Crossing the Great Divide

Annual Membership Conference
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B-School, Disrupted

In moving into online education, Harvard discovered that it wasn’t so easy to practice what it teaches.

By JERRY USEEM

If any institution is equipped to handle questions of strategy, it is Harvard Business School, whose professors have coined so much of the strategic lexicon used in classrooms and boardrooms that it’s hard to discuss the topic without recourse to their concepts: Competitive advantage, value chain.

But when its dean, Nitin Nohria, faced the school’s biggest strategic decision since 1924 — the year it planned its campus and adopted the case-study method as its pedagogical cornerstone — he ran into an issue. Those professors, and those concepts, disagreed.

The question: Should Harvard Business School enter the business of online education, and, if so, how?

Universities across the country are wrestling with the same question — call it the educator’s quandary — of whether to plunge into the rapidly growing realm of online teaching at the risk of destabilizing the on-campus education for which students pay tens of thousands of dollars, or to stand pat at the risk of being left behind.

At Harvard Business School, the pros and cons of the argument were personified by two of its most famous faculty members. For Michael Porter, widely considered the father of modern business strategy, the answer is yes — create online courses, but not in a way that undermines the school’s existing strategy. “A company must stay the course even in times of upheaval while constantly improving and extending its distinctive position.”

Clayton Christensen

“The only way that market leaders like Harvard Business School can survive ‘disruptive innovation’ is by disrupting their existing business themselves.”

CONTINUED ON PAGE 4
Today’s Agenda

1. The Macro Economic Issues Driving Real Change in Healthcare
2. The Statistical Picture
3. The Themes of “Real Change”
4. First Principles
The Driving Force Behind the Change to America’s Healthcare System

The Dominant Role of Healthcare Spending (CBO’s Long-Term Budget Projection)


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The Numbers Send a Clear and Present Message

“The implication for budgeteers is clear: If we can somehow solve the health care cost problem, we will also solve the long-run deficit problem. But if we can’t control health care costs, the long-run deficit problem is insoluble.”

Alan S. Blinder


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Hospitals have absorbed nearly $122 billion of new cuts since 2010.

**Impact of Hospital Cuts Since FY 2010**

- Bad Debt ($2.1b)
- Medicaid DSH ($16.6b)
- 3-Day Window ($4.2b)
- Long Term Acute Care Hospitals ($3b)
- Two-midnight Offset ($2.4b)
- MS-DRG Coding Offsets ($35.3b)
- Sequestration ($58.3b) including cuts from the Bipartisan Budget Act of 2013 and Military COLA Fix

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1Bad debt included in Middle Class Tax Relief and Job Creation Act of 2012 (MCTRJCA); Medicaid DSH cuts included in MCTRJCA, American Taxpayer Relief Act of 2012 (ATRA), Bipartisan Budget Act of 2013 and Protecting Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010; 3-day window cut included in Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010; MS-DRG coding cuts included in ATRA as well as CMS regulations (estimate of excess cuts based on hospital analysis); offset for two-midnight policy included in FY 2014 Final IPPS Rule; sequestration amount estimated from CBO Medicare Baseline and AHA projections of Medicare spending. Includes extension in Bipartisan Budget Act of 2013 and Military COLA Fix. Long Term Acute Care Hospital payment cut from Bipartisan Budget Act of 2013. Excludes ACA-related reductions.
Where Are We Now?

• The annual growth rate in real spending for healthcare increased by only 0.8% per person in 2012,¹ and is expected to be just 1.3% over the 2010-2013 period.² This is below the real gross domestic product.

• Healthcare prices in February 2014 rose only 1.2% above February 2013.

• Annual employment growth in the hospital sector has been very slow, increasing at an average rate of just 0.8% since 2007 and only 0.1% from March 2013 to March 2014.³

• Medicare spending per beneficiary grew at a rate of 1.6% annually from 2010 to 2012—down considerably from previous years, and roughly 2 percentage points below the growth rate of per capita GDP.⁴

What Is Changing?

• Overall growth in NHE for the past 4 years of about 3.7% is the slowest rate recorded in the 53-year history of the National Health Expenditure Accounts.¹

• NHE was 17.2% of GDP in 2012, an actual decline from 17.4% in 2009.²

• Prescription drug expenditures, which account for approximately 11% of overall U.S. healthcare expenditures, declined from annual growth of 12.4% in 2000 to 0.4% in 2013³; 17% of current pharmaceutical spending is on drugs that will go off patent in the next five years.⁴

• The use of advanced diagnostic imaging grew by more than 6% per year from approximately 1995 to 2005, but growth has flattened since 2005.⁵

• The number of bypass cardiac surgeries decreased by 20% from the volumes of the mid-90s.⁶

The Emerging Points of Disruption to Healthcare’s Business Model

1. Redesigning America’s Healthcare Business Model
2. The “Tipping Point”— The End of Inpatient-Centric Care
3. The Entry of New, Well-funded, and Highly Capable Competitors
4. Healthcare as a “Retail Good” with Real Price Sensitivity
5. Transformational Change to the Employee Insurance Market
1. Redesigning America’s Healthcare Business Model

The Fee-for-Service/ Medicare-Based Business Model
1. Redesigning America’s Healthcare Business Model (continued)

The Fee-for-Service/ Medicare-Based Business Model

- Employers
- Patients
- Medicare and Medicaid
- Healthcare Company
- Who Is This?
- Content of Care
- Hospital
- Doctors
- Outpatient Services
- Continuum of Care
- Select Contract (?)
- • Commodity
  • Make vs. buy
  • Low-cost provider
  • Contract to specifications
2. “The Tipping Point” – A Move from an Inpatient-Centric Care Model to an Outpatient-Centric Care Model

Inpatient Use Rates for Chicago, Cook County, and the State of Illinois Have Decreased by 9%+

Inpatient Use Rate Trends (per 1K population)

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Notes: Excludes Normal Newborns (MS-DRG 795 and DRG 391).
3. The Entry of New, Well-Funded, and Highly Capable Competitors

Disruptive Contextual Change Encourages the Entry and Aggressive Expansion of A-traditional Competitors

- Diagnosing and following chronic care patients in Walgreens clinics
- Theranos™ Wellness Centers at Walgreens stores
4. Healthcare as a Retail Good

Moving the Healthcare Delivery System from a Wholesale Business to a Retail Business

New points of competition
- Brand
- Access
- Convenience
- Customer satisfaction
- IT connectivity
- Consistent quality
- “Service”
- Price

Takes legacy providers out of their “comfort zone”
Price Competition Has Arrived

Source: Kalorama Information: The U.S. Market for Urgent Care, March 2013.

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5. Transformational Changes to the Employee Insurance Market

• A move to high-deductible health insurance plans
• Moving employees from employer-sponsored insurance to the private exchanges
A Rapid and Profound Movement to High-Deductible Insurance Plans

Percent of Covered Workers Enrolled in a High-Deductible Health Plan or Medical Savings Account, 2006-2013


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Walgreens Leads the Way from Employer-Sponsored Health Insurance to Putting Employees on the Private Exchanges

Accenture Projects That Private Exchange Enrollment Will Grow Rapidly


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The Disruptive Progression

- High Cost per Unit of Service
- Low Cost per Unit of Service

- Inpatient Centric
- Ambulatory Centric
- Web/Mobile Centric

Implications for:
- Value creation
- Delivery capacity
- Customer connectivity
- Human resource requirements
- IT sophistication

Current strategic positioning
The Dilemma for Legacy Providers

• Why didn’t Blockbuster become Netflix?
• Why didn’t Borders become Amazon?
• The *hospital* is your store. Are you so “store-centric” that you cannot disrupt your own business model?
First Principles in a Disruptive Environment

1. Can your organization become a “Healthcare Company”?

2. Are you capable of re-organizing your hospital as essentially an outpatient-based delivery system?

3. Are you aggressively re-positioning your hospital to operate under a fee-for-value reimbursement system?

4. Can you see your organization operating at an entirely different and much lower cost structure?
“Perform at your best when your best is required. Your best is required each day.”

John Wooden
Former Head UCLA Basketball Coach