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Healthcare Megatrends:
The future of healthcare financing and delivery

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The likelihood that the healthcare industry will experience significant change has grown stronger in the three months since President Barack Obama took office. The American Recovery and Reinvestment Act of 2009 (ARRA) passed in February includes more than $30 billion for healthcare related initiatives. President Obama's fiscal year 2010 budget, recognizing the certainty of increased costs in the Medicare program and anticipating a new program aimed at reducing the number of uninsured, creates a $634 billion reserve to fund government sponsored healthcare programs in the future, almost half of which would come from reduced payments by the Medicare and Medicaid programs. In addition, many Congressional leaders are as interested in comprehensive healthcare reform as the administration.

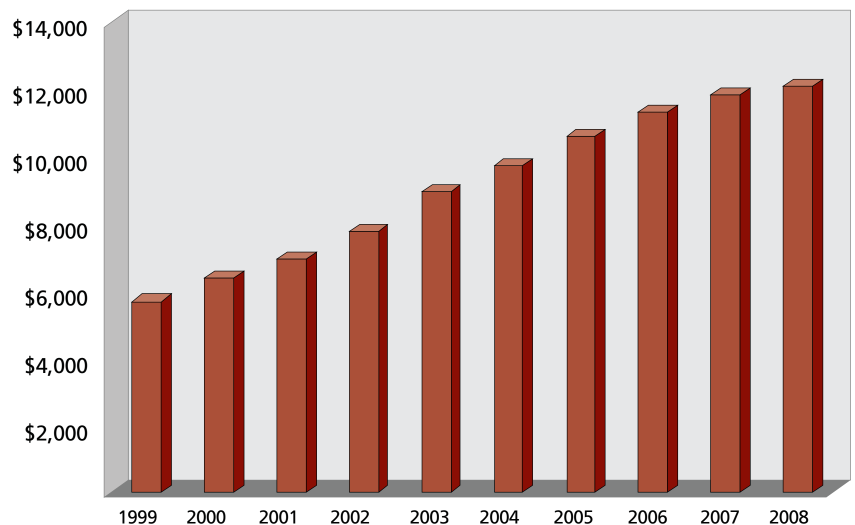
Although passage of healthcare reform is likely, the ultimate nature of reform is not yet certain. The administration and Congress will focus on a compromise solution during the next few months. At LECG, we continually research a broad set of healthcare data and policy alternatives to better understand the changes that will be made. Our efforts have led us to identify five megatrends that are likely to influence the future of US healthcare.

This paper describes the five megatrends and their importance. Expected effects of each megatrend are discussed and an analysis of how they will affect health plans is presented.

Megatrend #1: There will be a continual shift from employer-based coverage to federally provided coverage

Creation of a fully nationalized US healthcare system is as unlikely today as it was 10 years ago. However, there is evidence that the long-standing employer-based coverage model will gradually shift towards a federally subsidized coverage model. The healthcare reform plan outlined by President Obama during the presidential campaign included a national health plan that would be available to everyone. This plan would be geared primarily to the uninsured, underinsured, and those at risk of losing coverage. The plan will also benefit small businesses that experience difficulty in continuing coverage because of dramatic increases in health insurance premiums (see figure 1). The president also proposed expanding eligibility for SCHIP and Medicaid which, combined with the expected increase in Medicare enrollment from the aging of the baby boomers, would further the shift towards federally subsidized coverage.

Fig 1: Average Insurance Premium Per Year



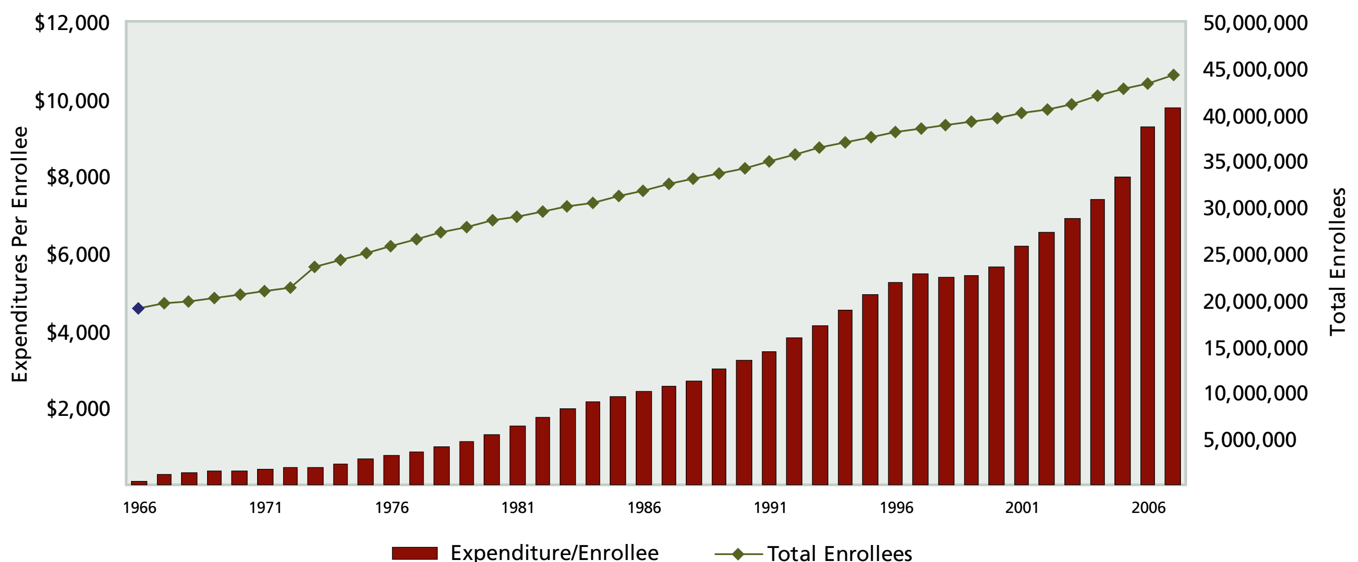
Source: Center for Medicare & Medicaid Services

The implications of a shift from employer-based coverage to federal coverage are significant, particularly for insurers. On average, small businesses pay 18 percent more for the same coverage as larger companies and the premiums for individual coverage are even more costly[1]. As small businesses and individuals opt for the more affordable national health plan, insurers that focus on these lines of business may experience dramatic reductions in revenues and as a result, may seek opportunities to consolidate with larger insurers. Additionally, as the number of people covered through a national health plan increases, the reimbursement models and coverage decisions established by the government will drive the overall health insurance marketplace. Although larger companies are likely to continue to provide coverage for their employees as they do today, the influence that the federal government has on the marketplace's structure will increase significantly.

Megatrend #2: Per unit reimbursement for healthcare products and services will decline

The cost of providing benefits to the average Medicare enrollee has increased at an annualized rate of over 11.5 percent since the program's inception in 1965, (see figure 2). This rate is greater than overall growth in healthcare spending and triple the rate of inflation. As the first baby boomers enroll in Medicare and the federal government considers taking an expanded role in addressing the uninsured, it is apparent that cost containment will become increasingly important. As a signal that the administration intends to contain costs by reducing per unit payments, the FY2010 budget identified an estimated 14 percent in "overpayments" to Medicare Advantage plans as a source for over $175 billion in savings[2 and 3]. These savings will be achieved by lowering per enrollee payments to health plans. The budget also identified Part D potential cost savings

Fig 2: Expenditures Per Enrollee vs. Total Enrollees



Source: Center for Medicare & Medicaid Services

1 http://www.nytimes.com/2008/07/10/business/smallbusiness/10bizhealth.html

2 http://www.latimes.com/news/nationworld/washingtondc/la-na-elements-healthcare27-2009feb27,0,3844653.story

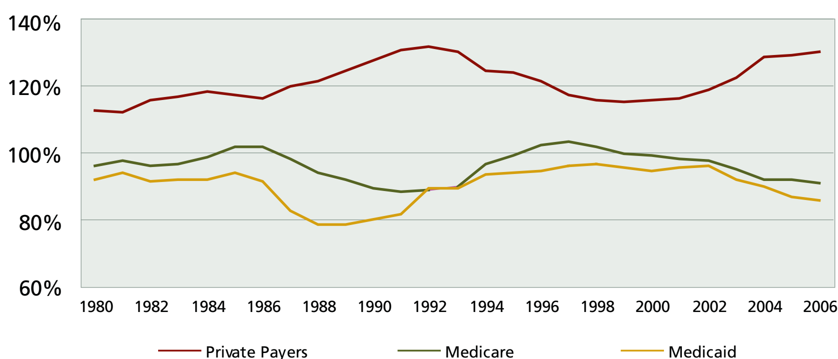
3 http://www.cbpp.org/cms/index.cfm?fa=view&id=2712

for pharmaceuticals arising from the repeal of legislation that prevents the government from directly negotiating pharmaceutical prices with manufacturers. In addition, CMS is proposing a dramatic 21 percent cut in Medicare physician payments in 2010 [4].

These changes will greatly impact providers, insurers and manufacturers. As per unit Medicare reimbursement declines, providers will be forced to shift costs to the private sector to an even greater degree than they do currently. Figure 3 shows the relationship between government and private reimbursement and the role of cost-shifting in maintaining hospital margins. If providers are unable to successfully shift costs, they will become more aggressive in negotiating lower prices on healthcare products and services that they purchase. Consequently, manufacturers will face a squeeze on profits as both providers and the federal government seek lower prices on pharmaceuticals and hospital supplies as a way of immediately lowering their costs. Insurers will also experience pressure on their profits as hospitals aggressively negotiate prices on services to help offset reductions in Medicare reimbursements.

Fig 3: Government vs. Private Reimbursement

Reimbursement-to-Cost Ratio



Source: Kaiser Family Foundation

4 http://www.ama-assn.org/ama1/pub/upload/mm/399/medicare-small-business-testimony.pdf

Megatrend #3: Health information technology will mature rapidly

Throughout the last decade, healthcare industry insiders predicted a surge in adoption of health information technology (HIT). And while there are some HIT success stories, particularly at newer and more specialized facilities, nationwide adoption of HIT has remained largely unrealized — less than 20 percent of all physicians report use of advanced IT capabilities[5]. There is evidence, however, suggesting growth in adoption of HIT will accelerate significantly during the next five years. The clearest evidence is in the ARRA which dedicates over $19 billion in spending and tax cuts to increase providers' adoption of HIT. Furthermore, both state and federal legislation increasingly prioritize and mandate the adoption of HIT including electronic health records and e-prescribing. Lastly, there is growing evidence that physicians and hospitals that use HIT see improvements in outcomes, reductions in cost and increased patient satisfaction.

Converting providers to more technologically advanced systems represents a major change that will impact not only providers but also payers and patients. The expected benefits of improved efficiency, reduced medical errors and lower administrative costs are all very real possibilities for providers, particularly as HIT systems become interconnected allowing real-time access to patient records. However, providers will experience growing pains that accompany any significant advancement in technological capability. Additionally, by accepting federal money to implement HIT, providers assume the responsibility of demonstrating to the government that the money was spent according to pre-established conditions. Insurers stand to benefit from improvements in the quality of claims processing but may find that they lose control of medical data. Patients should benefit from improvements in the quality of care and improved access to medical records but could

5 http://www.amcp.org/data/jmcp/Aug%20suppl%20C_S16-S18.pdf

experience delays in receiving these benefits as providers struggle with the adoption of HIT.

Megatrend #4: Standardization of the healthcare industry will be led by the federal government

US physicians exercise personal treatment preferences in their medical practices. The federal government has made some efforts to standardize care, but they have had little effect. The use of tiered formularies standardized prescribing behavior to an extent, but not uniformly since payers use different formularies. However, there is evidence that the federal government may begin to standardize care for patients receiving benefits through a governmental program. As discussed, the cost of care per Medicare beneficiary has increased dramatically over the last forty years. At the same time, there is significant disparity in outcomes and costs across providers for similar procedures. More concrete evidence of this trend is found in the ARRA which appropriates more than $2 billion for comparative effectiveness studies coordinated and conducted by the Agency for Healthcare Research and Quality (AHRQ) and the National Institutes of Health (NIH). These studies are intended to serve as the foundation for standardizing care. The legislation also created the Coordinating Council for Comparative Effectiveness to review studies. The council recently held its first public meeting.

Standardization of care would significantly impact healthcare providers. The philosophy of medicine as "art" could give ground to the philosophy of medicine as "science." Physicians may have less latitude in their approach to care. A patient's ability to direct their own care could be limited as certain procedures and products receive labels indicating they are not "medically effective". Manufacturers would also see a significant change in their business model. To the extent that standardized care determines prescribing behavior, the case for large sales forces and direct-to-consumer advertising would be severely undermined. Therapeutic categories that traditionally supported many products could be limited to only a few "government endorsed" products. Only those products that are truly innovative in their side effect profile, efficacy or disease category might be potential candidates for a successful product launch. Payers are likely to limit their formularies and may need to change approaches for determining medical necessity.

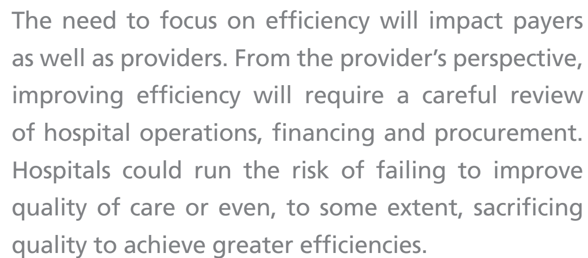
Megatrend #5: Providers will focus on efficiency improvements before they address quality of care improvements

In recent years, discussions focused on improving the healthcare system included an emphasis on improving quality of care. However, in the near-term, evidence suggests that improving efficiency will have greater priority than improving quality. Demand for healthcare services is expected to increase over the next 10 years. This demand will be driven not only by aging baby boomers and their increased use of services (see Figure 4), but also by newly insured individuals covered under national plans. At the same time, there is no evidence suggesting hospitals will increase capacity thereby implying that hospitals will need improvements in efficiency to handle increased demand. Beyond constraints on capacity, the expected decrease in reimbursement rates discussed previously will play a significant role in driving efficiency. Hospitals will recognize the need to improve profitability from use of their existing assets to offset expected losses in revenue from lower reimbursement.

Fig 4: Increased Demand for Healthcare Services

	45 - 64	65 & Older
Discharges per 1,000 pop	117.8	362.9
Days of care per 1,000 pop	591.6	2048.6

Source: Center for Disease Contrd



The need to focus on efficiency will impact payers as well as providers. From the provider's perspective, improving efficiency will require a careful review of hospital operations, financing and procurement. Hospitals could run the risk of failing to improve quality of care or even, to some extent, sacrificing quality to achieve greater efficiencies.

Implications for Health Plans

The ARRA and healthcare reform will create substantial changes in the US healthcare system. The short-term and long-term effects of these changes on health plans are described in the paragraphs that follow.

Short-term Effects

Health plans will experience a decline in profitability in the near term. As a viable public health insurance plan becomes available, individual and small group enrollment will migrate from private insurers to the public plan. Loss of these lines of business, which often generate higher profits, will have an immediate negative effect on profitability.

At the same time, overall enrollment will decline which will increase administrative cost ratios as fixed costs associated with individual and small group products are distributed over declining volumes. Because implementation of the government-sponsored health plan will take time and because reductions in individual and small group enrollment may occur over a period of a few years, health plans will have a limited amount of time to prepare and perhaps, to diversify their product lines.

Profitability will further deteriorate as health insurers respond to pressure to increase payments to providers. Hospitals are already struggling financially. A September 2008 survey of 440 hospitals reported nearly half had a net loss in their current fiscal year, which is especially important given the decline in the overall economy from October 2008 through March 2009. The median total margin reported in this survey was 0.12 percent, much lower than the 5.04 percent reported in 2007[6]. Signals from the administration indicate per unit reimbursement will decline in the near term forcing hospitals to shift even more costs to private health insurers. It can be assumed that difficult negotiations for private health insurers and hospitals will follow.

Long-term Effects

The short-term effect of declining profitability will increase interest in consolidation as health plans strive to reduce long-term administrative costs. Plans with effective administrative infrastructures may be able to reduce unit costs by acquiring plans that can benefit from access to more effective administrative infrastructures. Health plans that recognize the need to consolidate and initiate strategies to accomplish consolidation are likely to have greater success in assuring their viability.

As health plans experience pressure to increase provider payments there will be increasing interest in more effectively managing medical care costs with specific emphasis on managing chronic care costs. As higher prevalence of diseases needing chronic care increase the volume of services, health insurers will need to manage volume as they address higher prices. Chronic care management may be the best way to affect volume although current approaches need to be reviewed and evaluated for their efficacy. At the same time, government efforts at effectiveness measurement will identify new opportunities to standardize chronic care protocols.

6 Modern Healthcare. "Hospital Survey Finds Nearly Half Operating at a Loss." http://www.modernhealthcare.com/article/20090302/REG/303029944

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