

Health Services Industry Year End Overview and Trends for 2008

December 18, 2007 — We wish you, your colleagues, and your family a happy holiday season and a peaceful and safe New Year. As 2007 comes to a close, a booming international economy is helping the United States cope with credit problems, housing-sector issues, a weak dollar, expensive oil, and the ongoing costs of war. Although the political balance in Washington changed in 2006, with ramifications that spilled over into 2007, we are still in the early stages of reframing the national debate on a broad range of issues, including — in fact, especially — healthcare.

As we enter 2008, we'd like to briefly share our thoughts on the state of the healthcare industry and the trends we see for the year ahead.

2007: The Year of Living Safely

Although the healthcare industry saw some significant political and economic events in 2007, it was primarily a year for hunkering down, sticking to one's knitting, and trying to divine the future. The consensus for change continued to broaden and everybody seemed to roll out a plan, but serious change will have to wait for the 2008 presidential and congressional elections — and perhaps will have to wait for a good while after that. Our prediction in last year's letter, that 2007 would be a year of "politics — and pragmatism — as usual," was largely borne out.

Viewed from a high level, most sectors of the healthcare industry had another good or very good year. Profits at most major health plans continued to be strong, owing to effective trade-offs between pricing discipline, medical and network management, and reduction of administrative costs. Premium increases from health plans and rate increases from providers were both somewhat lower than in recent years — but they remain major issues, even if 2007 didn't feature those issues quite as frequently in the daily press. Although pharma had a less-robust year than other sectors, it did avoid a showdown on direct government price negotiations for Medicare Part D, the government program that provides drug coverage for the elderly. However, both this win and the sector's continued profitability need to be viewed cautiously, since they mask the issues of failed compounds, a less-robust product pipeline, and ongoing price and utilization constraints. Hospitals continued to enjoy strong sector-wide performance, but 2007 was still a story of the rich getting richer. Little or no progress occurred in spreading the riches to small hospitals and nonacademic urban facilities. *Pricing and quality transparency* remained a slogan, with little substance behind it.

If things were fairly quiet in the news and few developments occurred on the innovation front, 2007 was still notable for at least one thing: Consumerism, broadly conceived, achieved mainstream status and secured a strong place in any pluralistic reform of the healthcare system. Since Booz Allen Hamilton's first articles on the concept appeared in 1998, the shift to a retail market has gone from being a curiosity to being an idea with real traction in the marketplace and increasing acceptance from consumers. Not only is the healthcare infrastructure for consumer-driven plans in place, but players at the health/wealth

nexus are now gaining size and traction. In addition to efforts by several of the national plans, the Blues have established the Blue Bank to administer transactions and maintain balances for their consumer-directed health plan (CDHP) enrollees with high deductibles and health savings accounts. Reports of more large employers planning to switch to such plans in 2008 means that double-digit, “S-curve” growth will likely continue. Moreover, employers’ ongoing concern about the affordability of health benefits is leading to higher cost sharing and increased consumer participation in decision making in conventional products as well. CDHPs and other high-cost plans account for about 20 percent of the private market today and will certainly gain more share.

There were also signs of delivery system innovation in 2007, but they received little public attention. While pay-for-performance and various grand-scale IT programs (like electronic medical records) continued to languish for lack of consensus and funding, fast-service clinics and concierge medicine offerings enjoyed increasing popularity. In fact, at least one new player may be “stitching” fast-service clinics together with rented PPO (preferred provider organization) networks and sophisticated Internet tools to deliver plans that provide more convenience, better clinical care, and lower costs. Another promising development is the emergence of branded offerings for high-cost specialty care. Several national brands (MD Anderson Cancer Center, Texas Heart Institute, and Geisinger Health System, for example) are beginning to offer packaged pricing and evidence-based care programs for cancer and heart patients. These “clinical packages” – early signs of the emergence of true “products” in healthcare delivery – offer the hope not just of market differentiation for players, but of better outcomes, fewer hassles, and lower costs for consumers. Such “product plays” are likely to increase in importance and attractiveness.

Blockbuster asset plays were largely missing in 2007. The CVS–Caremark deal was the largest and most significant – furthering the shift in the marketplace toward consolidation between pharmacy benefit managers and drug retailers. Pharma saw several deals, including AstraZeneca’s acquisition of MedImmune and Schering-Plough’s acquisition of Organon, that were mostly driven by the need to improve product pipelines. The provider sector was fairly quiet except for the usual game of musical chairs played by the hospital chains. Interestingly, the breakup of several health systems in the not-for-profit sector grabbed as much press as any new activity. More subtle plays didn’t make headlines as multiple players (large health plans, mostly) created lash-ups with new entities – particularly in the rapidly emerging retail clinic space. This activity replaced the larger and more visible plays of recent years in which major healthcare plans added CDHP capabilities.

Although the structural “big plays” of recent years were missing, a series of unorchestrated but stunning shifts in risks and costs occurred in 2007. All of the shifts moved risk away from traditional players (i.e., payors). The biggest headline, of course, was the United Auto Workers’ (UAW’s) new deal with the auto industry, in which employers’ liability for more than \$50 billion in healthcare costs was shifted to the union. This cleaned up some balance sheets and potentially eased some price pressures, but the long-term goal (solvency for both parties) is uncertain. Other notable changes also occurred: CDHPs nearly doubled their enrollment, thus shifting additional costs (but not catastrophic risk) to consumers; private plans announced their intention to increase 2008 Medicare Part D premiums by 17 percent (for those staying with the same plan); and the shell game of Medicaid funding and eligibility rules continued to marginalize more and more citizens in the healthcare system. For all these payors, seeking shelter from the storm was the goal.

The political front, unsurprisingly, was more active this past year, but the big fight on Medicare Part D never materialized. Instead, the focus of this round of political proxy wars in healthcare was the State Children’s Health Insurance Program (SCHIP). Although billed publicly as a budget fight, it was equally significant as a battle between public and private solutions for the healthcare system’s problems. In other words, the SCHIP expansion was less a matter of money and more a matter of which programs, public or

private, would expand to fill the need. Most congressional Republicans took the politically unpopular position of limiting the expansion of government involvement – risking voter retribution. We can expect more of these symbolic skirmishes in the run-up to the elections.

The states were more active in moving forward with various experiments and new programs. While Maine's Dirigo plan for the poor and uninsured continued to limp along, owing to affordability concerns on the part of small employers and challenges funding the program, the new Massachusetts subsidized "pay-or-play" program was quickly oversubscribed and now needs a new appropriation (i.e., it will cost much more than expected). California's plan (essentially pay-or-play) remains stalled at the starting gate. These and other state programs can be viewed as laboratories testing various features of potential national programs – the better points perhaps being stitched into a full-blown national approach. But like the many plans offered by various presidential candidates, none can currently be viewed as the definitive solution.

The industry has long expected to see the effects of changing demographics (primarily aging), an epidemic of chronic diseases, and an inflationary spiral. These trends, combined with what must be viewed as mainstream acceptance of consumerism in the payor sector, have begun to catalyze early movement along long-dormant fronts: strategic experimentation in the provider sector, much of it from outside sources; philosophical shifts in employer-sponsored benefits; and government interventions involving coverage scope and levels. If 2007 was not a banner year for new developments in healthcare, it was certainly a year of populating the playing field with ideas and programs that are likely options for inclusion in an eventual national program of healthcare reform. Those looking for swift closure on the topic of reform will need patience.

2008: The Calm Before the Storm

The 2008 elections will determine the next occupant of the White House, but will not provide a strategic road map for industry players on how to navigate what will be a drawn-out series of health system changes and reforms. Even the slim possibility of a filibuster-proof (or veto-proof) Senate would be unlikely to speed along change of the magnitude and complexity likely to be proposed. The good news is that all of the mainstream candidates seem to have a healthy respect for the difficulties involved in such change and the unintended consequences that may arise from it. A monolithic new federal approach to the entire health system is not going to arrive on Congress's doorstep early in 2009, since the agenda will already be full with taxation, war funding, and entitlement issues. This is not to say that significant change won't occur; it just will not happen in 2008 or even 2009.

The complexities and challenges are clear. Among the most important:

- *Primary care is already in short supply* and the aging population (of caregivers as well as patients) will make the problem worse – even before adding in demand from newly empowered citizens. Without major funds to train more doctors, nurses, and other midlevel practitioners, expanded access may remain elusive.
- *Any new program to financially empower the uninsured (and others) will cost more* – a lot more – regardless of what steps are taken in the near term.
- *Tax policy* may be the first skirmish for the new administration and Congress – first, to sort out the problem of the alternative minimum tax and its increasing burden on the middle class, but later to deal with deductibility of health plan costs for employers and individuals, continued tax exemption for health savings accounts, and the sources of funding for any increased costs of new programs. The ongoing war and the huge downstream costs of caring for the wounded will also need resolution before Congress can consider new entitlements or mandates.

- Meaningful management of any new program will require *advanced IT capabilities* (interoperable health information technology and electronic medical records) at the clinical and transaction levels. Public sector-private sector groups such as the American Health Information Community (AHIC) have been set up to deal with standards and other challenges, but progress has been slow and no real advanced capability exists. Substantial progress in this area will take years and cost billions to implement.
- In proposing any sort of reform, stakeholders will need to be aware of *unintended consequences* that may bring major penalties or windfalls to particular sectors. For example, if a new system were to significantly reduce free care and bad debts for hospitals, how would such gains be minimized or repatriated? If similar factors improve doctors' income, how many of them might reduce their workloads and exacerbate current labor shortages?

Any proposals for reforming the current healthcare system must, at a minimum, address these challenges, and they will likely take many months to work out. Given the range of issues involved and the number of sacred cows that may be gored, the coming healthcare debate probably means full employment for every healthcare lobbyist in the nation for years to come. Furthermore, all of these issues and problems are essentially independent of the direction chosen.

At this point, the shape of the reform—whether proposed by Republicans, Democrats, or a bilateral coalition—is virtually impossible to predict. That said, we can posit a number of characteristics of the outcome and the process:

- The reforms will be *incremental and pluralistic*. No proposal currently on the table will become the single answer, as evidence from various state experiments and matters of affordability will forestall radical, wholesale change. Given the size and continuing growth of conventional products such as HMOs, PPOs, and CDHPs (and other consumer-active plans) already in the marketplace, new approaches will almost certainly include these options going forward.
- *Tax policy* and the related issue of *means testing* for new benefits (and probably Medicare as well) will share center stage as critical factors to be worked out under any new plan. Interestingly, if tax policy makes medical costs and premiums fully deductible for individuals (as they are today for employers), those individuals will need to find coverage that effectively forms a large group to aggregate risk. Further defections from employer-sponsored plans would be likely. Means testing is likely to become one of the most divisive issues to be tackled under any reform scheme.
- Medicare Part D will very likely be pulled under a *federal bidding* process and perhaps stricter rules on generic drugs. This may simply push prices even higher for on-patent compounds, but the short-term gain for Medicare will be nearly irresistible.
- *Significant change is unlikely prior to 2010* and is apt to be gradual thereafter. Although *urgency* is still the operative word, the players involved have a healthy respect for the complexity of the problem and the runaway costs that will result if they get it wrong. Even if some changes emerge in the first year of the new administration, implementation would take at least a year. Bigger changes would probably follow, being phased in starting in 2011.

The big issues won't be settled for a few years and the specifics are difficult to predict, but that does not mean that participants in the industry cannot do anything in the short term. A robust market exists for consumer-oriented products with more cost sharing. There are also problems that can be tackled immediately—with solutions that can form better businesses today and position players for a range of eventualities. Patient care is still fragmented, coordination of care and services is marginal at best,

connectivity and interoperability are largely absent, and, as always, costs are still growing too fast. These problems continue to merit the serious attention of industry leaders.

Themes and Directions for Industry Players

In periods of uncertainty, the industry needs to develop new approaches that will deliver lasting value – independent of tweaks or tremors in the funding and organizing of the healthcare system. None of the broad strokes currently on the table for healthcare reform will improve today’s bedside care or coordinate care and service throughout a patient’s healthcare episode. Quite simply, the clinical variability and often nightmarish bureaucracy of today’s system are problems waiting to be addressed, and those who develop the solutions can expect huge returns. Knowing this, and having an awareness of the opportunities that healthcare reform may create, we offer four high-level suggestions for the coming year.

1. Fix the big stuff – with a partner. Cardiac conditions, joint replacement, cancer, asthma, and diabetes account for a staggering percentage of total healthcare costs. These conditions and associated procedures also create huge challenges for patients and caregivers in coordinating care and navigating the system. Throw into the mix the slow uptake of evidence-based medicine and lack of standardization, and the industry has a big problem, regardless of how reform plays out. All the key players – doctors, hospitals, health plans, and pharmaceutical companies – have a stake in finding a better answer for patients and their families. In fact, no single player in the healthcare system can fix these problems, so joint efforts among payors, providers, and pharma companies are the most likely to bear fruit. State-of-the-art, branded ventures between leading providers and a select number of plans are starting to gain traction and will expand into many more markets – perhaps with pharma playing a role. In short, investments in better care and better service will be rewarded.

2. Continue to explore “market maker” and other advisory roles. Under any pluralistic healthcare reform measure, CDHPs and other plans encouraging consumer price sensitivity will continue to exist. The need for market makers that can provide reliable, unbiased cost and quality data is obvious but remains undeveloped. Regional market makers that can manage and use such data will be sorely needed, and many large plans are in a position to create such businesses. Although there is some risk that the market maker role may eventually devolve into that of an undifferentiated “utility,” that scenario lies well in the future.

3. Consider whether a utility play makes sense. Infrastructure and experience with large federal programs are likely to be necessary ingredients in the market under any reform scenario. Today’s Medicare and Tricare intermediaries are well positioned to benefit from reforms that move consumers into Medicare and FEHBP, the federal employees health benefits program. Companies that can offer online adjudication and payments, as well as those with the infrastructure to support electronic medical records, are also candidates for growth in any reformed healthcare system.

4. Reimagine risk aggregation. Many of the current proposals for reform include means for severing the link between employment and health insurance (though employers may still make major payments). Although some approaches would roll up individual insurance risk into Medicare or the FEHBP, others could create new opportunities for aggregation of risk. This opens up the possibility for a new entity, whether private or public, to aggregate catastrophic risk and create new, “virtual” groups of individual policyholders. Such an approach would require changes to insurance laws and regulations, but imagining a solution now could help shape the changes needed.

Whatever the specific developments in the year ahead, we believe 2008 will be most memorable for the political signals sent by the elections, the continued development of CDHPs (and variants), the growth of comprehensive “product” offerings for specific conditions, and the beginning of a multiyear process to chart the direction of the future health system. We live in interesting times—and we wish you every success.

Sincerely,

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