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State of the U.S. Healthcare Industry and Trends for 2006

December 2005 — In 2005, the domestic agenda came under pressure and consequently we are likely to see a deceleration in some previously high-profile new programs, with the exception of the new Medicare drug benefit. Looking parochially at the healthcare sector, 2005 saw a strong push forward in structural change to accommodate the growing acceptance of consumer-directed health initiatives. As we enter 2006, we'd like to briefly share our thoughts on the state of the industry and the trends we see for the year ahead.

2005—A Decent Year, Before the Flood

After hopeful news about Iraqi elections early in the year, subsequent developments in Iraq and natural disasters at home caused 2005 to become a tale of two years. The first half of the year suggested more peaceful and prosperous times were just ahead. But the continuing insurgency and the hurricanes of summer put a damper on such hopes, an energy hole in consumers' pockets, and a huge drain on the federal budget. After the hurricanes, virtually all fiscal bets were off (except Medicare Part D) and an increasingly election-wary Congress was poised to step up its challenges to a lame-duck executive branch. While hurricane reconstruction costs are scary in the near term, they seem likely to be a spur to economic growth over the next few years. Caution, not despair, is increasingly the order of the day at the end of 2005.

Despite the unsettling developments of the second half of the year, sectors of the healthcare industry continued to play out the structural adjustments needed to succeed in a consumer-directed world, while coping with the ramp-up for Medicare Part D and the possibilities afforded by health information technology (HIT). Insurers and health plans were boldest in their moves on consumer-directed health plans (CDHPs), while providers continued to underestimate their impact. Insurers and pharmacy benefit managers moved quickly into the Medicare drug plan space, while pharmaceutical firms tried to decide if the new program was good news or bad. Costs for all of these things, of course, rose sharply—again.

Healthcare costs rose nearly 10% in 2005—a slight improvement over the previous five years, but hardly a reason to believe that the industry has turned the corner. Somewhat lower cost increases are expected for 2006, but the most salient trend is for employers to shift more of the higher costs to employees. By and large, major employers absorbed about 60% of the annual increases. Perhaps the best illustration of the severity of the cost increases of the past few years is the UAW's healthcare concessions for its GM members and retirees, leading us to wonder if concessions for Ford and Chrysler can be far behind. Cost remains the major issue for the healthcare industry and for the national domestic agenda.

Companies that offered CDHPs continued to enjoy slower rates of cost increases for employees enrolled in those products. Unfortunately, while CDHP enrollment continued its S-curve growth rate, less than 5% of the overall insured population is currently enrolled in a CDHP. Health savings accounts (HSAs), linked to high-deductible health plans (HDHPs), continued to

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be the most popular CDHP variants for large employers. The CDHP sector overall is predicted to garner the largest portion of new health plan enrollees—largely because of the plans' portability and rollover features. Still, numerous analysts' reports call for CDHPs to achieve 20% to 30% penetration of the insured market over the next three to five years—a level certain to force even further structural change.

The list of major players who "got it" regarding CDHPs continued to grow in 2005, and their efforts became more far-reaching. This was especially true in the insurance sector, but plays in the information technology space also had their roots in the increased adoption of CDHPs, and the growing ability of larger-scale plans to gain high value from advanced healthcare informatics. Two other issues were also behind the structural plays of the past year: the HIT push, and the need for insurers and plans to counter the bargaining power amassed by market-leading providers in many markets. UnitedHealth Group continued to be one of the most aggressive of the major insurers in assembling an end-to-end solution for CDHP products. On the heels of its acquisition of CDHP pioneer Definity Health in 2004, UnitedHealth now has its own bank for managing customers' HSAs, as well as increasingly sophisticated disease-management and quality tools, plus online personal health records for members. Other leading health plans also continued to invest in CDHP capabilities. Aetna, for example, has expanded the rollout of its Aexcel tiered networks across targeted markets while enhancing its information and decision-support assets (including the acquisition of ActiveHealth Management).

Tellingly, virtually all of the CDHP specialist firms have now been acquired by major insurers and plans. In addition, the year's end provided further evidence of competition for the new CDHP value chain. In a move to reverse the convergence arrow between health plans and financial services, 31 Blue Cross affiliates formed the Blue Healthcare Bank to administer all aspects of personal spending accounts such as HSAs and health reimbursement arrangements (HRAs), from transactions to invested rollover balances.

But other factors were afoot in the structural changes that occurred in the industry. After years of successful market consolidation and brand building by leading providers, insurers seem to be saying, "I'll see your oligopoly and raise you an acquisition and a merger." WellPoint continued to consolidate the market via its acquisition of New York's WellChoice, while two other plans—HIP and Group Health—merged. Finally, to top the year off, UnitedHealth acquired John Deere Health. This new round of consolidations was also being driven by scale and HIT considerations, as insurers figured that if and when HIT becomes a reality, there will be IT leverage in crafting national, enterprise-level solutions. Similar thinking was also likely at play in the information services sector—leading GE Healthcare to acquire IDX in a move to broaden its service offering and potentially play a larger role in any HIT-driven standardization and mandates.

But not everybody "got it" in 2005. While there were exceptions, the hospital sector continued to be nearly oblivious to the coming impact of CDHPs. Marketing, cost-containment, and quality initiatives got the attention they deserved, but in an informal survey of hospital CEOs, CIOs, and COOs, we discovered that CDHPs were virtually off their radar screens. The issue is

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embedded in other concerns—such as transparency and HIT capabilities—but few, if any, leaders grasped the structural implications of a shift to a more retail-oriented marketplace. The possibilities were not lost on some venture capitalists, however. Steve Case started up Revolution Health Group, a group of businesses aimed squarely at the customer-service gaps inherent in today's industry structure, as well as flaws revealed in the rollout of CDHPs and in the early thinking about HIT implementation. Revolution's companies will be offering routine walk-in care at reasonable prices at Wal-Mart, while other ventures will focus on wellness, scheduling, benefit design, and health information.

Industry structure and value-added issues would have dominated the discussion of HIT in 2005—if only there were funding to take the debate that far. While groundwork on standards and demonstrations got underway, there was no agreement on where the value lies, who will garner that value, and therefore who should pay for it. Although the most straightforward analysis would show that government programs dominate the system's current costs, there has been limited formal movement as to who should pay the biggest portion. The current budget crunch makes government funding even less likely, at least in the near term. The latest approach has the government encouraging regional solutions—Regional Health Information Organizations (RHIOs)—which would then be stitched together to form a national system. There are some promising experiments, like Massachusetts' state-wide e-prescribing network and plans for state-wide deployment of electronic medical records, which could create a sustainable business model. Overall, however, the jury is still out on which model is needed to create and sustain local health networks. Unfortunately, most strong local players see RHIOs in their current form as giving a free ride to weaker competitors—both in the provider and insurer sectors. Until a new business model is developed, we can expect more of the "islands of automation" that are being built by the most affluent and visionary providers and payers.

On other fronts, the public sector was pretty quiet. The federal government continued its accommodative ways in enabling the growth of CDHPs. Late in the year, however, the tax reform advisory panel proposed capping the currently unlimited tax exclusion for employer-sponsored health insurance at $5,000 for an individual and $11,500 for family coverage in a year, but any action on proposals seems distant and subject to intensive politicking. No industry players are likely to change their strategies based on these early proposals. At the state level, the federal budget crunch is stressing many Medicaid programs to the brink. Realizing that the uninsured and underinsured make the problem worse, nearly 20 states were mulling legislation or referenda to require employers to provide at least basic coverage for their workers (or pay into a state fund). Similar efforts have failed recently in California and Oregon, but this is a movement that bears watching—if not for its realization, then for the message it is sending a healthcare system that is increasingly viewed as broken.

Given significant revenue growth and margin pressure, the pharmaceutical sector spent much of the year thinking about how to compete in a rapidly changing marketplace and simultaneously squeeze more out of its current go-to-market approach. With health plans and pharmacy benefit managers, pharma focused on competing for formulary access in new Medicare Part D plans. This effort required a delicate balancing act for the sector—aggressive bidding to ensure access, yet minimizing the spread between Part D contracts and other

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managed-care business to avoid heavier discounting overall. While the impact of Part D still remains to be seen, we believe it will create a small, short-term windfall for major pharmaceutical firms. Inclusion of dual eligibles and increased covered lives should provide both net price and modest volume upticks.

On the sales and marketing front, pharma continues to think through (and sometimes test) new commercial approaches that take into account physician access restrictions and greater payer influence on physician/consumer decisions. Even with these trends, the pharma sector has yet to fundamentally change its approach to the market. There have been some modifications to the typical dialogue between physicians and sales representatives, such as formulary-access discussions, but the predominant response has been to put greater pressure on the sales force for better productivity, even with more limited access to physicians. Many pharma companies have, however, revisited one element of their sales and marketing models: With diminishing returns on direct-to-consumer (DTC) advertising, many have de-emphasized spending in this channel.

In terms of new product development, the jury is still out on whether the pharma sector is turning the tide on declining R&D productivity. There is evidence that a few companies are beginning to improve late-stage product success rates by better validating targets and optimizing leads early in the discovery process, but the data continue to show declining—or, at best, stable—success rates on an industry-wide basis. The industry and the financial community are monitoring R&D success rates closely, given the clear understanding that at current success rates, the economic returns to the industry will be less than compelling.

Finally, 2005 was also a year in which pharmaceutical product-safety issues continued to make headlines, and in which it became increasingly clear that judgments about drug safety and effectiveness are being influenced not only by the pharmaceutical industry and traditional regulators, but by health plans and payers. Reflecting the trend, the FDA has indicated it will work with major payers in both the private and public sector, including UnitedHealth's Ingenix unit and the Centers for Medicare & Medicaid Services (CMS), to monitor drug safety and effectiveness.

For much of the industry, 2005 played out about as expected: CDHPs and Medicare Part D remained the biggest news, and HIT the greatest near-term conundrum. However, strategic moves by existing participants and the focused entry of some new players suggested strongly that a structural crisis lies ahead. The current federal budget squeeze—a pale shadow of the crunch coming when the baby boomers hit old age—is likely to accelerate the development of a consensus about restructuring and even radical change.

2006—The Clothes Have No Emperor

With limited public funds for new or expanded initiatives, 2006 figures to be a year of continued orderly and rapid growth of CDHPs, persistent but manageable difficulties with the Medicare Part D rollout, and further consolidation on the payer and backroom-services sides of the industry. Pressing near-term fiscal issues will continue to overshadow the demand bomb of

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the impending entry of the baby boomers into old age. However, even the modest push on HIT that the government can afford will begin to show the long-standing and deep structural flaws in the nation's healthcare system and infrastructure. We don't believe this will foment an immediate crisis, but we believe 2006 is the year that a consensus will develop about the existence of the problems, and that it should be the year that industry leaders in all sectors begin to parse the current structure and value with a view to structural innovation over the next three to five years.

Imagine taking a national collection of hundreds of thousands of businesses and banks and trying to bootstrap the entire Visa and MasterCard network in five years. Now, increase both the size and the complexity of the problem tenfold. This is a moderate analogy of the challenge facing the HIT initiative. The logic of an HIT system is clear—it's been the Holy Grail of healthcare management for at least 20 years—but its value to the players being asked to implement and pay for it is far murkier. Most of today's healthcare information systems and the patchwork of networks that tenuously connect some of them are at best a veneer over a fundamentally flawed structure and a poorly understood value-added profile. Some value is being extracted (e-prescribing, for example), but if HIT is ever to get funded, much less actually work, the underlying system will need to be far better understood and—almost certainly—restructured. HIT may be most important for its potential to reveal that, in healthcare, the clothes have no emperor.

That today's healthcare system is a jumble of workarounds, redundancies, and paradoxes will hardly come as a news flash to the industry's leaders. The list of serious symptoms of the problem include byzantine pricing, discounting, and rebating systems; uncoordinated care and coverage; rising costs and sometimes dubious quality with no one clearly accountable; high costs but low levels of customer service; state-mandated insurance features that make truly basic risk coverage unaffordable or unavailable; value accruing heavily to specialists and sophisticated medical centers; a pharmaceutical industry in which patent attorneys and defense lawyers are major profit drivers; and multiple layers of government that mandate services they know they don't pay enough for. Structural crises seldom coalesce rapidly, but we believe the confluence of HIT, CDHPs, Medicare Part D implementation, Medicaid shortfalls and cutbacks, and the ever-looming baby-boom crunch will begin the process of serious examination of the healthcare industry's structure and value-added characteristics.

The industry's self-examination should begin now and may be abetted by government's realization that CDHPs offer potential lessons and new options for large public programs like Medicare and Social Security. New, broader tax-advantaged savings plans and a national pooling of catastrophic risk may not only address very large issues, but also point the way to new conceptualizations about what the healthcare system should be and how it should work. It bears restating from the letters we have written in recent years: *There are only two options currently on the table for the U.S. healthcare system: a successful and equitable CDHP-type paradigm or some form of national (or even nationalized) coverage and care*. For those who suspect that the conservative revolution of the past 25 years is about to run its course and give way to a swing back to the left, making CDHPs work may be the only way to avoid the rationing and

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bureaucracy tolerated in other Western democracies as the *quid pro quo* for more predictable costs and a higher level of perceived equity.

We believe 2006 will be a deceptively pivotal year. Many of the actions we expect will appear routine: solid strategies to realize CDHPs' potential, initiatives to ramp-up and fine-tune the Medicare Part D plans, and variously motivated consolidation moves. However, among this activity, we hope to see leaders beginning their own—perhaps partnered—investigations into the more long-range possibilities of a reimagined industry structure and their places in it.

Themes and Directions for Industry Players

"Deceptively pivotal" is an intentionally mixed theme for 2006. On the surface, we expect the coming year to be a strategic extension of the past year. Much like 2005, the coming year will be full of opportunities and challenges for the insurance sector of the industry. We will see the continuing battle for the employee-benefits value chain and, ultimately, for ownership of the customer. The value chain is already being redefined—and fragmentation will continue to compete with consolidation and convergence as primary strategies. Beneath this layer of normality, though, we hope to see increased urgency on the larger structural issues facing the industry.

The imperatives and opportunities for insurers and plans are similar to those in 2005—strategic plays based on focused product offerings and a broader conceptualization of HSAs. HSAs are increasingly accepted as products that fit within the full range of consumer risk-protection and wealth-building services. The continuum includes transaction, protection, borrowing, and accumulation components. This broader framework, combined with the triple tax advantages of HSAs, should continue to drive innovation and draw competition from mainline financial services firms across the value chain of both insurance and financial services. Consolidation plays—both market-specific and more broadly—should focus on market dominance and, to a lesser extent, enterprise-level synergy (a potentially risky play until HIT sorts itself out). We also expect to see additional acquisition and partnering activity to build the full suite of services needed for CDHP rollout and development.

The provider sector will probably continue to take a wait-and-see approach on the impact of CDHPs—but it shouldn't. So far, CDHPs are not on the radar screens of most providers, who believe they are a blip or a fad. Even if CDHPs turn out to be bigger and longer-lasting, providers behave as if they will be no big deal—or worse, they think the magic wand of HIT will help them meet whatever challenges they encounter. The underestimation of CDHPs' importance and the overestimation of the benefits of HIT is a dangerous strategic mixture.

The key both to gaining competitive advantage under CDHPs and reaping whatever value resides in HIT is understanding the structural opportunities they create. While the transparency that CDHPs will bring (and that HIT will enable) is scary, the opportunities for competitive advantage are huge. Chief among these are creating new customer relationships and new business relationships with physicians, especially the procedure-based specialists who drive most hospital revenue and profits. Hospital leaders should ponder two questions: How would

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your core business be different if patients and their intermediaries could make real-time purchasing decisions based on quality, customer service, and today's price? Furthermore, what if the quoted price bundled both hospital services and professional fees? Such a world is coming, and hospitals are moving too slowly to develop their strategies to succeed in that world.

In the pharmaceutical sector, analysts will question how long pharma will retain traditional market approaches (with minor tweaks) given ever-diminishing returns. Most pharma companies will not shift their strategies significantly in the near term, given the real dangers of being a first mover. Leading-edge players, however, will continue to sharpen current approaches, using more sophisticated physician targeting and messaging enabled by enhanced segmentation, as well as more sophisticated rebate and discounting strategies informed by longitudinal analysis of benefits design and claims data. Most important, however, sector leaders will strive to crack the R&D productivity problem and hope that early efforts to improve effectiveness will bear fruit and translate into significant performance improvement.

The biggest unknowns for the pharma sector in 2006 and beyond are the actual impacts (versus promises) of the Medicare Part D benefit, and the implications of growth in CDHPs. Initial data suggest some good news in this emerging consumerism: Current financing schemes favor a short-term approach to evaluating drug benefits, while a consumer-driven world could force a longer time horizon (greater than five years) and a shift to prevention and related therapeutics. The potential bad news is that price-sensitive consumers have proven much more likely to use generics as their therapy of choice. A key question for the sector going forward is how to convince consumers and their physicians that branded drugs and innovative therapies have economic and health benefits that merit the premium cost.

Having said all that about each of the major sectors and their suggested strategies, 2006 won't be pivotal (deceptively or otherwise) if the industry does not take the first major steps of a fundamental reassessment. It may be a job too big for any one enterprise, perhaps suggesting that each major sector begin association-level explorations. It may even be too big for any one sector, and perhaps work driven top-down as part of the HIT initiative will be needed. If history is any guide, though, we think it is most likely that one or two visionary firms in each sector will undertake serious inquiries and develop hypotheses capable of mobilizing a larger examination and a broader, more integrated consensus. Quite simply, we need a new and accurate understanding of how the total healthcare system adds value, how best to deliver that value to customers, and how some of that value can be returned to shareholders and the public purse for future growth and tax sanity. Perhaps HIT should be developed as a public utility: If it were, the industry's entire value-added structure would tremble. Today, information and its availability is the source of potential competitive advantage—and tremendous cost. Take most consumer and clinical information away as a competitive factor and a variable cost, and much of what's left of the industry will need to rediscover its source of value creation.

Whatever the specific developments in the year ahead, we hope 2006 will be viewed both as the year that CDHPs and HSAs achieved inevitability and continued strong growth, and as the year that the industry began in earnest to find a better long-term structural solution. The worst

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outcome would be to remember 2006 as the year things got so bad that national solutions began to look good to a majority of Americans. We wish you every success in meeting these challenges.

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