What Happens When Patients Control ALL the Money?
The Emerging Threat/Opportunity for Providers and Insurers

Steve Hyde
10/14/14
A quick review of population health

Population health is being driven by 3rd-party pressure on FFS rates
Medicare FFS rates vs Medicaid and Private Health Insurance (PHI)

Insurance Reimbursements Under Current Law (assumes constant Medicaid, PHI rates)

Source: CMS Office of the Actuary
Medicaid Cuts

• “Illinois Medicaid Cuts: Gov. Quinn $1.6 Billion”
• “Thousands of Illinoisans to be affected by Medicaid cuts”
• “Colorado's Medicaid expansion plan must cut costs”
• New York State to eliminate most Medicaid FFS by 2016
• “White House Backs States' Power To Cut Medicaid Payment Rates”
• “California to reduce certain Medi-Cal payments by 10%”
• “13 States Cut Medicaid to Balance Budgets”
Commercial Insurance Cost-Shifting Pressure

- Shrinking commercial insurance market share
- Increased regulatory scrutiny of premium increases
- Lowering of hospital rate increases as payers face financial challenges
- Hospitals’ ability to cost-shift to commercial payers is rapidly being reduced

Hospital Revenues In Critical Condition; Downgrades May Follow, Moody’s Investors Services
Demise of 3rd Party FFS is Driving Population Health

Population Health Transition Framework

INITIATIVE I
Operating Efficiencies, Quality, and Patient Engagement

INITIATIVE II
Physician Network Development and Alignment Planning

INITIATIVE III
Service Network Rationalization Strategy

INITIATIVE IV
Data analytics
- PCMH
Payer contracting
- Network contracting
- Value attribution
- Plan design
Capitation management
- Risk management
- Network management
Provider based health plan

DELIVERY SYSTEM

INTEGRATED DELIVERY and PAYMENT SYSTEMS

PAYMENT SYSTEM

© Stroudwater Associates 2014
However...

The population health challenge...
...is just the beginning

3rd Party FFS

Patient Control of all The Money
We are seeing a significant, and largely unnoticed shift in control of the health care dollar from governments and employers to the individual consumers of medical care...
Two components of health care costs

1. Patient out-of-pocket costs
2. Insurance-covered costs
1. Patient out-of-pocket payments—traditional

• Until recently, patients typically paid only nominal amounts
  • Primarily copayments not based on actual costs
  • Relatively small deductibles and coinsurance
  • Low OOP maximums
Patient OOP changing very, very rapidly

Percentage of covered workers with an annual deductible of $1000 or more (single coverage)

Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits 2006-2013
1. Patient out-of-pocket payments—emerging

- Patient OOP rising rapidly
  - Copayments being replaced with price-based payments
  - Much higher deductibles ($1500-6000)
  - Coinsurance for higher cost services above deductible
  - Higher OOP annual maximums up to $6,450/$12,900 single/family
- Rapidly growing consumer demand for & sensitivity to transparent provider pricing
  - Medical tourism (foreign and domestic)
  - MediBid auction site
  - Growing impact on high-cost imaging
  - All-inclusive direct primary care (DPC) pmpm pricing
  - Bundled pricing for high-cost services
  - McKesson, others offering POS claims pre-adjudication software
“Doctor, how about zero? Is zero good for you?”
Saving $2,500 in 3 minutes...
2. Insurance covered costs—traditional approach

• Funded by premiums (private) and direct payments (government)
• Consumer premium costs typically small compared to total costs
• Covers both normally consumed and “catastrophic” care
• Controlled by non-consumer third parties
  • Employers choose insurers, benefits, providers networks, and premiums
  • Medicare/Medicaid dictate benefits, FFS rates, and premiums
  • Consumers/patients have had little, if any, role in choosing any of this
2. Insurance covered costs—emerging approach

- Funded by defined-contribution payments by employers & government payers
- High deductibles & OOP limits are shifting insurance coverage to high-cost “catastrophic” care...
- Leaving patients to pay for all their primary care and much of their specialty and high-cost care
- Individual insurance markets: The new paradigm
  - Public exchanges give individuals choice of plans
  - Private exchanges give individual employees choice of multiple plan offerings, insurers, benefits, provider networks, and premiums
  - Medicare & Medicaid offer their own private insurance options
  - Individual consumers are choosing lower premiums with higher OOP
Public exchange enrollment projections

CBO Projection of Exchange Plan Enrollment

Enrollees (Millions)

Private Exchanges*

- Offered by Mercer, Aon Hewitt, and Towers Watson to their clients
- Currently focused on large employers (e.g., Sears, Petco, and Walgreens)
- Employers de-linking benefit costs from health care costs w/ defined contribution
- Employees being given choice of multiple health plans
- 45% of employers adopting or considering private health insurance exchanges
- Currently covering 3 million lives (2014)
- Members buying down to HDHP/HSA plans ($1500 & $2500 most common ded)
- Members increasingly funding HSAs and/or buying supplemental products against residual risk
- Employers increasingly pointing part-time employees to public exchanges
- Exponential private exchange growth expected
Private Exchange Enrollment Projections

Private Annual Exchange Enrollment

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment in millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>3</td>
</tr>
<tr>
<td>2015</td>
<td>1</td>
</tr>
<tr>
<td>2016</td>
<td>9</td>
</tr>
<tr>
<td>2017</td>
<td>30</td>
</tr>
<tr>
<td>2018</td>
<td>40</td>
</tr>
</tbody>
</table>

Source: Accenture
Medicare Advantage has 30% of all beneficiaries...

Exhibit 1

Total Medicare Private Health Plan Enrollment, 1999-2014

In millions:

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>6.9</td>
</tr>
<tr>
<td>2000</td>
<td>6.8</td>
</tr>
<tr>
<td>2001</td>
<td>6.2</td>
</tr>
<tr>
<td>2002</td>
<td>5.6</td>
</tr>
<tr>
<td>2003</td>
<td>5.3</td>
</tr>
<tr>
<td>2004</td>
<td>5.3</td>
</tr>
<tr>
<td>2005</td>
<td>5.6</td>
</tr>
<tr>
<td>2006</td>
<td>6.8</td>
</tr>
<tr>
<td>2007</td>
<td>8.4</td>
</tr>
<tr>
<td>2008</td>
<td>9.7</td>
</tr>
<tr>
<td>2009</td>
<td>10.5</td>
</tr>
<tr>
<td>2010</td>
<td>11.1</td>
</tr>
<tr>
<td>2011</td>
<td>11.9</td>
</tr>
<tr>
<td>2012</td>
<td>13.1</td>
</tr>
<tr>
<td>2013</td>
<td>14.4</td>
</tr>
<tr>
<td>2014</td>
<td>15.7</td>
</tr>
</tbody>
</table>

% of Medicare Beneficiaries:

18% 17% 15% 14% 13% 13% 13% 16% 19% 22% 23% 24% 25% 27% 28% 30%

...and Growing

What is the future outlook for Medicare Advantage?

Actual and projected enrollment (in millions)

NOTE: CBO is Congressional Budget Office; OACT is CMS Office of the Actuary.
Medicaid managed care enrollment

Total Annual Medicaid Population Distribution by Year: Managed Care v. Other
as of July 1, 2011

Source: Medicaid Managed Care Enrollment Report, www.medicare.gov
Resulting effects

1. 125-150 million people to be making their own insurance purchases by 2020—where is the tipping point?
   a) 300 million people controlling how they spend their own medical dollars
   b) Customer service—from abysmal to responsive
   c) Medical quality improvement—from mediocre to standard-of-care
   d) Lower, more competitive premiums
   e) More individual accountability for preventable diseases
   f) Order-of-magnitude reduction in transaction costs

A major opportunity for integrated medical providers to disintermediate the insurers by creating their own branded population-health insurance products at the local level...

...much like 600 startup HMOs did in the 1970s and ‘80s.
2. Insurers moving to capitated provider payments
3. Insurers having to learn local retail
   a. Pricing
   b. Selling
   c. Customer service
   d. Co-branding with local PCP groups (primarily, but not exclusively, IMS)
4. Insurers vertically integrating downward
5. Providers vertically integrating upward
6. Neither knowing how to manage the other
7. Extinction event for many hospitals and insurers, worse than during the managed care revolution
Resulting effects

8. FFS isn’t going way, but morphing into consumer-facing rather than payer-facing pricing
   a. Normally consumed care
      1) Piece-rate pricing
      2) Direct Primary Care bundled pricing
   b. Bundled high-cost care procedure pricing
   c. Standard-of-care diagnostic and medical (i.e., non-procedural) treatment services become the norm under various pricing models

9. Provider focused factories with bundled pricing

10. Provider revenue cycle transitioning to two components
    a. Insurer-paid capitation and bundled payments
    b. Consumer-paid POS pricing and collection
Resulting effects

11. CMS a major potential barrier to change
   a. Major conflict with hospital-favored physician and ancillary reimbursement rates—imaging as the canary
   b. Conflicts with mandated RBRVS, DRG, ICD, HCPCS coding and RVU–based pricing requirements
   c. Conflicts with CMS-controlled prices and MFN requirements
   d. Conflicts with Medicare prohibition of provider balance-billing

FFS to providers: The reports of my death are premature.
Conclusion...

The population health challenge...
...is just the beginning

3rd Party FFS

Consumer Control of all The Money
What Happens When Patients Control ALL the Money?
The Emerging Threat/Opportunity for Providers and Insurers

Steve Hyde
10/14/14
Questions & Discussion
A note on bundled pricing drivers & barriers

1. For high-cost procedures and treatments
2. CMS Bundled Payments for Care Improvement Initiative*
   • 3-year initiative
   • 4 models: 3 retrospective, 1 prospective
   • Incentivize care redesign and enhancements
   • 100 current participants with many more interested
3. Why should providers develop bundled pricing?
   • Simpler than capitation
   • To preserve or increase market share
   • Provides incentive to reengineer high-cost care procedures
   • Learning-curve advantages in anticipation of CMS adoption
4. Barriers to bundling
   • Lack of compatibility with current FFS payment systems *
   • Requires hospital/doctor/rehab/etc. collaboration to reduce costs, standardize care pathways & supplies