The Transformation of U.S. Healthcare: Forces, Implications, and Actions

kpmghealthcarepharmainstitute.com
The current U.S. healthcare economy is unsustainable. This lack of sustainability impacts not only patients but also every player in the industry, including providers, payors, employers, life science companies, and other organizations.

Healthcare Expenditures by Age

The disproportionate cost of treating the Baby Boomer generation is just one example of factors driving the mandate for change in the U.S. healthcare economy.


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Issues with U.S. healthcare costs are well memorialized: An aging Boomer generation, more patients who are older and require more treatment, long-term care for chronic diseases, expensive medical technology, more sophisticated treatments, and rising drug prices are all contributors to escalating costs. Additionally, the volume-based economic incentives embedded in fee-for-service medicine are a critical overlay to the individual drivers of unyielding increases in healthcare costs.

While costs are higher than ever before, health status in the United States is not consistent with the level of spend in our healthcare economy, currently higher per capita than that of any developed nation. That spending level both threatens U.S. domestic economic stability and global competitiveness, thus leading to an unprecedented mandate for solving the simultaneous equation associated with cost, quality, and access.

While the legislative and judicial actions associated with “healthcare reform” dominate the headlines, market-based transformation is accelerating and will continue to accelerate regardless of the “institutionalized uncertainty” associated with federal, state, and local governments’ efforts at reform. The mandate to respond to improved quality and access with less aggregate revenue on a per capita basis for the industry is unequivocal. We believe that new business models are emerging with increasing velocity in response to key drivers for future success, which include clinical integration across many fronts, economic attribution based on quality, and the inevitable transition away from fee-for-service medicine.

The transformational dynamic is provocative, characterized by both the challenges related to an unprecedented competitive landscape and the fact that the regulatory environment at all levels will only grow more difficult to anticipate and manage.

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Obesity among U.S. Adults

Obesity rates in the United States have soared over the past 25 years. Obesity now accounts for 21% of healthcare costs.

Percentage of Obese* Adults in the United States (*with a BMI ≥ 30%)

<table>
<thead>
<tr>
<th>Year</th>
<th>&lt;10%</th>
<th>10-14%</th>
<th>15-19%</th>
<th>20-24%</th>
<th>25-28%</th>
<th>≥29%</th>
</tr>
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<tbody>
<tr>
<td>1985</td>
<td></td>
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<td></td>
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<tr>
<td>2010</td>
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How does the industry reverse this trend and the cost escalation that parallels?

Throughout the healthcare industry ecosystem, these developments are linked to different types of risk depending on the actions required. However, the greatest risk of all for organizations is to do nothing and assume that significant transformation can be postponed or achieved through nominal efforts.

We believe that business risk from ineffective transformational efforts will only increase, based on a number of factors. These include pressurized operating margins; growing consumer demands; the adoption of new, untested operating models; new levels of clinical collaboration and competition among providers, payors, and other market participants; the implementation of complex information technology systems; the ongoing market monetization of key intellectual property and other assets (especially in the payor community); and overall market consolidation as the need for scale increases dramatically.

This same provocative industry environment is emerging as opportunistic for both existing healthcare organizations and potential new market entrants. The opportunities to provide value here are profound. Overall “waste” in the U.S. healthcare ecosystem is estimated at US$700 billion annually according to a study released by Thomson Reuters in October 2009. More recent estimates of that same potential value achievement range from US$558 billion to US$910 billion per year. Organizations demonstrating the ability to drive savings through the ecosystem while raising quality should be able to position themselves for a significant “commission” on those results.

U.S. Healthcare Spending in 2009 Exceeded Estimated Spend According to Wealth (ESAW) in Almost Every Major Category

<table>
<thead>
<tr>
<th>Total U.S. spending on healthcare by category of care 2009</th>
<th>Spending above or below ESAW 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>USD billions</td>
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<tr>
<td>Outpatient care</td>
<td>1,019</td>
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<td>Inpatient care</td>
<td>498</td>
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<tr>
<td>Long-term and home care</td>
<td>245</td>
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<tr>
<td>Drugs and nondurables</td>
<td>293</td>
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<tr>
<td>Health administration and insurance</td>
<td>163</td>
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<tr>
<td>Durables</td>
<td>35</td>
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<td>Investment in health</td>
<td>233</td>
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<tr>
<td>Total</td>
<td>$2,486</td>
</tr>
<tr>
<td>Spending above ESAW</td>
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</tr>
<tr>
<td>Spending below ESAW</td>
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**Disruptive forces and step changes**

Healthcare transformation will require a step change in thinking and execution, much like the situation faced by some traditional film and camera companies with the market entry of digital cameras.

Meaningful change in clinical delivery includes the development of primary care platforms, adherence to clinical paths, narrow networks, and reductions in variability. Dartmouth researchers have concluded that the elimination of unwarranted variation might increase the quality of care and lower costs by up to 30 percent.⁶

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The KPMG Healthcare transformational framework links the forces described in the graphic on page 6 and the implications described in this section. This is not a framework that applies solely to the provider community; rather, it is representative of both the challenges and opportunities facing all stakeholders in the U.S. healthcare ecosystem who strive to add real value and help resolve the fundamental issues facing the U.S. healthcare economy.

First of all, the need to solve the simultaneous equation for cost, quality, and access will require meaningful change in clinical delivery, which itself will fundamentally be enabled and shaped by emerging new business models. This is more than a “health system” or general provider discussion; transformational forces are inspiring significant changes in how employers, payors, technology vendors, and new market entrants are facing up to the market opportunities associated with the articulated business challenges.

Employers, long concerned about rising healthcare costs, are eager for alternative solutions and are likely to serve as one of the disruptive forces driving change through the U.S. healthcare industry. With 60 percent of the under-65 population having insurance that is arranged through employers, companies from all industries are impacted negatively by the escalating costs and inadequate quality plaguing the healthcare industry today. Faced with a challenging competitive position in the global marketplace, these companies will play a large role in influencing how healthcare business models adapt to these transformational forces.
The payor business model may be the most challenged of any segment in this transformation. Payors often have the most current and comprehensive aggregated data on the health status of a given population, but traditional medical management has been more largely related to claims processing than working collaboratively with providers to improve the quality of care and reduce cost. Payors may face a seismic shift from being the administrator of the healthcare dollar to a supplier of critical competencies, such as data analysis, risk management, and clinical intelligence.

While certain reform initiatives remain unsettled, industry transformation has started, and all stakeholders should answer the call to action – or risk becoming a victim of evolution.

Payment model (and, therefore, revenue) disruption is a critical business issue in the transformation from fee-based models to value-based models incorporating accountable care principles. This concept should be an overriding driver of dialogue in all healthcare organizations as the transition from fee-for-service medical economics accelerates. Planning and forecasting associated with disparate payment models must consider that...
In such cases, the critical inflection point is beyond the traditional one-to-three-year (for operations) and five-year (for capital) planning horizon because those organizations have either underestimated or ignored the velocity and timing of payment model transformation—a potentially fatal business mistake. To manage this critical business issue, planning approaches must consider the inflection point as well inside the planning horizon. This graphic at the bottom right demonstrates actual management and acceleration of the slope of transition.

It is important to note that if the inflection point is considered to be inside the planning horizon, the curves approximate a step change rather than a smooth transition. This step change reflects a fundamental revenue transformation that will inevitably occur as per capita revenues decline across the healthcare economic system.

To successfully address this revenue transformation, organizations will have to bring the inflection point inside their planning horizon and consider a step change in their business models. These changes will not be simple or easy. However, the winners in healthcare—whether payors, providers, life science companies, or other organizations—will be defined by their leadership in recognizing the necessity of change and then planning and executing effective strategies based on this recognition.

More importantly, organizations need to recognize that payment model transformation will not occur either along a smooth curve or in incremental fashion. We believe that many organizations’ traditional planning approaches do not consider the active management of the “inflection point” related to the payment model tipping point. This creates a gap between strategic plans and executional imperatives as shown at bottom left.

![Diagram](image-url)
To be an effective manager in today’s step-change healthcare environment, leaders should consider KPMG Healthcare’s unique “6x3” framework for change characteristics and associated problem statements.

**Actions**

**Steps to Support Transformation**

Industry Characteristics

- Shifting Reimbursement/Funding
- Increased Provider Consolidation
- Changing Sites of Service
- Enhanced Consumer Engagement
- Transition to Wellness & Prevention
- Disruptive New Market Entrants

The Question

- How will you address the “shrinking balloon”?
- How will you be compensated for “health” and “wellness”?
- Where do you fit in the shifting intersection of risk and reward?

The Challenge

- Healthcare “cost” is revenue for somebody.
- Transition of care management to greater individual responsibility (e.g., “consumerism” in the new paradigm)
- Population-based care management focus
- Where does “risk” shift? Who gets paid to remediate, mitigate, and/or assume? As risk shifts, who can truly influence the amount of and variability of risk? What are the “intelligent information” requirements? Is quality a driver of economic reward?
Six Industry Characteristics:
First, we articulate six key industry change characteristics as the following:

1. **Shifting reimbursement/funding**, including the impact of movement from fee-for-service to value-based medicine; the need to quantify the contribution to higher margins with lower utilization, and the implications of adopting different payment models such as episodic care, bundled payments, global payments, and chronic disease management.

2. **Increased provider consolidation** to achieve scale and alignment; an understanding of the “centrality of clinical integration” and its critical role in a consolidating environment; the establishment of a culture of accountability; involving factors such as the place of the organization in the healthcare continuum; implications of current market share and sales channels; the need for a multidisciplinary sales force, technology support for sales channels, and the organization’s intersection with a consolidated market.

3. **Changing sites of service**, including considerations about a new continuum build, whether the organization’s portfolio is driving the most effective service sites, the impact of change to the portfolio, and the organization’s current and future competitors.

4. **Enhanced consumer engagement**, taking into account the organization’s business and professional relationship with patients and individuals; access to discounts; high-deductible health plans and their impact on buying decisions; the affects of consumerism and the retailing of healthcare; decisions by today’s educated consumer; consumer segmentation; and the impact of communication channels and technology such as social networking.

5. **Transition to wellness and prevention**, considering how the organization’s service portfolio contributes to this transition; market perceptions of this contribution by the organization; whether the necessary science is available to demonstrate a wellness contribution; how the wellness/prevention dynamic affects the revenue and profitability of the product portfolio; and whether the organization can leverage data in a proactive fashion.

6. **Disruptive new market entrants**, including new participants who drive wellness/prevention; large employers that can “bend the cost curve;” health managers; data analytics and technology innovations; portfolio challenges; and pipeline risks.
THREE STRATEGIC AREAS TO CONSIDER:

Address the shrinking balloon. Healthcare cost is revenue for somebody, so the transformation is not revenue-neutral. At the same time, revenue will not only reduce but also shift. Determine what defines winners and losers in the new industry ecosystem and remember that for successful organizations, “winning” is more than simply “maintaining.” You should also keep in mind that an effective strategy includes leveraging data to generate revenue.

Determine how you will be compensated for health and wellness. You need to have a clear understanding of the value chain and your place in it. This means calculating your return on investment for health and wellness, knowing how you will be affected by the growing importance of individual rather than physician decisions, and maintaining a focus on specific population groups while providing platforms to support these groups. It also means preparing for new developments in genomics and health prediction, as well as intelligent information.

Understand where you fit in the shifting intersection of risk and reward. In today’s prepaid healthcare model, risk is borne by employers and the general populace. As risk shifts to the individual and primary care provider, you need to understand who can truly influence levels of risk. In addition, you need to keep track of the intelligent-information requirements in the expected shift of this risk. This includes viewing quality as more than a pitch-point but as an economic reward driver.

WHAT NOW? KEY ACTIONS TO TAKE

Transformation in the healthcare industry is both dynamic and accelerating in velocity. In many important respects, it is not dependent on legislative reform. However, one thing is clear: The status quo is no longer an option. Industry leaders will have to ask hard questions and make difficult decisions as they evaluate their place in the market. Some organizations will strive for a leadership role in their selected markets, based on their mission or business goals. In other cases, a partnership or collaboration will be more appropriate. Some organizations will decide to exit from the industry in the best interests of their stakeholders.

For those organizations that remain, a new focus on next-generation strategies will be essential. The potential for guaranteed issue in the individual marketplace will have significant actuarial implications and will impact the payor’s financial outlook. Access to capital both today and tomorrow will be a prime consideration, including what level of capital will be required to execute against transformation plans. Organizations will also need to consider capital required for physical infrastructure such as brick and mortar facilities (while keeping in mind that these facilities may be replaced or consolidated through new approaches in care delivery).

In addition, new IT infrastructure will be needed for the timely transference of new data and the advanced analysis required by all parties across all dimensions of care delivery and payment. New mechanisms in the industry, like Health Benefit Exchanges, will require payors to review and revise their IT infrastructure and operational processes. More sophisticated “war-gaming” and modeling will become a necessary part of understanding an organization’s readiness for new payment models, helping to analyze various scenarios and assumptions, identifying which of those assumptions are key, assessing the associated risks, stress-testing models, and identifying the potential returns.
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