The Future of the Healthcare Marketplace: Playing the New Game

Ian Morrison PhD

www.ianmorrison.com

Twitter @seccurve
Outline

• Key Healthcare Issues
• Private Purchaser
• Public Purchaser/ACA
• Delivery System Transformation
• Implications for Retirees
Key Issues: ACA and Coverage Expansion

• **ACA** is the “the Law of the Land”...now we have to implement it, OMG!

• **Two Americas**

• **Public Exchanges** got off to a very **rocky** start

• **Private Exchanges** gaining momentum

• Exchanges both public and private shift the market toward **retail**
Key Issues: Health Systems

• Accountable Care is a megatrend, but maybe not ACOs
• Medicare Advantage may be the end game
• Pressure on costs and and delivering value intensifies
• Hospital “prices” under intense scrutiny by press and purchasers
• “Learning to live on Medicare” means taking out 10-20% of costs (more for academic institutions) and Medicare reimbursement rates will keep getting pressurized
• From Volume to Value means high cost procedure oriented specialties (cardiovascular, ortho, neuro, oncology) move from key assets to liabilities in a capitated environment, how long, how much is extremely uncertain
• Focus on Primary Care
Key Issues: Health Systems

• The **Massive Consolidation continues toward 100-200 Large Regional Systems**
  – Doctors running to hospitals
  – Hospitals consolidating regionally
  – Role of private equity and for profits in consolidation
  – Focus on “Essentiality” may run into Attorney Generals and Anti-Trust concerns
  – The rich get richer: significant returns to scale and to integration
  – Doctors discretion in selection of specific technologies and clinical protocols will be increasingly constrained by large motivated health systems that employ them

• **Purchasers are extremely unhappy** and are using consumer incentive tools, Skinny Networks and Spot Market trends as counter forces e.g. CalPers reference pricing

• **Care coordination** of transitions will be at a premium

• From fill the hospital to empty the hospital, it is going to be economically and **culturally challenging**

• Will **doctors and consumers** go along with all this?

• No matter what we **must redesign the delivery system**: and it needs to be science-based, technology-enabled and consumer friendly
OBAMA CARE: THE ORIGINAL SIMPLE VERSION

- Coverage Expansion to 30 million people by 2015 on
  - 15 million through Medicaid Expansion
  - 15 million through subsidized health insurance exchanges
- Regulation of health insurance practices
  - Guaranteed issuance
  - Individual Mandate
- Paid for by supplementary Medicare Tax on $250K+ earners and “voluntary” taxes on healthcare stakeholders
- Promising pilots and processes for reimbursement reform
  - Patient Centered Medical Homes
  - Accountable Care Organizations
  - Innovation Center at CMS
NOTES: *AR and IA have approved waivers for Medicaid expansion; MI has an approved waiver for expansion and plans to implement in Apr. 2014. NH passed legislation approving the Medicaid expansion in March 2014; the expansion will start July 1, 2014. WI amended its Medicaid state plan and existing waiver to cover adults up to 100% FPL, but did not adopt the expansion. IN and PA have pending waivers for alternative Medicaid expansions. These states along with MO, VA, UT have been classified as Open Debate on the Medicaid expansion decision.

The Not-So-United States Of Obamacare

Polls show the Affordable Care Act is covering previously uninsured people across the country. But the effect varies widely from state to state. According to a new Gallup survey, states that embraced Obamacare have seen bigger decreases in their uninsured rates than those that resisted the law.

Change in uninsured, 2013 to midyear 2014 (percentage points)

Source: Gallup
TWO COMPETING VISIONS

Berwickian Nirvana of large Accountable Care Organizations encourages rationalization of the delivery system

Atomistic view of consumers armed only with High Deductible health plans will impose market discipline on providers

PRIVATE PURCHASERS WILL ACT BY 2020

• Short Term (1-3 years)
  • Transparency on Cost and Quality
  • CDHP/HDHP
  • Benefit Buy Downs (including retirees and spouses)
  • Reference Pricing
  • Private Exchanges
  • Narrow Networks
  • Out of Network Prices

• Longer Term (3-10 Years)
  • Stay or Go
  • Defined Benefit to Defined Contribution
  • Activist Engagement
  • Cadillac Tax 2018
THE DEATH OF THE CHARGEMASTER

- The Brill Effect
- CDHP focuses the mind on price as much as use
- Reference pricing terrifies providers
- All payer transparency is coming soon at a theater near you from policy wonks, purchasers and toolmakers such as Castlight
CONSUMERS ARE WILLING TO MAKE TRADE OFFS: LOWER PREMIUMS FOR RESTRICTED CHOICE

Relative Importance of Benefit

- Low monthly premiums
- Keeping my current doctor(s)
- Unrestricted access to all medical technologies (e.g. MRI or CT scans)
- Direct access to leading specialist(s) in my area
- Low co-pay costs for generic drugs
- Direct access to all specialists
- Coverage for dependents
- Unrestricted access to cutting edge medical devices and procedures
- Reasonable co-pays for brand name drugs
- Unrestricted access to cutting edge drugs including cancer/specialty
- Access to all brand name drugs at low cost-sharing levels
- Choice of hospitals
- Coverage for a wide selection of brand name drugs
- Access to prestigious institutions

Average Importance = 100

Respondents were given a maximum difference trade off exercise in which they were forced to choose the most preferred and least preferred plan feature.

Base: All US Adults Less Than 65 (n=1983); All US Adults Older Than 65 (n=518)
SOURCE: Strategic Health Perspectives 2013 Consumer Survey
PRIVATE PURCHASERS REASSESSING THEIR ROLE

- **Redefinition of benefits**: Buy-downs (CDHP) and elimination or scaling back of commitment to spouses, dependents, retirees and early retirees, part timers etc
- **Consideration of the role of Exchanges and possible ‘exit’ from employer-sponsored benefits**
- **Growing interest in direct contracting** with providers and ‘accountable’ systems
- **Pushing greater responsibility onto employees to encourage them to shop based on cost, quality** (movement toward defined contribution strategy, more limited plan offering, consumer shopping tools).
- **More activist wellness** including biometric screening

Source: Personal Communication, PBGH, 2013
Cumulative Increases in Health Insurance Premiums, Workers’ Contributions to Premiums, Inflation, and Workers’ Earnings, 1999-2014

Average Annual Premiums for Single and Family Coverage, 1999-2014

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of $2,000 or More for Single Coverage, By Firm Size, 2006-2014

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Note: These estimates include workers enrolled in HDHP/SO and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

SIGNS OF AN EXIT?

More Employers are actively exploring ways to avoid providing health insurance to their employees

Employer Agreement with Key Benefit Sentiments

My company is actively exploring ways to get out of providing health insurance to our employees

My company feels it is worth it to pay the penalty associated with not providing employee health benefits rather than providing health benefits to our employees.*

Base: All Employer Health Benefit Decision Makers (n=313) * Asked only of Employers with 50 or more employees
Q800: Please indicate your level of agreement with the following statements. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree?
EMPLOYERS LIKELY TO MOVE AWAY FROM DEFINED BENEFITS

Retirees more likely candidates, but Active employees not far behind

Employer Likelihood to Move from Defined Benefit to Defined Contribution (Extremely/Very Likely)

For Active Employees
- 2013 (A): 41%
- 2012 (B): 32%
- 2011 (C): 7%

For Retired Employees
- 2013 (A): 47%
- 2012 (B): 42%
- 2011 (C): 10%

Sig increase over prior year

Base: All Employers who currently offer a defined benefit plan to active or retired employees (n=244 active; n=168 retired)
Q1055: How likely are you to move from defined benefit plans to defined contribution plans for each of the following?
CONFIDENCE IN HEALTH INSURANCE EXCHANGES GROWS AMONG EMPLOYERS

Over a third currently express a high level of confidence in public and private exchanges as viable alternatives to employer-sponsored coverage.

Employer Confidence in Public/Private HIXs as a Viable Alternative

<table>
<thead>
<tr>
<th></th>
<th>2012 (B)</th>
<th>2013 (A)</th>
<th>2012 (B)</th>
<th>2013 (A)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Exchange</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
<td>9%</td>
<td>7%</td>
<td>16% A</td>
<td>11%</td>
</tr>
<tr>
<td>Not at all conf</td>
<td>5%</td>
<td>11%</td>
<td>26%</td>
<td>27%</td>
</tr>
<tr>
<td>Not very conf</td>
<td>21%</td>
<td>27%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Somewhat conf</td>
<td>18%</td>
<td></td>
<td>6%</td>
<td>22%</td>
</tr>
<tr>
<td>Very conf</td>
<td>12%</td>
<td>11%</td>
<td>37%</td>
<td>37%</td>
</tr>
<tr>
<td>Extremely conf</td>
<td>9%</td>
<td>6%</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Private Exchange</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not sure</td>
<td>6%</td>
<td>9%</td>
<td>11%</td>
<td>8%</td>
</tr>
<tr>
<td>Not at all conf</td>
<td>9%</td>
<td>16%</td>
<td></td>
<td>7%</td>
</tr>
<tr>
<td>Not very conf</td>
<td>22%</td>
<td>18%</td>
<td>37%</td>
<td>35%</td>
</tr>
<tr>
<td>Somewhat conf</td>
<td>26%</td>
<td></td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>Very conf</td>
<td>37%</td>
<td>35%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Extremely conf</td>
<td>12%</td>
<td>16%</td>
<td></td>
<td>7%</td>
</tr>
</tbody>
</table>

Base: All Employer Health Benefit Decision Makers (n=303)

Q1400: How confident are you that public Health Insurance Exchanges will ultimately be a viable alternative to employer-sponsored healthcare coverage?
Q1405: And how confident are you that private Health Insurance Exchanges will ultimately be a viable alternative to employer-sponsored healthcare coverage?
SEVEN LARGE EMPLOYER ARCHETYPES

How do these archetypes view their benefit responsibilities?

**GE:**
- Large Diversified company with unions and high wage base.
- Very sophisticated Purchaser using consumerism and DB to DC for retirees to reduce benefit burden.
- Spread across a dozen or more regional markets

**Disney:**
- Bifurcated workforce: Theme Park workers and Johnny Depp
- Geographic Concentration in Orange County California and Orange County Florida
- Consumerism strategy and engagement with local delivery systems

**Wal-Mart:**
- National retailer with 2 million plus associates
- Centers of Excellence Model for high cost cases

**Walgreen’s:**
- Large pharmacy/retail chain of
- Private Exchange model outsourced to AON/Hewitt
- 142,000 signed up
- Insured product model
- Choice causes buy-down
- 80% picked silver or bronze

**Intel:**
- Geographic concentration of fabrication plants and facilities: OR, NM, and CA
- Healthcare treated just like any supplier: tough performance requirements
- Going direct e.g. Presbyterian in New Mexico, onsite clinics

**Silicon Valley Employer Network:**
- War for talent
- Average age 12
- Want the primary care on campus and telehealth for everything else

**CALPERS:**
- Large public purchaser system
- Unionized workers
- Pioneered reference pricing as shot across the bow of providers
- In the retiree health benefits business big time
- Wants high performing HMO product
# CalPERS 2015 Health Premiums - Regional Contracting Agencies Only - HMOs' Only

## Basic Premium Rates - Bay Area

Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, and Yuba

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Anthem HMO Select</td>
<td>$657.33</td>
<td>$1,314.66</td>
<td>$1,709.06</td>
<td>$662.41</td>
<td>$1,324.82</td>
<td>$1,722.27</td>
<td>0.77%</td>
</tr>
<tr>
<td>Anthem HMO Traditional</td>
<td>728.41</td>
<td>1,456.82</td>
<td>1,893.87</td>
<td>827.57</td>
<td>1,655.14</td>
<td>2,151.68</td>
<td>13.61%</td>
</tr>
<tr>
<td>Blue Shield Access+</td>
<td>836.59</td>
<td>1,673.18</td>
<td>2,175.13</td>
<td>928.87</td>
<td>1,857.74</td>
<td>2,415.06</td>
<td>11.03%</td>
</tr>
<tr>
<td>Blue Shield NetValue</td>
<td>704.01</td>
<td>1,408.02</td>
<td>1,830.43</td>
<td>870.60</td>
<td>1,741.20</td>
<td>2,263.56</td>
<td>23.66%</td>
</tr>
<tr>
<td>Kaiser CA</td>
<td>742.72</td>
<td>1,485.44</td>
<td>1,931.07</td>
<td>714.45</td>
<td>1,428.90</td>
<td>1,857.57</td>
<td>-3.81%</td>
</tr>
<tr>
<td>UnitedHealthcare</td>
<td>764.24</td>
<td>1,528.48</td>
<td>1,987.02</td>
<td>850.67</td>
<td>1,701.34</td>
<td>2,211.74</td>
<td>11.31%</td>
</tr>
</tbody>
</table>

Source: CalPERS, 2014
KEY EMPLOYER ISSUES TO WATCH

What happens to rates for 2015 in individual and small group market? Who wants to be an actuary in this environment?

What will small business do? Do we even need the SHOP exchange?

Pushback on Narrow Networks from public and providers e.g. Children’s hospitals

What will large employers do short medium and long term?

Are providers selling what purchasers are buying?

• “Not Paying the Cadillac Tax”
• Exit through Public or Private Exchanges
• Digging in and fighting: reference pricing, consumerism, wellness, transparency and Centers of Excellence, and going direct with providers

Low back pain, headache, diabetes, maternity and early cancers …not complex care management for the multiply co-morbid elderly
Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers, Percentage of Firms Offering Retiree Health Benefits, 1988-2014

NOTE: Tests found no statistical difference from estimate for the previous year shown (p<.05). No statistical tests are conducted for years prior to 1999.

Among All Large Firms (200 or More Workers) Offering Health Benefits to Active Workers and Retirees, Percentage of Firms Considering Changing the way they Offer Retiree Coverage Because of Healthcare Exchanges, by Firm Size, 2014

- All Large Firms: 72% No, Not Considering Changing, 25% Yes, Considering Changing, 3% Don't Know
- 200-999 Workers: 79% No, Not Considering Changing, 20% Yes, Considering Changing, 1% Don't Know
- 1,000-4,999 Workers: 60% No, Not Considering Changing, 34% Yes, Considering Changing, 6% Don't Know
- 5,000 or More Workers: 48% No, Not Considering Changing, 49% Yes, Considering Changing, 3% Don't Know

RICH AMERICANS: NOT FOR THE MIDDLE CLASS
While mean net worth of Americans is high, median is lower than many countries

<table>
<thead>
<tr>
<th>average net worth</th>
<th>median net worth</th>
</tr>
</thead>
<tbody>
<tr>
<td>$301K</td>
<td>$45K</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Switzerland 1</th>
<th>Australia 2</th>
<th>France 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Norway 4</td>
<td>Italy 5</td>
<td>United Kingdom 6</td>
</tr>
<tr>
<td>Sweden 7</td>
<td>Japan 8</td>
<td>Switzerland 9</td>
</tr>
<tr>
<td>France 10</td>
<td>Finland 11</td>
<td>Singapore 12</td>
</tr>
<tr>
<td>Singapore 13</td>
<td>Norway 14</td>
<td>Canada 15</td>
</tr>
<tr>
<td>Denmark 16</td>
<td>Singapore 17</td>
<td>Canada 18</td>
</tr>
<tr>
<td>Canada 19</td>
<td>Malaysia 20</td>
<td>United Kingdom 21</td>
</tr>
</tbody>
</table>

Source: Credite Suisse, Federal Reserve Survey of Consumer Finances

Real Median Net Worth, 1989-2013

Source: Credite Suisse Global Health Database
FIDELITY ESTIMATES A COUPLE NEEDS $220,000 ON RETIREMENT FOR LIFE TIME OUT OF POCKET MEDICAL EXPENSES

After eight years of consistent increases, the estimate peaks in 2010.

The first drop comes because Congress closed a gap in prescription drug coverage, saving retirees thousands of dollars over the course of their retirement.

The estimate increases modestly over 2011.

The second drop reflects multiple factors, including lower utilization of health care services caused by a slower economy.

Estimate remains steady, due in part to lower-than-expected Medicare expenses and continued savings on prescription drugs.

Source: Fidelity Benefits Consulting, 2014. The estimate is based on a hypothetical couple retiring at age 65 or older, with average (82 male, 85 female) life expectancies. Estimates are calculated for "average" retirees but may be more or less depending on actual health status, area of residence, and longevity. The estimate assumes that individuals do not have employer-provided retiree health care coverage but do qualify for Medicare. The calculation takes into account cost-sharing provisions (such as deductibles and coinsurance) associated with Medicare Part A and Part B (inpatient and outpatient medical insurance). It also considers Medicare Part D (prescription drug coverage) premiums and out-of-pocket costs, as well as certain services excluded by Medicare. The estimate does not include other health-related expenses, such as over-the-counter medications, most dental services, and long-term care.
BOOMERS ARE NOT PREPARED: THEY EXPECT TO HAVE $25K-75K EXPENSES

Boomers are more optimistic that they will have between 25k and 75k for out-of-pocket medical expenses.

Boomers’ Expected Out-of-Pocket Costs for Medical Expenses (from Ages 65-80)

Prepared for: Strategic Health Perspectives
Source: Q1305 From the ages of 65 to 80, how much money in total do you expect to need to pay out-of-pocket for medical expenses?

Mean:
2010 – $39,061
2012 – $39,888
2013 – $40,038
2014 – $44,440
BOOMERS NOT AWARE

Since peak uncertainty in 2012, current boomers don’t expect their retirement savings to be wiped away with medical expenses

Boomers’ Expected % of Retirement Saving Spent on Medical Expenses

<table>
<thead>
<tr>
<th>Year</th>
<th>0%</th>
<th>1% - 10%</th>
<th>11% - 24%</th>
<th>25% - 49%</th>
<th>50% - 74%</th>
<th>75% - 99%</th>
<th>100%</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>9%</td>
<td></td>
<td>11%</td>
<td>10%</td>
<td>10%</td>
<td>10%</td>
<td>8%</td>
<td>9%</td>
</tr>
<tr>
<td>2012</td>
<td></td>
<td>23%</td>
<td>27%</td>
<td>29%</td>
<td>29%</td>
<td>19%</td>
<td>11%</td>
<td>17%</td>
</tr>
<tr>
<td>2013</td>
<td></td>
<td></td>
<td>27%</td>
<td>24%</td>
<td>21%</td>
<td>20%</td>
<td>18%</td>
<td>16%</td>
</tr>
<tr>
<td>2014</td>
<td></td>
<td></td>
<td></td>
<td>12%</td>
<td>11%</td>
<td>10%</td>
<td>18%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Mean:
- 2010 – 18%
- 2012 – 16%
- 2013 – 16%
- 2014 – 17%

Prepared for: Strategic Health Perspectives
Source: Q1310 What percentage of your retirement savings do you expect to be devoted to out-of-pocket medical expenses?
MORE CONSUMERS EXPECT MEDICAID IN RETIREMENT

Consumers have less faith in retiree healthcare benefits as a source of healthcare coverage during retirement and more are looking to Medicaid

Expected Source of Healthcare Coverage during Retirement (for Boomers)

- Retiree healthcare benefits
- Medicaid
- Medicare
- Long-term care insurance
- Not sure
- I don't expect to have healthcare coverage

Prepared for: Strategic Health Perspectives
Source: Q1300 When you are retired, what source do you expect most of your healthcare coverage to come from?
Public Exchange Launch

Think Wright Brothers....

Not Indianapolis 500
Obamacare Enrollment Update 7/1/14

- Total exchange enrollment: 8.0 million
- 90% are eligible for financial assistance
- 85% pick Silver (65%) or Bronze (20%)
- 80-90% have paid their premium
- Some number were previously insured (McKinsey survey found only 27% were previously uninsured, KFF survey found 57% were previously uninsured)
- 28% of enrollees are 18-34
- Up to 14 million eligible for Medicaid expansion
- 6.7 million determined eligible for Medicaid expansion by exchanges and enrollment remains open
- By February 9 California has exceeded enrollment projection for open enrollment period
- Blumenthal and Collins in NEJM 7/2 estimate 20 million newly covered

Source: DHHS, Covered California 2014, NEJM 7/12/14
More Than Three of Five Adults Who Selected a Private Plan or Enrolled in Medicaid Were Uninsured Prior to Gaining Coverage

What type of health insurance did you have prior to getting your new coverage?

**Adults ages 19–64 who selected a private plan or enrolled in Medicaid through marketplace or have had Medicaid for less than 1 year**

*New enrollees include those who signed up for private coverage through the marketplace, those who signed up for Medicaid through the marketplace, those who signed up for coverage through the marketplace but are not sure if it is Medicaid or private coverage, and those who have been enrolled in Medicaid for less than 1 year.** This includes some individuals who enrolled in Medicaid outside of the marketplace, but have been covered by Medicaid for less than 1 year. Source: The Commonwealth Fund Affordable Care Act Tracking Survey, April–June 2014.
How to Pick a Health Plan on an Exchange

• Step 1. Decide on the diseases you and your family are going to have in the coming year
• Step 2. Find the best doctors and hospitals for those diseases
• Step 3. Identify which plans offer those doctors and hospitals
• Step 4. Select the cheapest plan
• Step 5. If there are no affordable plans with all the doctors and hospitals you want, go back to Step 1 and pick some new diseases
Shock and Awe

• Sticker Shock
• Healthcare.Gov Shock
• Cancellation Shock
  – Individual Fall 2013
  – Small Group Fall 2014
• New Coverage Shock: Drugs, Doctors then Hospitals
• Network Shock to Patients and Providers
• Cost-Sharing and Out of Network Shock
• Bad-Debt Shock: Outpatient not Inpatient, Doctors not Hospitals
Volume to Value Transition

Clarity Of Vision,
Challenge Of
Pace Of Change
And Execution

Slow
Inexorable
Growth Of
Value Based
Purchasing

Accelerators:
* Big payer move to value purchasing
* Medicare payment reform
* Health systems taking risk
* ACO Movement

Volume to Value Transition Continues
Ahead of the Curve on Value-Based Payment

- “The future is already here...it is just not evenly distributed”
  – William Gibson

- California has 41.8% value based payment
- Massachusetts has approximately 40%
- US has 10.9% according to CPR

Source: Catalyst for Payment Reform, 2013
Larger hospitals anticipate faster move to capitation

Anticipated Growth in Capitation/Value

**Completely Fee for Service**

- **Total:** (0)
- **<100 Beds**
  - TODAY: 16
  - IN 5 YRS: 16 (△0)
- **100-299 Beds**
  - TODAY: 34
  - IN 5 YRS: 55 (△21)
- **300-499 Beds**
  - TODAY: 37
  - IN 5 YRS: 52 (△15)
- **>500 Beds**
  - TODAY: 41
  - IN 5 YRS: 59 (△18)

**Evenly Split**

- TODAY: 35 (△2%)
- IN 5 YRS: 53 (△7%)

**Completely Capitated Payments**

- (100)

*Base: All Hospital-Based Execs (2014: n=202; 2013 n=210)*

Q705/Q706/Q707: Many hospitals are starting to be paid differently for their services, moving from a fee for service environment to more capitation or value based payments. Where is your hospital/hospital system on the spectrum today, and where will you be five years from now?
Physicians anticipate FFS will DECREASE

Anticipated Growth in Capitation/Value

<table>
<thead>
<tr>
<th></th>
<th>Current</th>
<th>Solo</th>
<th>Group, Affiliated</th>
<th>Group Unaffiliated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completely Fee for Service (0)</td>
<td>28</td>
<td>34</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>Evenly Split (50)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Completely Capitated Payments (100)</td>
<td>72</td>
<td>65</td>
<td>74</td>
<td></td>
</tr>
</tbody>
</table>

*New in 2014

Base: All 2014 Physicians (n=600)

Q1280: Many physician practices are starting to be paid differently for their services, moving from a fee for service to more capitation or value based payments. Where is your practice on the spectrum today, and where will you be in five years from now?
### Health Systems Taking Risk

<table>
<thead>
<tr>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lots of big systems showing interest patient flow through these models is not large except for legacy players.</td>
</tr>
<tr>
<td>Referral management (preventing leakage from the IDN) can provide FFS fuel for transformation to risk.</td>
</tr>
<tr>
<td>“Eat your own cooking” is a common starting point.</td>
</tr>
<tr>
<td>Link to ACO strategy.</td>
</tr>
<tr>
<td>Link to going direct to employers or exchanges e.g. North Shore Long Island Jewish.</td>
</tr>
<tr>
<td>Link to Population Health Interest.</td>
</tr>
</tbody>
</table>
Health Systems Taking Risk

• **Health Systems with Legacy Health Plans**
  – Inter-Mountain, Sharp, Presbyterian, Spectrum Health, Providence

• **Health Systems that recently built, acquired or merged with a Health Plan function**
  – Partners (Boston), Sutter, Dignity Health (Western Healthcare Advantage), Memorial (Long Beach), Baylor Scott and White, North Shore Long Island Jewish, Ascension (in discussions), CHI

• **Health Systems that are going deep on Commercial ACO plans and CMS ACOs with plan partners**
  – Montefiore, Steward, Aetna Whole Health (Inova, Banner, Aurora)

• **Health Systems “Go Your Own Way”**
  – Evolent Health (UPMC and Advisory Board Offering) includes Piedmont/Wellstar, Medstar
At the end of the day, people trust hospitals

% Trust in Industries

- Supermarkets: 2003: 30, 2013: 34
- Hospitals: 2003: 40, 2013: 34
- Online Search Engines: 2003: 18, 2013: 28
- Computer Hardware Companies: 2003: 18, 2013: 27
- Online Retailers: 2003: 22, 2013: 17
- Electric and Gas Utilities: 2003: 15, 2013: 14
- Life Insurance Companies: 2003: 11, 2013: 10
- Pharmaceutical and Drug Companies: 2003: 10, 2013: 13
- Health Insurance Companies: 2003: 10, 2013: 7
- Managed Care Companies, such as HMOs: 2003: 4, 2013: 6
- Social Media Companies: 2003: 4, 2013: 6
- Oil Companies: 2003: 4, 2013: 3
- Tobacco Companies: 2003: 3

Source: Harris Poll, December 2013
Key Takeaways: System

• Change is not going to stop
• Value matters
• Wright Brothers for ACA
• Regional variation
• Regional basis for competition
• Three segments:
  – Medicare Advantage/Commercial ACO
  – Managed Medicaid
  – HDHP/CDHP (including exchanges)
• Opportunities to take risk for providers
• Clinical Redesign can improve quality and value
  – Focus on heavy users and meet them in their lives
  – Measure and manage the key levers of performance for system transformation toward population health
Key Takeaways: Implications for Retirees

• Retiree Health Benefits are going away in corporate sector and moving to an exchange solution
• Public retirees may follow e.g. Ohio PERS moves 145,000 retirees to private exchange in 2016
• Core issue is affordability of the healthcare delivery system
• Some hope of slowing but no prospect of actual reduction
• So save, save, save and never retire