DISCERN ACTIONABLE FORESIGHT

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Winners and losers in the emerging U.S. Healthcare landscape

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Passage of the Affordable Care Act (ACA) has dramatically changed the conversation about healthcare in the U.S., opening new market niches, and creating new winners – and losers. Though the debate over the ACA continues, we believe repeal is unlikely. The critical question thus becomes one of how the provisions of the ACA will unfold, and what other trends are important to consider as actionable opportunities. This report offers an overview of who we believe will be the winners and losers in both the next year as well as the longer-term future.

U.S. Healthcare in the Coming Year

The roll-out of the ACA has taken center stage across healthcare as the most dramatic set of policy changes to U.S. healthcare in decades. Given the sustained and vocal opposition to its implementation from conservatives in Washington and the fumbled execution of the federal website introduction, it is not surprising that many observers are withholding judgment on the ACA's future prospects. Add in the possibility for extension of some deadlines, and some industry participants are finding themselves needing to respond quickly to unexpected developments.

ACA Milestones: key waypoints revealing winners and losers

Several upcoming milestones will provide more clues as to the near-term winners and losers in this space. In November, the Obama Administration announced an extension to the ACA's grandfather clause allowing insurance companies to offer continuation of many existing plans through 2014. Many states that had successful exchange launches have declined this option, others have accepted and now leave it to carriers to manage, and still other states remain on the fence as of mid-December. Although large numbers of healthy people keeping previous coverage might skew the risk pool for exchange-based plans, most consumers who get the option to keep an old plan would still see annual price increases and may find better deals with subsidies on exchanges if they care to look.

The first wave of exchange participants will begin to receive coverage on January 1st, 2014. Although the press and politicians are focusing on enrollment numbers, few industry experts are relying on these to project the success of the exchanges just yet. Experience with the Massachusetts exchange (in place since 2008), as well as other programs like Medicare and Social Security, tells us not to expect maximum enrollment until shortly before the final deadline of March 31 by anyone but the most eager buyers. This in no small part is due to the fact that the purchase of this new and complex product is expected to take multiple visits to the site for most users.

By the end of March 2014, we will know the mix of people who have enrolled: sick and healthy, old and young, singles and families. The ACA includes "reinsurance" programs and "risk corridors" to reimburse the market for especially high-risk participants so carriers will not bear the brunt of a less healthy pool of users, but private payers will certainly take learnings from 2014 into planning their offerings and pricing for 2015.

Hospitals and care providers will also have more information by April 2014 on local changes that will affect their service offerings and profitability. Facilities in states that have included Medicaid expansion will have more insured patients, and potentially see fewer acute and expensive cases. State-by-state numbers will be available to help in local planning for shifts in care provision.

New Patient Segments

The new pool of patients in the industry includes 57M previously uninsured[1] and 14M[2] individuals who previously purchased their own plans. Of these, 10M people are below the poverty line and either newly eligible in states that are expanding Medicaid (3-4M) or will be forced to go without coverage in states that have rejected Medicaid expansion (6-7M people.) Another 9-10M people have access to employer-sponsored insurance, which they must now accept or face a fine.

Up to 48% of Americans are estimated to have some condition that would previously have excluded them from private insurance coverage. Many of these people have insurance, but have suffered from lack of job mobility because of their ties to employee-sponsored coverage. Others who have not been covered are the segment most likely to take advantage of the new plans and will benefit immediately with new services, but so will the care providers and clinics that can effectively reach out to and efficiently treat them. Given that many of these patients have long-standing chronic conditions such as diabetes and heart disease, pharmaceutical and other product manufacturers, specialty clinics and coordinated care providers who serve them are be well-positioned to benefit. Cost-efficiency associated with treating large numbers of similar patients and coordination of the teams required to meet the complex needs of these patients will drive profitability for these winners.

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Insurance carriers that can attract and retain relatively healthy individual policy holders will likely come out ahead, as even with expanded coverage these members are less likely to use expensive services. New capabilities regarding consumer marketing and retention will be seen among those carriers that succeed. Among these healthy individuals, approximately half are eligible for subsidies, and all will benefit if they do utilize new preventative care services. Care providers of newly mandated "essential health benefits" such as mental health, rehabilitation, obstetrics/gynecology/maternity, and some wellness services may be inundated with new patients but are positioned well for growth if they can manage these new patients efficiently.

Losers over the coming year will be the insurance carriers who do not effectively acquire a diverse range of consumers, ending up with primarily sick members that may still have poor access to integrated care. Some consumers may be unhappy as well, if they have signed up later in the cycle and have difficulty finding access to overwhelmed physicians, or are unsubsidized and healthy and must pay more than they have in the past. Eligible would-be insureds do not sign up for coverage will face the prospect of fines and the possibility of ruinous uncovered costs in the event of major illness. Individuals eligible for Medicaid who live in states that have refused expansion will also face the possibility of uncovered expenses in the event of a major illness. Hospitals that serve these patients without coverage will continue to absorb the cost of unpaid emergency care. These latter risks may create voter peril for politicians in states resisting full implementation of the ACA's provisions.

Other changes in 2014

There has been much discussion leading up to ACA's launch regarding employers opting to pay penalties versus providing insurance. Suffice it to say businesses will make economic decisions that benefit themselves, and they have been struggling for years with increasing premiums. Some will opt to provide monetary benefits and private exchanges instead of specific plans, thereby avoiding fines, maintaining employee goodwill, and paying predictable annual costs rather than responding to inconsistent premium growth. All of this however, should have limited to no effect on the supply and demand for healthcare, but will benefit insurance carriers who can compete by offering consumer-facing private exchanges.

Healthcare providers will face continuing pressure to manage and provide evidence of returns on their IT investments. The HITECH Act has distributed $17B in incentives already and leading integrated systems are utilizing their new digital capabilities to reduce readmissions, meet Meaningful Use requirements for Medicare payments, and create new standards based on best-practices. Other technology elements that lay claim to the attention and resources of hospital leadership include transitioning to new ICD-10 codes, integration of new patient engagement platforms, and experiments with mobile support platforms. Healthcare-oriented IT providers are thus important potential winners.

Once care systems have committed to a specific platform and trained their employees they are unlikely to switch vendors, despite significant complaints about the product. Electronic Medical Record (EMR) and other health IT vendors are well-entrenched and well-positioned to partner or acquire new ideas and customers. A growing number of mobile and digital health start-ups are working on patient engagement and health tracking tools, hoping to sell to directly to providers or build on existing EMR systems.

Private payers are also leveraging their patient and payment data to produce standards for reimbursement, develop targeted programs for members, and focus on cost reduction. The largest payers are supporting incubators and open platforms to get entrepreneurs to write applications and design products for their members, and set themselves apart from competitors in the newly consumerized insurance marketplace.

Meanwhile, the Center for Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health Information (ONC) are working together to establish standards for interoperability of health data. They have created the Blue Button Initiative to provide safe and easy access to individuals' own health data and allow sharing with selected caregivers. Private efforts and investments are also being made to address the challenges of data transfer among providers and to integrate information for both personal health reasons and population-level research.

Looking beyond 2014: Longer-term changes and implications

Events occurring in 2014 as the ACA is implemented will have only a modest impact on the long-term healthcare landscape. Much to the chagrin of people on both ends of the spectrum, the core structure has not changed – we still have neither a completely market-driven nor a single payer system. Providing insurance and healthcare access to the final 1/6 of our population is affecting insurance carriers who have chosen to participate and acute care providers who will now see fewer unpaid patients, but the trends that have been brewing for years will dominate changes across many more sectors of the industry in the decade ahead.

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Key elements to watch for

Certain drivers and issues have been slowly stressing the system but are now pushing it to its limits. In combination, these elements are forcing creation of new care models and will provide opportunity for those that can leverage them:

- Demographics: The U.S population will be comprised of an ever-larger number of older Americans. This aging population will require more health interventions, both episodic as well as extended management of chronic conditions. Those over 65 years old generally consume/expend over 4 times more health services than the under-65s.
- Technology: Biotechnology, sensors, nanotech, and digital technologies will continue to be powerful transformative forces affecting the healthcare landscape. Key opportunity areas include networked and mobile devices, genomic-based diagnostics and treatment, and big data platforms driving personalized medicine and improvements in overall population health.
- Access: The flood of newly insureds compounded by an ever larger and aging population will dramatically increase the demand for care. Not only do we not have enough doctors to meet the anticipated demand, medical schools are graduating too few new doctors to replace the estimated 30% of currently practicing doctors expected to retire in the next 10 years. Regions where the current per-capita physician level is already strained will immediately struggle under the new demand.

General implications of foreseeable trends

Significant opportunities reside in new approaches to get around the doctor shortage. Health provider triage will include more use of doctors as supervisors for larger staffs comprised of physician assistants, nurse practitioners and nurses. We also expect to see growth in the number of walk-in and urgent care clinics, as well as more retail clinics staffed by nurses and nurse equivalents. This more complex landscape of entry points and care givers will in turn create demand for more mobility of data needed to follow patients and challenges in consistency of care.

Patients have never been a patient lot, and their impatience will grow as the effects of the professional shortage is felt and technology options expand. Opportunities for new products and services will include the creation of digital helpers, trackers, and home-based diagnostics and care management. Telehealth will become an important mode of delivery, particularly in rural areas, and digital conversations with health providers will become safe, secure, and commonplace.

Focused expertise and communities of care will drive increases in quality of care and cost-efficiency. New specialty clinics will emerge for efficient care of specific diseases, particularly chronic conditions. Management of diabetes, heart disease, cancer, and other conditions experienced by growing populations of sick will benefit from team-based care and coordination of specialists, as well patient communities and resources. Medical tourism – travel for access to specific expertise - will become popular as we see both quality improvements and cost-efficiency with high-volume procedures and a concentration of experts.

“Mass Customization” of medicine will become the norm. The intersection of new sensor technologies and big data analytics will drive the long anticipated arrival of personalized medicine on a large scale, though timing of this promising model based on genomics alone has been disappointing to date. Other contributing elements will need to include integrated health records, clinical and patient decision support tools, and population health analytics and research.

Industry sectors that stand to gain over the next decade

- Health IT: Driven by both “carrots” and “sticks”, providers continue to invest in digital health records and analytics to capture cost savings, receive incentive payments, attract and keep patients, and improve quality of care. Payers are increasingly using analytics for cost-efficiency purposes. And, patients expect more and better access to their records, capabilities to track and manage their own health, and access virtual care.
- Specialty care providers and clinics: Expertise in specific disease areas, especially those that require complex and ongoing care coordination, can be leveraged across economies of scale to serve more patients with higher quality at lower costs.
- Retail clinics and other new triage centers: Meeting the needs of people who want immediate care, these centers can treat up to 80% of the most common illnesses. Easy access and payment for preventative services will mean fewer acute events for patients and lower costs for payers.
- Large, integrated healthcare systems: Connected networks of primary and specialty care providers with both ambulatory and inpatient facilities allows for higher quality teaming and coordinated care for patients, referral and volume efficiencies for healthcare systems, and leverage of new payment models such as Patient-centered Medical Homes and Accountable Care Organizations.

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- Home health technologies: As patients access more information and participate in on-line communities, they are becoming more comfortable with self-diagnosis and self- care. Products and services will see success if they can meet these needs in easy-to-use ways that actually add value or change behavior.
- Rapid diagnostics and screening technologies: As triage and basic care spread from doctors to their assistants, triage centers and into people's homes, sensors and inexpensive diagnostics that can support this shift for the most common illnesses will be in demand.
- Patient decision support tools: Information overload is common with patients referring to "Dr. Google" for self- diagnosis and blogs from other well-meaning but uninformed peers. Patient support tools will likely emerge to help consumers wade through and qualify information, and make customized decisions tailored for their specific circumstances.
- Researchers using big data and bioinformatics: Scientific discovery has exploded in the last decade due to advances in bioinformatics and new research techniques. The more data we can acquire and integrate, the more analytic tools are required to help make sense of it, and the more likely labs are to produce new insights about human health.
- Genomics analytics, interpretation, and counseling: Personalized medicine only becomes meaningful when it is accurate and cost-effective. Early adopters are interested today in what they can learn from their genetic profile, but as the cost of sequencing comes down and the ability to match conditions and treatments to specific genetic variants increases, both doctors and patients will need guidance as to how to utilize this new information.
- Provider consolidation: Consolidation will likely continue and become more pronounced as providers seek to increase capacity to address the ever-increasing demand for healthcare expected in the wake of the ACA's passage. It is certainly conceivable that we could see mergers between insurance companies and healthcare providers, re-creating the staff model health maintenance organization, all driven by the imperative of greater cost control and the attempt to capture profit margins along the entire spectrum of care. Size will matter – a lot!

Industry Sectors in Trouble

- Independent or unaffiliated doctors, medical groups or small clinics: Without economies of scale, it is unlikely that independent offices can keep up with the quality improvements, cost reductions, and improved data infrastructures of larger healthcare systems. Some physicians may succeed at developing niche practices for targeted clients or in wealthy communities, but those in less affluent areas will be under pressure to join larger groups, become employees of larger systems, follow payer guidelines and accept lower payments.
- Community hospitals: Local hospitals must carry a full set of (inefficient, underutilized) staff and services to meet the breadth of needs of the community or region, especially in rural areas. Without a large population to maximize use of expensive diagnostic equipment and specialist services, these organizations will struggle with profitability and efficiency.
- Emergency rooms: Acute care facilities will still see patients who have true emergencies, as well as uninsured and those who could not get in to see a physician when needed. They may see cuts in funding but will continue to need to be responsive to local uncertainties and changes in their local care patterns. Patients who previously depended on public hospitals for care may turn up at private facilities closer to home and increase the need for emergency services there, while crowded public facilities may shift services and funds from acute to more preventative care services.
- Diagnostics labs: Improved near term demand will eventually give way to long-term headwinds. Better and coordinated digital health records mean less re-work of labs tests for patients, and fewer customers for lab services. The benefit of repetitive diagnostic procedures due to inefficient data keeping and sharing will diminish over time.
- Manufacturers of large/expensive medical equipment: As healthcare systems integrate for scale and efficiency, these larger but fewer centers mean that manufacturers of expensive equipment such as MRIs, robotic surgery units, as well as complex surgical centers will find fewer customers.
- Current owners of large data sets: Interoperability of data is in the best interests of patients and care providers, and anonymized health-related data from various government sources are already available to qualified users. Proprietary data currently resides in the hands of payers and manufacturers and has previously been a source of revenue sold to data integrators, but as information becomes more critical and common, the value of those unlinked data sets decreases rapidly.
- Large pharmaceutical companies: Companies that are unable to adapt to the changes confronting the industry will not survive. More productive R&D must occur in order to remain competitive. The luxury of profitably introducing nth generation "me too" products is unlikely to continue. Generic drugs and general pricing pressure will continue, if not become more acute. Many have argued that the strengths of large pharmaceutical companies lie in their development and marketing capabilities. Questions to consider include: Should they cease research and in-license all their products for development and marketing? Has the acquisition of biotech companies for

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technology and product pipeline benefits really paid off, compared to in-licensing? Absent dramatic change, the pharmaceutical industry will continue to struggle with growth and the evolution of personalized medicine will only contribute to their difficulties.

Uncertain but potentially high impact factors

As noted at the start of this report, some healthcare trends are fairly predictable, but others are much more uncertain. Depending on how some elements turn out and the timing, different sectors and players may find themselves either in leadership or challenging positions.

Political environment: Continuing polarization or a return to compromise?

Increasing political polarization will lead to increased healthcare disparity from state-to-state, continuing federal debate and lack of congressional action across other matters. More single-issue voters and corporate donors supporting cross-state politics could make this happen, but it is not in patient or system interests. However, rediscovery of a middle ground would result in a relatively smooth transition to new insurance markets. Noting the benefits enjoyed by others, citizens in non-participating states could put pressure on their elected officials to allow access comparable to other jurisdictions. In the end, we expect relatively common standards and coverage for healthcare for all to become the norm even in states that initially refused to participate.

Data ownership and privacy: status quo or open data flows?

The current data and privacy status quo presents continuing challenges in the form of ineffective data integration across systems and sources, continued silos between EMR vendors and slow advances in bioinformatics, analytics and population health. Limited patient data portability across payers and providers however, is likely the factor that pushes the market towards more open data flows. If the public becomes comfortable with privacy guarantees (much as it has in other industries such as banking and finance) we are likely to see increasing standardization across EMR systems and patient management of their own data. Increasing integration of health records, payment history and tracking data will be valuable for personal use and for population health analytics. Either way, health data is an area that presents important investment opportunities.

Payment model shifts: Value model is adopted slowly or stalls out?

New payment models are being explored by Medicare and many care providers, in which patient visits or episodes are reimbursed as a lump sum, rather than billed as a list of line items. Increasing numbers of providers are joining these Medical Homes and Accountable Care Organizations, and most are realizing some cost savings and quality improvements. Similar models have been tried in the past and have stalled out, but have not had the advantages of newer technologies and digital records. Given an early read and the theoretical incentives this could provide for better care coordination and cost controls, is likely that adoption will occur at least in niche markets, such as care for seniors with multiple or complex conditions, and may see broader application as well.

Consumers take more responsibility for their own health: status quo or increasing impact on everyone's overall health?

Patient status quo means increasing disparity between "health conscious" and early-adopter consumers with access to patient education, devices, and support services and the vast majority of consumers who continue less than optimal self-care habits leading to obesity, diabetes, and other chronic conditions. A shift to an overall healthy population is characterized by increasing awareness, motivation and action towards self-care and better diet and exercise habits, which could lead to stable or declining rates of chronic illness such as obesity and cardiovascular disease. Although we have seen growth in levels of obesity slow in the past year, the problem is far from solved. Americans enjoy sedentary lifestyles and large quantities of unhealthy food, and behavior change is unpredictable. Good health is in individuals' best interest and that of the government, but it remains unclear how and if these unhealthy habits will change in the long run.

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Summary

Even in the face of uncertainty, the outlines of early winners across the emerging health landscape are visible. Moreover, there are some areas such as health provider triage models, digital health, specialized care, and mass customization that are very likely to experience considerable growth and importance regardless of the direction the ongoing political debate takes. We recommend looking for these areas as a means for mitigating risk, but also be sure not to overlook areas of higher uncertainty that also present the potential for dramatic wins.

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[1] Agency for Health Research and Quality

[2] Kaiser Family Foundation

[3] Urban Institute and Kaiser Family Foundation