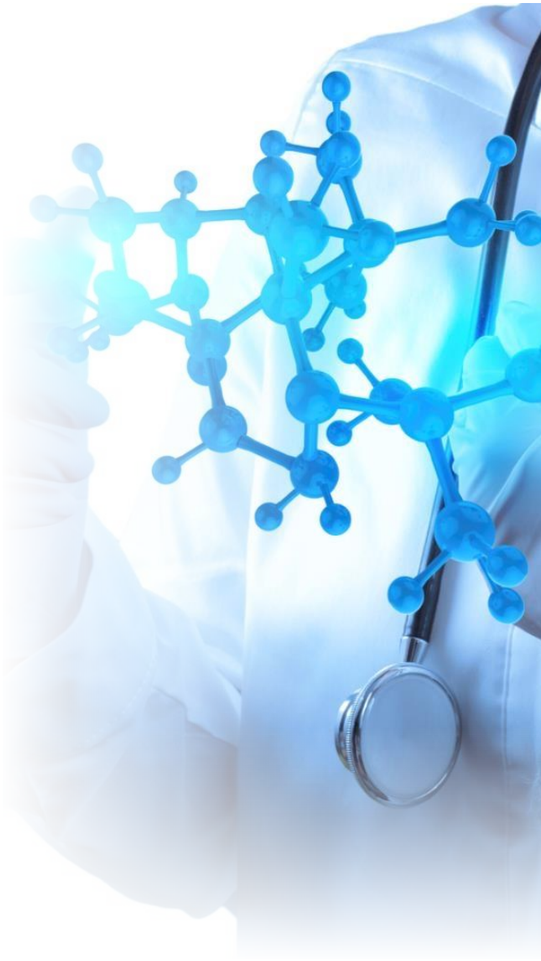
The Leadership Institute

Please note

We are a non-partisan firm and retain our ongoing policy of not commenting on the outcome of elections, advocating government policies, or providing policy advice or recommendations to clients.

However, because many of you have asked to understand what effect the new administration's positions– as they currently stand – might have on the healthcare sector, especially given the Republican control of both federal legislature branches, we are providing some information for you to consider.

Contents



The ACA had 3 closely related areas of reform

Key elements

Restrictions on payor policies

- **Guaranteed Issue:** Cannot deny coverage or set rates based on health status
- **Community rating:** Rating based only on age and geography; policies cannot be cancelled for illness
- **No annual or lifetime limits**
- **Coverage till age 26** on parents policy

Coverage mandates

- **Individual mandate:** Penalty (2.5% of income or $695[1]) for individuals forgoing coverage
- **Employer Mandate:** Must provide insurance if >50 employees, or be fined

Subsidized coverage

- **Medicaid Expansion:** Those making <133% (up from 100%) of the FPL qualify for Medicaid
- **Federal Subsidies:** Premium subsidies and limits on OOP[2] spending for those <400% FPL[3]

Overall goals

- Expand coverage
- Improved accessibility and affordability of coverage
- Improved efficiency of healthcare spend

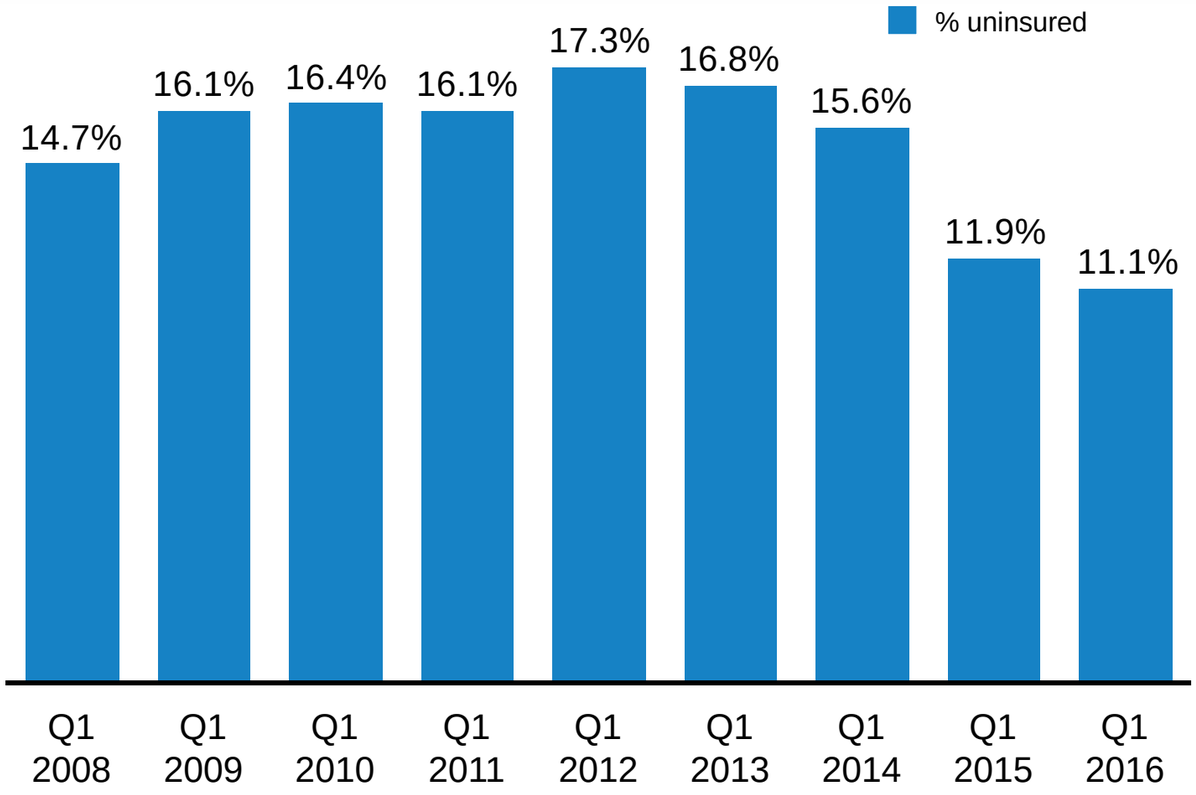
1 Penalty is 2.5% of income or $695 ($2085 for families), whichever is greater and inflation adjusted
2 Out of pocket
3 Federal poverty level

SOURCE: Web; Press

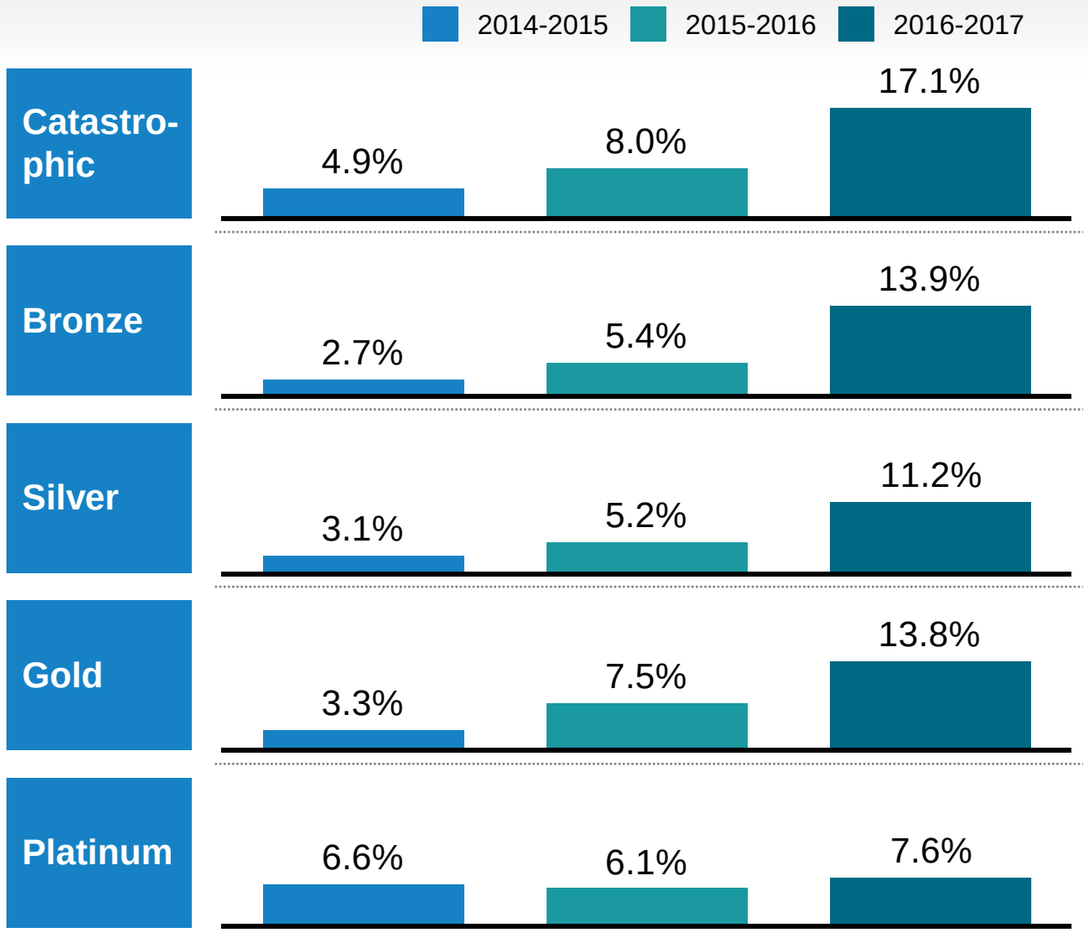
More (but incomplete) coverage, less affordable, less accessible

Percentage uninsured in the U.S by quarter

Do you have health insurance coverage? Among adults aged 18 and older



Change in exchange plan premiums by metal tier[1,2], 2015-2017

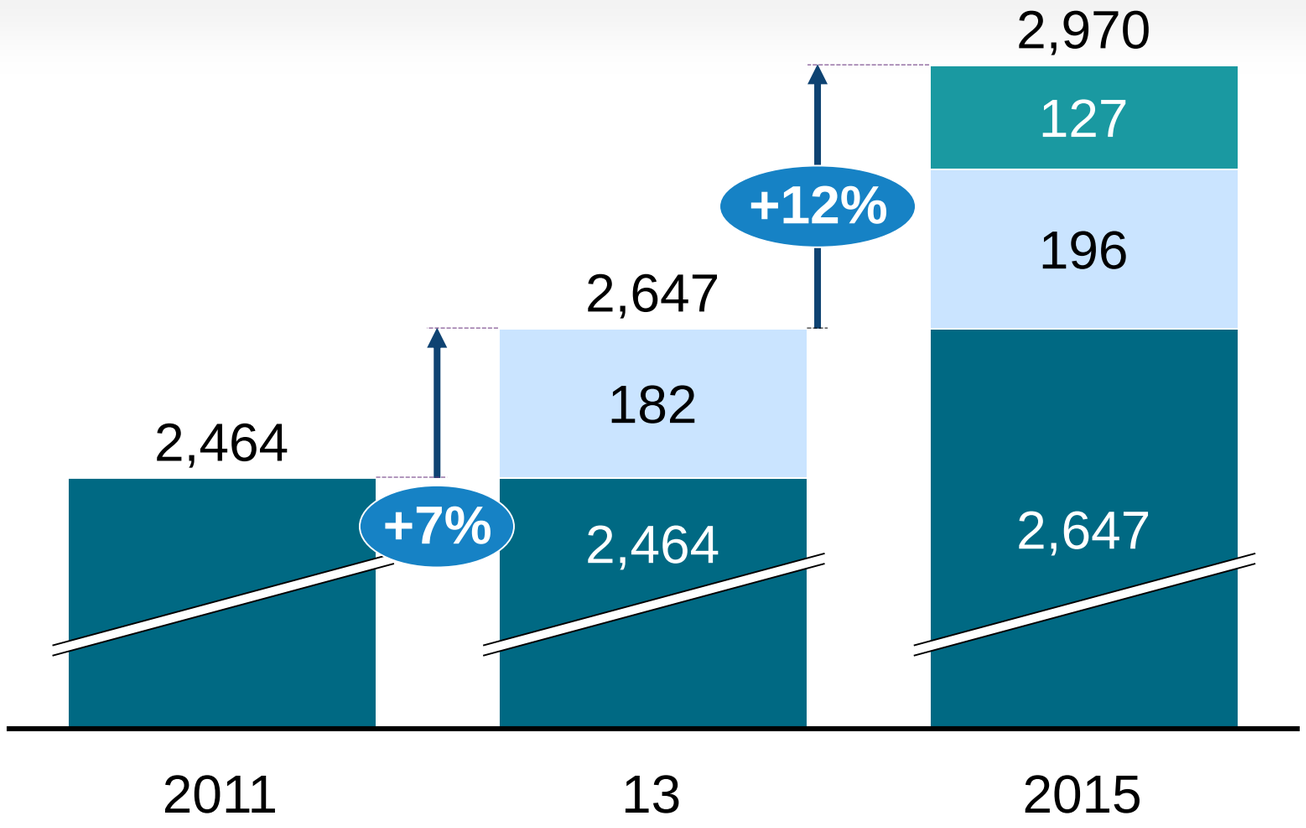


1 Gross premium, before subsidies
2 Annual percentage change from previous fiscal year

SOURCE: McKinsey Center for Healthcare Reform, Kaiser Family Foundation; Pew Trust; The National Association of State Budget Offices

The ACA increased healthcare spending

Health consumption expenditure[1], 2011-2015, USD B



- Annual growth rate for healthcare spend[3] increased by **~200 bps** after the ACA was enacted (5.8% vs. 3.6% per year)
- **Total increase** in annual spending from 2013 to 2015 was **$323B**, of which **~40% ($127B) was incremental** above historic trend

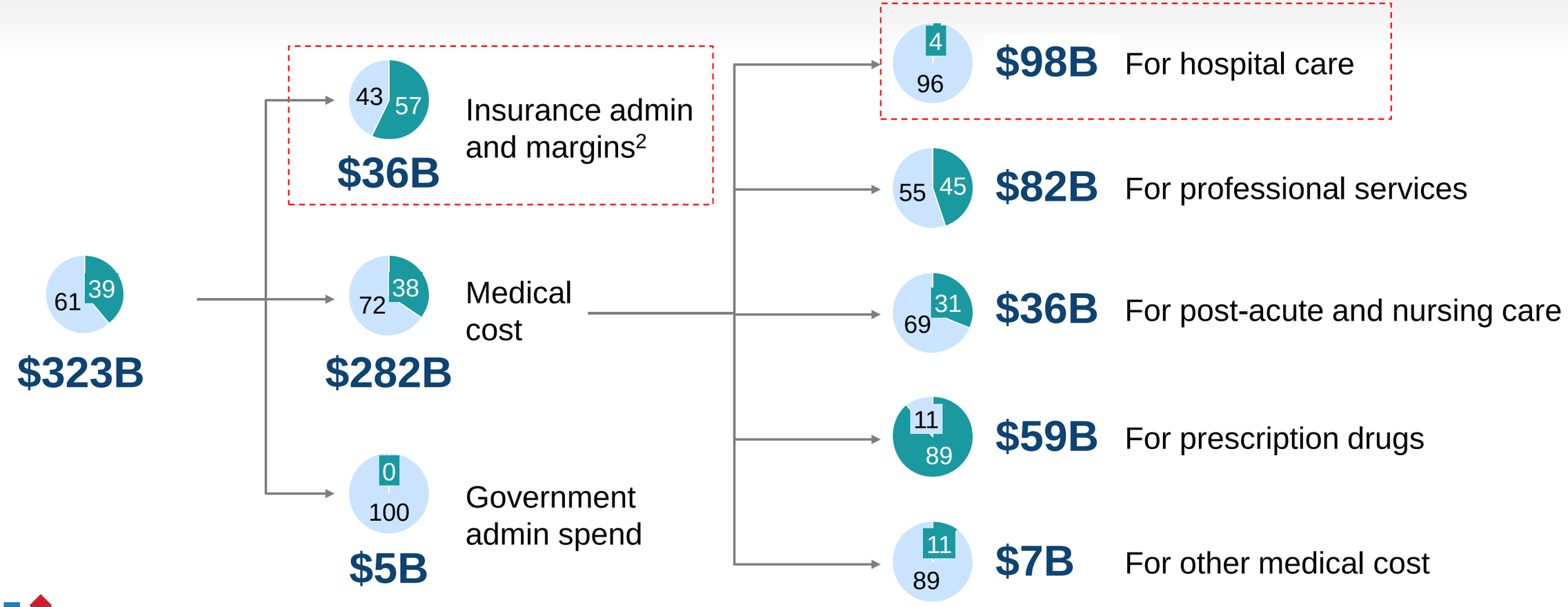
1 Excludes public health activities and investment activities
2 Spend expected based on 2011-2013 CAGR
3 Compound annual growth rate (CAGR)

SOURCE: CMS National Healthcare Expenditures

Payors and Pharma won from the ACA

Breakdown of the increase in annual healthcare spend[1]

(2013-2015)



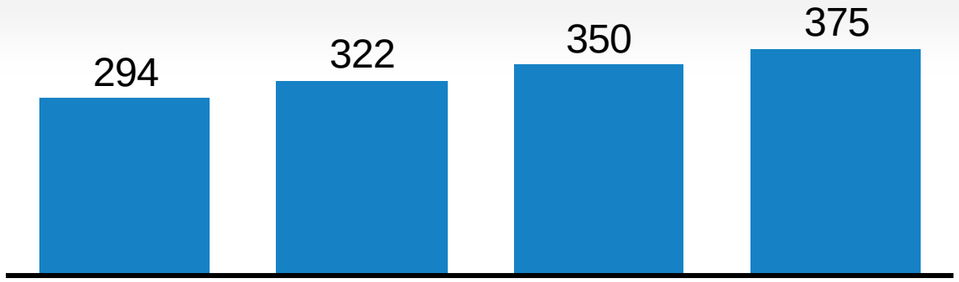
1 Refers to healthcare consumption expenditures, excludes public health activities and investment expenses
2 Refers to the net cost of private health insurance (difference between premiums and medical cost). Includes payor admin cost and margins and overhead for self-funded employer plans

SOURCE: CMS National Healthcare Expenditures

Payors' profit and stock price increased

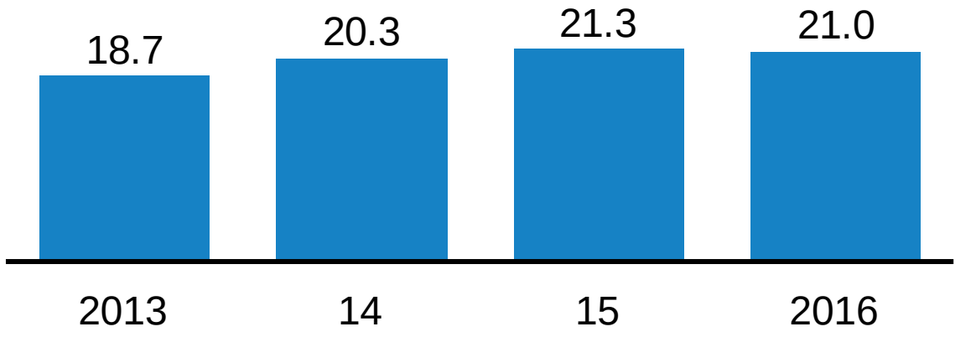
Operating revenue for 5 largest payors[1]

USD B



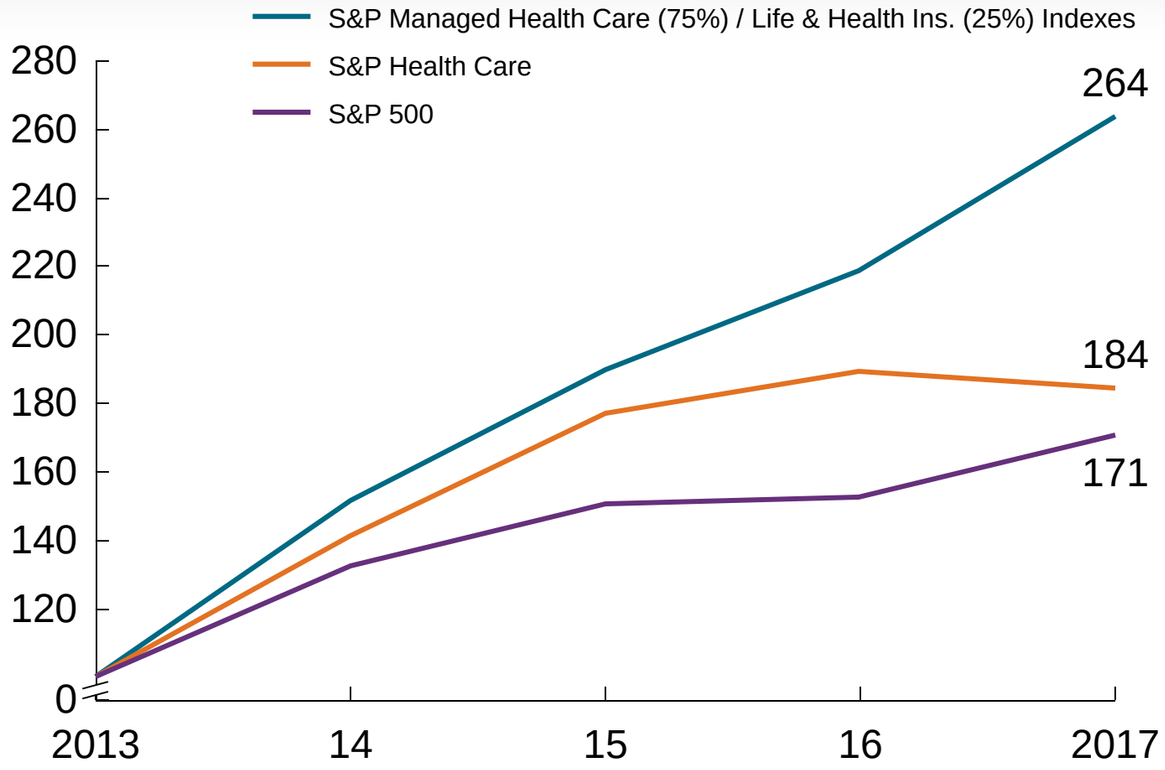
EBIT for 5 largest payors[1]

USD B



Stock market performance[2]

Value indexed to 12/31/2012, Percent



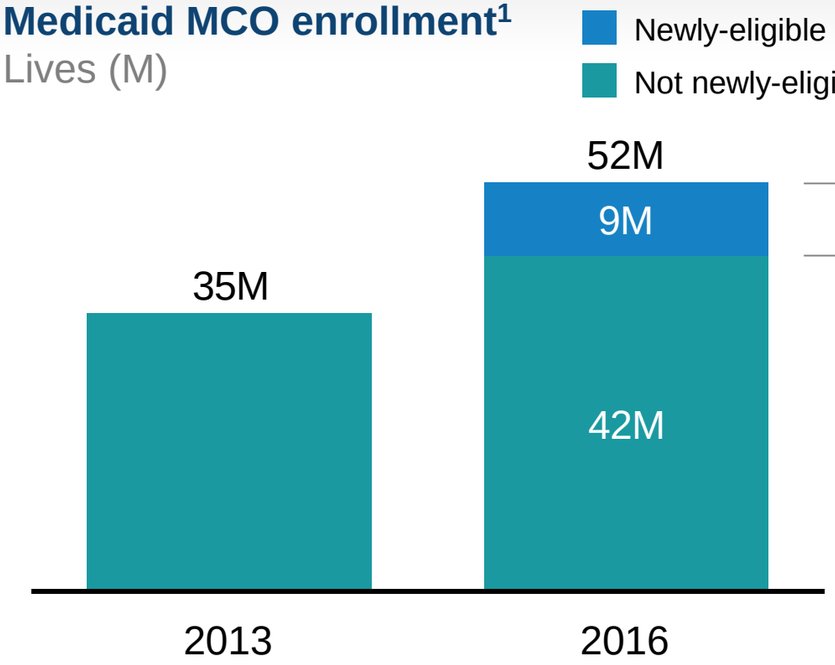
1 Aetna, Anthem, Cigna, Humana, UnitedHealthcare (excluding Optum)
2 Trend based on adjusted close price as of 12/31 every year for 2012, 2013, 2014, 2015 and 2016

SOURCE: S&P, company financial statements

Medicaid expansion drove margins for MCOs

Medicaid expansion more than doubled the growth in MCO enrollment…

Medicaid MCO enrollment[1]
Lives (M)



~80% of newly-eligible adults estimated to be in Medicaid MCOs

….and shifted ~$7.5B from providers to payor administrative expense and margin

Medicaid MCO costs and margin for newly-eligible adults in 2016

Avg Medicaid PMPY for newly-eligible adults:	$5,926		
Medical loss ratio:	~86%		
Administrative loss ratio:	~12%	→	~$6.4B
Profit margin:	~2%	→	~$1.1B

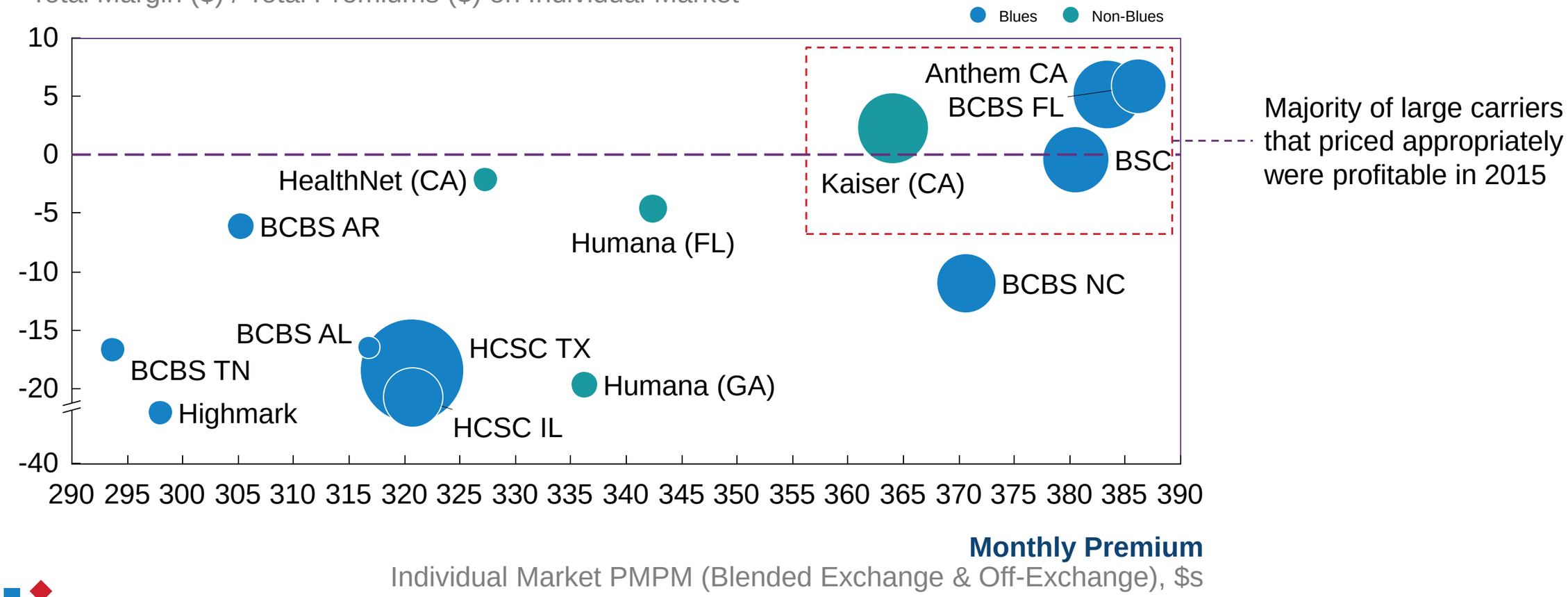
Newly-eligible adults accounted for **~23% of revenue[2]** for Medicaid MCOs in 2015

1 Enrollment for 2013 from Medicaid Managed Care Enrollment Reports. For 2016, state penetration rates from KFF were used to extrapolate national penetration rate.
2 Greater than enrollment percentage of 18% because newly-eligible adults had higher estimated costs than previously-eligible adults in 2016
SOURCE: Medicaid Actuarial Report, Medicaid Managed Care Enrollment Reports, Kaiser Family Foundation, MACPAC, Milliman

Individual market carriers who priced appropriately were profitable

Margin Percentage (2015)

Total Margin ($) / Total Premiums ($) on Individual Market[1]



Monthly Premium

Individual Market PMPM (Blended Exchange & Off-Exchange), $s

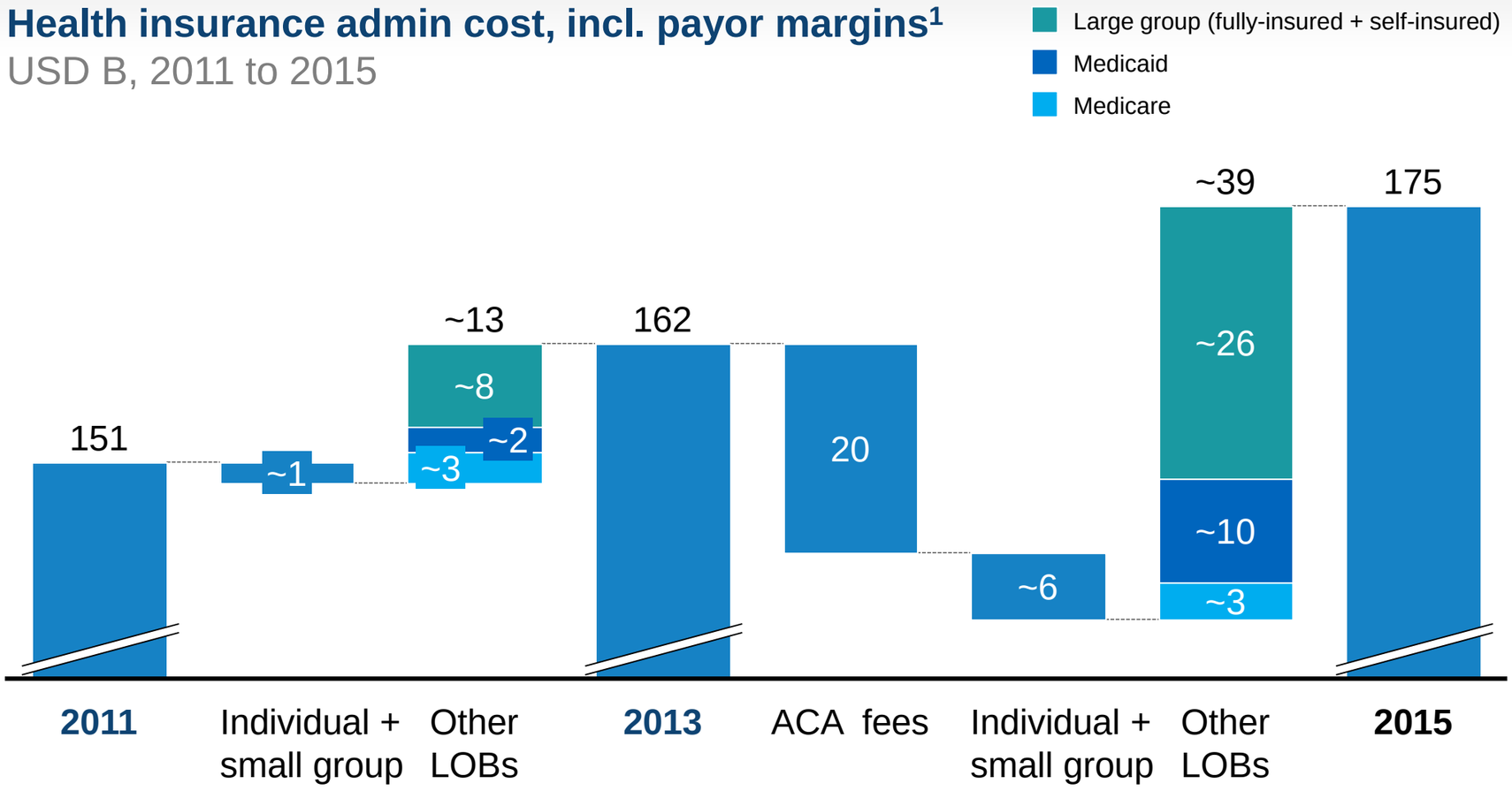
1 Includes carriers with >200K lives

SOURCE: Proprietary Payor Financial Database (2011-2015)

Payors passed on increased admin expenses and ACA taxes

Health insurance admin cost, incl. payor margins[1]

USD B, 2011 to 2015



- **ACA fees were fully subsidized** by consumers, employers and the government **via incremental premium revenue**
- Spread between premium and medical cost grew **~3X more from 2013-2015** relative to prior two years

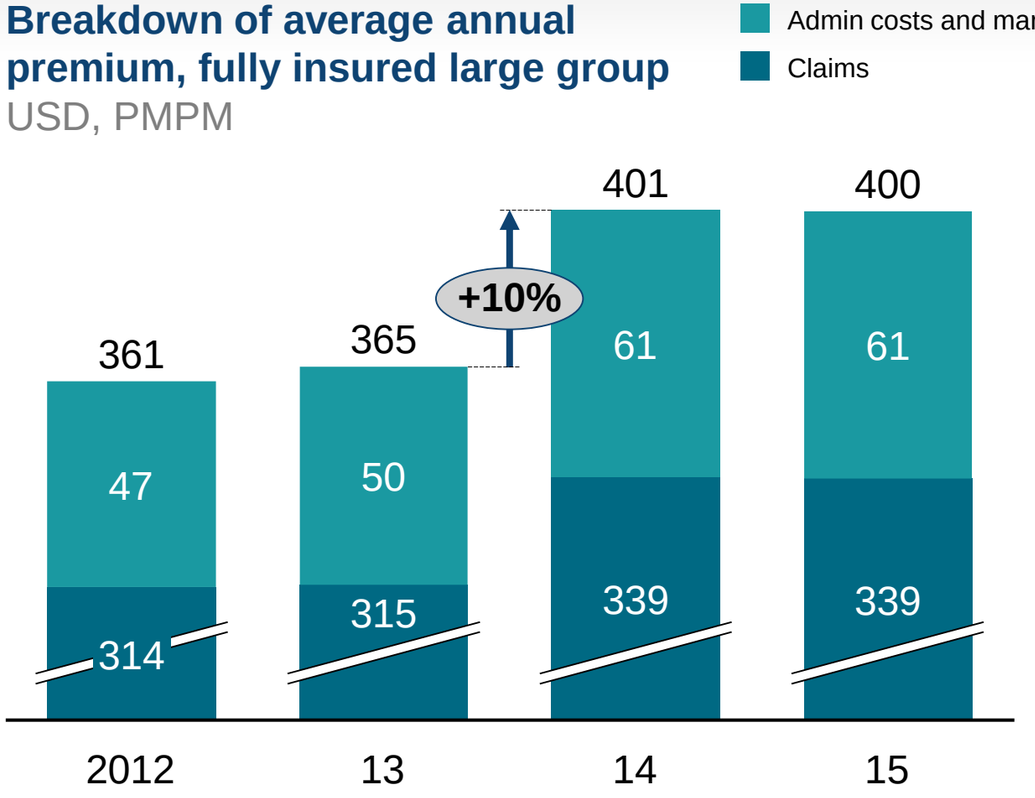
1 Includes overhead for self-funded employer plans. Does not include government administrative costs. Does not include worker's compensation. The total growth in admin and margin from 2013-2015 ($33B) is lower than the $36B increase reported earlier because of the exclusion of worker's compensation in this analysis

SOURCE: Payor financial database, Milliman, MPACT, CMS National Healthcare Expenditures

Commercial group business saw large premium increases

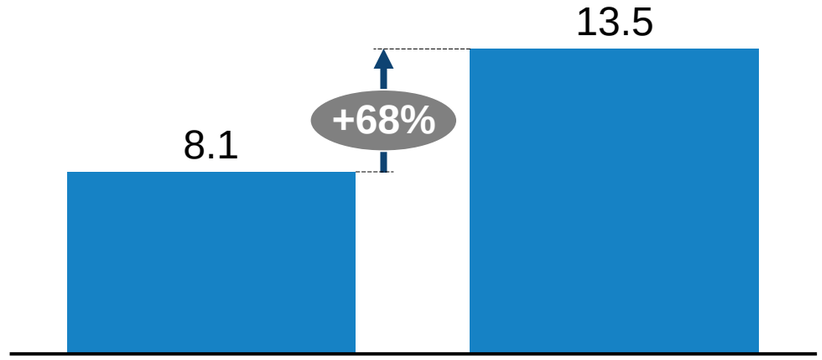
Large group premiums increased ~10% on average…

Breakdown of average annual premium, fully insured large group
USD, PMPM



…and pre-tax margin per life increased ~65%

Pre-tax margin[1], large group (fully insured & ASO)
USD Bn



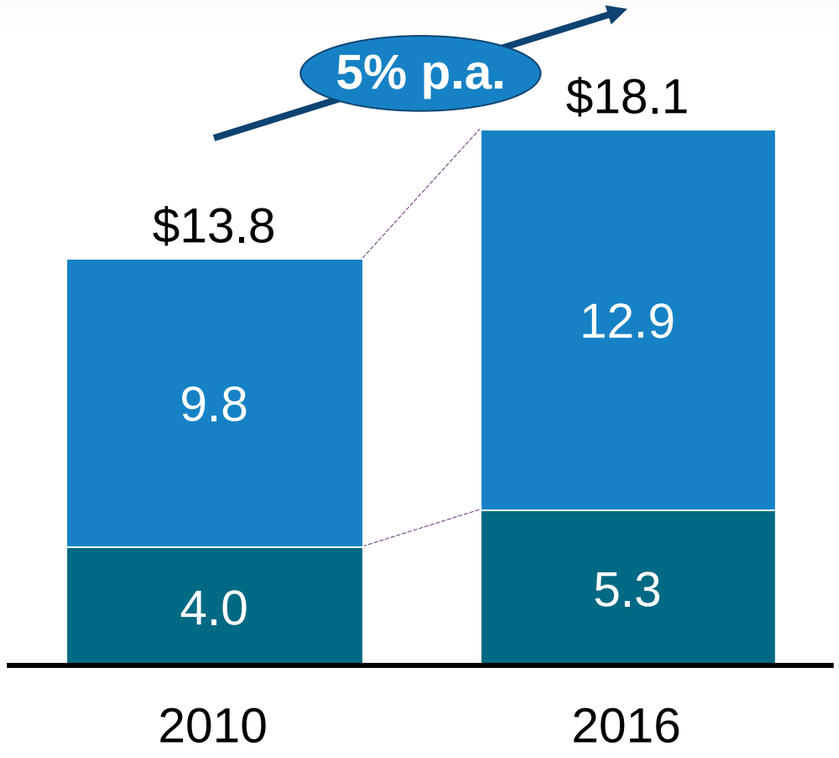
	2013	2015
Covered lives (Mn)	148	149
Margin per life[2] ($ PMPM)	4.5	7.5

1 Not including ACA fees. Certain forms of ASO income (e.g., TPA) may not be fully reflected
2 Weighted average margin per life for fully insured and ASO business

SOURCE: Payor Financial Database, Health Care Cost Institute

Premium increases are impacting employees as well

Average annual premiums for families with employer sponsored insurance[1,2], $ 000s



- Between 2010 and 2015, employee **premium contributions grew at ~5% annually**, while **household income only grew at ~3%[2]**
- For an average family, **~20% of the growth in income** seen during that period was **consumed by increasing premiums**
- **Real incomes remain at pre-recession levels[3],** and economic recovery is being delayed by rising premium contributions

1 Calculated for a family of four
2 Figures not adjusted for inflation
3 As of 2015 (most recent comprehensive data from Federal Reserve)

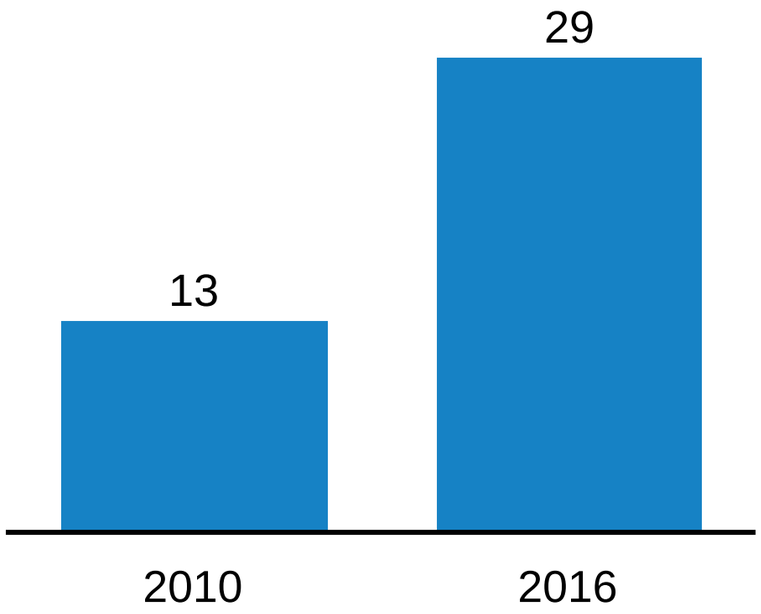
SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits; American Community Survey, FRED Federal reserve database

Similarly, deductibles have been rising faster than income

High-deductible plans are much more common…

Portion of covered workers enrolled in a high-deductible plan (HDHP)[1]

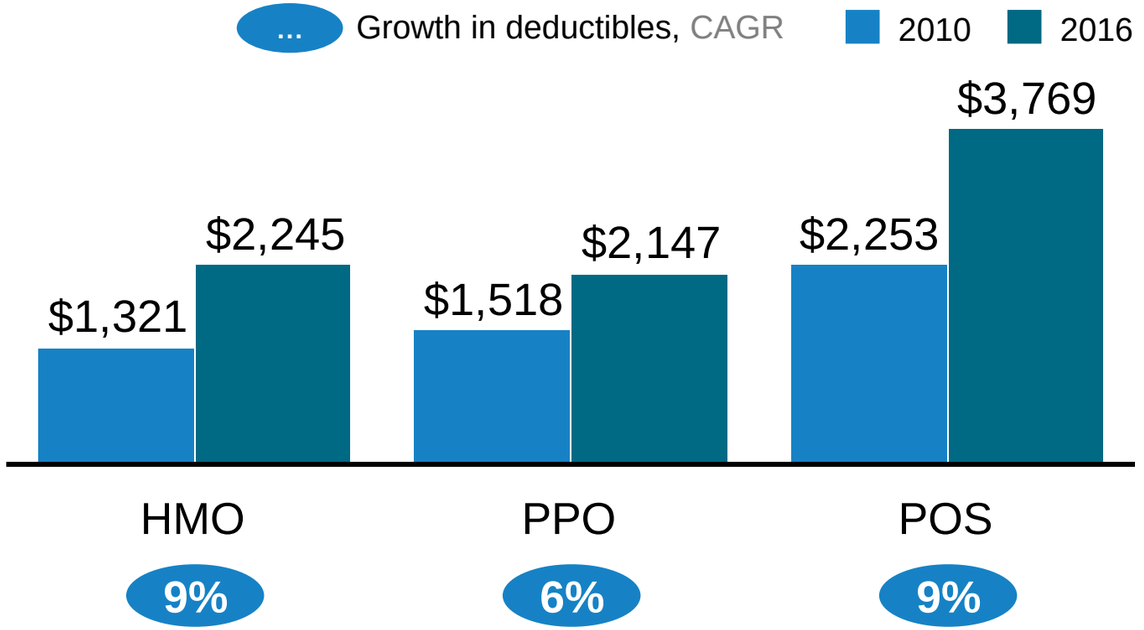
Percent



…and deductibles have risen faster than income even for other plan types

Average annual ESI deductible for families[2,3]

$

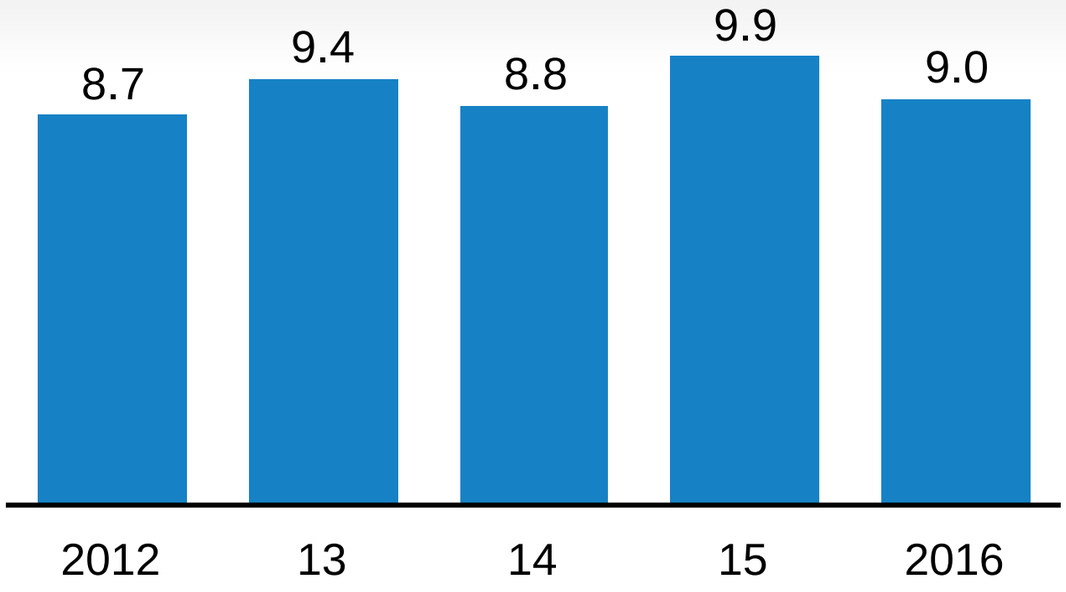


1 Includes workers enrolled in an HDHP/HRA (Health Reimbursement Account) or an HSA (Health Savings Account)-Qualified HDHP
2 Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services
3 Figures not adjusted for inflation

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits

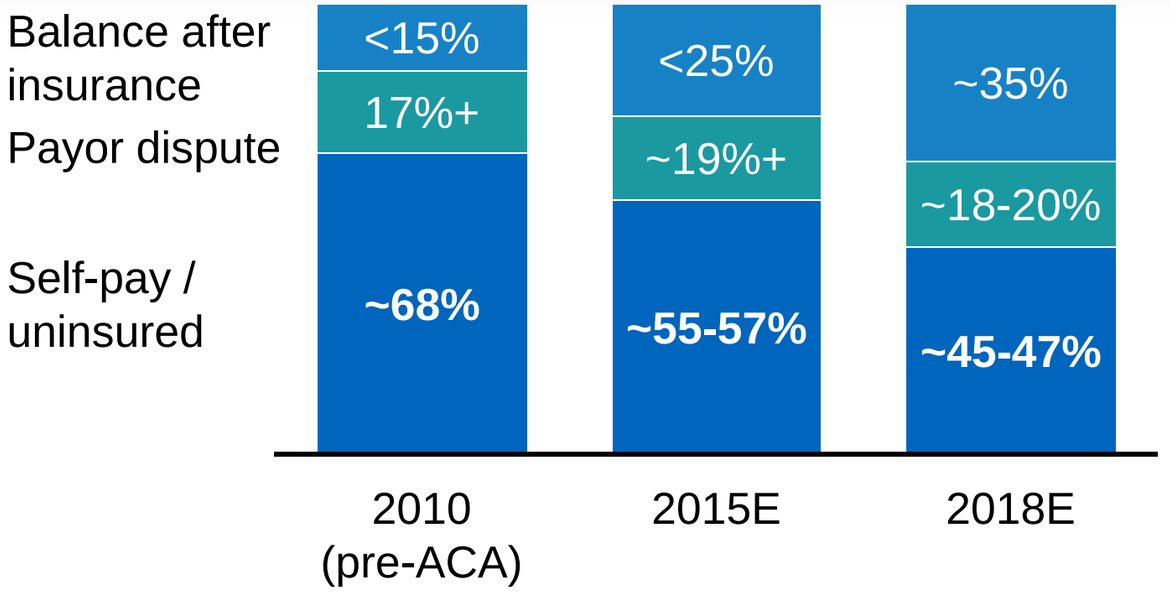
Provider bad debt levels remain high even with the ACA

Provision for bad debts of five publicly traded health systems[1], $ B



Estimated breakdown of US hospital bad debt

% hospital bad debt



Uninsured bad debt has been replaced by retail bad debt from increasing consumer responsibility

1 CYH, HCA, LPNT, THC, UHS

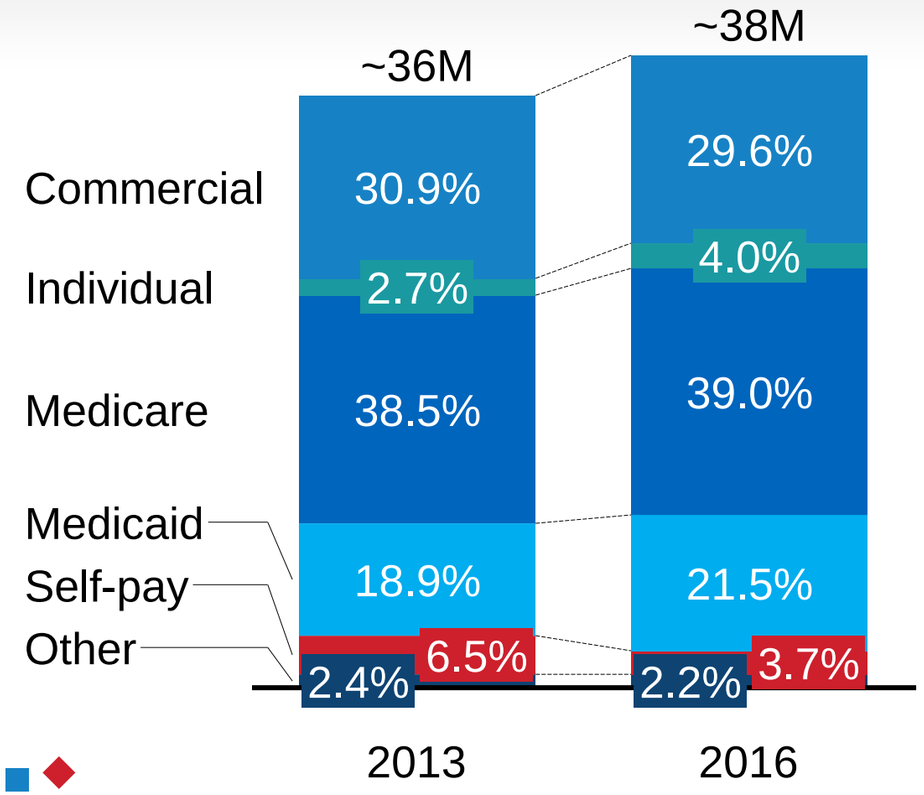
SOURCE: Financial statements of publically-traded companies, Health Affairs, Kaiser Family Foundation, Expert interviews

For providers, payor mix deterioration and Medicare cuts outweighed gains due to increasing coverage

Detail follows

Hospital payor mix
Percent of inpatient visits

Portion of incremental volume (%)



7%

17%

32%

44%

n/a

Total commercial mix remained stable at ~33.6%, but with a **shift from commercial group to less profitable Exchange** volume

Government volume increased from ~57.4 to ~60.5%, and **Medicare margins declined by 200 bps**

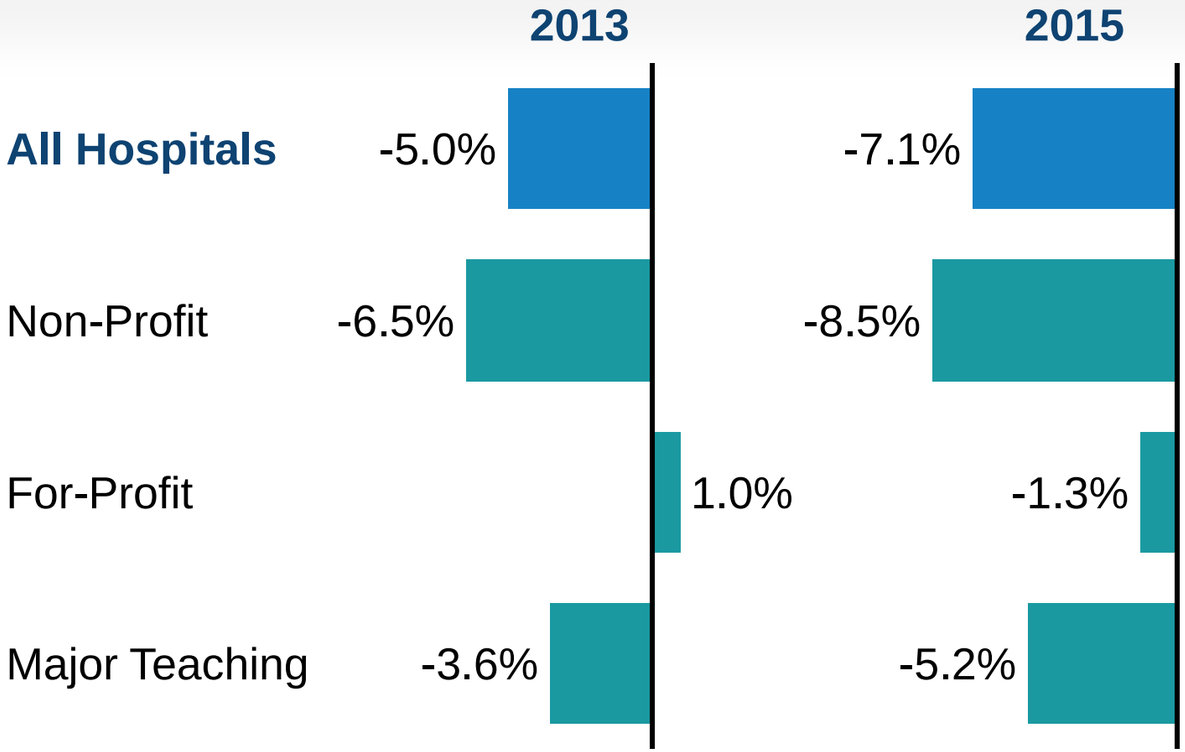
Uninsured volume declined but **total bad debt remained unchanged**

Note: all numbers above are estimates of national averages
SOURCE: Kaiser Family Foundation, MPACT, American Hospital Association

Medicare margins have deteriorated across provider types

Medicare Margin by Provider Type

Percent



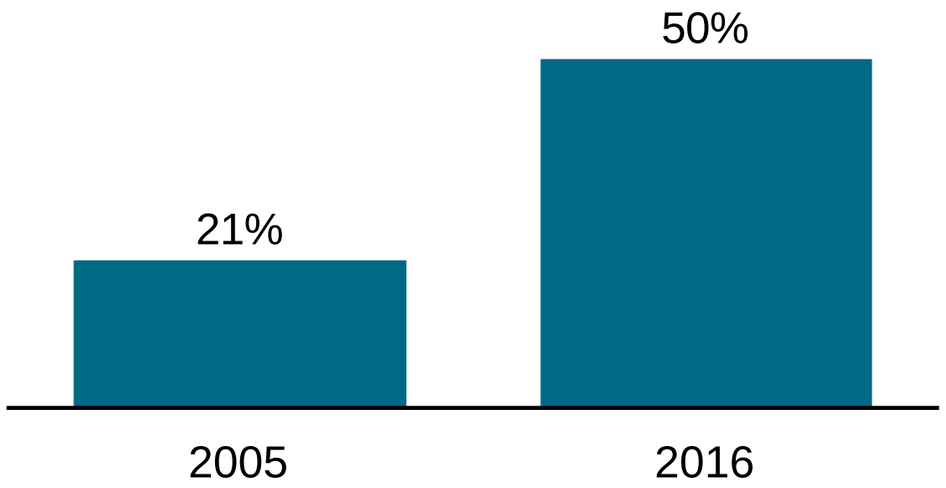
- Without changes to cost trajectory, **2017 Medicare margins may reach -10%**
  - Reimbursement cuts imply additional ~$350 per case headwind by 2017
  - Annual supplemental payments decreased by ~$2.5B from 2015 to 2017
- Losses are **impacting overall margins**
  - MedPAC reported **40 bps deterioration** of from **2013 to 2015**
  - Moody's reported **70-80 bps deterioration** from **2015 to 2016** for non-profits

SOURCE : MedPAC Data book, June 2016; MedPAC Report to Congress: Medicare Payment Policy (2017)

Regulatory burden is hurting physician productivity

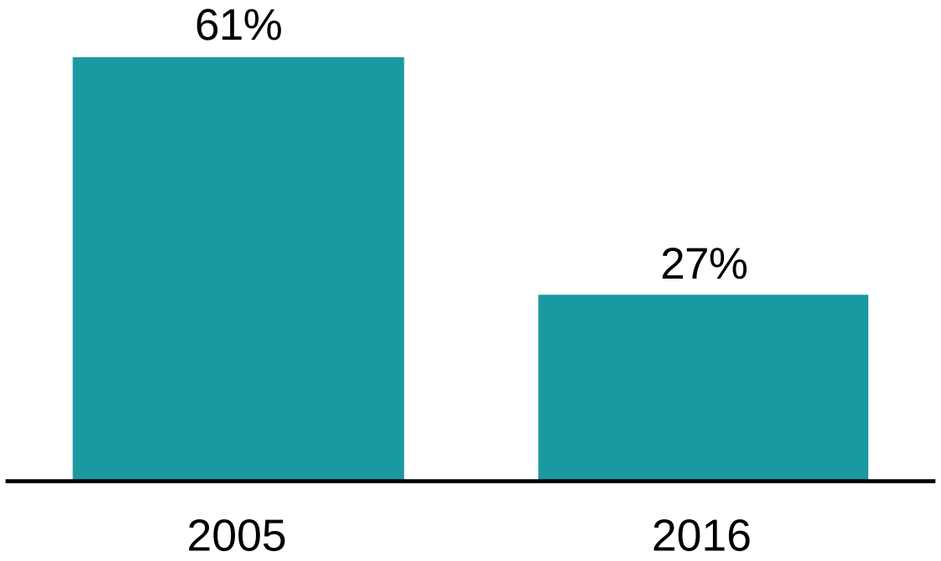
Physicians are spending more time on paperwork …

% physician time spent on EHR and administrative tasks[1]



… leaving less time for patients

% physician time on direct clinical face time

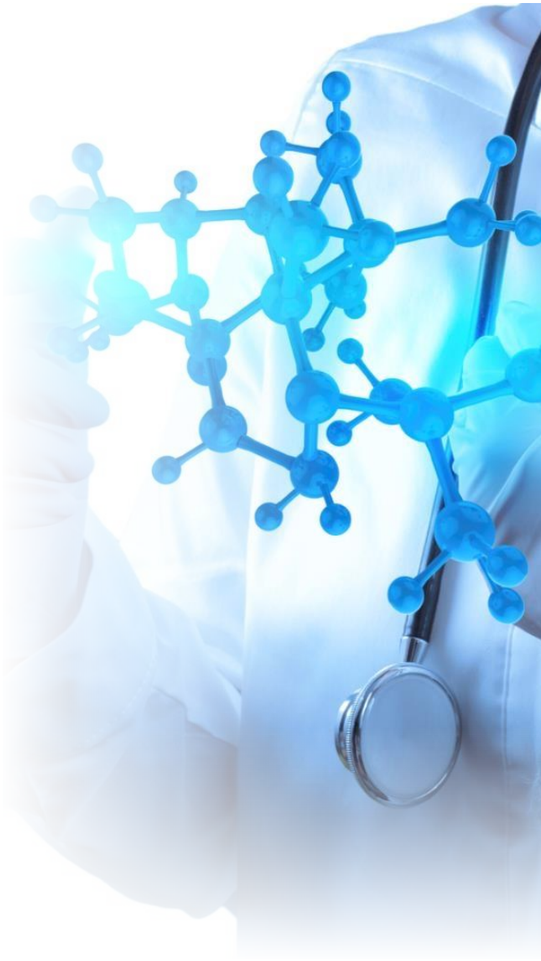


1 Majority of this time (70-75%) is spent on EHR review and documentation

SOURCE: Annals of Internal Medicine, Annals of Family Medicine

Contents

- Retrospective on ACA
- **“Reform 2.0” update**
- Looking ahead for providers

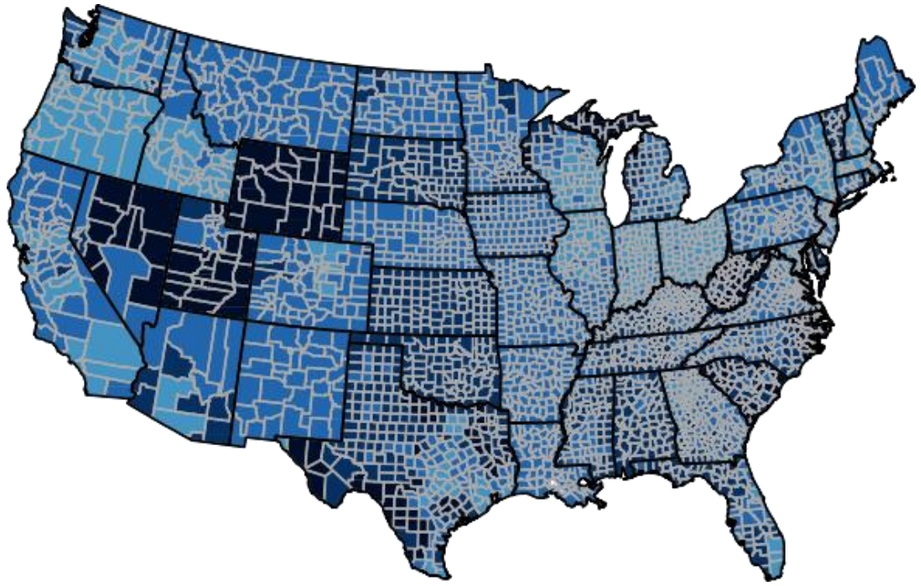


For 2017, 5 states have only 1 carrier participating across all counties

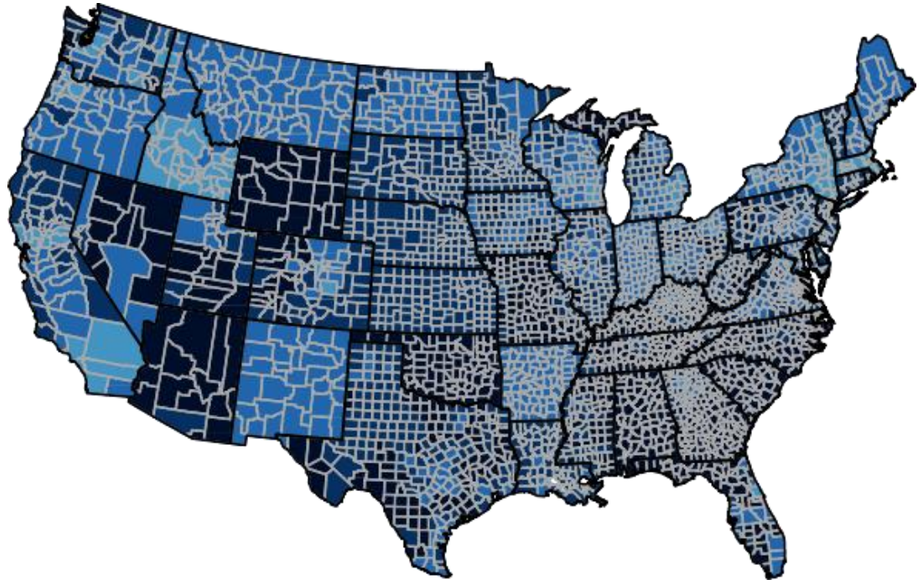
1 participating carrier
2 participating carriers
3-4 participating carriers
5+ participating carriers

Market view – count of carriers at a county level (Exchange carrier participation by country)

2016



2017



For 2018, many carriers have announced plans to exit at least one state exchange, including Humana, Molina, Aetna, and Wellmark

SOURCE: McKinsey Center for US Health System Reform

There are a range of potential scenarios for federal change to the ACA

Focus of today

Scenario	What this scenario could include, but may not be limited to[1]
Baseline	▪ **No change** to the current regulation or funding of the ACA (includes HHS stabilization regs) ▪ **Discretionary authority efforts** to limit effectiveness of the ACA (e.g., no mandate enforcement)
Regulatory and state leadership	▪ **Minimal legislative changes** to the ACA (e.g., Congress may appropriate cost-sharing reduction subsidies, give states additional flexibility) ▪ **Regulatory changes** within the authority of the Administration (e.g., EHB flexibility) ▪ **State discretion** on modifying key ACA provisions via individual market and Medicaid waivers
Federal budgetary changes	▪ The House passed the American Health Care Act (AHCA) by a vote of 217-213 on May 4, but the Senate did not pass the Better Care Reconciliation Act (BCRA) by a vote of 43-57 on July 25 ▪ The AHCA and BCRA aim to contain budgetary elements that would only require 51 votes to pass through the Senate ▪ These include an individual market stabilization package (e.g., cost sharing reductions) for transition as well as "future state" changes to individual market and Medicaid financing. However, these do not include Medicare reforms
Bipartisan plan	▪ Potential **Administration plan** and/or a deal struck between Republicans and Democrats; Details TBD ▪ "[I]nvite us — all 100 of us…— to Blair House to discuss a new bipartisan way forward on health care in front of all the American people." – Sen Chuck Schumer, June 2017
Compre-hensive overhaul	▪ Republican proposals: "A Better Way", introduced by **Paul Ryan** with input from **Tom Price** in July 2016, but requires bipartisan support and this is unlikely to be feasible in the near term ▪ Democratic proposals: Universal health care, discussed by 2016 and potential 2020 presidential candidates, but requires bipartisan support and this is unlikely to be feasible in the near term

1 Each set of proposals would be considered by the House and Senate, scored by the Congressional Budget office, subject to political feasibility, and may undergo change

SOURCE: Paul Ryan "A Better Way", February 2017 House Policy Brief, CMS Proposed Rule to Increase Patients' Health Insurance Choices for 2018. March 2017 American Health Care Act, Manager's amendment, MacArthur amendment, Upton amendment

HHS could use a range of authorities to make changes to the ACA

Details follow

	ACA-related component	Potential scenarios
A Individual market waivers (Section 1332)	▪ Key coverage provisions (e.g., essential health benefits, subsidies, mandates)	▪ States could use waivers to restructure their exchange markets starting as soon as 2018 ▪ HHS has substantial freedom in approving changes, and could revise application guidelines set by previous administration
B Medicaid waivers (Section 1115)	▪ Medicaid program design (e.g., operations, benefit design, eligibility, federal spending model)	▪ Additional alternative Medicaid models may emerge (e.g., Arkansas, Iowa, Michigan, Indiana) ▪ Advancement of a per-capita cap concept through federally driven model waivers for states
C Regulatory interpretation	▪ Cost-sharing reduction (CSR) subsidies in the individual market ▪ Medicaid managed care rule ▪ Individual market regulations	▪ Administration could decide to not continue the appeal in *House v. Burwell* (now *House v. Price)*, eliminating CSR payments ▪ Grant states more flexibility in Medicaid and individual markets (e.g., work incentives, essential health benefit design)
D Implementation discretion	▪ Innovation models (e.g., episode-based payments, SIM[1] grants) ▪ Individual and employer mandates ▪ Administration of FFM[2]	▪ Funding redirected toward or away from innovative ACA models currently administered by CMMI ▪ Administration could not enforce penalties ▪ Could change carrier requirements, plan design, etc.
Rate review and approval	▪ Annual QHP plan rate and benefit review and approval	▪ Administration could change standards for QHP plans (e.g., benefit design, rate increases, actuarial value requirements)

There are more than 2,500 references to the authority of HHS secretary in the ACA, giving the administration a considerable amount of flexibility in implementing the law

1 SIM = State innovation model, 2 FFM = Federally facilitated marketplace

SOURCE: ACA Repeal and replacement proposals. Paul Ryan A Better Way. Tom Price Empowering Patients First Act. Burr/Hatch/Upton Patient CARE act. Obamacare Repeal and Replace Policy Brief and Resources

A What could be changed and what couldn't using a 1332 waiver?

What could be waived ✓

- **Benefits and subsidies:** States may modify rules governing benefits and subsidies on exchanges. States can reallocate tax credits and CSRs
- **Marketplaces and QHPs:** States may replace marketplaces or supplant the process with alternative ways to provide choice, determine eligibility and enroll consumers
- **Mandates:** States may modify or eliminate the individual and employer mandates

What couldn't be waived ✗

- **Guaranteed issue and pre-existing conditions**: States can't allow insurance companies to deny coverage or charge more because of health status
- **Rating Bands**: States can't change the limits placed on how much premiums can vary based on age, health status, tobacco use and gender
- **No-cost preventive services**: States must require insurers to cover preventive services, such as immunizations and screenings

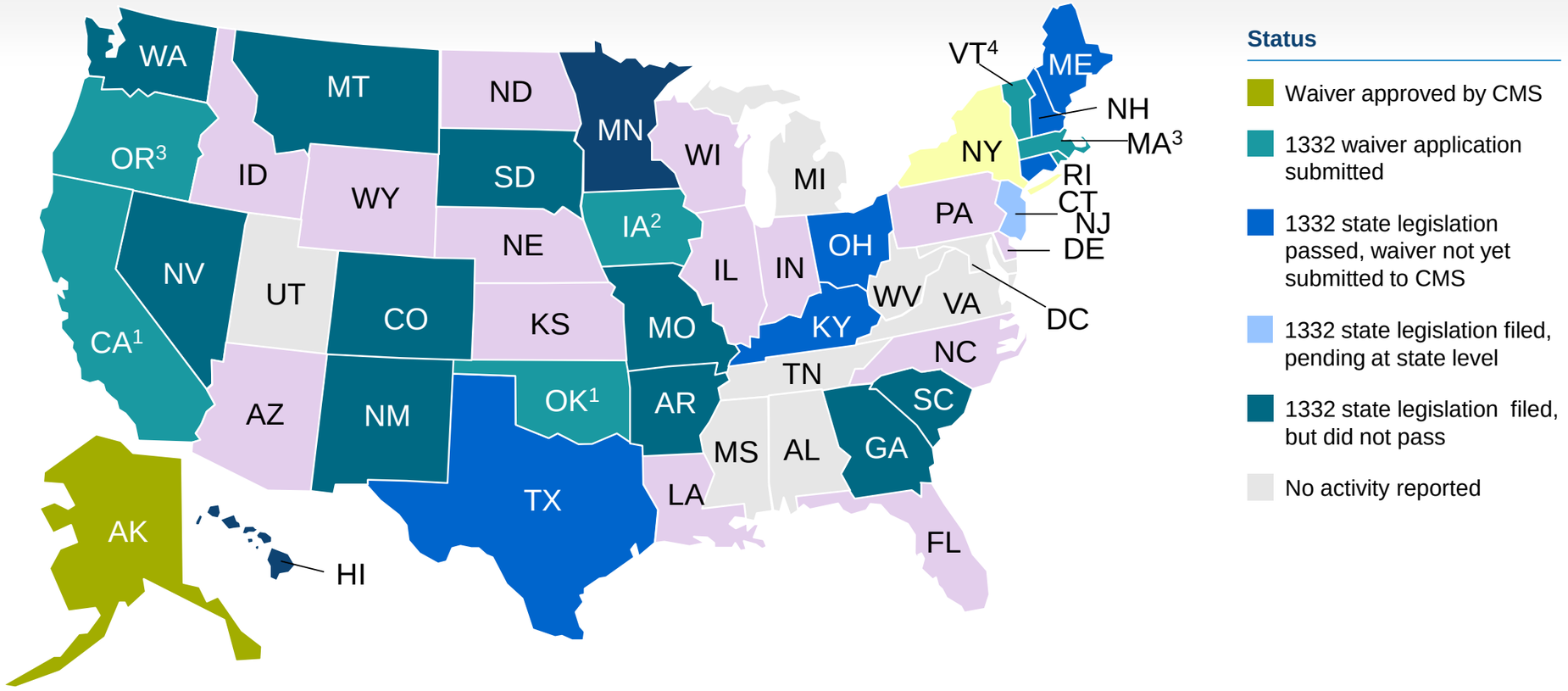
HHS leadership has stated several principles and priorities in a letter on 3/13

- Aims to expedite 1332 applications and provide checklists to assist states
- Proposals should be "as good or better" in terms of comprehensiveness, affordability, and coverage and be federal deficit neutral
- Programmatic priorities include high-risk pools and state-operated reinsurance, with the potential for states to receive pass-through funding to offset some costs
- HHS may be open to applications relaxing EHB requirements

SOURCE: Affordable Care Act; HHS, "Offering states flexibility to increase market stability and affordable choices," March 13, 2017

A A number of states have considered changes to their marketplace via 1332 waivers to date

1332 waiver activity by state, as of 10/4/2017



1 Application withdrawn 2 State did not pass authorizing legislation, waiver filed via executive action. CMS determined application complete, pending decision
3 State passed authorizing legislation, CMS determined application complete, application pending CMS decision 4 Application determined incomplete by CMS

SOURCE: National Conference of State Legislatures, "State Roles in Using Section 1332 Waivers", (accessed on 10/4/2017)
http://www.ncsl.org/research/health/state-roles-using-1332-health-waivers.aspx, http://www.statenetwork.org/more-states-looking-to-section-1332-waivers/ (accessed on 10/4/2017)

B What could be changed and what couldn't using an 1115 waiver?

What could be waived1 ✓

- **Operational rules** pertaining to Medicaid, Medicaid, and CHIP, such as:
  - Eligibility (e.g., expansion of coverage for childless adults)
  - Structure of benefits (e.g., limited benefit design) and cost sharing
  - Methods and procedures related to payment for healthcare services (e.g., FFS vs. Managed care)
- **Use of federal Medicaid funding:** allows states to fund services in ways that are not otherwise payable or matchable

What could be waived1 ✗

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  - Methods and procedures related to payment for healthcare services (e.g., FFS vs. Managed care)
- **Use of federal Medicaid funding:** allows states to fund services in ways that are not otherwise payable or matchable

HHS and CMS leadership have stated several principles and priorities in a letter on 3/14

- Aims to streamline application process (e.g., make the State Plan Amendment process more efficient/ transparent, "Fast track" extension approval)
- Discussed that the project is a demonstration to assist in **promoting the objectives of Medicaid**
- Programmatic focus areas outlined include, but are not limited to:
  - Alternative benefit design (e.g., premium contributions, healthy behavior incentives)
  - Eligibility: limitations on non-disabled adults, work incentives
  - Promotion of enrollment in Employer-Sponsored Insurance (ESI)

1 Section 1902-3 of the Social Security Act, which contain key operational components of the Medicaid program, and Section 1115A, created by the ACA
2 There is some precedent for alternative financing structures under 1332

SOURCE: : https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf. McKinsey: What can states do to change key parameters of Medicaid?

B Existing and emerging uses of 1115 waivers to modify Medicaid programs

Waiver themes *Not mutually exclusive*	Examples	Number of states with waiver Approved	 Pending
Delivery system reform	▪ Efforts that tie provider incentive payments to performance goals (e.g., shift to value-based payment), DSRIP delivery system reforms, funding for safety net hospitals	▪ 16	▪ 3
Behavioral health	▪ Enhanced services to targeted populations (e.g., individuals with a substance use disorder), integration of physical and behavioral health services	▪ 12	▪ 12
Long-term services and supports	▪ Delivery of LTSS via capitated managed care, streamlining of program admin, improving care coordination, expanding beneficiary access to home and community-based services	▪ 12	▪ 3
Medicaid expansion design	▪ Modifying key benefits and eligibility designs as part of expansion model (e.g., Healthy Indiana Plan 2.0)	▪ 7	▪ 1
Eligibility and enrollment	▪ Premium assistance for qualified health plans and employer sponsored insurance, requiring beneficiary premiums/monthly contributions, waiving reasonable promptness, retroactive eligibility, and 12 mo. continuous eligibility	▪ 7	▪ 8
Benefit restrictions, copays, healthy behaviors	▪ Modifications to required benefits, copays above statutory limits, and incentives (e.g., completing a health risk assessment)	▪ 5	▪ 6
Work requirements	▪ Requirement for beneficiaries to participate in activities such as employment, job search, or job training programs, for a certain number of hours (per week or month) to receive health coverage	▪ 0	▪ 6
Other	▪ Support during emergency situations (e.g., Flint water crisis), initiatives focused on targeted populations (e.g., HIV/AIDS, uninsured non-elderly adults)	▪ 16	▪ 3

Some states have multiple approved and/or multiple pending waivers, and many waivers are comprehensive, and may span multiple of the above areas.

SOURCE: Kaiser Family Foundation: Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers.

B 1115 Waiver case study: Indiana Medicaid expansion model

Context

- Indiana expanded coverage to ~350,000 new beneficiaries on February 1, 2015 through a 3-year 1115 waiver
- Expansion covered adults ages 19-64 with incomes from 0-138% FPL
- One of the most complex expansions to date, the waiver created multiple benefit packages with common themes of consumer responsibility and cost-sharing

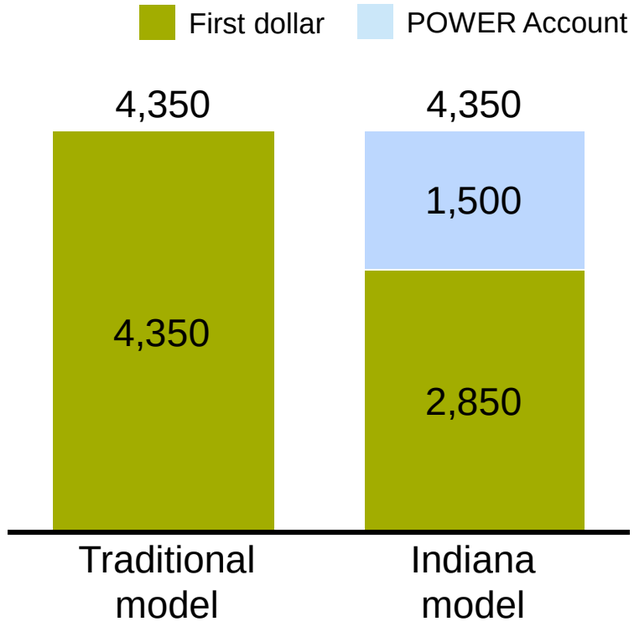
Distinctive features

- Pre-funded HSAs ("POWER" accounts) for members in capitated managed care
- Requirement of premium payments for certain benefit packages
- Six month coverage lock-out for non-payment of premiums for beneficiaries above 100% FPL

Benefit package variation

- **HIP Plus** for beneficiaries who pay premiums: includes expanded benefits and co-payments only for non-emergency use of the ER
  - Non-medically frail 101-138% FPL must pay premiums to obtain any coverage
  - Premiums capped at 2% of income; premiums for those with income below 5% FPL are $1.00 per month
- **HIP Basic** for beneficiaries with income at or below 100% FPL who fail to pay premiums: fewer benefits and required co-payments in state plan amounts

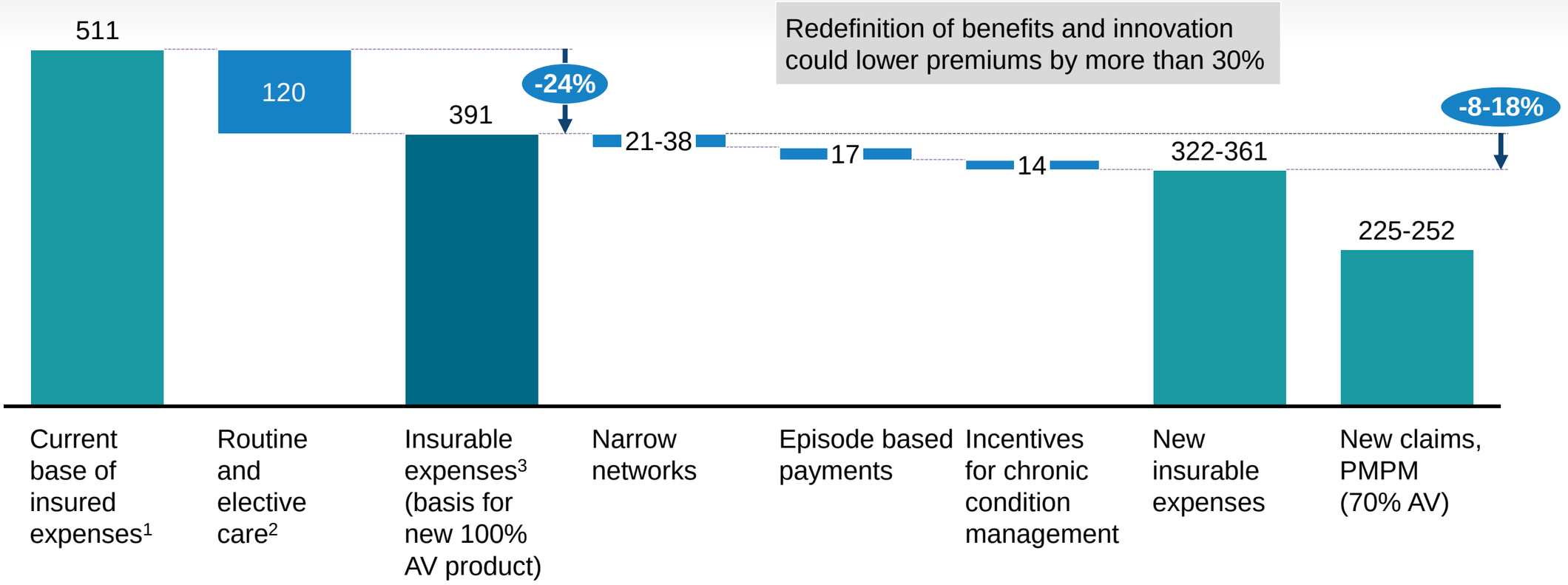
Medicaid benefit model, $ benefit value



SOURCE: Healthy Indiana Plan, http://www.in.gov/fssa/hip/ ; CBO Medicaid baseline 2017

C HHS could potentially redefine the 10 essential health benefit criteria

If essential health benefits were redefined, only 76% of today's covered health services would be insurable, $, PMPM



Note: PMPM – Per Member Per Month
1 Based on 2014 exchange premiums and actuarial value.
2 Based on breakdown of 2014 Truven commercial claims data.
3 Includes chronic, catastrophic, and preventive care (excludes routine and discretionary services).
SOURCE: Data from the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project, Medical Expenditure Panel Survey, National Health Expenditures Accounts, Office of the Assistant Secretary for Planning and Evaluation, Truven, and medical loss ratio reports from the Centers for Medicare and Medicaid Services; McKinsey Payor Financial Database; McKinsey Exchange Offering Database

D CMMI's mandate from Congress is to improve the quality and efficiency of health care; HHS has discretion over how

Overview of CMMI authority

- Test innovative payment and service delivery models **to reduce program expenditures while preserving or enhancing the quality of care**
- **Through rulemaking, expand the duration and scope** of these models (including implementation on a nationwide basis)
- Applicable to Medicare, Medicaid and CHIP segments
- Can **implement authority through several levers** including modifying existing models, direct Medicare waiver authority, facilitating testing in Medicare Advantage, developing new Medicare demonstrations (with Congressional approval)

Republicans emphasize several broad healthcare issues, which may be CMMI's focus going forward

- **Multi-payer collaboration** / private payer-friendly programs
  - E.g., General Republican focus on private sector partnerships
- **State flexibility**
  - E.g., "We commit to ushering in a new era . . . where states have more freedom to design programs that meet the spectrum of diverse needs" – Price, Verma, March 2017
- **Consumer-centric** care / consumer accountability
  - E.g., Seema Verma implemented prefunded Health Savings Account in Indiana Medicaid
- **Provider flexibility**
  - E.g., Tom Price's goal of ACA replace is to "get Washington out of the way while protecting and strengthening the doctor-patient relationship."

Altering CMMI funding levels would require legislation, but changes to use of existing funding can happen through regulation

SOURCE: Section 1115A of the Social Security Act, as added by section 3021 of the Affordable Care Act; CMMI website; Paul Ryan's "Better Way"

Update on White House Executive Order on Oct 12th

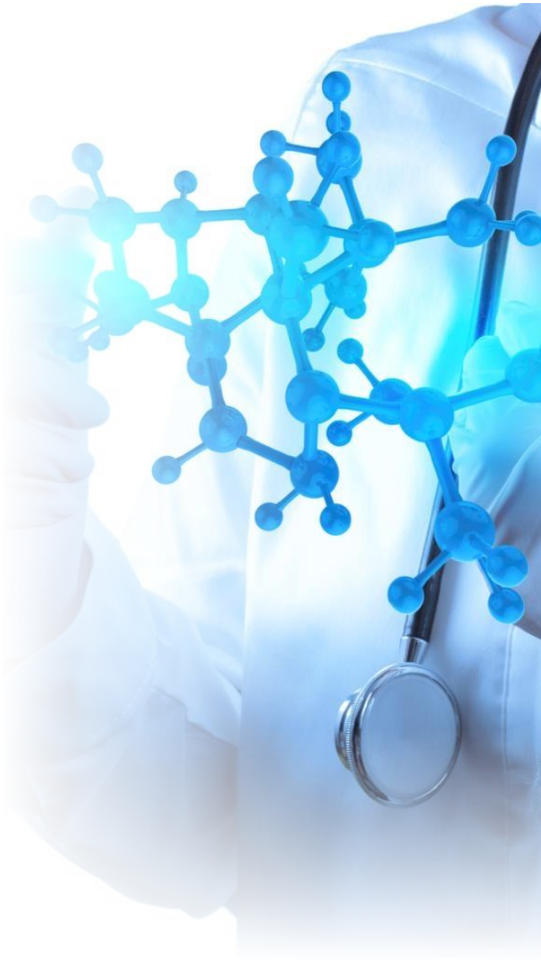
- President Trump **signed an executive order** (EO) that:
  - Is an official policy of the executive branch; however, it is “not intended to, and does not, create any right or benefit, substantive or procedural, enforceable at law”
  - Directs the **Department of Labor, Department of Health and Human Services (HHS), and Department of the Treasury** to consider actions through rule-making, from which resulting rules would carry the force of law
- The EO prioritizes **3 areas for improvement** in the near-term:
  - **Association Health Plans (AHPs)**: broadening interpretation of ERISA’s “commonality of interest” standard
  - **Short-term, Limited Duration Insurance (STLDI)**: extending duration and allowing consumers to renew them
  - **Health Reimbursement Accounts (HRAs):** expanding employers' ability to offer HRAs to employees and allowing HRAs to be used in conjunction with non-group coverage
- Implications of the EO will **depend on the final rule-making** by departments:
  - **Department of Labor, the Department of Health and Human Services (HHS), and Department of the Treasury** are required to consider **public comments** on proposed regulations
  - CMS administrator **Seema Verma**, US Secretary of Labor **Alexander Acosta**, and Secretary of the Treasury **Steven Mnuchin** have expressed their support of the EO

Update on individual market cost-sharing subsidies (CSRs)

- ACA included CSRs for those who have individual market exchange policies and incomes **less than 250% of the federal poverty level**, equivalent to ~**$30K in income**
- Turmoil has surrounded CSRs, starting with the House of Representatives suing the Obama administration in 2014, claiming the administration lacked the legal authorization to fund the CSRs; in 2016, a US District Court ruled for the House, with the Obama administration appealing that decision
  - Industry groups have expressed **a desire for CSR funding to continue**
  - **Carriers have received CSR payments on a month-to-month basis** to date
  - CMS reported that for the 2017 exchange enrollment period, **~7M (58% of enrollees) received CSRs**
- **States and insurers have taken several approaches** to addressing the uncertainty of CSR payment
  - Assume CSR is paid (e.g., MD, RI)
  - Assume not paid and load costs to plans of all metal tiers (e.g., CO, IN)
  - Assume not paid and load costs to silver plans (e.g., IL, MI)
  - Assume not paid and load costs to on-exchange silver plans (e.g., CA, FL)
  - Mixed strategy and/or no recommendation (e.g., OH, TX)

Contents

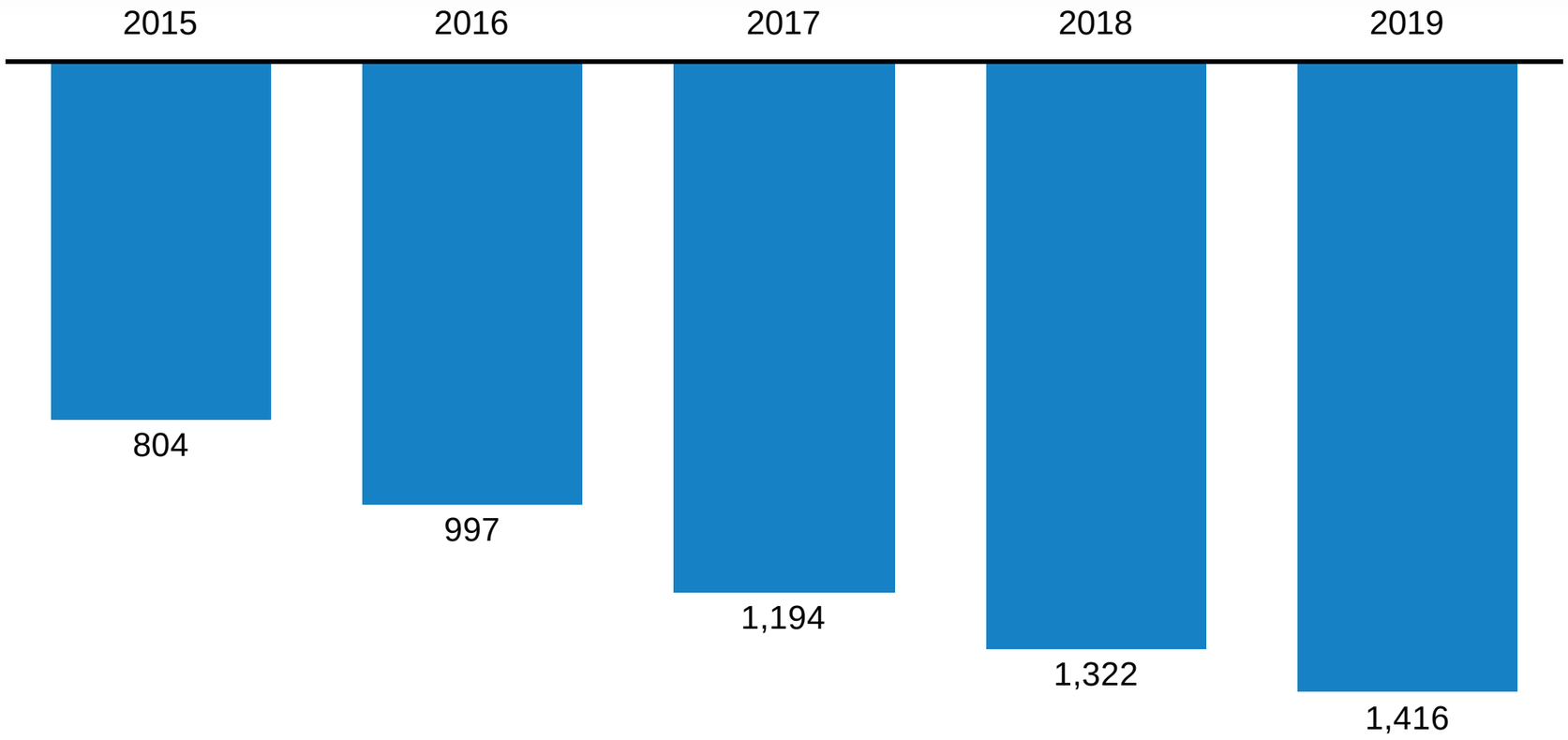
- Retrospective on ACA
- “Reform 2.0” update
- **Looking ahead for providers**



Payment adjustments will continue to negatively impact inpatient Medicare margins

Projected per admit loss in Medicare reimbursement rates[1]

$ per admission



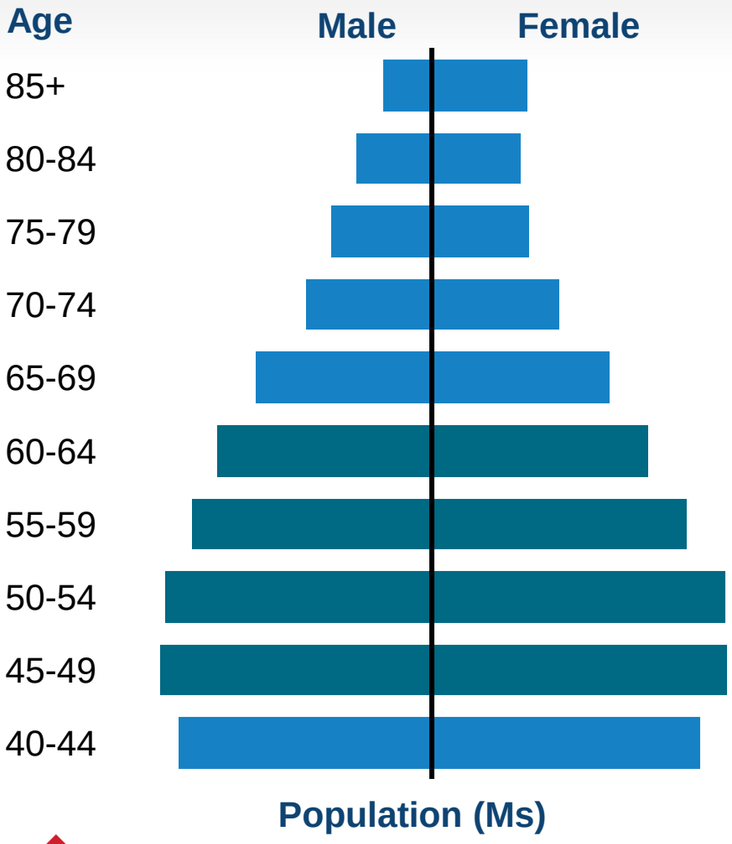
- **Key levers impacting reimbursement include**
  - Recoupment coding adjustments
  - ACA-legislated statutory adjustments
  - Two-midnight rule adjustment (One-time increase in 2017)
- **ACA-mandated adjustments persist through 2019**

Note: Final adjustments and payment rules for 2018 and beyond have not yet been released
1 Excludes effects of changes to uncompensated care payments, electronic health record incentives, quality penalties, value-based purchasing incentives, and potential Independent Payment Advisory Board (IPAB) recommendations

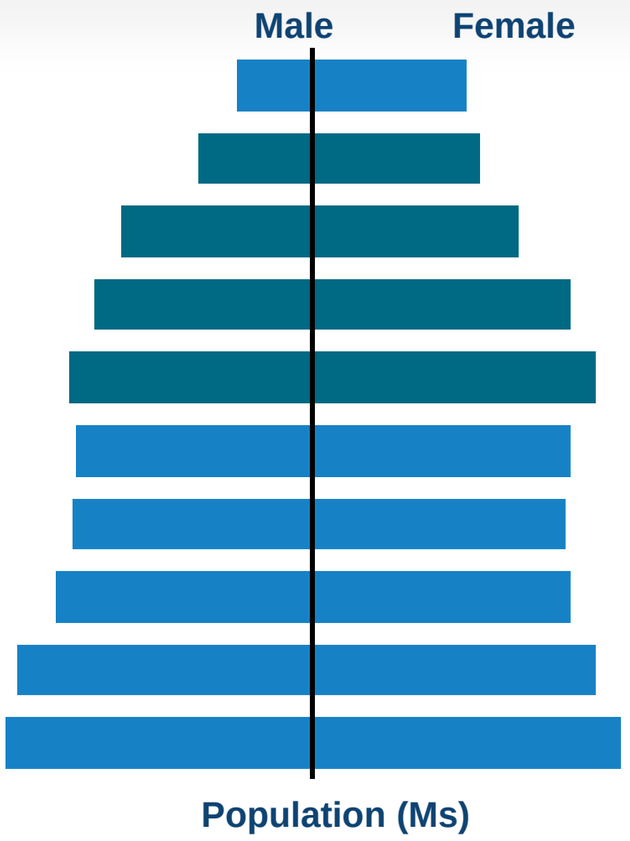
SOURCE : IPPS Rule FY2017, MedPAC Report to Congress (2017)

Demographic trends underscore the imperative to reach Medicare break-even

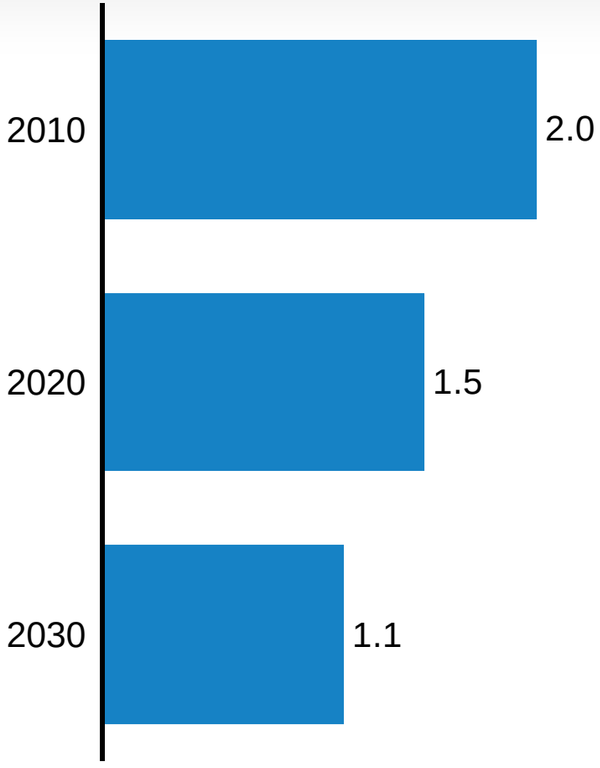
US Population – 2010



US Population – 2030



Ratio of Pre-Medicare (45-64) to Medicare (65+) lives



SOURCE: MedPAC Report to Congress: Medicare Payment Policy (2017), Medicare Trustees Report (2016)

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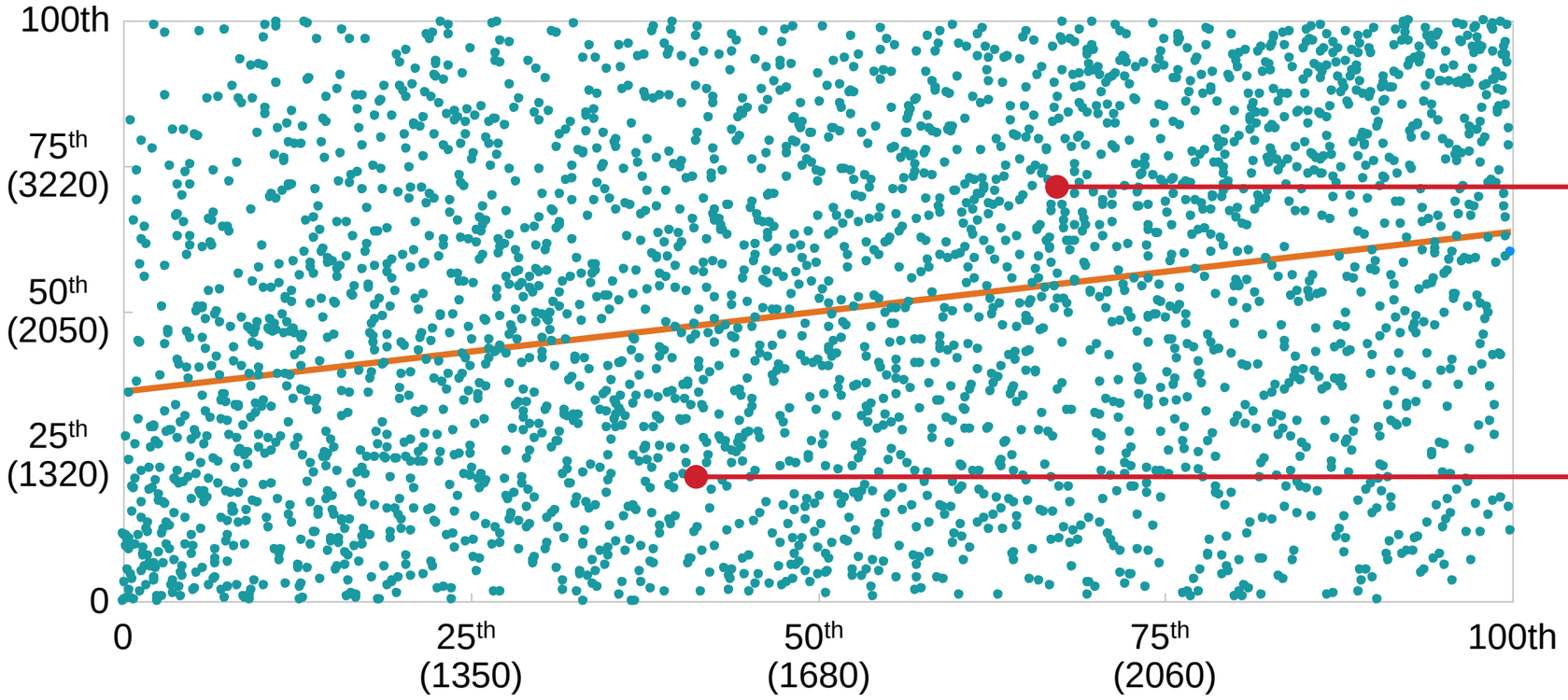
Other opportunities to “reform” delivery remain

Post-acute utilization among Medicare Part B beneficiaries

Home Health visits per 1000 beneficiaries, Percentile (county-level)



SNF covered days per 1000 beneficiaries, Percentile (county-level)

There are also major variations across states

SOURCE: Centers for Medicare & Medicaid Services

Providers need to shift their advocacy agendas

ACA policies to protect the uninsured	▪ Medical loss ratio requirements ▪ Taxes on pharmaceutical and insurance sectors to fund elements of ACA ▪ ACA policies to minimize uninsured (e.g., subsidies, Medicaid expansion, ban on pre-existing conditions, coverage for children up to age 26)
Elements of ACA to repeal	▪ Medicaid DSH cuts ▪ Redirect CMMI focus to help providers develop capabilities to manage risk ▪ Simplify administrative/regulatory procedures and limit mandatory programs
Non-ACA provisions	▪ Update Stark Law and Anti-Kickback Statute to reflect current environment ▪ Increase the number of graduate medical education slots ▪ Increase funding for community health centers and for trauma programs

As decision-making is increasingly pushed to the State level (e.g., via Section 1332 and 1115 waivers), providers have an opportunity to shape the way these tools are used to create value

SOURCE: Annals of Internal Medicine, Annals of Family Medicine

Health system CEOs should address 6 key imperatives

6

Ruthlessly manage costs through operational excellence to preserve margins, especially for Medicare and Medicaid patients, engaging medical staff to join in this crusade – with the goal of realizing negative cost trend moving forward

Focus on healthcare, not hospital care: Manage patient healthcare in and out of the hospital to targeted populations, and explicitly decide how and how not to participate in episodic care and/or the broader continuum

Experiment with vertical integration and build capabilities to engage physicians and payors to ensure value creation results from innovative relationships

Aggressively develop (or resource) functions and capabilities necessary to win, taking advantage of scale partnerships with individual hospitals to capture cost synergies and quality benefits

Create a clear strategy for the future Medicaid market: Understand how to care for the Medicaid population, given reimbursement pressures on already financially challenged cases, and implications that result

Capture a disproportionate share of the commercially insured and at least fair share of secular growth in Medicare lives to mitigate the impact of limited Medicare / Medicaid reimbursement growth rates

Questions and Thank You

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