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Healthcare Forecast 2017: Top Trends Driving Board Strategic Priorities

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2017 will be a transition year shaped by changes proposed by President-elect Donald Trump and a Republican Congress. Chief healthcare concerns include legislative proposals to "repeal and replace" the Affordable Care Act (ACA), along with the continued movement to implement alternative payment models (APMs) as called for in the Medicare Access and CHIP Reauthorization Act (MACRA). We will address the potential changes ahead when it comes to shifting health benefits, provider supply, new care models, transparency, and the continued growth of consumerism. 2017 will be a dynamic year as we pivot and move in a new political direction.

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1. Inpatient Volume Will Experience a Push-Pull Effect

As the population continues to age and grow, health status indicators decline, and the population with health insurance remains about the same for 2017, volume of both inpatient and outpatient services should continue to grow, but market trends will keep that growth in check. These mediating forces include new care models (e.g., ACOs, bundled payments, chronic disease management, and patient-centered medical homes that can help curb acute care utilization) and use of incentives and technology to improve efficiency (e.g., use of hospitalists, case managers, clinical protocols, and economic incentives to shift care to less expensive settings). Taken together, these forces have been very successful in reducing acute care utilization in several states, such as Maryland, so hospitals and health systems should anticipate that per capita utilization rates will remain flat or decline.

In the boardroom:

- Closely track new federal and state healthcare policies that affect volume, revenues, and payer mix.
- Track inpatient and outpatient shifts in utilization and their effect on revenues.
- Listen to your medical staff members to identify changes that affect physicians.
- Build partnerships with physicians to implement value-based payment arrangements through clinically integrated networks (CINs) and other vehicles.

2. Costs Continue to Rise

Pharmacy costs as a category are expected to increase more than 6 percent in 2017, but could rise as much as 19 percent for certain classes of medications, such as specialty drugs. In total, pharmacy costs will account for more than 12 percent of the overall healthcare spend. Post-acute care and behavioral health costs will outpace inflation as demand continues to increase and providers struggle to keep up with demand.

Labor costs will rise faster than inflation given the baby boomer retirements, shortages of workforce personnel, and union unrest. If inflation begins to creep into the economy (which it already has started to do), watch the potential growth of construction and equipment costs as well.

Consumer-driven health plans will cause consumers to fund a greater proportion of their healthcare costs and drive the continued growth of retail health services in areas such as urgent care, diagnostic imaging, etc.

In the boardroom:

- Monitor changes in bad debt as potentially more people are unable to pay their deductibles, and if more people move into the ranks of the underinsured.
- Look to pharmacy benefit administrators and services to mitigate the high cost of specialty drugs.
- Watch for the development and growth of restricted formularies for Medicare, Medicaid, and CINs to help mitigate the pharmaceutical cost curve.
- Technology innovations and applications may offer solutions to reduce workforce expenses.
- Monitor efforts to consistently improve work-flow and productivity among staff.
- Proactively address potential construction cost increases by locking in prices and structuring bids to mitigate fluctuations due to inflation.

3. An Increasing Focus on Consumerism

Consumers are being asked to foot more of the costs of their health plan premiums and out-of-pocket co-pays. Further, as commercial HMOs experience a decline in membership, PPOs and consumer-driven health plans with higher deductibles will grow. The PPOs will have significant employee participation in the cost of the premium. Employers will provide some relief to employees by offering health savings accounts (HSAs) and contributing approximately $1,200 dollars annually.

Consumers, because they have more money at risk, will be increasingly engaged in their healthcare and become more price sensitive for primary and retail healthcare services. They will use the ever-increasing Internet sites and apps to price shop and check cost, quality, and access to providers. Quality metrics will begin to matter more to the individual. Consumers will become more engaged with their healthcare as they use patient portals to access their personal health record and healthcare system. Providers will need to develop a strong social media strategy and focus on developing "patient stickiness."

On a final pricing note, some providers were early adopters and are doing a good job of providing price information on their Web sites. Check out Web sites for St. Clair Hospital in Pittsburgh, INTEGRIS Health in Oklahoma, and Geisinger Health System in Danville, Pennsylvania.

In the boardroom:

- What is your organization's transparency and social media philosophy and approach?
- What are you doing regarding benefits for your own employees?
- Have you evaluated the price competitiveness in outpatient services?

4. Growth in Information Technology

According to Intel and other technology observers, health information technology will become more user-friendly, accepted, sought after, and accessible, enabling and encouraging consumers and patients to use:

- App-enabled patient portals (73 percent)
- Telehealth (62 percent)
- Text communication (57 percent)
- Remote patient targeting (49 percent)

Of particular note is the explosive growth projected by Intel from approximately 250,000 telemedicine users today to 3,200,000 in 2018—and this growth is happening in spite of telehealth not being reimbursed in most cases. Currently only rural providers get paid for telehealth under Medicare, and it is possible to apply for a waiver under alternative payments. In essence, growth in telehealth is another way to get at growth of value-based care, since the organizations making this investment are likely those that are able to take advantage of the waivers and/or make up the costs they incur through shared savings.

Hospitals, physicians, home care services, and health systems will be investing in telehealth in 2017. This technology will also be critical to the growth and development of the "hospital in the home" model. Healthcare organizations will also continue to implement patient portals to create that "stickiness" we recommend.

Part of the healthcare technology explosion will come from new innovators improving the way we detect and diagnose disease to those changing how we deliver care. Look for more wearable devices, better analytics, and use of big data, 3D printing, and others.

But all that additional electronic data flowing around does create risks. Expect increased expenditures in the cybersecurity area, as healthcare providers have become high-value targets for cyber-attacks.

In the boardroom:

- Does your hospital/health system have IT strategies that proactively and effectively address telehealth, cybersecurity issues, and increased patient connectivity and engagement?
- As a board, ensure that there is a specific, effective longer-term IT strategic plan in place.

5. Physician–Hospital Alignment and Collaboration

Many hospitals and health systems have made a substantial investment in the acquisition and employment of physicians, even though many still lose $100,000 to $175,000 a year per physician. Expect a few hospitals and health systems to sell or transfer their employed physicians to another physician organization, and instead pursue contracts, agreements, and partnerships to retain the volume those physicians generate. Most hospitals are continuing to build alignment and partnership vehicles such as CINs, bundled payments, and gain-sharing models. Otherwise, health systems and hospitals will continue to pursue ACOs, co-management agreements, and shared risk pools to foster alignment and collaboration.

Some joint ventures of ambulatory surgery centers may be entering a phase where they are being sold or restructured to allow current investors to get out, new investors to get in, or buy outs of third-party operators from their ownership and/or management agreement. With the election results, we may see a rebirth of physician-owned and joint venture healthcare entities, such as surgical centers.

In the boardroom:

- Monitor your organization's physician integration, alignment, and partnership strategies—its performance and effectiveness.
- MACRA is a forgone conclusion. If you employ physicians, do an economic impact analysis of the options. If you have a MACRA roadmap, follow it religiously; if you don't, work with your physicians to develop one immediately.
- Assess your APM-qualifying options to determine whether Merit-Based Incentive Payment System (MIPS) or APM tracks are most advantageous for your physicians.
- Monitor the current (and projected) performance status of your alternative delivery and payment models (e.g., ACO, bundled payment, CIN, others).
- Monitor the performance of the organization's value-based payment arrangements to ensure the organization is optimizing the results and incentive payments.

6. Continued Consolidation, Alliances, and Affiliations

Healthcare industry consolidation should continue with health plans, super CINs, health systems, hospitals, surgery centers, imaging centers, and physician organizations. We have seen consolidation with urgent care centers and retail health centers as well. All of this action underscores the continued downward pressure on profit margins, and the need for scale and larger populations. Organizations are seeking to eliminate overhead, duplication of services (administrative, clinical, and management), or avoid capital expenditures. We can also see consolidation in the post-acute world.

The drivers that force the sale, merger, or affiliation are many:

- Access to capital is difficult or not feasible
- Greater relevance in the market to drive a larger population to the organization
- Enhance management depth and talent, and specialized expertise (such as medical informatics)
- Gain economies of scale
- Access to IT or existing facility investment
- Access to a population health service organization with alternative payment delivery models

Lastly, health systems may seek to gain greater control of the continuum of care through merger, acquisition, or affiliation with non-acute providers.

In the boardroom:

- Monitor competitors' performance and activities in this area.
- Monitor your own performance and benchmarks against best practices.
- Assess your organization using the six drivers listed above.

7. The ACA and Payment Sources

It is expected that the ACA will be "politically" repealed and replaced in 2017, yet implementation of the changes or new components of the model could be two to three years out. It is anticipated that Republicans will reduce the regulatory barriers to sell insurance across state lines, encourage growth of Medicare Advantage participants, and encourage increased competition among health plans.

As a result, employer-sponsored health plans will bump premiums up between 7 and 9 percent, while the health plans available on the exchanges appear to have increased premiums around 13 percent (with some going up 25–100 percent). Additionally, some major health plans have announced their intent to get out of the public insurance exchanges (e.g., United Healthcare, Aetna, and more than 35 others). Exchanges could be further destabilized if Congress does an immediate repeal of ACA over a three-year period, with a punt on replace until late. While they know changes are coming, insurers need certainty in order to know what products to offer, at what premium price, etc., so that uncertainty could lead to even more companies walking away from the exchanges.

There will be continued growth in direct-to-employer contracting (Boeing is a recent example). We expect this trend will continue in urban areas, especially where there are health systems that can offer themselves as a preferred delivery choice.

As mentioned earlier, HMO commercial enrollment is in decline, while the PPO high-deductible plans are growing. Medicare will have economic challenges given the growth of Medicare recipients (estimated at 10,000 new beneficiaries per day). Medicaid probably will be unchanged or grow slightly in 2017 if additional states find it palatable to expand Medicaid as a result of potential block grants and additional flexibility measures that are likely with this Congress. We also expect to see growth in Medicaid value-based payment models and a Medicaid choice program similar to Medicare Advantage.

The private exchanges that were of keen interest to employers' benefits managers in 2015 and 2016 should see slow growth, but will not be a major change factor in the short term.

Lastly, keep an eye on the site neutral pricing for hospitals. The days of getting paid more for hospital-based outpatient services may be coming to an end.

In the boardroom:

- Track new policies introduced by the Trump administration, but be careful not to be too reactive to the politics and rhetoric.

- Monitor payer mix changes and their impact on financial performance.
- Ensure that there is a strategy for your hospital/health system to listen to health insurance brokers in your market.
- Monitor new niche outpatient players in the market.

8. Provider Shortages Will Accelerate

The baby boomers who put off retirement after the Great Recession are finally running out of gas, and are ready to cut back or retire. With the recent stock market gains, the aging baby boomers have seen their net worth increase, retirement plans bounce back, and now feel more secure about their economic situation. As nurses, allied professionals, and physicians retire, expect to see more IT applications, self-diagnosis, and self-treatment. This includes increased use of telehealth, social media, apps, and patient portals. Use of more support staff to improve productivity of caregivers will rise, but expected productivity gains from the EMR will disappoint.

Expect salaries, benefits, performance bonuses, and sign-on bonuses to increase at a rate above inflation as hospitals seek to expand their reach into the population to gain market share. As the economics improve and salaries and signing bonuses go up, physician turnover will, too.

In the boardroom:

- Monitor staff vacancies, turnover, and project retirements (consider programs to attract and retain mature workforce members).
- Track recruiting efforts and costs to fill vacancies.
- Look for new delivery models and technologies to improve and ensure peak productivity of the existing workforce.

9. Patient Satisfaction

Healthcare organizations will continue to focus on patient satisfaction. The industry still has a long way to go to match other industries regarding communication and contact with its customers. Better and more frequent contact with the patient via social media, emails, patient portals, and follow-up phone calls will all matter more as provider compensation gets increasingly tied to patient satisfaction scores.

As providers compete for more lives (population), patient satisfaction will play a bigger role. The time has come to focus in this area, measure, and then improve.

In the boardroom:

- Monitor patient satisfaction, performance, and benchmarking.
- What are your patient engagement and "stickiness" strategies?
- Do you have a robust social media approach? Is it reviewed frequently to make sure it is effective and up-to-date?

10. Rating Agency Outlook for 2017

The rating agencies have a negative outlook on the non-profit sector. The for-profit operators have seen stock prices decline as analysts expect higher bad debt, fewer Americans having health insurance coverage, and price/revenue pressure due to transparency and low rate increases. Further, they expect continued movement to value-based payment systems. The rating agencies are very interested in hospitals and health systems and their focus on:

- Payer mix
- Movement to population health and alternative payment systems
- Quality and patient satisfaction scores vis-a-vis their competitors
- Bad debt
- Ability to manage expenses
- An aligned physician base

In the boardroom:

- Track financial performance, payer mix, and per-unit costs. What are the trend lines and future forecasts telling you?
- Track and analyze physician economic alignment. Do we have appropriately aligned economic incentives with our physicians? What more can be done in this essential area?

Conclusion

The rating agencies have concerns that we have raised. Hospitals, health systems, and physicians need to watch the Republican administration and its focus on "repeal and replace." You should also keep an eye on Medicaid changes (potential movement to block grant funding), and the economy (if job growth is robust it may help to offset the expected decline in people with insurance). Technology will play a greater role in our future as we seek to automate and integrate information, diagnosis, and assisted treatment. Amidst the turbulence, the future is as bright as your organization's ability to proactively anticipate and respond to inevitable change.

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