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The Megatrends Reshaping Healthcare:
Managing Change
and Maximizing
Opportunity

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Introduction

The American healthcare system continues its transformational journey into 2016 and beyond, with fresh evidence of the ongoing impact of the Affordable Care Act (ACA) as well as continued shifts in the economic and organizational models of healthcare. Providers, payers, regulators, and consumers are each adjusting their strategies, policies, and behaviors to an increasingly complex – and zero-sum – environment. As we note in our Conclusion, it's **Game On**, where the era of collaboration is giving way to sophisticated competitive strategies to gain or retain market share, attract and retain consumers, and control as much of the healthcare dollar as possible.

In 2013, Manatt Health first identified “**10 Megatrends Reinventing Healthcare**”¹ that would shape the healthcare marketplace across the next decade. Two years later, we now report that these same trends continue to drive changes in behaviors, expectations, and results across the healthcare sector. For 2016, we have added an eleventh trend: **Focus on the Whole Person**, bookending our first trend: **Consumers Take Charge**. This powerful trend recognizes that leading-edge healthcare stakeholders at every level are beginning to take an integrated approach to the medical, behavioral, public health and social influences on the health of populations and individuals.

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Healthcare Megatrends



Megatrend 1

Consumers Take Charge

Two years ago, we predicted the transformation of the patient to consumer. Since then, it's become clear that the pressure for consumers themselves to become more active purchasers continues to grow, because they are facing more immediate cost-benefit decisions at every juncture: in choosing among plans with different mixes of premiums vs. out-of-pocket exposure, in choosing among providers with different fees and charges, and in choosing among competing treatments. With

increased exposure to costs, consumers are demanding—and are beginning to receive—more information about insurance choices, healthcare prices and treatment options.

“Proactive Purchasers,” as we call them, will continue to demand more information delivered seamlessly through new technology-enabled forms (social media, smartphone apps, etc.) for ease of access and ease of consumption. As payers, providers, and drug/device manufacturers acknowledge

the consumer/patient as the focal point of their member loyalty and care delivery and management strategies, it will be critical to demonstrate a deep understanding of and market responsiveness to consumer demands, especially those of the digitally native Millennials and technically savvy Baby Boomers.

Over the next five years, we can expect to see three overlapping groups of consumers, each with a set of expectations and behaviors:

- **Plan Shoppers** who purchase insurance through the new healthcare marketplaces/ employer-sponsored programs will want, need and demand to compare plan designs and prices, and will not tolerate the current state of myriad designs that require apples-to-oranges comparisons. While consumers may be forced to understand and accept the increased offerings of high-deductible, high-cost-sharing plans, payers, providers and regulators should recognize the potential for these plans to inspire a backlash from the increasing number of people who will experience greater out-of-pocket costs for healthcare.

- **Service Shoppers** will demand more and more information before making purchasing decisions for healthcare

services. New means to collect and disseminate information on provider quality from hospital mortality metrics to consumer “Angie’s List”-type reviews of individual providers are emerging and equipping consumers to maximize the value of their healthcare dollars and abandon low-performing, high-cost providers. The growth in consumer-facing shopping tools will continue to inform and engage these consumers to make smarter financial decisions, with providers in particular reorienting patient engagement and outreach programs to include more technology-enabled features.

- **Self-Managers** will respond to the higher out-of-pocket cost environment by adopting healthier lifestyles. The market

is responding to this segment, with an explosion in wearable and ambient devices (Internet of Things) linked to smartphone apps that monitor health status, and insurance plan designs that include health behavior incentives (smoking cessation, weight control, etc.). Consumers will expect and demand that providers and payers find ways to connect these new data streams to their administrative and clinical data systems, and to reflect the combined insights into care models designed around the patient in the home. This extends to public insurance programs as well, with Medicaid and Medicare each using waiver authorities to experiment with care delivery models that integrate incentives and information.

Megatrend 2

More with Less: From Volume to Value

The accelerating pressure to reduce the rate of cost growth in our healthcare system continues to drive health system transformation. From new delivery models to new payment models to increased focus on cost-reducing products and technologies, organizations

are responding to the value imperative with a patient-centric reorientation of their products and services. The core challenge outlined in our 2013 paper remains: how will organizations optimize limited resources funded under the old fee-for-service world and make

the necessary investment to thrive in the new world of value-based incentives? Successful healthcare organizations must navigate this challenge as a manifestation of the “more with less” trend and continue to force difficult decisions:

- **Accelerating adoption of value-oriented payment models.**

Managed care plans, driven by purchasers' increased focus on the price of premiums and the cost of care and payers' (including employers and public payers) interested in driving down costs will become more adept in transforming their legacy claims systems to accommodate greater risk-sharing and value-based payment models. At the same time, provider organizations themselves are developing the technical and risk-management capabilities necessary to manage bundled payments and other partial-risk arrangements, though most are not there yet. Traditional Medicare is accelerating the volume-to-value shift with the recently enacted MACRA² Medicare Part B payment schedule changes starting in 2019. Meanwhile, the Healthcare Payment Learning and Action Network, an HHS-led public-private partnership designed to accelerate the same shift across sectors, will keep up the pressure in the market for "all-payer" alignment on payment models, regardless of barriers that still exist in state and/or federal law and regulation.

- **Integrated quality measurement.**

The current Tower of Babel of multiple quality metrics designed in good faith for a siloed delivery

system will gradually—although perhaps not quickly enough—become more rational, mirroring the trend in value-oriented payment models. End-to-end outcome measures will become more prevalent, linking pharmacy, primary care, inpatient care, and in some cases non-medical care data. Measurement of patient experience as part of integrated quality reporting will become more sophisticated and will need to become cheaper in the marketplace. At the same time, quality reporting will continue to shift from an exercise in claims analysis by individual payers to an analysis of whole-population data based on providers' own electronic health data. Providers, particularly smaller providers, are likely to struggle to keep up with the infrastructure and tools needed to capture and analyze critical quality measures. The new sophistication required by quality measurement and reporting is therefore feeding the related trends of payer/provider-led network/system narrowing and provider consolidation.

- **A broader definition of total cost of care.** As payers and providers take on increasing responsibility for the total cost of care of populations, all providers, treatment protocols, devices and drugs will be evaluated more closely on

their clinical effectiveness value. This will be an important—and challenging—shift, particularly for drug and device manufacturers, who up until now have been mostly on the sidelines of integrated quality and payment model discussions. The embedded cost of medical education is increasingly being forced into the open and therefore, demanding policy solutions as the legacy cross-subsidy by commercial reimbursement becomes squeezed in a world of narrow networks and CPI-indexed premium increases.

- **Care teams as the new normal.**

Driven by primary care shortages and a need to improve access, the role of nurses, physician assistants, pharmacists, social workers, nutritionists, physical therapists, and other allied health providers will be further elevated and integrated. Patients will increasingly interact with these professionals for routine care. Again, small provider organizations will struggle relatively more to offer flexible teams at the scale needed for efficiencies. Pressure to alleviate scope-of-practice restrictions will continue at the state level and interprofessional education and clinical training programs will start to take off nationally across health science schools to prepare the

new normal workforce. Some providers and consumers will prefer to opt out of the new normal of care teams by selecting a pay-as-you-go concierge model, and we expect to see continued growth of concierge medicine.

- **Tackling the “managing the care managers” conundrum.** Payers and provider systems will both continue their pursuit and adoption of more sophisticated care management models, competing for the role of the ultimate care

management provider and the commensurate rewards available for managing the “first-healthcare-dollar.” Providers will most benefit when they can integrate medical and non-medical services to create one-stop-low-cost-shops, whereas payers will take advantage of their experience using claims data to predict and manage high-cost patient populations. Both sectors will be challenged to integrate such services as home care, skilled nursing, long-term acute care, and

rehabilitation as an aging, chronically ill population places more demand on these services. At ground level, high-need patients will increasingly be offered multiple levels of care management, often creating confusion for patients and families and a need to “manage the care managers.” Solutions to the conundrum are likely to be local rather than one size fits all, reflecting local competitive dynamics between delivery systems and payers/plans.

Megatrend 3

Healthcare Everywhere

Experts anticipate a relatively flat increase over time in the demand for hospital care, contrasting with significant increases in the demand for care delivered in the outpatient, home-based, and retail care settings. The lower cost to deliver care in the different settings is one driver. However, patients are demanding that care be delivered closer to or in the home for many non-critical healthcare issues—or even for critical ones. Patients, particularly

tech-savvy millennials, are seeking connectivity to their primary care providers (e-mail, text, after-hours calls) to more easily manage their health and make healthcare decisions. Tools are emerging that connect consumers to their health no matter where they are (wearables, health apps, etc.) and are becoming more sophisticated to support sustained engagement. Three imperatives will continue the healthcare everywhere trend across the next five years:

- **Laser focus on providing the right care, in the right place, at the right time.** Providers will develop more community-based services and form relationships with pharmacies and retail clinics to connect to patients where they are and at times they are able to access care. New effort will be placed on digitizing physician practices to connect patients to their providers and their medical records and streamline the process to access care in the right settings. Payers

will be redesigning insurance approval processes and payment schedules to support reimbursement for care in lower-cost settings and seek to prevent unnecessary, clinically inappropriate care.

- **The explosion of wearables and other self-health-improvement technologies.**

Informaticists will continue to study personal health data from consumer- and medical-grade wearables in hopes of discovering patterns that improve early detection of health conditions. In the meantime, most healthcare providers won't want to see tracking data from consumer wearables anytime soon. However, business models may emerge where provider networks are willing to compensate nonclinical partners such as health clubs or established weight-loss programs for delivering measurable improvements in objective health indicators such as BMI, weight and A1c values as part of a clinically integrated network's

population health strategy. Programs focused on making healthy choices may include use of consumer wearables and mobile apps to deliver personalized feedback, individual goal-setting, community and accountability. To sustain consumer engagement, health-improvement apps that integrate with wearables also may become increasingly sophisticated by incorporating evolving modes of mobile engagement and the production values associated with mobile and media entertainment. Privacy issues will emerge, however, as data from consumer wearables is combined with other forms of personally identifiable data.

- **Greater acceptance and adoption of tele-health.**

Providers will continue to adopt new technologies to deliver primary and specialty services across their growing clinical networks and rationalize access to costly specialists and services, particularly as patients

become more accepting of e-consults and other forms of tele-medicine. These technologies not only include tele-video consults and store/forward review of imaging, but the use of native mobile device technologies for a wide range of medical screenings. Payers, including Medicare and Medicaid, are redesigning payment systems to accommodate reimbursement for clinically appropriate care delivered electronically. While Medicare and some Medicaid programs have accommodated reimbursement for remote monitoring, more widespread use of these technologies in post-acute transitions and in chronic care management will likely accelerate as the shift from volume to value in healthcare matures. As care management workflows integrate with other health technology systems and become more industrialized processes, improving outcomes at scale will become the dominant financial impetus for the use of remote monitoring technologies in clinically integrated networks.

Megatrend 4

Mega Health Systems

The formation of an integrated delivery system (IDS) has three elements to it: the scale and scope of services to include, the right corporate structure to facilitate system integration, and the right high-performance operating model to make the system work. Two years ago, we predicted that the pace of consolidation in healthcare would remain at a fever pitch and indeed it has. However, executives are now turning their attention to the latter two elements of IDS formation, asking the question, “How do we make our mega health system high-performing?” In parallel, payers and major drug and device manufacturers also have jumped into the consolidation game, seeking similar scale and efficiencies and a counterbalance to now significantly larger provider organizations. Consolidation and the battle for scale and leverage between and among major healthcare organizations is manifesting itself in several significant ways:

- **Development of innovative corporate structures to**

- **facilitate system development.**

Under current regulatory constraints and increasing state and federal scrutiny, providers are leveraging new and innovative corporate and governance models for system formation. While full-asset mergers will continue in some markets, looser partnership models, joint ventures, clinically integrated networks, accountable care organizations, and other arrangements are being developed to achieve the promise of scale and system-ness without the legal and regulatory challenges that come with full mergers, although existing fraud and abuse prohibitions, which were adopted in a different era, continue to pose challenges to these arrangements. However, we remain skeptical regarding the ability of these federated systems to achieve the efficiencies required to ultimately justify their existence.

- **Loss of truly independent community providers.**

The economic and policy/regulatory demands of the

current healthcare environment threaten the survival of independent practices and community hospitals, and in particular critical access facilities. Those that do not close up shop are pushing for relationships and clinical integration over full-asset mergers, and want flexibility with larger systems to continue delivering community-centric care with the benefits that come from a relationship with a larger system. We are reaching a watershed moment for the safety net of critical access not-for-profit healthcare in underserved and rural communities, as challenging economics and provider shortages threaten to exacerbate an already critical medical desert issue in many geographies.

- **Challenges for regulators.**

Regulators are faced with the challenge of ensuring the protection of consumers and guarding against conspiracy-pricing and monopolistic system development, while at the same time not stymieing what is perceived as needed

integration for the success of a population health approach to care. The pace and complexity of system formation will continue to rise, and regulators will be forced to consider multiple events in the chess game of consolidation across different sectors.

- **Renewed focus on systems re-engineering to achieve high performance.** With emerging evidence that scale and integration within health systems alone do not meaningfully bend the cost curve, clinical systems will embrace a radical restructuring of their operating models or risk becoming marginalized. Providers are focusing on issues relating to capacity management, length of stay, and throughput, as well as new models for transitional care. Organizations are now adopting LEAN principles and creating mechanisms for continuous process improvement at all organizational levels, including the deployment of new kinds of staff, such as engineers

and informaticians to design and implement systems improvements.

- **Technology-enabled healthcare continues its dramatic ascent to the bedside and beyond.**

As electronic medical records become the norm and health systems adopt sophisticated data management, integration, and analytic tools, a new paradigm of evidence-based, technology-enabled healthcare will start to emerge. Care protocols will be developed and embedded into patient records to inform bedside care and identify the right interventions for patients quickly. Patient and disease registries will evolve to inform population-level management approaches. Data systems will continue to grow in complexity, placing a premium on integration tools and technical expertise to drive insights into patient and population-level care.

- **Renewed focus on the relationship between the patient and provider.** While

the race to scale and the development of a suite of services is viewed as critical by many, fostering fundamental relationships with patients primarily via the clinical workforce will remain a key tool to secure patient loyalty.

- **Tug of war between payers and providers.** As we enter the second half of this decade, it has become increasingly clear that we are witnessing a tug of war between payers and providers regarding who has the critical relationship with the consumer. Many larger health systems are concluding they should either start their own health plans—many for Medicare Advantage or for Medicaid—or seek through a subcapitation agreement to wrestle control of medical management from the payer. Payers in their turn are reinventing their business models to be consumer-centric, including entering the world of direct service delivery, whether through delivering services or acquiring physician practices.

Megatrend 5

The Centrality of States as Payers, Public Health Agents and Innovators

The role of states as key players in the healthcare marketplace will continue to expand, with states embracing their explicit and implicit powers and authorities by which they can drive reform. Healthcare markets are local because delivery systems are local, and state governments have traditionally been at the center of their local markets as payers and financers of care; as regulators of health insurance companies and provider licensure, certification and care delivery; and as providers of public health and community-based services. States have long exercised at least some of these authorities in light of budget pressures, but in the last few years, states have all deepened their engagement in the transformation of the organization and oversight of their healthcare delivery systems. Over the next five to ten years, we expect to see accelerating manifestations of this trend, though dependent in some measure on electoral politics at both the federal level with a new administration in 2017 and the state level with the divide between blue and red

states ever growing with respect to healthcare.

- **More use of federal waivers to expand Medicaid, and develop comprehensive approaches to Medicaid program transformation.** As additional states decide to expand Medicaid, they will increasingly be leveraging Section 1115³ waivers to accommodate their unique clinical, economic, and political landscapes. Section 1115 waivers will grow in importance as vehicles for states to demonstrate tailored approaches to Medicaid program redesign, advancing new coverage, payment and delivery models.
- **Continued leverage of multiple federal transformation capital opportunities to drive innovation.** Through the 1115 waiver authority, Delivery System Reform Incentive Payment (DSRIP) programs continue to evolve, providing upfront capital for investment in provider-led delivery system redesign. ACA-related programs such as the State Innovation Model, Dual-Eligible Demonstration and the CMMI

Innovation Awards have also provided states with capital to support the state's role in convening stakeholders around a reform agenda.

- **Expanded use of Medicaid's purchasing power.** Medicaid agencies will continue to seek to leverage their purchasing power to achieve lower costs. As long as the federal government continues to invest, they will drive development of new delivery models, including patient-centered medical homes, health homes for the chronically ill, Accountable Care Organizations (ACOs), and a revitalized managed care system that moves from a fee-for-service model to more value-based purchasing. Medicaid managed care programs will also continue to take on high-cost beneficiaries needing behavioral and long-term services and supports (LTSS) that have been traditionally carved out of managed care. Should the federal government stop investing, it's more than likely that the agencies will revert to limiting access and

cutting prices to plans and providers. Furthermore, as more expensive therapies are brought to market, states will become more aggressive in demanding price concessions and value “guarantees” from innovators, and will drive a new balance between the traditional regulatory demands for coverage of all medically necessary treatments and emerging demands that treatments bring definable improvements in the quality of life and the full cost-of-care. State leadership to achieve success in this regard is critical, and many states will struggle to develop the organizational leadership and capacity to drive significant change.

- **Greater convergence of Medicaid, Medicare, Marketplaces and other private insurance.** With the growth in value-based payment models, and regulators’ awareness that changing plan and provider behaviors and incentives demand a common set of incentives across the various payers in a given market, some states will increasingly exercise their authorities to align payment strategies—and perhaps plans as well—across Medicaid exchanges, and the privately insured Marketplace. Self-insured employers have active coalitions in some states and can be important supporters, even leaders, of payment reform initiatives. Medicare has traditionally remained separate and apart from state reform efforts,

there have been exceptions, such as the Maryland all-payer hospital initiative. In the more aggressive states, this will result in “all-payer payment model” environments, where rates across plans and providers may vary significantly, but core structural elements of provider payment, plan benefit design, and quality metrics will converge to a limited set of common models. Similarly, Section 1332⁴ or State Innovation Waivers come online in 2017 and could provide states the opportunity to align and integrate the health coverage continuum, including approaches to coverage, payment, and delivery across Medicaid, Medicare, Marketplaces and the private insurance market.

Megatrend 6

Value Through Data

Aggregating the data necessary to shift to new models of care and developing actionable insights from this “big data” will continue to challenge stakeholders in the coming years. In the past, data was primarily collected and used

for very specific purposes: to pay claims; track patients in fragmented registries; or approve new drugs, biologics or devices. Organizations and vendors are now in the early stages of building systems of data that are capable of

answering a new, complex and ever-evolving set of questions around the delivery of more effective, more efficient and more targeted care. Venture capital money is flowing into big data startups, many of whom are targeting the health sector.

The systems of data span the clinical and non-clinical realms—hospital and outpatient data, pharmacy records, claims data, public health data, genetic data and post-acute care data, not to mention new forms of patient-generated data from the use of wearables and health apps.

Finding ways to generate subsets of more timely data securely and accurately associated with unique individuals and sub-populations will emerge as a necessary complement to broader, system-wide initiatives. More health systems will build the capacity to use data to target interventions to individuals and sub-populations in an efficient and timely manner. Ahead, we see several manifestations of this trend.

- **Continued shift from static, retrospective analyses to dynamic, predictive analyses to improve decision making at the patient and the sub-population level.** As the digitization of healthcare data expands, patient records will be linked to clinically established, evidence-based care protocols and treatment plans that will help providers and patients identify the best interventions

for particular conditions. On a lagged basis, sub-population-level data will be aggregated into intra- and inter-system rapid/real-time learning networks, where improvements in patient/population outcomes, costs, quality metrics and experiences will seamlessly manifest themselves in revisions to the underlying care protocols.

- **More consistent use of data to improve health system performance and test emerging clinical protocols, care models, and care teams.** Systems will increasingly turn to their ever-growing sources of internal quality, operational performance and financial performance data to drive quality and operational improvement programs aimed at lowering the unit cost of care and increasing overall quality.
- **Increased use of patient and population data and information in data-driven discovery, evaluation and innovation for drugs and medical devices.** Integrating and modeling clinical, molecular and demographic data sets will complement legacy investments in traditional laboratory and

prospective clinical trials, and the increased mining of natural retrospective and real-time “observational trials” will drive new research and development insights for pharmaceutical and medical device companies. The promise of these learning networks will create new linkages between pharmaceutical companies, medical device manufacturers and clinical providers and pose new challenges for regulators and payers to assess the validity of these new insights derived from nontraditional analyses and investigations.

- **Entry of Big Tech into healthcare.** Accelerating these trends will be the entry (or in some cases reentry) of the major technology players into the health space. IBM is making a new splash with Watson, as is Apple with its HealthKit. Google is targeting healthcare as its second-largest market after search. Others coming into the health space include Microsoft and a number of others with cloud-based solutions, as well as several “unicorns” with disruptive solutions: Palantir, NantHealth, and Oscar, to name a few.

Megatrend 7

Predict, Prevent, Personalize

The concept of precision medicine continues to evolve and is increasingly the focus of many leading health systems, specifically academic medical centers. Its promise is transformative, linking basic science-oriented insights to the development of individualized therapies to cure disease. Mapping and designing customized therapies to the unique patient and disease genetic markers will continue to be a major focus of physician-scientists and their institutions. In parallel, the concept of precision prevention is also emerging—linking an understanding of genetics and also environmental and socio-economic elements to design-appropriate clinical interventions to prevent the development of diseases later in life. Both of these trends will begin to test the ability of regulators and payers to develop targeted oversight regimes and payment models to replace the traditional one-therapy-fits-all orientation of review and payment. The market will experience several manifestations of this trend with

important consequences over the next few years:

- **Expanding impact of genomics, epigenetics and predictive diagnostics.** Genomics may change the face of healthcare through personalized medicine, genetic manipulation and predictive diagnostics. For example, the growing field of reproductive genetics has potential to eliminate nearly all single-defect conditions, including Cystic Fibrosis, Tay-Sachs, sickle-cell anemia, Huntington's, breast cancer (BRCA1, BRCA2), and others. As genome mapping becomes more prevalent, it will raise awareness around the importance of nutrition, lifestyle and preventive medicine. It also will cause new concerns about privacy and ethical issues— and new questions around how the statistical risk of a condition affects a person's treatment and coverage.
- **Continued convergence of biomedical, health practice, and health services research approaches.** The future of biomedical research as well as health services/population

health research will be defined by the convergence of the disciplines in health sciences, health delivery, life sciences, mathematics, engineering and others as critical research questions require transdisciplinary approaches and teams to design solutions, treatments and cures. Academic medical centers will continue to seek—and be challenged—to provide researchers with access to patients, patient data and clinician time to support research. This is increasingly true as pressure on clinical productivity increases. Federal funding for research will remain subject to the vicissitudes of federal fiscal politics, and health system funding to the schools of medicine for research and the academic mission is likely to diminish as margins get smaller. The restructuring of scientific research as organized within schools of medicine will be required to support the demand for converging disciplines.

- **A balance of precision medicine with precision prevention will emerge.** While an emphasis will remain on precision medicine with the goal of creating targeted therapies and ultimately cures for the most complex and debilitating diseases, a parallel focus on precision prevention that leverages clinical and environmental data to develop interventions that prevent disease and injury may also develop.

- **Increased regulatory focus on how to evaluate, cover, pay for, and afford these therapies.** Given the countless number of gene variations attendant to a given therapy, and given the diminishing applicability and utility of randomized clinical trials with such targeted interventions, product innovators, regulators, and payers will struggle to find common ground on coverage, coding, and reimbursement issues. At a minimum, payers

will require evidence of the clinical utility of these therapies, potentially complemented by other dimensions of value, to establish conditions of coverage. To ensure appropriate incentives for continued innovation and access to these new therapies, new models for assessing clinical utility and value, and of determining payment, value and affordability, will be essential.

Megatrend 8

Employers Recalibrate

With the ACA's employer mandate and taxation provisions (including the so-called Cadillac Tax under current scrutiny by Congress), and the increased eligibility of low-income workers—or their dependents—for subsidized coverage, employers face new and complicated choices in meeting the total compensation (wages and benefits) expectations of their workforce. With the continued tax advantages of providing insurance benefits as a portion of total compensation, and with ACA-derived reporting

requirements likely to persist whether or not an employer offers insurance, we expect little acceleration of the pre-ACA trend of gradual declines in the percentage of employers offering insurance to their employees. When offered, we do expect to see continued growth in high-deductible plans and plans with tiered and/or narrow networks, expanded offerings of flexible spending accounts, and growing interest in private or corporate exchanges. Over the next few years, we see the following:

- **The ongoing decline and reinvention of employer-based coverage.** Employers will continue to drop coverage for pre-65 retirees and shift them to the new Marketplaces. Even if the so-called Cadillac Tax is repealed, the continued threat of its eventual reintroduction in light of ongoing federal budgetary pressures will lead many employers to adjust their benefit and contribution designs. Many also will change how they provide support to current employees, shifting from a defined benefit to a defined contribution approach

(as employers have done with retirement accounts over the last three decades) and relying on private exchanges to enhance choice and purchasing power.

- **Self-insured companies seeking new opportunities to reduce healthcare costs.**

Large self-insured employers with concentrations of employees in confined geographies will be seeking exclusive contracts with providers in regional markets, and national contracts with national employers for destination services. They will also look to adopt more and more reference pricing contracts, publishing costs of particular procedures

and limiting reimbursement to drive patients to lower-cost providers. Employers will pick-and-choose among carriers to build the lowest-cost network for their employee distribution, continuing to move away from a single, national solution for their health insurance network needs.

- **Administration becoming more and more complicated.** In part due to the increased cost of managing multiple carriers, and in part owing to increased state and federal regulation and oversight of network adequacy and benefit design, employers still purchasing health coverage for employees will struggle with greater administrative complexity.

- **Continued growth of employer coalitions and private exchanges.**

Employers will pool their purchasing power to contract on a value basis with select providers. Private exchanges will become more prominent, facilitating defined contribution models that expand employee choice and allow employers to disintermediate and insulate themselves from healthcare cost/premiums increases—at least to some degree.

- **Increase in self-funded health benefit plans.**

Given the more flexible benefit mandates, smaller employers will seek to become self-insured, especially as more aggregators seek to offer services administering these plans and providing extensive stop-loss coverage.

Megatrend 9

The New Aging

Over the next 20 years, 74 million baby boomers will retire, and will expect convenient, low-cost access to a full suite of preventive, treatment and curative services. The cultural pressures on these retirees to remain active will generate unprecedented pressure on the

healthcare system to develop and deliver therapies that slow, if not reverse, the normal processes of aging and disease. Most Americans will live longer, often with chronic and disabling conditions. By 2040, 1 in 5 Americans will be 65 or older, with over one-third living

with a disability. Importantly, a growing number of the over-65 population will continue to work, many by financial necessity. The combined impact of more retirees living longer lives will strain not only our pension and retirement financing systems, but will

require Medicare, Medicaid and other public programs to adapt and more closely integrate their medical and long-term services and supports (LTSS) financing and delivery models, and with Medicaid currently paying for one-third of LTSS costs, will create enormous strains on Medicaid. Few individuals not eligible for Medicaid have private LTSS insurance coverage, creating equally-enormous strains on these individuals and families.

With persistent workforce shortages in the number of paid home health caregivers, retirees and their adult children will challenge our ability to provide long-term services and supports, and place growing demands on the compensation and training policies for the home healthcare workforce. The nature of illness will continue to shift from acute episodes to chronic disease, requiring continued development of models of care that extend outside of hospitals' walls. Care models will leverage medical advances into non-hospital sites of care, and link these advances in medicine and technology across traditional post-acute care settings (long-term care settings, hospice, etc.) and community-based support systems, including traditional public health, social service and community service

organizations that provide affordable and accessible housing and transportation options.

Successful fully-integrated delivery systems will include not only the full complement of traditional medical sites of care, but will be seamlessly linked to non-medical community support systems, as well as technology present in patients' homes. These trends, taken together, suggest the convergence of our healthcare and social services systems to cope with a dramatically growing group of older Americans—and to find (and finance) innovative ways to deal with the medical and functional needs of an aging population. Over the next few years, we expect:

- **Increased investment in home-based diagnostic and monitoring systems.** From self-care to connected care to monitoring devices, the focus will be on helping people manage chronic conditions and illnesses and be (self)-monitored and (self)-treated in their homes, avoiding the cost and inconvenience of facility-based care. As part of the focus on integrated care, effective approaches will link behavioral care management with traditional medical management.

- **Growing disconnects between the demand for and the supply of caregivers.** Given historically low wage levels, without improving wages and training, the supply of home health workers will continue to lag demand. The need for family caregiving will increase, and given the mounting physical, financial and emotional demands on these family caregivers, pressures will mount on employers for more generous leave policies, and on state and federal policy officials to develop and adopt a sustainable solution to making long-term services and supports more available and affordable.

- **Steady expansion in the supply of and demand for palliative and end-of-life care.** With expanded Medicare coverage, and growing awareness and acceptance of the need for end-of-life planning, more health and social service delivery systems will develop programs to educate and support the palliative and end-of-life needs of those with lifelong and life-threatening illnesses, as well as their families' needs. Public and private payers are implementing new policies to allow for payment for end-of-life counselling and for palliative care/hospice care services earlier on, citing recent evidence both for

cost-of-care and quality-of-life improvements from doing so. Challenges in identifying candidates for these services and preparing the clinical workforce to be stewards of this important work will remain a significant barrier to widespread adoption. The expansion of palliative, hospice

and related services will lead to new approaches for helping people face the end of their lives with dignity.

- **Continued development of the quest for longevity.** Companies are leveraging big data to identify the causes of human decline, developing mechanisms to monitor key

indicators of these biological processes, and then designing technologies and medications to intervene to prevent, reverse or slow those biological processes—ultimately seeking to slow the decay of body and mind, and potentially death itself. It is the quest for the “algorithm of youth.”

Megatrend 10

Healthcare Goes Global

In a world without information boundaries, the innovative care models and pricing regimes in other countries will become a more important part of our domestic approach to the delivery and financing of healthcare. Lower-cost approaches to common surgeries, such as cataracts and joint replacements, and drug and device price differentials between EU and U.S. markets, and between the U.S. and developing countries, will place significant pressure on U.S. stakeholders to adapt to these models and structures or to defend current practices. American providers and American companies will continue to lead in healthcare innovation and advancement globally, and will be held to rising

standards of value and efficiency, as well as transnational pricing equity. Leading academic systems will continue to establish outposts in both the developed and developing worlds, and many are linking into lucrative international private-pay markets. Domestically, increasingly active purchasers will seek delivery system partners that are receptive to adopting more cost-effective, high-quality nondomestic innovative care models.

Continued cost differentials in domestic procedures, relative to non-domestically delivered/available procedures and therapies of equal quality and outcomes, will push more Americans to seek care outside our borders. As a byproduct, U.S.

delivery systems and payers/plans will need to develop mechanisms and partnerships to ensure appropriate continuity of care once patients return home. We expect to see:

- **Complex market access issues.** Most emerging markets have complex access issues and regulatory structures. The pharmaceutical and medical device industries will need to create clear strategies for selecting the most productive markets for their product lines (or subsets of their lines) and achieving access in those target countries. Branded generics may become a useful differentiated source of revenue, relative to unbranded generics. Further, the growing trend of linking regulatory

approval to price will demand that these sectors consider alternative pricing mechanisms such as risk sharing and/or coverage and formulary placement based on evolving drug value frameworks, in order to gain access to institutional formularies on which their sales depend.

- **The expanding middle-income opportunity.** Countries such as Brazil, Russia, India and China (BRIC countries), Mexico, Turkey and Korea have an expanding middle class willing to pay cash for specialty products, making them attractive markets for pharmaceutical and device manufacturers. Some of these markets also are starting to see pharmacy benefit management emerge.

- **The globalization of delivery.** With globalization, many American payers and patients alike may seek to save money on testing, diagnosis and care through medical tourism—or remotely via telemedicine. The top five categories for medical tourism are cosmetic surgery, dentistry, cardiovascular, orthopedics and cancer.

Megatrend 11

Focus on the Whole Person

Leading-edge healthcare stakeholders at every level are beginning to take an integrated approach to medical, behavioral, public health and social issues. For many high-cost patients, effective care of their underlying conditions often requires managing a complex mix of medication and therapy services, addressing deeply embedded social, economic, cultural, and community issues and barriers to the effective adoption of proven medical treatments, and, most challenging, resolving the common community-based barriers to safe housing, a healthy diet and convenient transportation. With providers

and health systems increasingly accountable for the total health and total cost of care of an entire population, connecting the medical, social and community-based systems of care and support for these high-cost patients is a critical strategy for meeting population health goals. The market will see several manifestations of this trend over the next few years:

- **Broader acknowledgement of the need to address the social determinants of health.** Policymakers, providers, and payers will come to agreement and acknowledge that health and healthcare are tied strongly to issues related to poverty,

housing, education and other social factors, and the success of any reform efforts in healthcare is contingent upon improvements in the latter social issues.

- **Recognition that current funding levels for social/community services are inadequate,** and an ensuing debate over who is responsible and who pays.
- **Initial focus on integration of behavioral health as an important first step.** With the passage of mental health parity at the federal level and similar legislation at the state level, healthcare payers have begun to address coverage of a range

of mental health, substance abuse, and alcoholism issues in a more comprehensive manner than ever before—and policymakers are increasingly conscious of the enormous impact on cost, quality and outcomes presented by co-morbid patients with behavioral health issues. The new frontier for the care team approach will require eliminating siloes between behavioral and physical health as well as between acute-care and long-term services and supports.

- **Emerging efforts to connect healthcare to community-based organizations and social services.** While certainly not widespread and with significant logistical, payment and operational issues to be worked out, focus is shifting to the development of models that link the provision of healthcare services to the broader social safety net, including housing, nutrition, employment, etc. New York State, for example, through its DSRIP program, is seeking to motivate these kinds

of connections to support the Medicaid population.

- **All eyes will be on the early movers in this space.** Several states are out ahead of others in terms of piloting “whole person” approaches to care as part of their Medicaid reform agendas, including New York and Washington. All eyes will be on them as they work through the complexities of designing programs to address their beneficiaries’ social determinants of health.

Conclusion

Game On!

These 11 trends will continue their evolution across the remainder of the decade and well into the future. They will continue to alter the landscape within which all healthcare stakeholders operate. Successful organizations will understand and capitalize on these trends, whereas others will not adapt rapidly enough to these evolutionary changes and litter the landscape as poor performers, or worse—extinct organisms.

With a few more years of experience in the new, post-ACA marketplaces, with the

uptick in healthcare inflation, with the deeper insights into the challenges of integrating disparate healthcare provider sectors, their cultures, and their systems, and with a deeper appreciation of the consequences of the positive feedback loop of more transparency and more empowered consumers, the healthcare industry is entering into a new era of Darwinian competition.

Increasingly, consumer interests in affordability and government interests in sustainability are aligning, bringing forth

a deepening recognition on the part of healthcare organizations that a zero-sum, limited-growth revenue game is likely the new normal. In addition to the forward-looking strategies identified above to gain market and health-spend share, we expect a significant increase in legal and regulatory challenges relating to mergers and acquisitions, network and formulary design decisions, and transparency and anti-fraud requirements. To make progress in meeting consumers’ ever-increasing expectations on cost,

quality, access and experience will require guarding one's flank, leveraging shifting alliances, and aligning on a resilient, focused strategy.

Over time, and not without frequent missteps, the unfolding Darwinian struggle will result in a more efficient, safe and high-quality health system

that is highly attuned to consumer needs.

Game on!

¹ This paper updates our "2013 Trends" paper, authored by Thomas Enders, Kathleen Brown, Molly Smith, Jared Augenstein, Andrew Detty, and Elizabeth Osius. The authors of this paper are indebted to these colleagues for their initial identifications and framing of these trends. We are also especially grateful to our colleagues listed on page 2, who contributed their insights and experiences to this paper.

² Medicare Access and CHIP Reauthorization Act of 2015.

³ Social Security Act., §1115, 42 U.S.C. 1315.

⁴ Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1332, 124 Stat. 120, 203 (codified as amended at 42 U.S.C. § 18052 (2012)).

About Manatt

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