EXECUTIVE INSIGHTS

Looking Ahead: The US Healthcare Provider Landscape in 2035

Part 1: Pressure is mounting, but will the cost curve bend?

In early 2023, L.E.K. Consulting and the World Economic Forum released a special report[1] on the outlook for global health and healthcare to the year 2035. This multipart series builds on those findings and focuses on implications for the U.S. healthcare "provider" organizations — organizations that directly deliver healthcare services (health systems and hospitals, physician groups, post-acute care facilities, etc.).

Pressure is mounting to reduce healthcare spending (or 'bend the cost curve')

Annual U.S. healthcare expenditures have reached a new high of about $4.5 trillion. The U.S. spends more than 1.75x per capita on healthcare[2] than other developed nations and still lags on key health indicators. Over the past decade, U.S. healthcare expenditures have risen by approximately 5% annually, consistently outpacing inflation (roughly 1.8% annually).

External to inflation, drivers of this upward trend — population aging and the increasing prevalence of chronic conditions (the primary driver) and the introduction of new (and costly) care innovations (a secondary driver) — show no signs of abating. Cost pressures such as labor and supply chain costs and clinician shortages also continue to challenge bottom lines.

At the current pace, U.S. healthcare expenditures may reach $8 trillion by 2035,[3] more than 20% of forecasted total U.S. gross domestic product. While the principal goal of extending life remains paramount, public pressure is mounting to achieve better health outcomes at a lower per capita cost.

Potential cost limiters are either ineffective or unlikely to be implemented

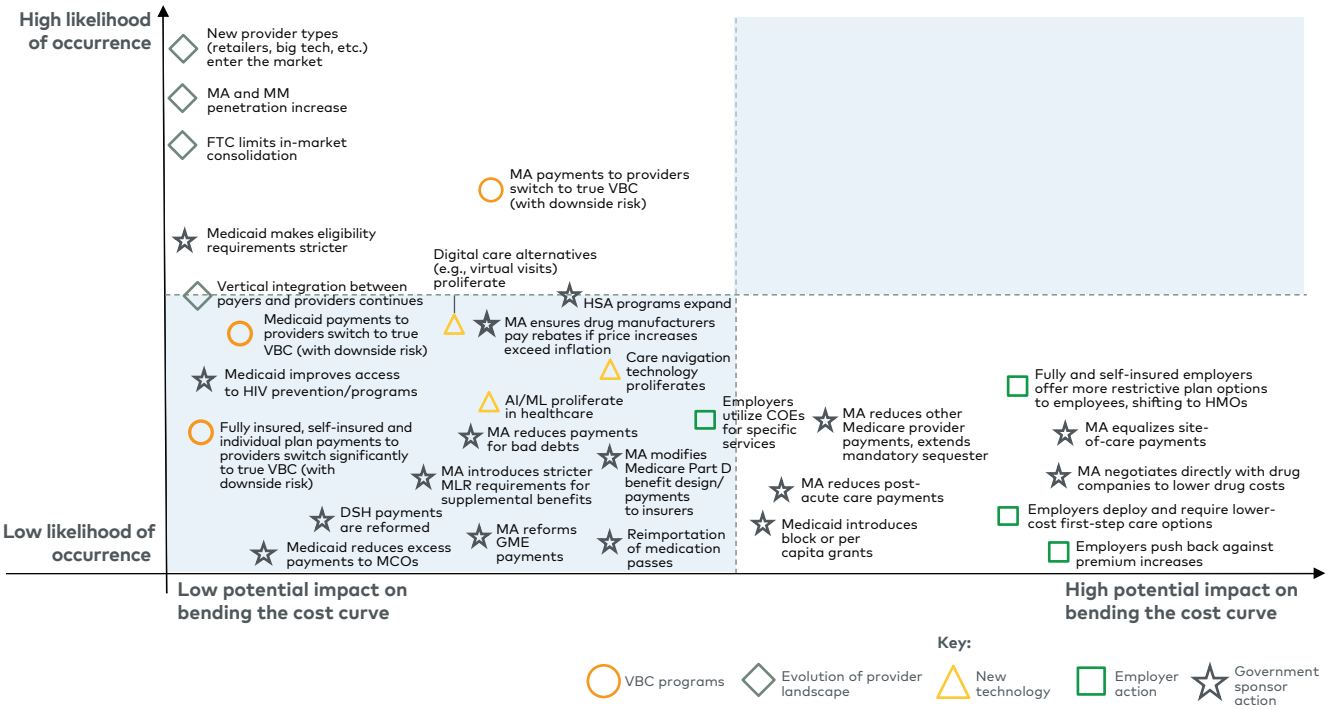
The transition to value-based care and the introduction of new technologies have positively impacted the U.S. healthcare ecosystem but have yet to deliver a meaningful reduction in total U.S. healthcare spend. Employers and public plan sponsors (e.g., the Centers for Medicare & Medicaid Services (CMS) and other federal/state agencies) are ultimately best positioned to place downward pressure on healthcare spend, but structural impediments (e.g., employer fragmentation, risk for employee/constituent abrasion) have prevented both groups from effecting significant change.

To evaluate whether a significant reduction in healthcare expenditure is likely by 2035, L.E.K. analyzed the magnitude and relative implementation probability of 30 in-flight or potential spend-reducing initiatives.

We found that while these 30 initiatives could drive an approximate $500 billion reduction in healthcare expenditure by 2035 (representing around 6% reduction in spend), the impact is likely to reach a more modest $75 billion (a roughly 1% reduction in spend) as the most significant spend-reducing actions are unlikely to be implemented.

While they are unlikely to yield a significant reduction in spend, many of the initiatives outlined below will drive continued market evolution and a redistribution of spend across healthcare market segments, with the large and ever-growing healthcare market continuing to attract investment and innovation (see Figure 1).

Figure 1
In-flight or potential healthcare spend-reducing initiatives



Note: AI/ML=artificial intelligence/machine learning; COEs=centers of excellence; DSH=disproportionate share hospital; FTC=Federal Trade Commission; GME=graduate medical education; HIV=human immunodeficiency virus; HMOs=health maintenance organizations; MA=Medicare Advantage; MCOs=managed care organizations; MM=Medicare-Medicaid; MLR=medical loss ratio; VBC=value-based care
Source: L.E.K. research and analysis

This raises new risks for healthcare provider organizations (e.g., competition, regulatory scrutiny) but also creates new opportunities for organizations that can adapt and rise to the challenge. In the following sections, we explore each type of potential cost-limiting action and implications for provider organizations in more detail.

Value-based care (VBC) programs

(Moderate likelihood of implementation, low potential impact on total healthcare expenditure)

By tying provider payments to cost and quality performance benchmarks, VBC programs are intended to drive higher-quality care at a lower cost than traditional fee-for-service arrangements. Several new delivery models (e.g., accountable care organizations, integrated payer/provider models) have emerged over the past decade in response to federal goals of rapidly shifting Medicare payments to VBC contracting arrangements.

These programs show great promise and are gaining traction, but unlike many that publish on this topic, we do not expect a rapid transition to true value-based payments (in which the

provider organization bears downside risk) or that VBC will meaningfully reduce total U.S. healthcare expenditure in its current form:

- Actual risk-based payment (e.g., shared savings and downside risk, condition-specific per member, per month payments) comprised around 20% of total payments in 2021,[4] up from about 15% in 2018[5]
- While these programs have yielded some improvement in quality/outcomes, cost savings have largely been reinvested in other organizational initiatives or distributed to physicians (versus returned to members)

Provider consolidation and new entrants

(High likelihood of implementation, low potential impact on total healthcare expenditure)

The U.S. care delivery landscape has seen significant consolidation in recent years, with small independent physician groups merging into larger platforms and health systems acquiring a broad range of provider organizations in pursuit of scale and associated synergies. In addition, managed care organizations (payers), retailers and tech companies have entered the U.S. care delivery market via acquisition and organic development strategies in the hopes of offering lower-cost care alternatives for U.S. consumers.

Neither increases in provider organization scale nor the entry of nonhospital "disruptors" has so far delivered significant reductions in U.S. healthcare expenditure. In fact, studies[6] have found that provider consolidation has increased prices and therefore total healthcare expenditure.

These shifts are expected to continue through 2035, even as provider consolidation slows. Yet, as evidenced by historical shifts, these changes are more likely to redistribute U.S. healthcare spend than to reduce it.

New technology

(Moderate likelihood of implementation, low potential impact on total healthcare expenditure)

A wave of digital care alternatives emerged during COVID-19 and may continue to proliferate based on their convenience for patients and clinicians. For provider organizations, these alternatives may require fewer staff and less facility space and may alleviate some cost pressures. However, reimbursement for virtual care remains a challenge, with patients frequently requiring in-person care and reimbursement parity protections lacking.

Artificial intelligence (AI) innovation is also accelerating rapidly, kick-started in 2017 by Google Brain's Transformer architecture and enhanced by ChatGPT's success. While the healthcare industry has been wary of the promotion of AI to date, strategic interest in AI is rising as the technology improves and clinician shortages worsen. Examples include:

- Buying/building applications to alleviate workflow pain points
- Using AI to gain market share or upsell in key verticals
- Funneling dollars into promising AI ventures

These tools have the real potential to reduce costs, build competitive advantage and address labor shortages. However, without action from public plan sponsors, employers or consumers, these savings will most likely be redeployed/reinvested into other high-priority organizational initiatives.

Public plan sponsor and employer action

(Low likelihood of implementation, low to high potential impact on total healthcare expenditure)

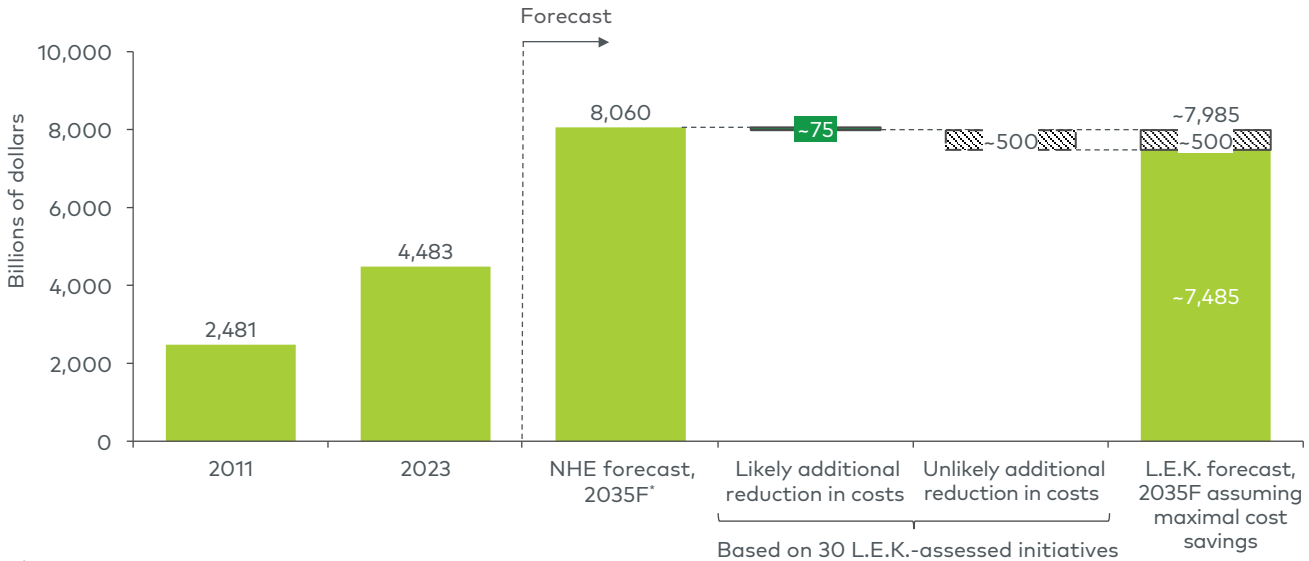
Employers and public plan sponsors (e.g., CMS and other federal/state agencies) are ultimately responsible for healthcare payments and are therefore best positioned to place downward pressure on U.S. healthcare spend. Despite this position and a stated desire to act (e.g., 69% of chief financial officers cite employee healthcare expense as a concern),[7] structural impediments have prevented both groups from effecting significant change:

- Employers cannot act in unison and therefore must manage the risk of employee abrasion/attrition in considering actions that could impact overall healthcare expenses
- Public plan sponsors must consider disparate and changing constituent priorities, which often leads to inaction or muted change/compromise

Measures to control costs, such as Medicare Advantage negotiations with drug companies or employer requirements for first-step, lower-cost care options, could theoretically significantly reduce total healthcare expenditure. However, these structural barriers to significant action are expected to persist, limiting likely actual impact to 10%-20% of this theoretical total. Previously proposed expansions to the Medicare program (i.e., some form of "Medicare for All") face similar barriers and could result in a wide range of healthcare expenditure outcomes (from decreases to increases) according to recent Congressional Budget Office estimates.[8]

L.E.K. expanded CMS' national health expenditure forecast through 2035 and estimated the annualized magnitude and probability of each of 30 in-flight or potential spend-reducing initiatives. Probability weighting was applied to assess likelihood of reductions (see Figure 2).

Figure 2
Forecast of total US healthcare spend (2011, 2023, 2035F)



*Grown from NHE forecast to 2030
Note: NHE=national health expenditure
Source: Centers for Medicare & Medicaid Services' NHE data; L.E.K. research and analysis

Continued growth yields new risks and opportunities

While these actions are unlikely to yield a significant reduction in spend, they will continue to drive market evolution and a redistribution of spend across healthcare market segments. In addition, the large and ever-growing healthcare market will continue to attract investment and innovation.

These dynamics are likely to create a range of challenges for U.S. provider organizations, including:

- Heightened competition in the care delivery ecosystem
- Continued redistribution and complication of revenue streams as the VBC transition continues
- Continued targeted and idiosyncratic cost pressures, such as clinician and staff constraints, and revenue variability across provider service lines
- Heightened pressure for plan sponsors and employers to take more significant action to reduce spend

But continued market growth and evolution also creates a range of new opportunities for provider organizations that can adapt and rise to the challenge — evolving quickly, proving their continued value and responding to a growing mandate for cost-effectiveness. These opportunities include the ability to:

- Leverage new types of partnerships to expand and create win-win solutions

- Develop the capabilities to combine care delivery and care financing and lead the continued evolution and improvement of VBC programs
- Participate in and capitalize on rapid technology innovation (e.g., venture investment, development)
- Adapt to rising consumerism with end-to-end clinical leadership and high-touch, integrated approaches
- Monetize leading capabilities into new revenue streams (e.g., brand, decision support, research)
- Drive targeted efforts in high-growth markets or new customer sets

In the next entries in this series, we will dive deeper into these potential evolutions, threats and opportunities as well as the actions that provider organizations can take now to ensure they are well positioned to capitalize on them.

In the meantime, if you would like to discuss this article and its implications for your organization, please do not hesitate to reach out to healthcare@lekinsights.com.

Endnotes

[1]Lek.com, "Global Health and Healthcare Strategic Outlook: A Shared Vision for 2035." https://www.lek.com/insights/hea/global/sr/global-health-and-healthcare-strategic-outlook-2023

[2]Healthsystemtracker.com, "How does health spending in the U.S. compare to other countries?" https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/

[3]Cms.gov, "Nation Health Expenditure Data." https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsProjected

[4]Hcp-lan.org, "2022 APM Measurement Infographic." https://hcp-lan.org/apm-measurement-effort/2022-apm/2022-infographic/

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[6]Kff.org, "What We Know About Provider Consolidation." https://www.kff.org/health-costs/issue-brief/what-we-know-about-provider-consolidation/

[7]Mercer.com, "The CFO perspective on health: New survey results." https://www.mercer.com/en-us/insights/us-health-news/the-cfo-perspective-on-health-new-survey-results/

[8]Cbo.gov, "How CBO Analyzes Proposals for a Single-Payer Health Care System." https://www.cbo.gov/publication/56898

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