Planning for the Unpredictable, The Future of Healthcare: Shifting the Burden of Risk
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No other industry in the United States is undergoing such dramatic disruption as the healthcare industry. A confluence of forces are restructuring the industry, making it impossible to predict who will emerge as winners and losers in the new alignment of care providers, payers and risk managers, consumers and other participants.

At the center of this restructuring is the relationship between care provision and risk management. Currently, the government and national health insurance providers (like UnitedHealth Group) and regional plans (like Harvard Pilgrim Health Care) provide financial coverage for individuals and employers to mitigate the risk inherent in the consumption of a product – healthcare – that is characterized by uncertainty about when or how any individual might use it, and at what cost.

Given the uncertainty surrounding the healthcare industry, business participants struggle to develop strategies that can guide both near- and long-term competitive and market positioning. Health insurers in particular are trapped. Most are hesitant to pivot too far from their current strategies because insurance markets remain profitable, but they are well aware that forces buffeting the industry could quickly erode their market advantages.

Fortunately, tools exist to help healthcare industry businesses develop strategic plans amid this extreme uncertainty. Fuld + Company has worked with healthcare payers, providers and industry suppliers,
such as pharmaceutical, staffing and healthcare IT companies, to chart strategies that acknowledge and confront uncertainty, not ignore it. For instance, employing scenario-based strategic planning has created for clients core strategies that have been tested for resiliency amid multiple plausible futures. It has also developed contingency plans mapped to early warning indicators that foretell near-term emerging conditions. The consistent outcome for our clients is a stronger sense of direction and goal-orientation, knowledge of where the organization can position itself in the future, and the immediate steps to get there.

Our experience throughout these engagements reinforces our belief that two forces are necessitating a change in the relationship between care and risk: rising healthcare costs and the construct of the traditional healthcare business model. The impact of these two drivers is forcing health insurers to redefine their value propositions, seek additional sources of revenue, and strike new relationships with providers and other players in the healthcare industry.

RISING HEALTHCARE COSTS

According to the U.S. Centers for Medicare and Medicaid Services (CMS), national healthcare expenditures in the United States grew 4.3 percent to $3.3 trillion ($10,348 per person) in 2016 and accounted for almost 18 percent of Gross Domestic Product (GDP). Per capita healthcare spending in the U.S. was almost three times higher than the OECD average.

Furthermore, CMS projects that U.S. healthcare expenditures will grow at an average rate of 5.6 percent per year through 2025, 1.2 percentage points faster than GDP growth per year over
the same period. The health share of GDP is projected to reach 19.9 percent by 2025. This level of spending growth vastly outpaces growth in any other sector of the U.S. economy and is unsustainable.

FLAWED BUSINESS MODEL?

For nearly 100 years, the underlying business model in the U.S healthcare industry has been a fee-for-service model: physicians get paid for every service they perform. For a long time, this business model worked, as most patient needs were acute in nature and could be addressed by a limited number of services. Before today’s medical advances, physicians only needed to provide patients with a few surgical interventions and inexpensive medications.

Today, although individuals’ medical needs have changed and medical technology has dramatically advanced, the underlying healthcare business model has not. Excess utilization of medical services – many of which come with questionable benefits – is driving up costs. Because physician compensation is tied to utilization – how many MRIs or colonoscopies a doctor can perform – there is little incentive among providers to change how they are reimbursed for services.

There is broad acknowledgment that the business model must change. Dozens of discussions conducted by Fuld + Company consultants with executives from healthcare payer and provider organizations, indicate widespread recognition that the fee-for-service model, as well as other payment schemes such as shared savings and accountable care organizations (ACOs), are not working effectively. However, there is little consensus on what should replace the system. One health insurance industry executive stated, “we don’t know what it (the next business model) looks like, but we have to do better.”

NO RISK, NO REWARD

It’s not as if policy makers and key industry stakeholders haven’t tried to change the model. The Affordable Care Act, signed into law in March 2010, included numerous provisions that encouraged providers to focus on value instead of volume in the delivery of healthcare. According to several surveys, between 86 and 95 percent of U.S. healthcare providers are still reimbursed on a fee-for-service model despite questionable outcomes. Although the U.S. spends more per capita on healthcare than any other industrialized country we rank at or near the bottom in most measures of healthcare quality (Figure 1).

For providers of risk mitigation – the U.S. government and health insurance companies—the manner by which the industry transitions away from the fee-for-service model, and the business model that replaces it, carry major implications for the role they play and the value they provide healthcare consumers and providers. With private health insurance coverage more prevalent than government coverage – by about a two-to-one ratio – the country’s insurance companies have much at stake in influencing how to transition from a fee-for-service to a value-based payment model (Figure 2).

Figure 1: Healthcare Systems Performance Compared to Spending

Note: Healthcare spending as a percent of GDP. Spending data are from OECD for the year 2014, and exclude spending on capital formation of health care providers. Source: The Commonwealth Fund.

Figure 2: Percentage of People by Type of Health Insurance Coverage and Change From 2013 to 2016 (Population as of March of the following year)

*Military health care includes TRICARE (Civilian Health and Medical Program of the Department of Veterans Affairs), as well as care provided by the Department of Veterans Affairs and the military.

Most attempts to change the model have called for a transfer of risk from insurance companies to healthcare providers, and have advocated payment schemes that pay for quality outcomes, not services provided. However, physicians may prove to be a major obstacle to this transformation. According to a survey conducted by the Mayo Clinic and reported in the Journal of the American Medical Association, only 36 percent of practicing physicians were willing to accept “major responsibility” for reducing healthcare costs. The research conducted on behalf of our healthcare clients demonstrates, however, that the more tools physicians have to manage risk, the more likely they are to tie reimbursements to outcomes instead of services.

COMPLICATING RISK

While rising healthcare costs and business model obsolescence are at the heart of the strategic challenges facing healthcare industry participants, efforts by industry executives to optimally position their agency amid these tectonic shifts are complicated by a myriad ancillary variables and drivers.

Our scenario planning work with payer and provider organizations illustrates that:

1. Whether healthcare is chiefly an individual or societal responsibility – based on government policy, personal attitudes, and prevailing political winds – will accelerate or decelerate the underlying business model transition. Should the responsibility of managing healthcare financial risk and paying for care fall to the individual, or should it be a collective responsibility taken on by employers, the government, or other collective organizations? The answer carries significant implications for health insurers.
2. Improved and enhanced access to care through non-traditional channels such as retail facilities and technology-enabled venues like telemedicine, will impact care affordability, consumer perceptions of care quality and how care is administered.

3. Technological innovation in healthcare, in the form of advanced data analytics, improved access, and more reliable connectivity, could serve as a catalyst to dramatically accelerate or slow down the shift in risk to providers. Developments such as personalized medicine, advances in diagnostics, electronic health records interoperability, and machine learning all hold the potential to dramatically improve care outcomes and help lower cost.

THE FUTURE IS NOW

There is substantial evidence to suggest that these forces are already shaking up the alignment of industry businesses. The most obvious development is the acquisition announced in 2017 of Aetna (one of the largest U.S. health insurance providers) by pharmacy retailer and benefits manager CVS Health. As Fuld + Company noted in June 2017 – some six months before the acquisition was announced – evolving industry competitive dynamics between health insurance companies and pharmacy benefit managers make such a marriage fruitful, and the deal puts CVS Health in a prime position to benefit from value-based contracts between insurers and providers. The 2018 announcement of an acquisition by Cigna of Express Scripts is another more recent example of corporate realignment in the face of these variables.

At the same time, the trend of provider consolidation over the past several years appears to be undergoing a directional change, as the original financial rationale for this strategy has largely failed to
materialize. DaVita Medical Group, which has been on an acquisition spree, announced in 2017 plans to divest its medical group by selling it to Optum in a $4.9 billion transaction. Furthermore, the long anticipated trend of mergers between healthcare providers and payers has not come to fruition, probably because the majority of integrated delivery networks (IDNs), according to recent research, are losing money.

**STRATEGIC OPTIONS**

Ultimately, healthcare companies will be pressured to make bold moves to improve or maintain their competitive positioning, secure new sources of revenue, and avoid being marginalized by the numerous forces impacting the U.S. healthcare system. While there is certainly no single, one-size-fits-all strategy appropriate for healthcare players universally, our scenario-based strategic planning work suggests that strategies need to address several critical themes:

*Occupy the optimal position in the broad continuum of care.*

Despite their profitability, many healthcare companies are hindered by excessive bureaucracy and organizational bloat. Organizations that can improve efficiency – by both streamlining internally and positioning externally in ways most advantageous alongside partners, suppliers, and customers – will achieve improved flexibility and nimbleness that will be essential to navigating the future industry landscape, whatever it might look like.

*Exploit data assets.*

Health insurance providers in particular have a significant and largely untapped asset – data on
member health conditions and outcomes. As the pressure mounts for providers to take on more risk in the provision of care for patients, insurers can provide valuable services by applying advanced data analytics that help providers chart the best care plans and ensure optimal outcomes on which they will ultimately be paid. UnitedHealth Group’s Optum spin-off is well regarded as an innovative use of this data asset by a national health insurance provider.

Rethink customer service.
Health plans need to redefine how they view and engage with consumers. The days of providing value to health plan members, or provider patients, only after it is determined that they must receive care, are over; healthcare companies must find ways to provide value at multiple points in the customer healthcare journey – from providing a broader array of healthcare management tools and services, to brokering a wider array of healthcare transactions, to completely re-thinking care-settings and appropriate treatment algorithms.

CONCLUSION
Healthcare executives can’t afford to wait for market forces to sort themselves out. Bold action is required to enable innovative organizations to set the stage for their own success. First acknowledge that the future is unpredictable, and then strategize for a wide range of plausible future market and industry conditions. Healthcare executives can choose, and occupy, the best position for their companies amid the emerging industry structural changes and avoid obsolescence and marginalization.
ABOUT FULD + COMPANY

Fuld + Company is a global competitive strategy consultancy that helps clients anticipate competitive activity, see beyond market disruptions, and develop or refine robust business strategies. Through research, analysis, and strategic consulting we work with the Global 1000 to identify and solve tactical and strategic challenges.

With over 35 years of experience, and offices on three continents, Fuld + Company developed many of the competitive intelligence and strategic analysis techniques used today. Having completed thousands of projects, we are recognized as an organization of thought leaders by publications such as Fortune, Fast Company, The Financial Times, The Economist and Time Magazine.