Health Care 2020

Population Health, Consumerism, and the Future of Health Care Delivery

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A New Era of Cost Containment

Health Care 2020

Defending System Value
A Return to the Good Old Days?

Health Care Spending on the Rebound

National Health Expenditures See Biggest Jump Since Pre-Recession

Bloomberg Businessweek
“U.S. Health-Care Spending Is on the Rise Again”

USA TODAY
“Health care spending growth hits 10-year high”

THE WALL STREET JOURNAL
“Health Spending Is Rising More Sharply Again”

Annual Growth in National Health Expenditures

A Closer Look at the Numbers

Higher Spending Not Exactly a Boon for Hospitals

Hospital Price Growth Down for First Time on Record

Annualized Hospital Price Growth, Jan. 2010-Jan. 2015

2015 Hospital Price Growth Down Across All Payer Classes

(2.9%) Medicare price growth

(0.1%) Medicaid price growth

1.6% Commercial price growth (lowest growth rate since 2002)

No End in Sight

Price Cuts Continue Unabated

Hospitals Bearing the Brunt of Payment Cuts

Reductions to Medicare Fee-for-Service Payments

New Proposals Continue to Emerge

President’s FY2016 Budget Proposal Includes Significant Cuts to Providers

2013 ($4B)
2014 ($14B)
2015 ($24B)
2016 ($29B)
2017 ($38B)
2018 ($54B)
2019 ($67B)
2020 ($76B)
2021 ($86B)
2022 ($94B)

ACA IPPS\(^1\) Update Adjustments
ACA DSH\(^2\) Payment Cuts
MACRA\(^3\) IPPS Update Adjustments

$30.8B
$29.5B
$14.6B
$720M

Reduction in Medicare bad debt payments
Savings from moving to site-neutral payments
Cuts to teaching hospitals and GME payments
Cuts to critical access hospitals


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1) Inpatient Prospective Payment System.
2) Disproportionate Share Hospital.
Market Forces Continue to Threaten Status Quo

All Purchasers Looking to Curb Spending

**Government**
- Medicare doubling down on risk
- Medicare Advantage poised for reform
- Medicaid experimenting with risk, consumerism

**Employers**
- Private exchanges increasing pricing pressure
- Self-insured employers focusing on utilization control

**Consumers**
- Continued premium sensitivity on public exchanges
- Price sensitivity increasing at point of care

Source: Health Care Advisory Board interviews and analysis.
**CMS Lays Down Marker for Value-Based Payment**

**Historic Payment Targets Demonstrate Commitment to FFS\(^1\) Alternatives**

### Aggressive Targets for Transition to Risk

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>20%</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>

**Examples of Qualifying Risk Models**
- Medicare Shared Savings Program
- Bundled Payments for Care Improvement Initiative
- Patient-Centered Medical Home

### FFS Increasingly Tied to Value

<table>
<thead>
<tr>
<th>Year</th>
<th>2015</th>
<th>2016</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>80%</td>
<td>85%</td>
<td>90%</td>
</tr>
</tbody>
</table>

**Examples of Quality/Value Programs**
- Hospital-Acquired Condition Reduction Program
- Hospital Value-Based Purchasing Program
- Hospital Readmissions Reduction Program
- Merit-Based Incentive Payment System

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\(^1\) Fee-for-Service.

Mandatory Risk Programs Taking a Toll on Providers

Readmissions, HAC Penalties Outweighing VBP Bonuses

After Accounting for Penalties¹, Few Receive VBP² Bonuses

3,087 hospitals in VBP program
1,700 hospitals received bonus payment
792 hospitals received net payment increases

Estimated Net Impact of P4P³ Programs, FY 2015

28%
Hospitals receiving a net bonus or breaking even

50%
Hospitals receiving net penalties between 0% and 1%

6.5%
Hospitals receiving net penalties of 2% or greater


¹) Hospital-Acquired Condition Reduction Program, Hospital Readmissions Reduction Program.
²) Value-Based Purchasing.
³) Pay-for-Performance.
Both Tracks Impose Greater Risk, Strong Incentives for Alternative Models

PFS¹ Payment Models Beginning in 2019

1. **Merit-Based Incentive Payment System (MIPS)**
   - Consolidates existing P4P programs²
   - Score based on quality, resource use, clinical improvement, and EHR use
   - Adjustments reach -9% / +27% by 2022
   - From 2019 through 2024, potential to share in $500M annual bonus pool¹

2. **Alternative Payment Models (APMs)**
   - Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS
   - Requires that physicians meet increased targets for revenue at risk
   - APMs must involve downside risk and quality measurement

MIPS Performance Category Weights
For 2021

- **EHR Use**: 25%
- **Quality**: 30%
- **Clinical Improvement**: 15%
- **Resource Use**: 30%

Revenue at Risk Requirements for APMs

<table>
<thead>
<tr>
<th>Year</th>
<th>Required for All Providers</th>
<th>Option 1</th>
<th>Option 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 – 2020</td>
<td>25%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021–2022</td>
<td>50%</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>2023 and on</td>
<td>75%</td>
<td>25%</td>
<td>75%</td>
</tr>
</tbody>
</table>

1) Physician Fee Schedule.
2) Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System.
3) Includes risk-based contracts with Medicare Advantage plans.

89 ACOs Join in 2015, Few Generating Shared Savings in First Year

Medicare ACO Program Growth Continues
As of January 2015

<table>
<thead>
<tr>
<th></th>
<th>Pioneer ACO</th>
<th>MSSP ACO</th>
<th>Total Medicare ACOs</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>13</td>
<td>31</td>
<td>44</td>
</tr>
</tbody>
</table>

One-Quarter of MSSP ACOs Share in Savings
First Performance Year

- Held Spending Below Benchmark, Earned Shared Savings: 26%
- Did Not Hold Spending Below Benchmark: 46%
- Reduced Spending, Did Not Qualify for Shared Savings: 27%

Early MSSP Participants Completing Third Performance Year (PY)

- April 2012 Cohort (27)
- July 2012 Cohort (87)
- Jan. 2013 Cohort (106)
- Jan. 2014 Cohort (123)
- Jan. 2015 Cohort (89)

Pioneer ACO Meets Requirements for Expansion

First-Ever CMMI Pilot Certification Expands Model to More Beneficiaries

Pioneer ACOs Generate Sufficient Savings to Merit CMS Expansion
Total Medicare Savings Generated by Pioneer ACOs, 2012-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings Generated by Pioneer ACOs, 2012-2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>$279.7M</td>
</tr>
<tr>
<td>2013</td>
<td>$104.5M</td>
</tr>
<tr>
<td>Total</td>
<td>$384.2M</td>
</tr>
</tbody>
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The Actuary’s certification that expansion of Pioneer ACOs would reduce net Medicare spending, coupled with Secretary Burwell’s determination that expansion would maintain or improve patient care without limiting coverage or benefits, means that **HHS will consider ways to scale the Pioneer ACO Model into other Medicare programs.**

**U.S. Department of Health & Human Services**

New MSSP Rule Encourages More Risk

Track Three Incorporates Features of Pioneer ACO Model

New Rule Offers Greater Flexibility for Providers

Track 1

- Option to renew for second three-year term
- Savings rate kept at 50% for second term

Track 2

- Shared savings, loss rate remains at 60% based on quality performance
- Revises MSR\(^1\) and MLR\(^2\) from fixed 2% to variable 2%-3.9% based on number of beneficiaries

Track 3

- Shared savings up to 75%, shared losses from 40%-75% based on quality performance
- Fixed 2% MSR and MLR
- Prospective assignment
- Waiver of SNF 3-day rule

Benchmarking Methodology Adjusted to Account for Prior Performance

- Benchmarks will be rebased in subsequent agreement periods based on an ACO’s financial and quality performance during prior agreement periods
- CMS plans to develop a regionally adjusted benchmark formula to take effect in 2017 or later


1) Minimum Savings Rate.
2) Minimum Loss Rate.
CMMI’s Next-Gen ACO Will Test Full Performance Risk

Model Significantly Expands Tools to Engage Patients, Control Utilization

<table>
<thead>
<tr>
<th>Financial Model</th>
<th>Engagement Tools</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prospective benchmark</strong> using one year baseline historical spending, trended forward using regional factors</td>
<td><strong>Beneficiary alignment</strong> through prospective attribution and voluntary beneficiary alignment</td>
</tr>
<tr>
<td><strong>Risk arrangements</strong> include 80%-85% sharing rate or full performance risk</td>
<td><strong>Coordinated care reward</strong> up to $50 annually for beneficiaries receiving at least 50% of care from ACO</td>
</tr>
<tr>
<td><strong>Payment mechanisms</strong> include traditional FFS (with optional infrastructure payments), population-based payments, or capitation</td>
<td><strong>Benefit enhancements</strong> through payment and program waivers for telehealth, home health, and SNF admission</td>
</tr>
</tbody>
</table>

Medicare Advantage Continues Record Growth

Penetration Varies by Geography

MA Enrollment to Nearly Double by 2025

Total Enrollment and Percentage of Total Medicare Population

- 2005: 10.4M (13%)
- 2015: 17.3M (30%)
- 2025: 30.0M (40%)

MA Penetration Varies by State

Total MA Enrollment as a Percent of Total Medicare Population

- States with 0%-13% penetration
- States with 14%-25% penetration
- States with 26%-38% penetration
- States with 39%-51% penetration

- 22% of newly eligible beneficiaries chose MA in 2011
- 39 states currently have provider-led plans in their markets
- 69% of provider-led plans offer MA coverage options

Provider Interest Fueling MA Growth

Ability to Customize Contracts, Maintain Narrow Network Key Differentiators

Attractive Elements of MA Contracts

- **Greater Control Over the Network**
  64% if beneficiaries choose HMO plans, offering improved utilization management and network control

- **Greater Opportunity to Tailor Risk**
  Carrier contracts can be structured to include varying levels of provider payment risk and quality incentives

- **Fewer Patient Identification Issues**
  Providers can target patients who are enrolled in the plan with lower levels of churn than in MSSP

- **Customized Cost Target Development**
  Providers can determine the cost target as part of negotiations with the plan, perhaps using the MLR

White Paper: Why a Successful Population Health Strategy Must Include Medicare Advantage

Highlights attractive elements of MA and offers strategies to incorporate it into population health strategy

- 70% of new MA plans approved since 2008 are provider-sponsored
- 18% of MA enrollees chose a provider-sponsored MA plan in 2014 (about 2.8M enrollees)

CMS Charting a Path Toward Greater Risk

Track 3, Pioneer and Next-Gen ACO Filling Out the Continuum

Continuum of Medicare Risk Models

Pay-for-Performance
- Hospital VBP Program
- Hospital Readmissions Reduction Program
- HAC Reduction Program
- Merit-Based Incentive Payment System

Bundled Payments
- Bundled Payments for Care Improvement Initiative (BPCI)

Shared Savings
- MSSP Track 1 (50% sharing)

Shared Risk
- MSSP Track 2 (60% sharing)
- MSSP Track 3 (up to 75% sharing)
- Next-Generation ACO (80-85% sharing)

Full Risk
- Next-Generation ACO (optional full performance risk)
- Medicare Advantage (provider-sponsored)

Increasing Financial Risk

Source: Health Care Advisory Board interviews and analysis.
Future of Medicaid Expansion Less Clear

Benefit of Expansion Clear for Hospitals, But Opposition Remains

29 States and DC Have Approved Expansion¹
As of April 2015

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

11.7M
Net increase in Medicaid, CHIP² enrollment, July-Sept. 2013 to Feb. 2015³

27% vs. 8%
Growth in Medicaid, CHIP enrollment in expansion vs. non-expansion states, July-Sept. 2013 to Feb. 2015


1) Montana's expansion requires federal waiver approval.
2) Children's Health Insurance Program.
3) Excludes CT and ME.
Medicaid Risk-Based Payment Models Expanding

Providers Expanding Care Management Infrastructure to New Populations

17 states have Medicaid ACO programs in place or are pursuing one

### Oregon
Coordinated Care Organizations
- 16 organizations accountable for 90% of Medicaid and dual-eligibles
- 21% reduction in ED use, 52% increase in PCMH\(^1\) enrollment since 2012

On track to generate 2% PMPY\(^2\) savings

### Colorado
Regional Care Collaborative Organizations
- Seven regional organizations that convene provider networks around PCMHs
- Uses a hybrid of several payment strategies to shift to value

Generated $29-$33M in net savings, 2014

### Minnesota
Integrated Health Partnerships
- 15 delivery systems participating in Medicaid ACO program
- Shared savings in year one; shared risk in following years

Generated $10.5M in savings in first year

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1) Patient-Centered Medical Home.  
2) Per Member Per Year.

Expansion States Experimenting with Benefit Design

States Using Waiver Flexibility to Redesign Benefits, Influence Behavior

Medicaid Waivers Encourage Healthy Behavior, Personal Responsibility

**Demonstration Proposals Approved by CMS**
- Premium Assistance for QHPs
- Benefits Lockouts
- Work Program Referrals
- Healthy Behavior Discounts
- Service Copays
- Premiums/Monthly Contributions
- Private Managed Care Plans

**Demonstration Proposals Rejected by CMS**
- Work requirements as condition of eligibility
- Mandated premiums for beneficiaries below 100% FPL
- Cost sharing exceeding amounts permitted under federal law

Employer Health Cost Growth Slowing, but Enough?

“Cadillac” Tax Motivating Quicker Action

Good News and Bad News

Predicted growth in per-employee health benefit cost, 2015 (second lowest since 1997)

3.9%

Annual consumer inflation, October 2014

1.7%

Refresher: The “Cadillac” Tax

- 40% excise tax assessed on amount of employee health benefit exceeding $10,200 for individuals, $27,500 for families
- Intended to encourage cost-effective benefits, offset ACA implementation cost
- Threshold adjustments tied to consumer inflation, not health care inflation
- If employers make no changes to current benefit plans:

31% of all employers could incur tax in 2018

51% of all employers could incur tax in 2022

Not Converging on a Single Strategy

Spectrum of Options for Controlling Health BenefitsExpense

"Activation"
Manage Proactively
- Offer and encourage uptake in care management, disease management, preventive care
- May involve direct partnerships with ACOs

"Delegation"
Shift to Private Exchange
- Outsource administrative burden to third party
- Facilitate shift to defined contribution
- Encourage employee uptake of HDHPs¹

"Abdication"
Drop Coverage
- Shift employees to public exchange
- Trade Cadillac tax for employer mandate penalty

¹) High Deductible Health Plan.
Source: Health Care Advisory Board interviews and analysis.
Four Primary Models for Controlling Employee Utilization

**Manage Costs at Point of Network Assembly**

- **ACO networks:** Employer contracts with single delivery system based on promise of reduced cost trend
- **“The One-Stop Shop”**

**Manage Costs at Point of Referral, Point of Care**

- **Enhanced primary care:** Employees directed to PCPs with proven ability to reduce utilization, refer responsibly
- **“The Accountable Physician”**

- **Personal health navigators:** Guide employees through all health care related decisions, refer to high-value providers
- **“The Neutral Third Party”**

- **Specialty carve-out networks:** Employees evaluated against appropriateness of care criteria, sent to centers of excellence
- **“The Second Opinion”**

Source: Health Care Advisory Board interviews and analysis.
Early Adopters of ACO Models Expanding Efforts

Intel Extends Connected Care Model

**Case in Brief: Intel Corporation**

- Large, multinational employer headquartered in Santa Clara, California
- In 2013, entered into narrow-network contract with Presbyterian Healthcare Services, an 8-hospital system in New Mexico, for employees at Rio Rancho plant
- In 2014, implemented similar model in Oregon with Kaiser Permanente and Providence Health & Services

**Key Components of Connected Care Oregon**

- Premium incentives to choose narrow network; both Kaiser and Providence networks set at $0 premium
- Members assigned to PCMH
- FFS payments tied to performance against cost, quality goals

Direct-to-Employer ACO Arrangements Remain Rare

Carrier, Broker Resistance

1. Little desire to disrupt stability of ESI[1] marketplace
2. Hesitant to narrow networks for fear of jeopardizing provider relationships necessary for broad product offerings
3. Resistance from national employers to compete directly with regional ACOs
4. Fear that employer partners will bypass completely and partner directly with providers instead

Market Immaturity

1. Hesitance by employers to disrupt employee benefits without concrete proof of efficacy of ACO model
2. Lack of mature “plug and play” solutions means employers must invest significant time, energy into implementing ACO model
3. More interest from employers in models requiring incremental changes, rather than broad disruption to benefits

1) Employer-Sponsored Insurance.

Source: Health Care Advisory Board interviews and analysis.
Not Everyone Buying Into the Value of Systemness

Innovators Looking to Unbundle the Delivery System

“Quality doesn’t happen at the system level. Quality happens at the individual physician level. If I steer my employees to a single delivery system, the one thing I can be certain of is that the quality of care that they’ll receive will be variable.”

Director of Benefits, Large National Employer

Pushing for Two Levels of Unbundling

Procedure Level

- Single health system may not be high-quality across all clinical areas
- Innovators cherry-picking facilities based on quality and cost efficiency with specific procedures (e.g. heart surgery)

Physician Level

- Aggregate level facility or procedural data not a guarantee of individual physician performance
- Innovators looking to identify high-performing clinicians and ensure steerage to those individuals

Source: Health Care Advisory Board interviews and analysis.
Centers of Excellence Help Employers Reduce Procedural Spend

BridgeHealth Offers Three Tiers of Service Targeting Surgery Spend

<table>
<thead>
<tr>
<th>Scope of Services</th>
<th>Description</th>
</tr>
</thead>
</table>
| SURGERY PATH              | • Web portal that helps guide employees when making surgery treatment decision  
                            • Offers shared decision-making and transparency tools                                      |
| HIGH PERFORMANCE NETWORK  | • Care coordinators direct employees to hospitals in top quartile of quality ranking system  
                            • Offers case rates 15-40% below typical PPO payments                                         |
| SURGERY BENEFIT MANAGEMENT| Combines Surgery Path and High Performance Network offerings to maximize impact, increase employee decision support options                   |

Case in Brief: BridgeHealth Medical

- Health care company based in Denver, CO; helps employers manage surgery spend
- Identifies high-performing hospitals and surgical teams for key procedures and negotiates preset case rates
- Uses care coordinators to guide employees through process of selecting facility for procedure, scheduling, and follow up

Incentivizing PCPs to Make Smart Referrals

Shifting Risk onto the Primary Care Physician

Case in Brief: Iora Health
- Progressive medical group based in Cambridge, Massachusetts with 12 clinics throughout the U.S.
- Refers selectively to high-quality, cost-effective specialty partners

Identifying High-Value Referral Partners

1. Eliminating High Spenders
   Use payer claims data to eliminate physicians who are drumming up volumes

2. Finding a Cultural Fit
   Identify most collaborative partners (e.g. those willing to commit to curbside consults)

Giving PCPs Control of the Budget

From Primary Care Capitation to Global Risk
- Under original model, Iora receives PMPM fee for primary care services
- New contracts with insurers include shared risk based on total cost

“In our initial arrangements, we were creating a lot of value, but not always sharing in it. Now, with broader shared risk, the incentives are more aligned.”

Zander Packard, COO, Iora Health

Concierge Navigators Influencing Referral Patterns

Compass Delivers Savings to Employers Through Premier Providers

Premier Providers Chosen for High-Quality, Cost-Effective Care

Compass reviews medical claims data, conducts interviews to identify top performers.

Providers must:
- Maintain updated medical practices
- Demonstrate compassion and concern for patients
- Deliver care that reduces excessive visits and spending

High-Quality Physicians Reduce Employees’ Average Annual Health Care Spending

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Average Annual Health Care Spending</th>
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<tbody>
<tr>
<td>Bottom 50%</td>
<td>$6,698</td>
</tr>
<tr>
<td>Top 50%</td>
<td>$3,875</td>
</tr>
<tr>
<td>Top 25%</td>
<td>$2,752</td>
</tr>
<tr>
<td>Top 10%</td>
<td>$1,795</td>
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</tbody>
</table>

$4,903 annual savings

Case in Brief: Compass Professional Health Services

- Health navigation and transparency company based in Dallas, Texas
- Markets a health activation platform to employers that provides cost and quality data, promotes wellness and prevention, and engages employees in care pathways using Compass Premier Providers
- Clients include Southwest Airlines, Dillard’s, Michaels, and The Container Store

Other Employers Taking a More Hands-Off Approach

Private Exchange Enrollment Continues to Grow

Private Exchange Enrollment Doubles in 2015, But Lags Behind Initial Projections

Projected Private Exchange Enrollment Among Pre-65 Employees and Dependents

Analysts Remain Bullish on Long-Run Growth Prospects

More Big Names Making the Jump

Newer Market Entrants Hitting Their Stride

Many Still in Wait-and-See Mode

Long-Run Impact Depends on Results, Broader Uptake Across Industries

Employers Waiting to See Results, Watching Industry Peers

Top Three Factors That Would Cause Employers to Consider a Private Exchange

- Evidence that private exchanges can deliver greater value than current model (74%)
- The actions of other large companies in our industry (56%)
- Inability to stay below the excise tax using our current approach (36%)

“For us, the decision to move to the private exchange model was independent of the ACA. We had pulled all of the levers available to us as a self-insured employer—there was nowhere left to go from a cost-savings perspective. At the end of the day, the private exchange was a way to achieve more predictable cost savings.”

Tom Sondergeld, Senior Director of Health & Wellness, Walgreens

Exchanges Delivering on First-Order Savings

Facilitating Shift to Defined Contribution, Encouraging HDHP Uptake

Sears Exchange Model

- Fully-insured
- Defined contribution
- Multi-carrier

Three Years In, Sears Continues to See Migration to HDHPs Grow Year-Over-Year

Percentage of Sears Employees Selecting HDHP Option

<table>
<thead>
<tr>
<th></th>
<th>Pre-Exchange</th>
<th>Year 1 Exchange</th>
<th>Year 2 Exchange</th>
<th>Year 3 Exchange</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of Sears Employees Selecting HDHP Option</td>
<td>3.5%</td>
<td>17%</td>
<td>27%</td>
<td>35%</td>
</tr>
</tbody>
</table>

Case in Brief: Sears Holdings Corporation

- Retail chain headquartered in Hoffman Estates, Illinois
- One of earliest large employers to adopt private exchange model; implemented Aon Active Health Exchange in 2013
- Has held defined contribution steady over the last few years; future adjustments based on premium growth and business performance

Source: Health Care Advisory Board interviews and analysis.
Future Success Hinges on Ability to Control Trend

Exchanges Must Innovate on Network Design, Population Health Tools

Controlling Cost Trend Crucial for Both Fully-Insured, Self-Insured Models

**Fully-Insured**
- Long-term sustainability depends on ability to keep premium growth low
- Carriers rely on low costs to keep premiums low

**Self-Funded**
- Long-term sustainability depends on ability to keep employers’ variable costs low (i.e. claims)
- Dependent upon reduced unit prices, reduced utilization, or a combination of both

### Strategies to Control Cost Trend

1. **$**
   - **Reduce Per-Unit Spending**
     - Control price growth; encourage consumers to use lower-cost options

2. **↓**
   - **Reduce Utilization**
     - Through care management, disease management, utilization management services. These could be provided by:
     - Carriers
     - Exchange operators
     - Providers

Source: Health Care Advisory Board interviews and analysis.
### Consumers Continue to Flock to Public Exchanges

#### Second Round of Enrollment Hitting Targets

#### Second Open Enrollment Period Yields Over 10 Million Enrollees

**Total 2015 Plan Selections in the Marketplaces**

<table>
<thead>
<tr>
<th></th>
<th>Total at end of OEP</th>
<th>Total as of April 2015</th>
</tr>
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<tbody>
<tr>
<td><strong>HHS Projection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.0M-9.9M</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2014 Enrollment</strong></td>
<td>8M</td>
<td></td>
</tr>
<tr>
<td><strong>2015 Total</strong></td>
<td>11.7</td>
<td>10.2</td>
</tr>
</tbody>
</table>

**Source:**

Demographics Largely Unchanged

- **28%** 2015 enrollees aged 18-34 (compared to 28% in 2014)
In Year Two, Premium Adjustments Abound

Competitive Marketplace Driving Premium Changes

Average Premium Increases Modest, but High Market-by-Market Variability

Statewide Average Premium Changes for Benchmark Silver Plans, 2014 to 2015¹

Average premium increase nationally

0%

Takeaways

**Competition Increased**
Number of carriers increased by 19%; number of products increased by 27%

**New Entrants Priced Competitively**
Over half of new price leaders were either recent or new entrants

¹ For 40-year-old, non-smoker.

Exchanges a More Fluid Marketplace Than Expected

Avoiding Premium Increases the Primary Motivation for Shoppers

Switching Rates Higher Than Expected

- 12\% average annual switching among active employees with FEHBP\(^1\) coverage
- 29\% returning federal exchange enrollees changing plans in 2015

Premium Increases the Primary Motivator

- 55\% switchers who cited rise in monthly premiums as among top three reasons for switching

Most Continue to Select Silver, Bronze Plans

<table>
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<tbody>
<tr>
<td>2014</td>
</tr>
<tr>
<td>Bronze</td>
</tr>
<tr>
<td>Silver</td>
</tr>
<tr>
<td>Gold</td>
</tr>
<tr>
<td>Platinum</td>
</tr>
<tr>
<td>Catastrophic</td>
</tr>
</tbody>
</table>

- 65\% 2014
- 2015

1) Federal Employee Health Benefits Plan.

Despite Predictions, Networks Remain Narrow

Insurers Betting Consumers Will Continue to Trade Choice for Price

Narrow Network Plan Designs Continue to Dominate Exchange Marketplace

Network Breadth in Largest City of Each State

<table>
<thead>
<tr>
<th>Network Type</th>
<th>2014</th>
<th>2015</th>
</tr>
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<tbody>
<tr>
<td>Ultra Narrow</td>
<td>22%</td>
<td>21%</td>
</tr>
<tr>
<td>Narrow</td>
<td>38%</td>
<td>41%</td>
</tr>
<tr>
<td>Broad</td>
<td>40%</td>
<td>38%</td>
</tr>
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Narrow Network Premium Advantages Increasing Over Time

Median PMPM Difference For Products From the Same Payer and Product Type

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<thead>
<tr>
<th>Year</th>
<th>Premium Advantage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>11-17%</td>
</tr>
<tr>
<td>2015</td>
<td>15-23%</td>
</tr>
</tbody>
</table>

Few Buying-Up to Broad Networks

17% Consumers with narrow-network plans for year one that switched to a broad-network plan in year two

Trading Low Premiums for High Deductibles

### Average Public Exchange Deductibles by Tier, 2015

- **Bronze**:
  - 2015: $5,181
  - 2014: $5,081

- **Silver**:
  - 2015: $2,927
  - 2014: $2,898

- **Gold**:
  - 2015: $1,198
  - 2014: $1,277

- **Platinum**:
  - 2015: $243
  - 2014: $347

---

### 2015 Enrollees Favor Higher Deductibles

2015 Enrollees Favor Higher Deductibles
Annual Deductibles as Percentage of All Individual Plans
Selected on eHealth Platform, 2014-2015

<table>
<thead>
<tr>
<th>Deductible Tier</th>
<th>2014 (%)</th>
<th>2015 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;$1,000</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>$1,000-$2,999</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>$3,000-$5,999</td>
<td>30%</td>
<td>34%</td>
</tr>
<tr>
<td>$6,000+</td>
<td>39%</td>
<td>34%</td>
</tr>
</tbody>
</table>

#### Source:
- Health Care Advisory Board interviews and analysis.
Majority Satisfied with Coverage

So Far, Backlash Against Narrow Networks, HDHPs Not Widespread

Exchange Enrollees Generally as Happy as Others with Health Coverage…

Ratings of Healthcare Coverage Quality, 2014

<table>
<thead>
<tr>
<th></th>
<th>All Insured</th>
<th>Newly-Insured Through Exchanges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good or Excellent</td>
<td>72%</td>
<td>71%</td>
</tr>
<tr>
<td>Fair or Poor</td>
<td>27%</td>
<td>29%</td>
</tr>
</tbody>
</table>

...And Particularly Satisfied with the Cost of Their Coverage

Ratings of Healthcare Coverage Cost, 2014

- 75% Newly insured satisfied with cost of health care
- 61% Satisfaction rate among all insured individuals

Higher Deductibles Driving Increased Price Sensitivity

Consumers Increasingly Soliciting Pricing Information

Many Americans Lack Cash Flow to Cover Potential OOP Costs

Households Without Enough Liquid Assets to Pay Deductibles

- 24% Mid-range deductible
- 35% Higher-range deductible

A surprising percentage of people with private insurance…simply do not have the resources to pay their deductibles.”

Drew Altman, President, Kaiser Family Foundation

More Consumers Attempting to Find Pricing Information

- 56% Consumers who have tried to find out how much they would have to pay before getting care
- 67% Those with deductibles of $500 to $3,000 who have solicited pricing information
- 74% Those with deductibles higher than $3,000 who have solicited pricing information

Pricing Tools Currently Falling Short

Few Consumers Have Actually Seen or Used Price Information
*Percentage of Consumers Who Have Seen or Used Price Information in Past 12 Months*

- **Health Plans**: 18% saw information, 9% used information
- **Hospitals**: 6% saw information, 2% used information
- **Doctors**: 6% saw information, 3% used information

Majority Report Difficulty Finding Cost Information
*Consumer Assessment of Difficulty Locating Pricing Information for Doctors and Hospitals*

- 
  - Very Difficult: 29%
  - Somewhat Difficult: 35%
  - Somewhat Easy: 23%
  - Very Easy: 10%
  - Don’t Know: 2%
Transparency Goes Mainstream

Tools Increasing in Accessibility, Sophistication

**Surprise Release Makes Pricing Information Available to General Public**

- Cost estimates are averages based on historical BCBSNC claims data.

- Estimates vary based on plan network design (broad vs. narrow).

**Payers Pooling Pricing Information to Create More Accurate Datasets**

**Case in Brief: BCBS North Carolina**

- Not-for-profit health insurance company based in Chapel Hill, North Carolina.
- In January 2015, released new pricing transparency tool to general public.

**Case in Brief: Guroo**

- Price transparency tool powered by the Health Care Cost Institute.
- Aggregates three billion insurance claims from over 40 million Americans.

Facing a Dizzying Array of Cost Control Efforts

Source: Health Care Advisory Board interviews and analysis.
Purchasers Pulling Four Distinct Cost-Saving Levers

Goal is Clear, but Methods Vary

Primary Focus of Public Payers

1. Care Management
   - High-risk care management
   - Disease management
   - Wellness/prevention

Primary Focus of Commercial Payers, Employers

2. Network Optimization
   - ACO networks
   - Discount networks
   - High-performance networks

3. Referral Management
   - At-risk primary care physicians
   - Second opinion services/COEs
   - Personal health navigator programs

4. Individual Accountability
   - HDHPs
   - Value-based insurance design
   - Reference-based pricing
   - Price transparency

Network Value: Delivering Through Integration
Approach to Value
Episodic Value: Maximizing Per-Unit Efficiency

Source: Health Care Advisory Board interviews and analysis.
Market Coalescing Around Two Broad Approaches

Purchasers Pulling Us in Two (Potentially Opposite) Directions

1. Incentivizing greater integration
   - Provider network held accountable for total cost of care
   - Care coordination put in hands of delivery system
   - Network may be formally narrowed around delivery system at the point of network assembly

2. Unbundling the health system
   - Consumers held accountable for financial implications of care decisions
   - Care coordination outsourced to a third party
   - Purchasers refer to high-performing physicians, rather than high-performing systems

Source: Health Care Advisory Board interviews and analysis.
Innovators Often Outclassing Incumbents

Health Systems Must Fight Back, But Also Play to Strengths

<table>
<thead>
<tr>
<th>Disruptor Strengths</th>
<th>Health System Strengths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low cost</td>
<td>Comprehensive clinical services</td>
</tr>
<tr>
<td>Transparent pricing</td>
<td>Care coordination</td>
</tr>
<tr>
<td>Convenient access</td>
<td>Provider network</td>
</tr>
<tr>
<td>Easy to schedule</td>
<td></td>
</tr>
<tr>
<td>Responsive customer service</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
"Systemness" Key to Proving Integration’s Value

Systemness Confers Distinct, Compounding Advantages

Operational Advantage
- Centralized business functions
- Supply chain efficiencies
- Scalable process efficiencies

Product Advantage
- Clinical standardization
- Solution-oriented product portfolio

Structural Advantage
- Footprint rationalization
- Optimal capital allocation

Transformational Advantage
- Transition to population health identity

Can we recognize and pursue obviously beneficial economies of scale?

Can we agree to work together toward difficult but common objectives?

Can we take actions that benefit the system as a whole even when they may be unattractive to some of its parts?

Can we commit to change that is disruptive to all parts when that change is necessary for long-term success?

Degree of “Systemness”

Source: Health Care Advisory Board interviews and analysis.
Our Leadership Challenge

Delivering on the Promise of Systemness

Core Competencies of a True System

Cost Efficiency
- Scale-enabled lean cost structure
- Rationalized footprint
- Rightsized services portfolio

Integration
- Interconnected care infrastructure that enables patient flow
- Single IT infrastructure with seamless transfer of information

Trend Control
- Care managers, navigators have system-wide perspective
- Cross-continuum assets are leveraged to send patient to appropriate care site

Standardization
- Uniform care processes to produce consistent clinical outcomes
- Ability to communicate best practices across a system

Source: Health Care Advisory Board interviews and analysis.
Patients the Greatest Beneficiaries of True Systemness

<table>
<thead>
<tr>
<th>System Competency</th>
<th>Patient Benefit</th>
<th>System Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost Efficiency</td>
<td>Affordability</td>
<td>Consumer Loyalty</td>
</tr>
<tr>
<td></td>
<td>Cost efficiency may be translated into market-facing unit price advantages</td>
<td></td>
</tr>
<tr>
<td>Trend Control</td>
<td>Quality</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reflective of an ability to effectively manage utilization</td>
<td></td>
</tr>
<tr>
<td>Integration</td>
<td>Coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interconnectivity creates seamless, stress-free experience</td>
<td></td>
</tr>
<tr>
<td>Standardization</td>
<td>Predictability</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Standardized outcomes, with a consistent experience, at a predictable price point</td>
<td></td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
Questions Guiding Future Strategy

1. How do we adapt our growth strategy to respond to diverging approaches within the marketplace? Which strategies that serve us well under the government’s push toward risk will also help us defend our value proposition in the commercial marketplace?

2. What is the true, unique advantage of a health system? Where are our biggest opportunities to use our scale and assets to deliver tangible value to purchasers?

3. How prepared are we to pursue those opportunities and where are we falling short today? Do we have the right leadership and governance structures in place to enable meaningful change?

4. How do we transition from a service-centric organization to a consumer-centric organization? What opportunities do we have to “productize” system value and sell directly to the end consumer?

5. How do we use our advantages not just to gain preference but to reinforce productive consumer behavior and engage our patients as true partners—encouraging financial responsibility, health-conscious behavior, and, ultimately, system loyalty?
Health Care 2020
Population Health, Consumerism, and the Future of Health Care Delivery

David L. Katz, MD, JD
Principal and Executive Director
The Advisory Board Company
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