



I'm OK, you're OK ... but will we be all right?

With the U.S. health care system undergoing massive change, some stakeholders are taking bold, innovative steps

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In *I'm OK—You're OK*, the 1970s self-help best seller, Thomas Harris, M.D. describes a dynamic often seen when major changes take place within micro systems, such as individual relationships, and macro systems, such as entire industries. One “incumbent” or participant in the system will complain to another that, “you’re okay, and I’m not okay.” In other words, I’m getting a raw deal, and you’re not. Sound familiar?

The U.S. health care industry is in such a state today. Since enactment of the Patient Protection and Affordable Care Act (PPACA), many stakeholders in the industry (as we've known it) have complained that new rules unfairly penalize them and don't deal with the true nature of the needed reform. Regardless of the legislation, many existing health care-related organizations could face challenges in the long term unless they change their business models. The PPACA is merely the tipping point for an industry already under pressure from a variety of economic, demographic and competitive "stressors."

Evidence of a crescendo in industry upheaval is widespread. Industry consolidation via mergers and acquisitions is returning to a landscape that existed prior to the financial crisis.¹ The Centers for Medicare and Medicaid Systems and state budget officers anticipate cuts to Medicare and Medicaid provider reimbursement, with ripple effects for all stakeholders.² New medical loss rules already in effect will limit health plan profits.³ And virtually all health care-related companies will be subject to new excise taxes.⁴ For many businesses in the industry—as well as employers that fund health coverage and consumers who pay an increasing share of the tab—health care costs are causing an increasing burden.

As some lawmakers and industry stakeholders remain focused on defining the appropriate role of government, and others debate specific components of health reform legislation, there are signs that the industry and American businesses are adapting to the new order. A few early innovators are actively responding to the financial, legislative and regulatory pressures in ways that really could make them okay:

- *Innovative incumbents* are forming new alliances and identifying new niches.
- *Nontraditional participants* are creating new business models and new products and services, thereby gaining access to health care markets that previously were off limits.

A common trait of these fast movers is acceptance of the industry's shift from a *volume* focus to a *value* focus. A closer look at why and how these leaders are tackling the dramatic change underway may be instructive for those in the health care business today, new entrants and other stakeholders because one thing is certain: inaction is possibly the fastest path to *not* being okay in the future.

WHY TRANSFORMATIONAL CHANGE IS HAPPENING: FOUR STRESSORS

Four "stressors" — *government health care reform initiatives, economic constraints, clinical innovation and demographic changes* — have applied increasing pressure to the



entire U.S. health care system for years, compelling many health care industry participants to change what are often longstanding practices.

Health reform

Passage of the PPACA in 2010 isn't just the most recent of these stressors. The legislation represents the most fundamental shift in U.S. health care delivery since the creation of Medicaid and Medicare.

In fact, components of the PPACA and other recent health reform initiatives are aimed directly at driving the

transition from a volume-based to a value-based health care system. Some provisions of the PPACA will likely be, or already have been, subjected to repeal efforts in the U.S. Congress. Regardless of such initiatives, many elements of the act may provide momentum for irreversible change.

SOME KEY COMPONENTS OF HEALTH REFORM LEGISLATION

- Restrictions on annual and lifetime coverage limits, required coverage for those with pre-existing conditions, and limits on premium increases and adjustments for risk factors
- Establishment of state health insurance exchanges to encourage local competition
- Shifting provider payments from fee-for-service based on volume to risk-based payments tied to outcomes and efficiency
- Increased transparency
- Requirements to link public health agencies with local delivery systems
- Required implementation of ICD-10 and electronic health records
- Alignment of physicians and hospitals in integrated systems to improve care coordination
- Additional taxes and industry fees
- Development of new pathways for drug development aligned with comparative clinical effectiveness and the newly created Patient Centered Outcomes Research Institute (PCORI)
- Higher state and federal rebates for pharmaceuticals

Economic realities

The math is inescapably, brutally clear. Health care costs have grown on average 2.4 percentage points faster than the GDP since 1970.⁵ With no end in sight, this gap is simply not sustainable and is exacerbated today by the continuing challenges to the broader U.S. economy. In fact, only one in four consumers remain confident about managing future health care costs, according to Deloitte Center for Health Solutions research.⁶

To the extent Medicare and Medicaid require cross-subsidization and higher taxes, as well as how they affect the cost of American-made goods, they will continue to affect the overall economy.

One way employers are addressing growing health care costs is to shift from providing defined benefit coverage to offering defined contribution plans. This is much like the changes in

The role, structure, and viability of these massive programs will likely be the subject of intense congressional and public debate in the months ahead.

the 1980s, when retirement programs switched from pensions to 401(k)s, which limited an employer's liability and shifted more responsibility to employees. However, these moves do nothing to address two of the primary

sources of cost growth: how much consumers are, or are not, assuming responsibility for their own health and well being; and the incentives associated with consumers changing their own behavior.

Seventy-five percent of U.S. health care costs are associated with lifestyle and chronic disease.⁷ The dramatic rise in the nation's obesity rate in the past 20 years offers a striking example of the problem. In 33 states, at least one in four residents are obese.⁸ Unless individuals alter their eating habits, exercise more and take medications as indicated, such numbers are only likely to rise.

For their part, physicians are rewarded financially in today's fee-for-service reimbursement system to admit more patients and use more tests, products and procedures. The inclination to emphasize volume over value can be intensified when providers hold financial interests in the facilities being used.

Of course, a major area of concern amid the federal and state budget crises is the

existing defined benefit entitlement programs, specifically Medicare and Medicaid. These programs are outsized contributors to the fiscal challenges facing federal and state governments. To the extent Medicare and Medicaid require cross-subsidization and higher taxes, as well as how they affect the cost of American-made goods, they will continue to affect the overall economy. The role, structure and viability of these massive programs will likely be the subject of intense congressional and public debate in the months ahead.

Clinical innovation

Treatment breakthroughs over the past decade are revolutionizing how and where health care is delivered and the effectiveness of the care. Many surgical procedures are now performed in a fraction of the time they used to take. Approximately 70 percent of surgeries are performed on an outpatient basis, according to recent estimates.⁹

Many of these innovations have been driven by the industry's ability to amass and analyze clinical data through *biomedical informatics* – the field of science in which biology, computer science and information technology merge to form a single discipline.¹⁰ Researchers and clinicians are using this data to identify new patterns of care and to predict future events. In doing so, they are compelling the health care profession to shift from opinion-based medicine to evidence-based medicine. The intended result is a more substantial foundation for research into causes and improvement of care patterns.

The promise of personalized medicine customized to a person's unique genetic footprint is also becoming a reality. Among exciting initiatives underway is the Coriell Personalized Medicine Collaborative, a study designed to determine the utility of personal genome information in health management and clinical decision-making. The study aims to enroll 100,000 participants and be a model for ethical, legal and responsible implementation of genome-informed personalized medicine.¹¹

In March 2011, Vanderbilt-Ingram Cancer Center launched "My Cancer Genome," the nation's first personalized cancer decision support tool. The Web-based information tool is designed to quickly educate clinicians on the rapidly expanding list of genetic mutations that impact different cancers.¹²

Clinical innovation drives change in the U.S. system. Consumers demand the latest and best, and physicians and hospitals are required to comply with ever-changing "best practices." The pressure on the U.S. system to offer the latest and best is a major source of its strength, but also a major catalyst for its high costs.

Demanding demography

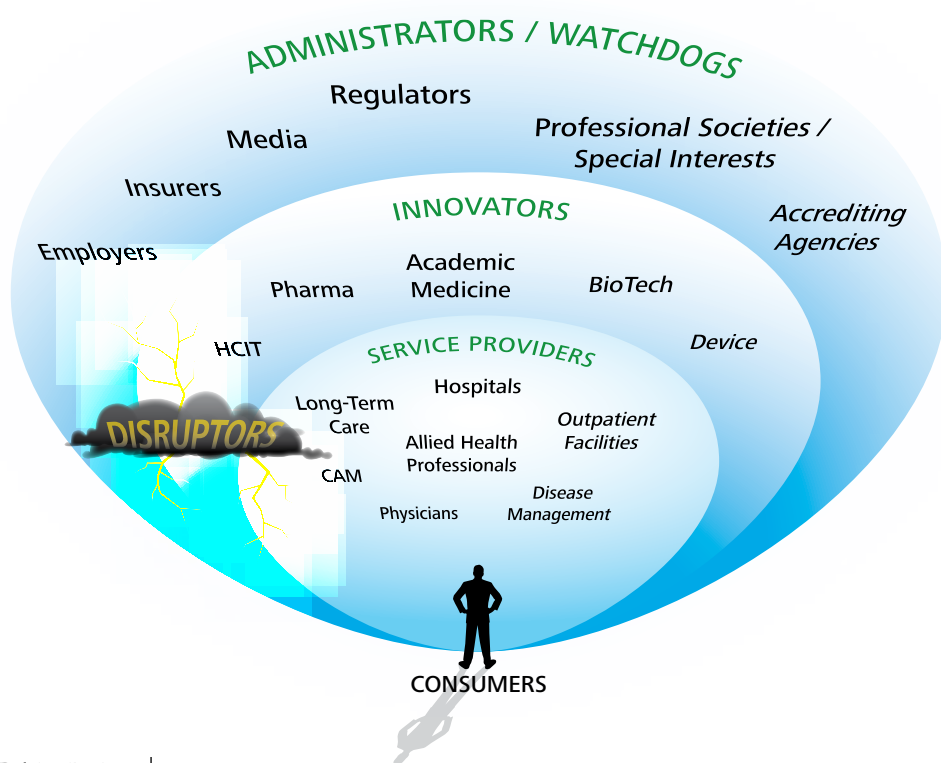
The impact on the health care system of aging baby boomers is widely recognized

and reported – and must not be underestimated. The Congressional Budget Office predicts that, absent changes in the system, spending for Medicare alone could more than double to 8 percent of gross domestic product by 2035.¹³ At the same time, the ratio of Americans under age 65 to those over 65 will likely continue to drop dramatically, which could potentially accelerate the decline in the country's ability to pay out defined-level Medicare and Social Security benefits.¹⁴

Aging isn't the only demographic force pressuring the health care system. Addressing the needs of an increasingly multicultural population likely requires a new mindset toward different medical approaches. The United States is rapidly becoming more heterogeneous – by 2050, more than half the U.S. workforce is estimated to be non-Caucasian.¹⁵ Beyond unique medical problems experienced by certain ethnic cohorts, the growing number of internationally born workforce members adds pressure to incorporate Asian and ayurvedic approaches with traditional Western allopathic medicine.

For example, Muslim patients are not inclined to accept blood from a donor, preferring autologous, or their own, blood instead. An Asian patient might decline a prescription drug in favor of an herbal remedy. The use of yoga to treat postmenopausal pain is becoming more popular among urban women, and the concepts of integrative health are being taught in many schools of medicine alongside traditional Western medicine.

Figure 1: The U.S. health system is big, complex, fragmented and expensive



Our aging, more ethnically diverse population is requiring the health system to make changes in its diagnoses and treatments. Changing the system from a homogenous platform focused on Western medicine methods to a heterogeneous one represents a huge paradigm shift.

HOW EARLY ADOPTERS ARE TAKING THE INITIATIVE

The four stressors described above are contributing to major shifts in the current health care industry structure (see Figure 1). The transformations can be grouped into two categories: incumbents working in new ways and nontraditional entrants pursuing newly emerging opportunities. The activities of both groups are driving changes that are critical to real health care system transformation, including increases in:

- Access to information about the safety, quality and outcomes for services provided by doctors, hospitals, and long-term care providers.
- Emphasis on the role of consumers as key decision-makers in choosing hospitals physicians and insurance plans that accommodate their needs.
- Awareness of the scientific support for recommended treatment options and the gap between evidence and practice.
- Alignment of incentives between purchasers (i.e., employers, health insurance plans, government programs) and providers — the shift from volume to value.
- Investment in information technologies and care management tools across the system to facilitate coordination of care and reduce redundancies and paperwork.
- Sensitivity to the costs of health care by policymakers and taxpayers coupled with new models for insuring consumers and employers against its risks.
- Public debate about the role of the state and federal government in managing the health system as health reform is implemented.

How are these activities playing out?

Health plans and front line health care providers are joining forces to challenge traditional treatment models, share information in new ways, and develop new leading practices to deliver greater value for consumers. Technology companies are using advancements in communications and information technology to break down barriers between care system segments. Retailers are adding health services and expanding over-the-counter remedies to accommodate demand. Employers, health care

providers and health plans are experimenting with new ways to encourage healthier lifestyles and more efficient use of the health care system among consumers.

In short, old industry rules are being thrown out and new, at times unusual, relationships are forming among both incumbent stakeholders and nontraditional entrants into the market.

INNOVATIVE INCUMBENTS ARE BREAKING DOWN WALLS, FORMING NEW ALLIANCES

Many forward-looking industry participants recognize they can no longer operate in silos. To survive, different segments may need to consider setting aside longstanding distrust and tensions and collaborate in new, novel ways – and move quickly. Leading incumbents, including doctors, hospitals, life sciences companies and health plans, are establishing a variety of arrangements across traditional boundaries.

One example of this shift is the increasing employment of doctors by hospitals and health care systems. According to the *New England Journal of Medicine*, more than 50 percent of practicing U.S. physicians now work for hospitals or integrated delivery systems.¹⁶ Virtually every hospital is seeking ways to better align with doctors to reduce costs, address risks and provide better care from preventive measures through diagnosis and treatment.

In the PPACA, doctors and hospitals are encouraged to share financial risk to qualify for payments or avoid penalties via accountable care organizations (ACOs), episode-based payments and other models.¹⁷ ACOs bring doctors, hospitals and other providers together to provide coordinated care to Medicare enrollees, with incentives tied to quality metrics and Medicare savings.

The emergence of ACOs, along with other delivery models, is also providing opportunities for health plans. For example, in March 2011, Aetna and Carilion Clinic in southwest Virginia announced plans to collaborate in an ACO initiative. The relationship is ultimately expected to encompass co-branded commercial health plans for businesses and individuals, joint opportunities to provide personalized care, and new payment models that encourage providers to share accountability to improve patients' health.¹⁸

Elements of ACOs and other delivery models could be linked by a medical “e-highway” that promotes sharing, better coordination, work flows, alerts and personalized applications that allow each user to get the most out of the data. Evidence of this may be seen in the development or acquisition by health plans of software companies providing this type of utility.

OptumInsight—a business unit of UnitedHealth Group formerly known as Ingenix—focuses on providing the health care industry with information and analytics

and establishing secure networks for information exchange.^{19,20} OptumInsight is one player in what is evolving into a new “infomediary sector” within health care – businesses that amass and analyze clinical and administrative data and monetize and sell it to hospitals, doctors and pharmaceutical companies.

Many life sciences companies are also realigning to strengthen their positions in the shifting health care landscape. Many large pharmaceutical companies are continuing to expand beyond their small-molecule focus into the large-molecule world of biotechnology. Biotech products such as vaccines and inhalers offer growth opportunities to companies buffeted by patent expirations and generic competitors to their traditional small-molecule, typically pill-administered products.

A notable example of this trend is the 2009 merger of Roche and Genentech. The companies, which had partnered for nearly two decades prior to the deal, saw their merger as a way to simplify the structure of the combined organization and maximize the benefits of enhanced scale.²¹

The merger of Switzerland-based Roche and U.S.-based Genentech is an example of how life sciences companies are seeking to expand globally through relationships and collaborations. Another example of greater global focus is Pfizer’s 2010 acquisition from Biocon of Bangalore, India, of rights to four insulin products – one of a number of recent moves by Pfizer to expand its business in emerging markets.²²

NONTRADITIONAL ENTRANTS ARE SUPPORTING AND DRIVING TRANSFORMATION

Several realities are driving the growing interest in health care from outside the field. Nonincumbents are looking at the market in fresh ways, developing new approaches that provide the opportunity to create value both collaboratively with incumbents and to fill gaps in the existing system.

Nonincumbents may also find the health care system’s “value gap” inviting. Deloitte* research found that 76 percent of respondents give the system a “C” grade or lower, and nearly half of them believe at least half of health care dollars are wasted.²³

Many new entrants have access to capital. Demand for health services is soaring. The potential for both domestic and global growth, the size of the market and system inefficiency represent opportunities for investors.

Among outsiders making a major impact on the industry are telecommunications and technology companies that are making deep pushes into health care. They are pursuing opportunities to help providers, health plans and Medicare and Medicaid share data more effectively and use broadband applications to conduct distance medicine. These companies are also supporting the engagement of con-

* As used in this article, “Deloitte” means Deloitte LLP. Please see www.deloitte.com/us/about for a detailed description of the legal structure of Deloitte LLP and its subsidiaries.

sumers in “technology-enabled self-care” – using technology to provide medication reminders, make medical records available and educate consumers regarding their own health conditions and needs.

Service portfolios, such as AT&T ForHealth, are accelerating delivery of wireless, networked and cloud-based solutions tailored to the health care industry.²⁴ Such solutions include medicine bottles that remind patients to take pills on schedule, devices that monitor patients’ heart levels from their homes, and audio/video links that can replace the need for an in-person visit to the doctor.

Thomson Reuters offers hospitals and health care providers evidence-based reference information for drug, disease, toxicology, patient education and neonatology through its Micromedex solutions.²⁵ Micromedex markets products for medication safety, health and disease management, patient education and toxicology to hospitals worldwide.

Other opportunity-minded outsiders are innovating in the delivery of information to support highly targeted therapies, with the goal of improving treatment and reducing spending on approaches that don’t produce desired outcomes. Companies such as 23andMe, Inc. and Navigenics offer consumers a tool to understand their own genetic information.^{26,27} DNA analysis of saliva samples is used to identify disease risk factors, predict drug responses and uncover ancestral origins. 23andMe offers the service directly to consumers, while Navigenics offers it through sign-up with a physician or corporate wellness program.

THE STATUS QUO REALLY IS UNSUSTAINABLE

As they work to make the U.S. health care system more “okay,” incumbents and nontraditional stakeholders are making important contributions to the system’s transformation. They are driving the critical shift from volume to consumer-oriented value, information-driven health care and coordination of care across an otherwise fragmented system.

Increased access for those lacking insurance; improved care through better alignment of practices with evidence; and lower costs for consumers, employers and government purchasers are some of health reform’s goals. Getting there is, and will likely continue to be, messy as incumbents are pitted against each other and nonincumbents challenge traditional stakeholders with new business models and new and potentially better value propositions.

Even as the rancorous political struggle over health care legislation continues, and as incumbents and nonincumbents clash, positive developments are happening across the system. The tension associated with transformation of the U.S. health system will likely result in its strengthening.

Will all stakeholders end up “okay” going forward? Probably not. The question is who will prosper and who will fall by the wayside? Based on the advances described above, it seems likely that individuals and organizations that are open to new ideas; willing to revisit their value proposition to improve what they do from a competency perspective and change what doesn't currently work well; and able to challenge the status quo could fare better than those that cling to familiar but outdated practices. If enough people and businesses move in that direction, the outcome really could be okay for the health care system and all of us it serves. **DR**

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