Health Care 2020

Toward a Value-Driven Payment and Delivery Model
At the Heart of the Federal Budget Debate

Projected Health Care Spending

Average Annual Growth Rate

- 6.1% Federal health expenditures as percentage of GDP, 2008
- 8.1% Projected federal health expenditures as percentage of GDP, 2018

- 7.5% Medicaid
- 6.9% Medicare
- 6.1% NHE
- 4.4% GDP

The Looming Demographic Conundrum

Aging Beyond Our Ability to Support

Number of People 20-64 for Every Person >65

<table>
<thead>
<tr>
<th>Year</th>
<th>Ratio</th>
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</thead>
<tbody>
<tr>
<td>1950</td>
<td>7.2</td>
</tr>
<tr>
<td>1980</td>
<td>5.1</td>
</tr>
<tr>
<td>2011</td>
<td>4.1</td>
</tr>
<tr>
<td>2050</td>
<td>2.1</td>
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</tbody>
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Living Longer

US Life Expectancy at 65
1940: 12 years
2007: 18 years

New Medicare beneficiaries each year 1995-2010
623 K

New Medicare beneficiaries each year 2010-2030
1.6 M

In 2030, Medicare will have twice as many beneficiaries as 2010
2X


1) Organization for Economic Cooperation and Development (OECD) average.
2) Males.
3) Projected.
Coming Wave of Medicare Inpatients

Medicare to Constitute a Majority of Discharges by 2021

Inpatient Volume by Payer Class

<table>
<thead>
<tr>
<th>Payer Class</th>
<th>2011</th>
<th>2021</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>22%</td>
<td>20%</td>
</tr>
<tr>
<td>Commercial</td>
<td>35%</td>
<td>27%</td>
</tr>
<tr>
<td>Self Pay</td>
<td>5%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Medicare</td>
<td>37%</td>
<td>52%</td>
</tr>
</tbody>
</table>

Source: Health Care Advisory Board interviews and analysis.
A Population More Predisposed to Comorbidity

Worsening Case Mix Not Just Due to Aging

Obesity Rate Among U.S. Adults

1988

Obesity Rate Among U.S. Adults

2009

No Data  <10%  10%-14%  15-19%  20-24%  25-30%  >30%


1) Body Mass Index ≥ 30, or 30 pounds overweight for 5' 4" person.
Chronic Disease Growth Outpacing Population Growth

Projected Increase in Chronic Disease Cases
2003-2023

29.0% Stroke
31.0% Pulmonary Conditions
39.0% Hypertension
41.0% Heart Disease
53.0% Diabetes
54.0% Mental Disorders
62.0% Cancer

19%: Projected population growth, 2003-2023

Looking to Put Health Care on a Budget

Three Manifestations of Health Care on a Budget

1. Federal Budget Framework
2. Budgeting in the Private Market
3. Individuals on a Budget

Source: Health Care Advisory Board interviews and analysis.
Unable to Remain Stuck in the Middle

Medicare Evolution Necessary—But in Which Direction?

Medicare Benefits Spectrum

Possible Future Scenarios

“Embracing Defined Contribution”

“Optimizing Defined Benefit”

Potential Medicare Spending

Medicare Involvement in Financing Care Delivery

Fee-for-Service

Medicare Advantage

Means Testing

Rate Cuts

Prior Authorization

Global Spending Caps

Accountable Payment Models

Pure Voucher System

Hybrid Voucher System

Source: Health Care Advisory Board interviews and analysis.
Shifting Risk and Accountability to Providers

Providing an Incentive to Remake the Delivery System

Source: Health Care Advisory Board interviews and analysis.
# How Much Does the 2012 Election Matter?

## Broad Agreement on Need to Bend the Cost Curve—But How?

<table>
<thead>
<tr>
<th>Medicare Model</th>
<th>Obama</th>
<th>Romney/Ryan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Maintain defined-benefit model&lt;sup&gt;1&lt;/sup&gt;</td>
<td>• Repeal entirety of Affordable Care Act</td>
<td></td>
</tr>
<tr>
<td>• Introduce risk-based contracts</td>
<td>• In 2022, transition to defined contribution model with competitive bidding to determine support levels&lt;sup&gt;2&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>• Encourage development of new care models</td>
<td>• Continue to offer traditional Medicare as option</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Medicare Spending</th>
<th>Obama</th>
<th>Romney/Ryan</th>
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</thead>
<tbody>
<tr>
<td>• Enact the following cuts over next ten years:</td>
<td>• Repeal all Medicare cuts over next ten years (likelihood determined by Congressional election outcomes)</td>
<td></td>
</tr>
<tr>
<td>o $415 billion to hospitals, physicians</td>
<td>• Reduce Medicare spending beyond 2022</td>
<td></td>
</tr>
<tr>
<td>o $156 billion to Medicare Advantage</td>
<td>• Limit program cost growth to nominal GDP plus one percent through market-based incentives (higher cost plans require greater out-of-pocket spending)</td>
<td></td>
</tr>
<tr>
<td>o $56 billion to DSH&lt;sup&gt;3&lt;/sup&gt; payments</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Limit program cost growth to nominal GDP plus one percent through cuts to hospital, provider reimbursement</td>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Obama</th>
<th>Romney/Ryan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increase eligibility in states participating in Medicaid expansion</td>
<td>• Combine federal Medicaid, other health spending into single block grant to states</td>
<td></td>
</tr>
<tr>
<td>• Ensure benefits meet exchange benchmarks</td>
<td>• Limit federal requirements on Medicaid coverage</td>
<td></td>
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<table>
<thead>
<tr>
<th>Commercial</th>
<th>Obama</th>
<th>Romney/Ryan</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Provide individual, small business subsidies for exchange-based plans</td>
<td>• Encourage individuals, small businesses to form purchasing pools</td>
<td></td>
</tr>
<tr>
<td>• Enact coverage mandates</td>
<td>• Provide tax credit for purchase of individual coverage</td>
<td></td>
</tr>
<tr>
<td>• Maintain minimum coverage requirements</td>
<td>• Allow purchase of insurance across state lines</td>
<td></td>
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1) Defined Benefit: The government procures medical goods and services for consumers, as determined by the physician.
2) Defined Contribution: The consumer is provided a monetary payment, but is responsible for procuring medical care.
3) Disproportionate Share Hospital.

Elevating the Value of the Existing Benefit

Strategies to Elevate the Value of the Benefit

Value-Based Benefit Design
- Increase beneficiary cost-sharing
- Link decision-making to value, cost of provider

Accelerated Value-Based Purchasing
- Expand metrics
- Increase provider reporting requirements
- Increase focus on patient experience

Delivery System Reform
- Reduce cost of broader care episodes
- Continue experiments in shared risk models

Source: Health Care Advisory Board interviews and analysis.
Medicare ACOs Off and Running

Providers Eying Opportunities to Evolve Beyond Fee-for-Service

64% ACOs in MSSP are physician group only
Assembling a Delivery System to Manage Risk

Laying the Groundwork for “Accountable Care”

**Physician Alignment**
- Explore opportunities to leverage either extensive physician employment or Clinical Integration as initial physician performance platforms
- Analyze ACO antitrust eligibility requirements beyond traditional strategies

**Information-Powered Care**
- Invest in infrastructure required for ACO core competencies, including interconnectivity, patient activation, population risk management
- Design IT strategy that exceeds Meaningful Use requirements, focuses on analytics to unlock power of digital data

**New Clinical Model**
- Build comprehensive ambulatory network to address medical demand, including investments in post-acute alignment, disease management, primary care access
- Consider medical home as primary strategy for medical management

Source: Health Care Advisory Board interviews and analysis.
Establishing the Medical Perimeter

Extensive Ambulatory Care Network to Mitigate Medical Demand

Medical Management Investments

- Patient Activation
- Post-Acute Alignment
- Medical Home Infrastructure
- Primary Care Access
- Disease Management Programs
- Population Health Analytics
- Electronic Medical Records
- Health Information Exchanges

Source: Health Care Advisory Board interviews and analysis.
Driving Innovation in the Commercial Market

Commercial Insurers Following Medicare’s Lead

**Providence Health & Services:** $30 M, two-year contract with public employee benefits board

**Blue Shield California:** Two ACOs in Northern California

**Anthem Blue Cross:** ACO pilot with Sharp HealthCare medical groups

**BCBS Minnesota:** Shared savings contract with five providers

**Humana:** ACO pilot with Norton Healthcare

**UnitedHealth Care:** ACO with Tucson Medical Center

**Maine Health Management Coalition:** Multi-stakeholder group supporting ACO pilots

**BCBS Massachusetts’s Alternative Quality Contract:** Annual global budget, quality incentives for participating providers

**BCBS Illinois:** Shared savings contract with Advocate Health Care

**CIGNA:** Medical home contract with Piedmont Physicians Group

**Aetna:** ACO pilot with Carilion Clinic

Cooperating to Deliver Distinctive Offerings

Newly Formed Payer-Provider Partnerships

- **Blue Shield, Hill Physicians Medical Group, AllCare IPA**
  - *Blue Groove*
  - Premium reduction: 10%

- **Steward Health System, Tufts Health Plan**
  - *Steward Community Choice*
  - Premium reduction: 15-30%

- **Fairview Health, Medica**
  - *Fairview Health Advantage with Medica (defined contribution plan for businesses)*
  - *Harmony with Medica and Fairview (individuals)*

- **Banner Health, Health Net**
  - *ExcelCare*
  - Premium reduction: 20%

- **Carilion Clinic, Aetna Banner Health, Aetna**
  - *Aetna Whole Health*
  - Premium reduction: 30%

- **MedStar Health, Evolent Health**
  - Supporting population management strategies

Spurred By a More Activist Employer Market

Employees Covered by ASO\(^1\) Versus Fully Insured Agreements

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>ASO</td>
<td>82</td>
<td>91</td>
</tr>
<tr>
<td>Commercial Risk</td>
<td>96</td>
<td>86</td>
</tr>
</tbody>
</table>

ASO increased by 11%

Percentage of Smaller Employers Self-Insuring\(^2\)

<table>
<thead>
<tr>
<th></th>
<th>2008</th>
<th>2010</th>
</tr>
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<tbody>
<tr>
<td>ASO</td>
<td>29%</td>
<td>48%</td>
</tr>
<tr>
<td>Commercial Risk</td>
<td>96</td>
<td>86</td>
</tr>
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1) Administrative services organization.
2) Firms with 1,000 or fewer employees.
Pushing Past Traditional Benefit Design

**Narrow Networks**
- Negotiates discounts of 20%-40% less than commercial rate
- Uses predictive modeling to identify high-risk employees
- Educates employee population about alternatives to surgery
- Sells network access, services to reduce surgical demand directly to employers

**Targeted Interventions**
- Program offered in groups at Chrysler headquarters; 200 employees with back pain initially targeted
- Uses occupational therapy and relaxation techniques to mitigate pain
- 55% of Employees reporting no pain following program completion

**On-Site Care**
- Over 360 employer campuses currently have Walgreens clinics on-site
- Option to customize wellness, health care service offerings based on specific needs
- On-site clinic minimizes employee absenteeism
- Walgreens reports ROI ranging from 60%-100%

**Case in Brief: BridgeHealth**
- Surgery benefits firm based in Denver, Colorado
- Aggregates high-quality providers to create virtual narrow networks for specific surgical procedures

**Case in Brief: Chrysler/HFHS**
- Chrysler partnered with Henry Ford Health System in 2007 to offer program designed to eliminate widespread, chronic lower-back pain, minimize work absenteeism

**Case in Brief: Walgreens**
- Largest U.S. drugstore chain
- Through purchase of a health management company, formed subsidiary to offer branded worksite health clinics

An Exit Ramp for Employers?

Health Insurance Exchanges Taking Shape Nationwide

Percent of Employers Predicted to Keep or Drop Health Coverage

<table>
<thead>
<tr>
<th>Source</th>
<th>Estimate</th>
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<tbody>
<tr>
<td>RAND</td>
<td>8.7%</td>
</tr>
<tr>
<td>Urban Institute</td>
<td>(0-2%)</td>
</tr>
<tr>
<td>CBO</td>
<td>(2-3%)</td>
</tr>
<tr>
<td>Mercer</td>
<td>(3-20%)</td>
</tr>
<tr>
<td>McKinsey &amp; Co.</td>
<td>(30%)</td>
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Employers “Very Confident” Health Benefits Will Be Offered At Their Organization a Decade From Now

<table>
<thead>
<tr>
<th>Year</th>
<th>Estimate</th>
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<tbody>
<tr>
<td>2007</td>
<td>73%</td>
</tr>
<tr>
<td>2008</td>
<td>62%</td>
</tr>
<tr>
<td>2009</td>
<td>57%</td>
</tr>
<tr>
<td>2010</td>
<td>38%</td>
</tr>
<tr>
<td>2011</td>
<td>23%</td>
</tr>
</tbody>
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1) Economic modeling, through 2016; due to employee demand driven by individual penalties for being uninsured and availability of lower-cost insurance options.
2) Congressional Budget Office; after 2014.
3) In November 2010 survey of 2,800 employers released by Mercer: 3% of employers >10,000 employees planned to drop coverage, 6% of employers >500 employees planned to drop coverage, and 20% of employers with 10-499 employees planned to drop coverage.
Enabling a Defined-Contribution Approach

Early Exchange Structure Allows Employers to Budget Contribution

Transition to Defined Contribution Plan

Orion contributes $125-$350 per month toward coverage
Employee selects individual policy on exchange

10%
Reduction in premium costs due to switch

Case in Brief: Orion Corporation

- 70-employee residential services firm located in St. Paul, Minnesota
- Converted HDHP1 to defined contribution plan managed by Minnesota-based Bloom Health

Payers Taking Notice

Wall Street Journal
“WellPoint, Non-Profits Invest in Private Insurance Exchange”

- WellPoint, Blue Cross Blue Shield of Michigan, and Health Care Service announce plans to acquire 78 percent share of Bloom Health
- Insurers plan to offer fully operational exchanges by 2013


1) High-Deductible Health Plan.
Past the Point of Incremental Change

Pressure on Industry Requires New Operating Paradigm

Adapting to Meet the Challenges of the New Environment

Changing the Evolutionary Profile

Physical Footprint
- Capturing the value of health system scale and scope
- Creating a “medical perimeter” around the health system

Information Asset
- Creating a truly data-driven health care enterprise
- Maximizing capture and use of patient-level intelligence

Clinical Workforce
- Leveraging new clinical technologies to support evidence-based care
- Mitigating shortage of critical workers with appropriate leverage

Patient Engagement
- Redesigning care processes around patient needs
- Changing the profile of the health system in the community

Finding a New Niche

Source: Health Care Advisory Board interviews and analysis.
Adopting a Patient-Centered Approach to Scale

Integrating Access Points, Full Continuum of Providers to Improve Care

Extending the Scope of the Organization to Meet Patients’ Needs

Home Monitoring
Medical Home
Retail Clinic
Hospital Network
Post-Acute Care Providers
Home Health
FQHC\(^1\)

Ongoing Care Management
Acute Care
Post-Acute Care

Affiliating Across the Care Continuum

Source: Health Care Advisory Board interviews and analysis.

\(^{1}\) Federally Qualified Health Center.
Looking Ahead to a Wired Health System

Emerging Data Systems Change Outlook of Competitive Asset

Today: Differentiate on Data Access

- Focus on data ownership
- Health system has possession of “the wires,” proprietary data
- Data analysis conducted in silos

Disruptive Technologies

- Cloud Computing
- National Network
- Health Information Exchanges

Future: Differentiate on Data-Informed Care Plan

- Data is prescriptive, predictive
- Focus on EHR\(^1\) capability
- Compete in a world of greater transparency

Physicians on the Fast Track

“Cloud-based technologies and PHRs\(^1\) are potential examples of disruptive technologies in health IT. These types of technologies might allow the 80 percent of physicians who are non-digital to leapfrog some of the existing limitations of EHR systems directly into more modern technologies.”

*Report to the President*
President’s Council of Advisors on Science and Technology


1) Electronic Health Record.
Enabling Constant Monitoring of Health Status

Reminders Help Patient Stay on Track and Reinforce Care Plan

Activation On the Go

WellDoc Alert
“Your most recent blood test shows that you have low blood sugar. It’s time to treat this before you eat your meal or take your meal time medication.”

Advice Triaged Across Multiple Sources

- Real-time biometric alerts via text message
- Longitudinal alerts and reminders via web portal
- Secure provider communication via e-mail

Technology in Brief: WellDoc, Inc.

- Health care technology company based in Baltimore, Maryland
- Initial clinical trials showed successful reduction of HbA1c levels by 2.03 percent
- Mobile health coach device can be used with variety of patients; with or without physician participation
- Two-year, 225-patient effectiveness study completed January 2010; participants included University of Maryland, Care First Blue Cross Blue Shield, Sprint, LifeScan

From Jeopardy to Clinical Practice

Rise of Watson and Smart Technology as Part of the Care Team

Leveraging Advanced Computational Resources for Clinical Care

Clinical interaction reveals symptoms, physician forms preliminary diagnosis

Watson generates ranked differential diagnoses, treatment paths for physician consideration

Physician leverages the capabilities of Watson to confirm diagnosis, confidently pursue treatment plan

Technology in Brief: IBM’s Watson Supercomputer

- IBM designed a supercomputer with the computational ability to answer natural language questions in real time; expanding breadth of material to include medical content
- Medical diagnostic capabilities of Watson currently being tested at Columbia University; intent is to support physicians with real-time clinical information and ranked differential diagnoses
- University of Maryland physicians working to determine how Watson could best interact with medical providers to enhance care delivery

Longitudinal Care Management Needs Guide Staffing

**Mitigating Shortage, Managing Health**

**Patient at the Center, Providers at the Top of Their License**

- First to deploy the MyChart iPhone app
- Increasing number of patients utilizing IT actively

- **Technology**
- **PCP**
- **Clinical Support**

- Service oriented
- Team manager
- Panel manager
- Task delegator to team
- Focus on clinical support working at the top of their license
- Goal is 1-2MD:1AP\(^1\) ratio at PCP offices

**Case in Brief: Dean Health System**

- Integrated delivery system including a multispecialty clinic network and health plan, located in Madison, Wisconsin; business model focusing on value-based care has been a priority since 2004
- Undergoing significant primary care redesign; focus on growing primary care and becoming magnet institution for PCPs

1) Advanced practitioner, primarily physician assistant and nurse practitioner.

Source: Health Care Advisory Board interviews and analysis.
Iora Health Contracts Directly With Employers to Deliver Primary Care

- PCPs, contracted specialists provide care to employee population
- Employer pays fixed PMPM\(^1\) fee for care, clinic reports outcomes at monthly meetings
- Iora physicians coordinate care with hospitalists; hospital provides data to Iora

Case in Brief: Iora Health

- Operating the Dartmouth Health Connect clinic for Dartmouth College in Hanover, New Hampshire and the Culinary Extra Clinic for the Culinary Health Fund in Las Vegas, Nevada
- Clinics manage top 10 percent of sickest patients using comprehensive, team-based approach
- Achieved 12.3 percent decrease in total spending for patients enrolled in 2009\(^2\)

Putting the Patient First

“We’ve been worrying about the impact of our decisions on physicians and hospitals, but it’s time to worry about the impact on the patient. The hospital perspective is not our problem, it’s creative destruction.”

Rushika Fernandopulle, MD
Iora Health

Looking Ahead to a Decade (or More) of Change

Entering an Era of “Accountable Care”

Betting on a Provider-Driven Solution Set

Hospitals

- Consolidation and integration
- Continuum-wide care
- Efficiency and standardization

Doctors

- Group aggregation and employment
- Enhanced primary care practice
- Embedding IT to drive to EBM¹

Patients

Who’s “accountable”?

Payers

- Public—price cuts and risk shifts
- Private—risk-based contracting
- All—value-based payment models

Employers

- Increased cost-sharing with employees
- Heavier emphasis on health management
- Defined (or no) contribution

¹ Evidence-based medicine
Health Care 2020

*Toward a Value-Driven Payment and Delivery Model*