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2014 Priorities for the Healthcare Industry

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2014 Priorities for the Healthcare Industry

by Minoo Javanmardian and Joyjit Saha Choudhury

The U.S. healthcare industry is undergoing unprecedented changes right now. The reforms of the Affordable Care Act, greater consumer choice, public and private exchanges, and new technology are all upending operating business models, as is a fundamental shift from the traditional fee-for-service approach to one based on quality and outcomes. These different ways of doing business have the potential to revamp the healthcare value chain and redistribute value among stakeholders, creating threats and opportunities for both payors and providers.

Understandably, many organizations remain uncertain about the best strategic response. But a wait-and-see approach is not sustainable. The current disruptions are only the beginning of a profound transformation—a long trip on a road that is not yet paved—and payors and providers must begin preparing for that process today.

Amid all the changes, two broad themes are clear. The first is consumerization. Patients already have far greater choice and control, after long playing the role of passive participants when the industry previously operated largely in a business-to-business environment. Today, patients are paying a greater share of the cost, and they have more options regarding payors. This presents a major challenge for organizations that do not have well-developed consumer capabilities.

The second major shift is the evolution of risk, which is migrating away from payors and toward providers. Properly evaluating and managing risk is the way that the industry has long generated profits—risk is where a lot of the money is—but it's not yet clear how critical risk-bearing activities will ultimately settle. That's why providers are altering their models of care delivery, through offerings such as bundled care, accountable care organizations, and other innovations that allow them to shoulder some risk in exchange for greater rewards. This shift also explains why payors are increasingly moving into the provider space, to diversify revenue and capitalize on their expertise in assessing, bearing, and managing risk.

In light of those two themes, we believe that payors and providers should focus on several strategic imperatives.

Strategic Imperatives for Providers

1. Determine an operational focus. Before doing anything else, providers need to identify a clear strategy of how they want to compete and win in the market, with the right differentiating capabilities to execute against that strategy. Some may opt to be value providers, with a focus on low-cost care at high volumes. Others may develop a center of excellence for a particular condition or disease state, providing specific types of

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care at high margins. These decisions have major ramifications in the way that providers build needed capabilities and allocate their resources.

2. Reduce the cost of care. Next, providers must figure out a way to reduce costs without affecting quality. But straightforward cuts will not be enough. This goal will require fundamental transformations on both the clinical and administration sides of the business, with a baseline of 20 to 25 percent in reductions.

3. Develop consumer-centric care models. As the clout of individual consumers grows, it is not enough to achieve better health outcomes at lower costs. Providers must also deliver a better patient experience. (If not, physicians might read about it on a patient's Twitter feed.) This points to the new care-delivery models that are slowly gathering momentum, such as bundled care, population management, and other innovations. These are radically different approaches to care, and they require correspondingly large changes in operations, including a better integration of hospitals, outpatient facilities, and long-term options into a single continuum of care.

4. Manage the transition. For the next several years, most providers will still generate the bulk of their revenue from the older fee-for-service approach, even as they develop new care models. This may be a painful transition. The two models represent different ways of thinking about patient care, and they require different operational priorities, creating complexity and even bioethical considerations that providers will need to address. Management needs to strike the right balance between both approaches and shift that balance over time, while ensuring that the organization remains financially viable.

Strategic Imperatives for Payors

1. Determine the right business lines. Most payors, especially the largest plans, have already made this choice and determined their ideal service offering—either the consumer segment, or a B2B model through employers—along with the right mix of commercial and government revenue. Yet it is critical for all payors to determine the right business lines, because this choice has huge implications on what they need to be good at, and where they need to invest in capabilities.

2. Understand consumers. The majority of growth over the next few years will come in consumer segments, as employees shift from company-sponsored plans to public exchanges, and as new patients get coverage under government programs. This is creating new opportunities, but only for those payors that truly understand consumers—what their needs are, what they're willing to pay for, and how they choose among the myriad options they now face. Digital technology can be a critical tool in understanding consumers and influencing their behavior. But technology is changing much faster than healthcare, which means that most payors are scrambling to keep up.

3. Reduce costs. As with providers, payors are also under significant pressure to reduce their cost structure. Yet their challenge is more acute given the medical-loss ratio constraints, which effectively put a cap on the money payors can make. Many plans have taken initial steps to reduce costs, but most have not yet reached what we consider a baseline goal of 20 percent reductions. At a minimum, that goal requires cuts in administrative costs, but payors also need to reduce the total cost of care. This is particularly true if they operate in government segments, such as Medicare Advantage,

which are facing significant cuts in reimbursement rates. Administrative cuts alone will not be enough.

4. Move into the provider space. As noted above, payors must follow the shift in risk, by engaging more directly with providers. For example, they can create risk-sharing partnerships, or enable providers by serving as the "intel inside," meaning the internal expertise wrapped within a more comprehensive provider offering. Payors can also buy provider assets outright, such as physician practices or home- and community-based care operations, which are less expensive than hospitals but have significant leverage in terms of managing patient populations.

Finally, both payors and providers should understand the risk posed by new competitors, such as technology and telecom players, data mining companies, mobile application developers, consumer goods makers, and financial-services firms. Some of these companies are highly nimble, without the institutional inertia and conservative philosophy of many payors and providers, making them a genuine threat.

Such a complex operating environment requires a mentality of "disrupt or be disrupted"—a major cultural change for many payors and providers. Yet they have few other options. Change is clearly coming, and the only choice for payors and providers now is whether to adapt on their own terms or have transformations forced on them by competitors. ✚

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