MANATT’S HEALTHCARE INDUSTRY MEGATRENDS

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There are strong forces shaping healthcare. Changing industry structures, advances in medicine and a consumer-centered perspective on healthcare delivery have given rise to ten megatrends that will influence healthcare over the next ten years. Industry leaders, ranging from company CEOs to state Medicaid directors will need to evaluate the impact that each of these ten megatrends will have on their organizations and how best to create opportunity and manage change in the years ahead.
Irrespective of the daily barrage of negative headlines about the rollout of Obamacare, inexorable market forces are reshaping, and will continue to reshape, the healthcare landscape. Changing industry structures, advances in medicine, disruptive technologies and a consumer-centered perspective on healthcare delivery have given rise to ten megatrends that will influence healthcare over the next ten years. Industry leaders, ranging from company CEOs to state Medicaid Directors, will need to evaluate the impact that each of these ten megatrends will have on their organizations and how best to create opportunity and manage change in the years ahead. Payers, providers and consumers, look out for the following ten megatrends!

MEGATREND 1: Consumers Take Charge

The role of the patient as the consumer in healthcare is growing, including in the purchase of insurance (through Health Insurance Marketplace shopping and consumer-directed health plans). The Marketplaces will give rise to a new legion of active shoppers who compare product attributes and prices and spur continued innovation in packaging healthcare services. Increased use of high deductible health plans and plans with increased cost sharing in their benefits will attune patients to costs of care and channel them to limited provider networks. However, there also will be a rise in the underinsured: for example, people who have insurance but whose benefit plans require high drug copays for specialty therapies.

A new Age of Aquarius is coming, when information will be liberated into the hands of consumers, and we see the signs all around us already. Price information on drugs, hospital care, lab tests, and you-name-it will become freely available, casting a harsh light on dramatic variations and irrational pricing. Consumers will have the ability to differentiate on the basis of value as provider outcomes become transparent. Clinical information, backed by smart decision support algorithms, will be in all our smartphones, giving us access to the same data that doctors, nurses, PAs and other healthcare professionals can access. Social media will continue to grow in the healthcare space, with consumers linking together to share their experiences on just about everything—including rating physicians, hospitals, and self-help applications—and connecting together into online disease communities. Think Expedia, Trip Advisor, Yelp!

Indeed, consumers will need to bear an increasing responsibility for managing their health, as well as actively participating in their care (e.g., home-based pain management), as personal behavior will be seen not only as central to health but also to containing healthcare costs. There will be a rapid growth in home-based self-care and self-monitoring resources and technologies. The uptake in self-care will initially be driven by incentives to reduce readmissions, as well as the new focus on patient self-management in ambulatory settings as a result of initiatives such as “pay for performance” and the “patient-centered medical home.”

Recognition that individual health can’t improve without community health will lead to a new focus on community action as the basis for improved consumer behavior, particularly diet and exercise, as central to containing healthcare costs. With diseases such as diabetes and heart failure growing to epidemic proportions, there will be new efforts to organize healthy “Blue Zone” communities. Employers will be recruited into this effort, as will social service, public health and provider organizations.

MEGATREND 2: More with Less: From Volume to Value

Across the board, stakeholders will need to support higher-quality outcomes and greater satisfaction—all while reducing costs. "Value" will be a central focus, as we seek to improve the results we achieve for every dollar we spend. Payers, whether insurers or states, will transition to more innovative payment
mechanisms and value-based purchasing (and away from traditional fee-for-service) to drive quality and manage cost. Payers will need to synchronize coverage and benefit structures with payment innovations for the goals of payment reform to be reached.

The delivery environment is shifting toward integrated delivery systems, such as accountable care organization (ACO) models, in which primary care really is primary. The demand for cost effectiveness is driving the emergence of research focused on comparative effectiveness. Expect a concurrent reform of the medical malpractice and medical education systems.

The future will see re-pricing of physician specialty services and continued emphasis on re-balancing primary care (through expanded scope of practice, use of care teams, improved payment and care management fees) and more targeted use of specialty care (through enhanced referral and care management processes). Coming reductions in specialist physician incomes will create new interest in physician hospital employment, stimulating further consolidation through acquisition of practices. Some physicians will opt out of traditional insurance in favor of concierge medicine.

More participants in the healthcare system will have to accept risk. Providers and product suppliers, such as pharmaceutical companies, will have to learn to become successful risk-bearing organizations, while increased cost-sharing, especially for specialty products, will shift risk to consumers.

The healthcare system may address its insufficient provider supply through an expanded role for non-physician providers (e.g., nurse practitioners and dental hygienists) and new models of mid-level providers to manage minor specialties. Care models are increasingly moving toward team-based care and lower-cost care providers, with expanding clinical roles and scope of practice and a concurrent increase in specialization of non-physician clinicians. Legislatures recognizing the need for accessibility and affordability will champion increased scope of practice regulations.

Reimbursement will increasingly be based on quality metrics. Health plans will have sophisticated tools to wean out providers that do not meet quality and efficiency measures. The healthcare system will see increased investment in tools to translate quality measures to empower consumers in choosing practitioners, networks, facilities and payers.

**MEGATREND 3: Healthcare Everywhere**

Driven by the rise of new technologies, experts anticipate that, over the next decade, as much as 50% of healthcare will move from hospitals and clinics to homes and communities. From smartphones to social media to sensors, new tools are empowering consumers with more information and control over their healthcare decisions—and physicians with more options for where and how they treat their patients.

Ubiquitous dissemination of smartphone technology will put the power of connectivity, health information and healthcare applications into everyone’s hands, enabling patient and consumer engagement (also known as m-health). Smartphones will be used for monitoring glucose, blood pressure, heart rate and just about every other vital sign. Implanted devices will serve as remote sensing computing devices. Remote monitoring of conditions and compliance with treatment plans will become routine, with alerts to a provider just a subscription away, similar to home alarm services.

The distribution of delivery of care will move out of acute settings and into ambulatory settings and retail clinics, where it will be delivered by lower-cost care providers, including pharmacists, nurse practitioners and physician assistants. There also will be a related development of systems of care, which will aim to optimize the allocation of care delivery across the care continuum.
MEGATREND 4: Mega Health Systems

Mergers and acquisitions among insurance companies, hospitals and health systems, pharmaceutical supply chain members and other healthcare entities will result in mega-healthcare systems managed by giant organizational entities. The role of the independent practitioner or stand-alone community hospital will come to an end.

Roles of provider entities may change as they become more focused on delivering the right care, in the right place, at the right time. Mega provider systems are growing, giving them increasing market power. The rise of insurers’ use of utilization control with narrow provider networks may have access implications that intersect with the consolidation and reorganization of providers.

Clinical systems will embrace population health, with a tidal wave of provider-sponsored health plans, payer-provider joint ventures, and direct contracts with employers and employer coalitions. Providers and institutions are rapidly adopting a proactive medical model that reaches out to patients not meeting clinical guidelines, focusing on prevention, and adopting “teach back” methods to support patient-centered care and self-management. Protocols, sometimes disparagingly associated with "cookbook" medicine, are increasingly being used in a much broader array of settings.

Provider adoption and adherence to protocols are being reported, and compensation is being tied to performance. The use of advanced analytics and predictive modeling to better understand, identify and effectively treat high-risk populations (including those with multiple chronic conditions and co-occurring behavioral health conditions) will increase.

Providers will continue to implement to federal standards and struggle to integrate and find value in their new tools and capabilities, while protecting themselves from the risks associated with poor implementation, inadequate training, and the shift to electronic tools and patient expectations for ubiquitous, well-functioning technology. Paper finally will be abandoned.

Lack of capacity and expertise in population health management will rapidly result in a multi-billion dollar health information technology and services industry to provide analytics and a care coordination infrastructure. Business models will range from traditional outsourcing to cloud-based application services.

Issuers in the Marketplaces are moving toward narrow networks to keep costs down. These limited networks will test consumer acceptance of limited choice.

In a landscape where access to capital for change will determine organizations’ ability to adapt, where major insurers are for-profit, and where there is increased access to health insurance, it will become challenging for independent, not-for-profit healthcare, safety net, solo and small community providers to survive and adapt. The decreasing role of these providers will leave a hole in the delivery of unreimbursed and charity care, and rural access will become limited. As a result, there will be attempts to enhance federal funding for these services.

MEGATREND 5: Centrality of the States as Payers, Public Health Agents & Innovators

Medicaid is undergoing the most substantial transformation since its inception, moving out of the welfare space and squarely into the health insurance market. The potential expansion of Medicaid coverage to an additional 16 million people coupled with concerns about the sustainability of the Medicaid program in the wake of growing federal and state budget deficits; Medicaid’s countercyclical spending cycles; and the
aging of the population, with its associated long-term care needs have fueled high interest in reforming Medicaid, and state agencies will need to become active purchasers. The ACA may lead to a third public program (Medicaid Plus) or an Exchange-like approach as a further evolution.

Medicaid expansion, growing reliance on Medicare, the increasing numbers and cost of dual eligibles, and the creation of Health Insurance Marketplaces have more closely aligned public coverage with private insurance. States also are increasingly devoting attention to multi-payer initiatives around payment and delivery system reform.

At the administrative, payer, and provider levels, entities are focused on simultaneously addressing medical, behavioral, public health and social issues. New financing and delivery system models are emerging to address these issues. Behavioral healthcare services will be desired, offered, and integrated with Medicaid managed care offerings.

The aged, blind, and disabled will be moved into managed care plans and included in integrated care initiatives. This will require a paradigm shift in thinking among providers and plans about how "healthcare" is delivered for populations with functional versus medical needs. It also will lead to new partnerships between acute and long-term care (LTC) providers, traditional and non-traditional providers, and LTC providers and health plans. Additionally, the current trends accept, without change, Medicaid as the payer of long-term services and supports (LTSS). This could shift over time, with focused efforts to increase public awareness about one's risk for needing or providing LTSS, how LTSS are provided and paid for, and private insurance/savings or other planning vehicles.

Public health officials are showing an increasing commitment to addressing behavioral issues, such as smoking, nutrition and fitness. They also are paying greater attention to other preventive and environmental health issues, and integrating these interventions into the broader healthcare system. These components of the system will not only be central to improving health status but also to containing healthcare costs. Additionally, the proliferation of cross-border viruses will require increasingly coordinated early detection and action.

MEGATREND 6: Value Through Data

A better ability to create and analyze giant data sets will allow insurers and providers to support quality improvement and planning processes, as well as engage in more effective population health management. State-based all-payer claims databases will create opportunities for innovation.

Integration of clinical, molecular, and demographic data sets, combined with advanced modeling, will drive new research and development (R&D) processes for the pharmaceutical and medical device arena, creating new linkages between pharmaceuticals, medical devices, and providers with clinical data. These data also will increasingly be used to identify safety concerns and evaluate cost effectiveness.

Big data-driven patient enrollment will facilitate the consolidation of clinical research trials and the acceleration of results through enhanced precision and more effective phenotyping.

MEGATREND 7: Predict, Prevent, Personalize

The field of genomics has the potential to change the face of healthcare through personalized medicine, genetic manipulation and predictive diagnostics. Genome mapping will become increasingly prevalent; create new opportunities for entrepreneurs; and raise new awareness of the impact of nutrition, lifestyle and preventive medicine. It also will raise new privacy and ethical issues around the management of this
information, as well as new questions about when the proclivity or statistical risk for a medical complication entitles a person to treatment and coverage of that treatment.

Evidence-based clinical decision support will become embedded in smart applications that provide real-time clinical decision support and can be integrated into the clinical workflow. Downstream uses include consumer self-management.

The next several years will see continued development of cybernetics (e.g., artificial vision, movement, and manipulation), cloning and regenerative medicine (e.g., stem cells, organ transplantation). Three-dimensional printing and organ printing may also become prominent.

Evidence-based clinical decision support will continue to develop over the next few years and is being built into the care delivery workflow, such that decisions made by providers are standardized and supported. The possibility exists that, in the future, a machine might take on some of the clinical judgment and cognitive steps from clinicians. Systems will need to be developed to ensure timely integration of innovative drugs and procedures in clinical decision support tools.

**Megatrend 8: Employers Recalibrate**

Employer retiree programs will continue to drop coverage and shift retiree beneficiaries to the Marketplaces. More broadly, employers will undertake a wider move toward vouchers with individuals directed to purchase their own coverage.

For employers who remain purchasers of healthcare, its provision may become more administratively complex and highly regulated. Employer coalitions and alliances will flourish, pooling their interests and purchasing power to contract directly on a value basis with select providers.

**MEGATREND 9: The New Aging**

As demographic trends continue, the population will get older. The new aging will provide many new opportunities for enhanced self-care, connected care, monitoring and assistance that enable individuals to stay in their homes longer. The importance of effectively managing chronic diseases will become even greater, as will the integration with behavioral health.

With the aging trend, there will be an increased role for family caregiving and large impacts on the health of caregivers, who will need to have a stronger knowledge of long-term care options and resources.

The dramatic change in the Medicare marketplace over the past 10 years with the shift to managed care will continue. New efforts will be made to integrate behavioral health services, particularly for dual eligibles, and to transition these beneficiaries to “care management” models. These models will require both state and federal governments to think outside the box about financial arrangements.

An aging population and cost pressures will lead to an increasing acceptance of the need for end-of-life care planning. A growing acceptance of the spiritual pathways to passing from this life and an associated expansion of palliative, hospice and related services will lead to new approaches for passage with dignity.
MEGATREND 10: Healthcare Goes Global

Burgeoning demand in emerging markets will have a disruptive impact on American pharmaceutical companies. Pharmaceutical companies will face increasing pressure to make branded pharmaceuticals available in low-income countries, if generics are not available.

Pharmaceutical companies are looking to enter middle-income markets, such as Brazil, where there is a rising middle class that is willing to pay cash for specialty products. We are beginning to see the emergence of pharmacy benefit management in these markets.

With globalization, Americans may start to receive their care in more global settings—getting tested, diagnosed and cared for remotely, through telemedicine and through medical tourism.

CONCLUSION

From health reform to scientific advances to technological innovation, a range of forces are converging to cause a seismic shift in the way we deliver and pay for healthcare. Over the next decade, our health system will be re-invented. The goals of the radical changes are to improve quality, care and outcomes while keeping costs in check. Will we be effective? Time will tell, but the cost curve already has turned downward. We will continue to monitor these trends in the days ahead.