1

A Vision for Tomorrow

Vision of a Fundamentally Different Future

It's the year 2025. It's hard to believe that just a little over a decade ago there was intense debate about healthcare in the United States. Today, we have more options than were ever available before. We spend less on healthcare delivery, and we seem to be generally healthier as a nation. Costs have come down dramatically in some sectors of the industry, and dynamic new businesses have sprung up to meet emerging needs. Traditional businesses have evolved with core components repurposed. Financing mechanisms have changed, and while not perfect, there is better alignment between cost and quality. There is better coordination of care, more personal accountability for health outcomes, more choice and competition, fewer restrictions, and generally less intervention and fewer procedures.

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

Of course, there have been some business “casualties” across the industry, as those organizations that held on to old models found themselves unable to adapt and therefore unable to compete in a new marketplace.

Medical tourism is up as the United States has once more become the global destination for elective procedures and continues to be the gold standard for complex care. Innovations here have been taken to other parts of the globe as researchers in the United States continue to work collaboratively with their global counterparts to find ways to improve health outcomes. New investments in research and development (R&D) have had big payoffs, as medical interventions have replaced surgery, and in some cases minimally invasive surgical procedures have replaced chronic medical treatment. Equally important, non-Western approaches to treatment have gained acceptance as the evidence for their efficacy is increasingly demonstrated. Personal accountability for critical behavioral choices affecting health outcomes has increased and incentives are aligned to reinforce good decisions.

Personalized medicine has become more normative with companion diagnostics and genomic testing helping people manage very serious conditions like cancer as chronic diseases. Scientific advances have even revolutionized how we think about and treat cancer.

Everyone in the United States has access to health insurance. Typically, it’s attached to the person like auto insurance, although there are still some sectors of the economy where employer-based healthcare is the preferred option. National access opened up competition. Local providers sprang up, sometimes coordinated with more

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

traditional care delivery organizations, which together built comprehensive or “bundled” approaches to disease management, wellness, and prevention. Whereas fragmentation and inefficiency still characterized healthcare in 2015, coordination and cost effectiveness increasingly characterize the industry. Of course, there are still niche players who are quite successful in their market segments.

What’s so remarkable is the creativity brought to bear on seemingly intractable problems that some argued could only be fixed by a single, government payer. Indeed, the creation of true market-based solutions, with very targeted policy (government) intervention, has enabled this magnitude of change in such a relatively short period of time.

Insurance payment reform enabled interstate access and reduced complicated rules and bureaucratic inefficiency. Member retention, once a major problem for the industry, due in part to an overreliance on employer-based benefit coverage, has dramatically increased in recent years. Whereas average member retention was once pegged at 18–24 months, it continues to increase, with some carriers reporting averages of 6–8 years and a positive trend line. Portability is characteristic of all insurance since most individuals hold their own policies, with myriad design options for consumers to choose from—long-term care, full coverage including vitamins and over-the-counter (OTC) products, basic catastrophic coverage, and specialty options including 10- , 20- , and 30-year life support.

Pooling and tax incentives have leveled the playing field and made this a reality. True competition has lowered costs and increasingly put consumers in the driver’s seat. Employers, where they do provide coverage, have almost entirely

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

moved to defined contribution approaches. Employers get to make the determination of what the contribution will be—not the insurance provider or the government. For insurers still in the business, the model has moved to a retail individual-dominated market.

On the delivery side, things are very different. Fundamental to change has been a shift in a basic assumption of the industry—that volume (or at least a certain type of volume based on payer and procedure) is good. In the world of the healthcare continuum—prevention, early diagnosis, intervention, and rehab—traditional hospitalization volume represents a cost, not revenue! Not wanting to repeat the mistakes of capitation in the 1980s, innovators committed to short- and long-term health outcomes.

This required enormous behavioral change on the part of physicians, social agencies, and consumers. It also required new approaches to metrics and the generation of evidence. Increasingly, healthcare delivery institutions are focused on optimal outcomes—the right treatment(s) in the right amount, administered in the right way, at the right time, at the right place, for the right patient. Hospitals are less frenetic for caregivers, and they tend to focus more on the things they do best—acute, complex intervention, often in specialty institutions. They are less likely to attempt to be "all things to all people."

Nurses who had previously focused on getting through the shift without hurting anyone, now focus on the bedside—on consumer and family education, on rehab, on care management, coordination, and health outcomes—and a smooth transition back into the home and community.

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

Hospital-acquired infection rates, while never reaching zero, have been dramatically reduced; medication errors also are down below 1%. No longer are hospitals generally recognized as unsafe.

Together with the elimination of redundant and unnecessary care, previously estimated at between 30% and 40% at some of the best hospitals, these changes resulted in the savings that enabled innovation and universal coverage without adding cost.

The refusal of the Centers for Medicare and Medicaid Services (CMS) to pay for such error-based *never events* initially forced healthcare delivery institutions to dramatically change practice—or suffer the financial consequences. Similarly, 30-day readmission penalties drove better coordination within the hospital setting and facilitated discharge planning and coordination with community agencies and post-acute care settings. Discharge planning now starts at pre-admission except in the case of emergent situations, and even there, it begins at the time of admission. Commercial insurers, not surprisingly, followed CMS's lead.

On the physician front, frightening trends in primary care have been reversed. With balanced payment increasingly recognizing the enormous contribution and broad system expertise of primary care physicians and a decrease in compensation for narrow *specialty* care, more physicians have been going into primary care medicine as a specialty, thus reversing earlier trends. Where there had been significant shortages projected for primary care physicians for 2025, now more than 20% have selected this specialty area. Contrary to what was anticipated, the small

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

business model for independent physicians continues, despite a period of massive consolidation between 2010 and 2015, as primary care and specialty physicians attempted to “take shelter” in the face of escalating costs, crushing regulation, and massive hospital consolidation. The use of nurse practitioners has become routine in physician practices; some have even opened their own offices, backed up by real-time telehealth physician consults and approved computerized decision support systems. Integrated cross-specialty practice models have emerged to offer their customers comprehensive healthcare solutions accessible to local communities. Increasingly, consumers get the care they need in their homes, at retail clinics, and sometimes at the office…when they need it.

The problem of defensive medicine, historically offered as a major contributor to the problem of overutilization, has been dramatically reduced. Essentially, physicians and hospitals had felt as though they needed to leave no stone unturned in diagnosis and treatment to protect against potential legal liability. Some patients, unencumbered by the need to actually pay for the services, would likewise demand that no stone be left unturned, even when the downside risk outweighed the upside potential. Clinical judgment was painted as a prisoner of the legal system, and tort reform became the obstacle to rational resource utilization. How things have changed in just a few short years.

Today, increased transparency, reliance on evidence, increased patient financial exposure to non-standard costs, and the redefinition of the consumer’s role in healthcare decisions have dramatically changed the pic-

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

ture. Patients are more likely to collaborate with their physicians, especially primary care providers, and evidence is used to determine which tests need to be done and when.

In the midst of this change, some hospitals have repurposed bricks and mortar, turning low-occupancy beds into assisted living, long-term care (LTC), and long-term acute care hospitals (LTACHs). Still others have created temporary residences for families visiting sick relatives receiving needed treatment and rehabilitation. And some communities, in partnership with social service agencies, have created residential living centers for vulnerable populations including the homeless and those suffering from severe mental illness. Finally, on the acute care side, specialty hospitals within hospitals have grown, sometimes catering to ethnic groups with unique preferences and treatment needs.

New players, not in the traditional healthcare space, created dramatic disruption by taking advantage of the industry's inability to see itself in a fundamentally different business model. The movement of primary care to walk-in clinics in retail settings that had begun slowly around 2010 picked up speed dramatically over the next decade. More and more people focused on convenience and began to trust nontraditional settings for blood pressure and other screenings, flu shots and other immunizations, and even nonurgent care.

Screenings have led to earlier diagnoses and referrals to specialists. Industry leaders including Walmart, Walgreens, and CVS shook up the industry. Capitalizing on location, they brought the health clinic into the retail space, tying in low-cost access to generic prescription medications and

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

store brand over-the-counter products. Their enormous success also disrupted traditional pharmacy benefit managers (PBMs) who, in retrospect, have been a bridge between the old and new model of healthcare.

It's truly a different world!

Seeds of Disruption

Getting to a new future isn't easy. But if it can't be envisioned, then it can't be realized. Typically, the move to anything radically different is sparked by a catalyst. But for the catalyst to work, the environment for change has to be prepared. The Patient Protection and Affordable Care Act (PPACA) served as the catalyst.

The PPACA legislation of 2010 reflects the largest appropriation of power from the individual to the administrative branch in our country's history. It has provoked phenomenal controversy in an industry that has been loath to change. It has accelerated industry *transition*—that painful process that forces market leaders to rethink their business models and allows new entrants, unencumbered by "the way we've always done it before," to become the market leaders of the future. The seeds of disruptive innovation are around us, beckoning to the truly innovative and threatening those wedded to the past. Fortunately, healthcare isn't the only industry to undergo fundamental transformation, and there are important insights to be learned from the experience of others.

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

Healthcare Isn't the First Industry in Transition

Some of the best insights can be learned from the experience of IBM, now a global leader, with nearly $100 billion in sales and approximately 380,000 employees. But in the late 1980s, IBM was close to bankruptcy.

In the early 1980s, IBM was dominant; it focused on mainframe computing, the "big iron" purchased by large corporations. The company enjoyed approximately 50% gross margins on mainframes and the lion's share of worldwide industry profits. It had a bullish future. Long-term projections were pegged at over $200 billion in sales. The company also enjoyed a stellar reputation and strong brand position—"Nobody ever got fired for buying IBM." In 1985 the company was, in the words of its new CEO, John Akers, "successful beyond [its] wildest expectations."

However, in just a few years, IBM flirted with bankruptcy, and between 1991 and 1993 reported over $24 billion in restructuring charges. IBM ignored the warning signs that the market was moving away from mainframes, holding on to the belief that the business computer was, and always would be, the mainframe. Their assumption was that PCs were for small businesses and home computing—at the desk and in the kitchen. As IBM saw it, mainframes had great margins and proprietary technology and IBM had solid customer relationships and market-leading products. PCs, on the other hand, were a niche invention, with "upstart" companies coming onto the scene.

As we all know, the PC wasn't just a niche product. It was the business model of the future. Even though IBM

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

was widely credited with inventing the PC, the company didn't fully appreciate the shift in the market. IBM wound up nearly bankrupt and endured a painful and difficult restructuring.

When hardware sales tanked, IBM's survival strategy was services, which had been the sweetener in its mainframe heyday. Ironically, services became the bread and butter of their business model and the bridge to their PC-based business. The IBM case demonstrates the need to know what's happening in the market and *in adjacent spaces*, understand the implications, and take the right actions to protect market leadership. Most importantly, it demonstrates the risk inherent in organizational arrogance, too frequently the blind spot of market leaders who erroneously believe they can't be unseated because they're so dominant. The need for continued market vigilance is underscored by analysts' criticism in October 2014 of IBM's failure to invest in cloud computing—which most industry experts see as technology's future.

Perhaps less dramatic, but nonetheless painful for those involved, have been recent disruptions in the travel and real estate industries. Travelocity and Expedia, both created in 1996, offer a window into an industry disrupted by technology. Travelocity, a subsidiary of Sabre Holdings, a division of American Airlines, revolutionized consumers' ability to compare and purchase tickets directly, without going through travel agents or brokers. It was the first website that allowed consumer access to Sabre's schedule and fare information, becoming more popular once AOL's travel portal became associated with the Travelocity brand in 1999. At the same time, Expedia was

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

launched by Microsoft, another online booking site that revolutionized how consumers researched and booked travel more generally. A small division in 1996, it was spun out in 1999, becoming a publically traded company on NASDAQ. It has grown dramatically since 2002, following InterActiveCorp's acquisition of a controlling interest in the company, and remains the world's leading online travel company, successfully disintermediating the traditional travel agent.

In real estate a similar dynamic has unfolded. The introduction of *for sale by owner* has taken a bite out of the profits of traditional real estate brokers. The model is attractive in that commissions are in the 1–2% range, not the traditional 6+% range that real estate brokers historically commanded.

In the publishing, music, and photography industries the dynamic is similar. Amazon disrupted the retail book sales world, while Apple Computer continues to disrupt through the creation of smart devices, replacing phones, cameras, calendars, and so on with smart phones.

In healthcare delivery disruption isn't entirely new, but the impact hasn't really been as well understood as it needs to be. Traditional hospital money makers have been dislodged and moved to other settings. Over the last fifteen years, entrepreneurial physicians and administrators, enabled by the emergence of new technology, have created free-standing specialty ambulatory care centers characterized by efficiency, convenience, and a consumer-centered model. Hospitals, struggling with silos and bureaucracy, have long recognized that they couldn't compete successfully with these more nimble enterprises, and

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

in some cases exited these specialty niches altogether.

Conflict-of-interest charges brought against some of these entrepreneurs have significantly restricted what these groups can and can't do. Nowhere has the question of hospitals' vested interests in this really been in the public spotlight, maybe because they've been seen as too big to fail or perhaps another "third rail." In many areas around the country, hospitals have become the dominant employers; other business leaders sit on their boards and their employees are an important part of the electorate. As the move to a consumer model in healthcare takes shape, coupled with increasing concerns about cost, all players in the industry should take note of what this means.

Where Are We Currently?

Popular discontent with the healthcare system has grown so significantly that legislators and regulators have responded with new laws, new mandates, and additional coercive controls, unfortunately not recognizing that sometimes *less is more*. The 2010 healthcare reform legislation included broad experimentation, new payment methods, and new market mechanisms that could profoundly alter market dynamics for healthcare delivery, and all other segments of the industry, but not necessarily in a positive way.

Federal and state regulations are moving toward greater disclosure of clinical metrics, based on the premise that consumers should be able to evaluate quality as part of their decision-making process. New organizational struc-

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

tures have been promoted, for example, accountable care organizations (ACOs), almost as a desperate attempt to fix the looming challenges we face. The inherent problems with this are discussed in Chapter 5. New payment methods are also evolving that attempt to link payment to more specific and robust quality measures, cost efficiency, and patient outcomes. As an example, the 2012 Center for Medicare and Medicaid Innovation (CMMI) bundled pricing demonstration projects laid out a series of guidelines and different models that attempted to align physician and hospital charges, improve outcomes, and foster integration across the continuum of care.

CMMI added new rules in 2013 and 2014 at great expense to taxpayers, as some participants dropped out of its programs citing bureaucracy and untenable risk-reward ratios, even as new ones entered. Committed to its vision CMS continues to tweak the rules, sometimes diluting efforts to connect payment to meaningful outcomes, typically under pressure from powerful lobbying groups representing organizations resistive to fundamental change.

This shows, in part, the inability of government to legislate real improvements in health or in the delivery of healthcare services. That said, the Federal government has been a catalyst for change. Transparency, a key ingredient of a market-based model, is in the air—sparked in part by CMS and its requirement that hospitals post prices. While the posting requirement has little bite in terms of penalties for non-compliance, it is a green-shoot for a market-based model. It has forced some delivery organizations to dramatically lower their posted “charges” to reflect a more realistic price structure.

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION

Providers are under increasing pressure to improve quality and deliver care in new ways. At the heart of the problem is fee-for-service (FFS) payment, now broadly recognized as creating perverse incentives for hospitals and physicians to offer more treatments and more options than may be medically necessary. FFS doesn't currently reward efforts that would improve quality or prevent unnecessary utilization, like chronic disease management for diabetics to reduce emergency room visits for low blood sugar reactions. A shift from FFS to a more accountable care model would mean a shift of responsibility for outcomes, increased sharing of risk for healthcare costs, and increased gain sharing as improvements are realized.

New delivery approaches are being piloted, like patient-centered medical homes (PCMHs) and ACOs, but the current excitement obscures the fact that many organizations lack the resources and capabilities to successfully implement them. Furthermore, CMS rules covering ACO governance models are enormously complicated and resource intensive, and rest on a faulty set of assumptions. Since treatments must be paid for, insurers and their network of providers have to work in tandem to implement new care delivery and payment models. Working in tandem requires collaboration, and that, in turn, requires trust. Unfortunately, that's a commodity that's been in precious short supply as we will discuss in Chapters 6 and 7. And at the end of the day, consumers need to behave differently. In the chapters that follow, we explore how the industry got here, define the implications for each of the major industry segments, and offer a plan for moving forward.

Copyright © 2015 Numerof & Associates
FOR REVIEW ONLY, NOT FOR DISTRIBUTION