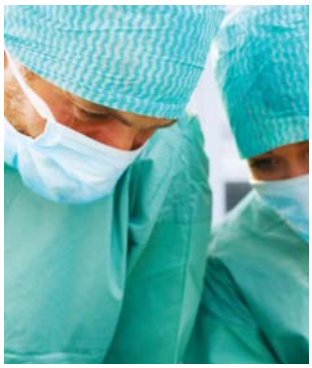
McKinsey Center for U.S. Health System Reform

Cross-currents in the health economy

Shifting economic incentives, sector responses, and remaining uncertainties



Introduction

Across the healthcare landscape, we are witnessing frenetic levels of activity. New products and business models are emerging, while some well-established players are considering reinvention. Although venture capital investment in healthcare has seen sharp declines since reaching peak levels in 2007, investment in health-related services reached $196 M in the first three quarters of 2010, the highest level in three years.[1]

Much of the movement marks an acceleration of ongoing industry trends, fuelled by the weak economy and rising healthcare costs. Some of the change however is in direct response to the Affordable Care Act.

Over the next several years, the insurance market will not only grow significantly, but will refashion itself to contend with new types of purchasers, new pricing rules, and new regulations. Employers, now responsible for providing coverage to 153 million Americans, face a complicated decision in whether to change or redesign company benefits or to discontinue offering insurance. Those that do provide benefits will have unprecedented leverage to induce healthier behaviors through premium adjustments.

As a result of health reform, 55-100 million Americans are expected to change their insurance coverage between 2010-2016 according to MPACT, the McKinsey Predictive Agent-Based Coverage Toolkit, which simulates the behavior of individuals and employers to forecast coverage levels. The number of Americans purchasing insurance directly—primarily through new state-based Exchanges— is likely to grow by 23-62 million people by 2016.[2]

Across the healthcare value chain, economic forces are leading incumbent firms and attackers to reassess their business strategies. In some cases, this is driven by a perceived opportunity to gain share and grow while in others it is driven by a need to preserve revenue, manage margins, and minimize risk.

In this issue brief, we have identified five emerging themes shaping how participants are responding:

1. Reallocating medical risk and a shift from “extracting value” to “delivering value” on the provider side;

2. Accelerating pace of vertical integration and coordination among providers;

3. Expediting the transition from “business to business” models to “business to consumer” models;

4. Intensifying productivity pressures on delivery systems;

5. Re-evaluating employer benefit strategies.

Whether these emerging themes will alter the healthcare system in a manner that contains cost inflation, improves quality and expands access depends on several factors that we take up in the second section of the paper.

1 ”PwC/NVCA MoneyTree Report based on data from Thomson Reuters
2 McKinsey Predictive Agent-based Coverage Toolkit (MPACT) v5.0

Part I: Emerging trends

Theme 1:
Reallocating medical risk and a shift from "extracting value" to "delivering value" on the provider side

The Affordable Care Act has had its most radical impact on the allocation of medical risk. For decades, health insurers focused on selecting, aggregating and pricing risk. Managing medical risk was less important for an insurer's bottom line since plans could offset additional risk by adjusting premium levels. The new law, however, places several restrictions on insurance companies that elevate the importance of medical risk management or outright reallocation. Unsurprisingly, as less and less of the medical risk in our system is truly "insurable" health plans aim to shift it to those most capable of managing it.

A major way for insurers to manage risk in the new environment is to realign incentives with the hospitals and physicians who provide care and drive costs. Historically, providers have been compensated based on the volume of services delivered. But the Affordable Care Act, following on trends initiated in the private sector, shifts payment models toward approaches designed to reward quality outcomes more than quantity. Insurers continue to develop reimbursement models that pressure providers to emulate some of the most effective approaches used by integrated delivery systems. As risk shifts, providers will likely receive financial incentives to refrain from excessive testing and treatment and to improve quality.

Moreover, the expansion of value-based payment models constitutes a paradigm shift in the relationship between health plans and providers. Rather than focusing solely on negotiating reimbursement rates, often in adversarial circumstances, health plans are now seeking to co-manage risk and identify ways of improving outcomes and productivity.

One of the first targets for insurers has been elective specialty interventions, where pricing is simpler, risk adjustment less crucial, and provider attribution clearer. In California, for example, four health plans working with several large provider groups have negotiated a bundled payment schedule for hip and knee replacements. The lump sum is expected to cover most aspects of treatment from initial work-up to surgery through 90 days of recovery.

Another example is a medical home pilot done in partnership with a regional health plan in New York that reimburses primary care providers under a risk-adjusted capitated model. The pilot encompasses 3 practices and 10,000 lives. Preliminary results utilizing a difference-in-difference methodology applied to the entire population (rather than episode based) show that admissions are down 24% from expected levels while ED visits are down 9% and imaging is down 18%.[3] As a result, the health plan saves on average about 12% on claims expenses.[4]

Because the trend toward new value-based payment models makes hospitals and doctors more cost conscious, they are likely in turn to direct patients toward more affordable medications and medical devices. Depending on how the incentives are designed, they may also direct patients towards

3 Difference-in-difference measures the delta between intervention and control groups. If costs in the control group grew 20%, and costs in the intervention group grew 5%, the difference-in-difference would be a 15% savings
4 Verisk

products that create greater long term value as well. In response, drug and device makers are re-evaluating their role in controlling costs, in some cases boosting investment in adherence programs, generic products, and most fundamentally, contemplating new commercial, or go-to-market, and research and development strategies.

Historically, financial success has come in developing drugs and devices with relatively lower R&D costs and a higher likelihood of regulatory approval – even if the resulting product was only incrementally different from one already on the market. Future R&D investments may include more higher-risk products with greater potential for relatively better quality, value advantages, or cost savings in response to a provider marketplace that is more value conscious.

While pharmaceutical companies have been dealing with this market shift over the past few years with increasingly aggressive payer and provider drug management approaches, it is likely to accelerate – requiring even more aggressive and bolder actions to respond. For medical device companies, this shift is perhaps more profound – requiring more radical shifts in traditional go-to-market and R&D approaches that focus on relative product value .

One of the largest pharmaceutical companies globally for example, is moving aggressively into medical management. The company announced in late 2010 that it was shifting from simple "transactional" sales generated largely by marketing efforts and physician detailing, toward a more sophisticated "outcome-based approach" that requires closer relationships with plans and hospitals to drive adherence and avoid complications.

In response to a more price sensitive marketplace in the future, pharmaceutical companies are also marketing cheaper versions of proven molecules. In 2010 alone, originator drug makers struck deals amounting to more than $5B to acquire generic molecules and biologics, double the investment made in 2009.

Theme 2:
Accelerating pace of vertical integration and coordination among providers

While measures in the Affordable Care Act have pressured insurance plans to swiftly alter their business models, hospitals and physicians are also beginning to define their post-reform strategies. To effectively manage the additional risk inherent in value-based reimbursement models and to avail themselves of a new Medicare shared-savings program, hospitals and physicians are strengthening their coordination. Increased coordination will take a variety of forms depending on which payment schemes gain acceptance. Some physicians and hospitals will consolidate into larger groups in order to develop better management, operational, and analytical skills. Some physicians may go to work directly for hospitals. While others will look to partner with hospitals, other physicians, and providers spanning the care continuum, such as home health, post-acute care and diagnostic imaging to develop networks that have the potential to deliver on quality gains and cost reduction.

Payment schemes designed to reduce unnecessary readmissions or that put hospitals at financial risk for undertaking extraneous treatment require active engagement with physicians and alignment of financial incentives. Hospitals are therefore stepping-up their efforts to employ doctors. A recent survey found that the share of hospitals employing physicians jumped to 55% in 2009, up from 30% in 2004.[5] Unlike the wave of physician employment in the 1990s, hospitals are making a concerted effort to recruit specialists in addition to primary care physicians.

More vertical integration is expected in light of a new Medicare reimbursement plan directed at Accountable Care Organizations (ACOs), entities that agree to take on responsibility for the quality,

5 Medical Group Management Association. *2009 Physician Placement Starting Salary Survey: 2010 Report Based on 2009 Data.* Rep. Print.

cost and overall care of a patient population. Still in the conceptual phase, the organizations will take many shapes - physician groups, hospital-physician partnerships or physician employing hospitals – but each will include the active participation and management of physicians.

In some respects, the consolidation mode is "back to the future." During the 1990s - the last time the nation attempted to rein in skyrocketing medical spending – hospitals sought to employ doctors in order to lock in profitable referrals and reduce the misaligned incentives of the traditional fee-for-service business. These approaches largely failed as hospitals were unable to manage practices effectively and recoup their investments.

One challenge likely to slow vertical integration is debate over how to equitably share savings. Hospitals, primary care physicians, and proceduralists will naturally argue that their efforts were responsible for the improved care and thus entitle them to a portion of the anticipated savings. To achieve savings, providers will need to work closely with networks to manage costs and complications while also engaging far more effectively with patients to increase drug adherence and preventive care. Since savings come from decreased utilization, capturing this value for hospitals will also require new capital investments, elimination of excess capacity and a reduction in fixed costs.

The impact of greater integration on prices, however, is far from certain. While tighter collaboration is needed to reduce excess cost, provider organizations may seek to leverage their structural advantage in negotiating higher reimbursement levels.

The accelerating pace of provider integration will also trigger further changes in the go-to-market approaches of drug and device companies – requiring more sophisticated segmentation and sales approaches.

Theme 3:
Expediting the transition from "business to business" models to "business to consumer" models

The Affordable Care Act served as a moment of "punctuated evolution" with respect to the role of the consumer in making healthcare purchasing decisions. By imposing an individual mandate and introducing state Exchanges and federal subsidies, the number of individuals purchasing insurance directly will grow between 24 million and 39 million people by 2016.[6] The market could expand even further if a large number of employers discontinue coverage. Regardless, the individual market is destined to become too big to ignore. What have traditionally been complicated negotiations involving brokers or human resource departments are moving toward web-based transactions done by non-expert consumers.

For insurance companies, the growth in the individual market poses significant challenges in product design, marketing, and customer retention. Just as the cable television and mobile phone industries have adapted to ever-discerning customers, so too must health plans devise new ways to attract and retain an entire new class of clientele. Exchanges could facilitate shopping for some consumers making churn an added challenge for plans.

One approach that continues to rise in popularity is the use of consumer-oriented wellness programs. In 2010, one large plan announced a partnership with Weight Watchers and the Alliance for a Healthier Generation to help participants lose weight. By offering consumers programs they already value, insurers hope to achieve the dual goals of improving health and instilling customer loyalty.

6 MPACT v5.0

As part of the move from B2B to B2C, plans are embracing technology. Through the Internet, mobile applications and even social media, insurers see the potential for reaching new customers and directing existing clients to programs that promote healthier behavior.

The next step in this evolution centers on more sophisticated efforts to customize insurance products, including the creation of new types of "supplemental" coverage. Akin to the Apple "app" model that allows consumers to personalize a computer or mobile phone with different features and functionality, insurers are trying to devise products that have the merit of increasing customer loyalty, result in positive margins and appeal to attractive segments. Insurers are expanding marketing efforts of separate plans for long-term disability, off-the-job accidents and critical illnesses such as cancer. Borrowing from their peers in the personal and commercial insurance market, health plans are also considering strategic elimination of deductibles.

The Affordable Care Act has also altered consumer buying factors for health insurance. Traditionally salient factors, such as breadth of network and coverage levels will diminish in importance. Consumers are likely to make decisions based on premium subsidies and cost sharing parameters, which will likely guide them toward lower cost silver and gold products on any exchange.

The growing importance of the consumer as decision-maker will also prompt drug and device companies to develop novel cost-effective consumer engagement models and could foster changes in patient assistance/safety net programs.

Theme 4:
Intensifying productivity pressures on the delivery systems

As a result of a major Medicaid expansion, the introduction of individual and employer mandates and purchasing subsidies, the Affordable Care Act is expected to increase the number of insured lives by as many as 24 million people.[7] However, it is uncertain if the total new dollars entering the system will permit reimbursement levels per procedure on average to match those experienced today. Thus, to meet the growing demand for medical services and to maintain profitability, hospitals and physicians must improve productivity.

Hospital systems with centralized corporate centers already have demonstrated improved productivity. Larger systems are better able to make investments in procurement processes, revenue cycle management, and IT systems that measure and monitor performance. A recent analysis by Citigroup found that hospital systems with more than $5 B in revenue enjoyed, on average, operating margins of 3.8% nearly 2.2 percentage points higher than hospitals with less than $1 B in revenue. Faced with a greater share of Medicaid patients and reduced Medicare payment growth, small hospitals will in many cases face considerable margin pressure.

In light of the American Recovery and Investment Act, which makes $22 B available to hospitals and physicians to adopt electronic health records, and the shifting of medical risk put in play by the Affordable Care Act, innovation in software to improve productivity in the healthcare sector is progressing at a rapid pace.

Providers will also consider how to expand the role of lower-cost physician substitutes, such as physician assistants and nurse practitioners – to the extent state law allows. Even before enactment

7 MPACT v5.0

of the law, studies projected a shortage of about 76,000 primary care and specialist physicians by 2020.[8] The expansion of insurance coverage naturally exacerbates this as millions of newly-insured seek services. At the same time, the number of physician assistants and nurse practitioners has grown by 5% per annum over the last 5 years, whereas the number of physicians has grown by 2% per annum over the same period.[9] Retail clinics, which rely predominately on physician substitutes, have grown tremendously, from 35 in 2003 to 1,360 in 2009.[10]

A more intense productivity focus on the part of hospitals and other providers may also trigger further changes in the pricing paradigms of medical device and pharmaceutical companies, such as novel risk-sharing arrangements and product/service bundling that address providers' productivity objectives.

Theme 5:
Re-evaluating employer benefit strategies

As much as the Affordable Care Act was intended to overhaul the nation's healthcare industry, its impact is being felt well beyond the medical sector. The law sets in motion the most far-reaching change in the value and nature of employer-provided health benefits in a generation. It introduces new requirements of employers, but more importantly provides significant opportunities for businesses to completely rethink benefits strategies.

Beginning in 2014, all companies with more than 50 employees must provide health insurance for workers or pay a penalty. Their decisions will rest on a complicated mix of direct economic and non-economic factors.

Not only must employers decide whether to offer insurance, but also who will pay for it, where it will be purchased, what it will cover, and how aggressively to promote healthier lifestyles. In addition to extracting efficiency from industry players, the reform also takes aim at consumer behavior. Employers, for example, will be able to vary premiums up to 30% to compel employee participation in wellness programs. These programs seek to shift utilization away from high-cost treatments to lower-cost prevention efforts. Moreover, these fundamental decisions could have vast—and largely unknown—consequences on employee coverage, recruitment and retention, corporate profitability and competitiveness and the success or failure of some health-related companies.

Many employers already have begun changing benefit policies in anticipation of provisions in the law that provide tax credits to small businesses and give all companies unprecedented authority to incentivize healthy behaviors through premium adjustments. Some companies are literally getting into the business of primary care, while others are considering whether the creation of new state-based purchasing Exchanges is reason to either remove themselves entirely from healthcare or shift towards a model of defined contribution.

Even at this early juncture, there are a wide range of responses from industry. For example, a large financial services institution has opted to continue offering health coverage in part because it is valued by employees. On the other hand, several employers in retail and other low-wage industries are considering making major benefit changes.

8 Association of American Medical Colleges
9 Bureau of Labor Statistics
10 Kalorama Information

Part II: Conditions affecting impact of the law

The extent to which these themes result in the goals of expanding access, improving quality and bending the cost curve depends on several conditions being met:

– **Consolidation/integration of providers does not lead to higher prices as a result of greater market power.** The law accelerates consolidation and integration by establishing shared-savings and value-based reimbursement models. Increased market power, however, could lead to higher prices. A report by the Robert Wood Johnson Foundation found that the consolidation wave of the 1990s gave hospitals significant leverage when negotiating reimbursement rates. Hospital mergers raised inpatient prices by at least 5% and up to 40% when merging hospitals were closely located.[11]

– **Linking prices to real benefits to ensure payment reflects underlying value.** Traditionally, government and commercial plans have based reimbursement levels on input costs. Value-based payment constitutes a momentous shift and could face significant implementation challenges. These challenges include simple cost accounting and provider inertia to the availability of technology and software that support such models. More generally, the system requires a better measure of "value" so consumers can discern whether prices are appropriate. This change could be driven by altering the unit of service, from specific procedures to outcomes, such as "achieving baseline level of functioning after a surgery."

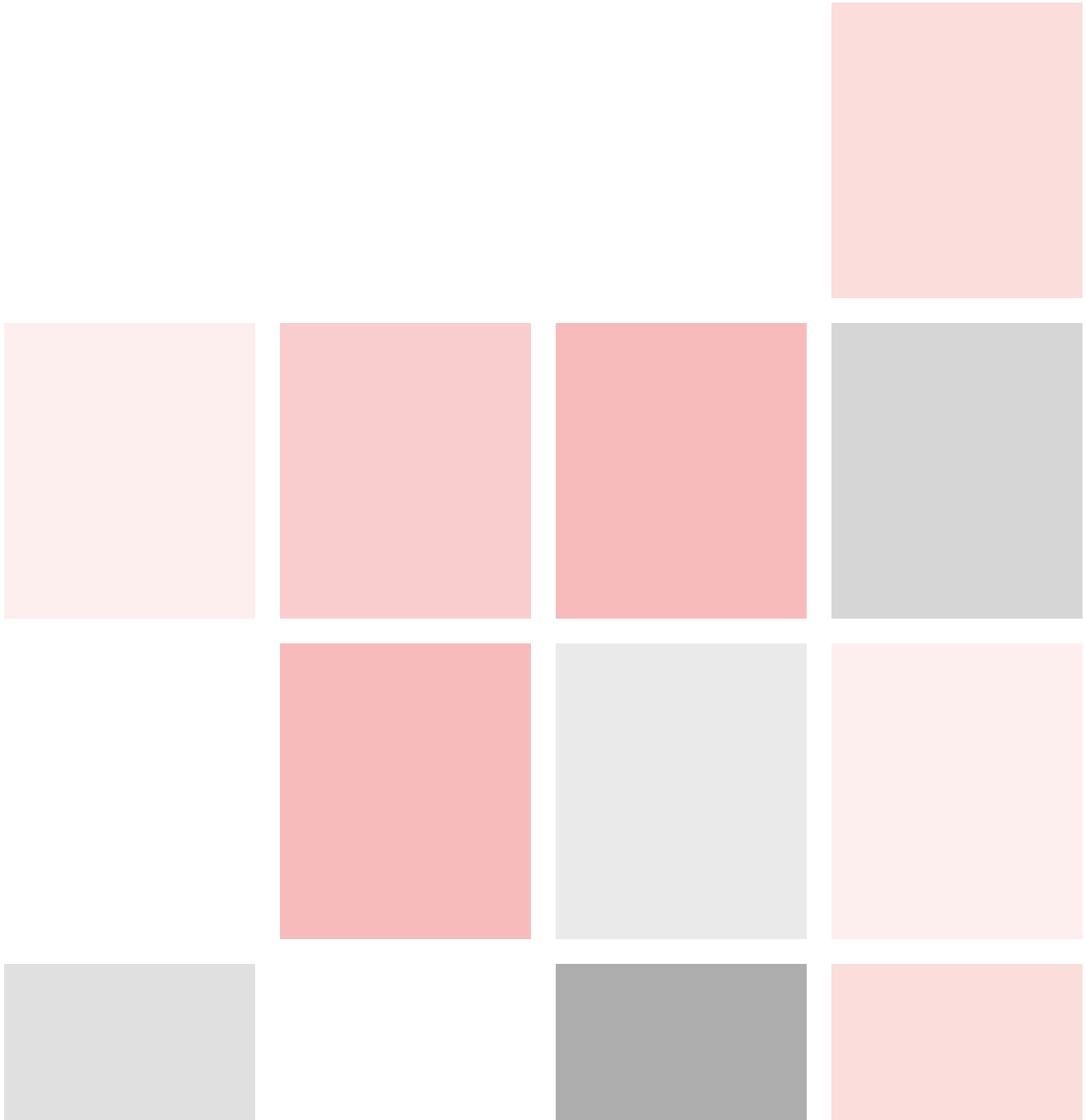
– **The speed and completeness of shifting away from fee-for-service payment to create strong and coherent incentives for providers to adapt their business models.** Sustainable change in the provider delivery model depends upon clear direction from insurers on reimbursement strategy. The challenge is well illustrated by the experience of hospitals that have tried more coordinated care for complex patients. Several health systems have successfully redesigned care pathways for back pain and premature deliveries that improved quality and reduced cost. But the hospitals suffered from a margin perspective. As a result, the system today has insufficient incentives to redesign care to be more productive. Payments must be better aligned for providers to invest in proper care redesign. This standardization could be driven by Medicare joining forces with private plans, by large employers banding together to define a common standard, or by large health systems demanding similar reimbursement models.

– **Well functioning insurance markets.** Consumer adherence to the individual mandate coupled with effective risk adjustment to avoid adverse selection is necessary to establish a well functioning insurance market. Whether the penalty imposed on those who do not carry health insurance will be sufficient to engender compliance has been widely debated. Economists project that the average fine nationally will be $674 in the first year, which is roughly $5,000 less than the average annual insurance premium.[12] In Massachusetts, however, compliance has been very high with an average penalty of $537.[13]

11 Vogt, William B., and Robert Town. "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?" *Robert Wood Johnson Synthesis Project 9* (2006). Print.
12 "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." CBO.
13 Frakt, Austin. "Individual Mandate Penalties Are Adequate." The Incidental Economist. 29 Mar. 2010. Web. 01 Mar. 2011. <http://theincidentaleconomist.com/wordpress/individual-mandate-penalties-are-not-too-low>.

Without strict adherence to the individual mandate and effective risk adjustment, the Exchanges may suffer from adverse selection, leading to higher premiums that further exacerbate the compliance problem.

– Liberation of high quality and timely data to enable providers to manage risk and consumers to exercise value conscious shopping and consumption. The lifeblood of a healthcare delivery system based on value is timely, accurate, comprehensive data. Fast, free-flowing, high quality data is critical at four junctures: i) in the design of value-based payment models, ii) in supporting clinical decisions iii) in ensuring money flows to high-value services, and iv) in helping consumers effectively shop for care, manage out-of-pocket cost and assist in the management of specific conditions. Several barriers, however, stand in the way of healthcare data liquidity, including lack of standardization, attribution, privacy, and in some cases court decisions.



Conclusion

The net economic effects of the Affordable Care Act will depend largely on how the themes and conditions outlined above play out. Moreover, several residual uncertainties will affect the extent to which the reform achieves its intended consequences. For example, the design of state Exchanges will impact the efficiency of the insurance market. Employer reactions will dictate how individuals attain coverage and the level of coverage they have as well as the fiscal impact of the law. Changing consumer incentives will affect how patients seek care. Pending political and constitutional challenges may lead to changes in the law itself or the implementation trajectory.

On February 2, 2011, the McKinsey Center for U.S. Health System Reform held a conversation with six leaders from across the healthcare system to discuss these themes and illuminate the practical changes and challenges currently affecting their sector. Participants included David Beier, Senior VP of Global Government and Corporate Affairs at Amgen; Susan Dentzer, Editor of Health Affairs; Dr. Mark McClellan, Director of the Engleberg Center on Health Reform at the Brookings Institute; Rick Norling, former President and CEO of Premier; Dr. Lewis Sandy, Senior Vice President of Clinical Advancement at UnitedHealth; and Linda Schwimmer, Director of Strategic Relationships and External Affairs at Horizon Healthcare Innovations.

Following are highlights from that conversation and six views on how the U.S. health system will evolve.

Panel participants

David Beier is senior vice president of Global Government and Corporate Affairs for Amgen. Among other things, he is responsible for driving health economics and outcomes research; shaping Amgen's policy on global health care issues; and managing relationships with United States federal and state agencies and legislatures. Mr. Beier previously served as Chief Domestic Policy Advisor to Vice President Al Gore.

Susan Dentzer is the editor-in-chief of Health Affairs, the nation's leading peer reviewed journal focused on the intersection of health, health care and health policy in the United States and internationally. Ms. Dentzer is an on-air analyst on health issues with the PBS NewsHour, and a frequent guest and commentator on National Public Radio. Ms. Dentzer is also an elected member of the Institute of Medicine and the Council on Foreign Relations.

Mark McClellan, M.D., Ph.D., is the director of the Engelberg Center for Health Care Reform at the Brookings Institute, which studies ways to provide practical solutions for access, quality and financing challenges facing the U.S. health care system. Dr. McClellan was the former administrator for the Centers for Medicare and Medicaid Services (2004-2006), the commissioner of the Food and Drug Administration (2002-2004), and served on President's Council of Economic Advisers at the White House (2001-2002).

Rick Norling is a Senior Fellow at the Institute for Healthcare Improvement. From 1997-2009, he served as president and CEO of Premier Inc, the largest healthcare alliance in the United States. Prior to joining Premier, Mr. Norling was president and CEO of Fairview Hospital and Healthcare System.

Lewis G. Sandy, M.D., is Senior Vice President, Clinical Advancement, UnitedHealth Group. He leads efforts to promote efficient and effective health care, provide tools and information to doctors and patients to promote health, and foster the growth of evidence-based medicine.

Linda Schwimmer serves as Director of Strategic Relationships and External Affairs at Horizon Health Innovations, a subsidiary of Horizon BlueCross BlueShield of New Jersey. Previously, Ms. Schwimmer served as Director of Legislation and Policy for the New Jersey Department of Banking and Insurance.

Interview excerpts

What are the biggest opportunities that we now see in the healthcare world?

Lewis Sandy
There is an unfreezing that's going on - a recognition that existing business models across the sector are collapsing. I think the general view even before the Affordable Care Act was that the model from the payer side was not sustainable because of rising healthcare costs, so there's a tremendous opportunity across the sector for an unfreezing. I think the critical element of the new opportunity relates to a transition from paying for volume to value and a path towards improved delivery systems.

Rick Norling
I think Affordable Care Organizations, which are supported in the new law, present a really interesting opportunity. ACOs are emblematic of a deep interest in population health, a sense of let's look at not just episodes of care, but let's look at populations and let's think about what a health system might do. To deliver population health, the sites of care and even the levels of care within sites of care all are handoffs from one to another, and that's where errors, complications, and waste reside.

Linda Schwimmer
I think that the greatest opportunity at this point in time is building new and different relationships with the payer community, the employer community, and I think soon the consumer community. Horizon, whether or not the ACA was enacted, saw that the status quo – a somewhat combative relationship between providers and payers - was unsustainable. The business model had become like the whack-a-mole game you see in arcades. If we designed a plan that limits out-of-network surgery centers to $1,000 a year, we'd expect the providers react defensively with their own measures. Controlling costs was a process of gamesmanship, not partnership.

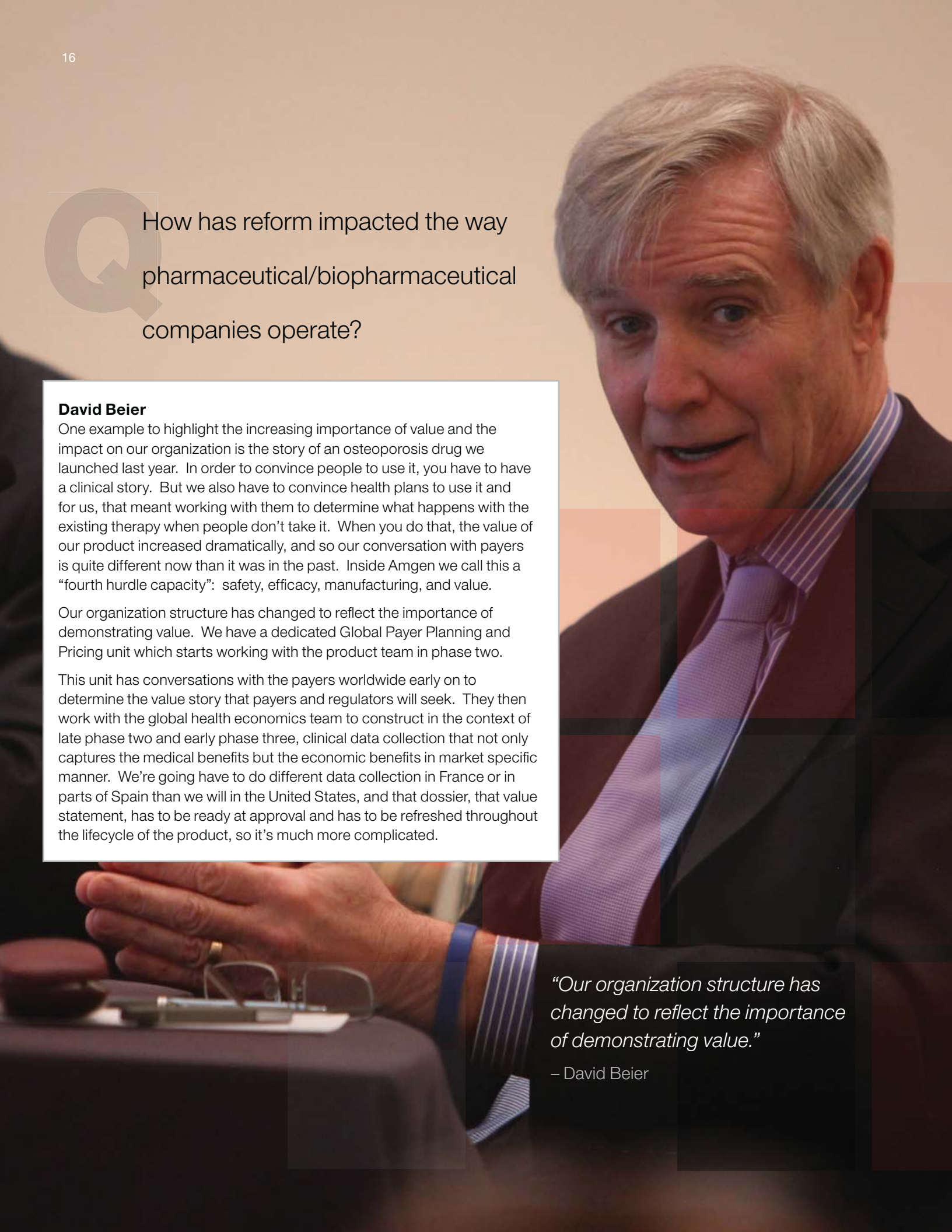
David Beier
If you were to ask anybody from the biopharmaceutical sector, the biggest opportunities are outside the United States. The growth in China, India, Russia, Turkey, South Korea, Mexico, and Brazil exceed the growth possibilities of the United States. You have to think of our industry as much more global than frankly the insurance industry, so that's probably the number one opportunity. Inside the United States, there is a movement towards higher-value products.

Do you anticipate any business models will altogether disappear?

Lewis Sandy
Because of the new regulatory approach and the Affordable Care Act, the idea that you could run your business predominantly through risk selection is, I think, a model that is going away and probably ought to go away. It's not been a major issue in our organization but across the payer sector. For certain players, it was a major part of their game, and I think that it will disappear.

Q Is the expansion of health insurance coverage up to 24 million Americans over the next several years a blessing or a curse?

Mark McClellan
It adds additional pressure and additional opportunity for reforming the way that the money flows and supporting the kinds of innovations in care delivery that we've been talking about. But if that doesn't really happen quickly, it is going to create additional pressure for squeezing down prices and restricting access perhaps forcing a lot of the relatively healthy middle class and above out of the same delivery system.



Q How has reform impacted the way pharmaceutical/biopharmaceutical companies operate?

David Beier
One example to highlight the increasing importance of value and the impact on our organization is the story of an osteoporosis drug we launched last year. In order to convince people to use it, you have to have a clinical story. But we also have to convince health plans to use it and for us, that meant working with them to determine what happens with the existing therapy when people don't take it. When you do that, the value of our product increased dramatically, and so our conversation with payers is quite different now than it was in the past. Inside Amgen we call this a "fourth hurdle capacity": safety, efficacy, manufacturing, and value.

Our organization structure has changed to reflect the importance of demonstrating value. We have a dedicated Global Payer Planning and Pricing unit which starts working with the product team in phase two.

This unit has conversations with the payers worldwide early on to determine the value story that payers and regulators will seek. They then work with the global health economics team to construct in the context of late phase two and early phase three, clinical data collection that not only captures the medical benefits but the economic benefits in market specific manner. We're going have to do different data collection in France or in parts of Spain than we will in the United States, and that dossier, that value statement, has to be ready at approval and has to be refreshed throughout the lifecycle of the product, so it's much more complicated.

"Our organization structure has changed to reflect the importance of demonstrating value."

– David Beier

Many of you have emphasized increased care coordination as a new opportunity, but how is this different from the 1990s?

Susan Dentzer
Although there are a lot of similarities with the 1990s, there are also very important differences. The population health focus was never a prominent feature of the discussion around managed care. Process improvement as applied to the health sector is also fairly new since that era, which has been driven in turn by the availability of data and analytics that have shown us that cost reduction and quality improvement are possible at the same time. We also have a younger generation of people in medical schools and who are used to the idea that they will be employed in organized care systems, who are angry when they have to go to hospitals that don't have HIT, and who don't have a dream of hanging up a shingle in one- or two-person practices. Then you have patients. The way that younger people are going to want to engage healthcare providers in the future is going to be different from the current model. This whole notion of in-person visits as the chief or only way to access health care is going to go the way of the dodo.

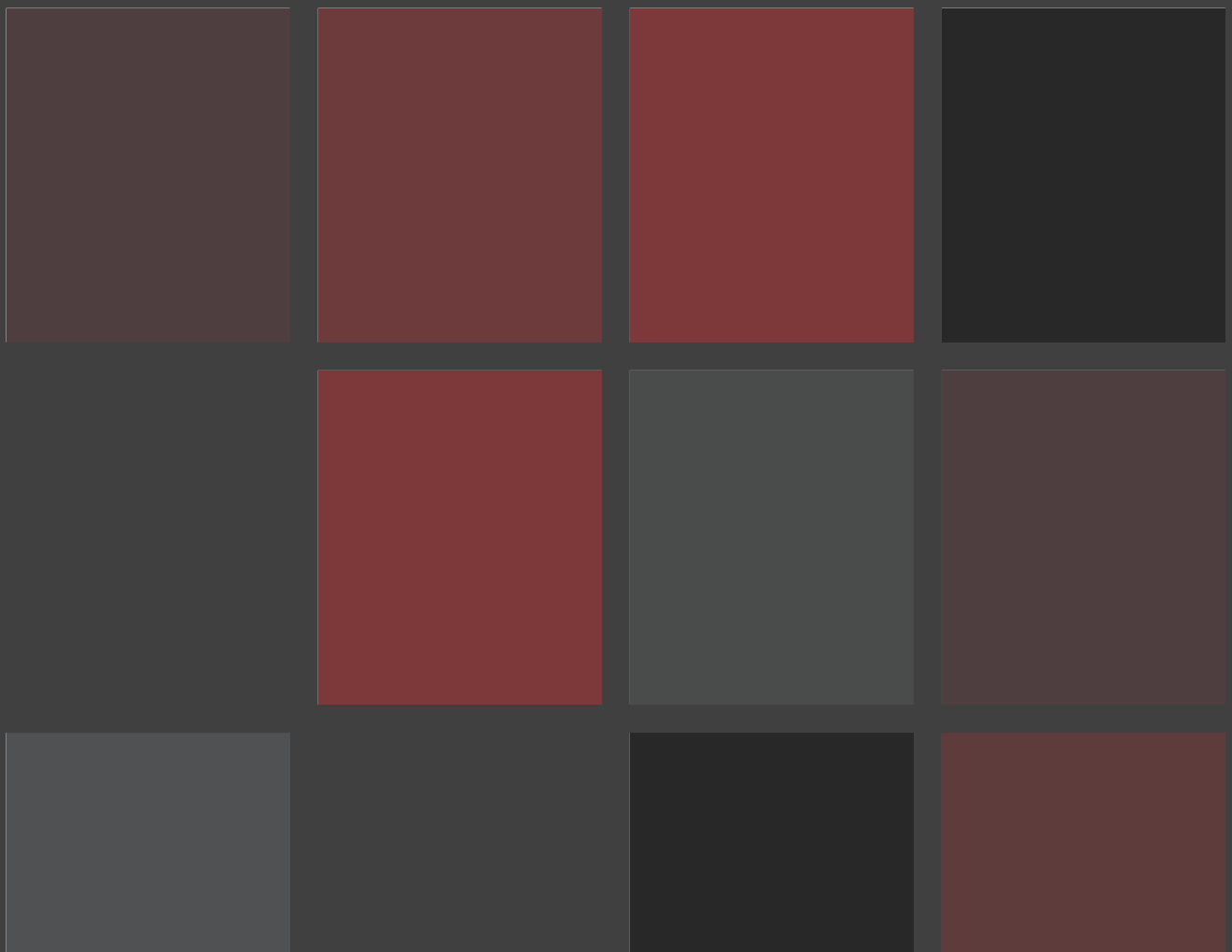
What concrete actions are health plans taking to develop a more collaborative relationship with stakeholders across the system?

Linda Schwimmer
We needed new ideas and new capabilities to alter the relationship between insurance companies and other stakeholders. Horizon decided to set up a new subsidiary, 50 percent of which is staffed with employees from outside the company who would be bringing in new ideas, new experiences, and new perspectives. About a third of our staff is informatics because back and forth exchange of information is key to the success of the different reimbursement models we're working on. Our new capabilities will allow us to share in nearly real-time pre-scrubbed claims information.

We're also designing our payment models in close collaboration with physicians and providers. We're actually talking to them about what grouper or technology they would prefer to use. We're also able to identify information they are lacking. We have discovered that they don't really have visibility on why hospitals one mile apart have such different readmission rates or length of stay.

“The underpinning of all of this is culture and the availability of actionable data. Culture is inherently behavioral and the best vehicle you have to change culture are values. Organizations need to get very explicit about how its people are going to conduct themselves.”

– Rick Norling

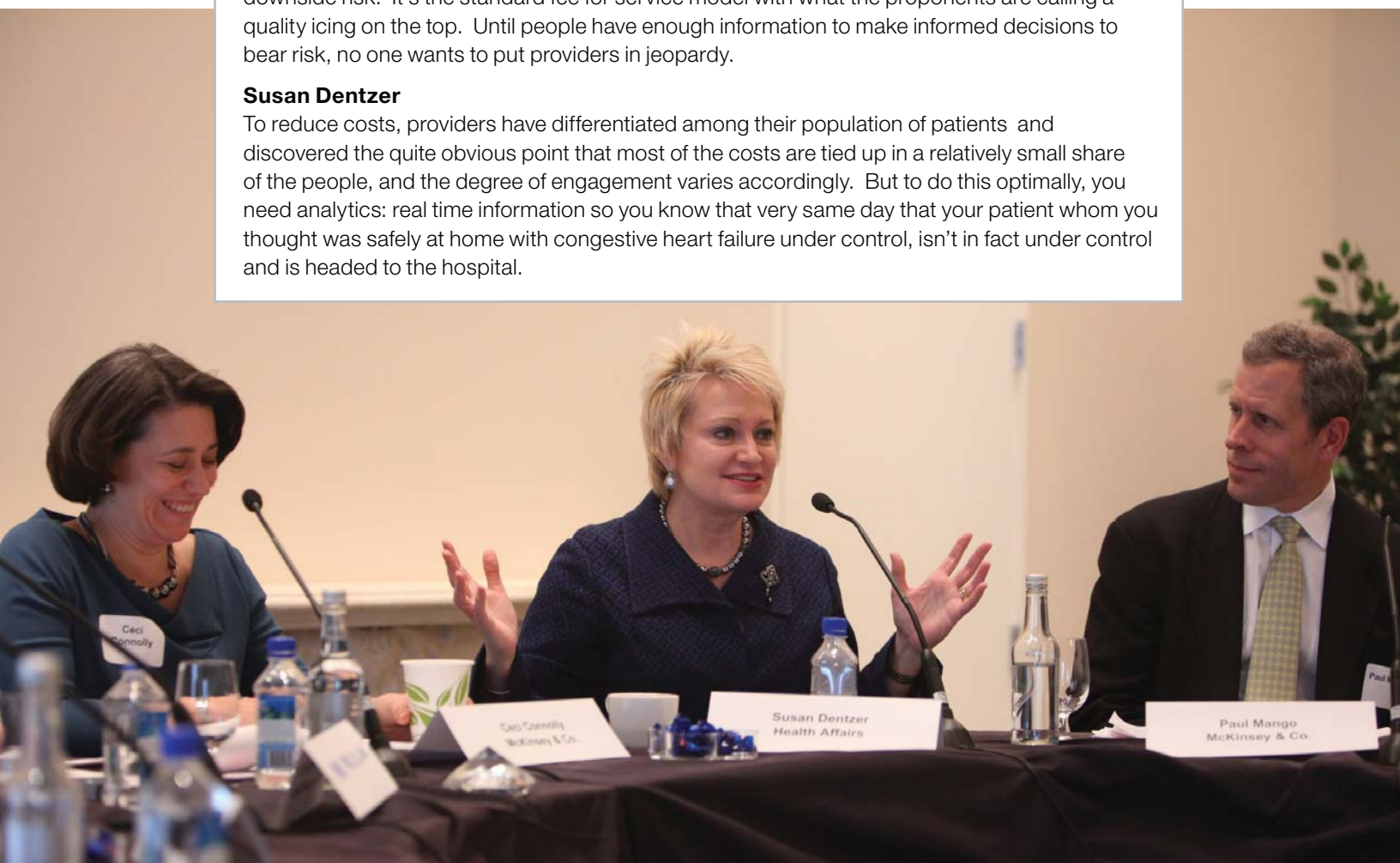


What are the barriers to shifting medical risk onto providers who, to a large degree, control utilization and care patterns?

Rick Norling
Hospital systems will need to focus on improvement opportunities across the continuum of care. Doing so is complex, as it requires coordination between organizations with different strategies, values, people, sophistication. The underpinning of all of this is culture and the availability of actionable data. Culture is inherently behavioral and the best vehicle you have to change culture are values. Organizations need to get very explicit about how its people are going to conduct themselves. Of course, culture needs to be reinforced by economic incentives, but it's critical to tackle culture in an explicit way. The ability to have useful data that both allows you to understand your gaps, track your progress, benchmark and compare yourself against others is also really important.

Linda Schwimmer
One of the problems is that providers don't have a lot of the required data to take on risk. The government has it's own concerns in light of this data gap. Regulators and politicians are weary of seeing doctor's offices close, particularly the primary care. New Jersey, for example, has organized delivery system regulations, which require providers to demonstrate a financial ability to bear risk. So right now, we're only seeing models where this is only upside potential but no downside risk. It's the standard fee for service model with what the proponents are calling a quality icing on the top. Until people have enough information to make informed decisions to bear risk, no one wants to put providers in jeopardy.

Susan Dentzer
To reduce costs, providers have differentiated among their population of patients and discovered the quite obvious point that most of the costs are tied up in a relatively small share of the people, and the degree of engagement varies accordingly. But to do this optimally, you need analytics: real time information so you know that very same day that your patient whom you thought was safely at home with congestive heart failure under control, isn't in fact under control and is headed to the hospital.



“Right now, we’re only seeing models where this is only upside potential but no downside risk. It’s the standard fee for service model with what the proponents are calling a quality icing on the top.”

– Linda Schwimmer

How are health plans helping providers prepare for new risk-based payment models?

Linda Schwimmer
Studies that have examined the failures of patient centered medical homes point to limited economic support as a cause. It is really hard for somebody to transform their practice when they're just trying to pay the bills and keep the lights on. So we helping by embedding population care coordinators. These nurses are Horizon employees, but they will be located in the physicians' practices. They're going to help with all of the patients but focus on the ones with chronic care needs. We also engage transformation coaches to first assess the practices and their needs and then to work with them to transform their practice into more of a team approach.

Given that physical integration requires dramatic changes in the way physicians and hospitals operate, do you expect to see virtual integration as a middle ground?

Rick Norling
I think so and hope so. You can't wave a magic wand and say, "We need more Geisingers," because it isn't going to happen and so the question is are there opportunities for smaller practices to get together and have some of the functional components to optimize care? I think the answer is yes and we're starting to see that. You see physicians saying, "I need to seek shelter at the local hospital. I'm selling my practice." Other physicians are saying, "I actually think if I can work with a network of superior colleagues in my local marketplace, I can pull something together that will be responsive to patient needs, address overuse and underuse, faster, better, quicker, than the lumbering large systems that I have around me and have a new business model out of that."

How painful will this transformation be on the healthcare industry, and what can we learn from other industries that have gone through a similar change?

Mark McClellan
Healthcare is going to be the biggest growth industry of the next decade no matter what. There will be significant changes for people employed in the healthcare sector now, particularly in hospitals. The question is, how fast is it going to occur. There are a lot of political and regulatory barriers that could slow down any disruption. As a result of the focus towards value, people who used to be employed as nurses or staff in a hospital moving to other parts of the healthcare industry, homes and elsewhere, and probably some new skill sets coming in from people who have a lot more of an IT background.

How will the US respond to the fiscal pressure of rising healthcare costs?

Susan Dentzer
The US is either going to go completely over a fiscal cliff over healthcare, or we're going be called to our senses and avert disaster. If it's the latter, we're ultimately going to have to do something that is pretty close to budgeting. We're going to have to decide how much we will spend on healthcare and not exceed that limit. We are unlikely to do this at a national level, since that would be way too dirigiste for our American sensibilities. Instead, I suspect we will move to embrace strategies such as a defined contribution approach in Medicare. Employers are increasingly doing the equivalent of this in their support for employees' health care. And that's not that bad if you want to pull yourself back from fiscal ruin, to take that as an approach. Assuming that a defined contribution approach is paired with capitated payments to health care systems, that automatically gets you out of the administered pricing role in Medicare. Then we let the market decide what "prices" of individual procedures and the like are going to be, and basically we put the onus on systems to lower costs and give people more for their money, since the resources the systems have to operate with are inherently limited.

What are the most significant uncertainties that remain?

David Beier
The Patient Centered Outcomes Research and the Independent Payment Advisory Board are hugely controversial in terms of containing healthcare costs. It has been said by some that IPAB is the only thing in the law that will contain healthcare costs, but the panel does not affect hospitals until 2019 and politics effectively exempts doctors. All the costs are out of the remaining segments in a random, unfair way. The biggest failing of the healthcare law is no rational, politically viable, sustainable method of evaluating changes to the rate of increase in healthcare spending. Instead, the law relies on a series of random political decisions in order to fund, using CBO methodology, a bill to fit within a box of a trillion dollars, and that makes it not likely to continue for a long period of time in a sustainable way.

Lewis Sandy
I think the Affordable Care Act creates an infrastructure that is permissive of HHS to become a much more prudent purchaser, an active purchaser on behalf of Medicare beneficiaries. I think the open question is to what extent will they actually do that, can they do that, dealing with the political dynamics that they must deal with and/or whether or not that crisis forces the country to deal with it.

Rick Norling
States face somewhere around $110 billion dollars of deficits and healthcare constitutes around 20 percent of spending, far more than higher education. I would not expect a coordinated federal response to the budget crises that will happen in the individual states, so each of the states will engage in experiments about how to constrain eligibility payment systems. How states respond will likely have the greatest effect on hospitals, perhaps even greater than all other aspects of health reform.

How is the relationship between employers, employees, and insurance plans changing?

Lewis Sandy
We're seeing, mainly among large employers, an ongoing interest in helping their workforce and dependents make more informed choices, and an evolving movement towards consumer activation and empowerment and a tremendous amount of interest in continuing to accelerate the whole field of performance assessment – with transparency being one element of that.

David Beier
My general sense is that employers are moving from negative sanctions to behavioral economics that nudge people into making the right choice about wellness. Employers have a better incentive in their employees than insurers do because insurers with churn don't keep people long enough to get the rewards of a wellness program, whereas the employer is likely to.

Linda Schwimmer
Two of our models, the patients in our medical home and the accountable care organization, are in partnership with self-funded plans [large employers]. We're doing all the heavy lifting with the providers and we're paying for the transformation coaches and administrative costs, but the employers are partners in these ventures. They are responsible for the medical costs, including the population care coordinators that are embedded in the practice and some of the performance payments as well as the ongoing per member per month payment, so it's a joint venture in a sense.

What about the uncertainty raised by constitutional challenges to the individual mandate? What will happen if the Supreme Court strikes down the mandate?

Mark McClellan
People will get very creative on ways to create future costs for not buying coverage. Even if the mandate isn't overturned, I have very limited faith that we're going to follow through on truly enforcing it. If you want a competitive health insurance market that works, you must find a better way to deal with risk selection. Whether it is risk adjustment or penalties for enrolling late or not allowing people to buy up coverage later, there has to be a version of individual responsibility that can get bipartisan support that will be a more viable alternative. Whatever the Supreme Court does is not going to end up being a solution to the health insurance market problems that our country is facing.

Do you expect to see tort reform enacted and what impact would it have on cost containment?

Mark McClellan
I would love to see liability reform. It's a drag on our healthcare system. It's a static and dynamic inefficiency in economic terms. But I don't see it happening in the next few years. In the meantime, I see a lot of missed opportunities for real physician leadership to improve the healthcare system. If you talk to any physician in any specialty right now they can give you ten ways off the top of their heads to save money and improve outcomes for their patients, yet they're not doing anything really to lead changes. It's not the top priority for their lobbying.

Susan Dentzer
If you could marry a system where you gave physicians immunity from lawsuits if they were following effectiveness guidelines or evidence-based guidelines, then you might reach an agreement. I think the Administration would like to tie such an approach to increasing patient safety, a subject that CMS administrator Donald Berwick has said his department is making a major push on.

What will the U.S. healthcare system look like ten years from now?

Mark McClellan
I think we're going to make significant efficiency gains. We'll have more confidence that we're spending the money better, we'll see some progress towards more integrated care, we'll see more involvement of families and individuals in making decisions, using web-based or iPad-based tools, and a lot more care delivered in the home and in settings away from traditional places of getting care. But it's not going to happen as fast as I think a lot of the futurists think, it will not be easier, and it's definitely not going to be cheaper.

Lewis Sandy
In ten years, we had better figure out how to address the issues of the aging population. Otherwise we will bankrupt the country. As Churchill said, we'll ultimately do the right thing after having exhausted all the possibilities, but I think we will have a different set of care configurations particularly for that population. I can envision unique kinds of benefit plans and clinical programs for the chronically ill in that population. If we don't, we'll be in trouble.

David Beier
Not much change.

Rick Norling
I have great hope in more activation of patients and the notion of the family as a caregiver. That to me could make a difference.

Linda Schwimmer
To bend the cost curve, we're going to need societal and cultural changes. It will require getting the patient engaged to effectively tackle obesity and all these other issues, and I think it's quite doable, but it's going take time and hard work.

"In ten years, we had better figure out how to address the issues of the aging population. Otherwise we will bankrupt the country."

– Lewis Sandy

About the authors

Hani Elias is a fellow, Ceci Connolly is a senior advisor, Bowen Garrett is a senior expert, and Bob Kocher is the Director of the McKinsey Center for U.S. Health System Reform.

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