

Predictions for Health Care in 2016 & Beyond



Agenda & Objectives



- Global Concepts
 - Consolidation
 - Consumerism
 - Access
 - Shift to Value
- 8 Predictions
 1. Doc Pay
 2. Advanced Practitioners
 3. Drug Costs
 4. Exchanges
 5. Machine Learning
 6. Telemedicine
 7. Interoperability
 8. Elections

Objectives:

- Understand the changes and developments expected in health care in 2016
- Identify how global changes to payment will have local impact on providers
- Describe, in depth, the impact of payment bundling on the provision of care to patients and the details of the joint replacement bundling program.
- Discuss new technologies that will improve quality and decrease cost, and identify barriers to implementation.
- Recognize the importance of Health IT interoperability and how current initiatives fall short of their goal.

Credit is given to The Advisory Board Company for many of the graphics in this presentation

The Eight Predictions for 2016



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2. The use of Nurse Practitioners and APRNs will accelerate.
3. Drug costs increase as medicines become more personalized.
4. United Healthcare will significantly modify its participation in the exchange market, but not fully leave it.
5. Robotics is no longer enough, but the industry now delivers intelligent solutions through machine learning.
6. Telemedicine technology will continue to mature and CMS will propose broader guidelines for covering telemedicine visits causing great interest by year's end for every rural clinic.
7. The Federal Government will declare an intention to create a language for interoperability of health IT systems.
8. And, finally, Americans will elect a new president that will insist that we need to make significant changes to ObamaCare (or even replace it), but have no power to do so.

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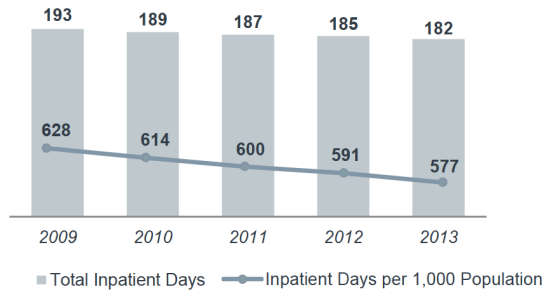
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Inpatient Days, Bed Occupancy Rate Continue Down



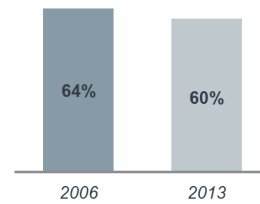
Historical Inpatient Volumes Growth

Millions of Inpatient Days;
Days Per 1,000 of Population



Inpatient Bed Occupancy

Percentage of Hospital Capacity



Factors Mitigating Demand Growth



Population health



Outmigration of inpatient care



Consumerism

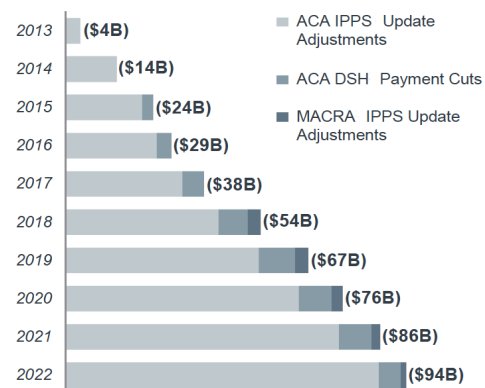
Source: American Hospital Association Annual Survey Data; US Census Bureau: National and State Population Estimates, available at: www.census.gov/popest/data/state/totals/2013/index.html; MedPac 2014, Chapter 3 Hospital Inpatient and Outpatient Services; Health Care Advisory Board interviews and analysis.

ACA Reductions Compounding Demographic Changes



Hospitals Bearing the Brunt of Payment Cuts

Reductions to Medicare Fee-for-Service Payments



\$30.8B

Reduction in Medicare bad debt payments



\$14.6B

Cuts to teaching hospitals and GME payments



3.4%

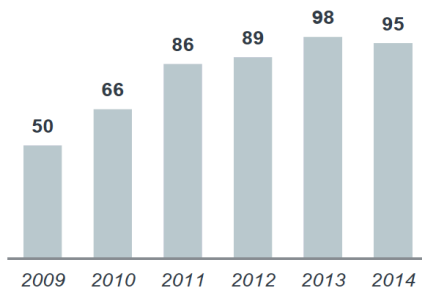
Average commercial price growth, 2014

Source: CBO, "Letter to the Honorable John Boehner Providing an Estimate for H.R. 6079, The Repeal of Obamacare Act," July 24, 2012; CBO, "Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015; Budget of the United States Government (Proposed) FY 2016; Health Care Cost Institute, "2014 Health Care Cost and Utilization Report," October 2015; Financial Leadership Council 2013 Revenue Cycle Benchmarking Survey; Health Care Advisory Board interviews and analysis.

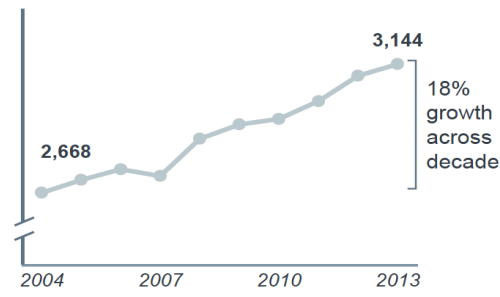
Many Hospitals Turning to M&A to Solidify Position



**Hospital and Health System
M&A Activity**
Total Deal Volume



Number of Hospitals Part of a Health System



Source: Becker's Hospital Review, "The Year of 95 Hospital Transactions," 2015, available at: www.beckershospitalreview.com/; American Hospital Association, Chartbook, 2015, available at: www.aha.org/; Health Care Advisory Board interviews and analysis.

Increased Provider Price Leverage the Primary Result



Impact of Consolidation

- 5%** Rise in inpatient prices due to hospital consolidation
- 40%** Rise in inpatient prices due to hospital consolidation when merged hospitals are closely located
- 59%** Proportion of acquired hospitals that failed to outperform their market peers two years after acquisition

Factors Contributing to the Lack of Success of Consolidation Efforts



Prioritizing and rewarding individual hospital performance over system plans



Operational challenges related to full integration of services



Limited political capital to drive change from M&A

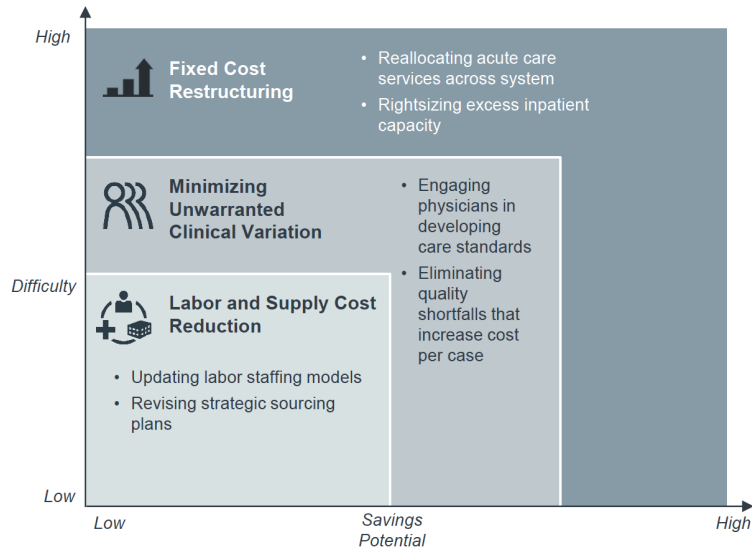


“Disturbingly, about one in five acquired hospitals actually went from having positive margins before a deal to negative margins two years after a deal.”

Booz and Company

Source: Saxena, Sharma, Wong, "Succeeding in hospital & health systems M&A: Why so many deals have failed, and how to succeed in the future," Strategy8, 2013; Vogt, Town, "How Has Hospital Consolidation Affected the Price and Quality of Hospital Care?," Robert Wood Johnson Foundation, 2006; Sar, "Do competition and managed care improve quality?," Economics of Health Care Systems, 2002; Pitch, Gottlieb, "The Urge To Merge In Healthcare: This Time, Will It Be Different?," Morning Consult, 2014; Health Care Advisory Board interviews and analysis.

The New Focus of Acute Care Cost Control



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Consumers Have Access to More Information than Ever Before



Transparency Comes to California

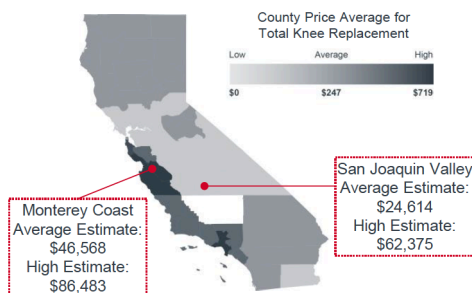


September 21, 2015

Attention Shoppers: New Calif. Website Details Costs, Quality of Medical Procedures

Where You Live Matters

What you pay may differ based on where you live



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Sample Transparency Sites



Source: Ostrov BF, "Attention Shoppers: New Calif. Website Details Costs, Quality of Medical Procedures," *Kaiser Health News*, available at: <http://khn.org/news/attention-shoppers-new-calif-website-details-costs-quality-of-medical-procedures>; Health Care Advisory Board interviews and analysis.

Competitors Benefiting from an Opaque Health System



Consumer Problem

Disruptor Response



"How much is this going to cost me?"



Guroo:

Search for price of service



"Who is the right doctor for my unique needs?"



DoctorDirectory.com:

Filter clinician by specific trait



"What do other patients think about this doctor?"



Yelp:

Read patient reviews on providers



"Can I get an appointment as soon as possible?"



Pokitdok:

Access physician schedules

Complacency Not an Option



	Baseline	Early Attempt	Ultimate Ambition
Price Transparency	Broad price approximations	Cash prices for common commodity services	Proactive, individualized price quotes
Customized Provider Search	Search by specialty	Search by characteristic	Provide custom personality search
Patient Experience Reviews	Advertise rankings, accreditation	Manage comments on external review sites	Proactively seek and publish reviews
On-demand Scheduling	Appointment call center	Digital appointment requests	Dedicated online scheduling product

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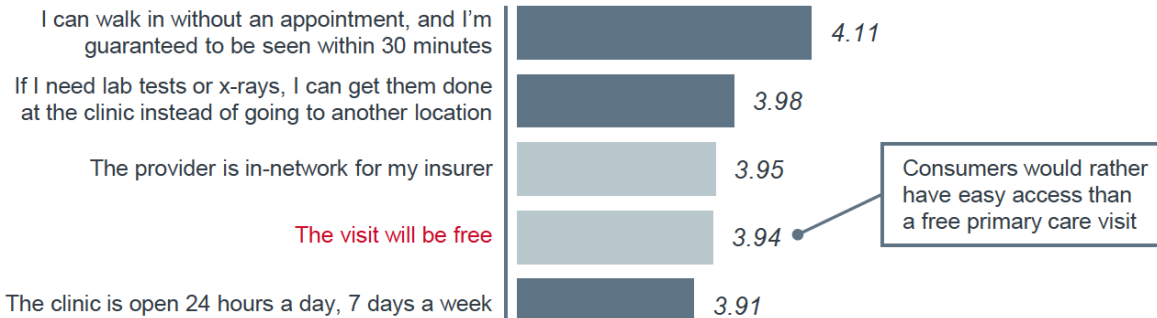
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Consumers Value Convenience Over Cash



Average Utility Scores for Top Five Preferred Primary Care Clinic Attributes

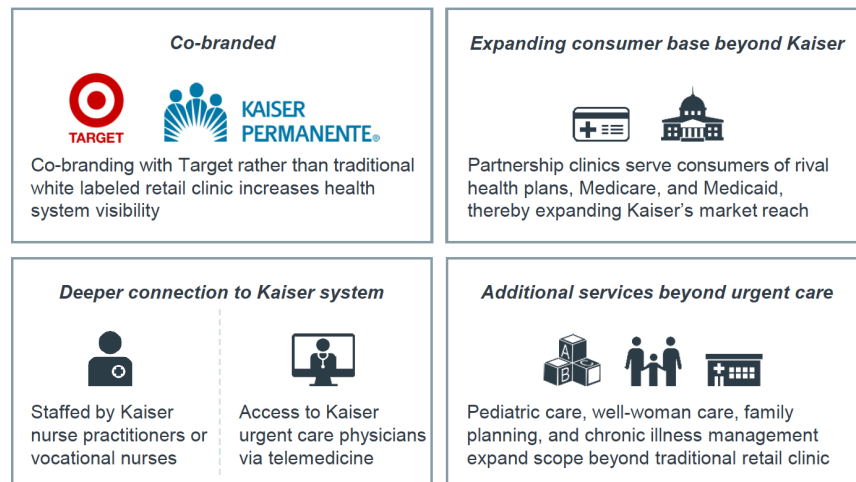
n=3,873



The Kaiser – Target Partnership: Disruptive Access



Retail Clinic Partnership Pushes Frontier of Convenient Care Strategy

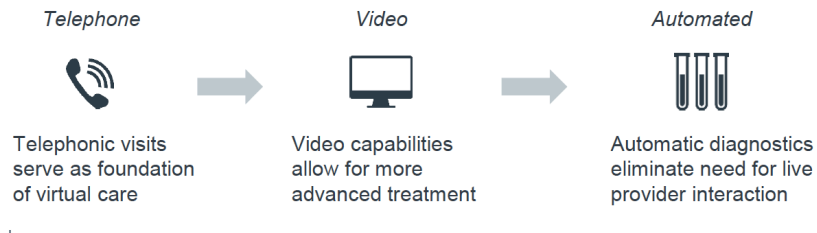


Source: Modern Healthcare, "Kaiser to Staff Clinics in California Target Stores," available at <http://www.modernhealthcare.com>; California Healthline, "Kaiser-Target Partnership Sign of the Times," available at <http://www.californiahealthline.org>; Health Care Advisory Board interviews and analysis.

Virtual Technology Offer New Access Opportunities



Three Stages of Virtual Care Development



Disruptor Offerings

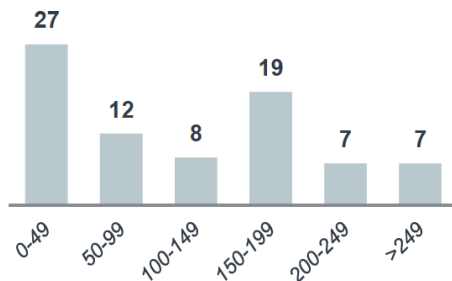


Virtual Follow-Up Creates Real Efficiencies



Miles of Driving Saved by Virtual Visits

Number of Patients



55%

Estimated percentage of post-operative visits that could be completed virtually

148

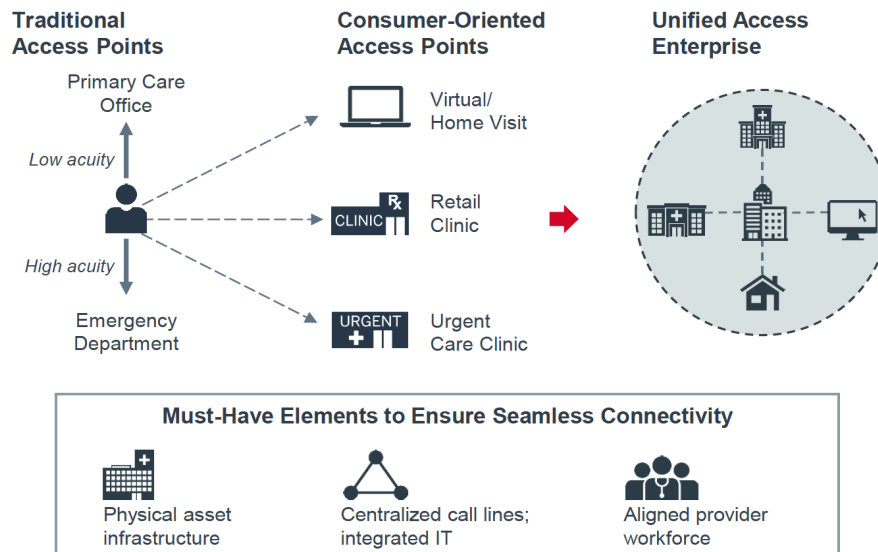
Average number of minutes saved per patient in travel time

110

Number of new appointments that could be scheduled with time saved

Source: Hea K, and Wren SM. "Telehealth Follow up in Lieu of Postoperative Clinic Visit for Ambulatory Surgery." JAMA Surg. 2013; 148:823-827; Health Care Advisory Board interviews and analysis.

Building Advantage Through Coordinated Access Options



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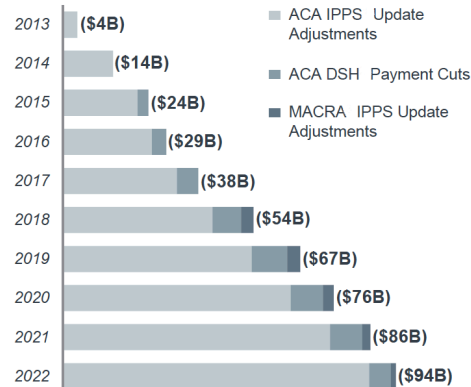
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Price Cuts Continue Unabated



Hospitals Bearing the Brunt of Payment Cuts *Reductions to Medicare Fee-for-Service Payments*



Site-Neutral Payment Taking Effect *Bipartisan Budget Act of 2015*



Eliminates pricing advantage for new hospital-owned outpatient sites



Scheduled to go into effect on January 1, 2017



Excludes sites receiving provider-based rates prior to the law's enactment on November 2, 2015



Upcoming rulemaking process will establish details of site-neutral payment policy

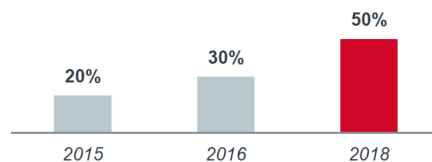
\$29.5B Potential savings from fully moving to site-neutral payments

Source: CBO, "Letter to the Honorable John Boehner Providing an Estimate for H.R. 6079, The Repeal of Obamacare Act," July 24, 2012; CBO, "Cost Estimate and Supplemental Analyses for H.R. 2, the Medicare Access and CHIP Reauthorization Act of 2015," The Daily Briefing, "How to Understand Last Week's Big Budget Deal," November 2, 2015; Budget of the United States Government (Proposed) FY 2016; Health Care Advisory Board interviews and analysis.

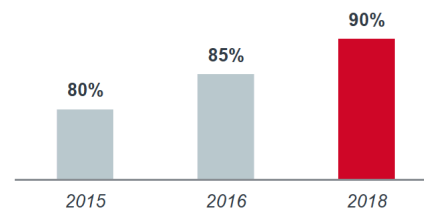
Explicit Targets Hint at Forceful Measures Ahead



Aggressive Targets for Transition to Risk *Percent of Medicare Payments Tied to Risk Models*



FFS Increasingly Tied to Value *Percent of Medicare Payments Tied to Quality*



“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.”

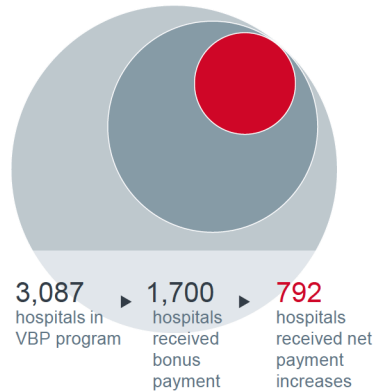
Senior CMS Officials

Source: HHS, "Progress Towards Achieving Better Care, Smarter Spending, Healthier People," available at: <http://www.hhs.gov>, accessed February 2015; Pham H, et al., "Medicare's Vision for Delivery-System Reform - The Role of ACOs," *New England Journal of Medicine*, September 10, 2014; Health Care Advisory Board interviews and analysis.

Readmissions, HAC Penalties Outweigh VBP Bonuses



After Accounting for Penalties ,
Few Receive VBP Bonuses



Estimated Net Impact of
P4P³ Programs, FY 2015

28%

Hospitals receiving a net bonus or breaking even

50%

Hospitals receiving net penalties between 0% and 1%

6.5%

Hospitals receiving net penalties of 2% or greater

Source: Rau J. "1,700 Hospitals Win Quality Bonuses From Medicare, But Most Will Never Collect," Kaiser Health News, January 22, 2015, available at: kaiserhealthnews.org. Health Care Advisory Board interviews and analysis.

The Comprehensive Care for Joint Replacement Model



Key Program Features



Focus on joints

Average expenditure varies from \$16,500 to \$33,000 by geography



Mandatory in 67 markets

Includes IPPS¹ hospitals only; excludes hospitals participating in BPCI² Model 1 or Phase 2 of BPCI Models 2 or 4 for LEJR³



Comprehensive episode

Includes all related Part A and Part B services for 90 days post-discharge



Retrospective bundle

CMS make FFS pay to each provider separately, conduct annual reconciliation process

Program Timeline

November 2015

Final details announced, including hospital participant list and revised quality methodology

April 1, 2016

First performance year begins; no episode discount for first year

2017-2020

Downside risk incorporated; up to 3% episode discount, depending on hospitals' quality performance scores

\$343M

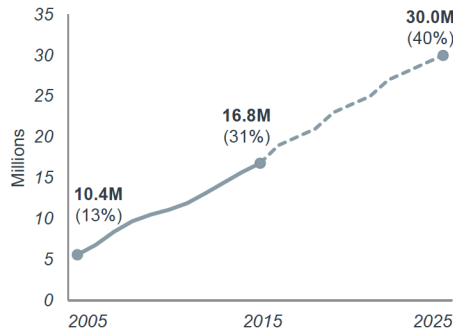
ESTIMATED SAVINGS TO MEDICARE OVER THE 5 YEARS OF THE MODEL

Medicare Advantage Grows, but Varies by Geography



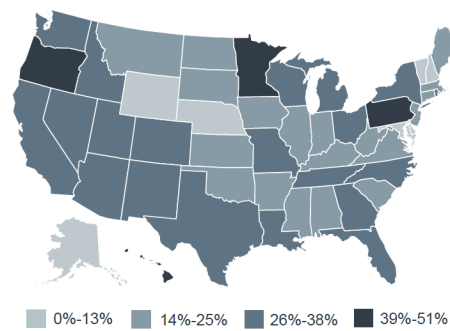
MA Enrollment to Nearly Double by 2025

Total Enrollment and Percentage of Total Medicare Population



MA Penetration Varies by State

Total MA Enrollment as a Percent of Total Medicare Population



22% of newly eligible beneficiaries chose MA in 2011

39 states currently have provider-led plans in their markets

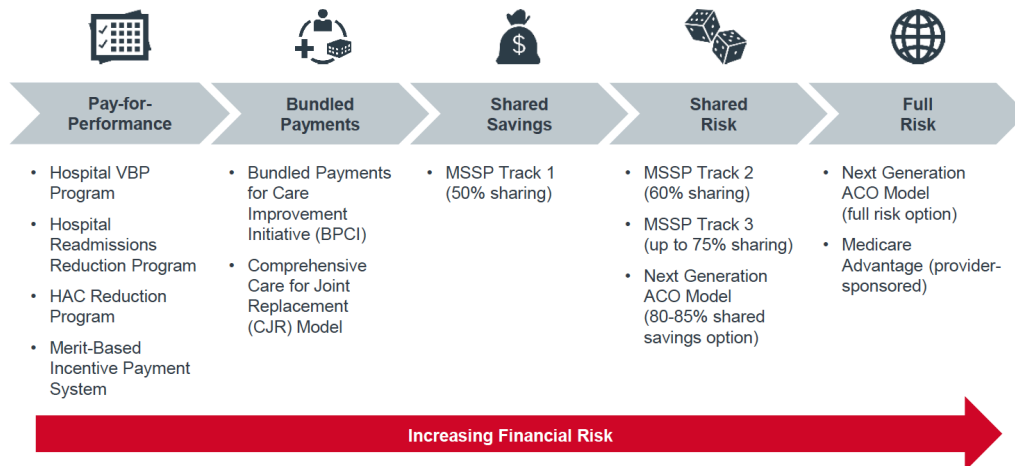
69% of provider-led plans offer MA coverage options

Source: KFF, "Medicare Advantage 2015 Spotlight: Enrollment Market Update," June 30, 2015; KFF, "Medicare Advantage Fact Sheet," May 1, 2014, available at www.kff.org; CBO, "March 2015 Medicare Baseline," March 9, 2015, available at www.cbo.gov; KFF, "Medicare Advantage Enrollees as a Percent of Total Medicare Population," 2014, available at www.kff.org; Mark Farrah & Associates, "Medicare Advantage Tops 17 Million Members," March 27, 2015, available at www.markfarrah.com; Jacobson G et al., "At Least Half of New Medicare Advantage Enrollees Had Switched from Traditional Medicare During 2006-11," Health Affairs, January 2015, available at www.healthaffairs.org; McKinsey & Co., "Provider-Led Health Plans: The Next Frontier—Or the 1990s All Over Again?," January 2015, available at healthcare.mckinsey.com; Health Care Advisory Board interviews and analysis.

New Programs are Filling Out the Continuum



Continuum of Medicare Risk Models

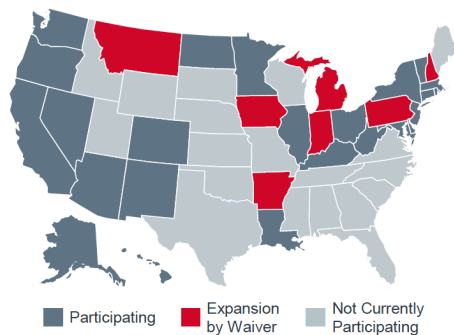


Benefit of Expansion Clear for Hospitals, Growth on Track



31 States and DC Have Approved Expansion¹

As of January 2016



11.7M

Net increase in Medicaid, CHIP² enrollment, July-Sept. 2013 to Feb. 2015³

Medicaid Expansion Positively Impacting Hospital Finances



Medicaid Admissions increased **21%** for investor-owned hospitals in expansion states



Self-Pay Admissions decreased by **47%** for investor-owned hospitals in expansion states



Uncompensated Care costs reduced by **\$5 billion** in expansion states in 2014

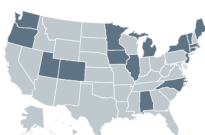
27% vs. 8%

Growth in Medicaid, CHIP enrollment in expansion vs. non-expansion states, July-Sept. 2013 to Feb. 2015

1) Montana's expansion requires federal waiver approval.
2) Children's Health Insurance Program.
3) Excludes CT and ME.

Source: Kaiser Family Foundation, "Current Status of State Medicaid Expansion Decisions," January 27, 2015, available at: www.kff.org; Fausset R and Goodnough A, "Louisiana's New Governor Signs an Order to Expand Medicaid," *New York Times*, January 12, 2016; HHS, "Insurance Expansion, Hospital Uncompensated Care, and the Affordable Care Act," March 23, 2015, available at: www.aspe.hhs.gov; PwC Health Research Institute, "The Health System Has and Has Not of ACA Expansion," 2014, available at: www.pwc.com; CMS, "Medicaid & CHIP: February 2015 Monthly Applications, Eligibility Determinations and Enrollment Report," May 1, 2015, available at: www.medicare.gov; Health Care Advisory Board interviews and analysis.

Medicaid ACOs Show Creative Opportunities



17

states have Medicaid ACO programs in place or are pursuing one

Oregon Coordinated Care Organizations

- 16 organizations accountable for 90% of Medicaid and dual-eligibles
- 22% reduction in per-capita ED use rate, 56% increase in medical home enrollment since 2011

On track to generate **2% PMPY¹** savings

Colorado Regional Care Collaborative Organizations

- Seven regional organizations that convene provider networks around PCMHs
- Uses a hybrid of several payment strategies to shift to value

Generated **\$29M-\$33M** in net savings, 2014

Minnesota Integrated Health Partnerships

- 15 delivery systems participating in Medicaid ACO program
- Shared savings in year one; shared risk in following years

Generated **\$61.5M** in savings, 2014

1) Per Member Per Year.

Source: Center for Health Care Strategies, "Medicaid Accountable Care Organizations: State Update," March 2015, available at: www.chcs.org; Colorado Department of Health Care Policy & Financing, "Accountable Care Collaborative 2014 Annual Report," available at: www.colorado.gov; Oregon Health Authority, "Oregon's Health System Transformation: 2014 Performance Report," June 24, 2015, available at: www.oregon.gov; Minnesota Department of Human Services, "Integrated Health Partnerships: Partnerships save \$76 million in Medicaid costs," 2015, available at: www.dhs.state.mn.us; Health Care Advisory Board interviews and analysis.

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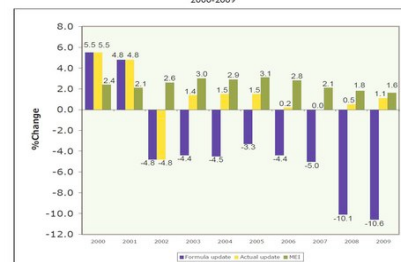
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The Permanent Doc Fix

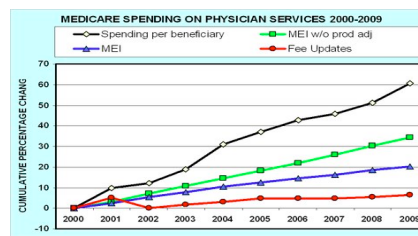


- The Sustainable Growth Rate formula started with the Medicare Modernization Act of 1997
 - Replaced the Medicare Volume Performance Standard
 - SGR's goal was to ensure yearly increases in spending don't exceed GDP
 - Delayed 18 times... And never implemented
- Issues with the "Fix"
 - Risk push (along with CMS promise)
 - Physician measurement
 - Economics (pay for \$35B of \$175B cost for rate change)

Figure 3. Formula Updates, Actual Updates, and the Medicare Economic Index 2000-2009



Source: 2009 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, p. 32. <http://www.cms.hhs.gov/ReportsTrustFunds/downloads/r2009.pdf>, and CMS, Estimated Sustainable Growth Rate and Conversion Factor, for Medicare Payments to Physicians in 2010, <http://www.cms.hhs.gov/SustainableGRatesConfact/Download.asp?2010p.pdf>.

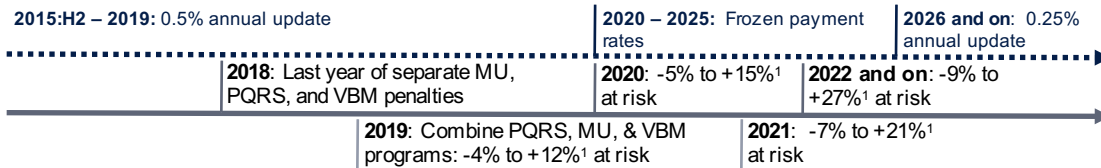


Source: Staff presentation Dec. 2, 2010 on the Medicare Payment Advisory Commission

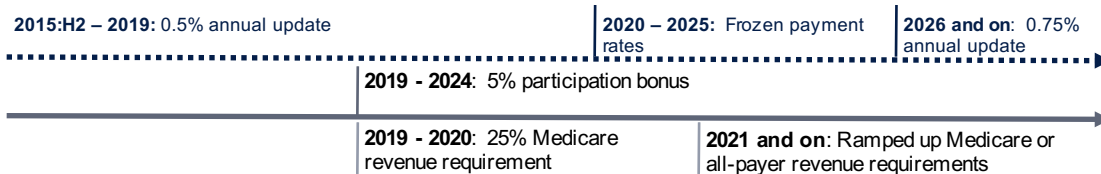
Two Tracks for Physician Payment



Merit-Based Incentive Payment System



Advanced Alternative Payment Models²



1. Fee for service.
2. Positive adjustments for professionals with scores above the benchmark may be scaled by a factor of up to 3 times the negative adjustment limit to ensure budget neutrality. In addition, top performers may earn additional adjustments of up to 10 percent.
3. APM participants who are close to but fall short of APM bonus requirements will not qualify for bonus but can report MIPS measures and receive incentives or can decline to participate in MIPS.

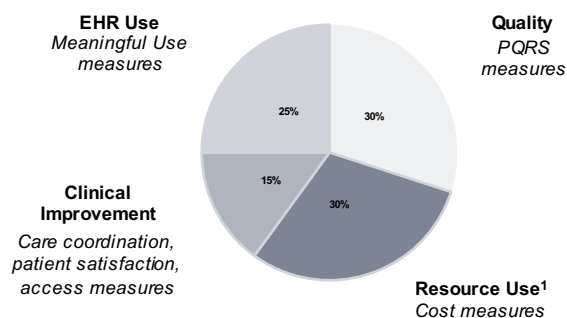
Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.

Merit-based Incentive Payment System



- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019
- Applies to physicians, NPs, clinical nurse specialists, physician assistants, and certified RN anesthetists
- Includes improvement incentives for quality and resource use categories

MIPS Performance Category Weights



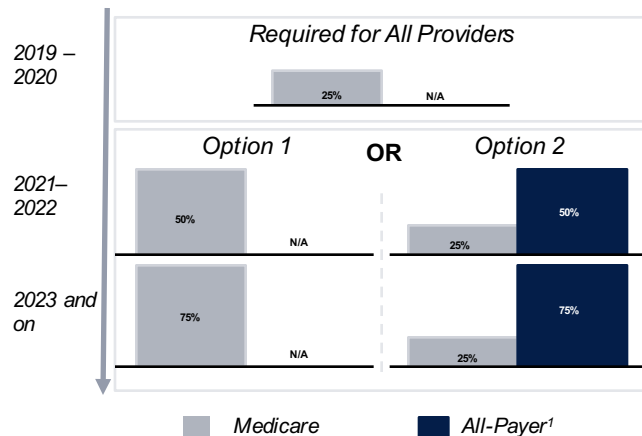
¹ Resource Use measures would be weighted less during first two years of MIPS program, reaching 30 percent in the third year of the program. Quality measures would be weighted more than 30 percent during the first two years to make up the difference.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.

Alternative Payment Model

- Requires significant share of provider revenue in APM with two-sided risk, and quality measurement; or in some cases participation in certified patient-centered medical homes
- Provides financial incentives (5% annual bonus in 2019-2024) and exemption from MIPS requirements
- Includes partial qualifying mechanism that allows providers that fall short of APM requirements to report MIPS measures and receive corresponding incentives or to decline to participate in MIPS

Required Percentage of Revenue Under Risk-Based Payment Models



1. Risk-based contracts with Medicare Advantage plans count toward the all-payer requirement category.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; Advisory Board analysis.

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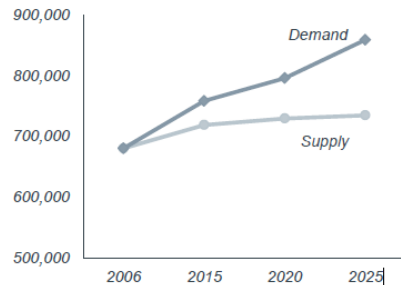
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Advanced Practitioners Expand Access, Boost Efficiency



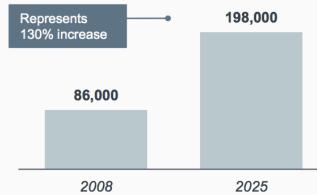
Physician Workforce

Projected 2005-2025



Projected Growth in Nurse Practitioner Workforce

2008-2025



Impact on Patient Access



Specialty Care
Long wait times for
consults, procedures

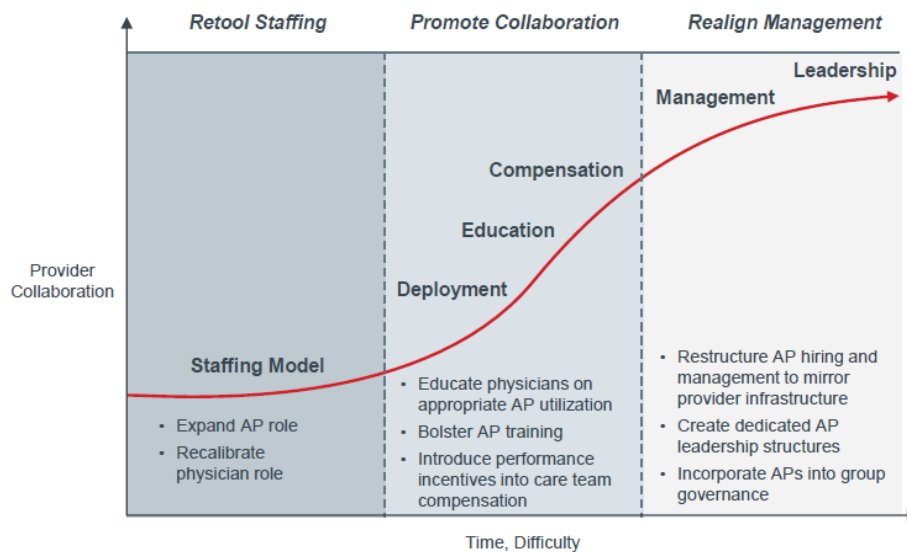


Inpatient Care
Unsustainable
patient-to-clinician ratio



Primary Care
Inadequate panel size
to serve population

Adapting AP Strategy to New Demands

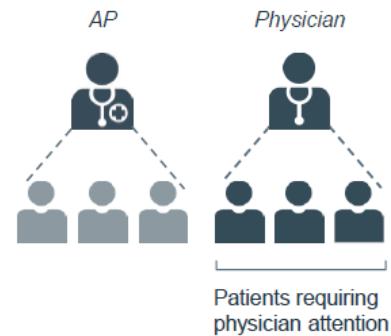


AP's, Physicians Both Must Be Utilized More Effectively

Common Team-Based Staffing Model



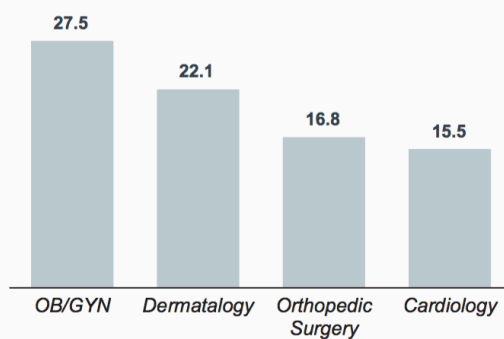
Ideal Team-Based Staffing Model



AP Value: Long Wait Times Hampering Referral Capture

Average Appointment Wait Time

In Days, 2009

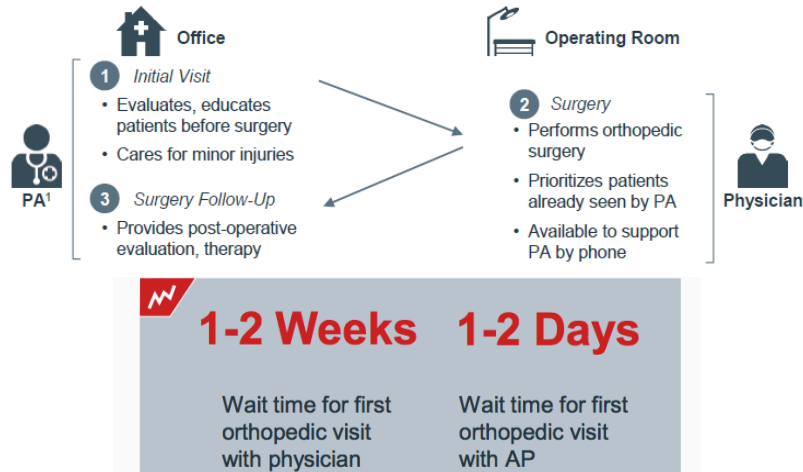


96%

PCPs reporting that appointment timeliness was of "major" or "moderate" importance when choosing specialist for referral

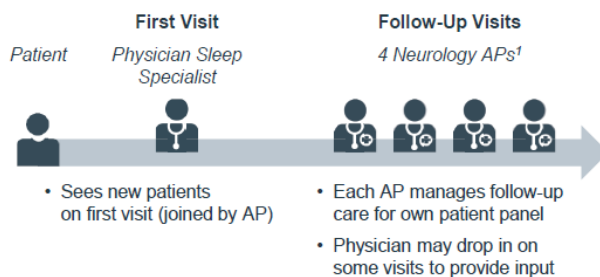
Orthopedics Efficiency Drives Access

Orthopedics Patient Flow



Sleep Lab Efficiency

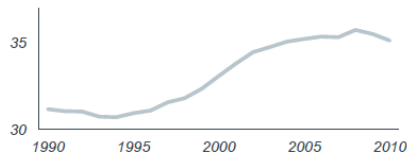
Distribution of Patient Visits in Sleep Lab



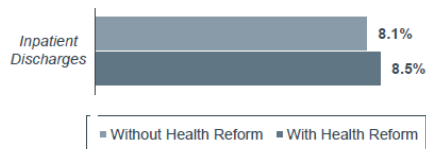
AP's in the Acute Setting Avoid Safety Issues



Inpatient Admissions in Community Hospitals
In Millions



Forecasted Annual Inpatient Volume Growth¹
2009-2019



Unsustainable Volumes

40%

Hospitalists reporting that their typical inpatient census exceeded safe levels at least once a month

>20%

Hospitalists reporting that their typical workload has contributed to patient transfers, morbidity, and mortality

The Eight Predictions for 2016



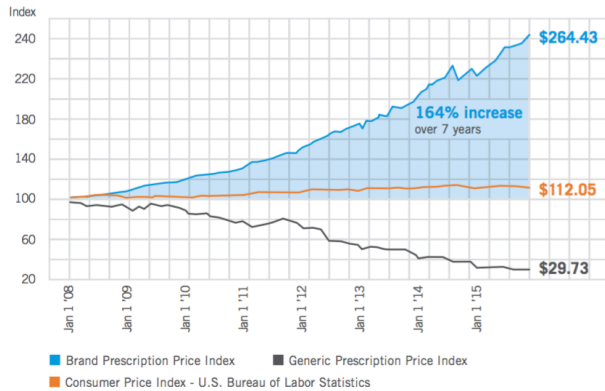
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Credit is given to The Advisory Board Company for many of the graphics in this presentation

Brand and Specialty Pharmacy Growth Far Outpacing CPI



THE EXPRESS SCRIPTS PRESCRIPTION PRICE INDEX



COMPONENTS OF TREND

2015

	PMPY* SPEND	TREND		
		UTILIZATION	UNIT COST	TOTAL
Traditional	\$708.09	1.9%	-2.1%	-0.1%
Specialty	\$352.66	6.8%	11.0%	17.7%
TOTAL TREND	\$1,060.75	2.0%	3.2%	5.2%

January-December 2015 compared to same period in 2014, commercially insured. Reflects total cost for both payers and patients.

*Per Member Per Year

Specialty Drugs Drive Increases in Pharmacy Cost



27 of 51 Specialty drug approvals by the FDA exceeded traditional drug approvals for the first time in 2010—a trend that has continued each year since. In 2014, 27 of the 51 drugs approved by the FDA were specialty drugs.

6% The Centers for Medicare & Medicaid Services (CMS) projects sustained increases in drug spending of 6% or more annually from 2015 to 2022, as both drug prices and utilization increase.

MULTIPLE SCLEROSIS

Top 5 = 84%

The top five most prescribed multiple sclerosis medications accounted for 84% of 2015 spend in this class.

FORECAST Brand inflation will continue to drive trend between 7% and 11% annually over the next three years.

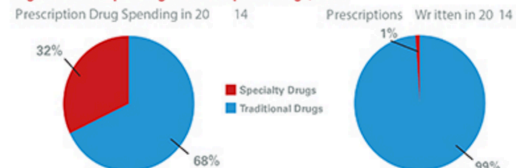
ONCOLOGY

22%

Gleevec® (imatinib) and Revlimid® (lenalidomide) accounted for more than 22% of oncology spend in the pharmacy benefit.

FORECAST Trend will continue to increase at approximately 20% annually over the next three years.

Figure 1: U.S. Spending on Prescription Drugs, 2014



Source: The Express Scripts 2014 Drug Trend Report, March 2015. Available at: <http://labexpress-scripts.com/drug-trend-report/>

Figure 2: Approximate Monthly Cost of Commonly Used Specialty Medications, 2014

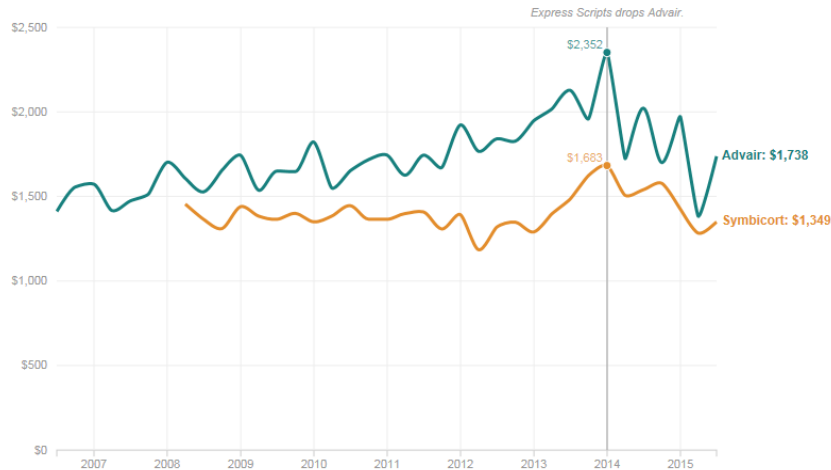
Medication	Sample indication for medication use	Monthly cost for sample indication
Provenge (sipuleucel-T)	Metastatic prostate cancer	\$105,800
Sovaldi (sofosbuvir)	Hepatitis C	\$29,900
Olysio (simeprevir)	Hepatitis C	\$23,600
Rituxan (rituximab)	Non-Hodgkin's lymphoma	\$21,900
Gleevec (imatinib)	Chronic myeloid leukemia	\$11,900
Avastin (bevacizumab)	Metastatic colorectal cancer	\$11,600
Revlimid (lenalidomide)	Multiple myeloma	\$9,300
Neulasta (pegfilgrastim)	Neutropenia	\$5,700

Formulary Changes Impact Pricing Strategies



A Change In Payment Policy Lowered Asthma Drug Prices

Figures show the net price of asthma drug treatment for a year.



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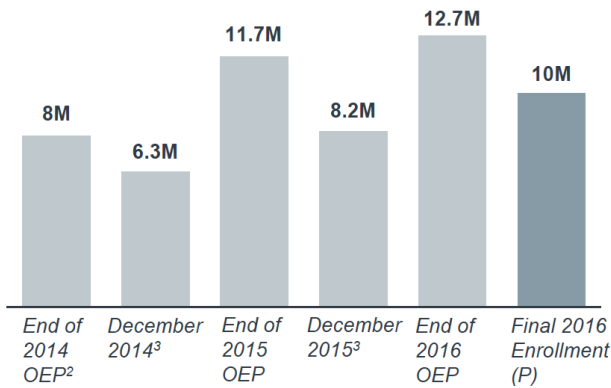
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Third Round of Open Enrollment Complete



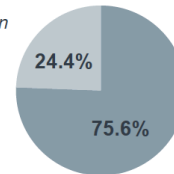
Exchange Enrollment Results and Projections

Plan Selections in the Marketplaces, 2014-2016



Federal Exchanges Driving Enrollment, 2016

Enrollment on state run exchanges



Enrollment on federally facilitated exchanges

Similar Enrollment of "Young Invincibles"

2.7M



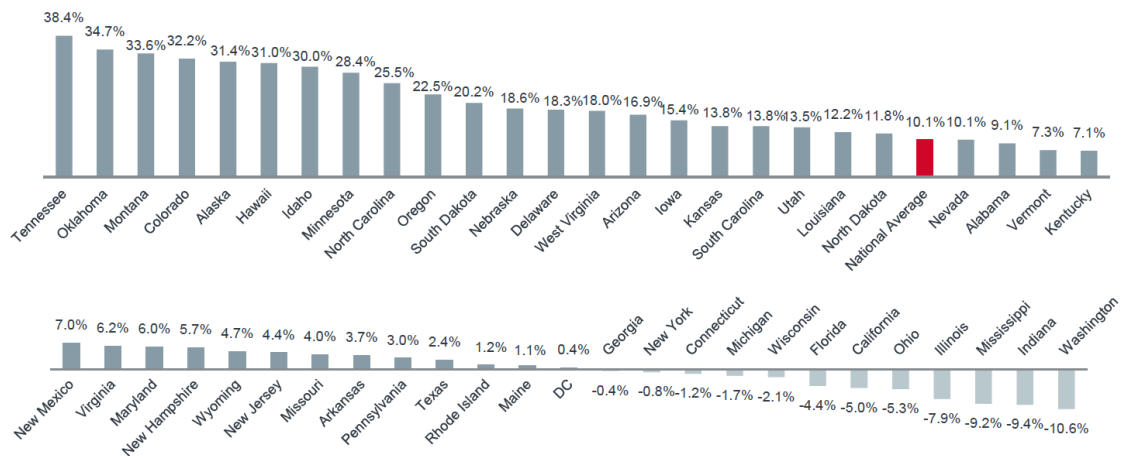
2016 federal exchange enrollees aged 18-34 (compared to 2.5M in 2015)

Marketplace Driving Premium Changes, Increases



Percentage Changes in Benchmark Silver Plan Premiums

2015 – 2016¹



Major Players Debating How—and If—to Compete



UnitedHealth Group Potentially Exiting Public Exchanges



UnitedHealth Group

- Covers 550K exchange beneficiaries in 34 markets
- Lowered Q4 2015 earnings projections by \$425M, citing exchange product performance

“The Company is evaluating the viability of the insurance exchange product segment and will determine during the first half of 2016 to what extent it can continue to serve the public exchange markets in 2017.”

For Some, Doubts Creeping In...



“Blue Cross Blue Shield Texas Dropping Individual PPO Plan”

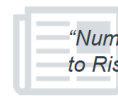


“More Than Half of ACA Co-ops Now Out of Insurance Marketplaces”



“Feds Short Insurers \$2.5 Billion on Exchange Plan Losses”

...But Others Sensing Opportunity



“Number of Obamacare Insurers to Rise by 25% in 2015”

Trading Low Premiums for High Deductibles



Average Public Exchange Deductibles by Tier, 2016

Bronze:

\$5,731 2016 \$5,181 2015

Silver:

\$3,117 2016 \$2,927 2015

Gold:

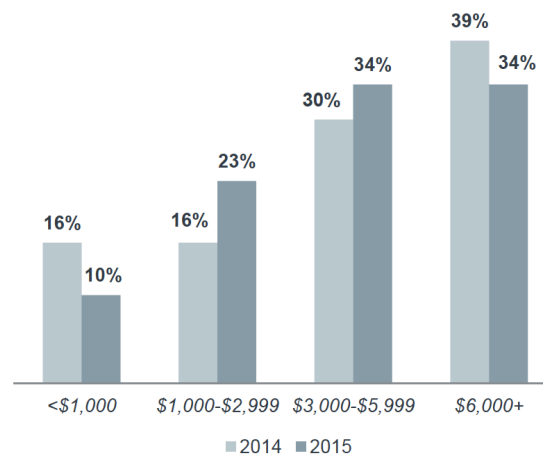
\$1,165 2016 \$1,198 2015

Platinum:

\$233 2016 \$243 2015

2015 Enrollees Favor Higher Deductibles

Annual Deductibles as Percentage of All Individual Plans Selected on eHealth Platform, 2014-2015

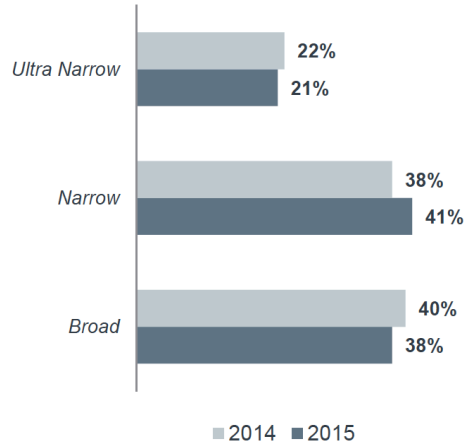


Insurers Betting Consumers Trade Choice for Price



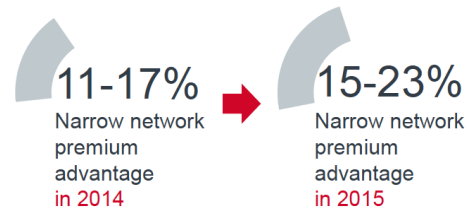
Narrow Network Plan Designs Continue to Dominate Exchange Marketplace

Network Breadth in Largest City of Each State

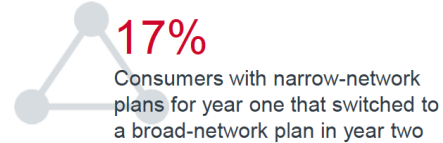


Narrow Network Premium Advantages Increasing Over Time

Median PMPM Difference For Products From the Same Payer and Product Type



Few Buying-Up to Broad Networks

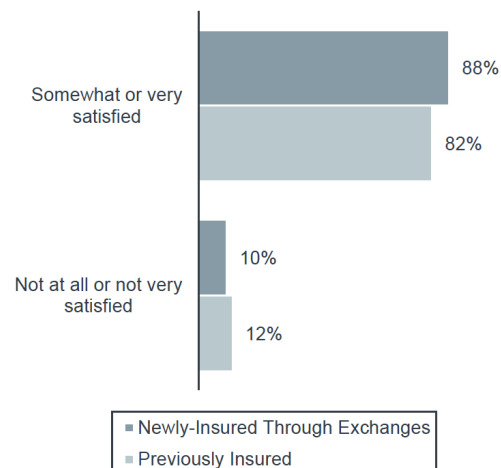


Little Backlash Against Narrow Networks, HDHPs



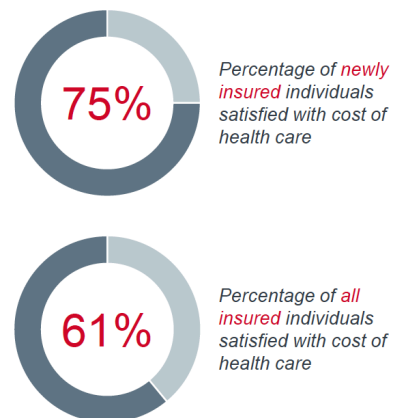
Exchange Enrollees Generally as Happy as Others with Health Coverage...

Ratings of Health Care Coverage Quality, 2015



...And Particularly Satisfied with the Cost of Their Coverage

Ratings of Health Care Coverage Cost, 2014



The Eight Predictions for 2016



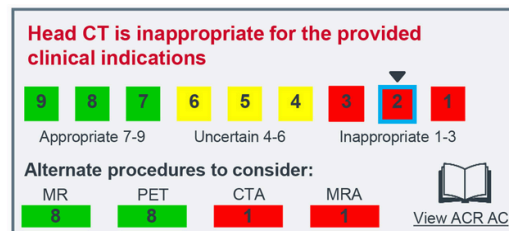
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Decision Tools: Not Data Repositories



- Included in the "Doc Fix" bill in 2014
- Requires physicians consult decision support tools when ordering "advanced imaging procedures" and directs HHS to provide physicians with such tools
- In order to receive reimbursement, physicians providing these services must:
 - Confirm CDS was consulted
 - Specify what CDS was used
 - Document whether or not the exam adhered to the criteria
- Appropriate-use criteria can only be developed or endorsed by national professional medical specialty societies or other provider-led entities
- Mandate that imaging programs provide clinical decision support software to ordering providers at no cost



Decision Tools: Not Data Repositories



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Direct-to-Consumer Virtual Visits



“2015 was the year that virtual visits went from an ‘up-and-coming trend’ to a ‘stay in business application’ for payers and pharmacy chains.”

*Dr. Joseph Kvedar
Partners Connected Health*

Strategic Benefit



- Enhanced rural access
- Improved patient convenience
- New patient capture/retention of existing patients
- Expanded PCP capacity

Popular Vendors



- Teladoc
- American Well
- MDLive
- Doctor on Demand

Clinical Applications



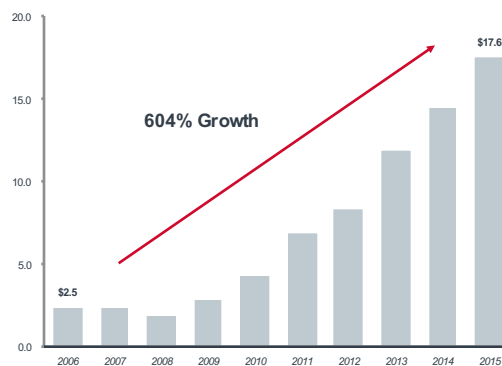
Source: Tahir D. "Telehealth services surging despite questions about value," *Modern Healthcare*, February 2015; Market Innovation Center research and analysis.

The Time Is Ripe for Virtual Care



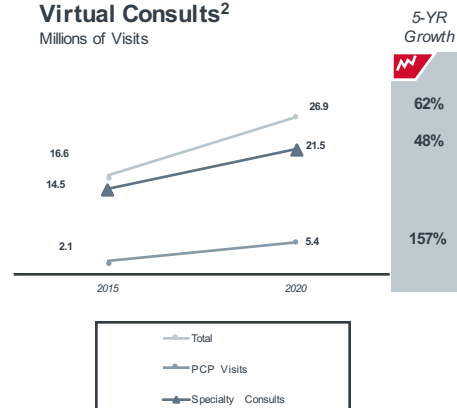
Year-Over-Year Medicare Reimbursement for Telehealth Services¹

In millions of dollars



Estimated U.S. Growth in Virtual Consults²

Millions of Visits



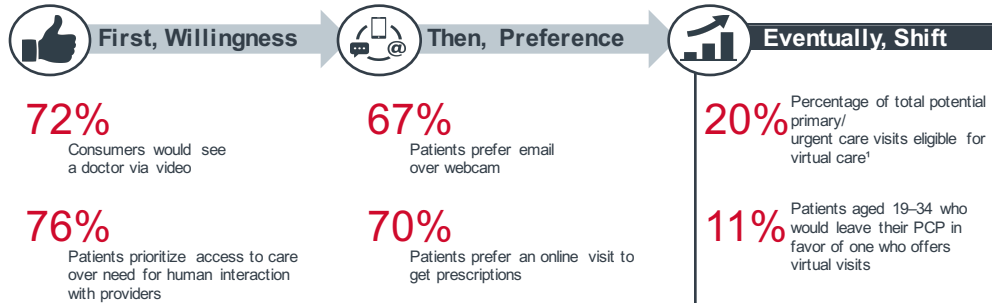
1) CMS data.
2) 2015 HIS Analytics report.

Sources: Herman B. "Virtual reality: More insurers are embracing telehealth," *Modern Healthcare*, February 2016, available at: <http://www.modernhealthcare.com/article/20160220/MA-GA-21NE02208980>; "Global Telemedicine Market - Growth, Trends and Forecasts (2015-2020)," *Market Intelligence*, <http://www.mordorintelligence.com/industry-reports/global-telemedicine-market>; December 2015; Jansen, Bruce, "Doctors' Virtual Consults with Patients to Double by 2020," *Forbes*, <http://www.forbes.com/sites/brucejansen/2015/08/09/a-s-4-tele-health-boom-s-doctors-to-double-by-2020/#2d4da3675d66>; August 2015; Market Innovation Center research and analysis.

Patients Favor Accessibility Over Type of Interaction



Surveys Show Strong Likelihood of Patients Shifting Care to Virtual



Key Takeaways

- Many patients aren't looking for the same type of intimate doctor-patient relationship of old
- Access to care is top concern
- Virtual interactions are preferable for low-acuity episodes
- Patients are looking for the fastest, easiest access point—no special skills or equipment needed
- Currently, about 1 in 5 outpatient visits could be done online
- Millennial patients are starting to actively choose tech-savvy providers

¹Calculated using CDC National Ambulatory Care Survey volumes by reason for visit

Source: Pennic J, "72% of Consumers Are Willing to See a Doctor Via Telehealth Video Conferencing," HIT Consultant, December 11, 2013; American Hospital Association "Trendwatch": The Promise of Telehealth for Hospitals, Health Systems and Their Communities, January 2015; American Well, "Telehealth Index: 2015 Consumer Survey," 2015; Market Innovation Center research and analysis.

Virtual Care Reimbursement Shift Quickening



Outlook for Commercial Reimbursement

- There are no consistent standards that govern private commercial payers
- As of January 2016, 32 states and DC mandate insurance companies to provide coverage for telehealth services, but with varying requirements and reimbursement rates.
- Some payers are partnering with non-health system innovators to offer covered virtual services for select groups of beneficiaries.

Sampling of Commercial Insurers Paying for Telehealth



- Covering real-time video, telephonic, and secure chat visits for non-urgent care consultations
- Scaled across 46 states; doctor visits and prescriptions available in CA
- Partners with American Well's LiveHealth Online platform



- Individual state Blues plans partner with variety of vendors, like American Well
- National Labor Office alliance with Teladoc
- Adds Teladoc services to benefits plans for labor trust funds, labor unions, and independent BCBS companies served by NLO



- Covers virtual visits for enrollees in self-funded employer health plans with access in 47 states and DC
- Expanding to employer-sponsored and individual plan participants in 2016
- Partners with Doctor on Demand and American Well

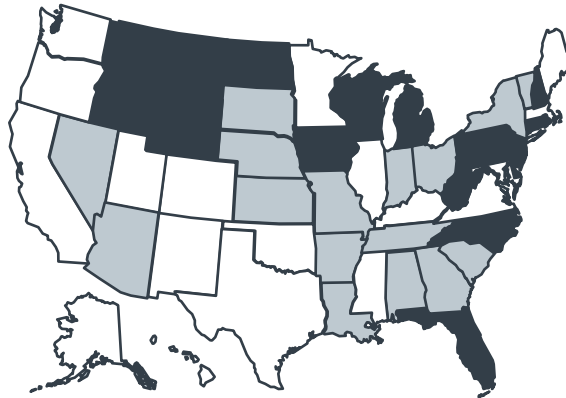


- Offers telehealth services to patients on multiple platforms, including patient portal and mobile app
- Invested \$10M in Vidyo telehealth platform in December 2015

Source: Center for Connected Health Policy, <http://chcpa.org/telehealth-policy>; American Action Forum, <http://americanactionforum.org/insights/cutting-the-provider-shortage-more-coverage-for-telehealth-services>; Market Innovation Center research and analysis.

Medicaid Policy & Reimbursement Varies by State

LEVEL OF STATE SUPPORT



□ Good to Excellent
□ Average
■ Fair to Poor

CRITERIA



CMS CY2016 Reimbursement Updates

Services Affected by Rule

2015 Expansion of Service

2016 Updates

Type of Interaction



Wellness visits are covered as long as there is an existing relationship between the patient and physician; the relationship can be initiated via a virtual visit

Two new codes added to reimburse for prolonged inpatient or observation care

Practitioners and Services



Psychoanalysis, family psychotherapy (both with and without the patient present), and prolonged service

Addition of certified nurse anesthetists to the list of qualified telehealth providers

Geographic Service Area



Payments allowed for patients in rural census tracts even if those tracts are within metropolitan statistical areas

Comprehensive Care for Joint Replacement (CCJR) model removes geographic restrictions for telehealth for hip and knee surgery care coordination

Chronic Care Management



CMS will reimburse providers for furnishing specific non-face-to-face services to qualified beneficiaries over a calendar month

Four codes added for services related to home dialysis for patients with end-stage renal disease

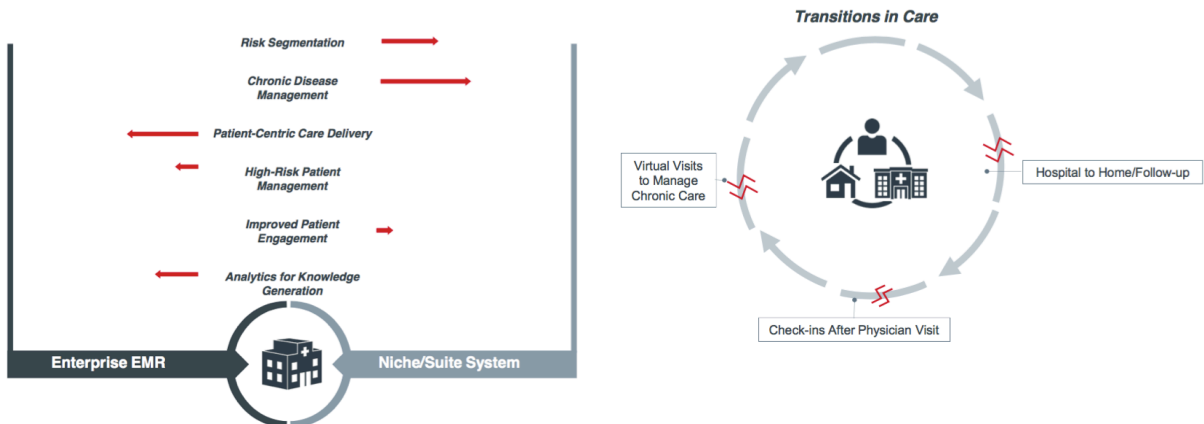
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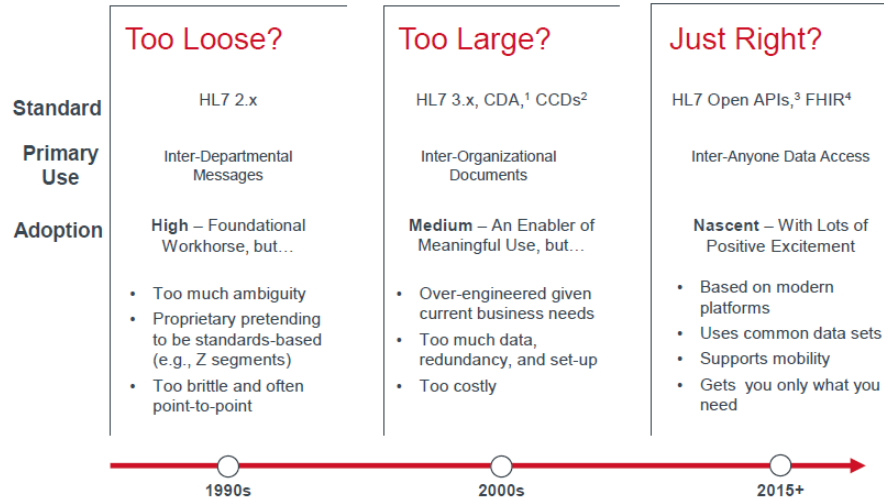
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A Unified System is Still a Long Way Off

Enterprise EMR vs. Niche/Suite Systems: 2016



HL7 Evolution: A Basis for Interoperability



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**Modern
Healthcare
A.M.** Everything
you need to know
to start the day

Wednesday, March 23, 2016

THIS MORNING'S TOP HEALTHCARE NEWS

ACA repeal more difficult as Americans get used to popular provisions

Well-liked measures of the Affordable Care Act, such as allowing young adults to stay on their parents' insurance longer and not allowing companies to discriminate against people with pre-existing conditions, rely on the more controversial individual mandate.

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