DISCERN ACTIONABLE FORESIGHT

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Structure and trends across the U.S. healthcare system

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In this, the second in our series of reports on the U.S. healthcare system, we explore the impact that crucial external driving forces --politics, demographic changes and technology -- are having on the various players across the industry. It is the intersection of these driving forces with the urgency implied by implementation of the ACA that is the dominant current shaping U.S. healthcare system trends. With this as context, we explore the characteristics we believe will be critical for industries hoping to thrive in the new healthcare environment.

U.S. Healthcare Structure

The structure of the U.S. healthcare system is unbalanced and complex compared to most other countries and other regulated industries. Customers for healthcare – those who pay for products and services – are primarily the private insurance companies and Medicare/Medicaid. Elsewhere, the customer is often the patient or an agency responsible for administering a single-payer system. The result is that in the U.S., patients are merely the cost of goods in the system, but unlike most elements of a supply chain, they have opinions and collectively elect the policy-makers who, in turn, regulate the payers.

"Cost of Goods" is changing

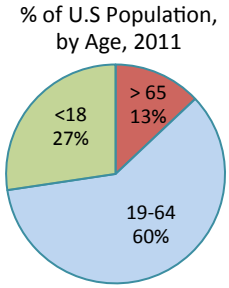
As the Boomer generation approaches retirement, an ever greater number of Americans are facing management of chronic illnesses such as diabetes and heart disease, and thus need more --and more complex-- health services. Health system successes in the past mean Americans are living longer. Instead of dying before 65, they are living into their 80s and having to manage diseases and conditions that otherwise would never have been presented to the health system because of the earlier mortality. Better treatment of patients with heart attacks, for example, leads to more people living longer with cardiovascular disease that providers must treat and manage. In short, the health system is being stressed by the very consequences of its own success.

These demographic changes are stretching resources, while advances in healthcare and communications technology provide opportunities for better but more expensive care. Both people and productivity set the stage for how various sectors across the industry are changing.

Although patients are the ones being treated, this is not a typical market where supply and demand rules apply. A patient may get care from a specialist, who was referred from a doctor, from among those in the network selected and paid for by an insurance provider, who was chosen and paid by an employer, who must by law now include this as a cost of doing business.

The personal choices made about one's health are disconnected from the items paid out-of-pocket such as insurance premiums. Simply put, the average American health consumer has no idea how to measure the connection between the costs paid and the benefits gained from their health system interactions. This lack of transparency and the opportunity for waste across the industry is immense, and the drive for profit across multiple stakeholders is far removed from the actual outcome of good health for any particular patient.

The bottom line is that the current status quo is neither practical nor desirable. The good news is that digital technology is presenting dramatic new ways to provide patients with the ability to become active partners in managing their own health with tools for self-awareness, self-diagnosis, self-monitoring, and self-care.



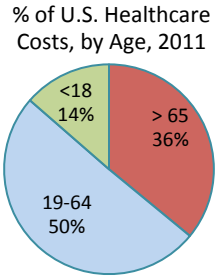


Figure 1: 2011 U.S. Population and Healthcare Costs by Age, Sources: U.S. Census Data, CDC Health 2012 Data, CMS Gender and Age Tables

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Care Providers and Products: A complex and changing landscape

The U.S. healthcare provider system serves 300 million patients and includes almost 12 million physicians and healthcare workers, nearly 6,000 hospitals and 15,000 nursing facilities. The complexity entailed in balancing individual care and population-level health in a cost-effective way is staggering.

Product industries range from drugs, devices and diagnostics, to implantable items, supplies, hardware and software. Technology advances provide care and quality opportunities in targeted medicine, genomics, sensors, and earlier and more-sensitive diagnostics, while IT, big data and predictive analytics promise efficiencies of care delivery and cost reductions. Disruptive products are emerging from small firms and labs, and many larger companies are integrating innovation through partnering.

The variety of service providers includes the full range of small and large organizations, specialized clinics and well-integrated systems, highly trained professionals and low-wage caregivers. Hospitals and care facilities are struggling with IT investments, profitability, and training, but they are also beginning to see efficiency improvements and development of standards of care, especially with scale.

Independent physicians have historically been the primary decision makers in the system, but their choices are increasingly dictated by practice standards, administrators, payers, and new structures such as Accountable Care Organizations (ACOs). Doctors are bombarded with decision support tools, EMR training, patient engagement apps, personalized medicine technologies, and patients with web-search results and fears. Some lament the changing practice of medicine, while others are embracing new business models such as Medical Homes and telemedicine. All these new tools and activities belie a profound shift: once upon a time U.S. healthcare was nominally a doctor-driven industry; today it is impossible to say who is in control, either symbolically or in fact.

Priorities for Private and Public Payers differ

Private and public insurance providers pay directly for healthcare services, negotiate for pricing with providers and define what their products and plans will offer. As the actual customers for healthcare products and services, payers hold more information and leverage across the system than either patients or providers. They are the financial link between sponsors who pay the premiums - employers, government and individuals - and healthcare providers, and they are also the gatekeepers between providers and patients.

Private insurance companies are charged with making a profit, and they do so by creating and administering plans that minimize their risk and costs while maintaining the health of members. For privates, the ideal member is someone who doesn't need any health services and doesn't die, ensuring a steady income stream. Not surprisingly, the privates managed their profitability by excluding members considered a cost risk because of pre-existing conditions. Because plans on the new healthcare exchanges must meet minimum conditions cannot exclude applicants with pre-existing conditions, profitability will depend upon sharing risk across larger pools of patients with varying needs, much like the existing plans for most employer sponsors and public insurance. Scale will matter as it will allow plans to attract and retain healthy consumers, rather than locking out sicker ones.

Medicare and Medicaid are nonprofit entities charged with care of the most-expensive groups of patients. Scale works in their favor. For example, the Center for Medicare and Medicaid Services (CMS) negotiates low reimbursement rates and has significant influence over provider standards of care, while creating innovation in both care management and health IT. Medicare is clearly subject to political pressures, funding, and management, though strong and emotional constituencies from every side limit significant change in any one direction.

State governments apply local priorities to local decisions, but differences challenge the mobility of patients and information across state lines, cost-efficiencies of cross-state payers, and integration of electronic medical records. States are responsible for regulating healthcare providers and insurance companies and for 50% of funding for Medicaid programs. For those states that have expanded Medicaid, federal payments will cover 100% of new costs through 2016, and no less than 90% thereafter. Acceptance or rejection of ACA's Medicare expansion program will be a major factor driving state-specific costs and will mean significant disparities in access to care from state to state.

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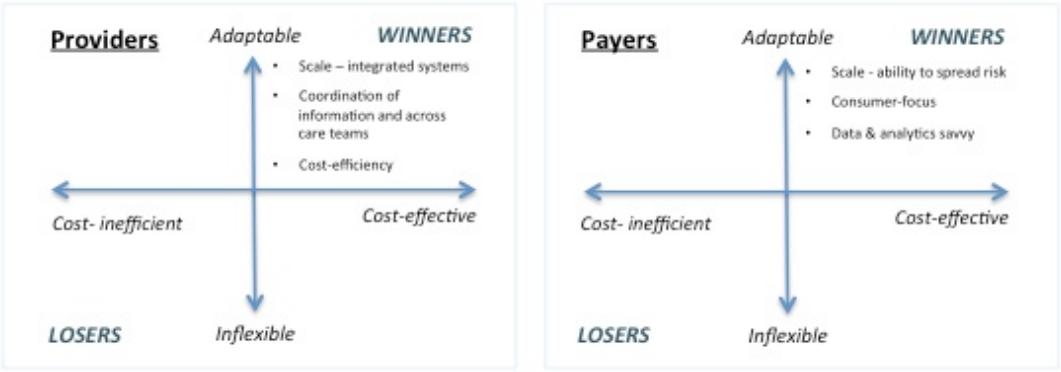

Figure 2: Winning Characteristics in Payer and Provider Industries, Source: DISCERN

Survival: It's about adaptability and cost-effectiveness

Healthcare organizations are a slow moving, watch-and-wait group of stakeholders. Hospitals make large and long-lived investments in buildings, diagnostic equipment, and IT systems. Doctors make sizeable and long-term personal investments in medical school and practice-building. Pharma companies make high-risk multi-billion Dollar investments over decades on drug development. Policy makers will argue for years about change. And patients may quickly adopt smart phones, but are very slow to change diet and exercise behaviors.

While some politicians continue vocal opposition to the ACA, the prospect of repeal is diminishing rapidly. Washington aside, the investments already made by health industry players to comply with the ACA make repeal or any partial reversal all the more impractical. And as the number of people who benefit rise, the voting public will increase its stake in the newly enacted status quo. We believe that the ACA is here to stay. A systematic bi-partisan effort to fix its obvious flaws such as happened following passage of Medicare legislation in the mid-1960s is desirable, but unlikely. Given the depth of the divide in Washington, the most the ACA's critics can hope for are a few changes around the margins. The thundering from politicians will continue for some time, absent some vast political seismic shift, little will change.

Underlying the political landscape however, are the long-term trends that are having a vast impact across all sectors of healthcare. Adaptability and cost-efficiency will become the key elements driving success. In the coming years the U.S must curb its spending on ever more expensive technological wonder tools and procedures while managing a growing population of older people and chronic illness. Product companies are investing to meet the needs and characteristics of this new audience, and care models are shifting to accommodate different populations. Patients have more and better access to information to make self-care decisions, and advances in wireless and sensor technologies are providing a base for more-distributed diagnostics and care. Private payers will need to reach out to broader consumer audiences, but will continue to offer tiered plans and access to a wider set of providers for those who are willing to pay a premium - those who can afford to pay will never be denied elite, gold-plated medical services.

What will the future look like

In the coming years, winners in the healthcare industry will pursue new technologies and models that either adapt to the changing patient population's needs or are cost efficient and include both value-add and cost-reduction elements. "Me too" products at best will get "me too" pricing and risk not being reimbursed at all and losing the attention of providers.

New models of care are emerging to adapt to the unmet needs and increasing numbers of patients. New treatment venues such as clinics in pharmacies and workplaces are proliferating as cost effective means to deliver basic care. As mobile technology becomes more reliable, mobile paramedic treatment services and telehealth are beginning to supplement expensive emergency rooms as low cost providers and gatekeepers. Patient empowerment services are being tested to manage patients outside the doctor's office, and disease management models are gaining greater influence and effectiveness.

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Cost-effectiveness is the second main success criterion. Payers have no choice but be more critical in what they will cover and reimburse, and they are using complex analytics to uncover learnings among their membership. As hospitals focus on IT implementation, they are capable of accessing data on their own patient outcomes, internal practices, and costs, and they are imposing more stringent practice guideline standards on their employees, doctors and nurse practitioners to help control their costs. Malpractice reforms may emerge as a consequence, with a goal of reducing the excessive waste incurred due to defensive medicine.

Next Report: Potential Winners and Losers Across the U.S. Healthcare Industry

Our next report highlights specific segments of the industry that are well-positioned for success, and describes both short-term milestones and long-term trends to watch for. We invite you to participate in the conversation or request topics for future reports by contacting us.

Special thanks to Barry Kurokawa, who offered extensive content suggestions and edits in the course of producing this report.