LOOKING AHEAD AT AMERICAN HEALTHCARE: PROGRESS AND PROMISE

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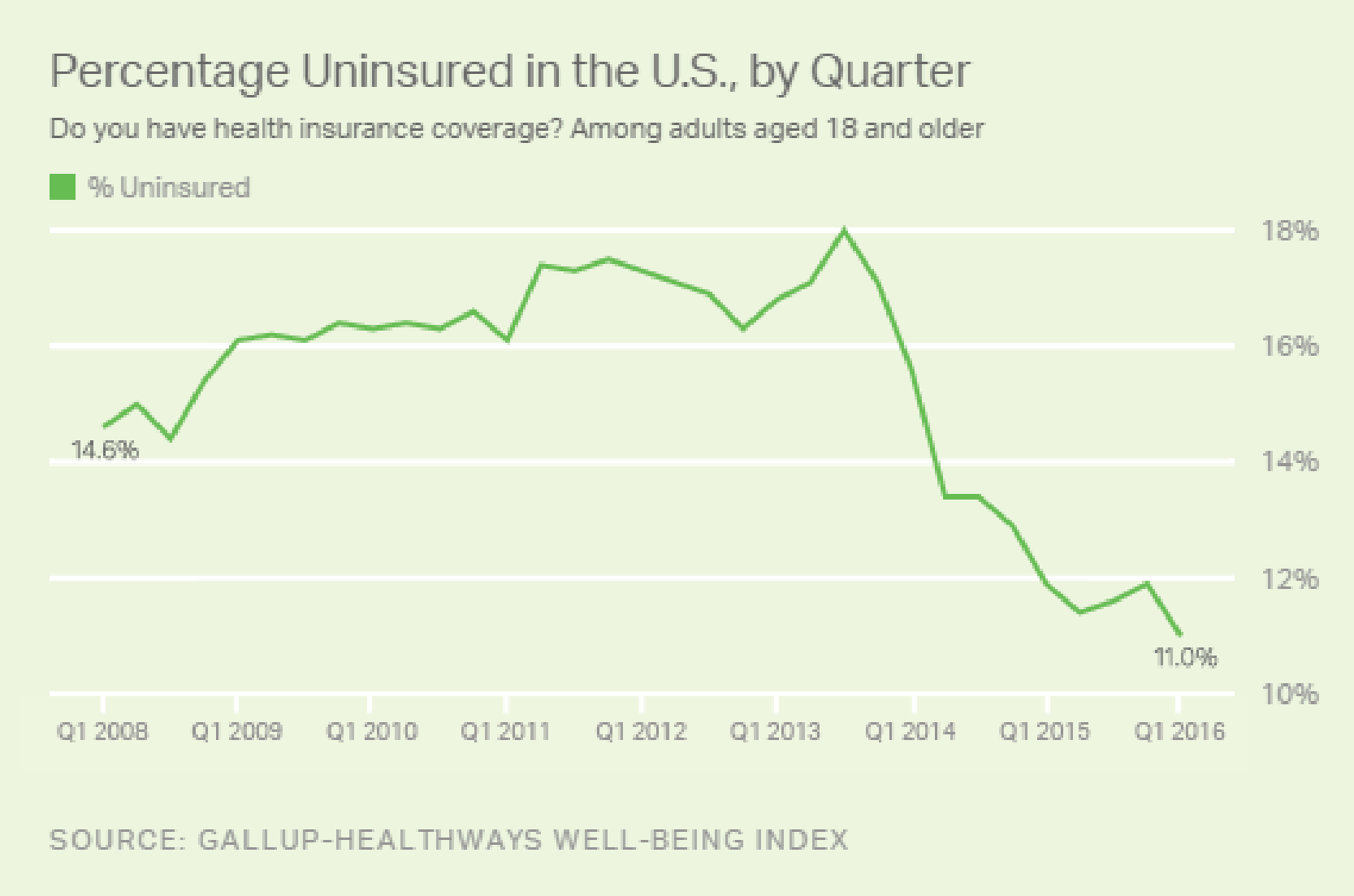
OUTLINE

- American Healthcare: Progress and Promise
- Looking Ahead:
  - 10 Big Stories for 2016 and Beyond
- Looking to 2020

AMERICAN HEALTHCARE: PROGRESS AND PROMISE

- **Coverage Expansion**
  - Obamacare: Exchanges and Managed Medicaid
- **Payment Reform**
  - ACOs, MACRA, Medicare Advantage, Managed Medicaid, Bundles and value based payment in private sector
- **Volume to Value**
  - Payment reform in concert with shift to Population Health, Providers at Risk
- **Consolidation and Integration**
  - Plans, health systems and physicians merging and partnering more and more
- **Delivery Shift to Ambulatory Environment**
  - Outpatient, alternate site and retail
- **IT Infrastructure**
  - Ubiquitous EHRs, Telehealth, Big Data, and Consumer facing apps
- **Enhancing the Consumer (and Provider) Experience**
  - High Deductible health care is a blunt instrument
  - High bar of service in a world of Apple, OpenTable, and Uber

BIG DROP IN UNINSURED UNDER OBAMACARE



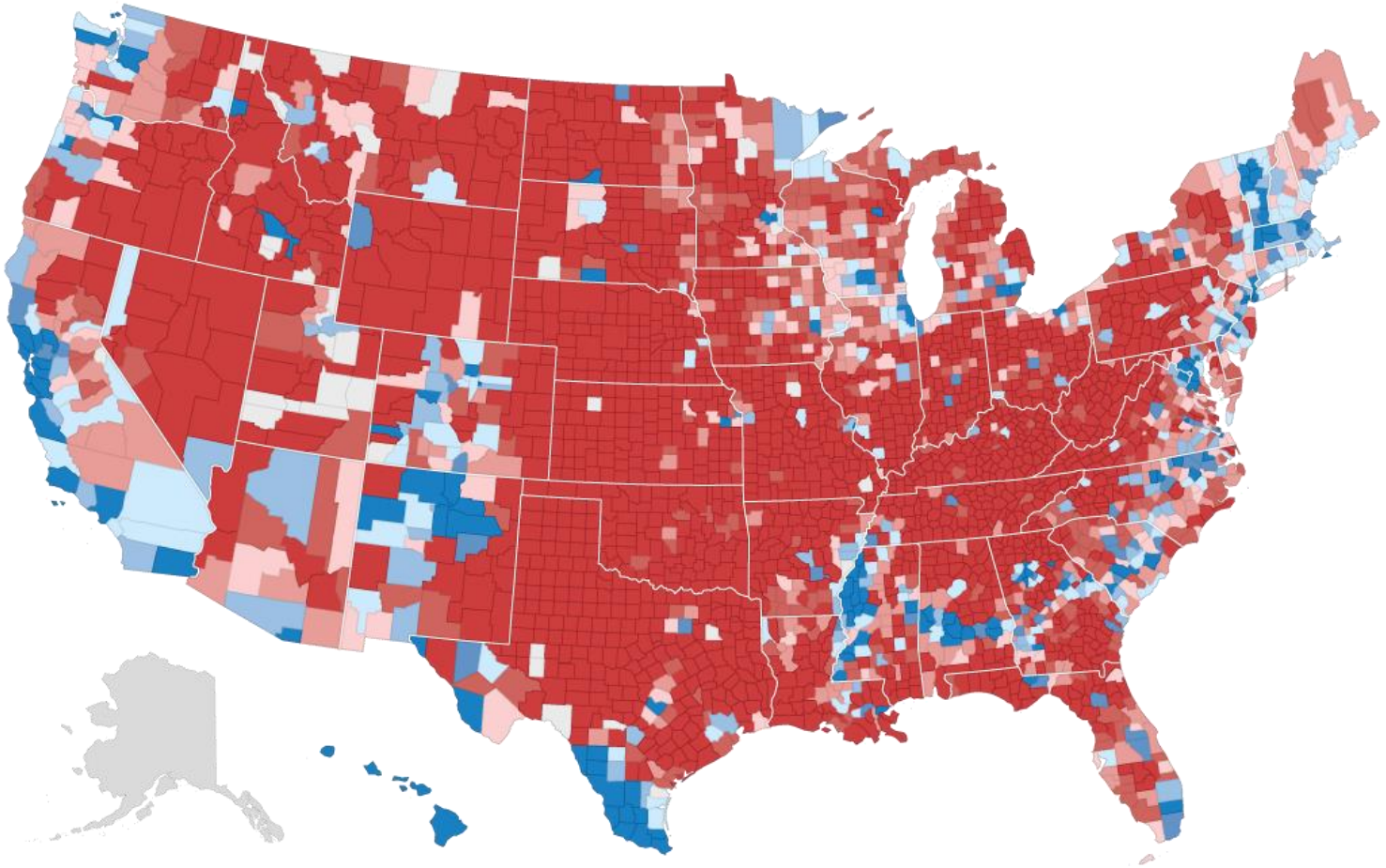
LOOKING AHEAD AT AMERICAN HEALTHCARE

10 Big Stories for 2016 and Beyond

- Elections Matter
- Serving Shallow-Pocketed Consumers
- Consolidation: Good or Bad?
- Employers: Stay or Go?
- Provider Prices for Private Insurance
- Specialty Pharmaceuticals
- Medicaid Transitions
- Making Volume to Value Real
- Population Health
- Innovation at Scale

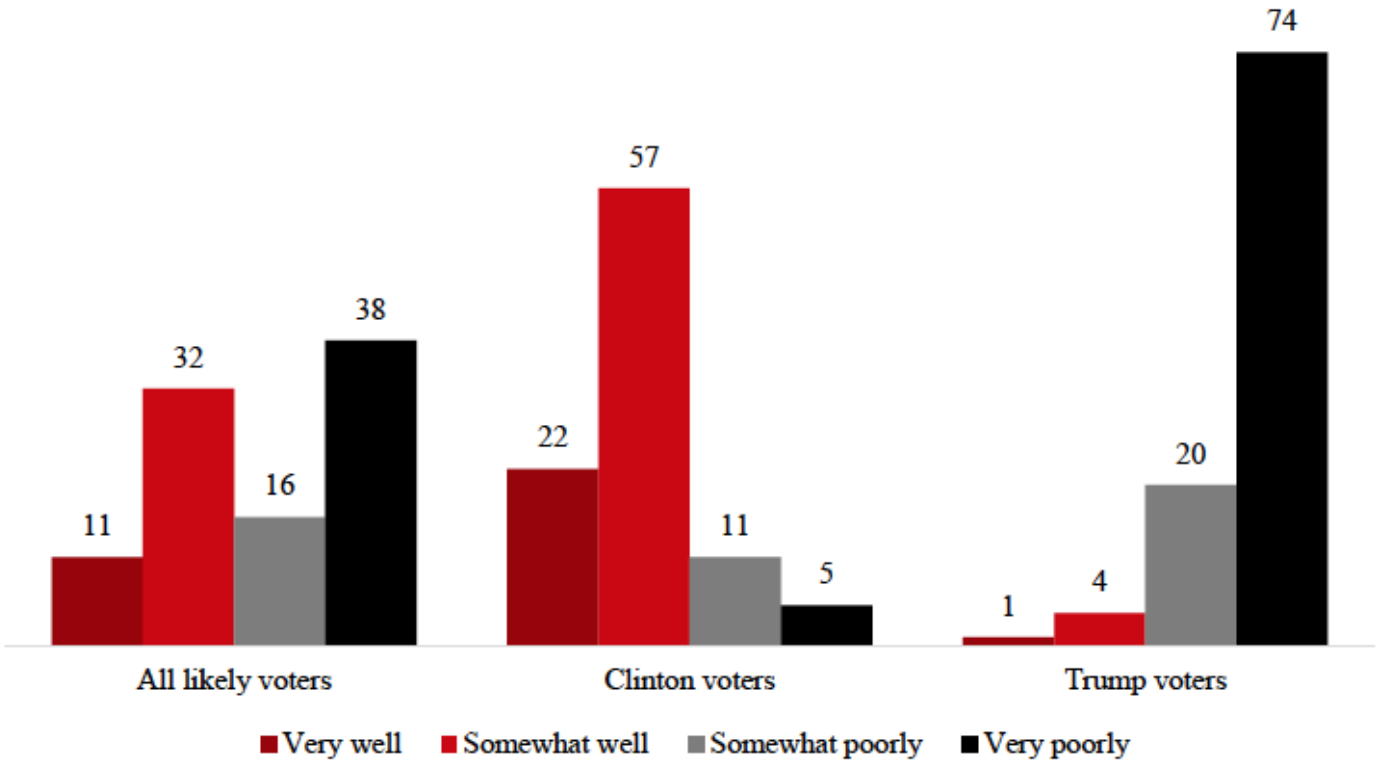
ELECTIONS MATTER

TRUMP TRIUMPHS



THE PARTISAN DIVIDE ON HEALTHCARE

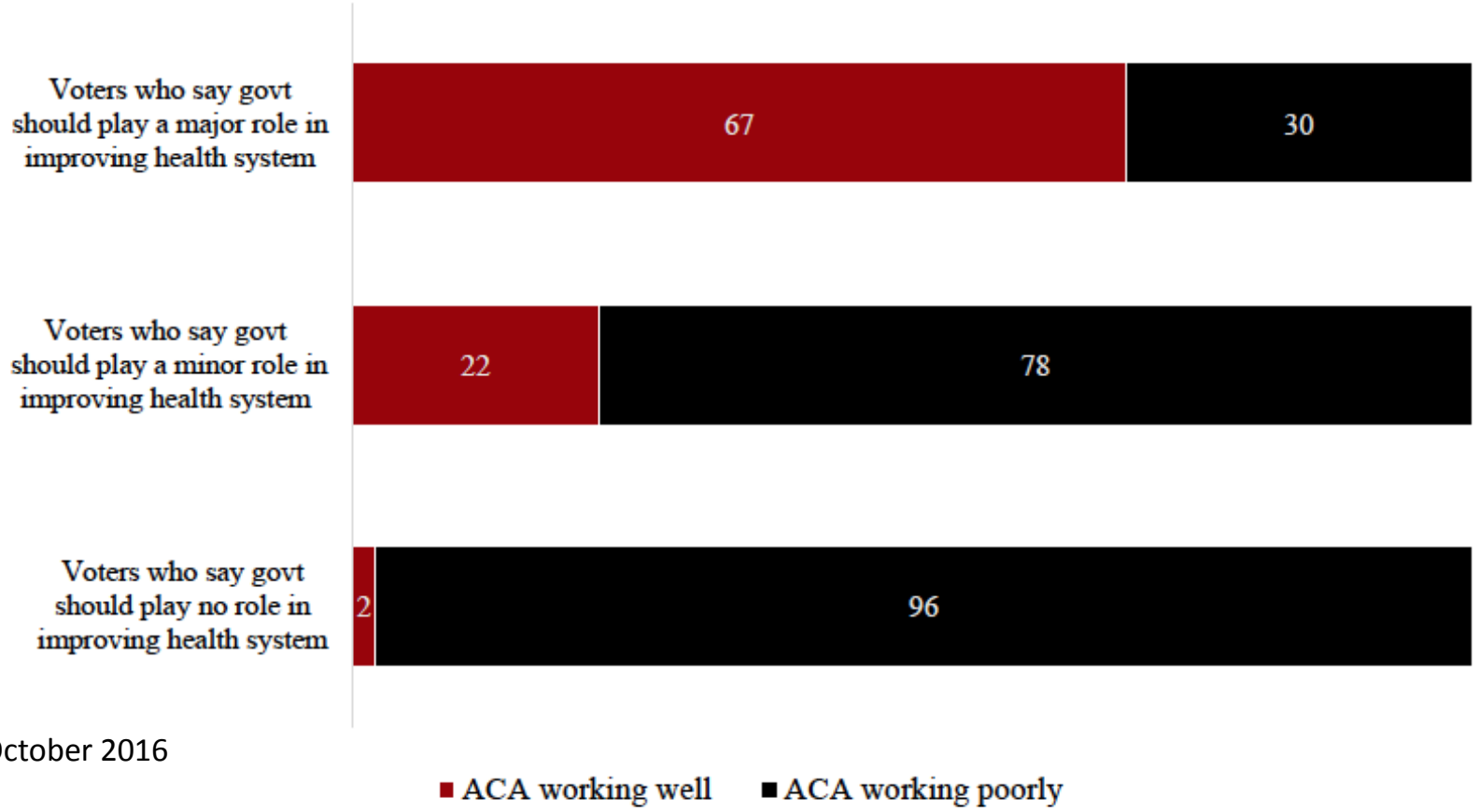
Figure 3:
Voters' Evaluations of How Well the ACA is Working



Source: Harvard/Politico October 2016

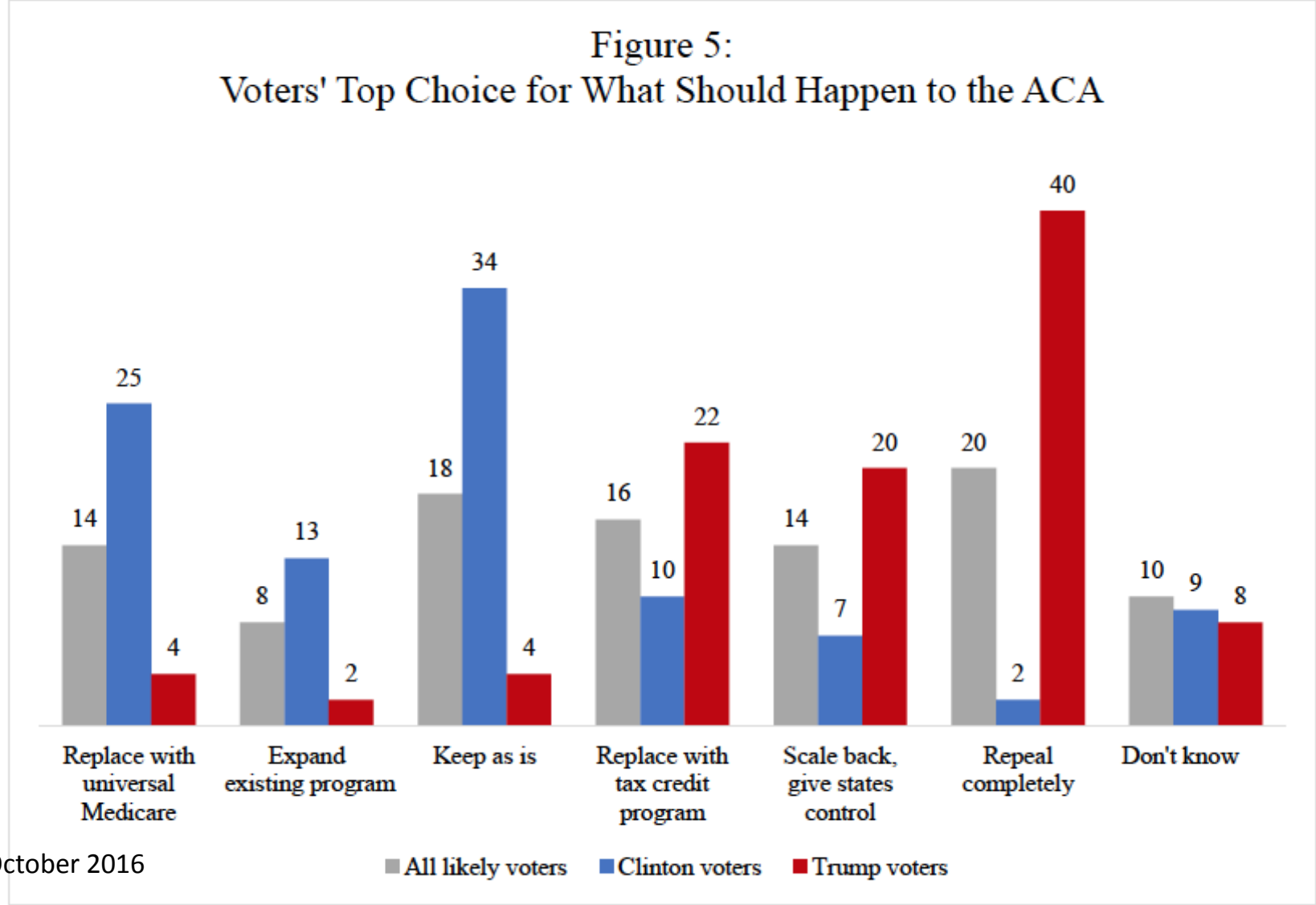
VIEW ON ACA ARE BASED ON VIEWS ON GOVERNMENT ROLE IN IMPROVING HEALTHCARE SYSTEM

Figure 4:
Voters' Views of the ACA According to Beliefs About the Role of Government in Improving U.S. Health System



Source: Harvard/Politico October 2016

WHAT SHOULD HAPPEN TO ACA?



Source: Harvard/Politico October 2016

MAJOR CHANGES IN ACA WITH REPUBLICAN WIN

- Major structural changes to ACA – changed name
- End of mandates – individual/corporate
- Elimination or reduction of “Cadillac insurance tax”
- Establishing state pre-existing condition pools
- Less federal subsidies for uninsured and Medicaid
- More state discretion for Medicaid spending
- Less insurance regulation

WHAT WILL CHANGE: COVERAGE

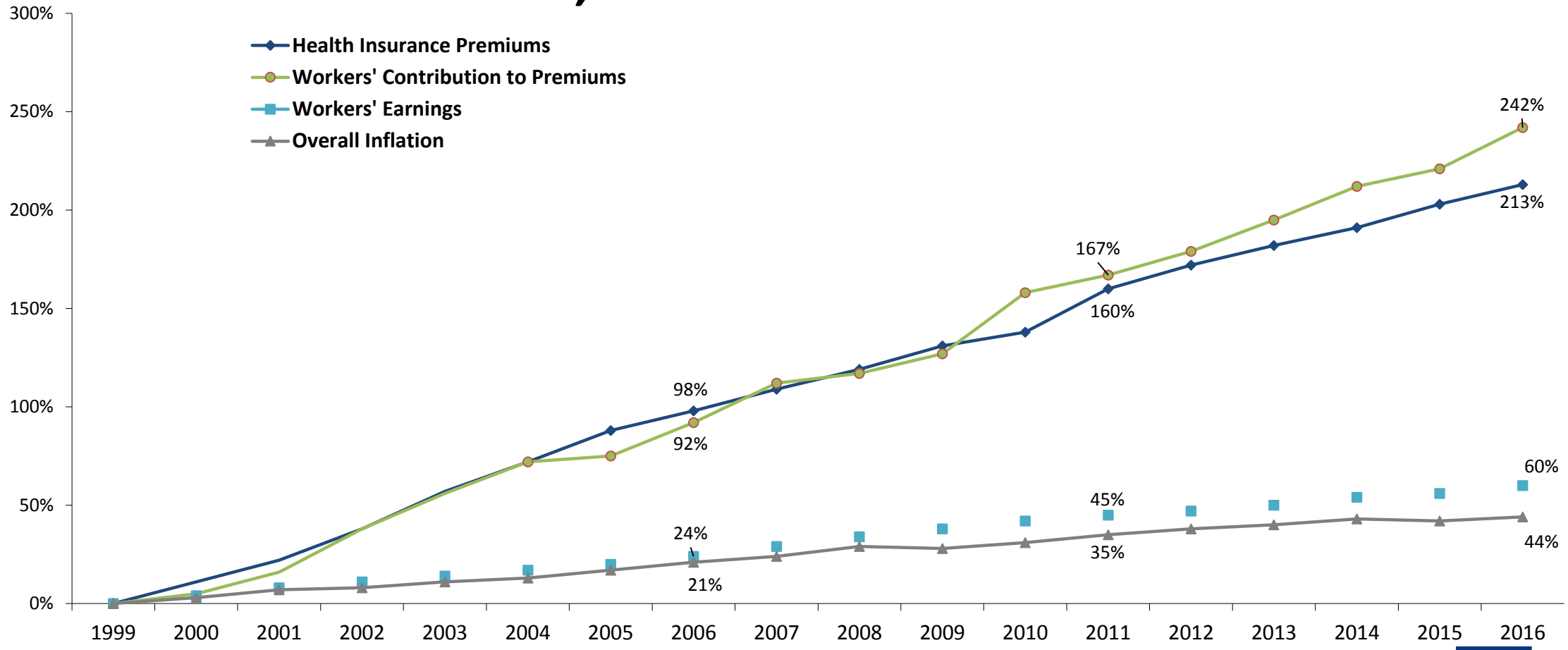
- Repeal and Replace ... Incrementally
- More Market Oriented less Heavy Handed Regulation
- Will coverage of 20 million be significantly eroded?
- “You Break It, You Own it”
- Guaranteed Issuance preserved but how if mandates are removed?
- Fragile individual market, and small group inflation: What to do?
- Sources of Market Failure in Private Health Insurance
  - Cream Skimming
  - Adverse Selection
  - Moral Hazard

WHAT WILL NOT CHANGE:
PAYMENT AND DELIVERY REFORM

- Shift From Volume To Value
- MACRA
- Payment Reform in public and private sector
- Managed Medicaid but more state flexibility
- Medicare Advantage Growth
- Consolidation
- Population Health and Continuum of Care

SERVING SHALLOW-POCKETED CONSUMERS

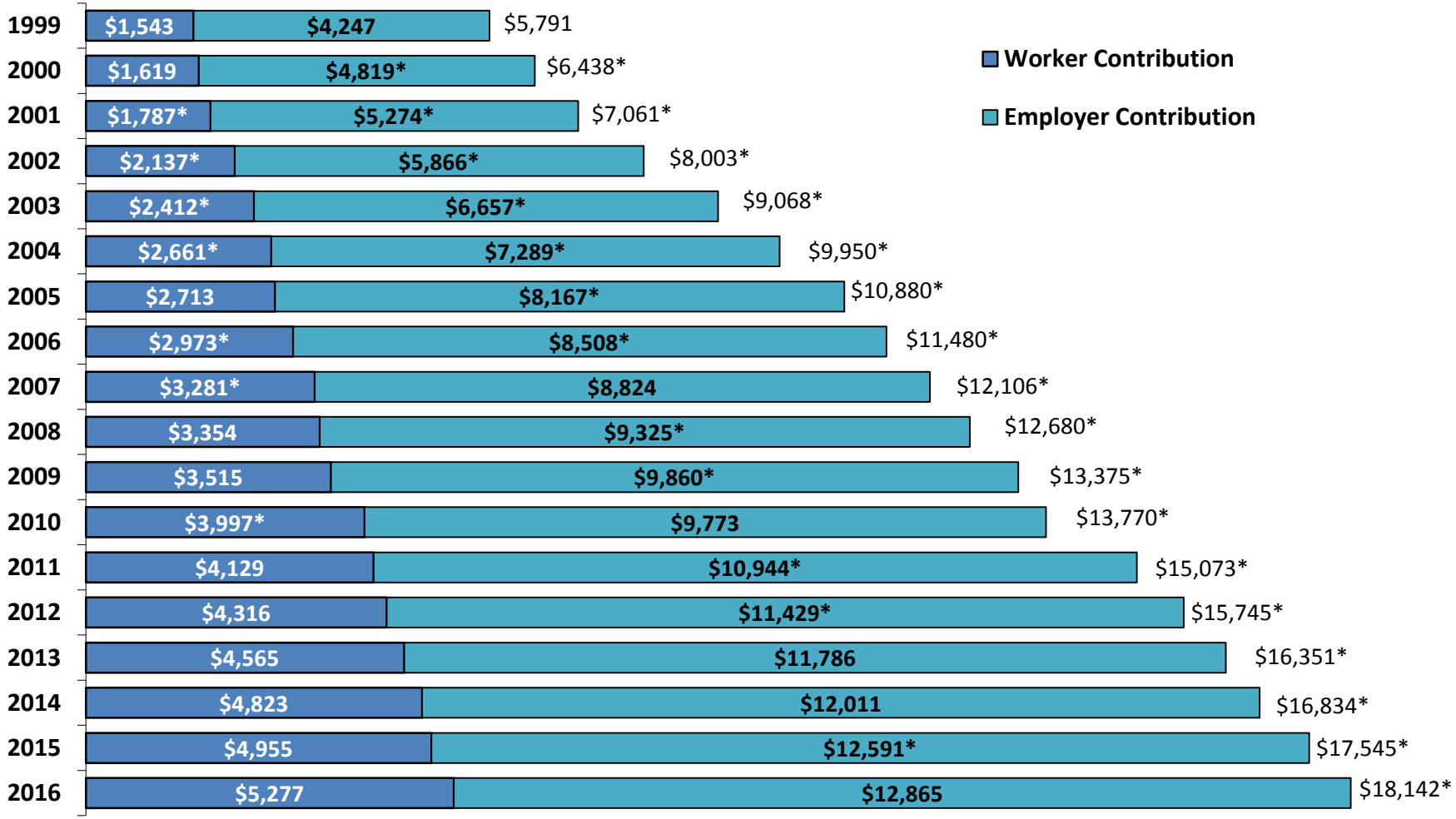
CUMULATIVE INCREASES IN HEALTH INSURANCE PREMIUMS, WORKERS' CONTRIBUTIONS TO PREMIUMS, INFLATION, AND WORKERS' EARNINGS, 1999–2016



SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2016. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999–2016; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999–2016 (April to April).

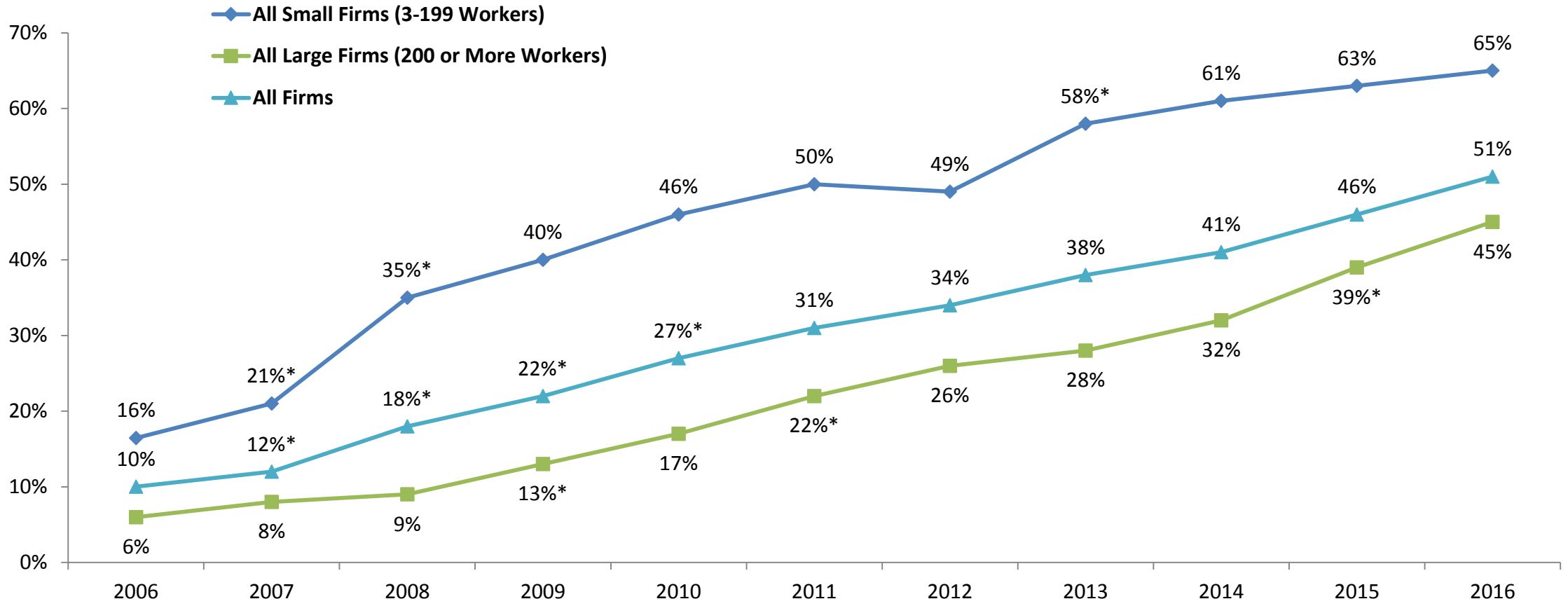
THE HENRY J. KAISER FAMILY FOUNDATION -AND- HRET HEALTH RESEARCH & EDUCATIONAL TRUST

AVERAGE ANNUAL WORKER AND EMPLOYER CONTRIBUTIONS TO PREMIUMS AND TOTAL PREMIUMS FOR FAMILY COVERAGE, 1999–2016



*Estimate is statistically different from estimate for the previous year shown ($p < .05$)
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999–2016.

PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006–2015



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

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

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2006–2015.

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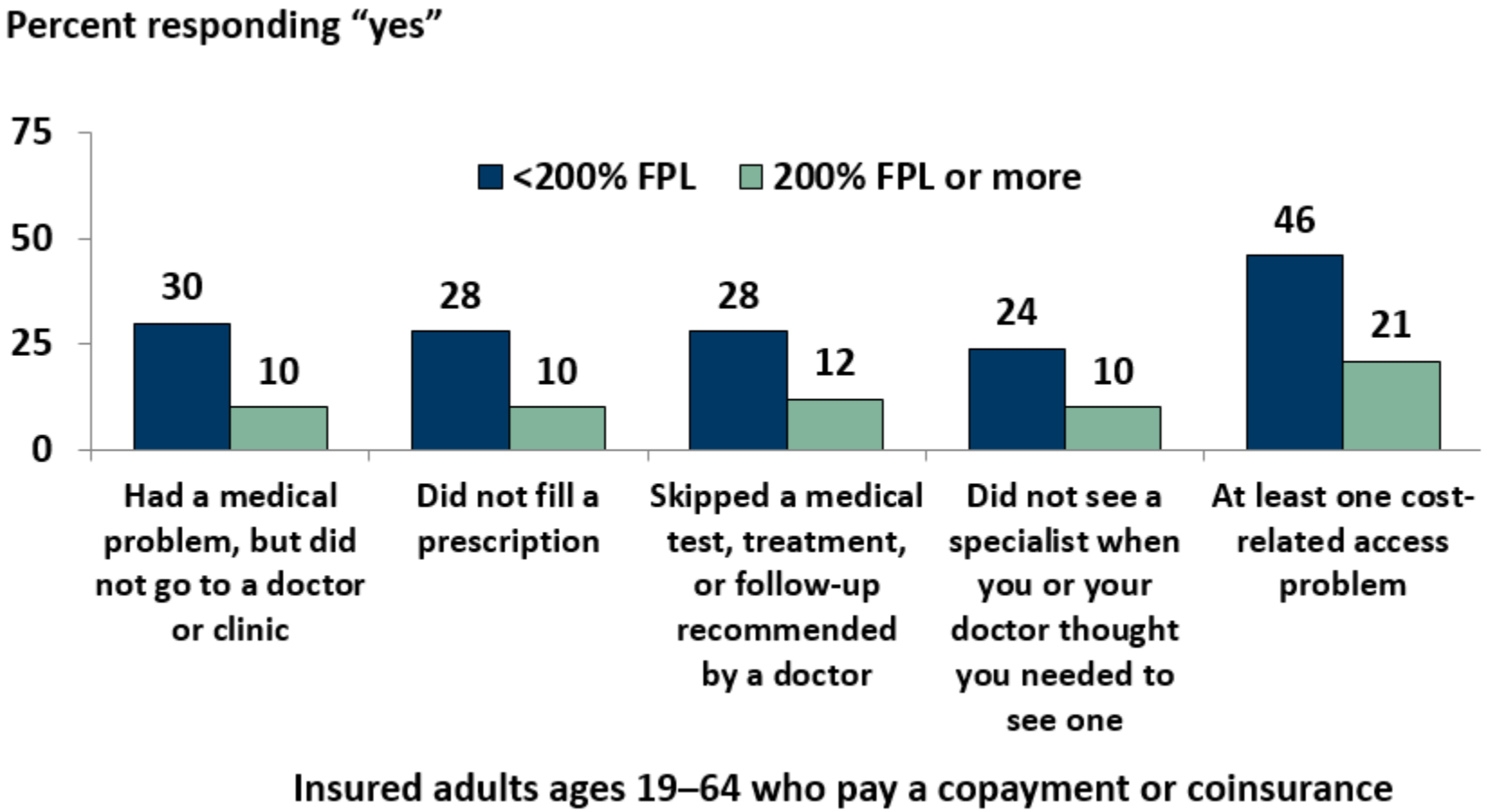
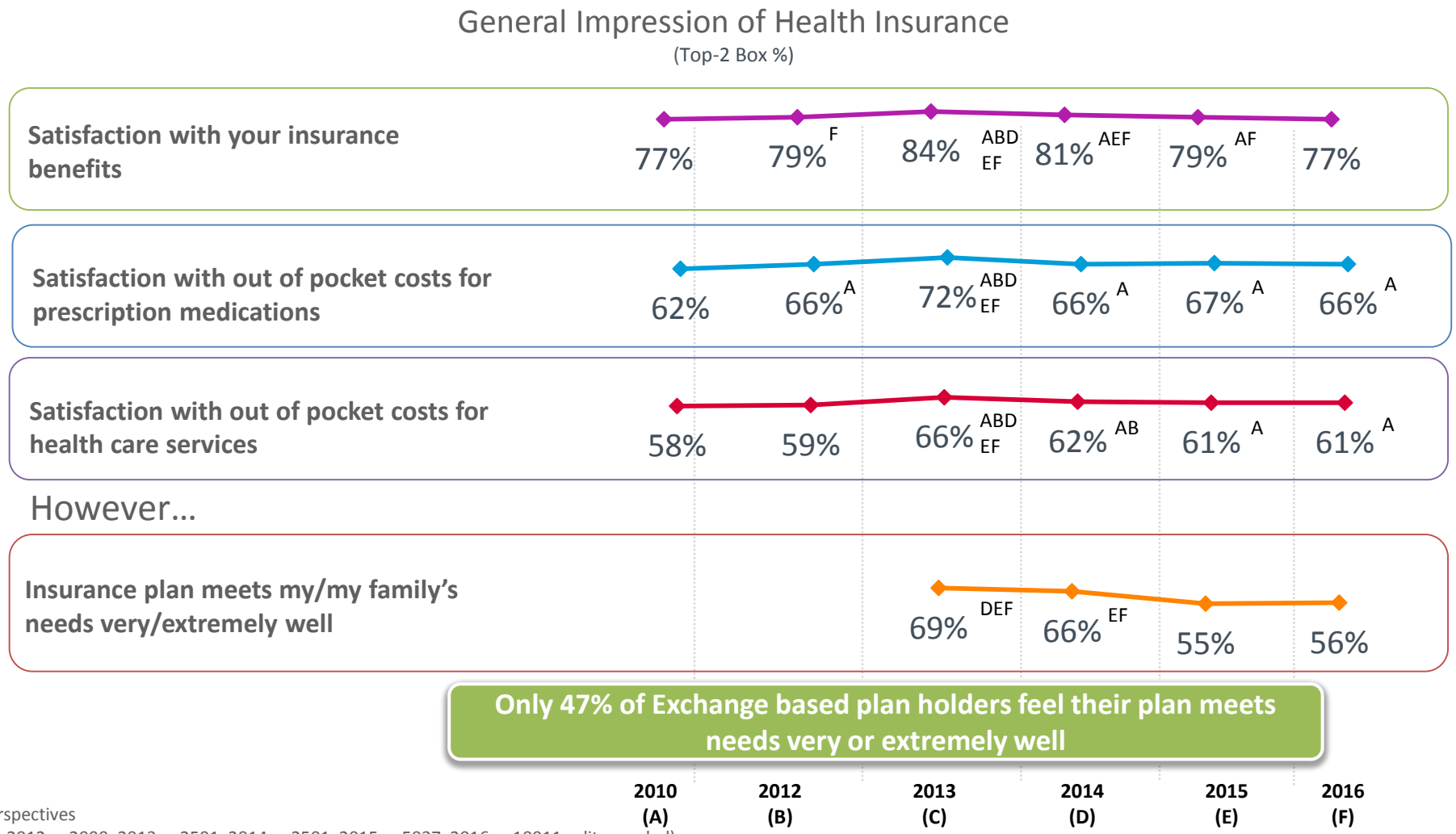
INSURED ADULTS WITH LOWER INCOMES WERE MORE LIKELY TO REPORT THEY HAD DELAYED OR AVOIDED GETTING CARE BECAUSE OF THEIR COPAYMENTS OR COINSURANCE



Note: FPL refers to federal poverty level.
Source: The Commonwealth Fund Health Care Affordability Tracking Survey, September–October 2014.

DOES SATISFACTION MATTER? COMPARED TO WHAT?

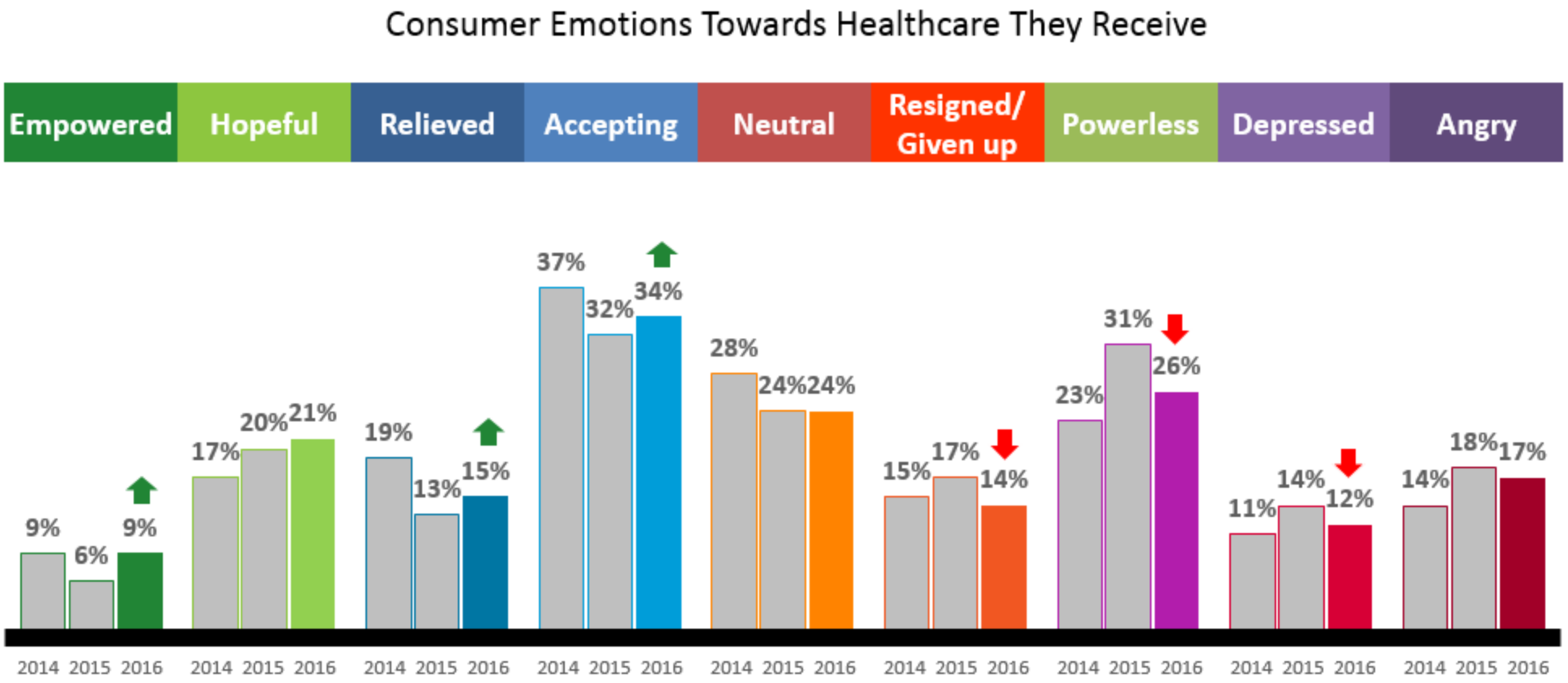


Prepared for: Strategic Health Perspectives
Base: All US Adults (2010 n=2775, 2012 n=2000, 2013 n=2501, 2014 n=2501, 2015 n=5037, 2016 n=10011 split sampled)
Source: Q600: How satisfied or dissatisfied are you with each of the following?; Q185: Thinking now about all the different components of your health insurance plan, how well does your plan meet your/your family's health needs?

Significance tested at 95%

CONSUMERS EMOTIONS TOWARDS HEALTHCARE THEY RECEIVE

Some change towards the positive, but 1 in 4 consumers remains powerless

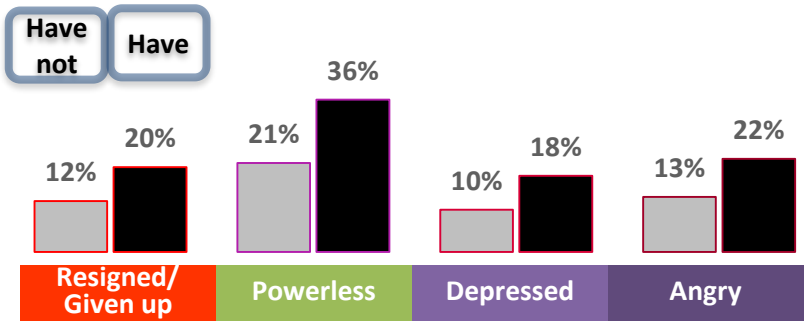


Prepared for: Strategic Health Perspectives
Base: All US Adults (2014 n=2501, 2015 n=5037, 2016 n=30052)
Source: Q90 How would you describe your feelings about the health care you receive today, including how much you pay for it and the benefits you receive? Please select all that apply.

Significant over prior year

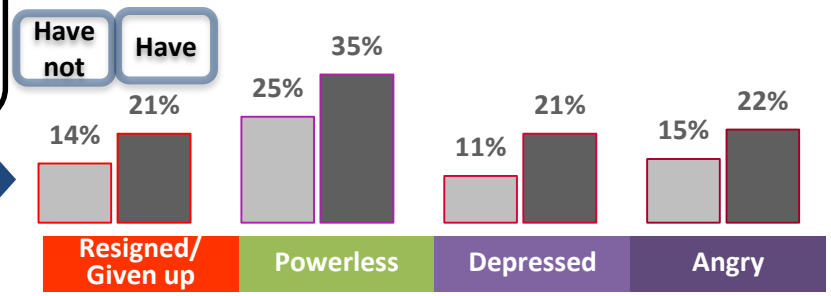
COST MATTERS BECAUSE CONSUMERS PAY MORE OF THE INCREASE…THIS MAKES THEM FEEL MORE POWERLESS

28% Received a balance bill for care they thought was covered



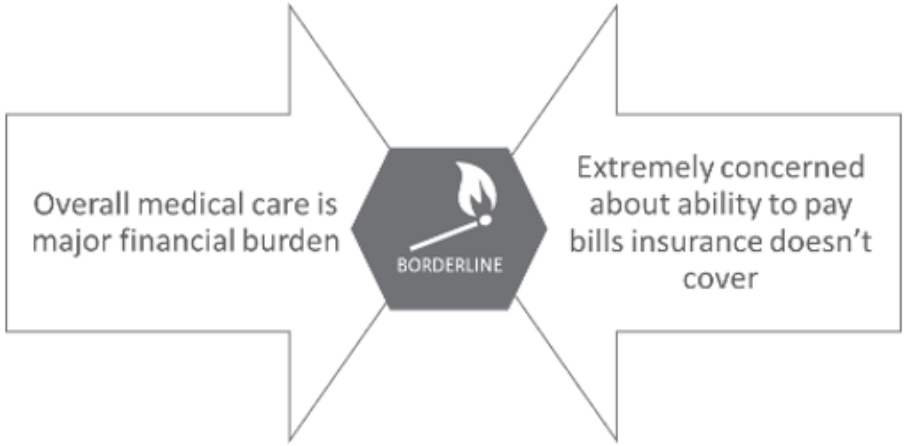
8% TOTAL
13% EXCHANGE

Received a bill for hospital services "not in network" even though the hospital was in network



Prepared for: Strategic Health Perspectives
Base: All US Adults (n=10011 split sample)
Q660. Please indicate if any of the following happened to you in the past year

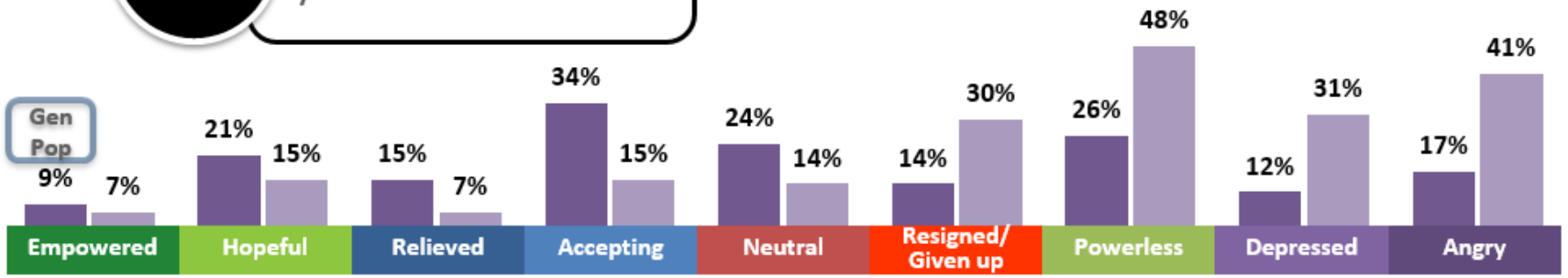
WHO IS Borderline?



They are **NOT** on public insurance!

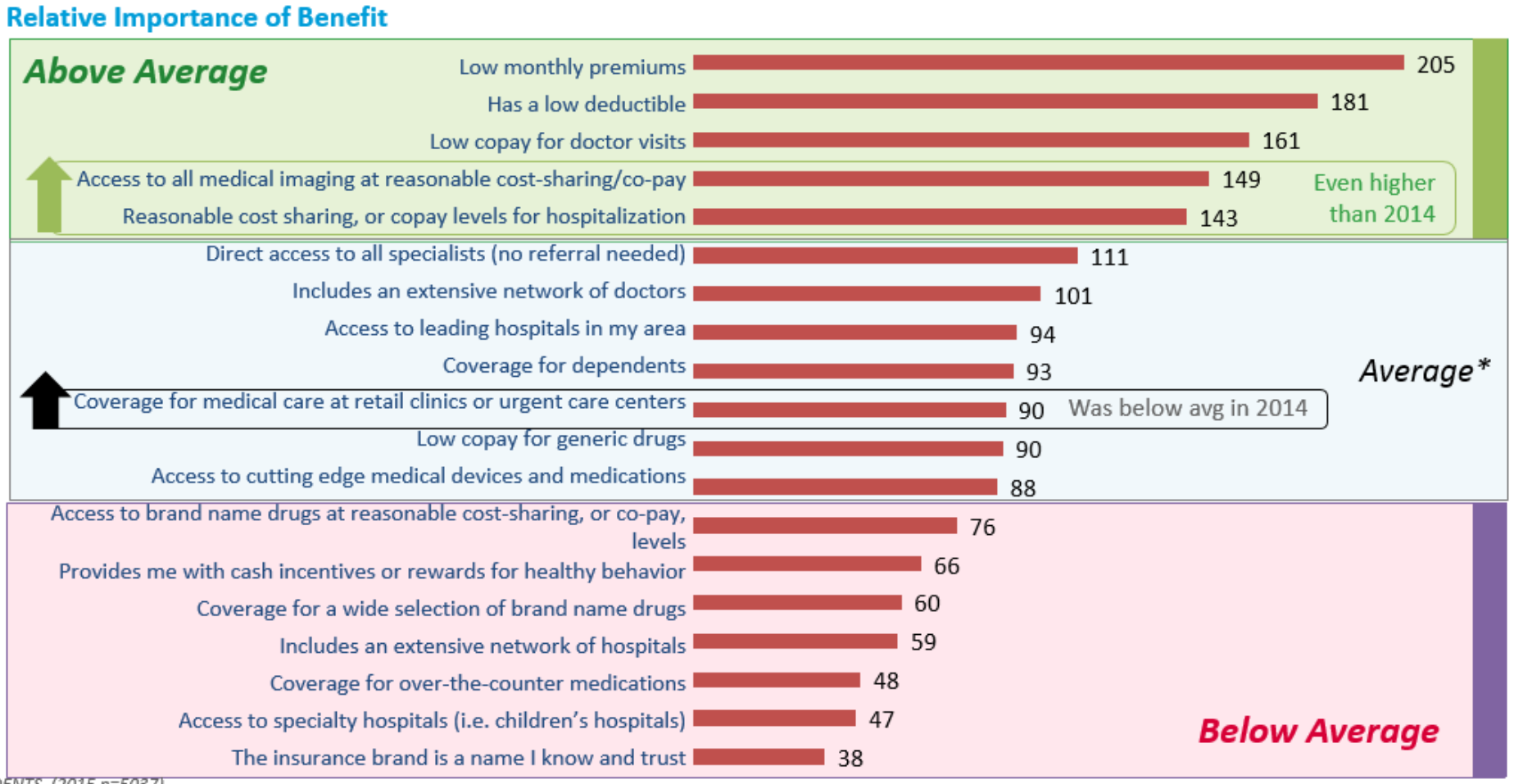
- 40% Have Employer based insurance
- 20% Are uninsured
- 32% Had 1+ ER visits last year

- 42% Had 3+ doctor visits last year
- 51% Received a balance bill for care they thought was covered



LOW OUT OF POCKET COST REMAINS CRITICAL IN PICKING INSURANCE

Consumers concerned with premiums, deductibles and copays…reasonable cost sharing for hospital services and retail clinic coverage are surging.

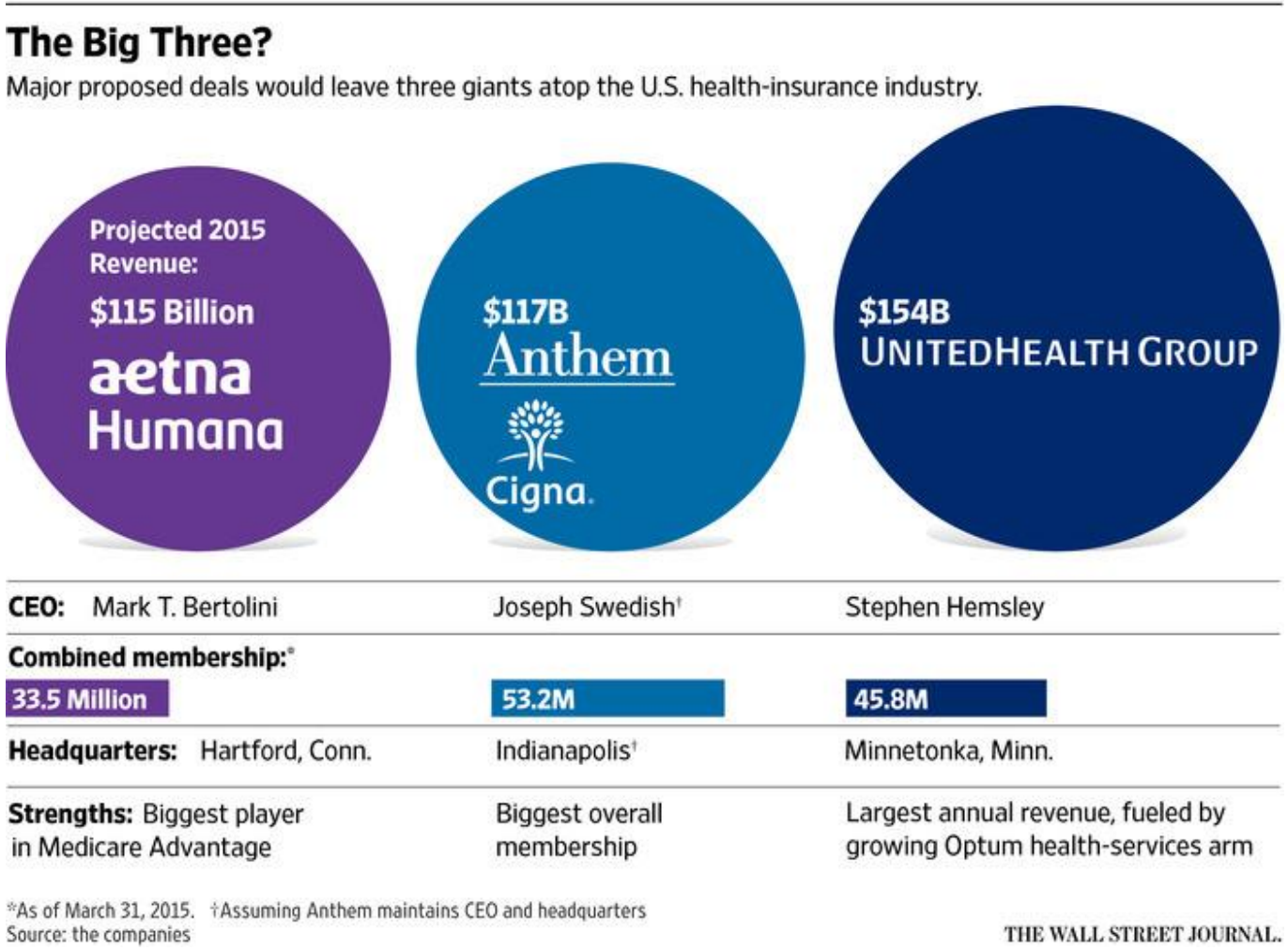


BASE: ALL QUALIFIED RESPONDENTS (2015 n=5037)

*Q65 Respondents were given a maximum difference trade off exercise in which they were forced to choose the most preferred and least preferred plan feature. *Average is 100, and the scores represent importance relative to that average.*

CONSOLIDATION: GOOD OR BAD?

HEALTH PLAN CONSOLIDATION CONTINUES



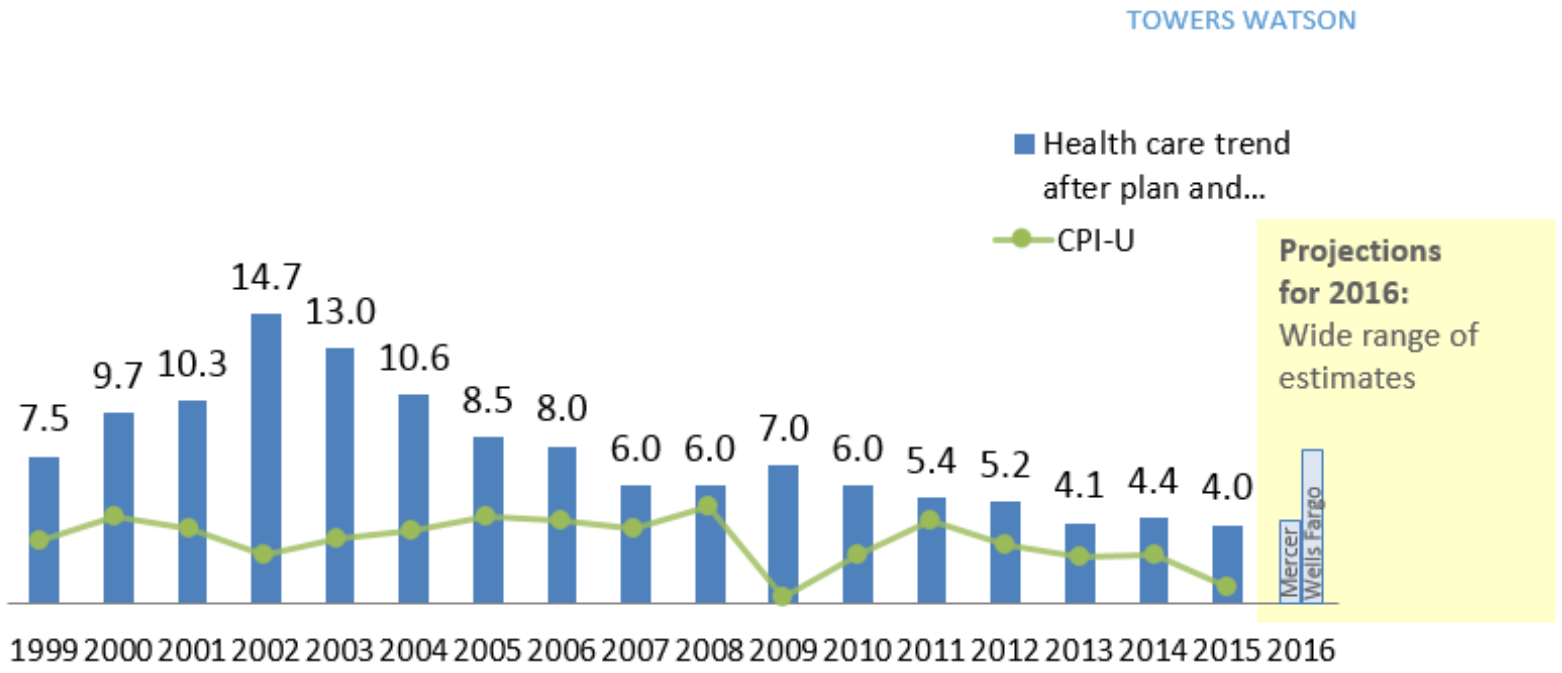
- Aetna buys Humana for $37 billion making a $115 billion run rate company
- Anthem closes on Cigna in $54 billion makes a $117 billion run rate company
- New Rivals for $154 billion UnitedHealth Group
- Other:
  - Centene buys Health Net for $6.3 billion

PROVIDER CONSOLIDATION CONTINUES

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

EMPLOYERS: STAY OR GO?

EMPLOYERS ARE SEEING A PROLONGED RESPITE FROM DOUBLE-DIGIT PREMIUM INCREASES, BUT THESE ARE STILL RUNNING AT TWO TIMES CPI

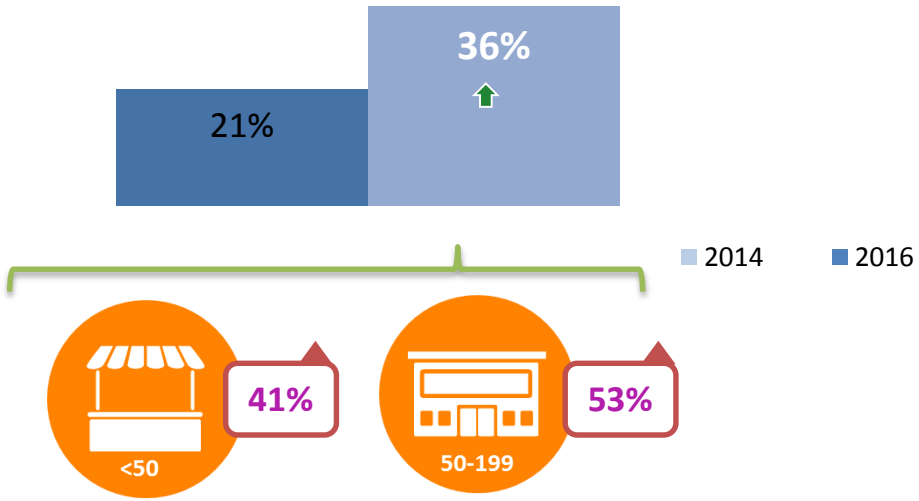


SOURCE: Towers-Watson NBGH Annual Surveys (2014–2015)

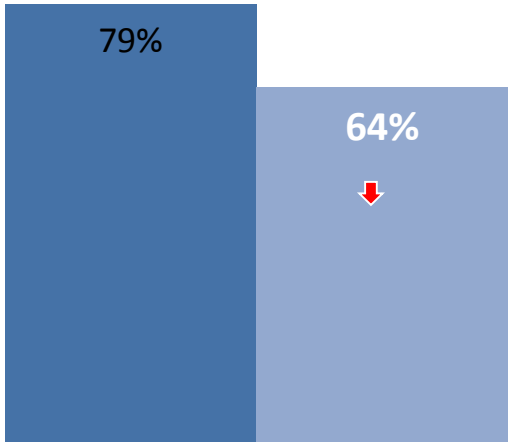
AND MORE ARE SAYING THAT BUSINESS PERFORMANCE SUFFERING AS A RESULT OF HEALTH INSURANCE COSTS

Current Company Attitude towards Health Insurance Benefits

Our business performance is suffering due to health insurance costs



Health insurance costs have very little impact on our business performance

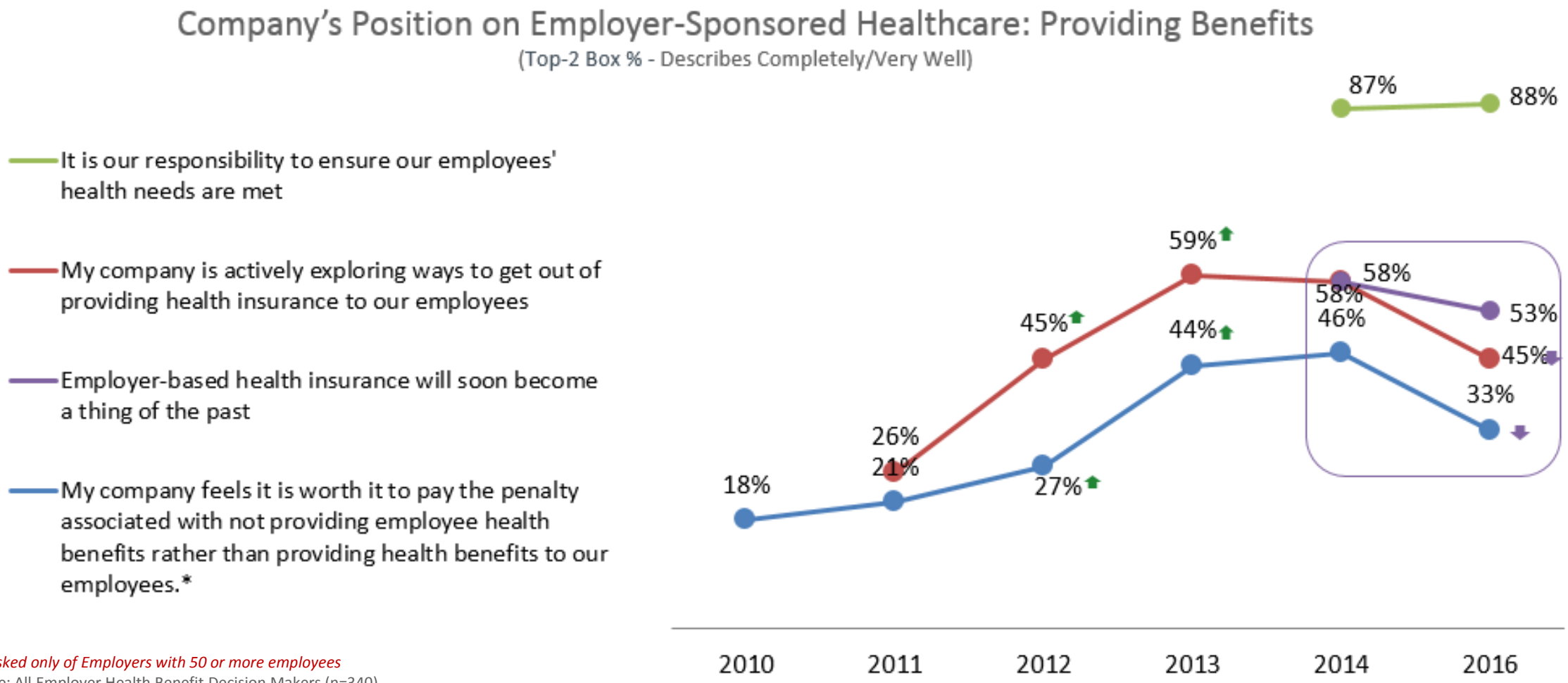


Base: All Employer Health Benefit Decision Makers (n=340)
Q805 Which comes closest to your company's attitude towards health insurance benefits?

Significance: <50 significantly higher than 200-999. 50-199 also significantly higher than 1000–4999 and 5000+.

Significant year over year change

FEWER EMPLOYERS ARE LOOKING FOR AN EXIT; CONTINUE TO FEEL RESPONSIBILITY FOR EMPLOYEE HEALTH NEEDS

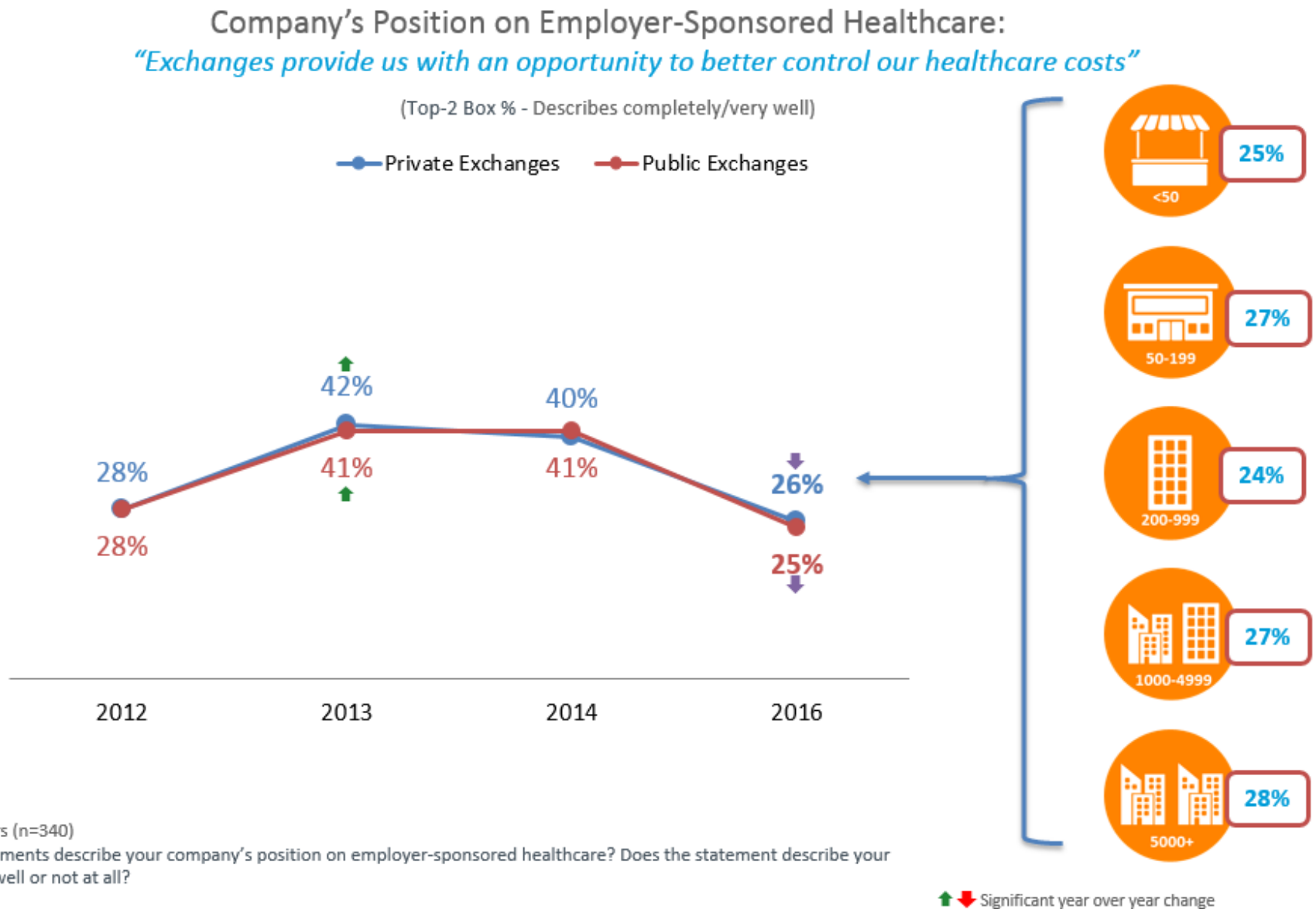


** Asked only of Employers with 50 or more employees*

Base: All Employer Health Benefit Decision Makers (n=340)

Q800: Please indicate your level of agreement with the following statements. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree?

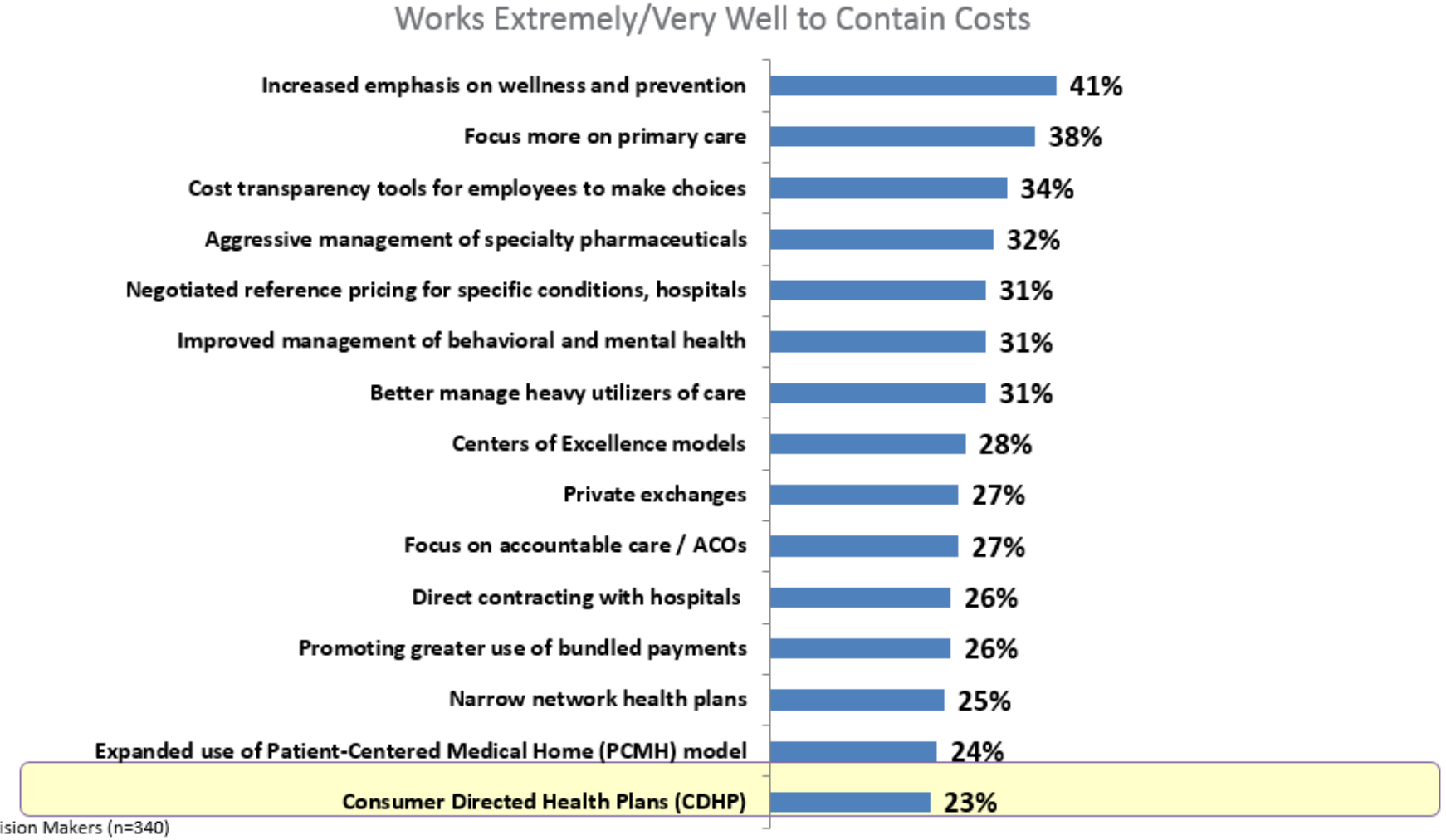
THE APPEAL OF EXCHANGES FOR CONTROLLING COSTS



Base: All Employer Health Benefit Decision Makers (n=340)
Q1100: How well does each of the following statements describe your company's position on employer-sponsored healthcare? Does the statement describe your company completely, very well, well, somewhat well or not at all?

MOST EMPLOYERS DO NOT THINK CURRENT INITIATIVES WORK WELL TO CONTAIN COSTS

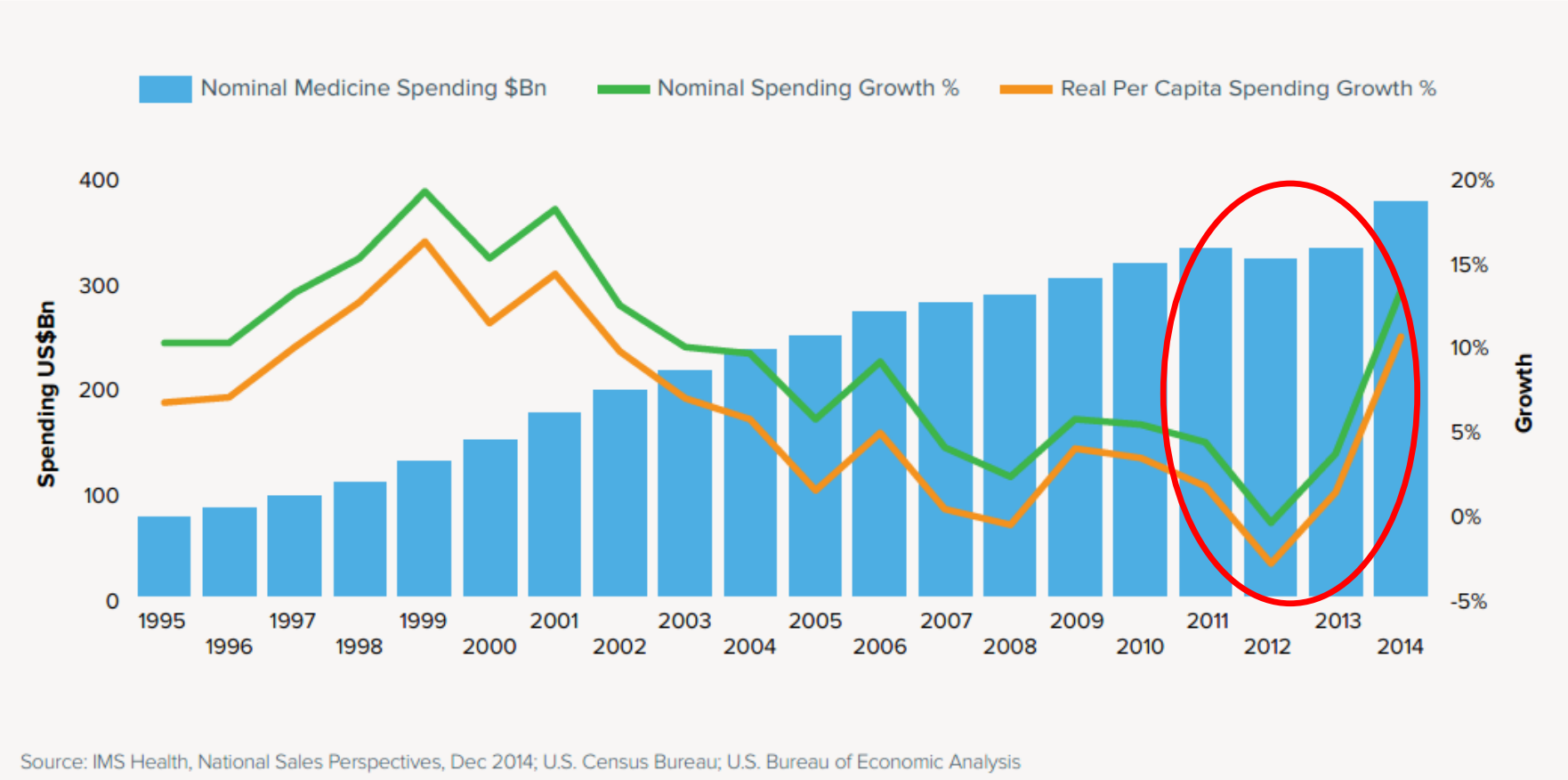
- CDHPs are at the bottom, but even wellness at the top of the list isn't viewed as very effective



Base: All Employer Health Benefit Decision Makers (n=340)
Q1709 How well do you think each of the following initiatives will work to contain costs?

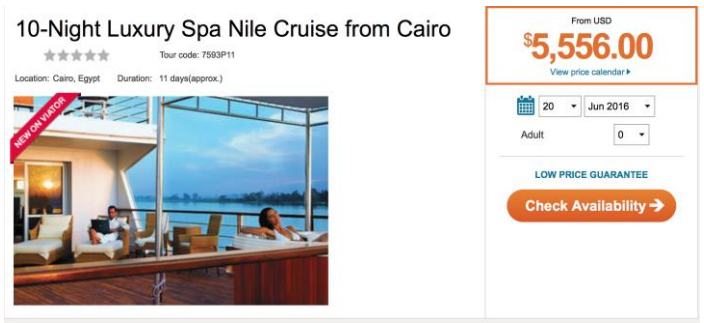
SPECIALTY PHARMACEUTICALS

END OF "PATENT CLIFF" AND EXPLOSION IN SPECIALTY SPENDING PUTS RX INDUSTRY IN THE SPOTLIGHT



Source: IMS Health, National Sales Perspectives, Dec 2014; U.S. Census Bureau; U.S. Bureau of Economic Analysis

HEP-C? TAKE A THREE MONTH LUXURY VACATION TO EGYPT AND GET YOUR EMPLOYER TO PAY FOR IT



The cost of a 12 week course of Sovaldi is **$84,000** in the US, **$900** in Egypt.

84 days at the Nile Ritz Carlton at $250 per night	=	$21,000
84 Days meal allowance at $100 per day	=	$8,400
Business Class Airfare from SFO	=	$2,800
TOTAL		**$32,200**
Savings to Your Employer		**$51,800**

Options

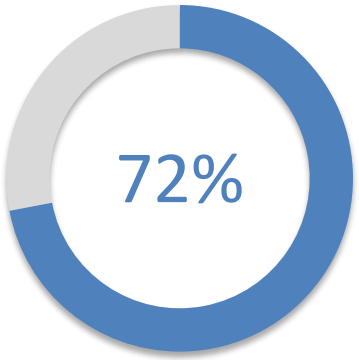
Bring your spouse/partner	Add	$11,200
10 day Luxury Nile Spa Cruise for Two	Add	$11,120
TOTAL		**$54,520**
Savings to Your Employer		**$29,480**

MAJORITY CONTINUE TO SUPPORT PRICE CONTROLS

- While most still feel the need for price controls for pharma and hospitals, physician price control significantly dropped this year

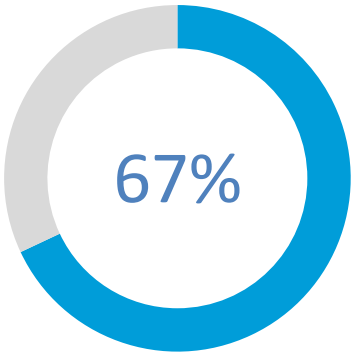
Level of Support for Price Controls

(Top 2 Box: Strongly/Somewhat Support)



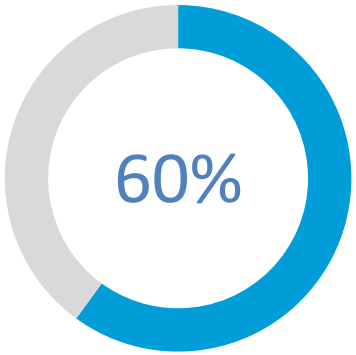
Price controls or caps on pharmaceutical/medical device manufacturers

Change from 2015: +0



Price controls or caps on hospitals

-1



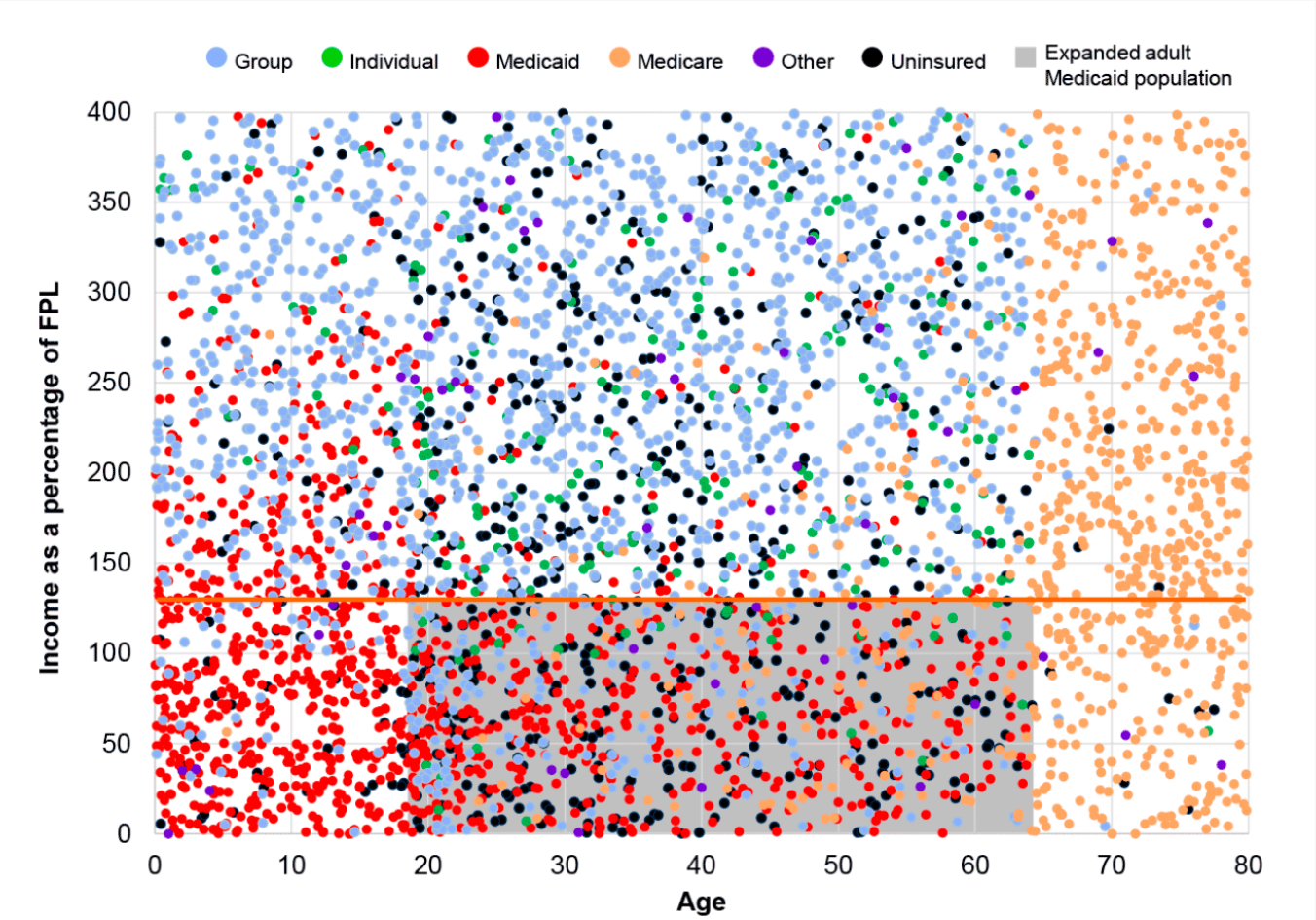
Price controls or caps on physician payment

-10

Strategic Health Perspectives, 2016 Consumer Research, Nielsen Consumer Insights
Base: All US Adults(n=30052)
Source: **Q80** How much do you support or oppose the following ideas?

MEDICAID TRANSITIONS

Transitions in Coverage Type are the Norm for Most Consumers Over Time (US population by insurance coverage type)



FPL = federal poverty level.
Note: Each dot represents 50,000 people. Medicaid figures exclude dual eligibles, who are counted in the Medicare category in MPACT. Medicaid enrollees above 138% FPL include children on CHIP, pregnant women, higher income parents in some states, and blind and disabled beneficiaries.

Source: McKinsey Center for US Health System Reform's MPACT7.5 model with data from the 2014 American Community Survey

- Medicaid is dominant for low income and children
- Medicaid population has significant churn of approximately 25%
- Exchange Population has 40% churn due mainly to changing life circumstances
- Get to 65 and you are “home free on Medicare” ….at least for now
- Republicans may move age of Medicare eligibility up
- Democrats may move age of eligibility (or buy in) down

MAKING VOLUME TO VALUE REAL

RISK BEARING STRATEGIES VARY CONSIDERABLY

- Hospitals committing to clinical integration for contracting w/ payers but full risk only for the few

Base: All Hospital-Based Execs (2016: n=205; 2015: n=200; 2014: n=202)
Q980: Which of the following best describes your hospital's/hospital system's "risk bearing" strategy?

THE TENSION

Bundles

- More is still better economically for providers
- Encourage improvement of teams on dimensions they actually control and that patients care about
- But what do you do about the complex co-morbid and the fact that not everything is easily bundled
- “Screw me on the bundle, and I’ll screw you on the rest”

Population Health/Risk/Accountable Care

- Frequency
- Appropriateness
- Determinants of Healthcare
- The Mutual Disrespect Problem
- Social Work not Medical Care

INNOVATION AT SCALE

LOOKING TO 2020

- Pressure on public payment sources will continue
- Private Payers will not tolerate costs shift willingly
- Exchanges, Medicare Advantage, Managed Medicaid and DB to DC among employers makes market more retail
- Consumer becomes more important as decision-maker
- Long run three payer segments: Managed Medicaid, HDHP (Exchange and Employer) and Medicare Advantage/ACO increase pressure to deliver value
- Care Redesign for higher performance
  - Migrating Business model to Risk
  - Care coordination and management across the continuum of care
  - Alignment of all physicians, nurses and caregivers with this process
  - Consumer facing innovation in delivery and tele-health
  - Innovation at Scale
- Governance and leadership to sustain it all