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How to tame rising US healthcare costs

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Improving the sector's productivity and market functioning could potentially lower healthcare-cost inflation to the rate of GDP growth.

Can the United States tame healthcare-cost inflation? We believe that two steps—increasing healthcare-sector productivity and improving healthcare-market functioning to better balance the supply of and demand for health services—would likely produce sufficient savings to lower the annual growth of national healthcare expenditures by about 30 percent without jeopardizing patient care. As a result, healthcare-cost inflation, which was 5.8 percent in 2015, would drop to about 4 percent, roughly the same as projected GDP growth.

What needs to change?

A reduction of this magnitude is not easy to achieve (especially for providers, given their high fixed-cost base), but change is possible. As detailed in the longer report from which this article is drawn, *The next imperatives for US healthcare,* our estimate of savings is based only on widespread adoption of current best practices. Technological advances will likely make additional future cost reductions possible, but we did not include them in our calculations given the current lack of empirical evidence establishing the technologies' impact.

Increasing healthcare-sector productivity

Most industry incumbents will need to become more innovative and significantly redesign their business models. For example, health services are often delivered today using outdated approaches that rely heavily on overly expensive labor and care venues. Alternatives exist, however. Ambulatory-surgery centers typically deliver high-quality, more convenient care at much lower cost to consumers. For many health insurers, the cost of signing up an individual member is $125 through online sales but $500 through traditional sales channels. Health insurers that fully digitize their interactions with providers and consumers could potentially decrease their back-office costs for account and membership administration by more than 20 percent.

Improving healthcare-market functioning

Innovation is also required to make the healthcare market more efficient. In the United States today, misaligned incentives—between patients and providers, providers and payors, and among different providers—all too often result in increased costs without any benefit to consumers. The best way to balance the incentives at scale is to consider the level and nature of medical risk. Medical problems vary in severity and frequency, the number of times treatment

will be needed, and the extent to which consumers can control the services received and absorb the cost of those services. Analysis of these factors reveals eight categories of medical risk; different financing and reimbursement approaches should be used for each one (exhibit).

Consumer cost-sharing levels, for example, should be low or nonexistent for preventive care but high for discretionary services, because high cost-sharing levels can decrease utilization rates. Episodes of care or other bundled payment approaches should be used to reimburse providers for discretionary services, since those approaches help control costs and discourage the delivery of unnecessary treatments. In contrast, fee-for-service reimbursement would encourage providers to deliver preventive care.

Although this redefinition of covered benefits does not match most people's current conception of health insurance, its adoption has the potential to significantly lower healthcare spending. Our analysis suggests that a payor that uses this approach could reduce its base of insurable expenses by almost 25 percent.

Exhibit

Medical-risk categories have implications for payment and reimbursement.

● Low ● Medium ● High

Risk category	Consumer discretion	Consumer abilty to absorb risk/ expense	Potential financing approach	Potential reimbursement approach
Routine	●	●	Savings, credit cards, prepaid cards	Fee-for-service
Preventive	●	●	Free	Fee-for-service
Chronic care	●	●	Insurance, with incentives for proper management; risk-impaired annuity	Nested episodes within population health models
Catastrophic, chronic	●	●		
Discretionary	●	●	Savings, credit cards	Episodes
Purely elective	●	●	Savings, credit cards	Episodes
Catastrophic, not chronic	●	●	Insurance	Episodes
End-of-life	●	●	Savings, viatical, reverse mortgage	Episodes

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The US healthcare system could realize $280 billion to $530 billion in savings during the next decade as a result of increasing productivity and adopting this new approach to health insurance. Achieving these savings will not be easy—but it is necessary. Unless healthcare-cost inflation is tamed, efforts to reform healthcare will not be sustainable. New entrants have already demonstrated the effectiveness of radically rethinking healthcare business models, and there is no reason to think others will not follow. Incumbents that want to avoid being overtaken by new entrants must pivot quickly to act like attackers themselves. ☐

This is an edited extract from *The next imperatives for US healthcare*. To read the full report online, visit McKinsey on Healthcare.

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