Prioritizing scenario planning in health care

How health plans and providers can plan dynamically for the future
Introduction

The massively disruptive spread of COVID-19 (novel coronavirus) across the global stage exposed numerous vulnerabilities in health care systems, supply chains, workforce dynamics, data access, and systems connectivity. At its onset, few could have predicted COVID-19’s quick acceleration to pandemic status—and how it would test public and private health sectors’ ability to respond.

However, clinical, financial, and operational learnings accumulated during the outbreak that can help health care providers and health plans prepare for unpredictable challenges to come. For example:

- How will our nation reckon with health care’s increasingly large share of gross domestic product (GDP), which is projected to rise from 17.9 percent in 2016 to 19.7 percent by 2026?\(^1\)
- How might the number of uninsured individuals change over time, especially considering potential political shifts? Currently, the Congressional Budget Office (CBO) expects the United States’ number of nonelderly uninsured will increase by five million over the next 10 years, from 30 million in 2019 to 35 million in 2029.\(^2\)
- How dramatically may the health care industry—like others before it—be disrupted by nontraditional entrants large and small?
- Will virtual care finally begin to dominate the care delivery space as often predicted, particularly given the recent focus on telemedicine (the remote delivery of health care services and information using telecommunications technology) as an effective prevention and treatment solution during the COVID-19 pandemic?

Forewarned is forearmed: The prospect of a future filled with unpredictable events should compel health care leaders to use scenario planning to delve deeply into the uncertainties that may affect their business, better understand the range of potential futures, and proactively plan their response.

Looking to the future

The emergence and rapid escalation of the COVID-19 pandemic starkly demonstrate how unpredictable events call for new and sometimes unconventional or nonlinear approaches to strategy—ones that use scenario planning to assist health care provider and health plan leaders in answering tough questions that can direct strategic investment choices:

- **Do we have enough scale?**
- **Are we appropriately diversified in terms of scope?**
- **Do we have the right technology in place and planned for development?**
- **Do we have the right talent?**
- **Do we have the right partnerships/alliances to enable our future-state vision?**

This article looks at four critical uncertainties facing the future health care industry and explores the implications and strategic questions that organizations must address to survive and thrive. This is not a pandemic preparation article; rather, our goal is to help health care leaders think strategically about how to prepare for unpredictability and how these uncertainties impact key questions about organizations. We can't predict the future, but we can tell stories about how aspects of that future might look, and how to think through appropriate next steps. In a post-COVID-19 world, scenario planning is more important than ever.\(^3\) The uncertainties explored in this piece can help jumpstart that process.
Four critical uncertainties facing the future health care industry

1. **Government involvement in health care**

As the United States gears up for a national election in which health coverage and financing are top campaign issues, the level of future government involvement in health care remains a critical uncertainty. Some proposals would create new coverage options, while others would fundamentally change how the US health care system is designed and financed by expanding the role of government and reducing the role of private insurers.

**Scenario 1: Single-payer system**

It’s 2030, and the current administration is pushing forward on the transition to a single-payer system. The health plan sector exists as a streamlined group of plans serving the roughly 20 percent of citizens who choose to buy additional private insurance to supplement the public option. The surviving plans have expanded beyond serving solely as a financial instrument into care delivery, data aggregation and analysis, or other adjacencies. Providers, meanwhile, are experiencing declining revenues and margin challenges due to a reduced number of privately insured customers, who previously subsidized lower Medicare rates. Shrinking health systems struggle to balance budgets and manage increased patient loads, even as the impending physician shortage intensifies care delivery issues.

**Scenario 2: Privatized health insurance**

After the individual mandate was ruled unconstitutional, legislators and the court system slowly continued to weaken the Affordable Care Act’s (ACA) protections. By 2030, the number of uninsured Americans has returned to pre-ACA levels; the number of underinsured is even higher, as catastrophic coverage and high-deductible health plans have grown exponentially. The government’s role in the health insurance market is more privatized and uses Medicare Advantage (MA) as the model for an increasing number of plans—a boon to payers with experience in managed care. Recent Medicaid expansion reverses and Medicaid managed care organization (MCO) outsourcing to larger organizations grows to cover those still eligible under a smaller Medicaid umbrella. As people wrestle with vastly higher out-of-pocket (OOP) burdens, hospitals are saddled with growing bad debt and forced to make cuts to provide mandated care.

**Key questions**

- How will this uncertainty affect risk-sharing efforts within government programs (and in the United States more broadly)?
- What is the impact on the uninsured or underinsured population and the associated impact on available coverage options?
- What technology and analytics advancements are needed to support organizations in these different scenarios?
- Most proposed universal health care plans include a provision to negotiate drug prices; how will this affect health care organizations?
Implications for providers and health plans

**Strategy**

- Effectively diversifying scope and adding scale will require time to invest in, buy, and/or grow new lines of business; plans should strategize how their strengths may be applied to new businesses and how these new businesses can generate usable cash flow.
- Plans should envision how they can adapt their business—specifically, how to tailor precision engagement—to fit an MA model (and its obligations, such as STAR ratings or direct-to-consumer marketing) and a more diverse pool of members.
- As some government involvement in the health care system is likely in either scenario, providers need to plan for continued pressure around service price transparency, drug pricing, and quality measurement and management.

**People**

- Plans and providers will likely need to adjust staffing levels to reflect new enrollment levels and different risk levels that come with new member and patient populations.

**Process**

- While a single-payer system could simplify the administrative burden that decreases providers’ margins, reduced payment rates may significantly reduce revenue and, potentially, intensify an already challenging physician shortage. Providers should identify ways to drive additional revenue by adding value-added services or growing their current scope of services and to reduce cost of care administration.
- Providers and plans should also consider investing in quality improvement initiatives to boost revenue through STARs and Health Care Effectiveness Data and Information Set (HEDIS) reimbursement, which will become even more critical if government programs greatly increase enrollment.

**Technology**

- Organizations should consider shoring up their technology infrastructure to prepare for future investments in data and analytics to support potential new populations and new products, and offerings.
- Plans and providers should intensify interoperability efforts to build a strategic foundation in order to ease potential friction points, enact FHIR standards, and improve service provision efficiency before pricing pressures hit.
As the COVID-19 pandemic began to take root around the United States, many hospitals and health systems were able to quickly stand up the technology they needed to conduct virtual visits between clinicians and patients. In almost all cases, responses to virtual health have been positive. As organizations move from responding to the crisis to recovering from it and adjusting to a new normal, virtual health is emerging as a significant contributor to care delivery evolution. Regulatory barriers to telehealth services are falling, insurers are providing coverage, and health systems are expanding services and training.

**Scenario 1: Care anywhere**
It’s 2030. Virtual care has displaced in-person care as the go-to option for obtaining medical advice. Doctors spend most of their days in an office designed for video visits, venturing into exam rooms only for more serious conditions that require in-person diagnosis. Every citizen’s health record and medical history are integrated and secured in the cloud, easily accessible to health care providers.

**Scenario 2: Localized in-person care**
It’s 2028, and most small physician practices—and even some smaller hospitals—have disappeared. Care is delivered either in large, super-specialized acute care facilities clustered in high-density locations or in lower-acuity clinics attached to grocery stores across the country.

**Key questions**
- How will telehealth reimbursement evolve to drive adoption?
- Who owns health care data? Do patients own their data? Does the patient need to provide permission for their medical information to be shared, or is it freely available?
- How will wearable technology security be maintained? What happens if this information is hacked?
- How are premium and coverage rates determined in these potential futures, particularly for providers that might be out of network in a highly specialized facility scenario?
Implications for providers and health plans

Strategy

- Health plans may need to invest directly in care delivery, whether that occurs through partnerships and other forms of collaboration or direct horizontal or vertical integration. Their strategy should consider both on the organization’s strengths and its capability gaps.

- Larger providers should diversify by site of service to capture every level of acuity and help direct patients to appropriate sites of care. Smaller providers should develop a clear strategy for the acuity level they are serving and form partnerships with physician groups and new entrants to cover other levels. Diversifying into retail, either through acquisition or innovative partnerships, may help preserve outpatient care market share.

- Providers should investigate the feasibility of expanding physical service sites (such as quick clinics and in-house pharmacies) and virtual care offerings to improve patient access and serve as a one-stop shop for all care needs. Planning variable capacity for virtual services is also important, as evidenced by the dramatic rise in telemedicine during the COVID-19 pandemic and subsequent capacity issues.

- Providers also should build competency in population health and clinical data science in order to better understand local needs and invest appropriately in the right services.

People

- Providers should plan how to shift personnel and modify responsibilities to staff both in-person and virtual care services; this may require hiring a variety of license levels to ensure coverage across the acuity spectrum.

- Plans should hire employees to help members navigate a care ecosystem that looks very different than today. They should also consider hiring more clinicians to accommodate moves into the care delivery space.

Process

- Plans should confirm that their organizations have the appropriate procedures, and benefits navigation and network tools, to enable patients to find and receive the right care in the right place.

- Plans also should reconsider benefit and offering design to incorporate and incentivize the right care for the right level of acuity, particularly regarding virtual care. Many plans have altered benefits and offerings to include telehealth services and free COVID-19 care.

- Providers should evaluate shifting infrastructure investments to build virtual care capabilities—while also maintaining in-person delivery capabilities—a dual burden for cash-strapped providers to shoulder.

Technology

- In these future scenarios, investing in data and interoperability is imperative; plans and providers should build, buy, or acquire capabilities to achieve seamless data integration adherent to FHIR standards that pushes, rather than pulls, the data clinical and business personnel need, when they need it. Also essential are analytics and predictive modeling capabilities that can help extend data access and use across the care ecosystem.
Although consumerism in health care has been increasing for years, people still do not consume health care services in the same way they do other consumer goods. It is uncertain whether and when people embrace a more retail-like mindset for purchasing and using health care services and tools that allow them to more directly manage their health. It is also unclear how consumers’ health care experiences during the coronavirus pandemic may influence their future attitudes and behaviors.

**Scenario 1: Consumers in control**

It’s 2030. Improved interoperability, as well as price transparency laws, have created a retail-like, consumer-friendly market for health care that is in tune with the attitudinal and behavioral shift toward greater consumer engagement and empowerment. Health services and procedures are often purchased prior to medical examinations and consultations. Providers are subject to patient reviews just like any other retail or service entity, encouraging them to offer the best possible rates and service. Medical records are stored on the cloud and shared with providers when patients purchase a procedure or enroll in their services through IoMT (Internet of Medical Things). Prices for all services are public, as are negotiated discounts. Smart health communities supported by population health management analytics enable earlier diagnosis and help focus consumers on prevention.

**Scenario 2: Cautious consumerism**

It’s 2028, and government regulations have led to a pronounced slowing of the march toward consumerism in health care. Price transparency proposals have stalled in Congress, and the industry’s attempts to boost interoperability have failed as subsidies have dried up. Meanwhile, as more and more tech companies have attempted to enter the health care market, the medical device approval process has become more stringent—requiring a greater burden of proof of efficacy—discouraging some device makers. Without a centralized provider rating system, consumers often do not have the information they need to choose the quality and price of care they receive.

**Key questions**

- Who owns the data in these worlds? Do patients own their data? Does the patient need to allow their medical information to be shared, or is it freely available?
- How is provider and plan network data managed and owned to enable price transparency?
- How might demographic trends accelerate or decelerate this scenario (for example, increasing proportion of senior citizens or increasing technology savviness)?
- How will current regulatory efforts (such as proposed price transparency rules) influence this scenario? What happens to quality oversight? What consequences do the providers and plans face if they don’t comply with Federalwide Assurance (FWA) and CMS protocols?
Implications for providers and health plans

**Strategy**
- To prepare for when consumerism’s inflection point finally hits, health plans should begin now to shift benefit and offering design and consumer-facing tools to support members’ efforts to take control of their health.
- Health care organizations should begin simplifying pricing and contracting where possible to ease the inevitable transition to full transparency.
- Plans and providers should collaborate on ways to simplify services and pricing and help guide consumers to understandable and appropriate health care choices.
- Investing in interoperability now will enable organizations to better serve customers in the future; however, doing so will require rethinking how the core business is run—how to sell and provide services differently and better than today.
- Growing your organization’s advanced data and analytics capabilities today will enable more agile delivery on your customer’s changing needs tomorrow. As part of this, it will be vital to rethink how to understand those customer needs and personalize accordingly (such as demographics) as well as how you price, given the added power of predictive analytics.

**People**
- Health plans should invest in hiring data science professionals who can analyze and use data-driven insights to help the plan better understand its members and succeed in a consumer-oriented world.
- Providers and plans will need to undergo cultural changes to match the shift in service delivery to customer-centric models (for example, training and process redesign to focus on the customer experience).

**Process**
- Plans should turn a critical eye to current processes and determine key intervention points to create a seamless customer experience.
- Providers should explore and consider adopting retail processes that support consumer-driven delivery and pricing models.

**Technology**
- Plans and providers should work together to develop new standards for data privacy that are secure enough to earn customers’ trust, yet flexible enough to enable organizations to move nimbly to serve their patients.
- Plans and providers should establish a solid technology infrastructure that can enable quick and safe data-sharing and management and establish a strong foundation for interoperability.
As technology giants and other disruptive players enter health care, incumbents must adapt to new market and business pressures. Will these new entrants displace existing players, or will their products fail to gain sufficient traction to effect real change? How might incumbents adapt to these challenges so they can survive and thrive?

**Scenario 1: Tech takeover**
It’s 2030, and technology giants have taken over the health care industry, expediting old, slow processes and disintermediating middlemen. Imagine... You wake up; a voice assistant asks how you’re feeling. Based on the device’s analysis of your response (and the biometric measurements it takes in your bathroom), the tech company's employed doctors automatically diagnose your condition and dispatch a drone to deliver drugs (generics which the tech company manufactures) straight to your door, covered by company-issued health insurance. The tech giant has taken over all functions in the health care chain, in its characteristic efficient, low-cost way.

**Scenario 2: Incumbents rule**
It’s 2030, just a few years after the second tech bubble has burst. Following a spate of tax evasion and data privacy convictions, the country has lost faith in technology’s ability to solve many of its challenges, particularly those in health care. Absent the competition and pressure to innovate, large health care incumbents have been able to regain market share and reclaim their once-dominant positions. Price transparency, consumer engagement, and other developments have stalled as innovation is stifled and incumbents resist changing long-established processes.

**Key questions**
- How will new entrants affect incumbents’ core business? How successful can these new entrants be in the historically hard-to-disrupt health care market?
- How can incumbents make anticipatory moves to preempt disruption?
- How can incumbents use their regulatory expertise to regain ground from disruptors?
Implications for providers and health plans

**Strategy**
- Incumbent health plans and providers should consider forming intra-industry partnerships and alliances that leverage and accentuate each participant's core capabilities, services, and markets. This may include rethinking the value proposition of current and new products and services to meet consumers' evolving health care needs and expectations.
- Established players should take advantage of their extensive regulatory experience and relationships to gain or maintain market share; new entrants often underestimate the importance of these relationships.
- Health plans will need to determine what role (or multiple roles) they can most effectively (and profitably) play in a reshaped health care ecosystem.
- Incumbents should partner with new entrants or purchase them when synergies arise, as these organizations often lack the deep expertise in health care (as well as industry relationships and regulatory experience) that incumbents possess. Forward-looking, collaborative partnerships can allow plans to adapt quickly to the entry of new players.
- Larger health systems should consider how to leverage their scale and resources to test new interventions (such as captive testing populations of patients and physicians) and build innovative partnerships with entities outside of health care (for example, banks, real estate developers, or technology firms).
- With cycle time and speed to market becoming important measures of success, providers should identify ways to adapt business and operational models more quickly.

**People**
- Plans and providers should hire new and/or upskill current employees with computer and data science skills to better compete with disruptors that excel in these areas.

**Process**
- Many incoming players succeed by exploiting old, inefficient processes and identifying shortcuts around them. Health plans and providers can counter their efforts by proactively analyzing and updating their current processes.

**Technology**
- Providers should invest in capabilities to effectively manage the immense amounts of data that they possess and to draw insights to improve services and processes.
- Providers and plans should use data as a platform (DaaP) capabilities to examine patient and other data in new ways and extract insights that can support opportunity areas such as care management, diagnosis, and product advertising.
The value of scenario planning to inform bold plays for the future

Scenario planning is designed to help organizations develop and test strategic choices for multiple potential futures to build out contingent strategies. Scenario planning is not sensitivity analysis; rather, it pushes participants to consider “what if’s” that may be unlikely—but certainly would be disruptive—and to challenge status quo thinking to prepare their organization for potential incidents or circumstances. Also, scenario planning is not meant to predict the most probable future but to help leaders develop and test strategic choices under a variety of plausible futures, which strengthens the organization’s ability to recognize, adapt to, and take advantage of, changes in the industry over time. By considering a broad set of possible divergent futures, organizations can also mitigate risk by gaining a more comprehensive view of potential problems.

Visualizing how an organization might operate in each scenario—what will be different; what will remain the same—will enable leaders to understand implications and options for strategic choices, invest in no-regret moves that maximize potential across a range of possible futures, and collect data to identify when course correction may be needed.

Uncertainty in health care will remain, but by considering different scenarios in this way, organizations can enact transformation while preparing for the unknown. While continuing disruption in health care is inevitable, scenario planning can help providers and plans prepare for whatever tomorrow may bring. By challenging the status quo, performing multiple cycles of adversarial analysis, and changing the strategy culture, health care leaders can position their organizations for success amidst uncertainty.
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Endnotes


4. For an overview of the different proposals from both sides of the aisle, read “Setting the stage for Medicare for All and the health care coverage debate” by the Deloitte Center for Health Solutions.


7. Ibid.


10. For additional discussion on this issue, see Deloitte’s blog post: https://www2.deloitte.com/us/en/blog/health-care-blog/2019/innovate-or-wait-and-see-which-path-will-health-stakeholders-follow.html.