue management solutions enabling payers to do everything from accounting and managing accounts payable/accounts receivable to processing and adjudicating claims. Some offered a broader suite of services to cater to all software/technology needs (including consulting and outsourcing services). Clients included public and private payers of all sizes. While a number of these

IT companies were piloting RTA with a few customers, they did so knowing that by introducing an RTA solution, they were potentially jeopardizing sales of their existing products.

RTA-focused Start-ups Finally, there were a number of small companies dedicated to RTA solutions. Some, such as Availity and A-claim, were subsidiaries or spin-offs from healthcare payers who were trying to pilot RTA solutions for their own use. Others, such as MediKredit, had developed RTA solutions for other countries and were looking to leverage that knowledge in entering the U.S. market. (MediKredit was a South African-based company with an office in Boston, MA.) The one commonality these players shared was that none of them had more than one or two U.S. customers, and it did not look like any of them would be signing any major deals soon.

Figure 3 Conexia's Competitors' Capabilities



Source: Casewriters' analysis.

Potential Paths to Entry

With the G-Lab findings in hand, Navas pondered the various U.S. market entry strategies the team presented. Given the complexity of the U.S. healthcare market, there would be no simple solution, and each course of action had its own set of tradeoffs.

A. Enter as planned with a full RTA solution

Entering the U.S. market with a full RTA solution had been Conexia's preferred strategy. To this end, the team had identified a segment of payers that Conexia could target first, including both small

government payers (primarily small state Medicaid programs) and small- and medium-sized private payers. In addition, Conexia could limit its geographic focus to the concentrated market in the Northeast while pursuing leads in other regions. This approach would allow Conexia to offer the most complete product and command the highest prices (relative to the other options). However, the challenge would be whether potential clients would be willing to purchase a full RTA system from an unknown international entrant. In addition, given RTA's low adoption rate in the United States, Conexia would need to spend substantial time and resources—more than $500,000—educating the market and cultivating sales leads. (See **Exhibit 7** for an estimate of the costs of establishing a U.S. presence.) Navas was also mulling over whether the company's efforts to create and sustain a presence in the U.S market would drain resources away from other growth opportunities.

B. *Establish credibility through simpler products*

One option to overcome Conexia's initial lack of credibility in the United States was to enter the market with simpler, easier-to-sell products. For instance, Conexia could sell a real-time patient eligibility verification system, or a real-time payment estimation system, both of which were more widely accepted than full-scale RTA. The advantage of these products was that, unlike RTA, Conexia wouldn't need to invest in educating the market and, therefore, could focus purely on sales. Additionally, each of these solutions represented a module within the full RTA solution and would not require Conexia to engage in any significant product development. However, a stripped-down product would command lower prices and profits, still require a substantial sales effort, and compete with existing products made by U.S. vendors. Though Conexia had yet to decide how much to charge for its services in the United States, it planned to use the same value-based pricing framework it adopted in Argentina.

C. Establish credibility through services

A third option was to offer IT services (e.g., application development) to healthcare payers. For example, Conexia could help payers migrate their existing systems in order to be compliant with the upcoming transition to ICD-10 codes. Providing these services would enable Conexia to build relationships and gain a deeper understanding of the U.S. healthcare market. However, the healthcare IT services market was extremely crowded, with price, relationships and a good reputation being the keys to winning a deal. Although the need for these services was great, this was unlikely to be a high-margin business and was not one that Conexia was familiar with.

D. Partner with an existing U.S. IT services company

Another option, which would help Conexia build credibility in the United States, was to partner with a U.S.-based IT services company. This would enable Conexia to jointly pursue sales leads with that company and potentially bid for projects larger than Conexia could handle by itself. However, there were a few tradeoffs. Revenues would be lower since Conexia would be sharing them with a partner. Furthermore, a partnership model would make it difficult for Conexia to build its own customer base and establish its brand, even after it had identified a suitable partner in the first place.

E. Focus on other Latin American countries while waiting for the U.S. market to mature

Finally, Conexia had the near-term option of shifting its focus away from the U.S. market and towards neighboring Latin American markets including Chile, Brazil, and Colombia. Conexia might have an easier time selling in these countries by leveraging its experiences and reputation in Argentina. While these markets were small compared to the United States, they could offer a means for Conexia to grow in the short term while RTA awareness and acceptance in the United States matured. However, the biggest risk with this option was that by not being an early mover in the U.S. market, Conexia might end up arriving too late.

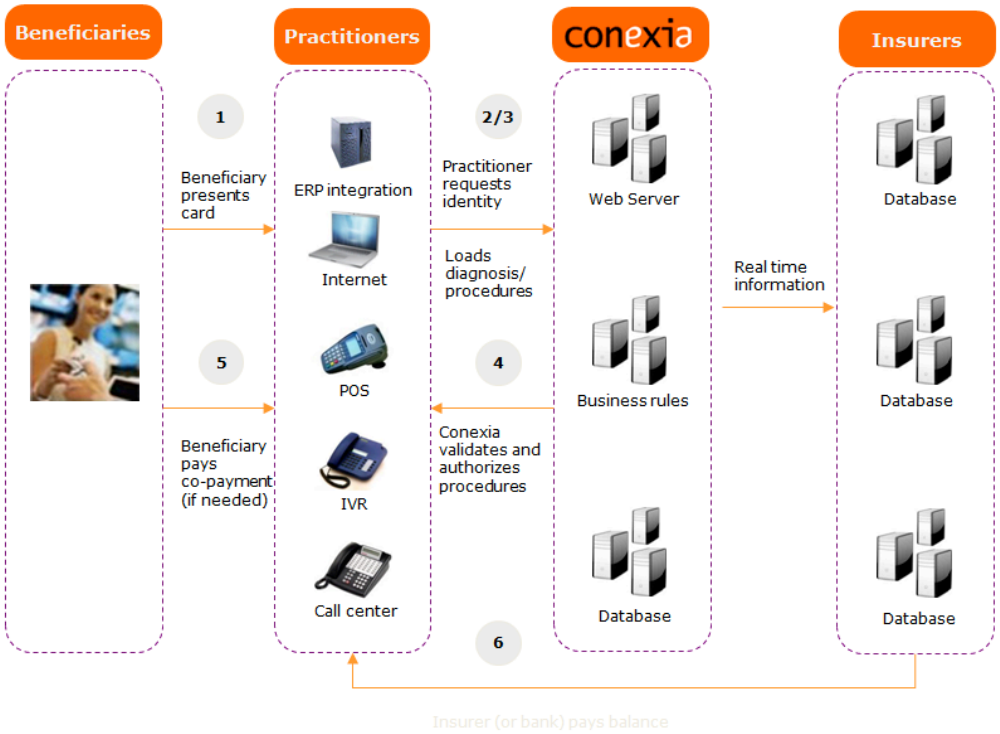
Decision at Hand

As Navas weighed the options in front of him, he realized that what had seemed to be an obvious decision to enter the U.S. market had grown murky. Conexia needed to enter the U.S. market if it was to be transformed into the large, public, multinational company Navas had set his mind on creating. However, if the market were not ready for his product, he did not want to drain the resources of his still relatively young company. Even without the U.S. market, Conexia was profitable and growing. Navas wondered, "Should we leave well enough alone?"

Study Questions

1. What has made Conexia successful so far?
2. How will the U.S. market be different from what Conexia has seen in Argentina?

Exhibit 1 Conexia's Service Model



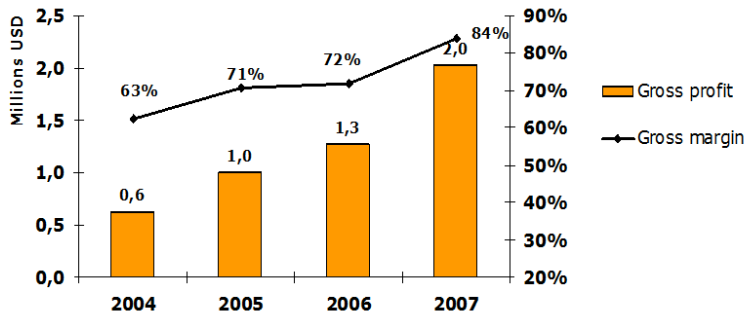
Source: Conexia.

Exhibit 2 Conexia Income Statement, 2006-2007

Figures in USD	2006	% of revenues	2007	% of revenues
Revenues				
Beneficiaries	657.786	37%	1.018.652	42%
Fees	656.055	37%	533.653	22%
Data Capture Points	355.587	20%	388.405	16%
Transactions	76.130	4%	97.775	4%
IT Services	58.658	3%	390.362	16%
Others	13.840	1%	61.912	3%
Sales Tax	(52.954)	-3%	(74.723)	-3%
NET REVENUE	1.765.103		2.416.037	
Direct Costs				
Telephony	(96.907)	5%	(67.578)	3%
Housing	(29.622)	2%	(29.961)	1%
Links	(140.800)	8%	(96.552)	4%
Terminal Manteinance	(130.335)	7%	(100.711)	4%
Others	(101.179)	6%	(95.403)	4%
TOTAL DIRECT COST	(498.843)		(390.205)	
GROSS PROFIT	**1.266.260**		**2.025.833**	
Gross Margin %	72%		84%	
Fixed Expenses				
Salaries & Wages	(509.787)	29%	(825.751)	34%
Selling, G&A Expenses	(537.370)	30%	(607.835)	25%
TOTAL FIXED EXPENSES	(1.047.157)		(1.433.586)	
OPERATIVE MARGIN - EBITDA	**219.103**		**592.246**	
EBITDA Margin %	12%		25%	

Source: Conexia.

Exhibit 3 Conexia Historical Gross Profit Margins, 2004-2007



Source: Conexia.

Exhibit 4 Conexia Revenue and EBITDA: Actual (2007-2009) and Projected (2010-2012)

	2007 (A)	2008 (A)	2009 (A)	2010 (P)	2011 (P)	2012 (P)
Revenues	2,416.04	3,081.04	5,187.25	7,376.60	10,327.24	14,458.14
EBITDA	592.25	957.65	1,573.59	2,212.98	3,098.17	4,337.44
EBITDA mgn	25%	31%	30%	30%	30%	30%

Source: Conexia.

Exhibit 5 Capsule Biographies of Key Conexia Executives

Luis Navas, 51, CEO since 2000. Previously Sales Director of IMPSA, the flagship company of the Pescarmona Group. Was based overseas for 12 years, heading the Beijing, Hong Kong and Lucerne offices. Luis is a Mechanical Engineer from Universidad Nacional de San Juan and attended the Program for Management Development at Harvard Business School.

Sebastián Letemendía, 43, COO since 2000. Previously worked for the Pescarmona Group as Finance Manager, for the Exxel Group, a private equity fund, and between 1991 and 1997 for Chase Manhattan and ING Barings banks, where he was a Vice President. Holds an MBA from Wharton School and a BBA from Universidad de Buenos Aires.

Alfredo Semeniuk, 35, Sales Director since 2000. Alfredo developed his professional career at IMPSAT, which he joined in 1991. He was involved in the launch of Conexia in 1996, and in the implementation for its customers. Alfredo is an Electronic Technician.

Guillermo Fernández, 36, Technology Manager. Guillermo joined Conexia in 2001. Previously he worked at Accenture. Is a Bachelor in Systems from Universidad Católica de la Plata.

Dino Ronconi, 43, Project Manager, joined Conexia in 2001. Dino is a Bachelor in Systems from CAECE university.

Silvana Lema, 26, Administration Manager since 2005. Prior to Conexia she worked at Price Waterhouse Coopers. Silvana is a CPA from Universidad de Buenos Aires.

Mariela Blanc, 33, Commercial Manager, responsible for sales, marketing and field team support. Mariela joined Conexia in 2005 having previously worked at Comsoft and Microsoft. She holds a degree in marketing from the Universidad Argentina de la Empresa.

Virginia Carena, 26, HR Manager, at Conexia since 2005. Prior to Conexia she worked at CIE Argentina, a Mexican entertainment conglomerate. She is an HR graduate from the Universidad de Palermo.

Emilio Etlis, 58, QA Manager at Conexia since 2006. Previously he worked at PIXART as a Senior QA analyst. He has a degree in Physics from the Universidad de Buenos Aires and another in Computer Science from the Universidad Tecnologica Nacional.

Exhibit 6 Conexia Pricing in Argentina

Average payer costs per member per month (Costs pm pm)		**ARS*** **
Administrative		$20
Medical		$80
Total costs pm pm		**$100**
Savings generated by Conexia's RTA system		
% of administrative costs*	10%	
Administrative cost saved pm pm		$2
% of medical costs saved**	5%	
Medical costs saved pm pm		$4
Total savings pm pm		**$6**
Pricing Rationale		
Conexia value created pm pm		$6
% of value captured by Conexia	33%	
Conexia pricing pm pm		**$2**

*Drivers of administrative cost savings, according to Conexia's Argentine clients:
- Reduction of pended claims due to errors being caught in real-time
- Migration from paper to electronic claims forms
- RTA deployment in both medical and pharmacy claims

**Drivers of medical cost savings
- Detection of abnormal usage patterns (fraud / overuse)
- RTA deployment in both medical and pharmacy claims

*** 1 Argentine Peso (ARS) = 0.26 USD on Jan 22nd, 2010

Source: Conexia.

Exhibit 7 Conservative Annual Cost Estimates for Conexia U.S. Entry ($USD)

Operational overhead	$60,000
Sales	
Sales representative	$100,000
Clinical / healthcare sales support	$100,000
Selling expenses	$200,000
Marketing	
Marketing collateral	$40,000
Tradeshow, websites, etc.	$25,000
English product support	$40,000
Total	**$565,000**

Source: Conexia.