

2015 health care providers outlook United States

The United States spends more on health care than any other country in the world, at an estimated 17.7 percent of Gross Domestic Product (GDP) in 2013.¹ U.S. health care spending is outstripping revenue as a percentage of GDP,²

Estimated health care expenditure:
\$2.8 trillion in 2013

Health care as a share of GDP:
17.7 percent in 2013

and is projected to grow by an average of 4.9 percent a year in 2014-18, to 17.9 percent of GDP by 2018.³

Even though spending growth slowed during the recession and has continued to grow more slowly than historically seen,⁴ containing and reducing persistently high health care costs — which are attributable to both demographic and economic factors — is likely the biggest challenge facing U.S. health care providers and other industry stakeholders in 2015.

Both U.S. health care funding and insurance coverage are undergoing significant transformation through the 2010 Affordable Care Act (ACA), which has expanded Medicaid and introduced mandatory health insurance in an effort to increase coverage from approximately 85 percent of the population to around 95 percent by 2019, and to slow the rise in health care costs.⁵

But even though more consumers are gaining health insurance coverage, they are by no means insulated from the burden of health care costs. Consumers are paying a greater portion of their health plan premium and experiencing higher out-of-pocket (OOP) cost-sharing for all types of health care services. These increases are expected to continue as employers shift to high-deductible offerings⁶ and individuals gain coverage through insurance marketplaces⁷ (also known as public health insurance exchanges).



¹ *Industry Report, Healthcare: United States*, The Economist Intelligence Unit, June 2014

² Tax Policy Center, "Historical Federal Receipts and Outlays Summary as Percent of GDP: 1940-2019," April 21, 2014. <http://www.taxpolicycenter.org/taxfacts/displayafact.cfm?Docid=200>

³ *Industry Report, Healthcare: United States*, The Economist Intelligence Unit, June 2014

⁴ Centers for Medicare and Medicaid Services, "National Health Expenditures 2012 Highlights". <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/downloads/highlights.pdf>

⁵ *Ibid*

⁶ *Health care costs, benefits, and reform: What's the next move for employers? Results of Deloitte's 2013 Survey of U.S. Employers*, Deloitte Center for Health Solutions, 2014 http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/Health%20Plans/us_lshc_employersurveyexecsummary_111213.pdf

⁷ *Consumers and health insurance exchanges: Awareness, preferences, and concerns*, Deloitte Center for Health Solutions, http://www.deloitte.com/view/en_US/us/Industries/health-plans/retail-consumerism/0d60e49ad8621410VgnVCM2000003356f70aRCRD.htm

Moreover, government estimates of health care spending do not take into account discretionary consumer spending on a number of products and services; Deloitte's Hidden Costs Analysis shows these purchases add considerably to the total.

A rise in consumer OOP will affect health care providers and other stakeholders along the care continuum, but it is just one of numerous challenges to revenue and market share growth. Among the critical issues that providers face in 2015 are:

Addressing costs of providing care



Cost is the biggest health care issue facing every country in 2015. This is certainly true for the United States, the only country that doesn't have a health care budget. While other nations spend only what they can afford, the U.S. traditionally "spends what it needs to spend." The result in 2013 was an estimated \$2.8 trillion in health care spending, and projections of continued cost increases. Spending per capita in the U.S. is roughly twice other developed economies.⁸

Increasing pressure to contain health care costs and demonstrate value is coming from all sides:

- Medicare fee-for-service (FFS) payments may be replaced. If Congress passes Sustainable Growth Rate reform legislation, the U.S. will see much more emphasis on pay for quality and alternative payment methods.
- Even without Medicare reform, physicians will likely see more patients because of an aging population and greater access of the newly insured. And increasing numbers of patients will likely be covered through managed care plans, which are emphasizing narrow networks and more value-based payment approaches.
- Advances in diagnostics and therapeutics continue to helping drive costs higher. Unraveling the human genome, targeted therapies and new medical devices are exciting but also costly. How to prioritize and pay for these advances is an ongoing challenge.
- Patient coverage is changing. More patients will likely have coverage from Medicaid (which typically pays less than commercial payors) and through exchanges.

- Employers shifting health insurance costs. Employers are not as actively changing the basis for payment but are shifting costs to employees, especially through deductibles.
- Patients are becoming more price-sensitive. Patients may become more cost-conscious as they have large deductibles and face large cost-sharing for services, including specialty pharmaceuticals and medical devices. Consumers would like to see pricing transparency.

While hospitals and health systems should benefit from reductions in the percentage of uninsured individuals, they may see continued prevalence of high deductibles for people with employer and marketplace coverage. In response, providers will need to develop new strategies to capture a greater proportion of payment up front, or risk incurring higher levels of bad debt. For example, some hospitals are using analytical programs and technologies to support collection efforts.⁹ These programs also help hospitals move towards monitoring outcomes and linking them to reimbursement rates, particularly under value-based payment models like Accountable Care Organizations (ACOs).¹⁰

As expenses mount and reimbursement declines, health care providers should operate more efficiently, lower their unit costs, and identify ways to optimize the value of their limited resources — for example, by developing expertise in population health management. Also, as inpatient volumes decrease, providers will likely need to diversify their revenue stream by offering new products, services, and care settings.

Transitioning to value-based care



The evolution of the U.S. health system from volume- to value-based care (VBC) is under way, spurred by widespread efforts to control/reduce costs, improve outcomes, and obtain more value for money spent. While this evolution impacts all health care stakeholders, VBC's future depends most heavily on physicians, due to their integral role in health care delivery.¹¹

⁸ : MedPAC, "Medicare Payment Policy," March 2013; NHE "Historical NHE, Including Sponsor Analysis, 2011"; MACPAC, "March 2013 Report to the Congress on Medicaid and CHIP"; CBO, "As the Population Ages, Social Security's Spending is Projected to Outpace Its Tax Revenues," October 2012; : CBO, "The Budget and Economic Outlook: Fiscal Years 2013 to 2023," May 2013; CBO, "The Budget and Economic Outlook: Fiscal years 2012 to 2022," January 2012

⁹ *Health Care Revenue Cycle Management: Getting back in Balance*, Deloitte, 2010 https://www.deloitte.com/view/en_US/us/Services/consulting/Strategy-Operations/28d10d054fb0c210VgnVCM1000001956f00aRCRD.htm

¹⁰ *Dig deep: Impacts and implications of rising out-of-pocket health care costs*, Deloitte Center for Health Solutions, 2014

¹¹ Preparing for the inevitable: Physician priorities in a value-based world: *Perspectives from the Deloitte 2014 Survey of U.S. Physicians*, Deloitte Center for Health Solutions, 2014, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/center-for-health-solutions-us-physicians-survey-health-information-technology.html>.

Physicians participating in the Deloitte Center for Health Solutions' 2014 Survey of U.S. Physicians say they are aware that the shift to VBC is happening and inevitable. In fact, they anticipate that value-based payment models will equal about 50 percent of their total compensation in the next 10 years. But they are reluctant to participate, preferring the status quo, and are concerned about the consequences of financial risk (e.g., being held accountable for things out of their control).¹²

To boost physicians' participation in VBC, health care partners (health systems, hospitals, health plans, and other stakeholders) should build physician-centered strategies around the clinical and business resources, capabilities, and skills that survey respondents say they need for VBC success. These include expanded clinical support capabilities, enabling technology, health information technology (HIT), access to non-physician staff to coordinate patient care, and managerial expertise and business knowledge. As well, physicians want fairly structured value-based payment models and support to manage risk and protect financial interests.¹³

The transition to VBC likely will take multiple years to play out. In 2015, both physicians and health systems likely will be just dipping their toes in the water; no one has yet invested heavily in the necessary systems and processes. As Deloitte's survey reveals, however, physicians know that the shift to VBC is basically inevitable; as it becomes a more significant aspect of their income, physicians likely will choose to work with health systems that fully and fairly enable an equitable approach to compensation. Partners, therefore, will need to move quickly to attract and support physicians by providing them with the resources they need; doing so should enhance collaboration and, potentially, lead to market advantages over time.¹⁴

Adapting to a realigned market



Eight million U.S. residents selected an insurance plan through the new state-based and federally facilitated Health Insurance Exchanges (HIXs) during the initial annual enrollment period in 2013-2014.¹⁵ A similar number is expected to enroll in the coming year. A large majority of enrollees selected Silver (65 percent) and Bronze (20 percent) plans, both of which have narrow provider networks.¹⁶

As patient rolls lengthen and networks narrow, providers may need to adapt to this realignment of market forces. Smaller players (e.g., single hospitals, independent physician groups) may be in danger of exclusion from more narrow networks. In contrast, market-dominant players are likely to be immune from exclusion and can negotiate from a position of strength. Dominance comes partly from being big, and the need to be big is driving sector consolidation.

Consumers are realigning the health care market, as well, using their increased purchasing power and access to information to drive health care decisions and purchases. Providers will need to identify and employ innovative ways to satisfy the unmet needs of these consumers, who want transparency, value, and convenience. In this way they can help strengthen their consumer relationships to build future brand loyalty and market share.

How hospitals and health systems fare in a realigned market depends, in large measure, on their place within the health care hierarchy. Centers of Excellence (e.g., health systems focusing on children, cancer, hearts, and joints) likely will continue to proliferate. However, where there is acknowledgement that community hospitals can't deliver similar outcomes to COEs or large systems, consumers may elect to go elsewhere for treatment.

Achieving scale



Significant regulatory changes, technological innovations, financial pressures and market dynamics are setting the stage for what may be a period of rapid consolidation among health care providers. From 2009 through 2013, hospital deal volume increased 14 percent annually.¹⁷ Physicians are rapidly moving from private practice to an employed model and are being acquired by health systems and health plans. Both vertical (health systems acquiring physician practices, ambulatory centers, diagnostic centers, home care services, and durable medical equipment and wellness companies) and horizontal (hospitals acquiring other hospitals) consolidation has been increasing, despite heightened regulatory scrutiny. In addition, cross-sector convergence is expected to increase: It will likely become more common for a health plan to offer clinical services — both professional and technical — and for health care providers to offer health care financing products.

¹² Preparing for the inevitable: Physician priorities in a value-based world: *Perspectives from the Deloitte 2014 Survey of U.S. Physicians*, Deloitte Center for Health Solutions, 2014, <http://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/center-for-health-solutions-us-physicians-survey-health-information-technology.html>.

¹³ Ibid

¹⁴ Ibid

¹⁵ Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period. HHS. May 1, 2014

¹⁶ Ibid

¹⁷ Irving Levin Associates, Inc., *The Hospital Acquisition Report 2014*, July 2014, pg. 6, 7, http://www.levinassociates.com/sites/default/files/abstracts/hosp_abstract.pdf, accessed September 9, 2014.

While consolidation typically includes traditional mergers and acquisitions (M&A), options such as joint ventures, affiliations, or collaborations could also prove attractive as health systems seek to build scale, add capabilities, increase purchasing power, streamline services, and cut costs. For example, the shift to VBC will likely require health systems to differentiate through innovation and/or diversification. Few health systems have the financial and organizational resources to “go it alone” and accomplish these strategies. Thus, conditions may be aligning to support a period of rapid consolidation.¹⁸

How far might health system consolidation go? Using three approaches, Deloitte modeled an estimate of its potential. All three estimates independently converged at a similar outcome: approximately 50 percent of current health systems will remain after consolidation in the next decade.¹⁹

Health system consolidation should be pursued cautiously, given heightened regulatory scrutiny. Additionally, other industry stakeholders may be wary, particularly health plans and consumers, who at times have seen costs rise as a result of consolidation. Regulators did limit earlier periods of consolidation to address such concerns, although activity levels subsequently picked up once regulatory scrutiny eased. Similar starts and stops are expected in this latest wave.

Managing regulatory and risk



The health care regulatory environment will likely continue to change and grow in complexity during 2015, as rules, guidance and enforcement related to ICD-10, 340B, meaningful use, ACA, transparency, and security and privacy are released by federal and state policy makers. In response, health care providers should assess their current compliance programs and, if necessary, invest in new HIT and processes to meet reporting requirements. This can be a daunting proposition, especially for small health systems, which may lack the infrastructure and funding to meet requirements. Instead, these providers may look to consolidation as a way to ease their compliance burdens.

Among major developments, ICD-10 coding and documentation standards will go into effect October 1, 2015. The push to increase adoption through regulatory requirements in the Health Information Technology for Economic and Clinical Health (HITECH) Act (2009) has raised physicians’ levels of awareness about electronic health records (EHRs). Health care reform-related programs requiring clinical integration (accountable care organizations, medical homes, bundled payments) have accelerated adoption. This has occurred as physicians accept more risk for cost-savings and patient outcomes. However, implementation and operational integration costs are major concerns to many physicians. While those physicians who use HIT are optimistic about its prospects for better care and lower administrative costs once fully integrated, they may be skeptical about clinical value and concerned about implementation costs. As a result, care coordination via cross-practice clinical data sharing is not widespread. And the clinical impact of HIT on population health outcomes is not readily apparent in many communities.

Safeguarding security and privacy is likely to become more challenging with the evolving health care environment. A day does not go by where we don’t hear about a new breach of consumer, health care, or corporate data. A rising data flow and number of organizations sharing sensitive information electronically escalates the risks of hacking and infection with malware and viruses. As evidence, health care information security breaches cost the industry up to \$5.6 billion annually.²⁰ Preventing all breaches is nearly impossible. Providers can, however, mitigate cyber security and privacy risks with a secure, vigilant, and resilient cyber security program that addresses both internal and external threats. Organizations should consider whether they have a need to promptly assess potential capability gaps, define their security and privacy vision and needs, and develop appropriate remediation programs.²¹

The impact of the Physician Payment Sunshine Act and Medicare reimbursement transparency efforts may become even more apparent in 2015. Exactly how consumers will react to the large amounts of information that has become available is still evolving—will 2015 be the year they begin to take notice? Concerns about data accuracy and whether users will take the data out of context or confuse payments for research with marketing and entertainment relationships could still be major challenges facing providers in the coming months.

Containing and reducing persistently high health care costs is likely the biggest challenge facing U.S. health care providers and other industry stakeholders in 2015.

¹⁸ The great consolidation: *The potential for rapid consolidation of health systems*, Deloitte Center for Health Solutions, 2014

¹⁹ Ibid

²⁰ Ponemon Institute, Fourth Annual Benchmark Study on Patient Privacy & Data Security, March 2014, via <http://www2.idexperts.com/ponemon-report-on-patient-privacy-data-security-incidents/>

²¹ *Update: Privacy and security of protected health information*, Deloitte Center for Health Solutions, 2014

If consumers do begin to take notice, new areas for individual organizations and the industry may need to be addressed:

- What will be the impact on policies at institutions? Some organizations may lack rules around relationships and the release of this data could serve as a call to action.
- How will the information impact innovation, public-private partnerships and industry-sponsored research? A major category of the Open Payments program is clinical research. Will institutions begin to reconsider their relationships?

Changing the way in which Medicare pays physicians continues to be a challenge for Congress. While lawmakers continue to discuss ways to replace the sustainable growth rate in Medicare, it is likely that they will settle on another patch in 2015, continuing this issue through the year. The current patch expires in March, and many expect that the new Congress will punt again and give more time to debate the options for paying for a replacement formula. There is

hope among some that the new Congress will succeed in finding the budget cuts necessary to offset the increases in spending associated with passing a fundamental change not only to the SGR formula but to physician payment policies. Last year's proposed solution would have implemented a process that includes more incentives for physicians to provide excellent care by working in teams. If a substantive change to the SGR occurs in 2015, providers could be faced with the challenge of aligning clinical and financial interests with a potential shared risk environment.

Finally, three programs— the Value-Based Payment Modifier, Physician Quality Rating System, and Meaningful Use — all coincide in 2015. Incentives built into the programs now have turned into penalties, and could mean that some physicians face cuts in their Medicare payments for not reporting on quality measures in the programs. These programs could begin to have a significant effect on profit margins for providers.



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