Healthcare Reform Beyond the ACA

Ken Leonczyk, Senior Director
The Advisory Board
leonczyke@advisory.com
Poll question

What’s your role at your organization?

a) Physician
b) Nurse or mid-level
c) Practice Administrator
d) IT/ Data Analyst
e) C-Suite
Poll question

How familiar are you with today’s healthcare reform efforts?

a) Not at all
b) A little bit
c) I follow it closely but am not an expert
d) I know a good deal
e) I’m a healthcare policy expert
1. A New Turning Point for Health Care Reform

2. Reflecting on the First Era of Health Care Reform

3. Adapting Provider Strategy to New Market Realities
Congratulations, Mr. President

Trump Wins in Stunning Upset

Congress and Executive Branch Now in Republican Control

Congressional Control:
- Senate Republicans: 52/100
- House Republicans: 241/435

Image: © 2016, Chip Somodevilla/Getty Images

Source: Health Care Advisory Board interviews and analysis.
Health Care Tops the Day One Agenda

Trump Takes Aim at ACA with Executive Order on First Day in Office

“To the maximum extent permitted by law, the (Secretary) and the heads of all other executive departments and agencies (agencies) with authorities and responsibilities under the Act shall exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden on any State or a cost, fee, tax, penalty, or regulatory burden on individuals…”

Executive Order

Released by the White House, Office of the Press Secretary, January 20, 2017

Executive Order Does:

- Signal Trump administration’s commitment to ACA repeal
- Point to potential for future executive action to weaken ACA

Executive Order Does Not:

- Immediately repeal any elements of the ACA
- Provide authority to ignore or alter portions of the ACA that are set in law

1) Possible administrative changes include broadening exemptions to and/or reducing enforcement of the individual and employer mandates, reducing essential health benefits requirements, and granting states greater flexibility in administering Medicaid and/or regulating insurance markets.

The ACA at a Turning Point?

Two Repeal Options on the Table for Congress

Wholesale Immediate Repeal
A full repeal of the ACA through a congressional vote in both the House and the Senate

Piecemeal Change
Changes to specific components of the ACA; most likely through budget reconciliation which only requires a majority vote in Congress

Key Considerations of Each Approach

- Potentially requires filibuster-proof majority in Senate
- Must contend with Republican governors in states supporting Medicaid expansion
- May have to contend with widespread industry pushback

- Complicated by entangled ACA policies
- Budget reconciliation options limit repeal to tax-related measures
- Requires line-item specific transition planning

Source: Health Care Advisory Board interviews and analysis.
## An Ambitious Three-Part Agenda

### GOP Outlines Three Phases to Health Care Reform

#### A Three-Pronged Approach to Repeal and Replace the ACA

<table>
<thead>
<tr>
<th>1</th>
<th>Budget Reconciliation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process:</strong></td>
<td>Requires simple majority in House and Senate</td>
</tr>
<tr>
<td><strong>Proposed Target Areas:</strong></td>
<td></td>
</tr>
<tr>
<td>• Repeal ACA taxes, employer and individual mandates</td>
<td></td>
</tr>
<tr>
<td>• Replace insurance subsidies with refundable tax credits</td>
<td></td>
</tr>
<tr>
<td>• Reform Medicaid financing</td>
<td></td>
</tr>
<tr>
<td>• Increase contribution limit of health savings accounts</td>
<td></td>
</tr>
<tr>
<td>• Allocate funds for state innovations</td>
<td></td>
</tr>
<tr>
<td>• Require continuous coverage insurance incentive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2</th>
<th>Administrative Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process:</strong></td>
<td>Federal agencies issue regulation through rulemaking</td>
</tr>
<tr>
<td><strong>Proposed Target Areas:</strong></td>
<td></td>
</tr>
<tr>
<td>• Shorten individual market enrollment period and limit special enrollment</td>
<td></td>
</tr>
<tr>
<td>• Loosen restrictions on actuarial value of individual market plans</td>
<td></td>
</tr>
<tr>
<td>• Enable state flexibility through waiver process</td>
<td></td>
</tr>
<tr>
<td>• Approve state Medicaid eligibility changes (e.g. work requirements, premiums)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3</th>
<th>Additional Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process:</strong></td>
<td>Requires simple majority in House, super-majority in Senate</td>
</tr>
<tr>
<td><strong>Proposed Target Areas:</strong></td>
<td></td>
</tr>
<tr>
<td>• Allow insurance to be sold across state lines</td>
<td></td>
</tr>
<tr>
<td>• Expand use of HSAs</td>
<td></td>
</tr>
<tr>
<td>• Allow formation of Association Health Plans</td>
<td></td>
</tr>
<tr>
<td>• Remove “essential benefits” requirements</td>
<td></td>
</tr>
<tr>
<td>• Reform malpractice regulation</td>
<td></td>
</tr>
<tr>
<td>• Streamline FDA processes</td>
<td></td>
</tr>
<tr>
<td>• Expand flexibility of state use of federal dollars</td>
<td></td>
</tr>
</tbody>
</table>

### GOP Withdraws American Health Care Act Due to Lack of Votes

**Key Elements of the American Health Care Act**

<table>
<thead>
<tr>
<th>Repeals ACA Taxes</th>
<th>Reforms Individual Market</th>
<th>Reforms Medicaid Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Beginning in 2017, eliminates ACA taxes on health plans, medications, HSAs, medical devices, tanning services, investment income, etc.</td>
<td>• Eliminates individual mandate as of December 31, 2015</td>
<td>• Freezes expansion, ends enhanced match after 2020</td>
</tr>
<tr>
<td>• Delays implementation of the Cadillac Tax until 2026</td>
<td>• Requires insurers to penalize individuals who do not maintain continuous coverage</td>
<td>• Reverses DSH cuts(^1), provides additional funding for FQHCs, safety net providers</td>
</tr>
<tr>
<td></td>
<td>• In 2020, replaces subsidies with refundable tax credits adjusted for age and income</td>
<td>• Shifts Medicaid to block grant and/or per capita cap in 2020(^2)</td>
</tr>
</tbody>
</table>

### American Health Care Act

- Reconciliation bill released by House Republicans on March 6\(^{th}\) and withdrawn on March 24\(^{th}\); would have repealed, replaced, or adjusted some components of the ACA
- CBO estimated that by 2026, would reduce federal deficit by $150 billion, reduce Medicaid spending by $839 billion, and increase number of uninsured by 24 million

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\(^1\) Restores funding in 2018 in non-expansion states and 2020 in expansion states.\(^2\) Block grant option only available for traditional adult and children populations.

Future of Repeal and Replace Legislation Now Unclear

Mixed Messages Following Withdrawal of AHCA

Initial Resignation Gives Way to Renewed Commitment

“We did not have quite the votes to replace this law…[and so] we’re going to be living with Obamacare for the foreseeable future.”

Paul Ryan, March 24th Press Conference

“We are going to keep getting at this thing…We’re not going to just all of a sudden abandon health care and move on to the rest.”

Paul Ryan, March 26th Team Ryan Donor Call

Three Potential Legislative Paths Forward

1) House Republicans Renew Effort
2) Senate Republicans Take Charge
3) GOP Shifts Focus to Non-ACA Legislation

1) E.g., allowing insurers to sell plans across state lines, approving the creation of association health plans, and adjusting HSAs.

Source: Health Care Advisory Board interviews and analysis.
Meet the Key Players

**HHS Secretary: Tom Price**
- Six-term Representative from Georgia; retired orthopedic surgeon
- Sponsor of the Empowering Patients First Act
- Confirmed by 52-47 vote

**CMS Administrator: Seema Verma**
- National health policy consultant from Indiana
- Helped shape Medicaid expansion in IN, OH, KY, TN
- Confirmed by 55-43 vote

Potential Administrative Actions

- End cost-sharing reduction payments
- Delay Cadillac Tax
- Eliminate, delay, or modify Innovation Center programs (e.g., CJR)
- Limit special enrollment periods
- Reduce enforcement of insurance mandates
- Narrow scope of essential health benefits
- Allow Medicaid work requirements through 1115 waivers
- Allow Medicaid premiums, others forms of cost-sharing through 1115 waivers
- Eliminate contraception requirement

Individual Market Hangs in the Balance

Future of Public Exchanges May Depend on GOP Actions and Inactions

Administration Has a Spectrum of Options for How to Manage Exchanges

Roll Back

• End cost-sharing reduction payments
• Reduce reinsurance payments
• Refuse to settle the risk corridor litigation
• Reduce enforcement of individual mandate
• Eliminate/reduce advertising

Maintain

• Continue to enforce and implement provisions of the ACA related to exchanges (e.g., individual mandate, cost-sharing payments)
• Hold off from enacting any new fixes for exchanges (e.g. limiting special enrollment periods)

Fix

Already Proposed¹:
• Limit special enrollment
• Establish continuous coverage requirement
• Relax actuarial requirements

Other Potential Actions:
• Expand age rating band
• Tweak essential health benefits requirements

¹ Through market stabilization proposed rule released on February 15, 2017.
Medicaid to Remain a Top Priority

Waivers Will Allow Continued Innovation and Experimentation

State Flexibility Through Waivers Likely to Intensify Competing Medicaid Philosophies

Coverage Model

State-Run Entitlement (Pre-ACA Status Quo)
Cover low-income/vulnerable as defined on state-by-state basis, so long as certain federal minimum standards are met

Expansive Entitlement (Democrats’ Vision)
Cover anyone not eligible for Medicare, covered by an employer, and unable to afford individual coverage

Limited Safety Net (Republicans’ Vision)
Cover truly low-income/vulnerable, provides temporary coverage for unemployed adults (e.g., contingent on work requirements)

Cost Containment Model

Payer-Led Managed Care
Capitate payments to private managed care organizations e.g., Florida State Medicaid Managed Care

Provider-Led Care Management
Incentivize provider to control utilization, coordinate care e.g., Oregon’s CCOs

Consumer-Driven Health Care
Encourage consumers to be cost-conscious, prioritize high-value care e.g., Indiana’s HIP 2.0

Source: Health Care Advisory Board interviews and analysis.
The Next Era of Health Care Reform

Four Key Principles Guiding GOP Reform Efforts

1. **Reduce Federal Entitlement Spending**
   Focus more aggressively on reducing federal health care spending.

2. **Devolve Health Policy Control to States**
   Reduce federal role in health care; provide states more autonomy to make decisions, cut spending.

3. **Embrace Free Markets and Consumer Choice**
   Use free-markets to promote private sector competition in payer, provider markets.

4. **Promote Transparency of Cost and Quality**
   Mandate greater consumer choice and shopping at the point-of-care and point-of-coverage through improved transparency.

Source: Health Care Advisory Board interviews and analysis.
A New Turning Point for Health Care Reform

Reflecting on the First Era of Health Care Reform

Adapting Provider Strategy to New Market Realities
Hope and Change, Eight Years On

Surely President Obama’s Signature Achievement

A Grand Promise for Change

“The bill I’m signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see.”

Barack Obama, on the Affordable Care Act, March 23, 2010

“This is a big [expletive] deal”

Joe Biden, on the Affordable Care Act, March 23, 2010

Evaluating the ACA Against its Intentions

Major Reform Goals

1. Replace Costly Fee-for-Service Incentive Structures
   - **Chosen Method:** Medicare-led Payment Reform
     - FFS cuts
     - New payment models
     - Intent to catalyze broader commercial market change

2. Improve Health Care Quality
   - **Chosen Method:** Incentives + Transparency
     - IT mandates
     - Pay-for-Performance programs
     - Market-facing transparency

3. Achieve Universal, Affordable Coverage
   - **Chosen Method:** Expansion of Existing System
     - Insurance market regulation
     - Expanded public coverage
     - Market-based exchanges

Obama-era Enabling Legislation

- **February 17, 2009:** Health Information Technology for Economic and Clinical Health (HITECH) Act
- **March 23, 2010:** Patient Protection and Affordable Care Act
- **April 16, 2015:** Medicare Access and CHIP Reauthorization Act (MACRA)

Source: Health Care Advisory Board interviews and analysis.
Objective #1: Replace Costly Fee-for-Service Incentive Structures

Kicking the Legs Out From Under Fee-for-Service

Policymakers’ Intention to Migrate Payment Perfectly Clear

“Productivity” Adjustments and Other Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>ACA IPPS Update Adjustments</th>
<th>ACA DSH Payment Cuts</th>
<th>MACRA IPPS Update Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013</td>
<td>($4B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td>($14B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>($24B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2016</td>
<td>($29B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2017</td>
<td>($38B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>($54B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>($67B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>($76B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>($86B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>($94B)</td>
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</tr>
</tbody>
</table>

No Subtlety Here

Providers should compare ACO earnings not with what they could earn in today’s fee-for-service payment environment but with what they could expect to earn in the future if they didn’t participate in such alternative payment models.”

CMS Officials

MACRA Rewriting the Rules of Risk

Bipartisan Support at Center of MACRA Rollout

Legislation in Brief: MACRA

• Legislation passed in April 2015 repealing the Sustainable Growth Rate (SGR)
• CMS released final rule in October 2016 stipulating program to be implemented on Jan 1, 2017
• Created two payment tracks:
  – Merit-Based Incentive Payment System (MIPS)
  – Advanced Alternative Payment Model (APM)

This historic law has been a collaborative effort from the start. We are encouraged by this final rule and CMS’s commitment to ongoing collaboration with Congress and the health care community.”

Bipartisan Leaders from House Energy and Commerce Committee and Ways and Means Committee

A Sweeping Impact Across Providers

Who is Included and Who is Exempt

**Included**

- Medicare Physician Fee Schedule
- Physicians, PAs\(^1\), NPs\(^2\), Clinical Nurse Specialists, Certified Registered Nurse Anesthetists
- Groups that include any of the above clinicians

**Excluded**

- Inpatient Prospective Payment System, Outpatient Prospective Payment System (mostly Medicare Part A)
- Clinicians, groups that fall under low volume threshold:
  - $30,000 or less in Medicare charges OR
  - 100 or fewer Medicare patients
- Medicare Part A (i.e., inpatient, outpatient technical hospital payments)

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MACRA is the burning platform for progress in care delivery, just as the ACA was in health care coverage.”

*Andy Slavitt,*
*CMS Acting Administrator*

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1) Physician Assistant.  
2) Nurse Practitioner.  
3) CMS estimates between 592,000 and 642,000 clinicians will be required to participate in MIPS in CY 2017, while 70,000 to 120,000 clinicians will participate in APMs in 2017.

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Dealing Physicians in on Risk

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

<table>
<thead>
<tr>
<th>MIPS Bonuses/Penalties</th>
<th>APM Bonuses/Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>+/-4%</td>
<td>5%</td>
</tr>
<tr>
<td>+/-9%</td>
<td></td>
</tr>
<tr>
<td>$500M</td>
<td></td>
</tr>
</tbody>
</table>

Maximum annual adjustment, 2019
Maximum annual adjustment, 2022
Additional bonus pool for high performers

Annual lump-sum bonus from 2019-2024
(plus any bonuses/penalties from Advanced Payment Models themselves)

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Baseline payment updates¹:

- **2015 – 2019:** 0.5% annual update (both tracks)
- **2020 – 2025:** Payment rates frozen (both tracks)
- **2026 onward:** 0.25% annual update (MIPS track) 0.75% annual update (Advanced APM track)

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¹ Relative to 2015 payment.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.
No Dodging Downside Risk in Many Major Markets

Unavoidable Episodic Price Cuts Expanding in Coming Years

CMS Rapidly Scaling Mandatory Bundled Payment Efforts to New Conditions, Markets

Comprehensive Joint Replacement (CJR)

- Covers the most common inpatient surgeries for Medicare beneficiaries: hip and knee replacements\(^1\)
- Estimated savings to Medicare over the 5 years of the model: **$343M**
- Geographic areas (MSAs) selected: **67**

Episode Payment Models (EPM)

- Includes models for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG); and Surgical Hip and Femur Fracture Treatment (SHFFT)\(^2\)
- Estimated savings to Medicare over the 5 years of the model: **$170M**
- Geographic areas (MSAs) selected: **98**

Common Characteristics Across Both Bundles

- **Retrospective Payment**
  - CMS makes FFS payment to providers separately, conducts annual reconciliation process

- **Comprehensive Episodes**
  - Participating hospitals accountable for all related Part A and B services 90 days post-discharge

- **Qualifies for APM Track**
  - New HIT requirements in 2018 allow bundles to count toward MACRA APM track

- **Targets PAC Spend**
  - Aimed at DRGs with a large portion of cost due to variation in PAC utilization

---

1) MS-DRGs: 469, 470.
2) MS-DRGs: 280-282; 246-251; 231-236; 480-482.
3) Applies to AMI and CABG Models; SHFFT Model to be implemented in 67 CJR markets.

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.
Medicare Shared Savings a Slow Transition to Risk

Overwhelming Majority of ACO Participants Still in Shallow Water

Continuum of Medicare Risk Models

<table>
<thead>
<tr>
<th>MSSP Track 1</th>
<th>MSSP Track 1+</th>
<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>Next Gen ACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Upside-only model&lt;br&gt;• Option to renew for second three-year term; savings rate kept at 50% for second term&lt;br&gt;• MSR based on population size between 2% and 3.9%</td>
<td>• Lowest-risk two-sided model; intended to be attractive to small organizations&lt;br&gt;• Loss rate fixed at 30%; shared savings rate of up to 50%&lt;br&gt;• Prospective attribution, SNF 3-day waiver</td>
<td>• Shared savings, loss rate remains at 60% based on quality performance&lt;br&gt;• Select symmetrical MSR/MLR(^1) between 0% and 2% at 0.5% intervals or same methodology as Track 1</td>
<td>• Shared savings up to 75%, shared losses from 40%-75% based on quality performance&lt;br&gt;• Same MSR/MLR options as Track 2&lt;br&gt;• Prospective assignment, SNF 3-day waiver</td>
<td>• 80%-85% sharing rate or full performance risk&lt;br&gt;• Option for capitation&lt;br&gt;• Prospective attribution; SNF 3-day, telehealth, and post-discharge home visit waivers</td>
</tr>
<tr>
<td>428 Participants</td>
<td>Available in 2018</td>
<td>6 Participants</td>
<td>36 Participants</td>
<td>45 Participants</td>
</tr>
</tbody>
</table>

1) Minimum savings rate/minimum loss rate.

Unintended Consequence: Reinvigoration of MA

Medicare Advantage Growth Continues

Potential Advantages of MA over MSSP

Control Over Network, Benefit Design
64% of beneficiaries choose HMO plans, offering improved utilization management, network control, benefits customization

Opportunity to Tailor Risk
Contracts can be structured to include varying levels of provider payment risk, quality incentives

Straightforward Patient Identification
List of enrollees simpler, more immediate than MSSP attribution models

Full Upside Potential
Control of whole premium dollar creates clear incentive for total cost management

MA Enrollment to Nearly Double by 2025

Total Enrollment and Percentage of Total Medicare Population

Provider Sponsorship of Medicare Advantage Plans, 2016

37%
Of existing MA plans¹

58%
Of new MA plans¹

1) MA plan refers to a Medicare Advantage Organization, the entity that has contracted with CMS to sell Medicare Advantage products.

Metrics and Transparency Drive Quality Approach

Emphasis on Collection, Reporting of Performance Data

Information-Focused Approach to Quality Improvement

1. IT-Powered Delivery System
   (Meaningful Use Mandates)

2. Rigorous Scorekeeping
   (P4P Programs)

3. Public Transparency
   (Hospital Compare, Physician Compare)

Source: Health Care Advisory Board interviews and analysis.
Objective #3: Achieve Universal, Affordable Coverage

Expanding Coverage by Reforming Existing System

Correcting for the Deficiencies of the Market

**Insurer Regulations**
- Essential health benefits
- Guaranteed issue
- Dependent coverage to age 26
- Community rating

**Employer mandate**
Intended to prevent dumping into new safety nets

**Individual mandate**
Intended to preserve quality of risk pools

**Medicaid expansion**
- Intended to apply to all adults under 138% of federal poverty level
- Supreme Court decision gave states option not to expand

**Exchange subsidies**
- Commercial insurance sold on consumer-facing marketplaces
- Subsidies for those between 100%-400% of federal poverty line

Source: Health Care Advisory Board interviews and analysis.
Public Exchange Enrollment Falling Short of Targets

Group Market Longevity Limiting New Growth

<table>
<thead>
<tr>
<th>Exchange Enrollment</th>
<th>2014-2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>End of 2014 OEP¹</td>
<td>8.0M</td>
</tr>
<tr>
<td>Dec. 2014²</td>
<td>6.3M</td>
</tr>
<tr>
<td>End of 2015 OEP</td>
<td>11.7M</td>
</tr>
<tr>
<td>Dec. 2015²</td>
<td>8.2M</td>
</tr>
<tr>
<td>End of 2016 OEP</td>
<td>12.7M</td>
</tr>
<tr>
<td>Dec. 2016 (P)</td>
<td>10.0M</td>
</tr>
<tr>
<td>End of 2017 OEP</td>
<td>12.2M</td>
</tr>
</tbody>
</table>

Employers Not Dropping Coverage

Concerns about employer-sponsored health insurance evaporating after the implementation of health reform have not materialized...as of now, the law has had little to no effect on employer-sponsored insurance.”

Kathy Hempstead
Robert Wood Johnson Foundation

Smaller and Sicker Than Expected

| 25M      | Original CBO Projection for public exchange enrollment |
| 28%      | Proportion of total public exchange population made up of “young invincibles”³ |


1) Open Enrollment Period.
2) Drop-off due to individuals not paying premiums or voluntarily dropping coverage.
3) Enrollees aged 18-34.

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Increasingly Unstable Public Exchanges?

Established Carriers Scaling Back, Co-ops Faltering

Some Insurers Reconsidering Participation

Aetna 11 State exchanges Aetna is departing in 2017

Humana 8 State exchanges Humana is departing in 2017

We cannot broadly serve [the exchange market] on an effective and sustained basis.”

Stephen J. Hemsley
CEO of UnitedHealth Group

Startup Ventures Largely Failing

Notable CO-OP failures:

70% of CO-OPs closed as of Aug 2016

To date, more than half a million Americans have lost coverage thanks to the failure of these co-ops.”

Adrian Smith
The Wall Street Journal

Difficulties Facing Exchange Plans

- Adverse selection
- Inaccurate risk adjustment
- Risk corridor underpayment
- Abuse of special enrollment period

Source:
- Sachdev A. “Blue Cross Parent Lost $1.5 Billion on Individual Health Plans Last Year.” Chicago Tribune, Mar. 2016.
### Rate Increases and Reduced Competition

### Subsidy Growth Likely to Stress Federal Budget

#### 2017 Individual Marketplace Premium Increases

*Minimum, Average, Maximum  
As of August 30, 2016*

<table>
<thead>
<tr>
<th></th>
<th>Requested (All states)</th>
<th>Requested (Approved states only)</th>
<th>Approved (Approved states only)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>24.4%</td>
<td>29.9%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Average</td>
<td>66.4%</td>
<td>59.0%</td>
<td>58.6%</td>
</tr>
<tr>
<td>Maximum</td>
<td>3.6%</td>
<td>3.6%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

#### Subsidy Growth Tracks Premium Spikes

> More than eight in 10 marketplace enrollees won’t be directly affected by increases in [2017] premiums because they receive a government subsidy that will insulate them.”

*—Kaiser Health News*

Of exchange regions will have only one participating insurer in 2017

<table>
<thead>
<tr>
<th>State exchanges with only one participating insurer</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
</tr>
</tbody>
</table>

Medicaid Expansion Stagnating

Opposition Remains Strong in Many States

31 States and DC Have Approved Expansion¹
As of October 2016

Medicaid Expansion Positively Impacting Hospital Finances

- **Medicaid admissions** increased 21% for investor-owned hospitals in expansion states
- **Self-pay admissions** decreased by 47% for investor-owned hospitals in expansion states
- **Uncompensated care** costs reduced by $5 billion in expansion states in 2014


1) Montana’s expansion requires federal waiver approval.
Coverage Expansion Impact Unmistakable

“Universal Coverage” Still a Distant Goal, but Millions More Now Covered

US Adult Uninsured Rate

Q3 2013: 18.0%

Major ACA coverage expansion provisions took effect January 1, 2014

22M

HHS estimate of adults gaining health insurance coverage as a result of the ACA

Summer 2016 uninsured rate of 8.6% is the lowest in US history

Serving Two Masters

Public, Private Markets Demanding Different Value in Different Ways

Purchaser Approach to Value:

“Public Utility”
- Rate setting
- Regulation
- Accountability controls

“Market Commodity”
- Market dynamics
- Consumer preference

Provider Approach to Value:

Public Sector
- Medicare, Medicaid
- High cost per capita
- Chronic illness, comorbidities
- Rising share of population

Private Sector
- Insurers, employers, individual consumers
- Generally healthy with episodic care needs
- Access, experience, convenience paramount
- Large share-of-wallet opportunity

End-user Focus
- Unit cost control
- Consumer-oriented innovation

Population-level Focus
- Total cost control
- Care management

Public, Private Markets Demanding Different Value in Different Ways

Source: Health Care Advisory Board interviews and analysis.
Sentinel Efforts to Circumvent Traditional Approach

Boeing Signs Value-Based Direct Contracts in Two New Markets

2015: Direct Contract with Major Systems Near Seattle Headquarters

- Provider partners: Providence Health & Services - UW Medicine

- 78K Total employees

2016: Expansion to Other Major Boeing Locations

- St. Louis: Mercy
- Charleston: Roper St. Francis

Enhanced Benefits Attract Employees

- Free primary care
- Free generic drugs
- Reduced premiums

Case in Brief: The Boeing Company

- Over 148,750 US employees
- Issued highly-prescriptive RFP for risk-bearing health system partners in Seattle region
- Early success prompts expansion to other markets

Source: Health Care Advisory Board interviews and analysis.
United Airlines Expands Bundle Offerings to Orthopedics

**Case in Brief: United Airlines**
- 82,000 employees; headquarters in Chicago, Illinois
- Recently launched bundled payment contract with Rush University Medical Center for hip and knee replacements, and spinal fusion surgeries
- Bundled payment contract also in place with Cleveland Clinic for cardiac surgery

**Quality Is Top Concern**
“The entire motivation for us is the quality of the care…. We don’t want cost to be a barrier for our employees.”

*Anthony Scattone, VP of Benefits United Airlines*

**Key Program Features**
- Financial incentive for participating employees (waiving of copays and coinsurance)
- Physicians review medical record, determine eligibility
- Comprehensive travel planning for patient and caregiver
- Flat bundle price paid to Rush
- Rush at financial risk for complications, such as infections or implant failures

Onboarding Risk, then Offloading to Employees

Employers Increasingly Turning to High-Deductible Plans

ESI Average Deductible for Single Coverage\(^1\)
*By Plan Type, 2006-2015*

<table>
<thead>
<tr>
<th>Year</th>
<th>HMO</th>
<th>PPO</th>
<th>All Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>$958</td>
<td>$1,025</td>
<td>$1,025</td>
</tr>
<tr>
<td>2007</td>
<td>$1,025</td>
<td>$1,318</td>
<td>$1,318</td>
</tr>
<tr>
<td>2008</td>
<td>$1,318</td>
<td>$1,400</td>
<td>$1,400</td>
</tr>
<tr>
<td>2009</td>
<td>$1,400</td>
<td>$1,400</td>
<td>$1,400</td>
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<tr>
<td>2010</td>
<td>$1,400</td>
<td>$1,400</td>
<td>$1,400</td>
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<tr>
<td>2011</td>
<td>$1,400</td>
<td>$1,400</td>
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<td>2012</td>
<td>$1,400</td>
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<tr>
<td>2013</td>
<td>$1,400</td>
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<td>$1,400</td>
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<tr>
<td>2014</td>
<td>$1,400</td>
<td>$1,400</td>
<td>$1,400</td>
</tr>
<tr>
<td>2015</td>
<td>$1,400</td>
<td>$1,400</td>
<td>$1,400</td>
</tr>
</tbody>
</table>

Percentage of Covered Workers with Annual Deductible of $2,000 or More\(^3\)
*By Firm Size, 2006-2015*

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>3-199 Workers</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>All Firms</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>200 or More Workers</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
</tr>
</tbody>
</table>

Defined Contribution the Next Major Shift?

Private Exchange Enrollment Continues to Grow

Private Exchange Enrollment Still Grows in 2016, But Lags Behind Initial Projections

Projected Private Exchange Enrollment Among Pre-65 Employees and Dependents

2013 projections

2015 projection

2014 2015 2016

1M 3M

6M

8M

12M

19M

40-60% Employees on private exchanges who select a high-deductible health plan option

Newer Market Entrants Hitting Their Stride

50% Enrollment growth for Towers Watson’s exchange solutions, 2014-2015

(800k → 1.2M)

500 Enrollment growth for Mercer’s exchange solutions, 2014-2015

(220k → 1M)

Employees on private exchanges who select a high-deductible health plan option

Many Apparently Willing to Bear Point-of-Care Costs

Consumers Electing to Bear Very High Cost Exposure

Average Deductible for Exchange-Sold Health Plans
2014-2016

<table>
<thead>
<tr>
<th>Metal Tier</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronze</td>
<td>$1,277</td>
<td>$1,198</td>
<td>$1,165</td>
</tr>
<tr>
<td>Silver</td>
<td>$2,907</td>
<td>$2,927</td>
<td>$3,117</td>
</tr>
<tr>
<td>Gold</td>
<td>$5,081</td>
<td>$5,181</td>
<td>$5,731</td>
</tr>
<tr>
<td>Platinum</td>
<td>$347</td>
<td>$243</td>
<td>$233</td>
</tr>
</tbody>
</table>

Exchange Enrollment, by Metal Tier
2015

- Platinum: 4%
- Gold: 7%
- Silver: 69%
- Bronze: 20%

Nearly 90% of exchange enrollees are in bronze or silver plans

Consumers Proving to Be Savvy Coverage Shoppers

Purchase Decisions Driven Largely by Price

Switching Rates Higher Than Expected

- **100%**
- **12%** Average annual switching among active employees with FEHBP¹ coverage
- **43%** Returning federal exchange enrollees changing plans in 2016

Premium Increases the Primary Motivator

- **55%** Switchers who cited rise in monthly premiums among top three reasons for switching

Active Health Plan Shopping on the Rise

- **Percentage of those renewing coverage who actively shopped for plans**
  - 2015: 53%
  - 2016: 70%
- **Percentage of those renewing coverage who switched plans**
  - 2015: 29%
  - 2016: 43%

Source:


¹ Federal Employee Health Benefits Plan.
Higher Deductibles Driving Increased Price Sensitivity

Consumer Responses Generally Dangerous for Provider Economics

1. **Forgo Care?**
   - **Spending Reductions Following Implementation of High-Deductible Health Plans**
     - 25% Reduction in physician office spending
     - 18% Reduction in ED spending

2. **Fail to Pay?**
   - **Households Without Enough Liquid Assets to Pay Deductibles**
     - 24% Mid-range deductible
     - 35% Higher-range deductible

3. **Shop Carefully?**
   - 56% Consumers searching for price information before getting care
   - 74% Consumers with deductibles higher than $3,000 who have solicited pricing information


1) $1,200 Single; $2,400 Family.
2) $2,500 Single; $5,000 Family.

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Living Under a Microscope

Consumers Have Access to More Information than Ever Before

Transparency Comes to California

September 21, 2015

Attention Shoppers: New Calif. Website Details Costs, Quality of Medical Procedures

Where You Live Matters
What you pay may differ based on where you live

County Price Average for Total Knee Replacement

- Low: $0
- Average: $247
- High: $719

San Joaquin Valley
Average Estimate: $24,614
High Estimate: $62,375

Monterey Coast
Average Estimate: $46,568
High Estimate: $86,483

Sample Transparency Sites

Turning to Unlikely (and Uncomfortable) Sources

Crowdsourced Reviews Getting More Reliable

“Now the millions of consumers who use Yelp… will have even more information at their fingertips when they are in the midst of the most critical life decisions, like which hospital to choose for a sick child or which nursing home will provide the best care for aging parents.”

Jeremy Stoppelman, CEO Yelp

Acclaimed news source partners with review website with more than 85 million monthly users
Incorporates Medicare data on more than 25 thousand facilities, including 4,600 hospitals

ProPublica compiles and provides Yelp with Hospital Compare metrics on ER wait time, doctor communication and room noise levels

Just What Consumers Are Looking For

Yelp Reviews Capture Surprisingly Detailed Picture of Consumer Experience

Topic Domains Addressed by Yelp, HCAHPS

Yelp

HCAHPS

12
Domains covered in Yelp reviews, but not HCAHPS

7
Covered in both Yelp and HCAHPS

4
Covered by HCAHPS only

Study in Brief: Yelp Reviews Of Hospital Care Can Supplement And Inform Traditional Surveys Of The Patient Experience Of Care

• Published in Health Affairs, April 2016
• Analysis of 16,862 hospital Yelp reviews, HCAHPS scores for 1,352 hospitals
• Moderate correlation found between Yelp, HCAHPS scores

Topics Covered in Yelp Reviews Without Clear HCAHPS Analogue

• Cost of hospital visit
• Insurance and billing
• Ancillary testing
• Facilities
• Amenities

• Family member care
• Quality of nursing
• Quality of staff
• Quality of technical aspects of care
• Specific type of medical care

Source: Ranard B et al.; “Yelp Reviews Of Hospital Care Can Supplement And Inform Traditional Surveys Of The Patient Experience Of Care,” Health Affairs, April 2016; Health Care Advisory Board interviews and analysis.
## Innovations Crowding Onto the Field

### Disruptive Services and Tech for Consumer Use (Existing and In Development)

<table>
<thead>
<tr>
<th><strong>Inexpensive, rapid care at a ‘provider’ site</strong></th>
<th><strong>Retail Clinics</strong></th>
<th><strong>Physician hailing</strong></th>
<th><strong>Remote diagnosis and link to clinicians</strong></th>
<th><strong>Patient apps for condition self-management</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>![Hourglass]</td>
<td>![Retail Clinic]</td>
<td>![Car]</td>
<td>![Wireless Signal]</td>
<td>![Mobile Phone]</td>
</tr>
<tr>
<td><strong>SmartChoice MRI</strong></td>
<td><strong>Walgreens</strong></td>
<td><strong>Payer.com</strong></td>
<td><strong>Opternative</strong>: iPhone eye exam, e-mail RX</td>
<td><strong>Iodine’s</strong> Start app: Tracks depression symptoms and drug efficacy</td>
</tr>
<tr>
<td><strong>Right Care</strong></td>
<td><strong>CVS Health</strong></td>
<td><strong>Heal</strong></td>
<td><strong>Google contact lens</strong>: glucose monitoring</td>
<td><strong>OneDrop</strong>: diabetes tracker</td>
</tr>
<tr>
<td><strong>PediaQ</strong></td>
<td><strong>Wal-Mart</strong></td>
<td><strong>Dispatch Health</strong></td>
<td><strong>EpiWatch</strong>: predicts seizures</td>
<td><strong>ACC’s</strong> Statin intolerance self-checker</td>
</tr>
<tr>
<td><strong>Mend</strong></td>
<td><strong>Mend</strong></td>
<td><strong>MedZed</strong> (pediatric house calls)</td>
<td><strong>MoleMapper</strong>: cancerous mole screening</td>
<td></td>
</tr>
<tr>
<td><strong>OrthoNow</strong></td>
<td></td>
<td></td>
<td><strong>Iphone-directed walk tests, cognition, fine motor skill, tremor evaluations</strong></td>
<td></td>
</tr>
</tbody>
</table>

### 25%

Consumers used a retail clinic in 2015—up from 15% in 2013

Case in Brief: Zoom+

- Private network of consumer-oriented clinics based in Hillsboro, Oregon; founded in 2006 as Zoomcare
- Low prices, evening and weekend hours, and co-located services appeal directly to consumers
- Currently offering primary, specialty, and urgent care services at more than 25 locations; multiple tiers of coverage through Zoom+ Performance Health Insurance

Illness visits start at $145, specialty at $200 for self-pay patients

Most clinics open until midnight on weekdays, more limited hours on weekends

Scheduling, e-visits, bill pay can all be accomplished via mobile app

Establishing a Loyal Base

Annual Zoom users, 2014 (before rebrand, expansion)

250K

### Growing A Health System From A Very Different Seed

#### Zoom+ Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Zoom+Super</strong></td>
<td>For “near-emergency” needs, open 20 hours a day</td>
</tr>
<tr>
<td><strong>On-Site</strong></td>
<td>Pharmacy, labs, and imaging</td>
</tr>
<tr>
<td><strong>Zoom+Performance</strong></td>
<td>“Olympic-level” coaching, neuro-agility, body composition analysis</td>
</tr>
<tr>
<td><strong>Pediatric</strong></td>
<td>Primary, specialty, and wellness care</td>
</tr>
<tr>
<td><strong>Specialty care</strong></td>
<td>Including cardiology, dermatology, orthopedics, and ENT</td>
</tr>
<tr>
<td><strong>Wellness coaching</strong></td>
<td>Including food and movement-as-medicine</td>
</tr>
<tr>
<td><strong>Zoom+Super</strong></td>
<td>For “near-emergency” needs, open 20 hours a day</td>
</tr>
</tbody>
</table>

#### Expansion Plan

1. **Adds Specialist Services**
   - Employs common specialists
   - Partners with local health systems for others
2. **Incorporates Insurance Plan**
   - First sold on Oregon exchange in 2015
3. **Expands to new Markets**
   - Expanding into California
   - New clinics opening in Portland, Boise, Seattle

1. A New Turning Point for Health Care Reform

2. Reflecting on the First Era of Health Care Reform

3. Adapting Provider Strategy to New Market Realities
No-Regrets Priorities for Next Era of Health Care Reform

**Accessibility**
- Multi-channel navigation platform, including search, price estimation, and triage/scheduling helps streamline transactions
- Development of diverse network of access points (e.g. urgent care, retail, enhanced access to specialty care, primary care) to meet varied consumer access demands

**Reliability**
- Organization-wide commitment and investment in service delivery and quality improvement drives broad engagement in delivering superior outcomes
- High-reliability approach to both service delivery and clinical quality ensures baseline of performance

**Affordability**
- Willingness to partner with lower-cost providers offers patients affordable options, helps prevent markets from becoming overbuilt
- When markets are already overbuilt, commitment to scale back excess capacity ensures affordability in the long-term

Source: Health Care Advisory Board interviews and analysis.
Poll question

Are you interested in attending ENGAGE?

a) Yes

b) No

c) I’m thinking about it, I’d like to talk to somebody first