Health Care Reform Beyond the ACA
The Next Generation of Medicare Risk, High Deductibles, and Physician Integration
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

Source: Health Care Advisory Board interviews and analysis.

© 2016, Chip Somodevilla/Getty Images
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 ACA¹

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

Potentiallly 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>Phase</th>
<th>Budget Reconciliation</th>
<th>Administrative Action</th>
<th>Additional Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process:</td>
<td>Requires simple majority in House and Senate</td>
<td>Federal agencies issue regulation through rulemaking</td>
<td>Requires simple majority in House, super-majority in Senate</td>
</tr>
</tbody>
</table>

### Proposed Target Areas:

**Budget Reconciliation**
- Repeal ACA taxes, employer and individual mandates
- Replace insurance subsidies with refundable tax credits
- Reform Medicaid financing
- Increase contribution limit of health savings accounts
- Allocate funds for state innovations
- Require continuous coverage insurance incentive

**Administrative Action**
- Shorten individual market enrollment period and limit special enrollment
- Loosen restrictions on actuarial value of individual market plans
- Enable state flexibility through waiver process
- Approve state Medicaid eligibility changes (e.g. work requirements, premiums)

**Additional Legislation**
- Allow insurance to be sold across state lines
- Expand use of HSAs
- Allow formation of Association Health Plans
- Remove “essential benefits” requirements
- Reform malpractice regulation
- Streamline FDA processes
- Expand flexibility of state use of federal dollars

Easier Said Than Done

GOP Withdraws American Health Care Act Due to Lack of Votes

Key Elements of the American Health Care Act

**Repeals ACA Taxes**
- Beginning in 2017, eliminates ACA taxes on health plans, medications, HSAs, medical devices, tanning services, investment income, etc.
- Delays implementation of the Cadillac Tax until 2026

**Reforms Individual Market**
- Eliminates individual mandate as of December 31, 2015
- Requires insurers to penalize individuals who do not maintain continuous coverage
- In 2020, replaces subsidies with refundable tax credits adjusted for age and income

**Reforms Medicaid Financing**
- Freezes expansion, ends enhanced match after 2020
- Reverses DSH cuts, provides additional funding for FQHCs, safety net providers
- Shifts Medicaid to block grant and/or per capita cap in 2020

**American Health Care Act**
- Reconciliation bill released by House Republicans on March 6th and withdrawn on March 24th; 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


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.
©2017 Advisory Board • All Rights Reserved • advisory.com • 33594A
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) E.g., allowing insurers to sell plans across state lines, approving the creation of association health plans, and adjusting HSAs.

1 House Republicans Renew Effort

2 Senate Republicans Take Charge

3 GOP Shifts Focus to Non-ACA Legislation

Source: Health Care Advisory Board interviews and analysis.
Regulatory Agenda Taking Center Stage

Administration Has Considerable Leeway to Impact ACA Implementation

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>
<td></td>
<td></td>
</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


©2017 Advisory Board • All Rights Reserved • advisory.com • 33594A
MACRA Rewriting the Rules of Risk

Bipartisan Support at Center of MACRA Rollout

Legislation in Brief: MACRA¹

- 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)

Legislation Enjoyed Bipartisan Support

Senate vote on MACRA

92-8

House vote on MACRA

392-37

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

<table>
<thead>
<tr>
<th>Included</th>
<th>Excluded</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Physician Fee Schedule</td>
<td>Inpatient Prospective Payment System, Outpatient Prospective Payment System (mostly Medicare Part A)</td>
</tr>
<tr>
<td>Physicians, PAs¹, NPs², Clinical Nurse Specialists, Certified Registered Nurse Anesthetists</td>
<td>Clinicians, groups that fall under low volume threshold:</td>
</tr>
<tr>
<td></td>
<td>• $30,000 or less in Medicare charges</td>
</tr>
<tr>
<td></td>
<td>• 100 or fewer Medicare patients</td>
</tr>
<tr>
<td>Groups that include any of the above clinicians</td>
<td>Medicare Part A (i.e., inpatient, outpatient technical hospital payments)</td>
</tr>
</tbody>
</table>

712,000

Estimated number of clinicians affected by MACRA changes in first performance year³

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.

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

Andy Slavitt, CMS Acting Administrator

Source: Centers for Medicare and Medicaid Services; CMS, "Acting Administrator Slavitt Speech at Datapalooza," May 2016; Health Care Advisory Board interviews and analysis.
Dealing Physicians in on Risk

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

<table>
<thead>
<tr>
<th>Year Range</th>
<th>MIPS Bonuses/Penalties</th>
<th>APM Bonuses/Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 – 2019:</td>
<td>+/-4% Max annual adjustment, 2019</td>
<td>5% Annual lump-sum bonus from 2019-2024</td>
</tr>
<tr>
<td>2019 – 2022:</td>
<td>+/-9% Max annual adjustment, 2022</td>
<td></td>
</tr>
<tr>
<td>2022 onward:</td>
<td>+/–9% Max annual adjustment, 2022</td>
<td></td>
</tr>
</tbody>
</table>

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.
Advanced APM Qualification No Simple Feat

Substantial Share of Payment Must Flow Through Risk-Based Models

Advanced APM Qualification Thresholds

<table>
<thead>
<tr>
<th>Year</th>
<th>Non-Medicare Payments Eligible</th>
<th>Payments through Advanced APMs</th>
<th>Patients in Advanced APMs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019-20</td>
<td>25%</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>2021-22</td>
<td>50%</td>
<td>35%</td>
<td></td>
</tr>
<tr>
<td>2023-24+</td>
<td>75%</td>
<td>50%</td>
<td></td>
</tr>
</tbody>
</table>

A Long Way to Go

Physicians currently projected to qualify for Advanced APM track in calendar year 2019

10% - 17%

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, October 14, 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.

- **$343M**
  - Estimated savings to Medicare over the 5 years of the model

- **67**
  - Geographic areas (MSAs) selected

**Episode Payment Models (EPM)**

Includes models for Acute Myocardial Infarction (AMI), Coronary Artery Bypass Graft (CABG); and Surgical Hip and Femur Fracture Treatment (SHFFT).

- **$170M**
  - Estimated savings to Medicare over the 5 years of the model

- **98**
  - Geographic areas (MSAs) selected

**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

Source: Centers for Medicare and Medicaid Services; Health Care Advisory Board interviews and analysis.

---

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.
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>Model</th>
<th>Participants</th>
<th>Upside Risk Only</th>
<th>Downside Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP Track 1</td>
<td>428</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSSP Track 1+</td>
<td>6</td>
<td>Available in 2018</td>
<td></td>
</tr>
<tr>
<td>MSSP Track 2</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSSP Track 3</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Next Gen ACO</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **MSSP Track 1**: Upside-only model, option to renew for second three-year term; savings rate kept at 50% for second term. MSR based on population size between 2% and 3.9%.
- **MSSP Track 1+**: Lowest-risk two-sided model; intended to be attractive to small organizations. Loss rate fixed at 30%; shared savings rate of up to 50%. Prospective attribution, SNF 3-day waiver.
- **MSSP Track 2**: Shared savings, loss rate remains at 60% based on quality performance. Select symmetrical MSR/MLR\(^1\) between 0% and 2% at 0.5% intervals or same methodology as Track 1.
- **MSSP Track 3**: Shared savings up to 75%, shared losses from 40%-75% based on quality performance. Same MSR/MLR options as Track 2. Prospective assignment, SNF 3-day waiver.
- **Next Gen ACO**: 80%-85% sharing rate or full performance risk. Option for capitation. Prospective attribution; SNF 3-day, telehealth, and post-discharge home visit waivers.

1) Minimum savings rate/minimum loss rate.

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

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

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

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

**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

Exchange Enrollment
2014-2016

- 8.0M (End of 2014 OEP)
- 6.3M (Dec. 2014)
- 11.7M (End of 2015 OEP)
- 8.2M (Dec. 2015)
- 12.7M (End of 2016 OEP)
- 10.0M (Final 2016 Enrollment)
- 16.0M (CBO Projection for Final Enrollment)

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”)

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

Source:
- CBO, January 2015 Baseline: Insurance Coverage Provisions for the Affordable Care Act;
- KFF, “Survey of Non-Group Health Insurance Enrollees, Wave 3”, May 2016;

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

- Kentucky Health Cooperative
- Louisiana Health Cooperative
- Nevada Health CO-OP
- Health Republic

70% of CO-OPs closed as of Aug 2016

“Too 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
- Risk corridor underpayment
- Inaccurate risk adjustment
- Abuse of special enrollment period

## 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>3.6%</td>
<td>3.6%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Average</td>
<td>24.4%</td>
<td>29.9%</td>
<td>30.2%</td>
</tr>
<tr>
<td>Maximum</td>
<td>66.4%</td>
<td>59.0%</td>
<td>58.6%</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*

<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>Subsidy Growth Tracks</td>
<td>24.4%</td>
<td>66.4%</td>
<td>29.9%</td>
</tr>
<tr>
<td>Premium Spikes</td>
<td>3.6%</td>
<td>5.0%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

---

**36%** Of exchange regions will have only one participating insurer in 2017

**5** State exchanges with only one participating insurer

---

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

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

22M

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

GOP Reform Efforts Taking Center Stage

Trump Administration Reframing the Health Care Conversation

Five Health Policy Issues to Watch in 2017

*Possibilities Include*…

<table>
<thead>
<tr>
<th>Coverage Expansion</th>
<th>Payment Reform</th>
<th>Medicare Reform</th>
<th>Medicaid Reform</th>
<th>Deficit Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion of HSAs</td>
<td>Adjusting reform programs to drive greater savings</td>
<td>Expanding Medicare Advantage</td>
<td>Rolling back Medicaid expansion</td>
<td>Maintaining ACA-related payment cuts</td>
</tr>
<tr>
<td>Insurance market protections</td>
<td>Eliminating CMMI, scaling back associated programs</td>
<td>Increasing age of eligibility to 67</td>
<td>Transitioning financing to per capita allotment</td>
<td>Expanding payment cuts</td>
</tr>
<tr>
<td>Tax credits for individual market purchasers</td>
<td>Implementing MACRA, with potential tweaks</td>
<td>Implementing “premium support” model</td>
<td>Transitioning financing to state block grants</td>
<td></td>
</tr>
<tr>
<td>Capping employer tax exclusion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
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

Population-level Focus
- Total cost control
- Care management

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

Source: Health Care Advisory Board interviews and analysis.
Moving from Zero-Sum to Positive-Sum Competition

Value-Seeking Agents Catalyzing New Market

“Competition at the wrong level has been exacerbated by the pursuit of the wrong objective: reducing cost…The right goal is to improve value (quality of health outcomes per dollar expended).”

Michael Porter, 2004

Employers Reaching the Limits of Their Tolerance

Scale, Data Assets, Provider-Side Expertise All Command Attention

HTA’s Announced Goals

- Greater marketplace efficiencies
- Learning from data
- Educating employees
- Breaking bad habits

Founding Members

- American Express
- American Water
- BNSF
- Brunswick Corporation
- Caterpillar, Inc.
- Coca-Cola
- DuPont
- HCA
- Hartford Financial Services Group
- IBM
- Ingersoll Rand
- International Paper
- Lincoln Financial
- Macy’s
- Marriott
- NextEra Energy
- Pitney Bowes
- Shell
- Verizon
- Weyerhaeuser

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

- 78K
- Total employees
- Provider partners: Providence Health & Services, UW Medicine

2016: Expansion to Other Major Boeing Locations

- St. Louis
- Charleston

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.
Some Employers Steering for Specific Procedures

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

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

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

Significant Barriers Slowing Wider Adoption

Basic Practical, ROI Questions Are Still Unanswered

**Employer Interest in Direct Contracting with Providers**

- Little Interest: 41%
- Moderate Interest: 47%
- Significant Interest: 12%

88% of employers have little or moderate interest in provider partnerships

**Largest Barriers to Partnering with or Purchasing Services Directly from Providers**

*Percentage of Surveyed Employers Ranking Barrier in Top 3*

- Administrative complexity/resource constraints: 66%
- Providers lack sufficient geographic or service coverage: 48%
- Don’t know how best to proceed: 42%
- Insufficient economic rationale: 38%
- Potential to jeopardize carrier relationships: 26%
- Broker pushback: 20%
- Employee pushback: 18%
- Providers lack track record and experience compared to others: 16%
- Lack of provider interest: 11%
- Providers don’t offer relevant services today: 10%
- Providers only looking to steer hospital volumes: 4%

Source: CEB Survey of Employers on Future Health Benefits Changes 2015; Health Care Advisory Board interviews and analysis.
Onboarding Risk, then Offloading to Employees

Employers Increasingly Turning to High-Deductible Plans

ESI Average Deductible for Single Coverage¹
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></td>
<td></td>
</tr>
<tr>
<td>2007</td>
<td>$1,025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>$1,318</td>
<td>$1,025</td>
<td>$1,318</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Percentage of Covered Workers with Annual Deductible of $2,000 or More³
By Firm Size, 2006-2015

- 3-199 Workers
- All Firms
- 200 or More Workers

<table>
<thead>
<tr>
<th>Year</th>
<th>3-199 Workers</th>
<th>All Firms</th>
<th>200 or More Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>2007</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>2008</td>
<td>10%</td>
<td>15%</td>
<td>20%</td>
</tr>
<tr>
<td>2009</td>
<td>15%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>2010</td>
<td>20%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>2011</td>
<td>25%</td>
<td>30%</td>
<td>35%</td>
</tr>
<tr>
<td>2012</td>
<td>30%</td>
<td>35%</td>
<td>40%</td>
</tr>
<tr>
<td>2013</td>
<td>35%</td>
<td>40%</td>
<td>45%</td>
</tr>
<tr>
<td>2014</td>
<td>40%</td>
<td>45%</td>
<td>50%</td>
</tr>
<tr>
<td>2015</td>
<td>45%</td>
<td>50%</td>
<td>55%</td>
</tr>
</tbody>
</table>

1) Among covered workers with a general annual health plan deductible.
2) Includes HDHP/SO.
3) For single coverage.

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

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

Newer Market Entrants Hitting Their Stride


50% (800k→1.2M)

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

500% (220k→1M)

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>$2,907</td>
<td>$2,927</td>
<td>$5,731</td>
</tr>
<tr>
<td>Silver</td>
<td>$1,277</td>
<td>$1,198</td>
<td>$3,117</td>
</tr>
<tr>
<td>Gold</td>
<td>$1,165</td>
<td>$1,198</td>
<td>$1,165</td>
</tr>
<tr>
<td>Platinum</td>
<td>$347</td>
<td>$243</td>
<td>$233</td>
</tr>
</tbody>
</table>

Exchange Enrollment, by Metal Tier
2015

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

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 FEHBP\(^1\) coverage

43%
Returning federal exchange enrollees changing plans in 2016

Active Health Plan Shopping on the Rise

Percentage of those renewing coverage who actively shopped for plans

Percentage of those renewing coverage who switched plans

Premium Increases the Primary Motivator

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


---

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.
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

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

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

25% Consumers used a retail clinic in 2015—up from 15% in 2013

Not Your Father’s Urgent Care

Consumer Demands are the Center of the Zoom+ Universe

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

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

Establishing a Loyal Base

250K Annual Zoom users, 2014 (before rebrand, expansion)

# Growing A Health System From A Very Different Seed

**Zoom+ Services**

<table>
<thead>
<tr>
<th><strong>1</strong></th>
<th>Adds <strong>Specialist Services</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Employs common specialists</td>
<td></td>
</tr>
<tr>
<td>• Partners with local health systems for others</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>2</strong></th>
<th>Incorporates <strong>Insurance Plan</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>First sold on Oregon exchange in 2015</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>3</strong></th>
<th>Expands to new <strong>Markets</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Expanding into California</td>
<td></td>
</tr>
<tr>
<td>• New clinics opening in Portland, Boise, Seattle</td>
<td></td>
</tr>
</tbody>
</table>

---

### Expansion Plan

1. **Employs common specialists**
2. **Partners with local health systems for others**
3. **First sold on Oregon exchange in 2015**
4. **Expanding into California**
5. **New clinics opening in Portland, Boise, Seattle**

---

### Source

- Portland Business Journal, “ZoomCare inks investment deal with Endeavour Capital,” July 8, 2014
A New Turning Point for Health Care Reform

Reflecting on the First Era of Health Care Reform

Adapting Provider Strategy to New Market Realities
Path Forward Not Dependent on Politics

No-Regrets Priorities for Next Era of Health Care Reform

<table>
<thead>
<tr>
<th>Accessibility</th>
<th>Reliability</th>
<th>Affordability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Multi-channel navigation platform, including search, price estimation, and triage/scheduling helps streamline transactions</td>
<td>• Organization-wide commitment and investment in service delivery and quality improvement drives broad engagement in delivering superior outcomes</td>
<td>• Willingness to partner with lower-cost providers offers patients affordable options, helps prevent markets from becoming overbuilt</td>
</tr>
<tr>
<td>• 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</td>
<td>• High-reliability approach to both service delivery and clinical quality ensures baseline of performance</td>
<td>• When markets are already overbuilt, commitment to scale back excess capacity ensures affordability in the long-term</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Viewing Our Strategy Through a New Lens

Competitor-centric Strategy

- Strategic Benchmark: Closest competitor’s performance
- Financial Metric: Share of existing market
- Executive Focus: Stewardship of community asset

Customer-centric Strategy

- Strategic Benchmark: Maximum consumer value
- Financial Metric: Share of wallet, lifetime loyalty
- Executive Focus: Ongoing drive for improvement

“I have a] passion to figure out customer-focused strategies as opposed to, say, competitor-focused strategies. If you’re competitor-focused, you tend to slack off when your benchmarks say that you’re the best. But if your focus is on customers, you keep improving.

Jeff Bezos
CEO, Amazon
