

THE SPARKS ARE FLYING

Lighting a Fire
Under Healthcare

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Imagine a different healthcare future. Medical advice we can follow, making a difference we can see. Clinical care delivered in the setting that's best for us. Affordable. Easy to navigate. Working for us, not against us.

Why can't we have it all? Maybe we can...

AN INDUSTRY MISALIGNED

We've typically defined the US healthcare industry around two core models: health systems and insurance companies.

Health systems were built around large, high fixed-cost, general purpose hospitals to treat diverse patient populations. These systems developed networks of affiliated local physicians to extend their reach into the community. This scale and density of local coverage promised, but didn't deliver, efficiency. Instead, scale has provided negotiating leverage over a shrinking pie.

On the payer side, the business model required investment in sophisticated administrative and distribution processes, which became fixed assets for administrative platforms and a sales infrastructure rewarding scale across millions of covered lives – another strong motivator for consolidation. (Ironically, the actual insurance process – actuarial pricing and risk management – can be competitively managed at smaller scale points, often with populations of 10,000 or 20,000.) Expensive fixed-cost processes are now being challenged by technology-enabled models.

The industry structure is designed around the economics of supply with a one-size-fits-all, general value proposition. Whether in the doctor's waiting room, the emergency department, the health plan design, or the benefit structure, this system is designed around clinicians and assets, not consumers. And it has been frustratingly slow to evolve and improve.

JUST ONE SPARK

Traditional roles are under increasing pressure. The combination of advancing technology, consumer activation, regulatory shifts, and business model innovation is challenging incumbents across the ecosystem. Market disruption follows patterns, like the laws of entropy in physics: if purposeful technology and business creativity can be combined in the right mixture, healthcare will be disrupted to deliver better outcomes, experiences, and economics. In industry after industry, sparks have appeared that burned down the underpinnings of old models. In healthcare, those emerging sparks are beginning to define the dimensions of a new healthcare industry:

ECONOMIC PRESSURE

For providers, health system costs are growing much faster than revenue. Nearly 20 percent¹ of US hospitals are either at or near insolvency. Cross-subsidization of commercial and government paid populations is unsustainable. Inefficiencies of care delivery networks are being exposed.

DATA ENABLEMENT

Digital medical records and the explosion of behavioral data consumers generate are an opportunity to think about how data is used. Relying on patient-physician exchange as the core of healthcare decision making is risky.

CONSUMER EXPECTATIONS

Healthcare's consumer experience and reputation is poor – Oliver Wyman research on consumer perceptions puts both core business models (health plans and hospitals) at the bottom of cross industry ratings. Problems are well documented. Consumers expect and experience seamless, convenient, transparent services in other aspects of their lives. They will gravitate toward companies that can meet those expectations in healthcare.

BUSINESS DESIGN INNOVATION

A new group of disruptors is making credible, aggressive moves. Both from inside the industry (such as significant new moves by Aetna, Cigna, UnitedHealth/Optum) and from outside (most notably, Amazon-Berkshire Hathaway-JPMorgan, Apple, and Google), innovators are targeting the failings of traditional models.

Each of these is a strong enough spark to drive real change. Together, they create the conditions to ignite the fire.

Across the broad front of innovation, we are seeing the emergence of five new roles capable of delivering value to the consumer and the funder. These roles are based on new business designs that have a compelling value proposition and an economic model that can change consumer behavior patterns and spark a new industry structure.



ROLE 1: ACCESS SPECIALISTS

By some estimates, three in four primary care encounters can either be resolved via virtual bots and self-care programs, or else be addressed by clinicians remotely or at home. New front door options are beginning to offer compelling alternative propositions:

1. Retail clinics are continuing to expand, diverting consumers away from emergency rooms and traditional primary care offices based on need and convenience.
2. Established retailers are converting their retail footprint toward healthcare options around pharmacists and nurse practitioners.

THE SPARKS BECOME A BLAZE: NEW ROLES TO DRIVE HEALTHCARE

REBUILDING THE INDUSTRY ON NEW DIMENSIONS

TODAY'S STRUCTURES
ARE BEING BROKEN APART...

HEALTH SYSTEM

- Primary care providers
- Hospitals
- Clinics
- Specialists



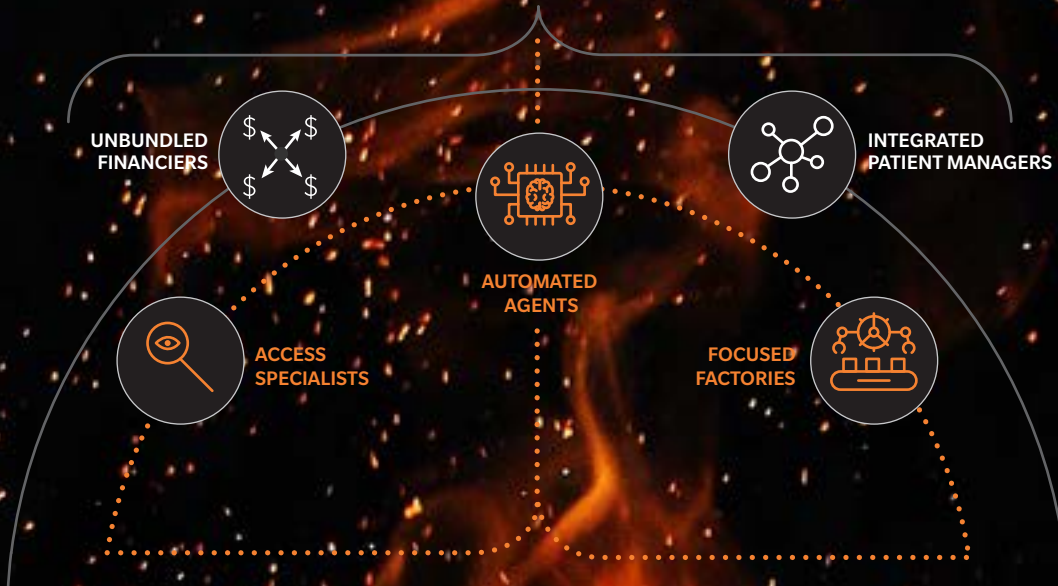
HEALTH PLAN

- Sales and distribution
- Network contracting
- Risk management
- Benefit design
- Member services

... AS THE INDUSTRY RACES TO
INNOVATE ON THE FUNCTIONAL PIECES...



... AND A NEW INDUSTRY STRUCTURE EMERGES



3. Telehealth is increasingly offered alongside physical locations by retailers (such as recent launches by both Walgreens and CVS). Leading health systems such as Cleveland Clinic are deploying virtual channels. Insurers, including the Centers for Medicare & Medicaid Services, are expanding coverage.
4. Home-based services are being targeted for innovative delivery models, with Comcast and AT&T building on their central role in customers' daily lives as a platform for accessing and managing care.
5. Automation to drive consumer self-service is progressing from theory to practice. Firms like Babylon and Ada are moving to automate parts of the diagnosis and triage process for major health systems.

The 2018 Oliver Wyman Consumer Survey confirmed rapid growth in the past three years in both the willingness to consider these options and a corresponding growth in consumers who have had direct experience in doing so. Those who have used these new access points have found them convenient and easy. Such consumers will use them again, over an increasingly broad set of services. Despite hurdles such as concerns about data continuity and portability, these models offer a compelling proposition of the easy, convenient access that consumers increasingly expect.

Health systems will see profound implications of this Access Specialist role. As transactional convenient care migrates to new delivery channels, visit volumes and Current Procedural Terminology (CPT) transactions will no longer drive the economics of primary care providers. The idea of "controlling" a patient for the benefit of capturing ongoing care delivery revenue or for the benefit of cost-effectively managing the continuum of care will become increasingly antiquated. This will be a battle of data and insight, not a battle of control.

For payers, the rise of convenient access points raises the possibility of greater consumption. Easy access will stimulate demand. How can they ensure these touchpoints will be beneficial, and help their members navigate a broad set of options, some of which will sit outside of contracted networks?



ROLE 2: AUTOMATED AGENTS

This second role has the potential to be our greatest breakthrough. Traditionally, responsibility for health and wellness has fallen to the individual, shared by family and caregivers. But human beings are fallible and notoriously bad at correcting behaviors, as evidenced, for instance, by the growing prevalence of lifestyle diseases such as heart disease and obesity.

Information accessibility and artificial intelligence offer promise in delegating impulse control to technology. Automated Agents will use the explosion in available consumer data to provide reminders and nudges toward healthy behaviors in a personalized, "right time, right place" kind of way. They will know we're getting sick – either physically or mentally – before we do. They will

account for our genetic profile and health status to plan, predict, and prevent. Despite a “Big Brother” stigma, we openly give our information to Alexa, Siri, and Google.

These Automated Agents could become widely and cheaply available, impacting social health determinants beyond providers’ current scope through continual monitoring and constant connectivity. This intelligent network’s knowledge may exceed human expertise, provided at zero marginal cost. Health systems will be disrupted as a new cycle of prevention diminishes primary care physician duties and mandating hospitals re-tool toward preventative procedures. Payers’ strategic control over member claims data may become significantly less important, as automated agents provide even richer data repositories.



ROLE 3: FOCUSED FACTORIES

The community hospital model is increasingly challenged to deliver value and operate with sustainable economics. Despite years of effort to streamline processes and manage costs, the inherent complexity of offering a wide “whatever walks through the door” set of services has left them inefficient, expensive, and ineffective. Delivering low volumes of a wide variety of services limits the ability to truly optimize on cost, quality, or outcomes. Hospitals thus represent the highest cost factor in the current delivery system.

This general hospital model will be undermined by the rise of the Focused Factory: a set of business models delivering a narrow set of services at dramatically better cost, quality, and experience – fulfilling the so-called “Triple Aim”. Although this is a longstanding concept, we’re not quite there yet. Nonetheless, procedure factories have already begun pulling apart the hospital model in some markets. Whether freestanding imaging models or ambulatory surgery centers, lower price points and a more consumer-friendly model make them compelling for many services.

As Focused Factory models extend in new directions, it is instructive to consider models where the funding of delivery businesses is direct from consumers. In India, for example, several effective “procedure factories” deliver a narrow set of inexpensive services with high-quality outcomes. From the Aravind Eye Hospitals’ focused factories for cataract surgery with high throughput and standardized clinical processes (and a \$25 price point) to Dr. Devi Shetty’s heart hospital where they deliver cardiac bypass surgery for \$2,400 (with better outcomes than any US hospital), models built around industrial principles are demonstrating the art (and science) of what’s possible. As Shetty puts it: “It’s about process innovation, not product innovation.” The potential of these models to affect the cost of delivering care is profound.

It’s likely these models will extend beyond procedural specialties. In fields like oncology, where the nature of diagnosis, therapy, and disease management is technology-intensive, the development of remote Center of Excellence models is brewing. World-class oncologists will work remotely, integrated into local infusion centers.

As specialized models pull apart hospitals' economics, choices will be required about the scope of services where general service models can remain competitive. These new models cannot simply redeploy the existing hospital/community care structure; gaps in skills/knowhow and culture/mindset make the "we'll just reinvent" hurdle for most systems too high.

For payers, these new models – often sitting outside traditional local/regional systems – will become part of contracted networks. Members and employers will gravitate toward these models because of both cost and experience. Early stages of these network redefinitions existed with Center of Excellence programs defining "best in class" destinations for selected procedures, often outside of local geographies. The "standard" network will need to look quite different.



ROLE 4: UNBUNDLED FINANCIERS

Consumers' desire for personalization, choice, and control doesn't stop with how they access doctors. The model of financing of care – the standard health plan – offers a monolithic product designed to be agnostic to varying consumer needs. The tension in this inefficiency creates opportunity. We can expect to see the rise of Unbundled Financiers, with products meeting diverse needs and purchasing behaviors. Healthcare financing will shift toward curated solutions. Insurance markets will begin to disaggregate, serving discrete consumer needs individually. Consumers will be able to insure themselves based on unique needs, seeking care, coverage, and support at specific "purchase occasions." Social platforms enable micro-segmentation. A proliferation of benefit designs and financial products will target population segments beneath the "catastrophic layer."

The Unbundled Financier faces headwinds in the regulatory environment. Most national and state regulation creates standard benefit requirements. Many policymakers have concerns about moving away from large group risk pools, potentially raising coverage costs for those with health risks. But the pressure of overall cost containment raises the possibility that a move toward the "consumerization" of healthcare finance becomes a viable alternative. The momentum behind "Medicare for everyone" could give way to a more affordable "catastrophic healthcare for everyone." As convenient care options proliferate, demand for full-benefit packages decreases. Consumers may well move toward high deductible or catastrophic plans supplemented by cheap primary care visits. Incumbent payers face disintermediation.

Most insurance incumbents operate via processes incapable of the required flexibility, segmentation, and personalization. Product launch timelines are measured in years. The scale assets they've built for today's model are not well aligned with future requirements. New entrants appear to be better positioned to respond to shifts. For provider systems, the advent of Unbundled Financiers raises challenging questions about contracting, price transparency, and how to ensure services are affordable.



ROLE 5: INTEGRATED PATIENT MANAGER

This last role is based on the logic and principles of population health management. Combining the incentives of managing total cost of care with the ability to manage the full continuum of care will power Integrated Patient Management models effective in managing a selected population. This role is broad in scope, requiring the ability to combine and integrate the other roles to effectively deliver value.

The early models of CareMore and Healthcare Partners demonstrated the power of a strong, complex primary care model combined with the ability to take full financial risk for the entire care needs of a member/patient. Kaiser has a track record of managing the cost of care with its combined health system/health plan model. The more recent moves of UnitedHealth building the Optum Health delivery business (Optum is now one of the largest employers of physicians in the country) and the pending CVS-Aetna merger (linking a comprehensive benefit structure with community care resources) signal the Integrated Patient Manager's significance going forward. Notably absent from these more recent moves? Care delivery assets in expensive hospital care settings.

Integrated Patient Managers will have strong incentives for investment in innovative programs to better prevent and manage care (see Automated Agents) to help systems manage the most complex patients. They will need to find ways to deliver care in more efficient deliver models (see Access Specialists and Focused Factories).

Not everyone will want to operate in the open access, convenient, and transparent consumer market of Unbundled Financiers. For some, especially those with more complex health needs, the idea of a highly curated, well managed, and integrated experience will be very appealing.

HOW DO WE GET THERE FROM HERE?

The five roles outlined above each represent a source of innovation and a source of value in the healthcare market going forward. Others may appear as the pace of disruption picks up. The advent of affordable genetic information and tailored treatment and pharmacy regimens will likely require roles nonexistent today. The visions of non-healthcare entrants likely will go in directions the healthcare industry has not yet fathomed. The boundaries are already blurring, as a new industry structure emerges.

For incumbents, built on traditional models and boundaries, this creates a crossroads that raises questions. Everyone will need to invest in new capabilities, but which ones will be most important? Everyone will face questions of pace: How long can my traditional model deliver value and returns on investment? How rapidly will my market evolve toward new roles? Everyone will face questions of talent and culture: How ready is my organization to be nimble and responsive? Do I have the right mix of talent?

Too many organizations aren't yet facing up to these questions, focused on serving their traditional model – more assets, patients, and members – without examining the benefits of that scale. Every dollar and hour invested in entrenching is a missed opportunity to become

competitive. For incumbent health insurers, their technological and operational infrastructure will not survive, as employer (and consumer) demand surges for cheap, personalized products tailored to employees' health and engagement needs.

Incumbent health systems will continue to erode as well-reimbursed commercial patients seek acute care at Focused Factory Centers Of Excellence beyond local communities. As consumers opt for a broader set of care settings, the certainty of volumes and margin will erode. For all incumbents, the question of how aggressively they need to move toward reinvention will be central. Temptation to stick to current models will be strong.

Moving toward new roles is hard, but not impossible. In 2016, Mount Sinai in New York announced² the plan to replace its 400+ bed Beth Israel hospital with a more focused 70-bed facility, to transform its ambulatory care center to an urgent care and specialty center, to launch aggressive home health and hospital at home programs, and to add a women's health center. That move took leadership and courage. And a different view of roles the health system should play. Like Mount Sinai, incumbents should ask: **When's the right time to change?**

We know standard answers don't exist. But we also know these five roles are both threats and opportunities, offering the promise of a better system where today's spark sets tomorrow ablaze.

KEY TAKEAWAYS

- Across the broad front of innovation, five new roles capable of delivering value to the consumer and the funder are emerging. These roles are based on new business designs that have a compelling value proposition and an economic model that can change consumer behavior patterns and spark a new industry structure.
- Health Systems will face challenges in how to move their high fixed cost, asset intensive, general purpose model toward new, very different roles in delivering care in their communities.
- Health Plans will face questions about whether and how they develop new roles in delivery while building much more flexible and nimble product processes.