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

Hancock, Daniel, Johnson, & Nagle PC
July 12, 2017
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Health Care Reform Beyond the ACA
The Next Generation of Medicare Risk, High Deductibles, and Physician Integration

Ken Leonczyk, Jr. – Senior Director
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A New Turning Point for Health Care Reform
Reflecting on the First Era of Health Care Reform
Adapting Provider Strategy to New Market Realities
Congratulations, Mr. President

Trump Wins in Stunning Upset

Congress and Executive Branch Now in Republican Control

Congressional Victories

52/100 Senate Republicans

241/435 House Republicans

Health Care Tops the Day One Agenda

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

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

Executive Order

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

Executive Order Does:

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

Executive Order Does Not:

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

Source: Health Care Advisory Board interviews and analysis.

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

Key Considerations of Each Approach

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

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

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

An Ambitious Three-Part Agenda

GOP Outlines Three Phases to Health Care Reform

A Three-Pronged Approach to Repeal and Replace the ACA

1. Budget Reconciliation
   - Process: Requires simple majority in House and Senate
   - Proposed Target Areas:
     - 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

2. Administrative Action
   - Process: Federal agencies issue regulation through rulemaking
   - Proposed Target Areas:
     - 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)

3. Additional Legislation
   - Process: Requires simple majority in House, super-majority in Senate
   - Proposed Target Areas:
     - 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

House Passes the American Health Care Act

Reconciliation Bill Would Drastically Cut Spending, Reduce Coverage

Legislation in Brief: American Health Care Act

- Reconciliation bill proposed by House Republicans on March 6th that would repeal or modify many elements of the ACA, while leaving others intact.
- Following series of amendments, passed by the House on May 5th.
- Bill’s major goals are to:
  - Repeal ACA’s taxes
  - Reform the individual insurance market
  - Remake the Medicaid financing model

Bill Passes House with Razor-Thin Margin

Final House vote on AHCA; required 216 votes to pass

CBO’s Projected Impact of the AHCA

$150B Decrease in federal deficit
24M Increase in number of uninsured

Heavy Focus on Medicaid, Individual Markets

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 penalties for not maintaining continuous coverage
- In 2020, replaces subsidies with age-based tax credits

Reforms Medicaid Financing

- Freezes expansion, ends enhanced match after 2020
- Reverses DSH cuts\(^1\), provides funding for safety net providers
- Shifts Medicaid to block grant and/or per capita cap in 2020\(^2\)

MacArthur Amendment Boosts State Flexibility on Key Insurance Market Regulations

- Health Status Underwriting: States may allow insurers to charge more based on pre-existing conditions\(^3,4,5\)
- Age-Ratio Pricing Bands: States may create pricing bands with age-ratios greater or less than the AHCA’s 5:1
- Essential Health Benefits: States may define the categories and benefits insurers must provide

1) Congressional Budget Office projections as of March 13, 2017, does not include MacArthur and Upton amendments.
2) Block grant option only available for traditional adult and children populations.
3) Only permitted for individuals who fail to maintain continuous coverage.
4) Contingent on state demonstration of plan to provide additional financial assistance for high-risk individuals.
5) Includes funding to help states support high-risk individuals: $1.7B annually from 2018-2026 plus any unappropriated dollars from Patient and State Stability Fund. Upton amendment provides additional $8B.


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A More Limited Scope Than Previous Proposals

Notable Components of Past Proposals Left Out of Current Bill

Noteworthy Absences from AHCA
Proposed Bill Does Not Target:

- **Insurance Market Protections**
  - Dependent eligibility until 26

- **Payment Reform**
  - Center for Medicare & Medicaid Innovation (i.e., no impact on funding)

- **Medicare**
  - Medicare payment (i.e., no repeal of ACA payment cuts)
  - Medicare coverage (i.e., no shift to premium support)

- **Employer Health Benefits**
  - Tax exclusions for employer-sponsored insurance

- **Drug Spending**
  - Medicare Part D (i.e., no move to Medicare bidding system)
  - Restrictions on drug importation

Far From a Done Deal

Senate Likely to Make Significant Changes

Major Roadblocks Remain in Senate

 Ensuring Compliance with Reconciliation Rules
Senate parliamentarian must strike any AHCA provisions that she determines do not meet rules of budget reconciliation

Overcoming Thinner Voting Margin
GOP can only afford to lose 2 votes; potentially gives moderates greater influence and ability to dial back coverage losses

Awaiting Pending CBO Score
Senate must extend voting timeline until CBO scores final, amended bill

Senate Promises Longer Timeline, Signals Prospect for Significant Change

“There will be no artificial deadlines in the Senate. We’ll move with a sense of urgency but we won’t stop until we think we have it right”

*Sen. Lamar Alexander (R-Tenn.)*

“Any bill that has been posted less than 24 hours, going to be debated three or four hours, not scored? Needs to be viewed with suspicion.”

*Sen. Lindsay Graham (R-S.C.)*

“The bill that passed out of the House is most likely not going to be the bill that is put in front of the president”

*Mick Mulvaney, Director, Office of Management and Budget*
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\(^1\)
- Reduce reinsurance payments
- Refuse to settle the risk corridor litigation
- Reduce enforcement of individual mandate\(^1\)
- Eliminate/reduce advertising

**Maintain**
- Continue to enforce and implement provisions of the ACA related to exchanges (e.g. cost-sharing payments)

**Fix**
- Limit special enrollment
- Establish continuous coverage requirement\(^3\)
- Relax actuarial requirements\(^3\)

**Already Underway**\(^2\):

**Other Potential Actions**:
- Expand age rating band\(^4\)
- Tweak essential health benefits requirements\(^4\)

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\(^1\) Would be eliminated by AHCA.
\(^2\) Through market stabilization rule finalized on April 13, 2017.
\(^3\) Would be enforced by AHCA.
\(^4\) Would be implemented by AHCA.


Source: Health Care Advisory Board interviews and analysis.
Medicaid to Remain a Top Priority

Waivers Will Allow Continued Innovation and Experimentation

State Flexibility Through Waivers Likely to Intensify Competing Medicaid Philosophies

<table>
<thead>
<tr>
<th>Coverage Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State-Run Entitlement</strong> <em>(Pre-ACA Status Quo)</em></td>
</tr>
<tr>
<td>Cover low-income/vulnerable as defined on state-by-state basis, so long as certain federal minimum standards are met</td>
</tr>
<tr>
<td><strong>Expansive Entitlement</strong> <em>(Democrats’ Vision)</em></td>
</tr>
<tr>
<td>Cover anyone not eligible for Medicare, covered by an employer, and unable to afford individual coverage</td>
</tr>
<tr>
<td><strong>Limited Safety Net</strong> <em>(Republicans’ Vision)</em></td>
</tr>
<tr>
<td>Cover truly low-income/vulnerable, provides temporary coverage for unemployed adults (e.g., contingent on work requirements)</td>
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<table>
<thead>
<tr>
<th>Cost Containment Model</th>
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<tbody>
<tr>
<td><strong>Payer-Led Managed Care</strong></td>
</tr>
<tr>
<td>Capitate payments to private managed care organizations</td>
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<tr>
<td><em>e.g., Florida State Medicaid Managed Care</em></td>
</tr>
<tr>
<td><strong>Provider-Led Care Management</strong></td>
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<tr>
<td>Incentivize provider to control utilization, coordinate care</td>
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<tr>
<td><em>e.g., Oregon’s CCOs</em></td>
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<tr>
<td><strong>Consumer-Driven Health Care</strong></td>
</tr>
<tr>
<td>Encourage consumers to be cost-conscious, prioritize high-value care</td>
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<tr>
<td><em>e.g., Indiana’s HIP 2.0</em></td>
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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.
Post-Acute Care: Four Primary Forces at Play

Providers Must Respond to Essential Challenges in Order to Succeed

1. Transitioning to Value-Based Payments
2. Operating in Narrowed Acute/Post-Acute Networks
3. Responding to the Rise in Patient Acuity
4. Navigating Third Party Vendors

A New Turning Point for Health Care Reform

Reflecting on the First Era of Health Care Reform

Adapting Provider Strategy to New Market Realities

Source: Post-Acute Care Collaborative interviews and analysis.
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
   - Medicare-led Payment Reform
     - FFS cuts
     - New payment models
     - Intent to catalyze broader commercial market change

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

3. Achieve Universal, Affordable Coverage
   - 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)

Policymakers’ Intention to Migrate Payment Perfectly Clear

“Productivity” Adjustments and Other Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>ACA IPPS¹ Update Adjustments</th>
<th>ACA DSH² Payment Cuts</th>
<th>MACRA³ IPPS Update Adjustments</th>
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<tbody>
<tr>
<td>2013</td>
<td>($4B)</td>
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<tr>
<td>2014</td>
<td>($14B)</td>
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<tr>
<td>2015</td>
<td>($24B)</td>
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<tr>
<td>2016</td>
<td>($29B)</td>
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<tr>
<td>2017</td>
<td>($38B)</td>
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<tr>
<td>2018</td>
<td>($54B)</td>
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<tr>
<td>2019</td>
<td>($67B)</td>
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<td>2020</td>
<td>($76B)</td>
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<tr>
<td>2021</td>
<td>($86B)</td>
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<tr>
<td>2022</td>
<td>($94B)</td>
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</tbody>
</table>

No Subtlety Here

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

CMS Officials

MACRA Rewriting the Rules of Risk

Bipartisan Support at Center of MACRA Rollout

Legislation in Brief: 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

1) Medicare Access and CHIP Reauthorization Act.
2) Disproportionate Share Hospital.

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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

Medicare Shared Savings a Slow Transition to Risk

Overwhelming Majority of ACO Participants Still in Shallow Water

Continuum of Medicare Risk Models

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%

428 Participants

Upside Risk Only

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

Available in 2018

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

45 Participants

Downside Risk

1) Minimum savings rate/minimum loss rate.

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ACO Program Expands Amidst Mixed Results

CMS Bullish Despite Lack of Net Program Savings

CMS Highlights
Positive Headlines

Total ACOs which earned savings grew by 4% from 2014 to 2015

Medicare saved $55M more in 2015 than 2014 for total savings of $466M

A Closer Look at ACO Program Generates Concern

Insufficient Savings
CMS owes $214M more in 2015 bonus payments than was generated in savings

Select Few Drive Savings
$458M out of 2015’s net MSSP savings attributable to just 10 ACOs

Benchmarking Suspect
Providers question accuracy of CMS’s benchmarking methodology

Experience Matters
Of ACOs that began in 2012, 42% generated savings above their MSR, 5% higher than those that started in 2013, 20% higher than those that began in 2014 or 2015

Unintended Consequence: Reinvigoration of MA

Medicare Advantage Growth Continues

Potential Advantages of MA over MSSP

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

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

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

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

MA Enrollment to Nearly Double by 2025

Total Enrollment and Percentage of Total Medicare Population

Provider Sponsorship of Medicare Advantage Plans, 2016

37% Of existing MA plans
58% Of new MA plans

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


1) Minimum savings rate.

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M&A on the Rise

Eroding Prices, Demands for Integration Driving Many to Seek Scale

Two Priorities of Transition to Value Drive Toward Consolidation

Erosion of FFS Foundation

- Cuts in provider reimbursement
- Transformational shift of incentive structures
- Reporting, infrastructure burdens

Push Toward Integration

- Physician alignment/care coordination
- IT/operational efficiency

Hospital and Physician Consolidation

Merger and Acquisition Activity

| 102 | Hospital M&A deals, 2015 |
| $8.7B | Value of hospital M&A transactions, 2015 |
| 94,000 | Increase in vertically-consolidated physicians, 2007-2013 |

Regulators Challenging Recent Consolidation

But FTC’s Assertiveness Under New Administration Uncertain

FTC Delivering on Earlier Threats

Recent Mergers Challenged

- Advocate and NorthShore
- Penn State Hershey and PinnacleHealth

Cited Concerns

- Higher prices
- Fewer incentives to boost quality, serve consumers

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Metrics and Transparency Drive Quality Approach

Emphasis on Collection, Reporting of Performance Data

Information-Focused Approach to Quality Improvement

Objective #2: Improve Health Care Quality

IT-Powered Delivery System
(Meaningful Use Mandates)

Rigorous Scorekeeping
(P4P Programs)

Public Transparency
(Hospital Compare, Physician Compare)

Laying the Groundwork for Performance Management

Today’s Focus on Connectivity; Quality Impact Still Over the Horizon

Over the past five years, we’ve more than doubled the adoption of electronic health records for physicians. So that means they can track what’s going on better and make fewer mistakes.”

President Obama, 2013

Current State

Stage I (2011-2014):
Data Capture, Sharing

- Basic EHR functionality
- Connect to public health
- Privacy and security protections

Stage II (2014-2017):
Advanced Clinical Processes

- Care coordination
- Patient engagement
- Data-driven quality improvement

Stage III (2018-Onward):
Improved Outcomes

- Data improves delivery, outcomes
- Enhanced access, care continuity
- Evidence-based medicine, team-based care/case management
- Patient-centered care coordination
- Engaged, self-managed patients
- Disease registries, population health management

Multiple Initiatives to Measure and Incent Quality

Rapid Proliferation of Metrics

**Hospital Readmissions Reduction Program**
- Reimbursement penalty based on excessive 30-day readmission rates
- 1%-3% hospital inpatient Medicare payments at risk

**Hospital Value-Based Purchasing Program**
- Pay-for-performance based on success against variety of value measures
- Only 792 hospitals out of 3,087 received bonuses in 2015

**Hospital-Acquired Conditions Program**
- Reimbursement penalty targeted hospitals with higher rates of HACs
- 25% of hospitals mandated to face penalty

Other CMS Programs

700+ Measures in the CMS Measures Inventory

Having a Measurable Impact on Quality

**CMS Estimates of ACA’s Impact on Quality 2010-2014**

- **2.1M** Fewer hospital-acquired conditions
- **$20B** Health care cost reductions
- **87K** Patient lives saved

"These results represent real people who did not die or suffer infections or harm in the hospital."

*Patrick Conway, MD*
*Chief Medical Officer, CMS*

**Hospital Readmissions HRRP\(^1\) and all-causes, 2010-2014**


\(^1\) Hospital Readmissions Reduction Program; focuses on heart attack, heart failure, pneumonia, COPD, and elective hip/knee replacement.
Creating Winners and Losers

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.

Public Transparency

Scant Efforts Toward Meaningful Transparency

Compare Websites Not Hitting the Mark

Establishment of Compare Websites

1998: Nursing Home Compare
2005: Home Health Compare
2005: Hospital Compare
2010: Physician Compare

Difficult to Use…

“Historically, the Compare websites have conveyed few conceptual clues to help orient lay users to the sites’ overall purpose and content.”

L&M Policy Research and Mathematica Policy Research

…And Little Used

Hospital, Physician Compare users

10M Annually

Healthgrades users

8.9M Monthly

Expanding Coverage by Reforming Existing System

Correcting for the Deficiencies of the Market

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

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

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

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

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

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**Public Exchange Enrollment Falling Short of Targets**

**Group Market Longevity Limiting New Growth**

**Exchange Enrollment 2014-2016**

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<thead>
<tr>
<th>Exchange Enrollment</th>
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<tbody>
<tr>
<td>End of 2014 OEP¹</td>
<td>8.0M</td>
</tr>
<tr>
<td>Dec. 2014²</td>
<td>6.3M</td>
</tr>
<tr>
<td>End of 2015 OEP</td>
<td>11.7M</td>
</tr>
<tr>
<td>Dec. 2015²</td>
<td>8.2M</td>
</tr>
<tr>
<td>End of 2016 OEP</td>
<td>12.7M</td>
</tr>
<tr>
<td>Final 2016 Enrollment</td>
<td>10.0M</td>
</tr>
<tr>
<td>CBO Projection for Final Enrollment</td>
<td>16.0M</td>
</tr>
</tbody>
</table>

**Smaller and Sicker Than Expected**

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

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Increasingly Unstable Public Exchanges?

Established Carriers Scaling Back, Co-ops Faltering

Some Insurers Reconsidering Participation

- **aetna**: 11 State exchanges Aetna is departing in 2017
- **HUMANA**: 8 State exchanges Humana is departing in 2017

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

*Stephen J. Hemsley*

CEO of UnitedHealth Group

Startup Ventures Largely Failing

Notable CO-OP failures:

- **70%** of CO-OPs closed as of Aug 2016

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

*Adrian Smith*

The Wall Street Journal

Difficulties Facing Exchange Plans

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


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><strong>Minimum</strong></td>
<td>66.4%</td>
<td>24.4%</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Average</strong></td>
<td>59.0%</td>
<td>29.9%</td>
<td>3.6%</td>
</tr>
<tr>
<td><strong>Maximum</strong></td>
<td>58.6%</td>
<td>30.2%</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

Subsidy Growth Tracks Premium Spikes

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

*Kaiser Health News*

Of exchange regions will have only one participating insurer in 2017

- **36%**

State exchanges with only one participating insurer

- **5**

**Coverage Expansion Impact Unmistakable**

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

**US Adult Uninsured Rate**

Major ACA coverage expansion provisions took effect January 1, 2014

Q3 2013: 18.0%


**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:**

Population-level Focus
- Total cost control
- Care management

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

**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

Source: 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 Coverage

By Plan Type, 2006-2015

Percentage of Covered Workers with Annual Deductible of $2,000 or More

By Firm Size, 2006-2015

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


Financial Exposure

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

Exchange Enrollment, by Metal Tier

2015

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

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

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


Radical Transparency

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

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

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

Sample Transparency Sites

Turning to Unlikely (and Uncomfortable) Sources

Crowdsourced Reviews Getting More Reliable

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

Jeremy Stoppelman, CEO
Yelp

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

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

Just What Consumers Are Looking For

Yelp Reviews Capture Surprisingly Detailed Picture of Consumer Experience

Topic Domains Addressed by Yelp, HCAHPS

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.
Online Marketplaces Flourishing

New Exchanges Enabling Consumers to Shop for Range of Services

Consumer-Oriented Marketplaces Span a Variety of Health Care Needs

**Honor**
- Connects home health professionals with seniors in need of care
- Funded by $20M in venture capital investment
- Reported 100% total growth in visits in 2015

**Amwell**
- Offers on-demand telemedicine via video or phone to serve needs including urgent care, therapy, and chronic care management

**ZendyHealth**
- Allows consumers to shop based on their own preferred price for bundled procedural episodes
- 80% of consumer proposed prices are accepted within two days

**MediBid**
- Brings patients options for high-end surgeries through an online marketplace in which they can bid for care
- Typically offers a 50% average discount over insurance-negotiated prices

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Non-Hospital Innovators

Innovations Crowding Onto the Field

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

**Inexpensive, rapid care at a ‘provider’ site**
- Walgreens
- CVS Health
- Wal-Mart

**Physician hailing**
- Pager.com
- Heal
- Dispatch Health
- MedZed (pediatric house calls)

**Remote diagnosis and link to clinicians**
- Opternative: iPhone eye exam, e-mail RX
- Google contact lens: glucose monitoring
- EpiWatch: predicts seizures
- MoleMapper: cancerous mole screening
- Iphone-directed walk tests, cognition, fine motor skill, tremor evaluations

**Patient apps for condition self-management**
- Iodine’s Start app: Tracks depression symptoms and drug efficacy
- OneDrop: diabetes tracker
- ACC’s Statin intolerance self-checker

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

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

Path Forward Not Dependent on Politics

No-Regrets Priorities for Next Era of Health Care Reform

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

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

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

Source: Health Care Advisory Board interviews and analysis.