What’s Ahead on the Trail? – The Economic Forecast for Independent Hospitals

State of the Union 2017
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What’s Ahead on the Trail? – The Economic Forecast for Independent Hospitals

State of the Union 2017

1. Unpacking the Political Process

2. The Next Era of Health Reform

3. Adapting Provider Strategy to New Market Realities
Health Care Squarely in the Hands of the GOP

Congress, Executive Branch, and Majority of States Now in Republican Control

33/50 Republican Governors
32/50 Republican-Led Legislatures
52/100 Senate Republicans
241/435 House Republicans

Majority of Americans Hold GOP Responsible for Health Care

64%

Individuals who believe “President Trump and Republicans in Congress are now in control of the government and they are responsible for any problems with the ACA going forward.”

An Ambitious Three Part Agenda

GOP Laid Out Three Phases to Health Care Reform

A Three-Staged Approach to Repeal and Replace the ACA

1) Budget Reconciliation
2) Administrative Action
3) Additional Legislation

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

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)

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
• Reform malpractice regulation
• Streamline FDA processes
• Expand flexibility of state use of federal dollars


1) Telephone survey of 1,171 adults age 18+ living in the US.

Easier Said Than Done

GOP Budget Reconciliation Bill Stalls

House, Senate Iterate on Repeal Strategy

<table>
<thead>
<tr>
<th>January 2017</th>
<th>June 22</th>
<th>July 27</th>
</tr>
</thead>
<tbody>
<tr>
<td>House, Senate vote to initiate budget reconciliation process</td>
<td>Senate introduces the Better Care Reconciliation Act (BCRA)</td>
<td>Senate introduces the Health Care Freedom Act (HCFA)</td>
</tr>
</tbody>
</table>

May 5
House passes AHCA with a final vote of 217-213

July 18
Senate introduces the Obamacare Repeal Reconciliation Act (ORRA)

July 27-28
Senate votes down BCRA, ORRA, and HCFA

Weighing Three Main Options

- **Repeal-and-Replace (AHCA/BCRA)**
- **Repeal-and-Delay (ORRA)**
- **“Skinny” Repeal (HCFA)**

Conservative Principles Driving Repeal Legislation

<table>
<thead>
<tr>
<th>Reconciliation Bills Target Individual Market, Medicaid, and Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium subsidies</td>
</tr>
<tr>
<td>Cost-sharing reduction payments</td>
</tr>
<tr>
<td>Guaranteed essential health benefits</td>
</tr>
<tr>
<td>Health status underwriting</td>
</tr>
<tr>
<td>Individual mandate penalties</td>
</tr>
<tr>
<td>Medicaid expansion enhanced match</td>
</tr>
<tr>
<td>Per-capita spending limits</td>
</tr>
<tr>
<td>Block grant option</td>
</tr>
<tr>
<td>Optional work requirements</td>
</tr>
<tr>
<td>“Cadillac” tax</td>
</tr>
<tr>
<td>Taxes on high-earners, investment income, executive compensation</td>
</tr>
<tr>
<td>Medical devices tax</td>
</tr>
<tr>
<td>Other ACA taxes</td>
</tr>
<tr>
<td>Creates or preserves CMMI</td>
</tr>
<tr>
<td>Advances or does not repeal Medicare payment reform</td>
</tr>
</tbody>
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1) Restores funding in 2018 in non-expansion states and 2020 in expansion states.
2) Block grant option only available for traditional adult and children populations.

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Future of Repeal Legislation Now Unclear

Ready to Move On From Repeal-and-Replace?

Senate Leadership Ready to Move on to Other Priorities

“This is clearly a disappointing moment… I regret that our efforts simply were not enough… we look forward to colleagues on the other side suggesting what they in mind [for health care]… now it is time to move on…”

Senate Majority Leader Mitch McConnell (R-KY), July 27th statement before the Senate

“Until there’s something that can get us 50… I think we’ve had our vote and we’re moving on to tax reform. Everybody wanted to give… the bipartisan approach a chance. People not have that opportunity.”

Sen. John Thune (R-SD), Republican Conference Chairman

Three Potential Legislative Paths Forward

1) Senate Republicans Renew Effort

2) Bipartisan Health Reform Effort

3) GOP Shifts Focus to Non-ACA Legislation

Regulatory Agenda Taking Center Stage

Administration Has Considerable Leeway to Alter ACA Trajectory

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., CJR1)
- Reduce enforcement of insurance mandates
- Narrow scope of essential health benefits
- Allow Medicaid eligibility, cost-sharing reform through 1115 waivers

ACA Leaves Enormous Amount to the Secretary’s Discretion

1442

Times the ACA says “the secretary shall” or “the secretary may”

1) Comprehensive Joint Replacement.

Individual Market at a Crossroads

While Some Participants Falter, Others Renewing Commitment

Certain Insurers and States Struggling

No longer selling exchange plans in 2018; expects to lose $200M on exchange business

Plans to withdraw from exchanges in 2018; stands to lose $45M in 2017

Two major carriers weighing departure; would leave 15,600 without insurance

Increase in counties with only one insurer in 2017

But Market Showing Signs of Stabilization

Looking forward, we expect insurers, on average, to get close to break-even margins in this segment in 2017…If the market continues unaffected…we expect 2018…to be one of gradual improvement with more insurers reporting positive (albeit low single-digit) margins.”

Standard and Poor’s analysis of 32 BCBS insurers with exchange plans

"Insurer Centene Commits to Shaky ACA Exchanges for 2018”

"Centene Corp.’s exchange enrollment has swelled 74% since last year, up to nearly 1.2 million people"

Public Exchanges Hang 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
- Eliminate individual mandate
- Reduce reinsurance payments
- Refuse to settle the risk corridor litigation
- Eliminate/reduce advertising

Maintain

- Guarantee cost-sharing reduction payments in short-term
- Continue to offer premium subsidy support
- Preserve ACA’s federal exchange infrastructure

Fix

Included in Final HHS Market Stabilization Rule:
- Limit special enrollment
- Establish continuous coverage requirement
- Relax actuarial requirements

1) Subsidies ruled unconstitutional by district judge in May 2016; ruling stayed additional 90 days at Trump administration request, May 22, 2017.

New Administration Already Impacting Enrollment

Coverage on Public Exchanges Dips Following Change in Administration

Exchange Enrollment Numbers Fall for First Time

Enrollees in ACA Marketplaces
In Millions

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>2017 Q1</th>
<th>2017 Q2</th>
<th>2017 Q3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st Open Enrollment</td>
<td>8.0</td>
<td>11.7</td>
<td>12.7</td>
</tr>
<tr>
<td>2nd Open Enrollment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3rd Open Enrollment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4th Open Enrollment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

0.4% Increase in total uninsured rate in the first quarter of 2017

Administration's Decision to Pull Advertising Hurt Enrollment Down Homestretch

"Just 367,260 people signed up for coverage in the final two weeks of [2017] enrollment on the federal exchange... compared to more than 700,000 plan selections in the last week of 2016 enrollment."

CNBC News

For Providers, a Relatively Limited Impact

Despite Political Significance, Exchanges Only a Small Segment of Market

Approximate Coverage of US Population by Payer Sector
As of March 2016

~11.5M Individuals with insurance through public exchanges

~153M Individuals with employer-sponsored insurance

- Employer-Sponsored Insurance (47%)
- Medicare (17%)
- Medicaid and CHIP (19%)
- Public Exchanges (4%)
- Off-Exchange Plans (2%)
- Other (1%)¹

1) Student, IHS, CH+

Confronting a Larger Problem

Last Era of Health Reform Expanded Coverage and Increased Spending

Coverage Expansion to Millions…

22M

HHS estimate of adults who gained coverage as a result of the ACA

US Adult Uninsured Rate

Q3 2013: 18.0%

Q1 2017: 11.3%

Drove Spike in Health Care Spending

$44.6B

Estimate of increase in hospitals’ net income due to new coverage under the ACA, 2014-2016

National Health Expenditures

Actual Spend FY2010-2015, Projected FY2016-2025, in billions

The Next Era of Health Care Reform

Four Key Forces Shaping the Next Era of Reform

1. Direct reimbursement pressure
2. Federalism and state-based coverage reform
3. Dilution of employer-sponsored insurance
4. Deregulation and the new era of competition

National Health Expenditures

Last Era of Health Reform: Expanding Coverage

Next Era of Health Reform: Reducing the Price of Care

Current Spending Trajectory

Reform-Enabled Trajectory

Time
Unpacking the Political Process

The Next Era of Health Reform

Adapting Provider Strategy to New Market Realities

Guess What’s Not Getting Repealed

Even Under Repeal, Majority of Obama-Era Cuts Would Have Remained

“Productivity” Adjustments and Other Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>ACA IPPS(^1) Update Adjustments</th>
<th>ACA DSH(^2) Payment Cuts</th>
<th>MACRA(^3) IPPS Update Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>($32B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>($48B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>($60B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>($71B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2021</td>
<td>($82B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2022</td>
<td>($94B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2023</td>
<td>($103B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2024</td>
<td>($116B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>($143B)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

No Subtlety Here

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

CMS Officials


1) Inpatient Prospective Payment System; year-over-year estimates based on CBO total projected payment reductions, 2016-2025.
2) Disproportionate Share Hospital; repealed for non-expansion states under BCRA.
No Relief Ahead

New Administration Continuing to Pursue Cost Cutting Goals

House Budget Proposal Would Make Substantial, Additional Medicare Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>2018</th>
<th>2021</th>
<th>2024</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reimbursement</td>
<td>$3B</td>
<td>$8B</td>
<td>$17B</td>
<td>$24B</td>
</tr>
<tr>
<td>Proposed Rule</td>
<td>$31B</td>
<td>$37B</td>
<td>$55B</td>
<td>$88B</td>
</tr>
<tr>
<td>Total Cut</td>
<td>$487B</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Federal Medicare dollars cut in House budget proposal

Hospital 340B Program Also Attracting Scrutiny

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Hospitals Participating in 340B</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1,365</td>
</tr>
<tr>
<td>2014</td>
<td>2,140</td>
</tr>
</tbody>
</table>

45% of hospitals

2018 OPPS Proposed Rule to Cut 340B Payments

Current Reimbursement:
Average Sales Price + 6%

Proposed Reimbursement:
Average Sales Price – 22.5%

$900M Total cut to 340B reimbursement

Payment Reform Marches On

With MACRA Underway, 2017 a Pivotal Year

Bipartisan Support Guarantees Continued Implementation

Senate vote on MACRA 92-8

House vote on MACRA 392-37

Physician Leaders Praise Transition Year

“These] actions help give physicians a fair shot in the first year of MACRA implementation. This is the flexibility that physicians were seeking all along.”

Dr. Andrew Gurman, President of the AMA

2017 MIPS Reporting Structure

1. Clinicians report all MIPS-required data for at least 90 days and are eligible to receive the full bonus

2. Clinicians report more than one measure for at least 90 days and are eligible to receive a smaller bonus

3. Clinicians report any data for any period of time and receive no positive or negative adjustment in payment

Source: Centers for Medicare and Medicaid Services; Dickson, V., “CMS will give providers flexibility on MACRA requirements,” Modern Healthcare, September 2016; Health Care Advisory Board interviews and analysis.
MACRA Dealing Physicians in on Risk

Greater Payment Updates, Bonuses Depend on Payment Migration

Annual Provider Payment Adjustments

<table>
<thead>
<tr>
<th>Year</th>
<th>MIPS Bonuses/Penalties</th>
<th>APM Bonuses/Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015-2019</td>
<td>+/-4%</td>
<td>5%</td>
</tr>
<tr>
<td></td>
<td>+/-9%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500M</td>
<td></td>
</tr>
</tbody>
</table>

**Baseline payment updates**: 0.5% annual update (both tracks)

**2020 – 2025**: Payment rates frozen (both tracks)

**2026 onward**: 0.25% annual update (MIPS track)

**Advanced APM Track**

**MIPS Track**

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.

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Changing the Calculus Around ACO Participation

MACRA Already Moving the Dial on Participation in Downside Models

Model Selection Determines MACRA Track Qualification

<table>
<thead>
<tr>
<th>Model Selection</th>
<th>MIPS</th>
<th>MSSP Track 1</th>
<th>MSSP Track 1+</th>
<th>MSSP Track 2</th>
<th>MSSP Track 3</th>
<th>NGACO</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Risk</td>
<td>MIPS</td>
<td>MSSP Track 1</td>
<td>MSSP Track 1+</td>
<td>MSSP Track 2</td>
<td>MSSP Track 3</td>
<td>NGACO</td>
</tr>
<tr>
<td>Upside Risk</td>
<td>MIPS</td>
<td>MSSP Track 1</td>
<td>MSSP Track 1+</td>
<td>MSSP Track 2</td>
<td>MSSP Track 3</td>
<td>NGACO</td>
</tr>
<tr>
<td>Upside &amp; Downside Risk</td>
<td>MIPS</td>
<td>MSSP Track 1</td>
<td>MSSP Track 1+</td>
<td>MSSP Track 2</td>
<td>MSSP Track 3</td>
<td>NGACO</td>
</tr>
</tbody>
</table>

- MIPS: Not in an ACO or other APM; will receive MIPS payment adjustment
- MSSP Track 1: Maximum share rate of 50%; 428 Participants
- MSSP Track 1+: Fixed loss rate of 30%; Maximum share rate of 50%; Begins in 2018; 6 Participants
- MSSP Track 2: Maximum share/loss rate of 60%; 36 Participants
- MSSP Track 3: Maximum share/loss rate of 75%; 45 Participants
- NGACO: Choice of 80% or 100% share/loss rate


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40 Participants in downside ACO models, 2016 → 87 Participants in downside ACO models, 2017

117% Percent increase in downside ACO model participation, 2016-2017

1) Relative to 2015 payment.

2) As of January 2017.

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Future of Bundled Payments In Question

CMS Poised to Iterate on Voluntary Programs, Scale Back Mandatory Ones

Cardiac EPMs\(^1\) Cancelled

- **Mandatory** bundling for CABG and AMI\(^2\), originally slated to go into effect July 2017
- Proposed rule released on August 15\(^{\text{th}}\) would cancel programs entirely

CJR\(^3\) Scaled Back

- **Mandatory** bundling for hip and knee replacements, originally in 67 markets
- Proposed rule would make participation in 33 markets voluntary, cancel planned expansion to SHFFT\(^4\)

What's Next for BPCI\(^1\)?

- **Optional** bundling program; providers may opt into any of 48 different conditions across four risk models
- Current Models 2, 3, and 4 extended through September 30\(^{\text{th}}\), 2018

GOP Historically Opposed to CMS’s Mandatory Models

“CMMI has overstepped its authority and there are real-life implications—both medical and constitutional. That’s why we’re demanding CMMI cease all current and future mandatory models.”

Letter from GOP Lawmakers, including current HHS Sec. Tom Price to CMS, September 2016

Impact of Price Cuts and Payment Reform Adds Up

Medicare Payment Cuts Threatening Future Margins

**CBO Analysis of Impact of Medicare Payment Cuts\(^1\)**

- **60%** Projected increase in the share of hospitals with negative profit margins by 2025\(^2\)
- **(0.2%)** Projected average hospital profit margin in 2025\(^2\)

MACRA Poised to Further Exacerbate Financial Pressures

**RAND Analysis of Change in Utilization and Spending Under MACRA\(^3\)**

- **($22B)** Spending decrease in “medium-prospectiveness\(^4\)” scenario
- **($250B)** Spending decrease in “high-prospectiveness\(^4\)” scenario

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1) Episode Payment Models.
2) Coronary artery bypass graft and acute myocardial infarction; MS-DRGs: 280-282; 246-251; 231-236
3) Comprehensive Joint Replacement.
4) Surgical hip/femur fracture treatment; MS-DRGs: 480-482.
5) Bundled Payments for Care improvement.


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### Federal Medicaid Funding Set to Phase Down

**ACA’s Medicaid Cuts Poised to Take Effect Beginning in 2017**

#### 31 States and DC Have Approved Expansion

*As of March 2017*

- **$68B** Federal spending on Medicaid expansion population, FY2015
- **$4.3B** State spending on Medicaid expansion population, FY2015

#### Impending Federal Cuts to Safety Net Spending Threaten Stability

**Federal Matching Rate for Expansion Population**

<table>
<thead>
<tr>
<th>Year</th>
<th>Matching Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>100%</td>
</tr>
<tr>
<td>2017</td>
<td>95%</td>
</tr>
<tr>
<td>2018</td>
<td>94%</td>
</tr>
<tr>
<td>2019</td>
<td>93%</td>
</tr>
<tr>
<td>2020</td>
<td>90%</td>
</tr>
</tbody>
</table>

**$43B** Cut to federal Medicaid DSH payments, 2018-2026

31 States face revenue shortfalls, Jan. 2017

“Medicaid could make up close to half of Louisiana’s state budget”

“We can’t control our costs. We’re growing out of control,” said state Rep. John Schroder, R-Covington.”


### Waivers Offer Opportunity for Funding and Innovation

#### States Using Waivers to Drive Three Major Types of Medicaid Reform

1. **Payer-Led Managed Care**
   - Section 1932 and 1915 waivers, some 1115
   - Implemented in 39 states
   - Controls state spending by shifting beneficiaries to managed care with per-capita spending limits and/or home-based care alternatives

2. **Consumer-Driven Insurance Design**
   - Section 1115 waivers
   - Implemented in 7 states
   - Allows states to change Medicaid coverage and eligibility options, often implementing more conservative features (e.g. beneficiary cost-sharing requirements)

3. **Provider-Focused Delivery Reform**
   - Section 1115 waivers, notably DSRIP\(^1\) waivers
   - Implemented in 16 states
   - States receive federal dollars upfront; commit to delivery and/or payment reform that will save federal government money in long-term

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\(^1\) Delivery System Reform Incentive Payment.

Medicaid Managed Care Reaching Its Limits

39 States and DC Have At Least One Medicaid Managed Care Organization
As of September 2016

Implications of Medicaid Managed Care for Providers

- Continued payment rate cuts
- Increased opportunity for provider-sponsored health plans

[The number of Medicaid beneficiaries covered by insurers] is staggering. It’s nearly a quarter of the population, [but] the easy growth is over.”

Ari Gottlieb,
Director Health Industries Payer Strategy, PwC Advisory


1) Capitated Medicaid managed care organizations.


Consumer-Driven Insurance Design

Indiana Tests Medicaid Coverage Reform
Injecting Consumer-Driven Principles Into Medicaid Market

Case in Brief: Healthy Indiana Plan

- Section 1115 Medicaid expansion-enabled model modifying traditional program elements implemented in 2015
- Includes enrollee premiums, co-pays, incentives for preventive services, 2 plan tiers, and penalties for non-payment
- Providers reimbursed at Medicare rates to encourage provider acceptance of Medicaid
- 73% of eligible Medicaid beneficiaries participated in 2015, the first year

HIP1 Attempts to Encourage Three Behaviors:

1) Taking Personal Responsibility
   - Requires monthly contributions to “POWER” health savings account; failure to pay results in reduced benefits
   - No retroactive coverage

2) Using Preventative Services
   - Free preventative services
   - POWER account balances roll over if beneficiaries access these services
   - Higher copays for use of ED in a non-emergency situation

3) Staying on Employer-Sponsored Coverage
   - HIP Link program offers Medicaid-eligible individuals with employer-sponsored insurance a state-funded POWER account with $4,000 to cover out-of-pocket expenses

1) Healthy Indiana Plan.

Mixed Results in First Year of Healthy Indiana Plan

Challenges with Cost, Complexity Somewhat Offset by Coverage Expansion

First-Year Results

- **60%** Of enrollees were previously uninsured or became eligible due to a change in income

- **75%** Members that remained in the program for a year who accessed preventative care

- **46K** Applicants earning above the FPL were never enrolled because they didn’t make their first payment, Feb. 2015-Nov. 2016

- **13K** Beneficiaries were disenrolled after failing to pay, Feb. 2015-Nov. 2016

Key Takeaways

**Program Impact**

- Significantly expanded number of individuals with coverage
- Not yet clear if POWER accounts truly encourage enrollees to shop for the highest value providers and services

**Provider Response**

- Employed navigators to assist eligible resident with enrollment

**Future Plans**

- In February 2017, officials filed to extend the waiver through 2021, with the addition of voluntary job-related services

Following in Indiana’s Footsteps

New Proposals Even More Expansive than HIP

Key Components of Select State Medicaid Waiver Requests Further Embrace Conservative Aims

<table>
<thead>
<tr>
<th>Eligibility and Enrollment</th>
<th>Indiana</th>
<th>Arizona</th>
<th>Ohio</th>
<th>Kentucky</th>
<th>Maine</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage conditional on first premium payment</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Waives retroactive eligibility</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Work requirements</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Substance abuse screening and testing</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Time limit on coverage</td>
<td>✗</td>
<td>✓</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
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</table>

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Indiana</th>
<th>Arizona</th>
<th>Ohio</th>
<th>Kentucky</th>
<th>Maine</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coverage or select benefits conditional on continued premium payments</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Healthy behavior incentives</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Indiana</th>
<th>Arizona</th>
<th>Ohio</th>
<th>Kentucky</th>
<th>Maine</th>
<th>Wisconsin</th>
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</thead>
<tbody>
<tr>
<td>Waive non-emergency medical transportation</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>


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1) Federal poverty level.
2) Either because they had not heard of a POWER account or because they could not afford the payment.

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Payment Reform an Increasingly Popular Strategy

State Demonstrations Span Value-Based Payment Spectrum

**Pay-for-Reporting**

- **Arkansas and Tennessee**
  - Arkansas: Offers PMPM payments and shared savings potential if cost and quality thresholds are met.
  - Tennessee: Accountable physicians rewarded or penalized based on quality and cost performance.

**PCMHs**

- **New Jersey**
  - Funds private hospital projects focused on one of eight conditions.
- **New York**
  - Offers provider coalitions incentive payments for delivery reform.

**Bundled Payments**

- **Arkansas and Tennessee**
  - Arkansas: Offers PMPM payments and shared savings potential if cost and quality thresholds are met.
  - Tennessee: Accountable physicians rewarded or penalized based on quality and cost performance.

**Population-Based, ACOs**

- **Alabama**
  - Regional Care Organizations.
- **Oregon**
  - Coordinated Care Organizations.
- **Vermont**
  - Accountable Care Organizations.
- **Maryland**
  - Global budget caps for hospital services.

**Total Cost of Care**

- **Arkansas**
  - Offers PMPM payments and shared savings potential if cost and quality thresholds are met.
- **Colorado**
  - Distributed PMPM payments to cover enhanced services (e.g., care coordination).

**Upside Risk Only**

- **Potential for Downside Risk**

1) Patient Centered Medical Homes.
2) Per Member Per Month.

Delivery Waivers Offer Most Opportunity for Providers

An Alternative to Cuts to Coverage and Reimbursement

**Items to Watch For**

- Will more comprehensive data on cost, savings, and quality from existing demonstrations be forthcoming?
- How will the Trump administration assess new and renewal waiver proposals?
- Will more commercial payers get involved in these demonstrations?
- Will CMMI create a third round of State Innovation Model (SIM) grants?

**Provider Considerations**

- Take advantage of money available from current demonstrations to fund new initiatives or ongoing projects.
- Leverage model parameters to enhance value-based care capabilities; align incentives across distinct Medicaid, uninsured enrollment groups; and prepare for population health under MACRA.
- Proactively engage with state officials to participate in shaping and improving program structure.


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Source: Health Care Advisory Board interviews and analysis.
Employer Health Spending Continues to Grow

**Employer Health Benefits Clearly Not a Legislative Target**

- **“Cadillac Tax” Delayed**
  - 40% excise tax assessed on employee health benefit spend exceeding $10,200 for individuals, $27,500 for families
  - Originally proposed in ACA to begin in 2018; effective date postponed to 2020

- **Cap on Tax Exclusions Dropped**
  - Limit on existing tax exclusions for employer contributions to health plans
  - Model proposed in “A Better Way” absent from House’s AHCA and Senate’s BCRA

---

**Even Without Regulatory Pressure, Employers Still Have a Cost Problem**

- ~47% US population covered by employer-sponsored insurance

**Average Annual Growth Rate Among Private Business’s Health Expenditures**

<table>
<thead>
<tr>
<th>Year</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
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<tbody>
<tr>
<td>Rate</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

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**Cost-Shifting Remains the Dominant Response**

**Migration to High Deductible Health Plans Well Underway**

**ESI Average Deductible for Single Coverage**

<table>
<thead>
<tr>
<th>Year</th>
<th>HMO</th>
<th>PPO</th>
<th>All Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>$917</td>
<td>$1028</td>
<td>$1,478</td>
</tr>
<tr>
<td>2016</td>
<td>$1,000</td>
<td>$1,500</td>
<td>$2,000</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Year</th>
<th>3-199 Workers</th>
<th>All Firms</th>
<th>200 or More Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>16%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>2016</td>
<td>23%</td>
<td>23%</td>
<td>23%</td>
</tr>
</tbody>
</table>

---

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


Cost-Shifting Reaching Its Limits

Employers Increasingly Looking to Supplement Cost-Shifting Strategies

Cost Shifting Causing Consumers to Forgo Care, Increasing Bad Debt...

Spending Reductions Following Implementation of HDHPs

- **25%** Reduction in physician office spending
- **18%** Reduction in ED spending

Increasing Bad Debt as Consumers Face Growing Financial Exposure

- **61%** Of those reporting difficulty paying medical bills used up all or most of their savings, 2016
- **20%** Increase in bad debt among Minnesota Hospital Association Members, 2014-2016

...But Not Incentivizing Shopping

“[We found] that spending reductions are entirely due to outright reductions in quantity. We found no evidence of consumers learning to price shop after two years in [a HDHP].”

The National Bureau of Economic Research

“Consumers want to make better choices. They want to save money. They just want someone else to do the work and show them how.”

Chief Innovation Officer, Global Benefits Consulting Firm

Cost Shifting Causing Consumers to Forgo Care, Increasing Bad Debt...

New Tools Aim to Facilitate Consumer Shopping

Helping Employees Make High-Value Choices

Employers Entering a New Era of Health Benefits Strategy

First Phase: Cost Shifting

- Shifted costs to employees by transitioning to high-deductible health plans

Current Phase: Facilitating Decision Making

1. Leveraging scale to demand greater value from delivery system
2. Offering enhanced tools to simplify value-based shopping
3. Curating networks to incentivize use of higher-value providers

Source: Health Care Advisory Board interviews and analysis.
Using Scale to Incentivize Transformation

Employer Coalition Demanding Greater Value

HTA’s First Priority Areas

Prescription Drug Purchasing
- Three-year contract with CVS and OptumRX
- Members receive full transparency on rebates/discounts, ability to audit fees, and participation in formulary decision-making

Data and Analytics
- Contract with IBM Watson Health
- Will aggregate and analyze claims data to better-understand impact of medical interventions and wellness initiatives

Narrow Network Curation
- Partnering with Cigna and UnitedHealthcare
- Payers will build high-value networks for Type II Diabetes, joint replacements, and back pain in Dallas, Phoenix, and Chicago


Select Founding Members
- American Express
- American Water
- BNSF
- Coca-Cola
- DuPont
- HCA
- IBM
- Ingersoll Rand
- International Paper
- Lincoln Financial
- Macy’s
- Marriott
- NextEra Energy
- Pitney Bowes

$14B Annual health spending
4M Covered lives

Engagement Tools Simplify Shopping Process

Personalized Support Helps Facilitate Decision-Making

Technologies Span a Variety of Engagement Mediums

Aggregator Platforms
Integrated interfaces that aggregate all health benefits related tools and resources

Example: Jiff
Increased use rates of price transparency tool by 62% within two months for Activision Blizzard

Customized Messaging
Communication platforms that use predictive analytics to tailor messaging

Example: Evive Health
Increased flu vaccine rates by 4% among high-risk employees at a large, Midwest utility company

Concierge Navigation
Phone- or web-based service that provides access to a dedicated health navigator

Example: Accolade
Improves health care outcomes and engagement (e.g. 98% consumer satisfaction, 3% reduction in ED visits) across clients


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Others Curating Through Network Design

High-Performing Networks Most Prevalent Among Large Employers

Percentage of Firms With Health Plans Offering a Narrow Network, High-performance Network, or Tiered Network

By Firm Size, 2016

Even More Companies Poised to Join the Trend

46%

Of employers surveyed in Q1 2016 are considering implementing value-based plan designs or high-performance networks in 2017


Force #4: Deregulation and the new era of competition

Regulatory Reform a Centerpiece of the GOP Agenda

White House, HHS, Congress Looking to Scale Back Regulations

Executive Orders to-date include:

- January 20th order to “[minimize] the economic burden” of the ACA
- January 30th order requiring at least two regulations be identified for elimination for each new regulation issued
- February 24th “Enforcing the Regulatory Reform Agenda” order requiring every federal agency to create Regulatory Reform Task Force

HHS/CMS

RFIs on reducing regulatory burden included in:

- 2018 inpatient prospective payment system (IPPS) rule
- Standalone RFI on reducing the regulatory burdens of the ACA; comments were due on July 12
- The proposed outpatient prospective payment system (OPPS) rule for 2018; comments due on September 11
- The proposed physician fee schedule (PFS) rule for 2018; comments due on September 11

Congress

Medicare Red Tape Relief Project seeks to:

- Deliver relief from regulations that “impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries”
- Request feedback from stakeholders to identify opportunities
- Host stakeholder roundtables
- Drive Congressional action based on the stakeholder input efforts

### Market Forces, Regulatory Changes Have Driven Rapid Transformation in Other Sectors

<table>
<thead>
<tr>
<th>Industry</th>
<th>Transformative Forces</th>
<th>Industry Evolution</th>
</tr>
</thead>
</table>
| **AIRLINES** | • 1978 Airline Deregulation Act  
• Influx of low-cost carriers drives price competition | **Market Share Among Four Largest Domestic Carriers** |
| | | 1977 | 2000 | Present |
| | 56% | 61% | 87% |
| **BANKS** | • Deregulation in 80s decreases barriers to geographic expansion, expands scope of allowable services  
• Development of ATM technology | **Number of Commercial Banks in the US** |
| | | 1984 | 2000 | Present |
| | 14,400 | 8,458 | 5,031 |
| **TELECOM** | • Rapid advancement of technology (e.g. smartphone) in 2000s rewards those with massive capital resources  
• Demand for national infrastructure, coverage rewards geographic scale | **Market Share Among Four Largest US Wireless Carriers** |
| | | 2003 | 2009 | Present |
| | 63% | 90% | 98% |


### Value to Consumers Paramount

#### Consolidation and Scale Deliver End-User Value in Other Industries

- **Lower prices**: After adjusting for inflation, airline prices have declined by 50% since 1978
- **Superior delivery model**: Increase in number of routes, fare classes has made flying more accessible
- **Upgraded infrastructure**: Number of branches grew from 53,000 in 1980 to 71,000 by the end of 1998; digital banking now on the rise
- **Superior delivery model**: Wider range of products and services (e.g. types of accounts, personal finance)
- **Lower prices**: Cost of wireless voice service per minute has declined by more than 30% since 1993
- **Upgraded infrastructure**: National networks now ubiquitous, enabling affordable long-distance calls

#### Imperatives for Health Systems

- **Reduce Prices**: Bring down both unit cost and total cost of care
- **Improve Delivery Model**: Make care more convenient and consumer-focused
- **Upgrade Infrastructure**: Use scale to improve and expand asset base

Source: Health Care Advisory Board interviews and analysis.
States Renewing Push to Eliminate CON Laws

State of CON Laws, 2016

In 2016, NH became first state in over 15 years to eliminate CON laws


New Administration Encouraging the Trend

2018’s Outpatient Payment Proposal Promotes Lower Acuity Settings

Total Knee Arthroplasty (TKA) to be Reimbursed in the Outpatient Space

$12,380.78
Inpatient Reimbursement

$9,912.69
Outpatient Reimbursement

48% Average percentage of Medicare TKA cases per organization that are potentially eligible to be performed in outpatient setting

Non-Excepted Hospital Outpatient Clinic Reimbursement Rate to be Cut in Half

Proposed CY2018 Rates
Percentage of HOPPS Reimbursed by Setting

100%
100%
55%
25%
25%

CY 2017 non-excepted provider rate: 50%

1) Proposed rate for FY2018.
2) Proposed rate for CY 2018.
3) Analysis of MEDPAR inpatient Medicare claims from FY 2016 per six-digit Medicare CCN. Analysis reviewed cases assigned MS-DRG 469 or 470 with a TKA primary procedure code for distinct Medicare CCN. Cases with MS-DRG 470 were considered eligible to shift outpatient if the patient did not fulfill any of the exclusion criteria listed above. Please note that this is a generous analysis of eligibility, as other patient criteria not present in claims data (e.g., preference for no hospital stay; post-operative presence of a caregiver in patient’s home) also impact whether a case should be performed outpatient.

Source: Kort et al., Patient selection criteria for outpatient joint arthroplasty,” Knee Surgery Sports Traumatology Arthroscopy, April 2016; CMS; Health Care Advisory Board interviews and analysis.
Innovators Doubling Down on Ambulatory Care

Meeting Demands of Market Requires New Forms of Partnership

Access

Diagnostics

Procedures

Partnered with:
- Legacy Health (18 clinics)
- Dignity Health (8 clinics)
- Northwell Health (35 clinics)
- Hartford Healthcare (1 clinic)

Partnered with:
- ThedaCare ($3M investment)
- Edward-Elmhurst Health ($7M investment)

Partners include:
- Tenet Healthcare ($425M investment for 50.1% stake)
- Baylor Scott & White Health (25 ASCs and 7 short-stay hospitals)
- Over 50 other health systems

“Smart Choice MRI shares our vision to put patients and consumers at the center of the health care experience. We sometimes collaborate with competitors in the best interests of consumers.”

Keith Livingston, SVP of Systems of Care Support, ThedaCare

The Next Era of Health Care Reform

Four Key Forces Shaping the Next Era of Reform

Last Era of Health Reform: Expanding Coverage

Next Era of Health Reform: Reducing the Price of Care

1. Direct reimbursement pressure
2. Federalism and state-based coverage reform
3. Dilution of employer-sponsored insurance
4. Deregulation and the new era of competition


Source: Health Care Advisory Board interviews and analysis.
The “Checking in on Granny” Economy

Health Care Forced to Confront a Larger Societal Issue

From the Factory Floor…
…To the Rocking Chair

Demanding an Entirely Different Set of Services

Retirees, Millennials Have Vastly Different Demands From Middle-Aged

Health Care Needs:
- Low-to-mid acuity urgent care
- Women’s health, maternity care
- Pediatrics

Health Care Needs:
- Imaging
- Surgeries

Health Care Needs:
- Chronic disease management
- Cancer care
- Post-acute care, palliative care

Millennials: ~79.4M
Gen X: ~65.7M
Baby Boomers: ~75.5M

Provider Customer Base
Delivery Model at a Crossroads

Reimbursement Model and Customer Needs Shifting Simultaneously

Yesterday's Model:
Privately-Reimbursed Procedural Care

Largest patient base comprised of commercially-insured, middle-aged patients in need of imaging services and surgeries

Today's Model:
Publicly-Reimbursed Medical Care

Patients covered by Medicare or HDHPs, in need of medical management, low-acuity preventive care

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Source: Health Care Advisory Board interviews and analysis.

ROAD MAP

1. Unpacking the Political Process

2. The Next Era of Health Reform

3. Adapting Provider Strategy to New Market Realities
Our Leadership Challenge

Delivery System Transformation Central to Future Success

<table>
<thead>
<tr>
<th>Time</th>
<th>High</th>
<th>Medium</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rebuild Health System</td>
<td>Unsustainable fixed costs</td>
<td>Unsustainable fixed costs</td>
<td>Unsustainable fixed costs</td>
</tr>
<tr>
<td>Transform Care Delivery Model</td>
<td>Insufficient scale, market relevance</td>
<td>Insufficient scale, market relevance</td>
<td>Insufficient scale, market relevance</td>
</tr>
<tr>
<td>Reduce Cost of Operations</td>
<td>Unrealized system advantages</td>
<td>Unrealized system advantages</td>
<td>Unrealized system advantages</td>
</tr>
<tr>
<td>Near-Term</td>
<td>Continued site-of-care shifts</td>
<td>Greater total cost of care accountability</td>
<td>Greater total cost of care accountability</td>
</tr>
</tbody>
</table>

As Drivers of Unit Cost Shift, Expenses Continue to Rise

Major Cost Drivers Evolving

**Past**
- Medical device costs
- Facility construction

**Present**
- Low-hanging fruit (devices, back-office) increasingly tapped out
- Shifting demographics driving demand for different-in-kind services
- Increasing administrative, compliance burden driving workforce demand

Over the next year, rising labor and pharmaceutical costs will continue to pressure the expense growth rate.

Beth Wexler, VP, Moody’s Investors Service

Pharma Costs Dominating the News

Pharmaceutical prices

Beyond the Headlines, A Much Broader Problem

Pharma Spending on the Rise Across the Board

Drug Spending Growth Outpacing Broader Health Care Spending and Overall Economy

Annual Change

A Rapidly Growing Line Item

14.8% Change in brand drug prices in 2015

$435.3B Projected drug spending in 2020

The U.S. healthcare system spent $373.9 billion on drugs in 2014 — 13.1% more than it did the previous year and the highest rate of spending growth since 2001.”


Bipartisan Alarm

“Over the last several years, Mylan Pharmaceuticals has increased the price of EpiPens by more than 400%. That’s outrageous.”

Sen. Amy Klobuchar
D-Minnesota

“I am a very pro-business Republican, yet I am really sickened by what I’ve heard about [the EpiPen] situation. Nobody can really earn or deserve that much money.”

Rep. John Duncan
R-Tennessee

I think it will be huge...Almost all of it is profit and I think we will get three years of that or more. Should be a very handsome investment for all of us.”

Martin Shkreli, Former CEO
Turing Pharmaceuticals

Radical Solutions Proposed on Campaign Trail

- Allow Medicare to negotiate prices
- Allow foreign drug imports

"We’re the largest buyer of drugs in the world and yet we don’t bid properly. We’re going to start bidding and we’re going to save billions of dollars over a period of time."

President-Elect Donald Trump
Press Conference, January 11th, 2017

Draft Executive Order Takes Softer Approach

- Scaling back 340B program
- Value-based drug pricing
- Extending patent life for drugs overseas
- Reforming regulatory landscape
- Expediting generic drug approvals

Focus Leadership on Actionable Opportunities

Pharma Costs Require C-Suite Attention

1. Reining in Employee Health Spend
   - How actively do we manage our outpatient formulary?
   - Are we collecting and utilizing data on prescriber variation patterns?

2. Commercializing Pharmacy Management Expertise
   - Have we expanded our health plan to outside entities?
   - Have we initiated conversations with retail pharmacies?

3. Managing Prescription Costs for At-Risk Contracts
   - Are pharmacists integrated in our clinical care teams?
   - Is medication reconciliation being performed at all transitions of care?

4. Evaluating the Opportunity for Specialty Pharmacy
   - Have we evaluated our eligible patient population and their drug coverage?
   - Have we created a strategy to manage limited distribution drugs?

To explore these topics in more depth, members can watch our on-demand webconference: “5 Things CEOs Need to Know About Pharmacy”
**Labor Force Reaches Unprecedented Heights**

Job Growth Rises to Meet Demands of Reform, Coverage Expansion

**Hospital Jobs in Millions, By Year**

![Hospital Jobs Chart]

"More people—15.5 million—now work in health care than live in the state of Ohio... Based on job numbers, no sector is healthier than health care."

*Politico*

**Competition for Physician Assets Heating Up**

Physicians Have Growing Number of Alternatives to Employment

**Four Main Alternatives to Health System Employment**

1. **Large Independent Groups**
   - 25%
   - Growth in median medical group size, 2013-2015
   - 35%
   - Physicians currently part of a group of 100 or more

2. **National Practice Companies**
   - 3-5 years
   - Common investment duration for private equity firm
   - $400M
   - Venture investment in Privia for care delivery innovation, primary care expansion, 2016

3. **Private Equity Firms**
   - 3-5 years
   - Common investment duration for private equity firm
   - $250M
   - Invested by equity firm Summit Partners in DuPage Medical Group, a 459 physician multi-specialty group in Illinois

4. **Health Plans**
   - 75
   - Markets for which United subsidiary Optum aims to provide primary care and ambulatory services
   - 40%
   - Surveyed independent groups who reported interest in acquisition by health plans

Source: Diamond, D., "ObamaCare, the secret jobs program," POLITICO, July 13, 2016; Health Care Advisory Board interviews and analysis.

Health Care’s Incurable “Cost Disease”?  
Labor-Intensive Industries Struggle to Reduce Costs

Theory in Brief: William Baumol’s “Cost Disease”

- Productivity in labor-intensive service industries grows much more slowly than the overall economy
- Wages must grow with the overall economy to maintain talent
- This combination increases costs and reduces return on investment

"The number of players, the number of instruments, the amount of time it took to ‘produce’ a Mozart quartet in the 18th century will not have changed one whit two centuries later."
— Sen. Daniel Patrick Moynihan presenting Baumol’s work to the Senate Finance Committee

Industries Plagued by Seemingly Unavoidable Cost Growth


Reconsidering the Reliance on Costly Human Capital

Translating Labor-Intensive Services into Discrete Goods

From the Concert Hall…
- Highly skilled symphony orchestra
- Unique occurrences

Evolution of technology and consumer expectations

…To the Living Room
- Individually accessible concert recording
- Infinitely repeatable

From the Operating Room…
- Technically skilled, hands-on surgery team
- Procedure-focused encounter

Evolution of technology and consumer needs

…To the Patient’s Bed
- Diagnosing physician and hands-on nursing team
- Ongoing care management

Source: Health Care Advisory Board interviews and analysis.
Administrator, Cure Thyself

Clinical Workforce Only a Small Piece of the Puzzle

Growth of Physicians and Administrators¹, 1970-2013

1) Spans three occupational categories: management, non-financial administrative support, and financial administrative support.


Improving Cost Structure Only the First Step

Future Demands Transformation of Care Model

Outlook for Cost Control

Reduce Cost of Operations  Transform Care Model

Rationalize Variable Costs

Shift Site of Care Delivery

Manage Total Cost of Care

Cost Growth

• Pharma costs
• Workforce costs

• IP¹ to OP² shift
• HOPD³ to freestanding shift
• Convenient care alternatives

• Care management
• Risk-based contracting
• PSHPs⁴

Transformation to Clinical Model

Historical cost growth

Long term cost growth goal

¹) Inpatient
²) Outpatient
³) Hospital outpatient department
⁴) Provider sponsored health plan

Source: Health Care Advisory Board interviews and analysis.
Providers Move Up the Value Chain

But Health Plan Ownership Entails Distinct Challenges

Growth in PSHP1 Enrollment

<table>
<thead>
<tr>
<th>Year</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>12.4</td>
</tr>
<tr>
<td>2011</td>
<td>12.7</td>
</tr>
<tr>
<td>2012</td>
<td>12.9</td>
</tr>
<tr>
<td>2013</td>
<td>13.7</td>
</tr>
<tr>
<td>2014</td>
<td>15.3</td>
</tr>
</tbody>
</table>

Far From a Slam-Dunk Investment

Modern Healthcare

“Health Systems With Insurance Operations Stumble in 2015”

CATHOLIC HEALTH INITIATIVES

“Catholic Health Initiatives to Divest Health Plan Operations”

Neighborhod Health Plan

Batters Partners HealthCare’s Finances in 2014

Mountain States Terminating CrestPoint Health Insurance Plans for Employees, Medicare Advantage

Payers and Providers Find Common Ground

Health Insurance Partnerships, Joint Ventures Increasingly Common

aetna

Offers range of “accountable care solutions” from delegated risk to co-branding and joint ventures

Joint venture agreements with providers as of 2017

Cigna

Launched CareAllies Inc. to help providers, including those launching their own plans, transition to value-based care

Joint venture agreements with providers as of 2016

Anthem

Partnering with providers in select markets; after launching Vivity in 2014, expanded to Wisconsin in 2016

Joint venture agreements with providers as of 2016


1) Provider sponsored health plan.
Risk Demands Substantial Scale

Benchmarks Heard in the Research

<table>
<thead>
<tr>
<th>Category</th>
<th>Target Population Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Absolute minimum population size to transition risk contract to downside risk, depending on risk tolerance of organization</td>
<td>1,000-5,000</td>
</tr>
<tr>
<td>Minimum population size required to ensure baseline viability of a provider-sponsored health plan</td>
<td>40,000-50,000</td>
</tr>
<tr>
<td>Target population size to ensure consistent profitability and market relevance of a provider-sponsored health plan</td>
<td>100,000-250,000</td>
</tr>
</tbody>
</table>

1) Based on 15.56% of anticipated annual health expenditures; assumes annual per-capita health expenditure of $5,141.

136,336
Average enrollment in core line of business for 25 highest-performing PSHPs

10%
Average market share in core line of business for 25 top-performing PSHPs

$329M
Minimum risk-based capital for 250,000-member provider sponsored health plan

Rebuild Health System
No Shortage of M&A Activity
Providers Actively Building Scale Through Consolidation

Hospital M&A Activity
Total Deal Volume

<table>
<thead>
<tr>
<th>Year</th>
<th>Deal Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>66</td>
</tr>
<tr>
<td>2011</td>
<td>88</td>
</tr>
<tr>
<td>2012</td>
<td>95</td>
</tr>
<tr>
<td>2013</td>
<td>98</td>
</tr>
<tr>
<td>2014</td>
<td>95</td>
</tr>
<tr>
<td>2015</td>
<td>112</td>
</tr>
<tr>
<td>2016</td>
<td>102</td>
</tr>
</tbody>
</table>

Number of Hospitals Part of a Health System

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005</td>
<td>2,716</td>
</tr>
<tr>
<td>2010</td>
<td>3,198</td>
</tr>
</tbody>
</table>

Not Exactly Delivering on the Value Proposition

Horizontal, Vertical Consolidation Have Added Cost to the System

Reduced Hospital Competition Significantly Correlated with Increased Price

**Percent Increase in Hospital Price Compared to Markets with Four or More Hospitals**

- **One Hospital**: 15%
- **Two Hospitals**: 6%
- **Three Hospitals**: 5%

$2,000

Per-admission price differential between markets with one hospital and markets with four or more hospitals

**Physician-Hospital Integration also Driving Up Prices**

**Physicians Practice Prices Increase After Health System Acquisition**

- Average price increase by primary care physicians: 12%
- Average price increase by specialists (e.g., cardiologists): 34%

$1,450

Average payment increase per patient per year

Lack of “Systemness” Often to Blame

Excess Capacity Remains Despite Consolidation and Utilization Declines

**Fragmentation Evident Among Key Constituencies…**

- **Facility-level Executives**: Local leaders focused on maximizing performance of separate, often competing “fiefdoms”
- **Physician Workforce**: Twin cultures of individualism, tribalism persist despite stronger contractual alignment
- **Frontline Staff**: Rank-and-file workers unaware of, disengaged from system priorities

**…And in Concrete Manifestations of Sub-par Performance**

- **Operational inefficiency**: $190B Health care costs attributed to excess administrative costs
- **Unjustified clinical variation**: 1,200 days Extra inpatient LOS due to unjustified variation in total hip & knee replacements for typical health system
- **Overgrown portfolios**: 1 in 3 Markets with average inpatient occupancy rates under 50%
- **Sluggish response to market stimuli**: 25% Hospitals and health systems reporting no plans for total cost of care contracts before 2018

True Systems Able to Weather Any Storm

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

Generate enough efficiencies to improve pricing flexibility; support new investments
Assemble reliable, attractive care products for value-driven market
Eliminate fixed-cost albatrosses; position system footprint for any eventuality
Remove remaining barriers to change; reduce strategic “turning radius”

Our Leadership Challenge
Radical Delivery System Transformation Central to Future Success

Strategic Challenges
- Rebuild Health System
- Transform Care Delivery Model
- Reduce Cost of Operations

Strategic Imperatives
1. Identify opportunities to inflect pharma spending
2. Eliminate unwarranted care variation
3. Rightsize and reconfigure the clinical workforce
4. Expand to new sites of care
5. Reevaluate risk strategy, transition path
6. Reallocate services across the system
7. Eliminate excess capacity
8. Capitalize on internal advantages of scale
9. Embrace radical growth strategies

Source: Health Care Advisory Board interviews and analysis.