

# The Future of the Healthcare Marketplace: What's Next?

Ian Morrison PhD

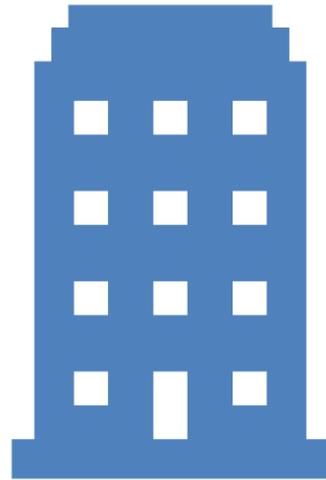
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# Outline

- Looking Ahead
  - Politics and Policy
  - Consolidation and Disruption
  - Shallow Pocketed Consumers
  - Employers Stay or Go
  - Providers: Ten Common Themes of Health Systems Strategic Plans
  - Physician Discontent
- The End Game

# Three Payers

## Three Payers



Business



Government

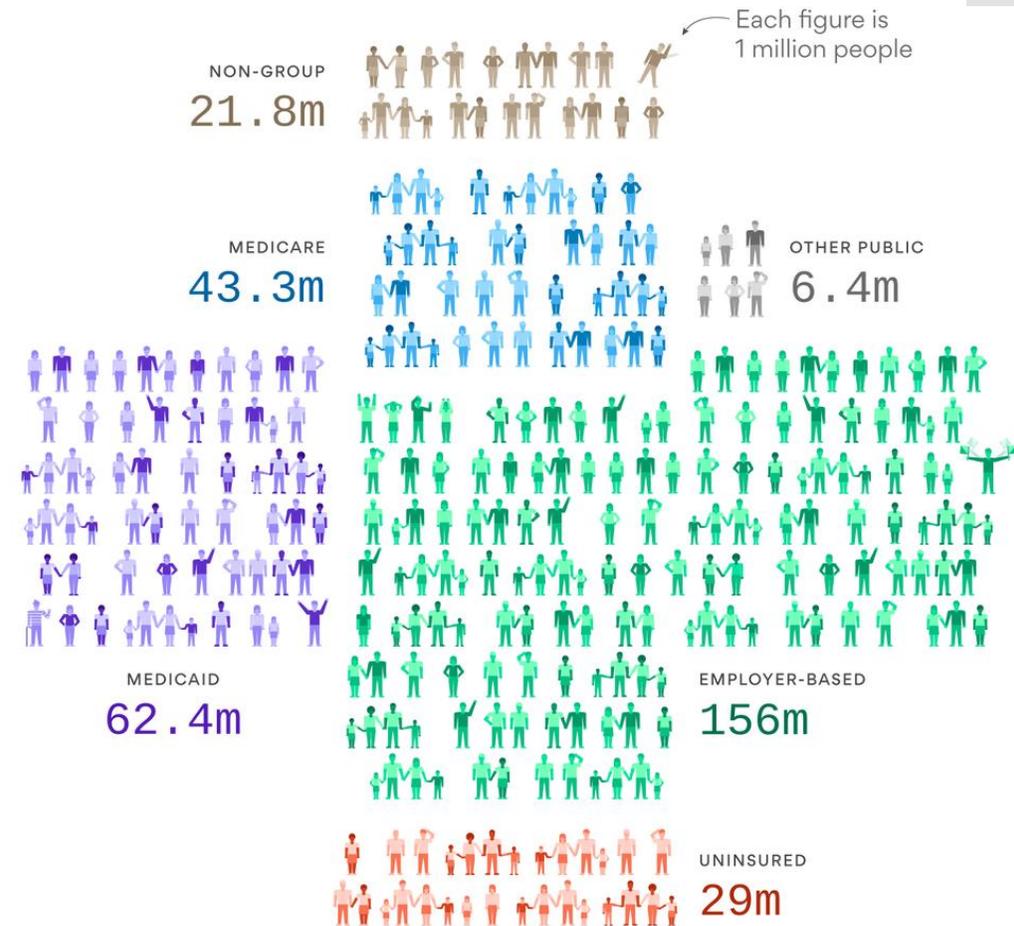


Households

But ultimately **it all comes from households** whether as taxes, foregone income at work, or directly as out of pocket costs and premiums paid by consumers

# How Americans Get Health Insurance, 2017

- ACA has impacted a small portion of the insurance market relative to how it is covered in the public debates on health care
- Medicaid is now the largest public insurance program and covers many of the neediest beneficiaries as well as expansion populations
- Medicare is highly valued and Medicare Advantage grows
- Employer-Sponsored health insurance for most Americans and it is the financial lifeblood of the delivery system

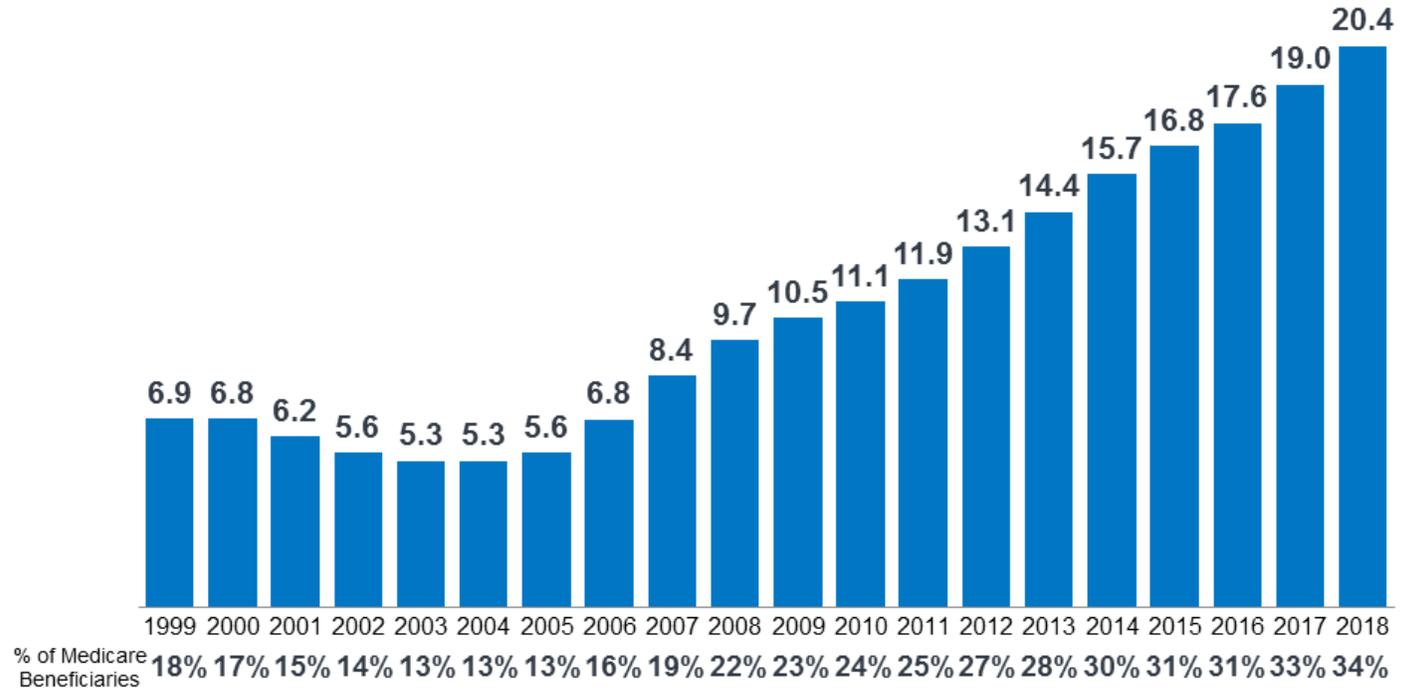


# Medicare Advantage Growth



Figure 1

## Total Medicare Advantage Enrollment, 1999-2018 (in millions)

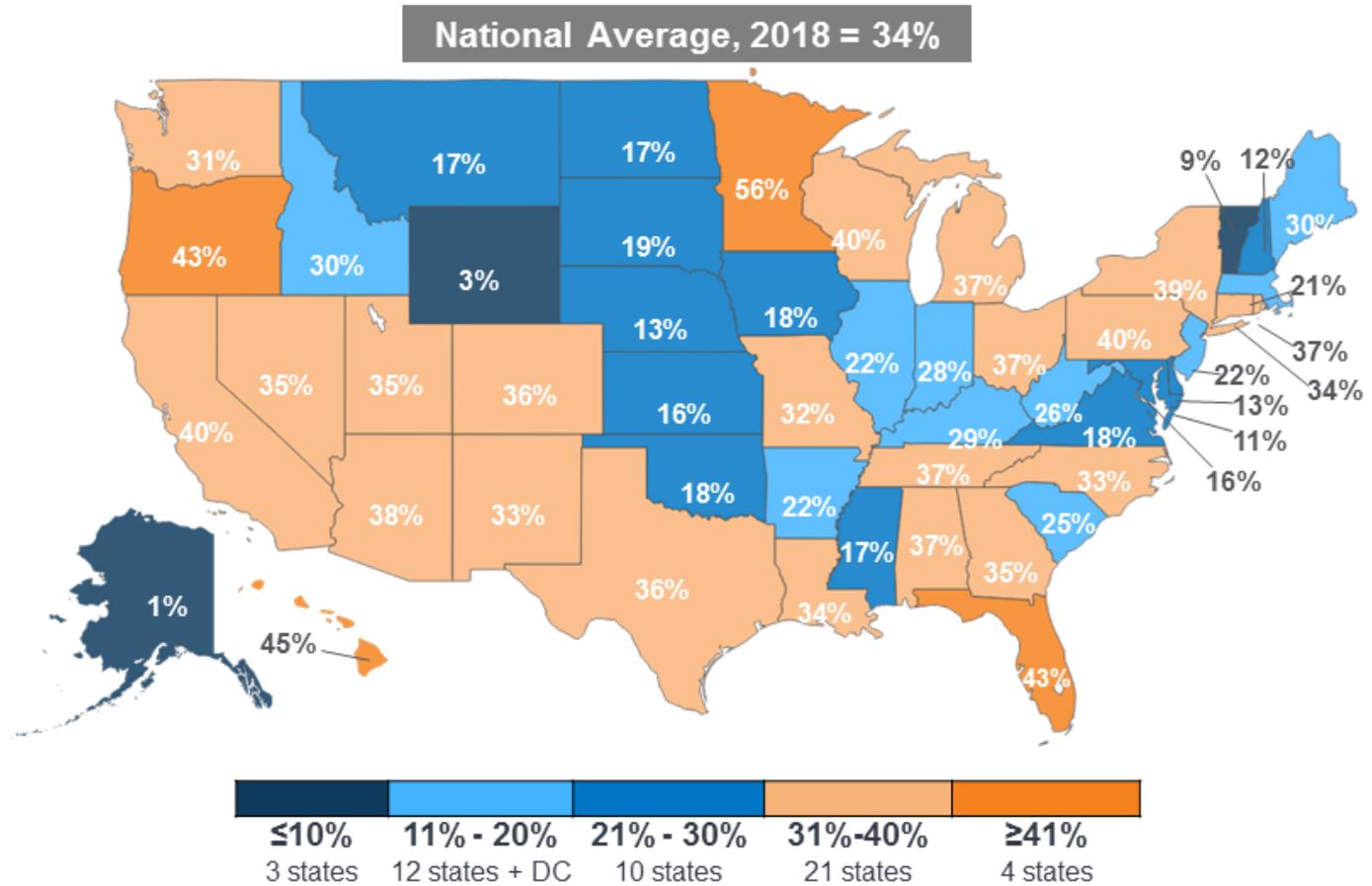


NOTE: Includes cost plans as well as Medicare Advantage plans. About 61 million people are enrolled in Medicare in 2018.  
SOURCE: Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2018, and MPR, 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

# Medicare Advantage Penetration by State, 2018

Figure 3

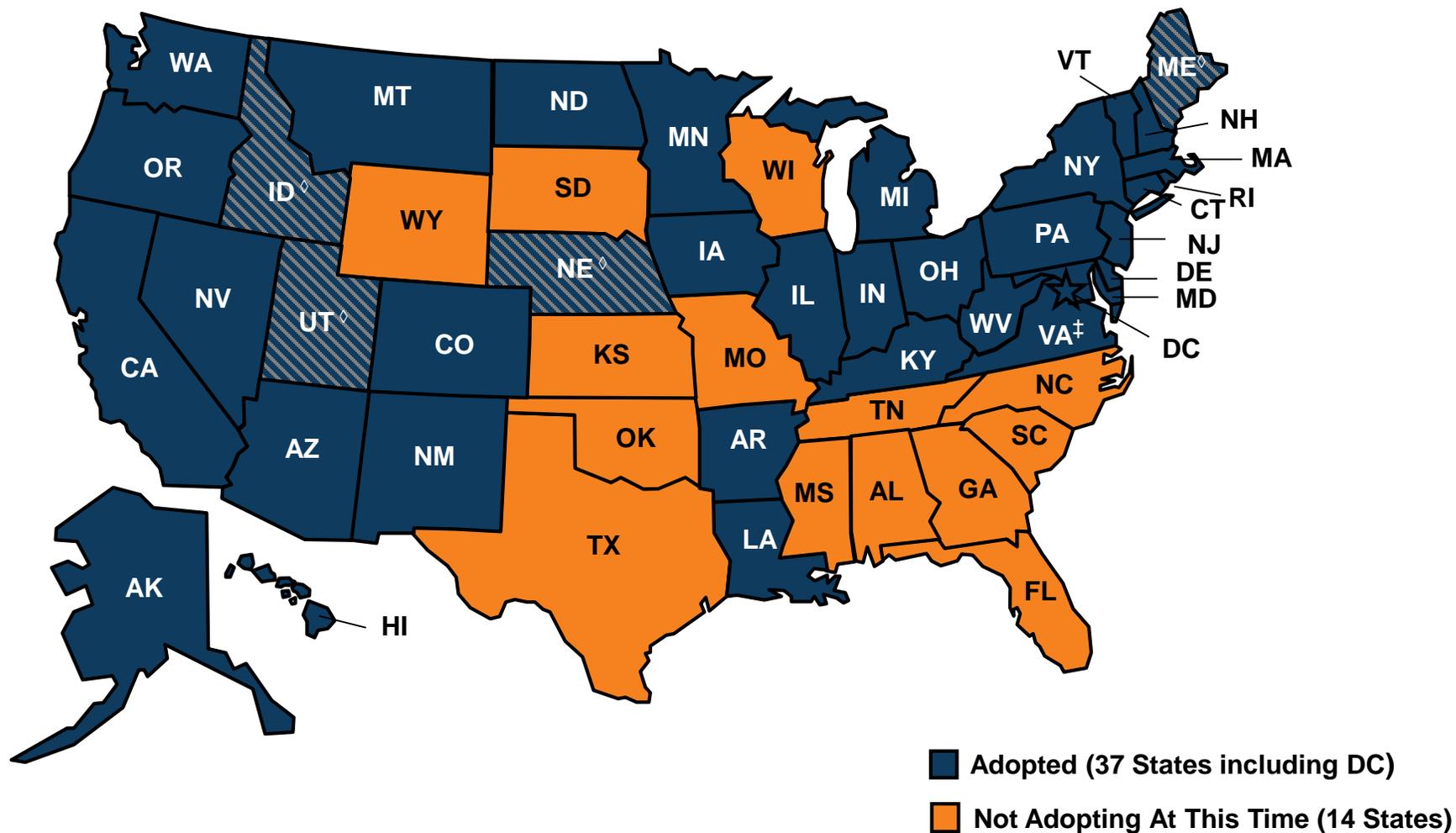
## Medicare Advantage Penetration, by State, 2018



NOTE: Includes cost plans, which comprise the majority of enrollment in MN, ND, and SD, as well as other Medicare Advantage plans. Excludes beneficiaries with unknown county addresses.

SOURCE: Kaiser Family Foundation analysis of CMS State/County Market Penetration Files, 2018.

# Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KFF tracking and analysis of state activity. <sup>o</sup>Expansion is adopted but not yet implemented in ID, ME, NE, and UT. <sup>+</sup>VA began enrollment on November 1, 2018 for Medicaid expansion coverage that will take effect on January 1, 2019. (See link below for additional state-specific notes).

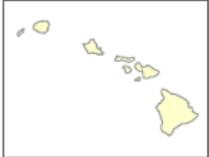
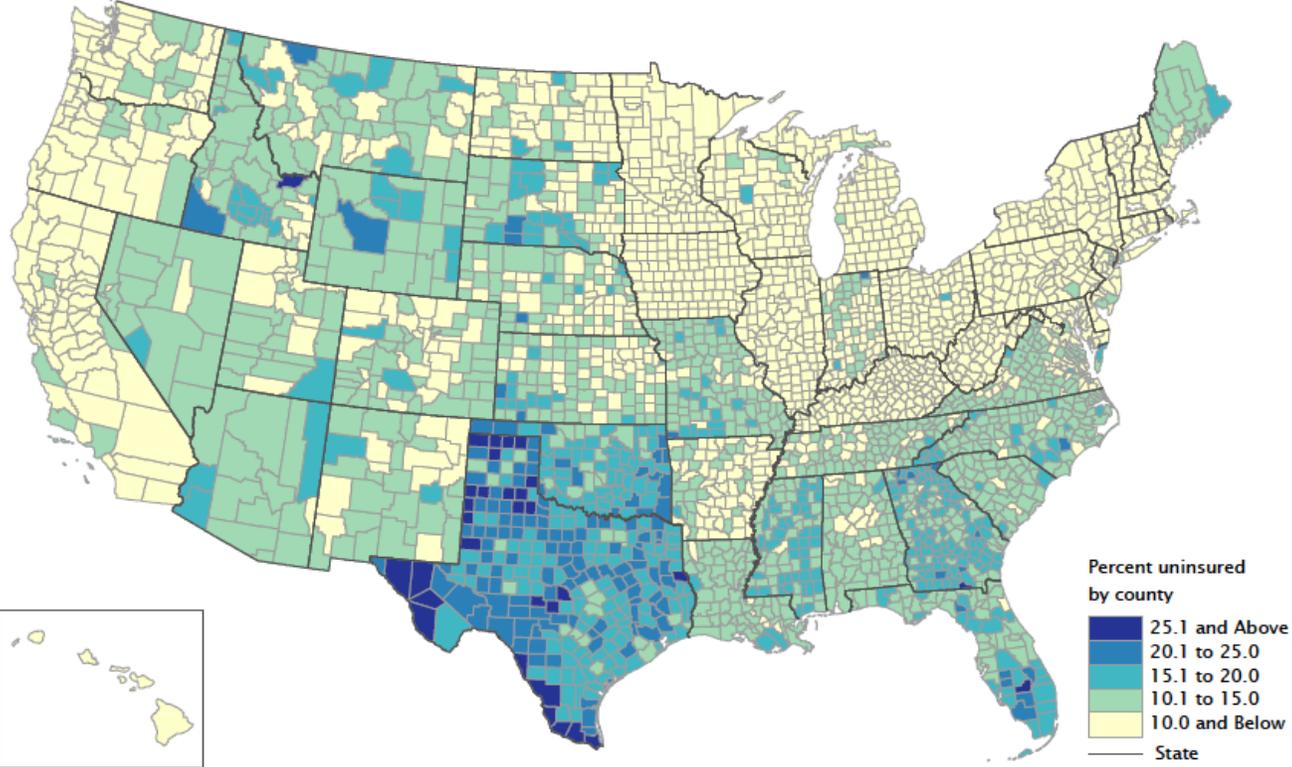
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated November 7, 2018.

<https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/>

# Uninsured Rates by County, 2016

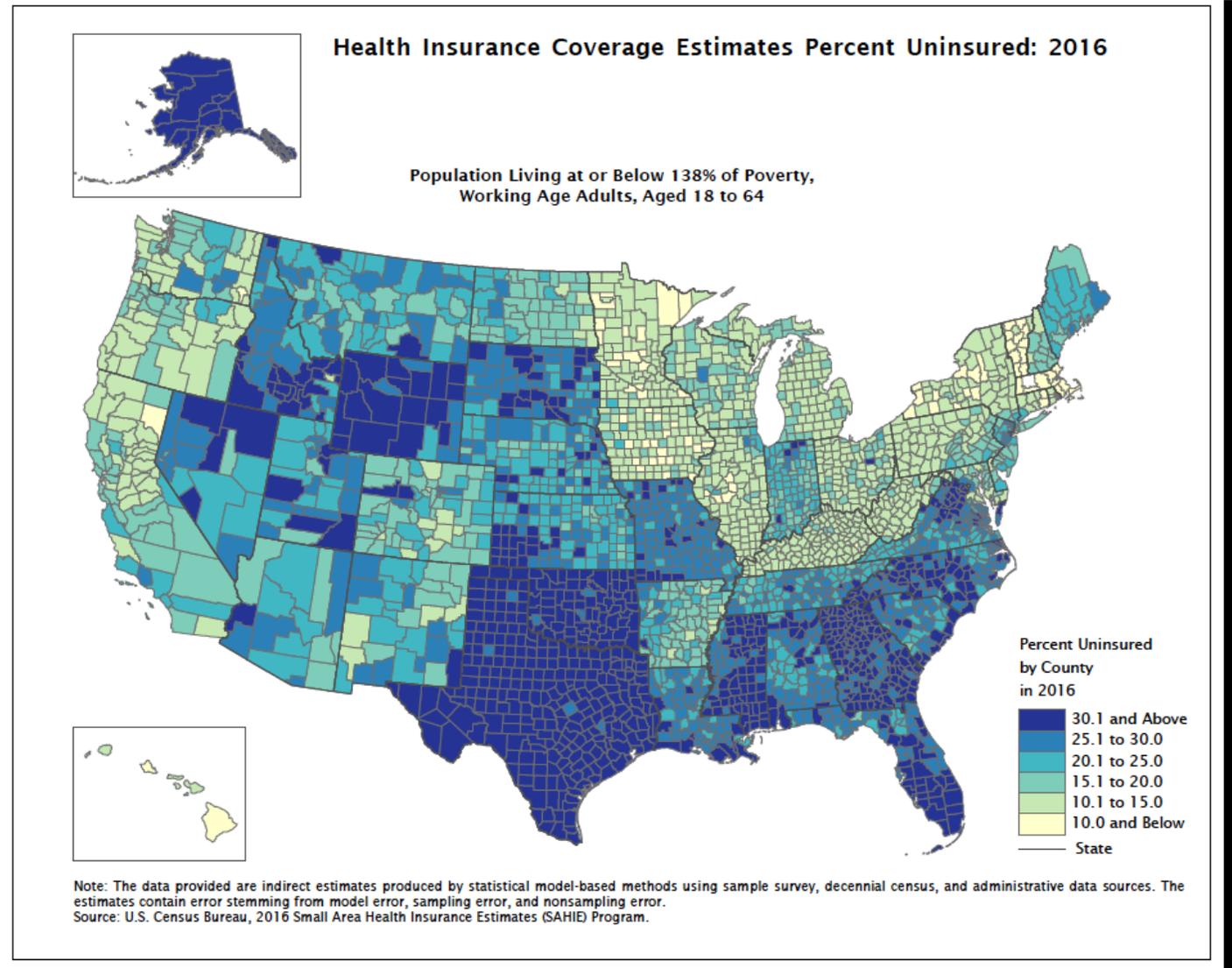


Figure 1.  
Estimated Uninsured Rates for the Population Under Age 65: 2016



Note: The data provided are indirect estimates produced by statistical model-based methods using sample survey, decennial census, and administrative data sources. The estimates contain error stemming from model error, sampling error, and nonsampling error.  
Source: U.S. Census Bureau, 2016 Small Area Health Insurance Estimates (SAHIE) Program.

# Uninsured Rates by County 2016 Working Age Adults Below 138% of FPL



# REPEAL AND REPLACE IS LIKE BREAKING UP THE BEATLES: JUST KEEP GEORGE AND RINGO AND EXPECT IT TO SOUND GOOD

Taxes and Fees Raised  
Mandates



Subsidies to Medicaid and  
Exchanges

Guaranteed Issuance



Stay on Parents Plan

"All you are left with is Ringo" Chris Jennings

"Republican policies are ideologically coherent, they just aren't actuarially coherent." Ian Morrison

# The Era of Ideological Repeal And Replace

## Use Executive Orders

- Association Health Plans
- Short Term Plans
- Essential Benefits Erosion

Cut CSRs (maybe we don't want them back)

Zero out the individual mandate fine for 2019 and beyond

Cut Medicare and Medicaid Budgets

“Give back Obamacare Taxes to (rich people/taxpayers) in Tax Reform”

Don't enforce the law

“The Secretary shall” .....but maybe not

Waiver Authority to states

- Fees for Medicaid
- Work Requirements (under legal challenge)
- Short term plans
- Essential Benefits/Life time Caps?

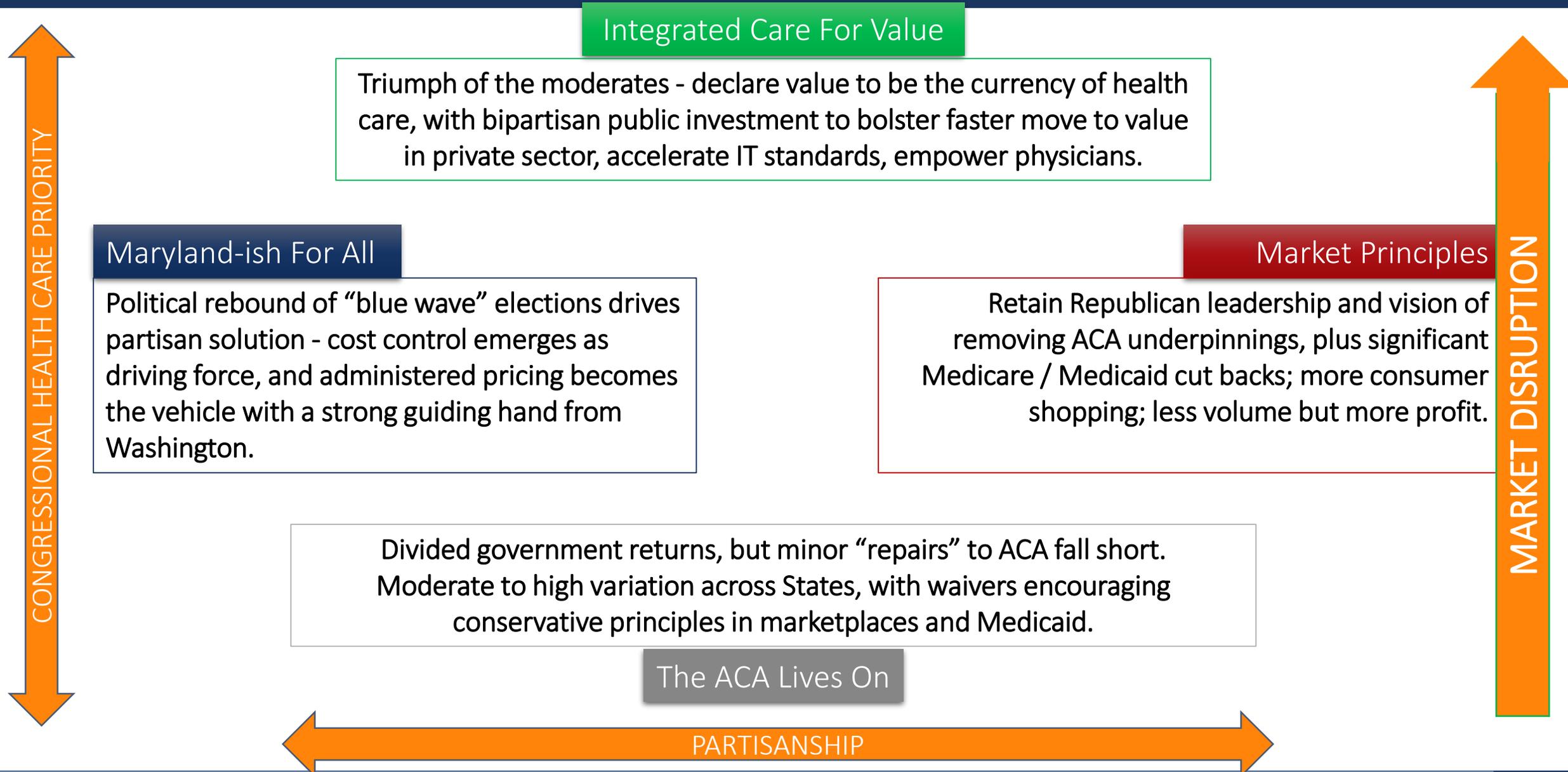
2019 Signups confirmed at 11.5 million will end up down 2.4% from 2018 despite massive reduction in federal outreach support

## TOP STATES IN 2019 EXCHANGE ENROLLMENT

STATE	ENROLLMENT (000)	EXPANDED MEDICAID	VOTED TRUMP IN 2016
FLORIDA	1,783		✓
CALIFORNIA	1,514	✓	
TEXAS	1,087		✓
NORTH CAROLINA	501		✓
GEORGIA	458		✓
PENNSYLVANIA	365	✓	✓
VIRGINIA	328		
ILLINOIS	312	✓	
MASSACHUSETTS	300	✓	
MICHIGAN	274	✓	

Sources: Ian Morrison, Charles Gaba ACA Signups, @Aslavitt, Leavitt Partners

# LP Scenarios: The Road to Value Requires Deliberate Action

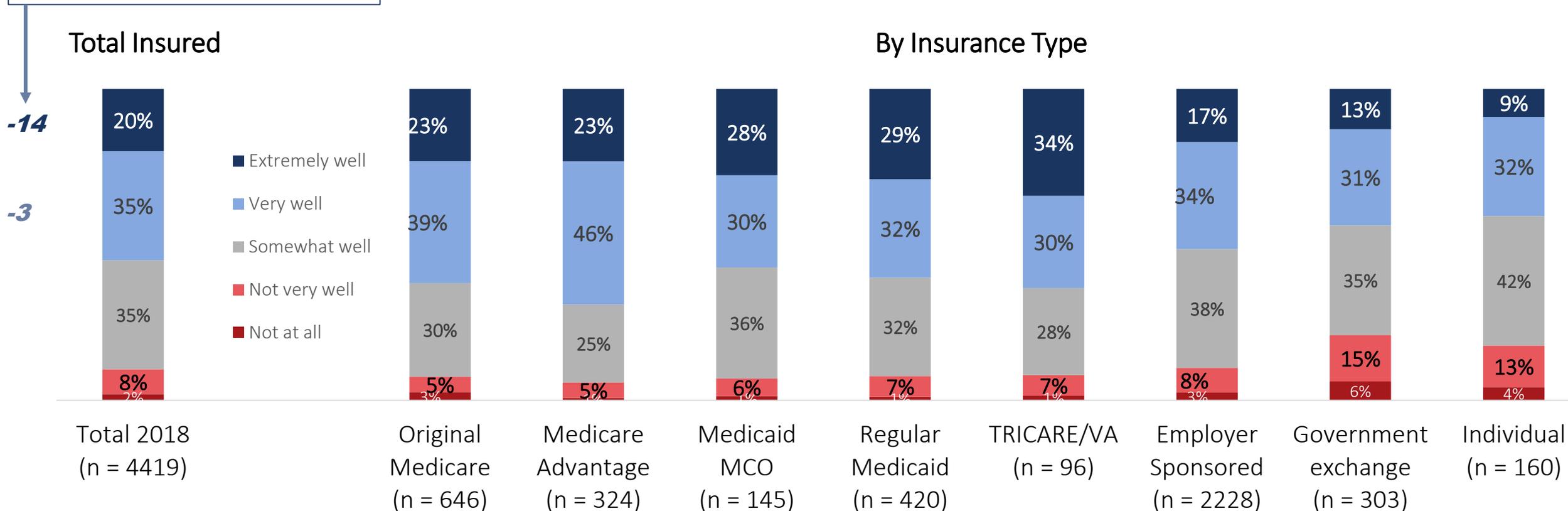


# LP Surveys: Overall Americans are not feeling secure with their insurance, across all insurance types, though public insurance does score higher.

Overall, how well does your health insurance plan meet your family's health needs?



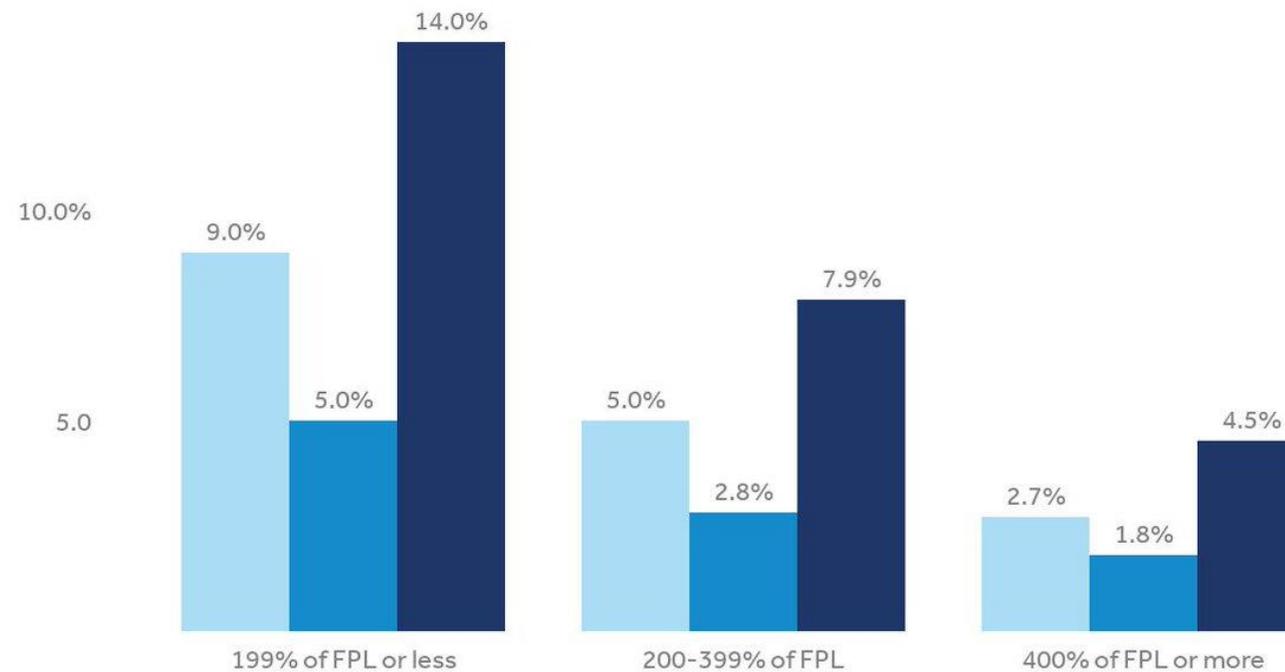
On total, big drop from 2017



# Why Employer Coverage Is No Longer Beyond Reproach

Average share of family income going towards health insurance premium contributions and out-of-pocket medical expenses, 2017

■ Premium (employee contribution) ■ Out-of-pocket payments for medical care  
■ Combined (premium contribution + out-of-pocket)



Among people in working families with employment-based coverage

Source: [KFF analysis of 2017 Current Population Survey](#) • [Get the data](#)  
• [PNG](#)

Peterson-Kaiser  
**Health System Tracker**

# Why Employer Coverage Is No Longer Beyond Reproach

## EXHIBIT 9

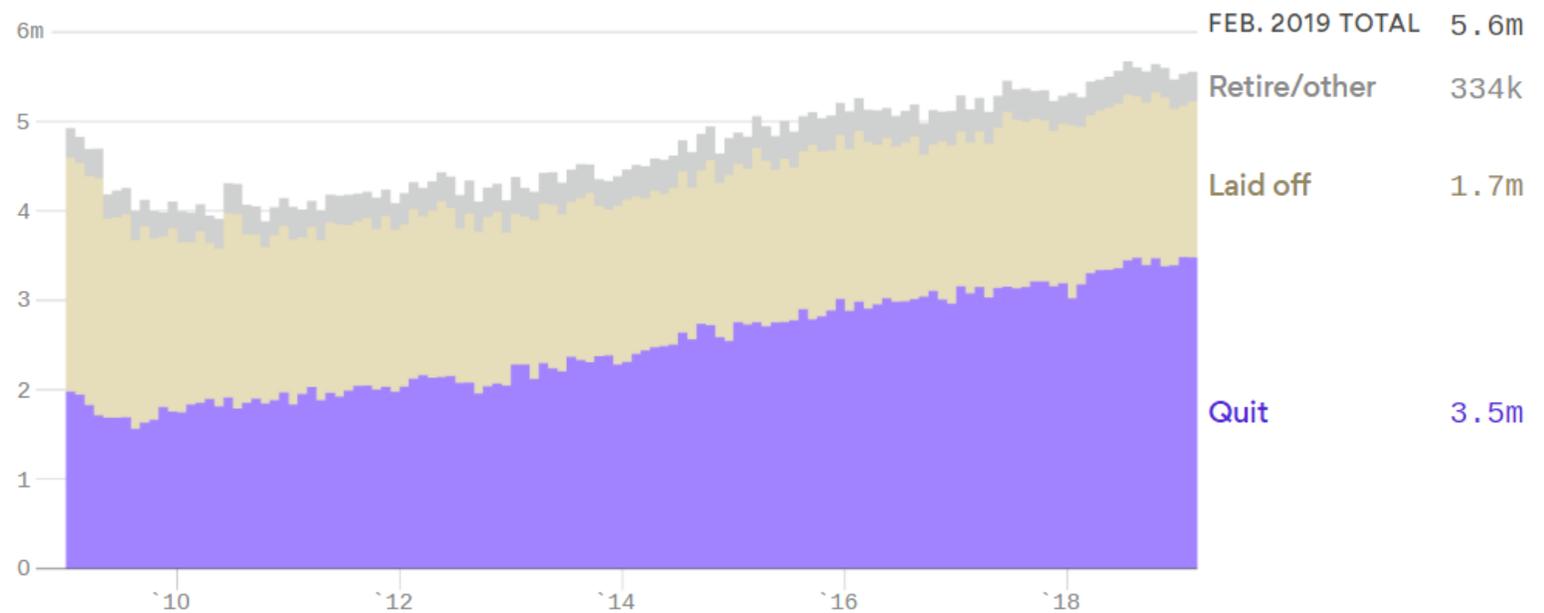
### Underinsured indicators among adults with employer coverage

Millions already lose or change health plans every year

Underinsured indicators among adults ages 19-64 insured all year, with employer coverage at the time of the survey*	2003	2005
Out of pocket medical expenses equal 10% or more of family annual income	6%	8%
Out of pocket medical expenses equal 5% or more of income if low income <sup>^</sup>	6%	5%
Cumulative percent/millions, using two indicators above	9%	11%
Deductible equals 5% or more of income	2%	2%
Cumulative percent/millions, using all three indicators <sup>^^</sup>	10%	12%

### How U.S. workers leave their jobs

Jan. 2009 to Feb. 2019

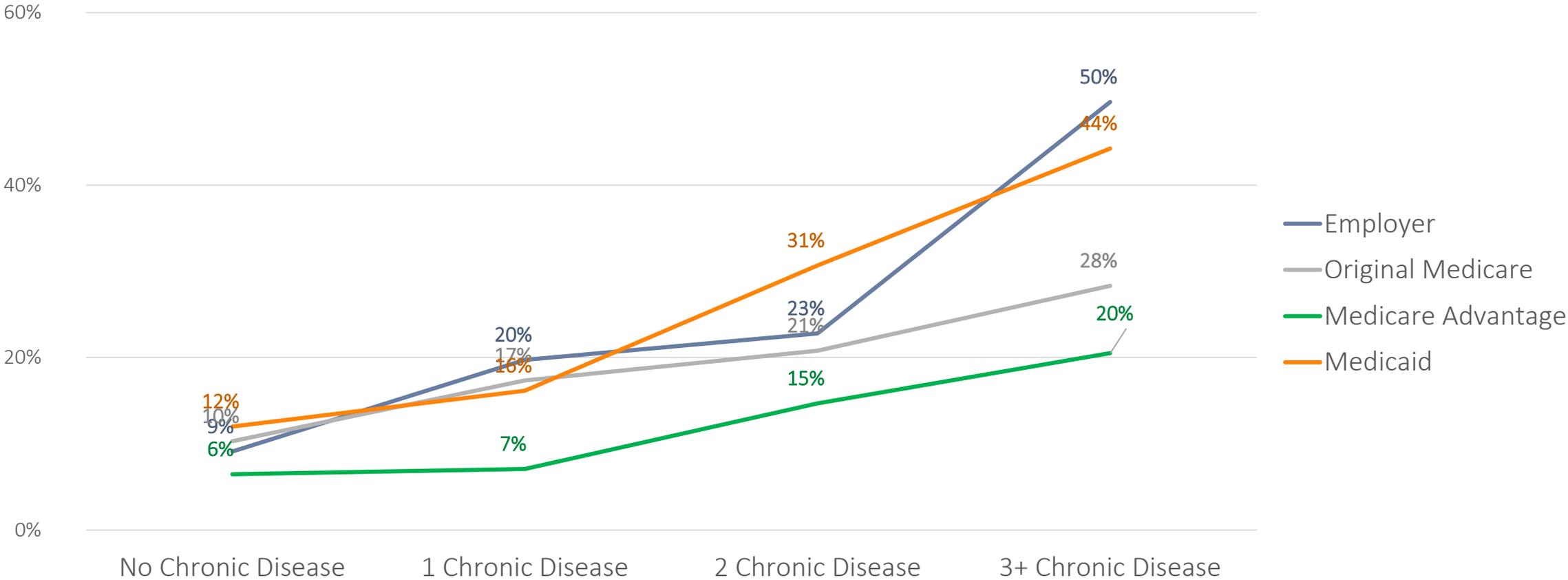


\* Respondents may have had another type of coverage at some point. <sup>^</sup> Less than 200% of the Federal Poverty Level. <sup>^^</sup> Underinsured pocket expenses, excluding premiums, equaled 10% or more of income if low income (<200% of poverty); or deductibles equaled 5% or more of income. Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005)

Data: Bureau of Labor Statistics; Chart: Andrew Witherspoon/Axios

# LP Consumer Survey: Sicker Americans with employer coverage more likely to feel their condition makes it difficult to take care of themselves.

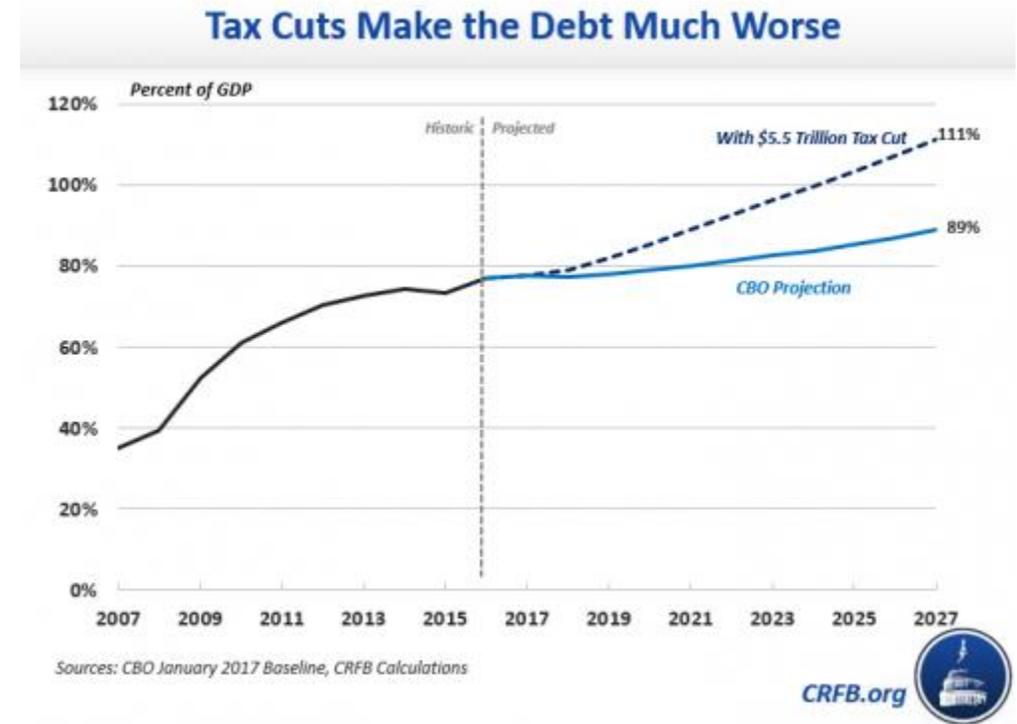
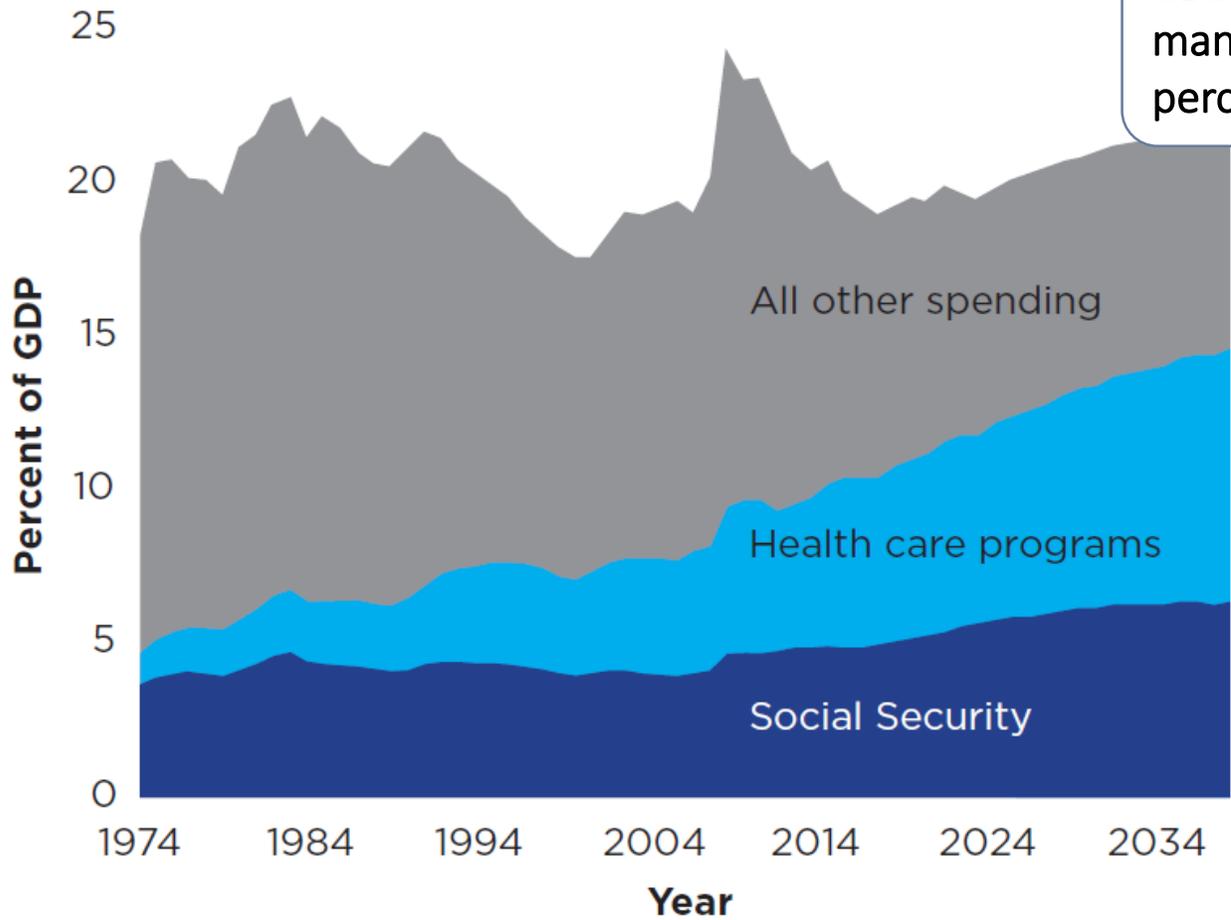
% Total Agree "My health condition makes it difficult to take care of myself"



October 2018 LP Survey of Consumers, n=5000;

# Health Care Is A “Budget Buster” At The Federal Level

CBO: “Overall the Administration’s proposals would reduce mandatory federal spending for health care by \$1.3 trillion (or 8 percent) over the coming decade.”



SOURCE: Congressional Budget Office

# Single Payer: Simple, Seductive Solution?

- “You are not Canadian”
- FFS Hamster Care
- Massive transfer of income from rich to poor
- Reduce the prices and incomes of all actors through government monopsony
- “Balloon in a Box”
- Change the mix: Get Rid of the Specialists
- Good Luck With That
  
- If Not Pure Play Single Payer, in a Bluer World, expect
  - Medicare X and Medicaid X
  - All Payer Rate Setting
  - Balloon in a Box Solutions
  - Drug Price Limits tied to Measured Value

# Balloon in a Box



 New episodes moving to Yahoo Screen March 17

# Broad Public Support for Medicare and Medicaid Expansion Options

## Public's Attitudes On Proposals To Expand Medicare and Medicaid

Percent who **favor** each of the following:

Allowing people between the ages of 50 and 64 to buy health insurance through Medicare

77%

Allowing people who don't get health insurance at work to buy health insurance through their state Medicaid program instead of purchasing a private plan

75%

Creating a national government administered health plan similar to Medicare open to anyone, but would allow people to keep the coverage they have

74%

Having a national health plan, sometimes called Medicare-for-all, in which all Americans would get their insurance from a single government plan

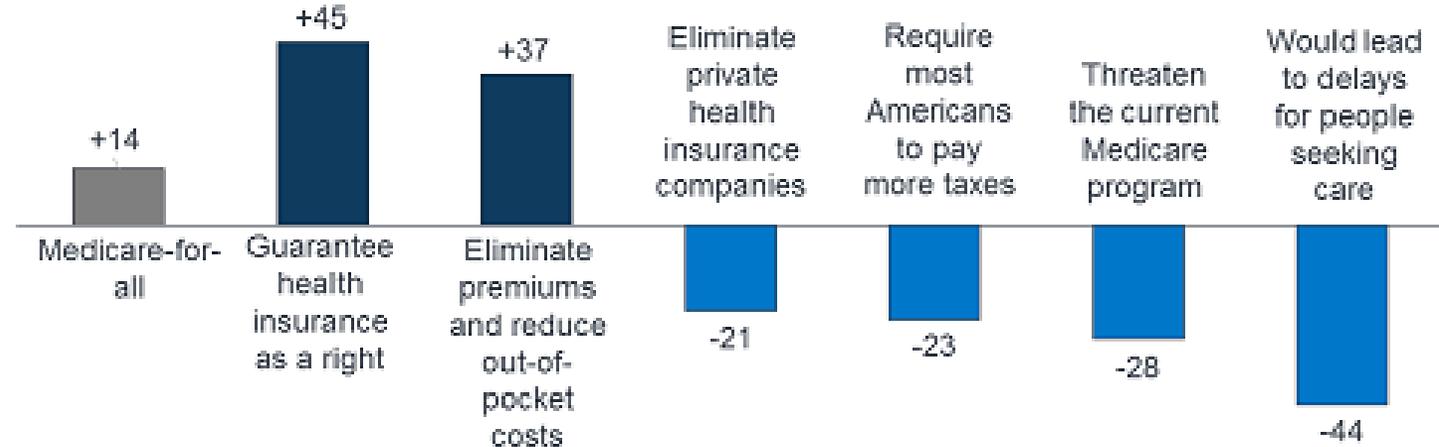
56%

SOURCE: KFF Health Tracking Poll (conducted January 9-14, 2019). See topline for full question wording and response options.

Support for Medicare for All Drops when assumed consequences are considered

## Public Opinion Towards National Medicare-For-All Plan Shifts After Hearing Information About Potential Effects

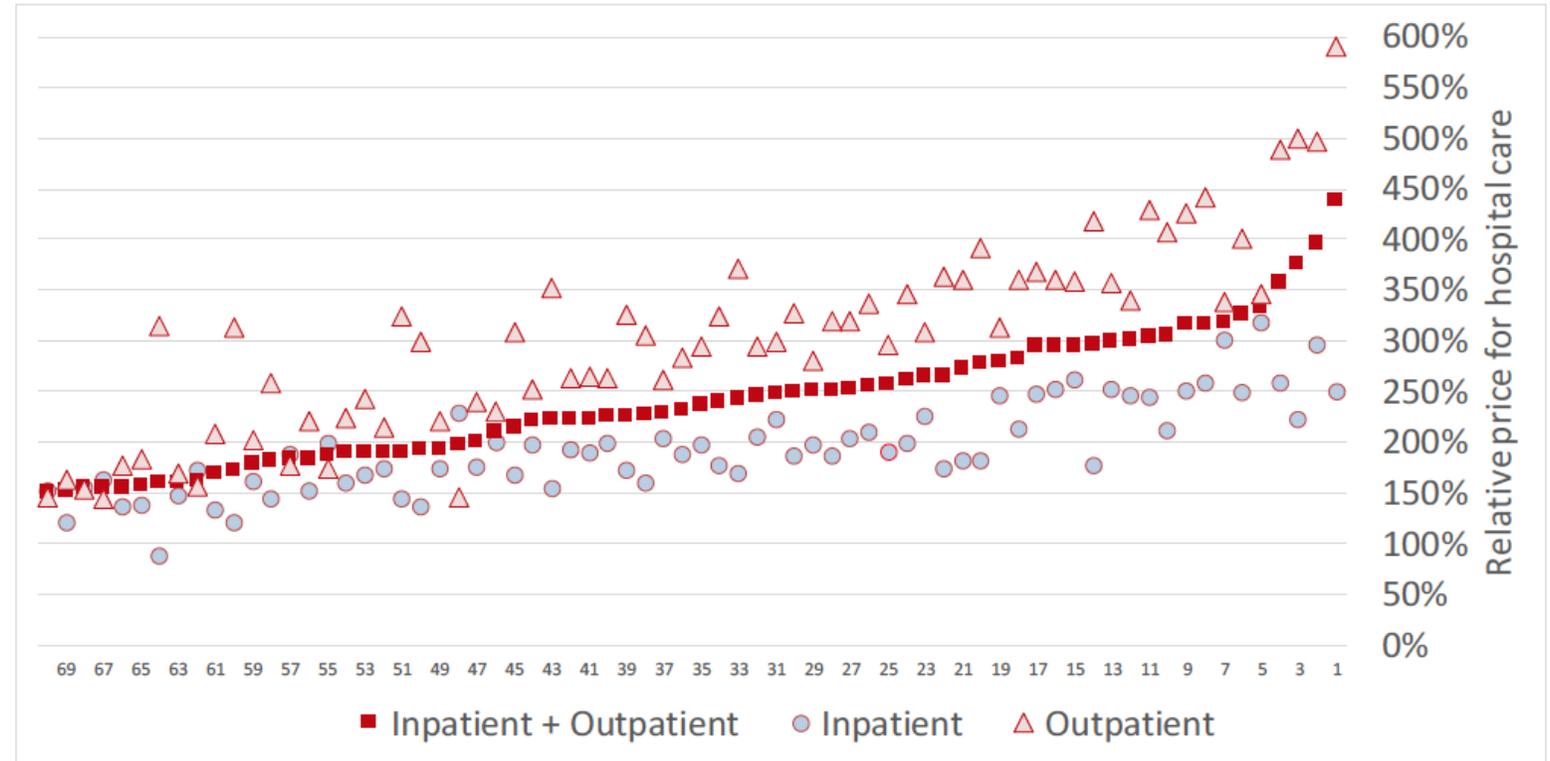
Net favorability towards a national Medicare-For-All plan after hearing each of the following:



SOURCE: KFF Health Tracking Poll (conducted January 9-14, 2019). See [tapline](#) for full question wording and response options.

# It's the Prices Stupid

Figure 4.4. Relative Prices of Hospital Systems in 25 States, 2015–2017

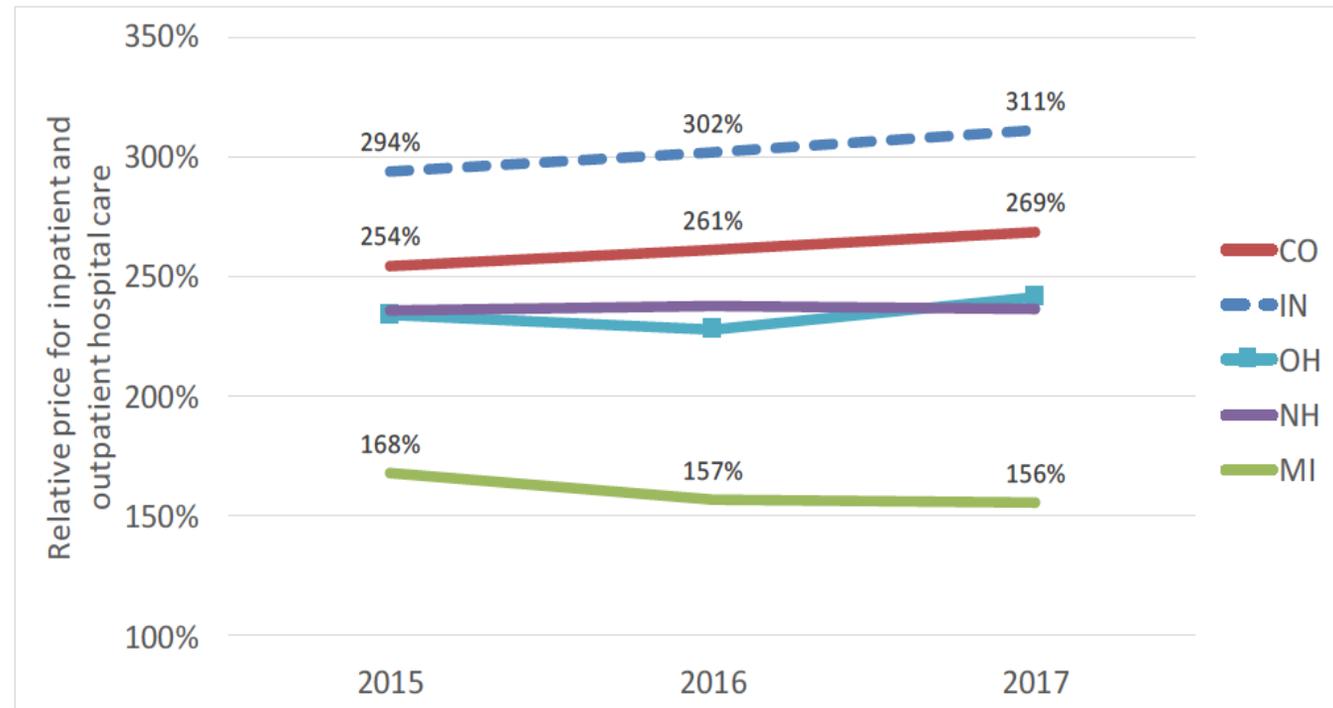


NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare's price-setting formulas.

Source: Rand 2019, [https://www.rand.org/pubs/research\\_reports/RR3033.html](https://www.rand.org/pubs/research_reports/RR3033.html)

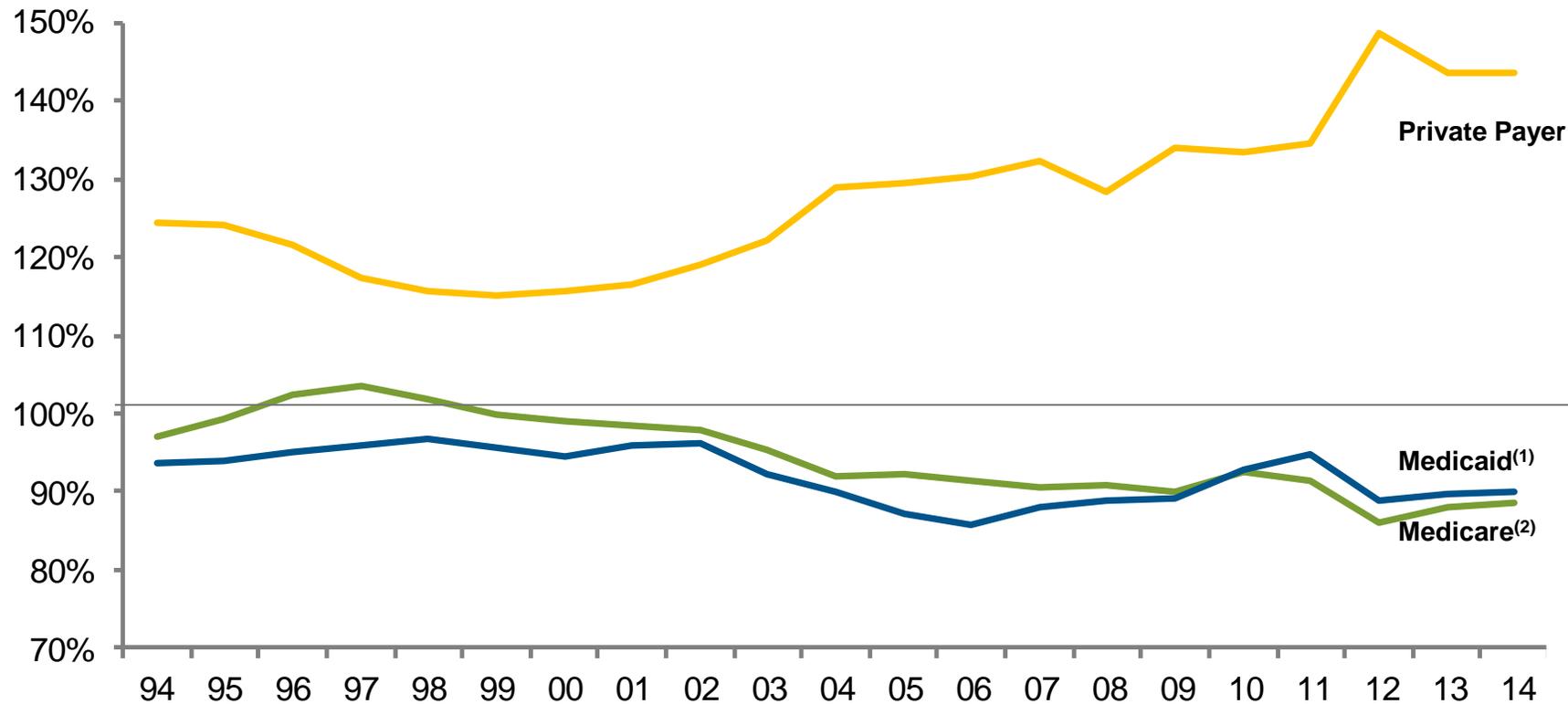
# Price Trends Vary by State: Average 241% of Medicare in the 25 States

Figure 4.3. Trends in Relative Prices for Selected States, 2015–2017



NOTE: Relative prices equal the ratio of the amounts actually paid divided by the amounts that would have been paid—for the same services provided by the same hospitals—using Medicare’s price-setting formulas.

# AGGREGATE HOSPITAL PAYMENT-TO-COST RATIOS FOR PRIVATE PAYERS, MEDICARE AND MEDICAID, 1994 – 2014



Source: Analysis of American Hospital Association Annual Survey data, 2014, for community hospitals.

<sup>(1)</sup> Includes Medicaid Disproportionate Share payments.

<sup>(2)</sup> Includes Medicare Disproportionate Share payments.

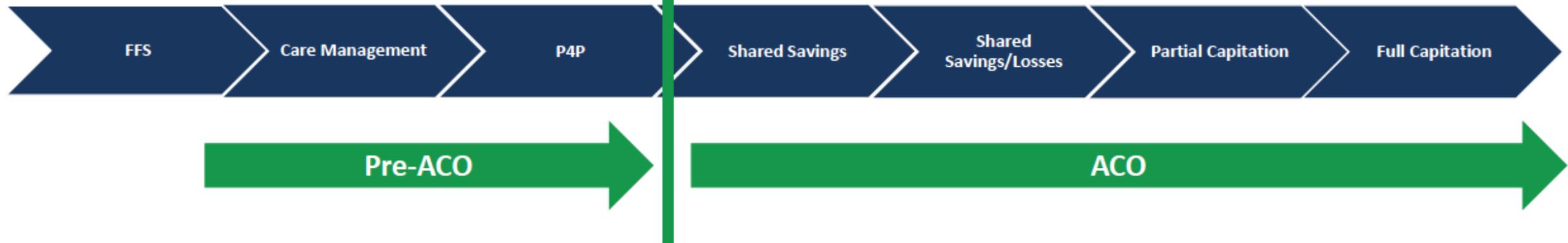
# Implications : Big Picture Politics And Policy

- Prepare for less financial support from DC for Medicaid and exchanges and more state flexibility through waivers (e.g. work requirements)
- Expect intense Medicare and Medicaid reimbursement pressure in longer run because of the massive deficit, debt and tax cuts
- Expect more focus on commercial prices including surprise billing and out of network prices
- Anticipate belt tightening in the eco-system, generally as margins tighten
- Expect even more consolidation as weaker players capitulate
- Anticipate stronger signals on volume to value from Azar as DHHS Secretary
- Hope that there is no extreme retaliatory behavior toward Blue states from Trump Administration if Repeal and Replace is really dead
- Expect California and other Blue states to push ahead on reform despite all this
- Expect some more Red States to pick up on Conservative forms of Medicaid expansion
- If it gets Bluer in 2020: Medicare for All Debate but can it become policy?
- If it gets Redder in 2020: More devolved to the states and “Block Grantanistas”
- Flexibility without money is not flexibility

# Progression of Payment arrangements



## Population-Based

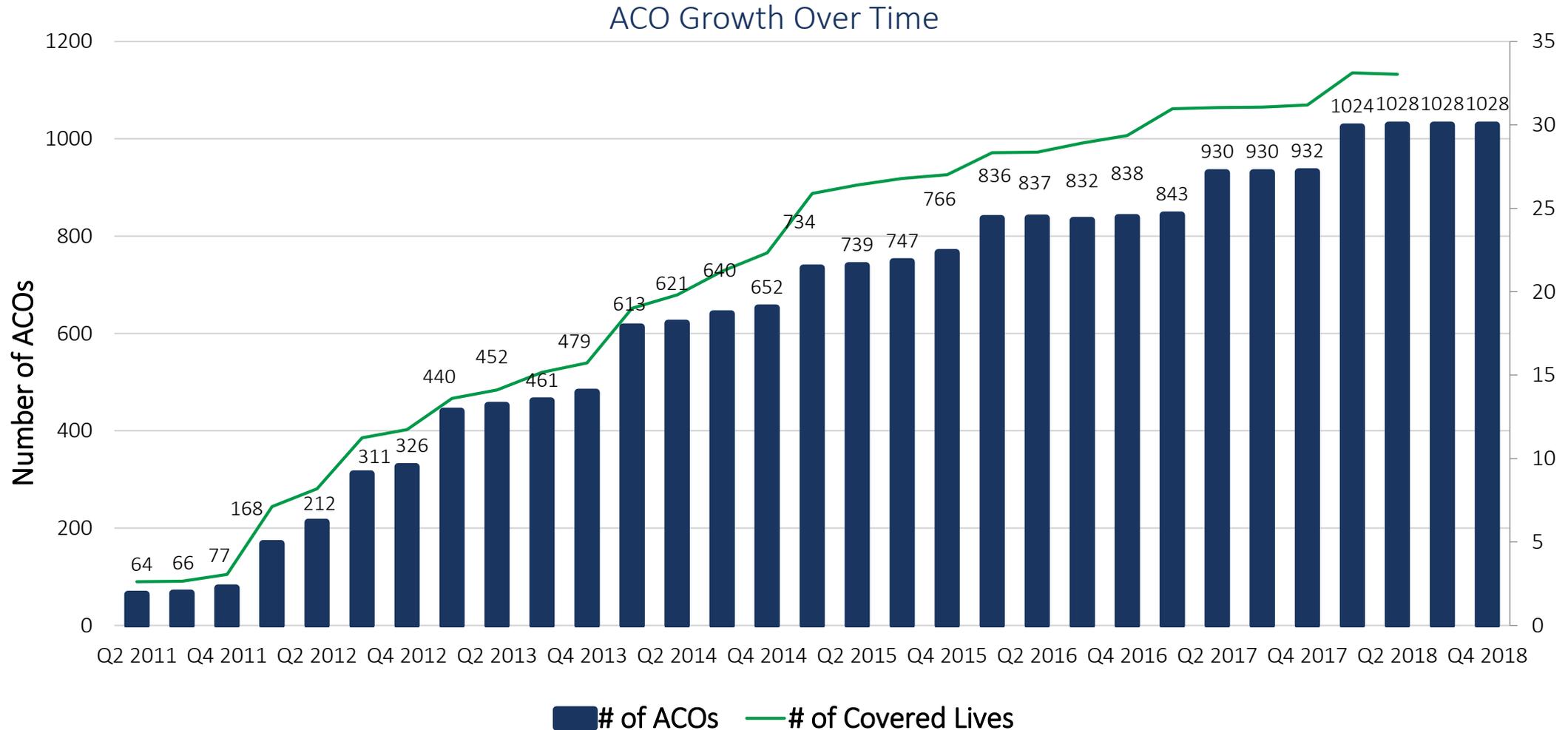


## Episode-Based



# ACO Growth Over Time

ACO activity continues to increase over time, with about 10% of the US population covered by an ACO.

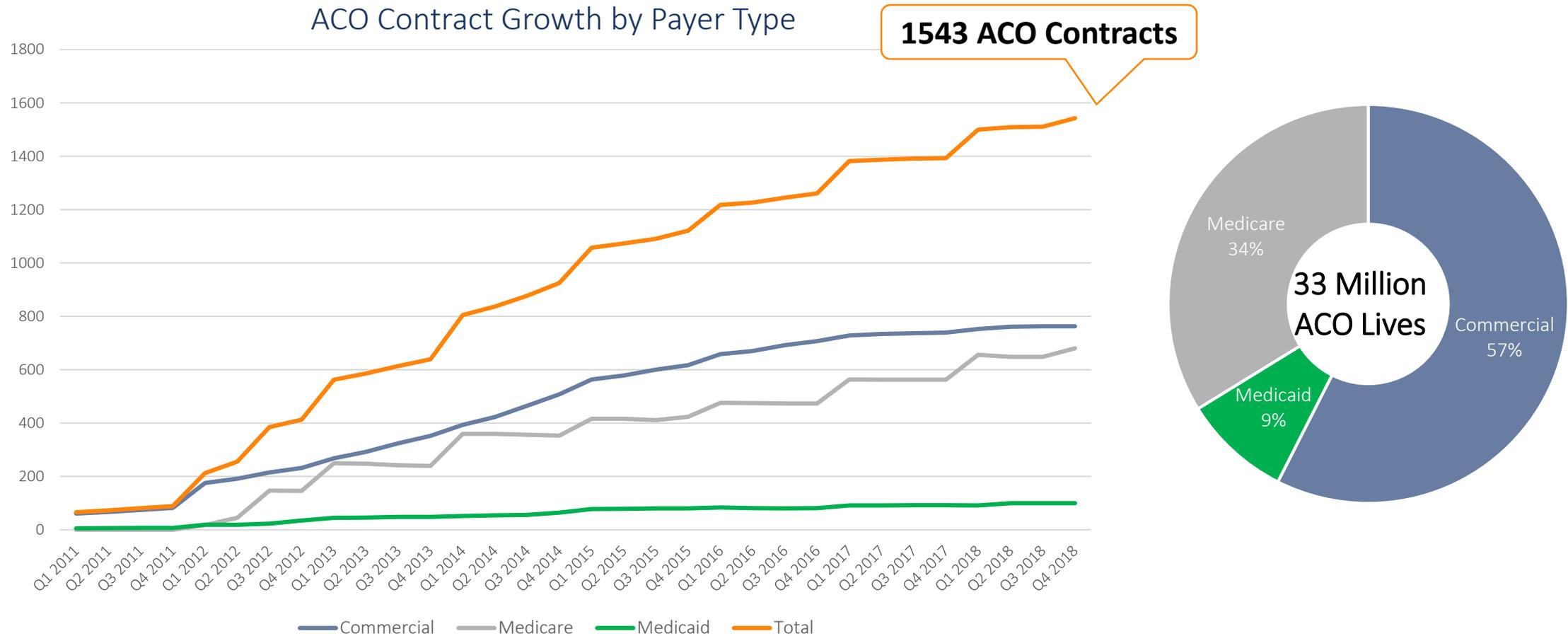


Source: Leavitt Partners Center for Accountable Care Intelligence

NOTE: Data reflects all ACOs currently in the LP ACO Tracking Database. As LP processes new data sources, these numbers may change.

# ACO Growth by Payer Type

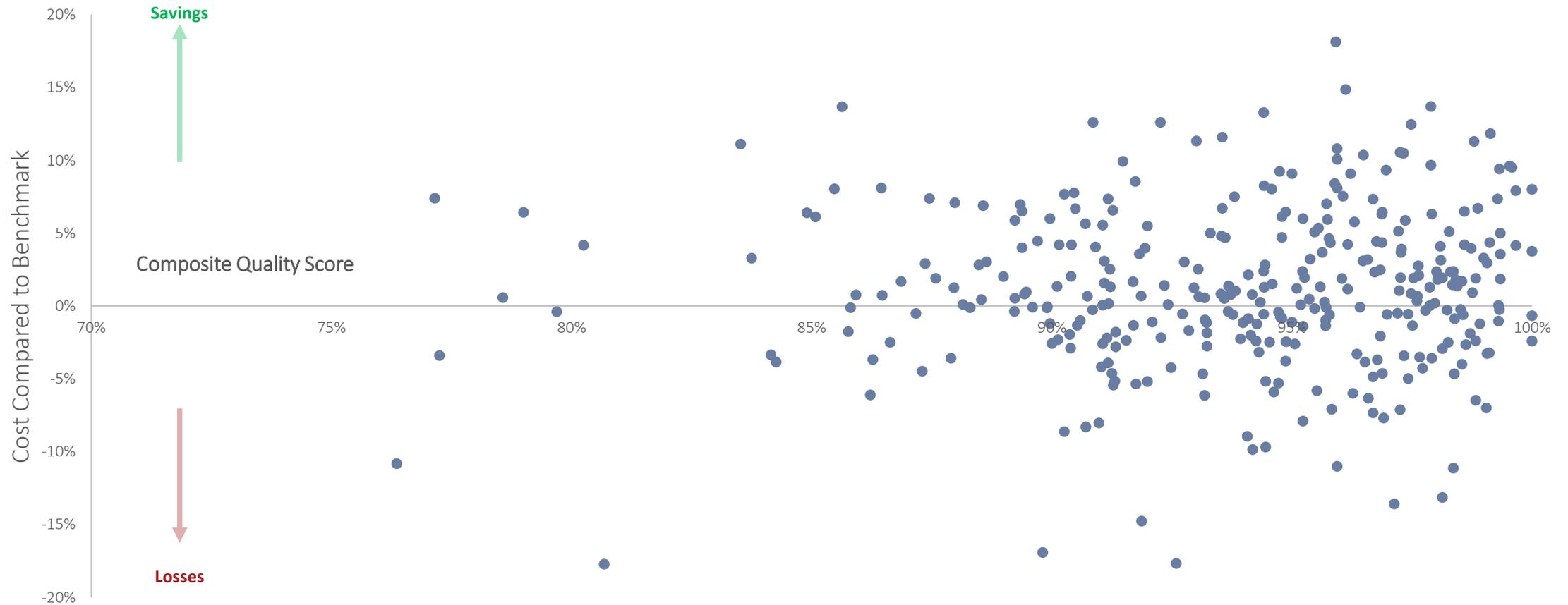
ACO contracting has increased steadily over time. Both commercial and Medicare contracts have driven much of this growth, but commercial contracts currently cover the majority of ACO lives.



Source: Leavitt Partners Center for Accountable Care Intelligence. \*Note: Q4 numbers are current as of December 1, 2018.

# ACO Quality and Savings Results

Results from Medicare Shared Savings Program ACOs do not yet reveal a correlation between cost and quality.



Source: Saunders, Robert, David Muhlestein, and Mark McClellan. "Medicare Accountable Care Organization Results For 2016: Seeing Improvement, Transformation Takes Time." Health Affairs Blog, November 21, 2017.

# Global Drivers of Disruption

- Money: Private Equity and Venture Capital
- Large Corporate Mergers and Non-Profit Consolidation
- Massive and Relentless transformation to ambulatory environment leads to retailization of healthcare, focus on new players and new settings of care
- Specialty Pharma ascendant over hospital inpatient
- Prediction and Cure Paradigm rather than Primary prevention and Acute Care Treatment
- Technology enablers: AI, Machine Learning, Mobile, Cloud, Blockchain, Voice Recognition, Open Data and API
- Fear of New Entrants like Amazon, Apple, Google and Facebook with global reach causing health systems to disrupt rather themselves rather than being disrupted
- An aging society with insufficient retirement assets
- The Rise of Consumerism

# New Combinations

CommonSpirit 



 Wake Forest<sup>®</sup>  
School of Medicine

 Atrium Health

 Wake Forest<sup>®</sup>  
Baptist Health

**CENTENE**<sup>®</sup>  
Corporation

 WellCare<sup>®</sup>  
Beyond Healthcare. A Better You.

 **CVS**  
Health. | **aetna**<sup>®</sup>

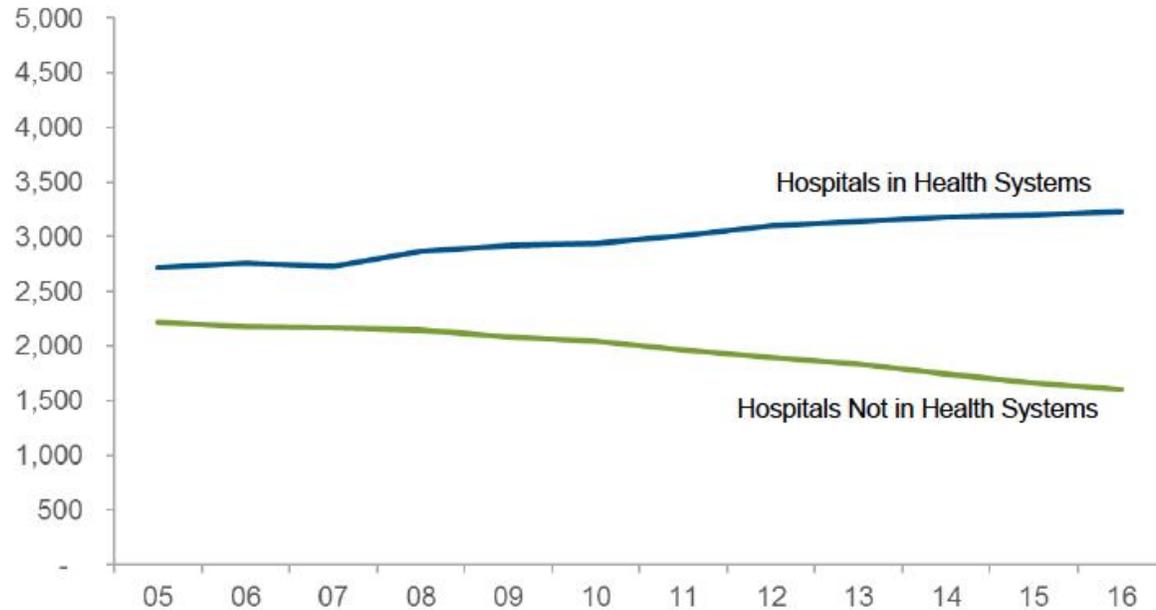
 OPTUM<sup>™</sup>

*Davita*<sup>®</sup>

 Cigna. +  EXPRESS  
SCRIPTS<sup>®</sup>

# Hospitals in Health Systems

Chart 2.4: Number of Hospitals in Health Systems,<sup>(1)</sup> 2005 – 2016



Source: Analysis of American Hospital Association Annual Survey data, 2016, for community hospitals.

<sup>(1)</sup> Hospitals that are part of a corporate body that may own and/or manage health provider facilities or health-related subsidiaries as well as non-health-related facilities including freestanding and/or subsidiary corporations.

# Employers on the Edge

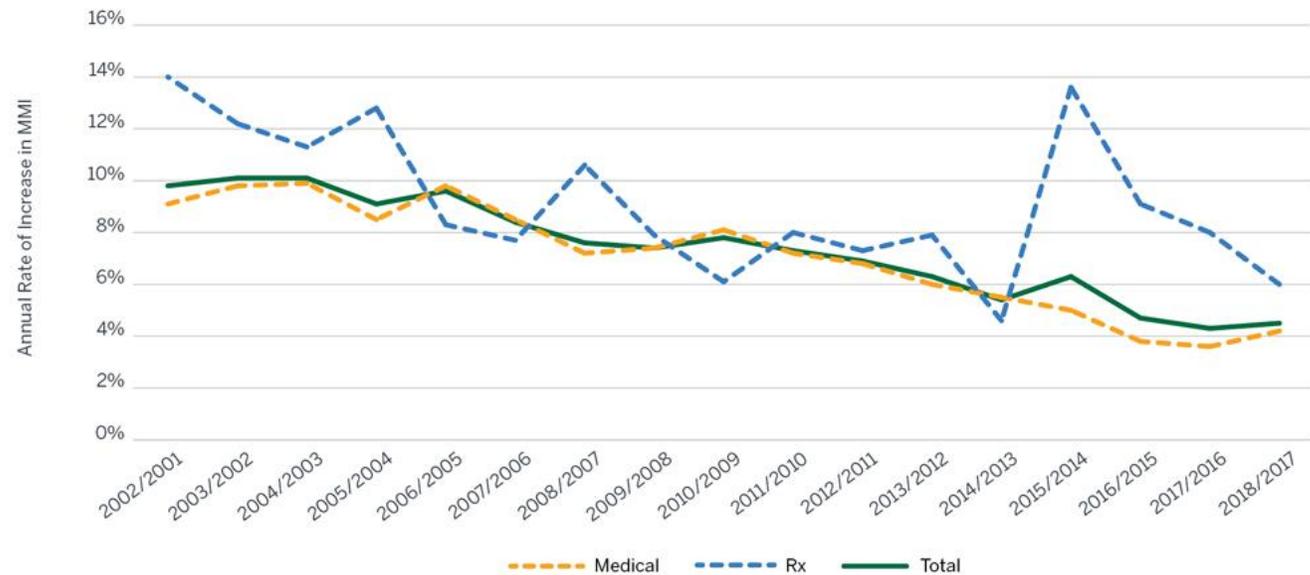
- Self-Insured Employers are the financial lifeblood of the healthcare delivery system
- Not exiting in a full employment economy but steady erosion of coverage among small business and low income workers
- Reaching limits of Cost-Shifting to employees ....but still doing it
- Looking for alternatives
- Trying many initiatives to increase value
- Stitching together responses
- Specialty pharma a key concern
- What will they support as policy?

# Milliman Medical Index

**FIGURE 1: MILLIMAN MEDICAL INDEX (MMI)**



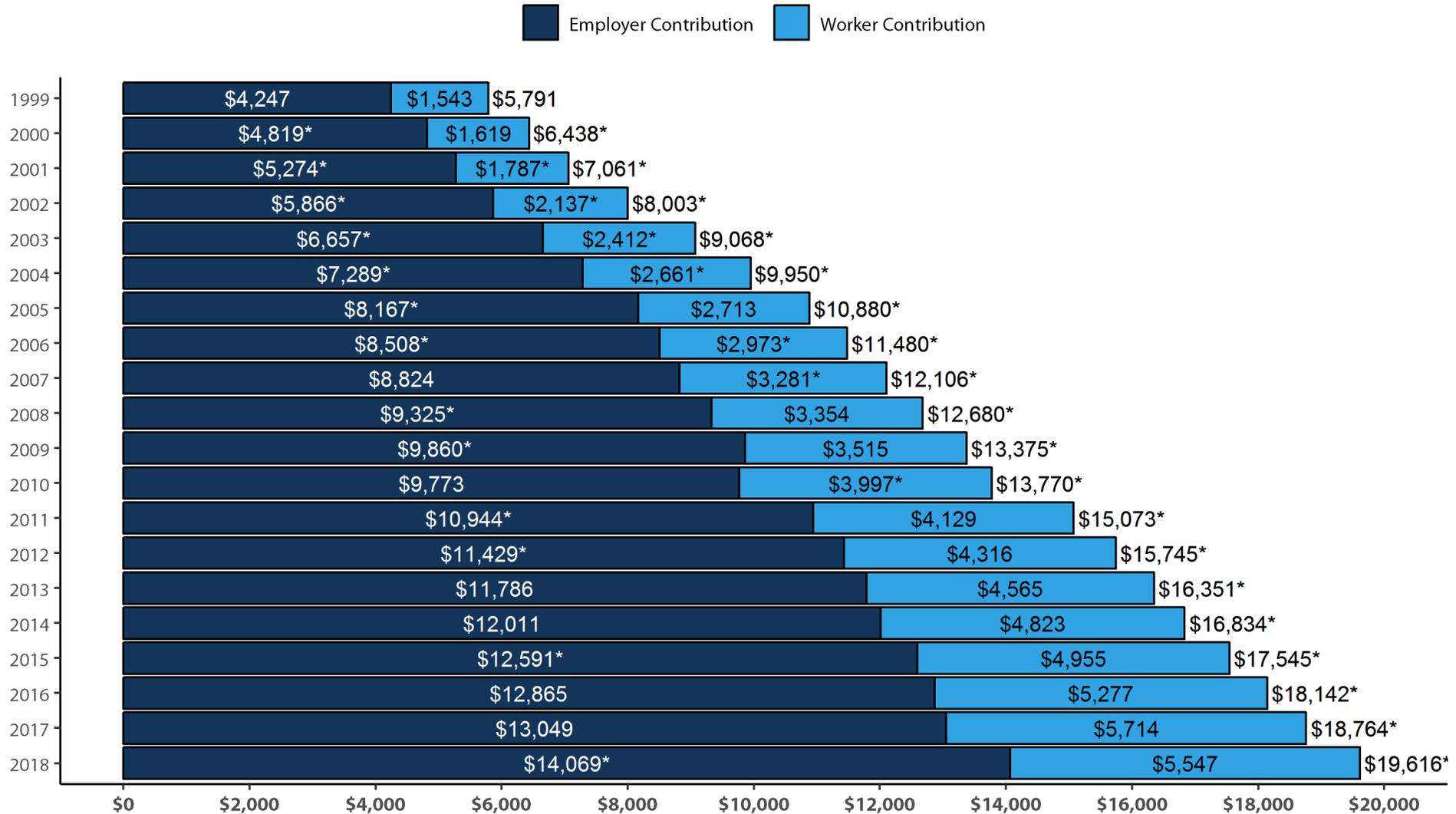
**FIGURE 2: ANNUAL CHANGES IN THE MILLIMAN MEDICAL INDEX**



Note : Includes Out of Pocket Costs

**Figure 6.5**

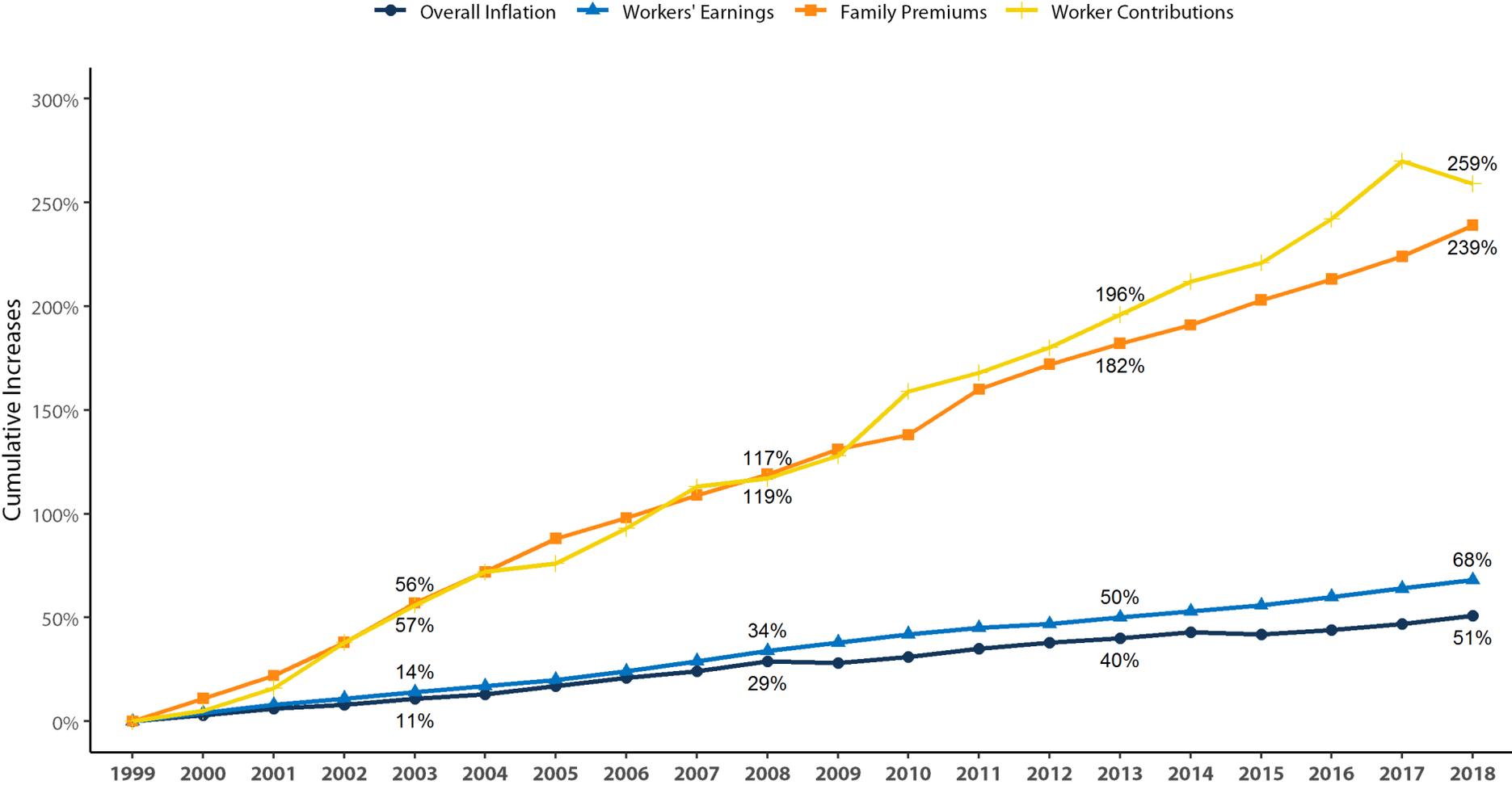
**Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2018**



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

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017

# Cumulative Increases in Family Premiums, Worker Contributions to Family Premiums, Inflation, and Workers' Earnings, 1999-2018

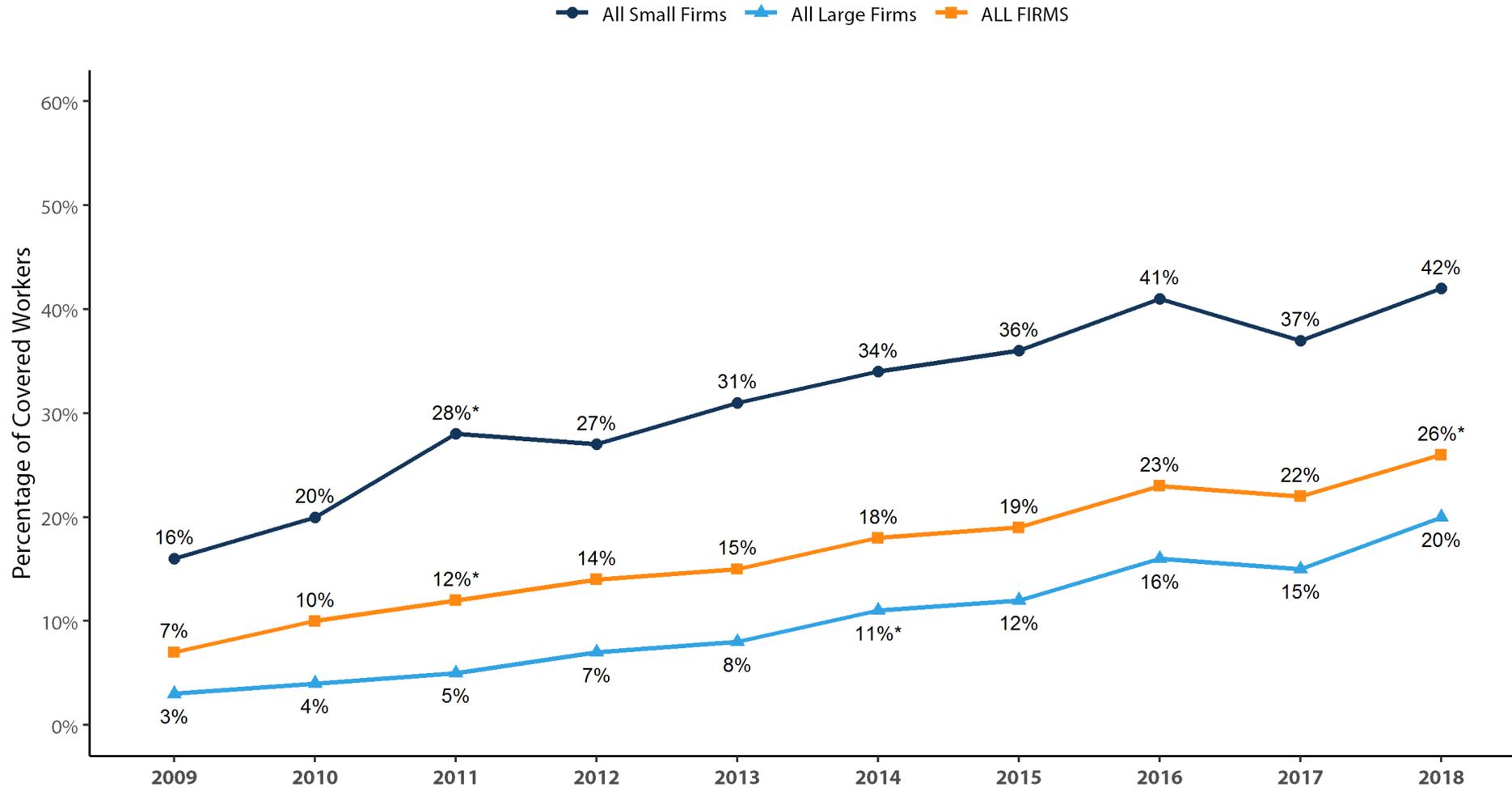


SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017. Bureau of Labor Statistics, Consumer Price Index, U.S. City Average of Annual Inflation (April to April), 1999-2018; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 1999-2018 (April to April).



**Figure 7.15**

**Percentage of Covered Workers Enrolled in a Plan with a General Annual Deductible of \$2,000 or More for Single Coverage, by Firm Size, 2009-2018**



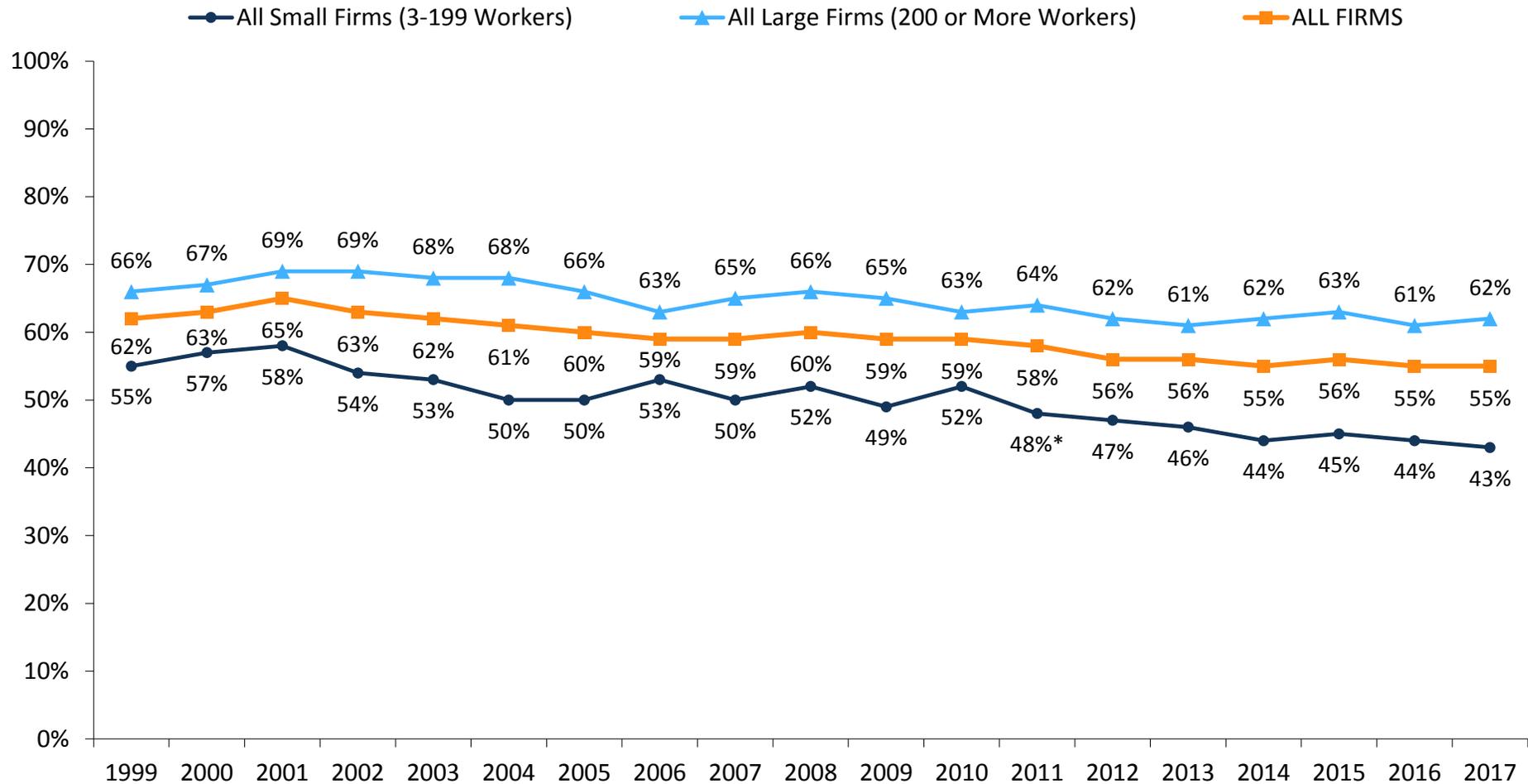
\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

NOTE: Small Firms have 3-199 workers and Large Firms have 200 or more workers. These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual deductibles are for in-network services.

SOURCE: KFF Employer Health Benefits Survey, 2018; Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009-2017

**Figure 12**

**Percentage of All Workers Covered by Their Employer's Health Benefits, Both In Firms Offering and Not Offering Health Benefits, by Firm Size, 1999-2017**



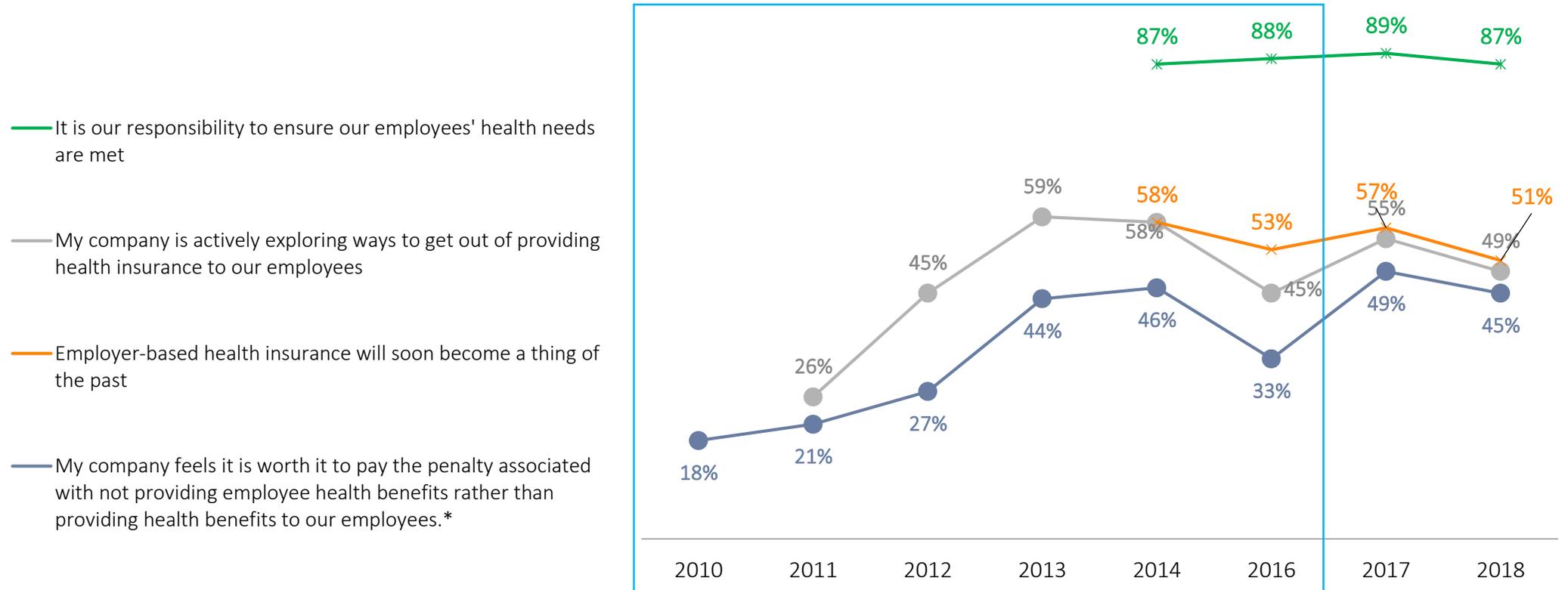
\* Estimate is statistically different from estimate for the previous year shown ( $p < .05$ ).

SOURCE: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2017.



# HIP Surveys: Fewer employers are looking for a way out; continue to feel responsibility for employee health needs

Company's Position on Employer-Sponsored Healthcare: Providing Benefits  
 (Top-2 Box % - Describes Completely/Very Well)



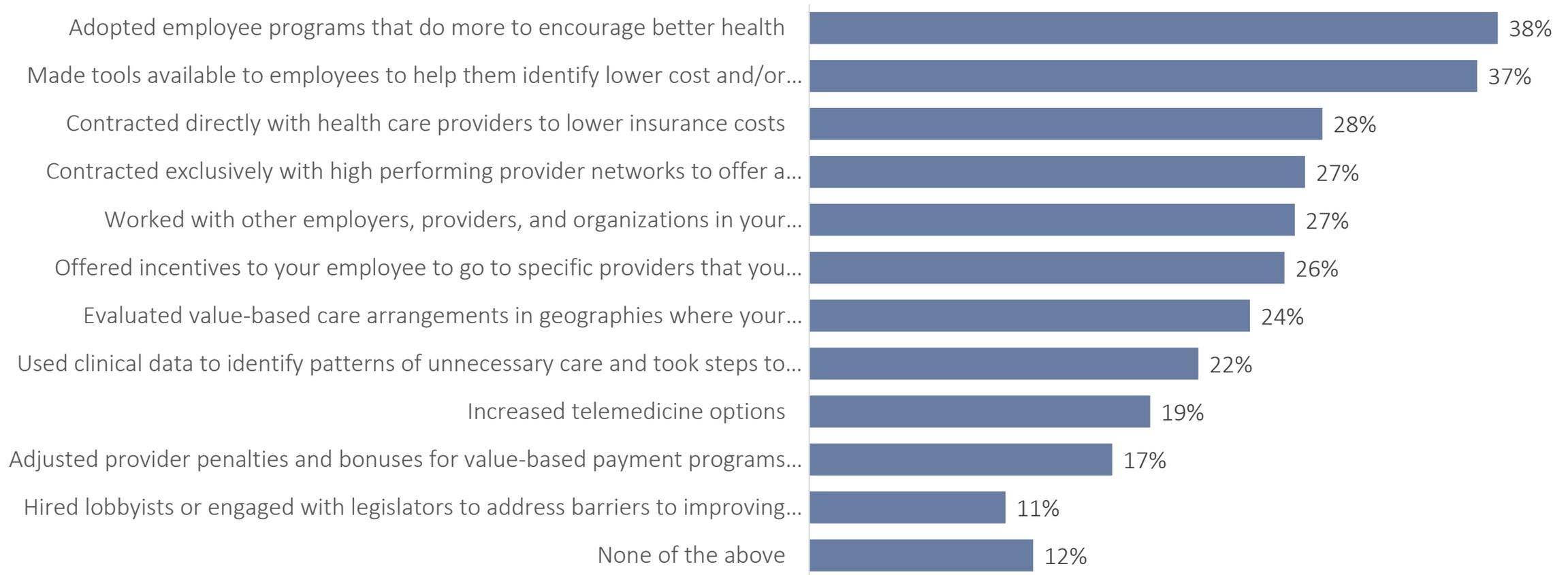
\* Asked only of Employers with 50 or more employees

Base: All Employer Health Benefit Decision Makers; 2014-2016 data from Nielsen's Strategic Health Perspectives (n=340); LP Surveys (2017 n=538; 2018 n=550)

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

# Programs Initiated to Contain Health Care Costs

Employers focused on wellness, cost transparency tools to contain health care costs



# Employer-Sponsored Health Insurance & ACOs

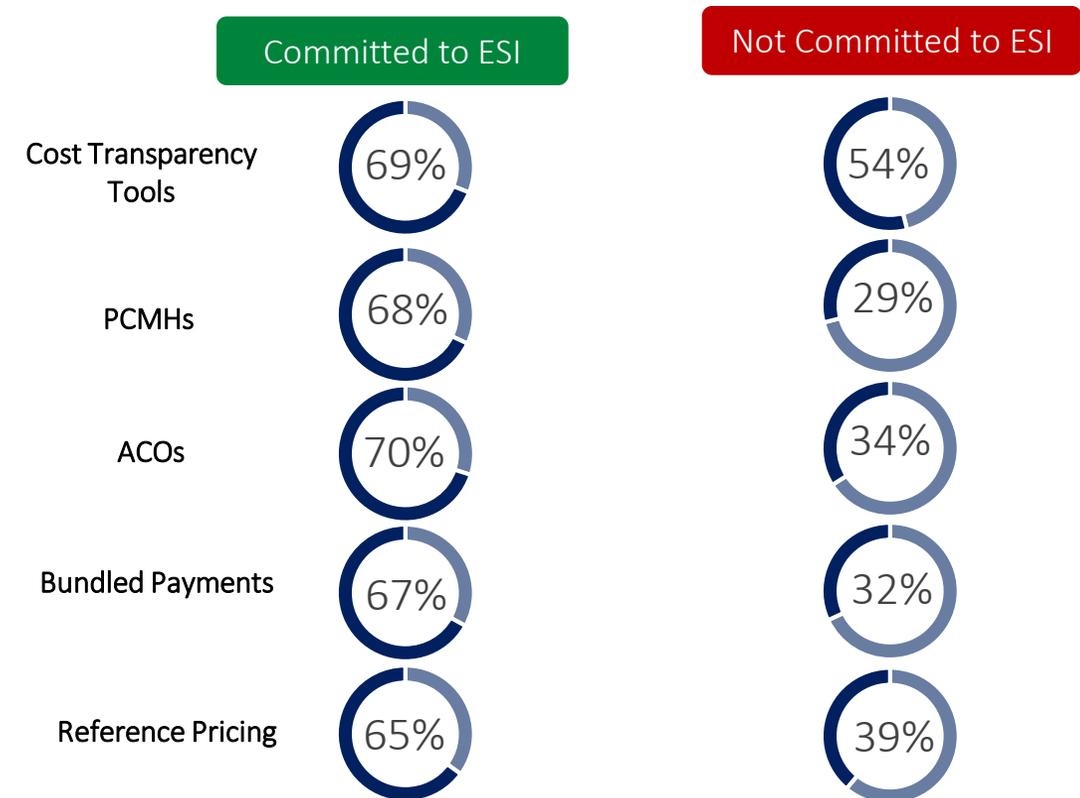
Employers are split on whether ACOs and other VBP models will be effective; However, employers who show more commitment to Employer-Sponsored Insurance (ESI) are also more likely to say ACOs and other programs work.

## ACO Beliefs: Percent Who Say Statement Describes Company Completely or Very Well



Source: 2017 HIP Employer Survey, Leavitt Partners; Base n = 503

## Perceived Program Effectiveness: Percent Who Said Initiative Will Work Extremely or Very Well



Source: 2017 HIP Employer Survey, Leavitt Partners; Base n = 520

# EMPLOYERS MOST CONCERNED ABOUT HOSPITAL PRICES, SPECIALTY PHARMACEUTICALS AND CANCER CARE

Level of Concern for Healthcare Cost Drivers, Total Employer Benefit Decision-Makers  
(Top 2 Box: Extremely/Very Concerned)

	2013	2014	2016	2017
Hospital inpatient prices	-	-	60%	69%
Specialty pharmaceuticals	47%	54%	55%	60%
Cancer care	54%	56%	54%	62%
Hospital outpatient prices	47%	49%	50%	55%
General pharmaceuticals	46%	50%	50%	62%
Physician prices	54%	53%	48%	65%
Obese patients generally	45%	53%	48%	52%
Health plan fees for care management	45%	44%	44%	57%
Diagnostic imaging	43%	47%	41%	55%
Hospital outpatient utilization	40%	50%	40%	55%
Innovative, breakthrough treatments/cures for disease	-	46%	40%	52%
Orthopedic surgery (hips/knees/etc)	41%	44%	39%	49%
Diabetes patients	-	-	39%	54%
Physician utilization	45%	45%	37%	50%
NICU/early childhood disease costs	--	--	36%	46%
Low-back pain treatment	43%	40%	34%	46%
Maternity care	41%	40%	32%	45%
Routine preventative testing	40%	43%	31%	46%

Base: All Employer Health Benefit Decision Makers (bases vary)  
Q1707: Please indicate your level of concern for the following drivers of health care costs

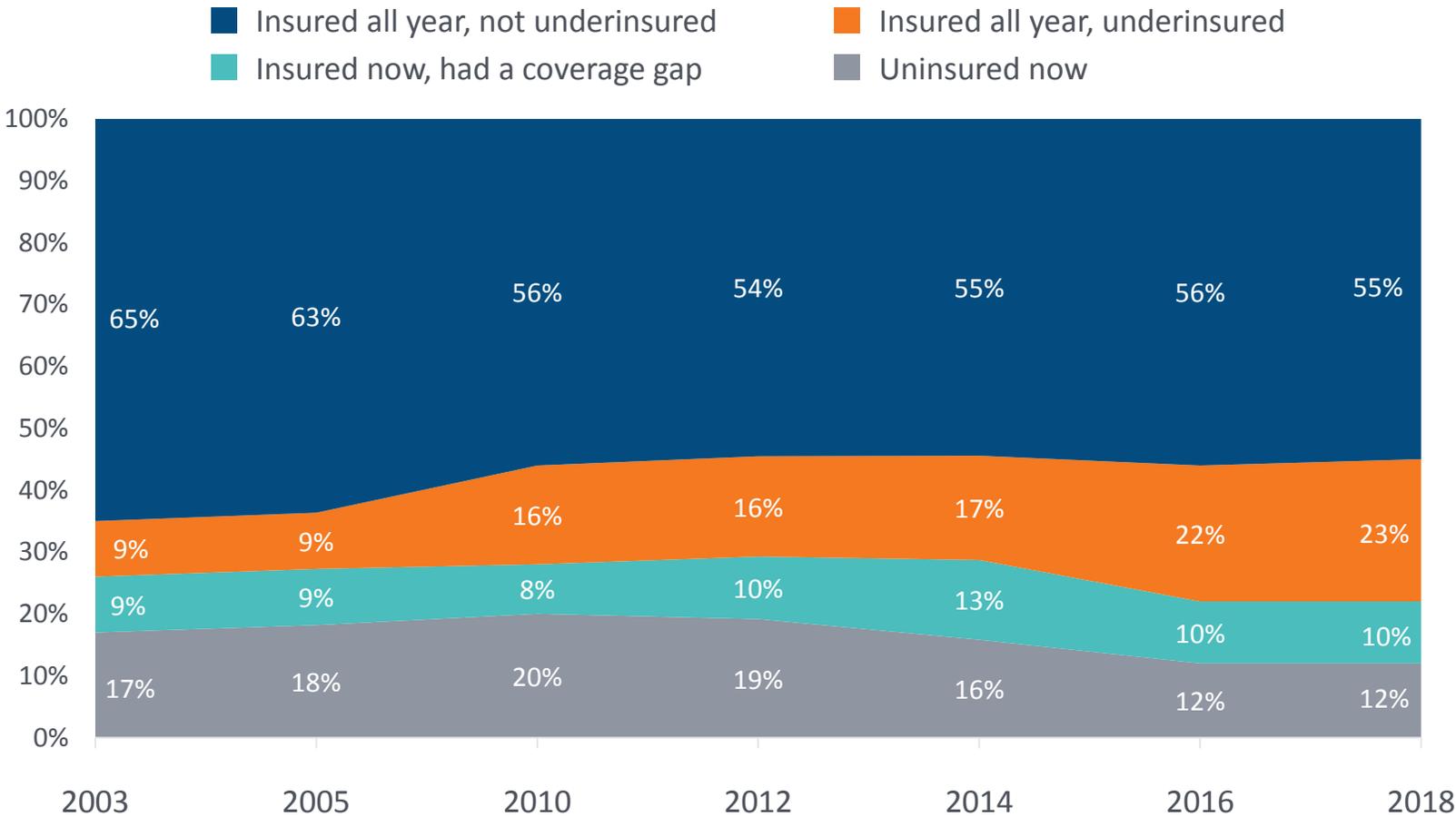
.SOURCE: SHP 2013-2016, Leavitt Partners, 2017

# Five Dimensions of Consumerism

- Increased use of transparency and consumer navigation tools to guide choices
- Importance of consumer experience to providers and plans, both in terms of patient acquisition, retention and loyalty, as well as patient satisfaction
- Ever higher expectations of service industries driven by their positive experience with high-technology-enabled consumer offerings
- Consumers need to be more proactive and engaged in their own health and wellness
- Rising out-of-pocket cost burden

# Since the ACA, Fewer Adults Are Uninsured, but More Are Underinsured

Percent of adults ages 19–64

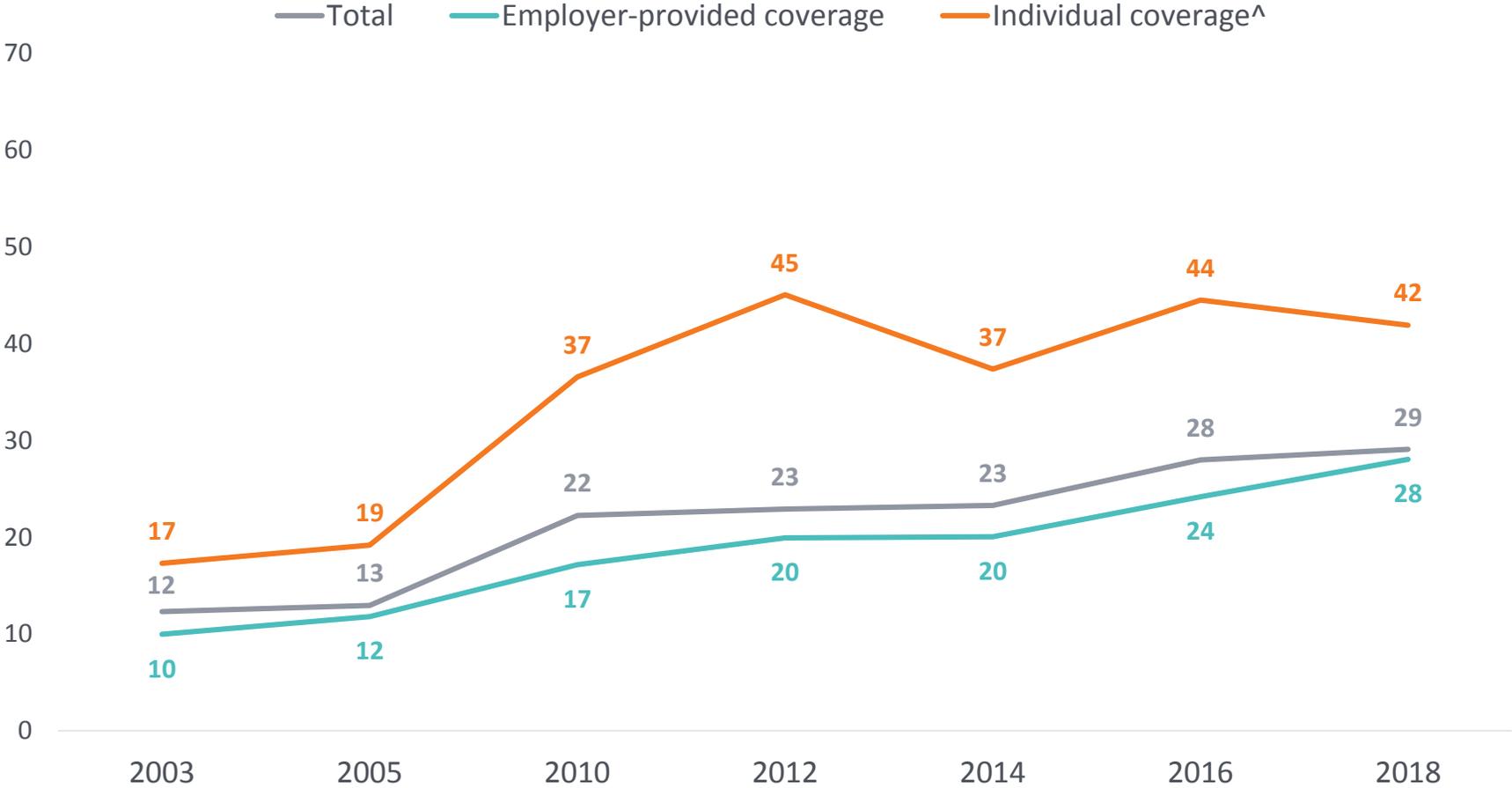


Notes: “Underinsured” refers to adults who were insured all year but experienced one of the following: out-of-pocket costs, excluding premiums, equaled 10% or more of income; out-of-pocket costs, excluding premiums, equaled 5% or more of income if low-income (<200% of poverty); or deductibles equaled 5% or more of income. “Insured now, had a coverage gap” refers to adults who were insured at the time of the survey but were uninsured at any point in the 12 months prior to the survey field date. “Uninsured now” refers to adults who reported being uninsured at the time of the survey.

Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).

# More Adults Are Underinsured, with the Greatest Growth Occurring Among Those with Employer Coverage

Percent of adults ages 19–64 insured all year who were underinsured



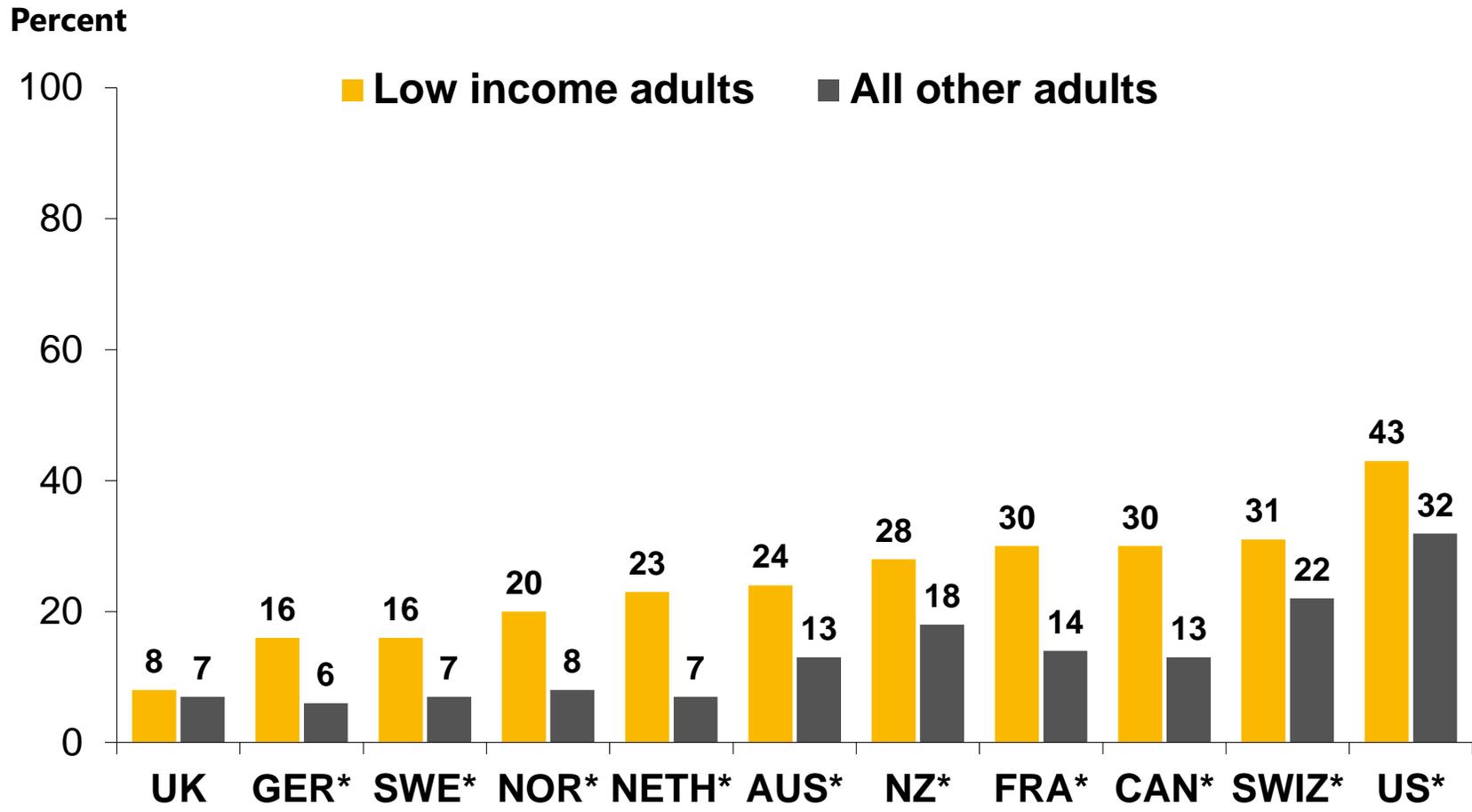
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Data: Commonwealth Fund Biennial Health Insurance Surveys (2003, 2005, 2010, 2012, 2014, 2016, 2018).



# Cost-Related Access Barriers

## Cost-Related Access Barriers in the Past Year, by Income



\*Indicates differences are significant at  $p < 0.05$ .  
Note: "Low income" defined as household income less than 50% the country median. Sample sizes are small ( $n < 100$ ) in the Netherlands and UK.

# Shallow-Pocketed Consumers Create Challenges And Opportunities

- Consumer/Patient experience matters in value payment for all payers
- High Deductible Care becoming norm In employer sponsored market and exchanges
- HDHP is a blunt instrument and applies to pediatrics too\*
- Consumers (particularly women) are becoming key decision-makers in selecting services under these budget constraints
- Loyalty can be bought/changed through cost sharing
- Increased Competition for the Out of Pocket dollar from worksite clinics, retail clinics, pharmacy and free-standing urgent care, ERS and micro-hospitals
- Self-Insured using new channels for employees e.g. Lemon-Aid, Book MD and Omada
- Convenience is key to many consumer choices
- Considerable competition and cream skimming potential by income and geography
- Potential disruptors from Amazon to Apple
- Retail Clinic and Urgent Care activity may be additive not substitutive
- Raise Issues: “Fragmentation of care, relevancy, loyalty, and patient flow”

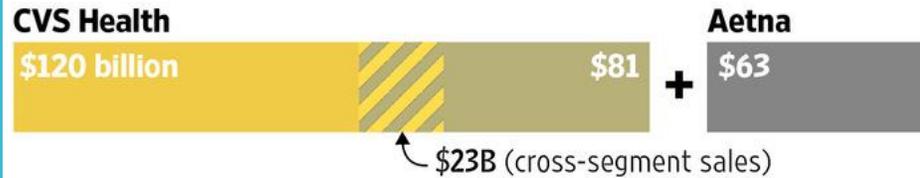
\* Fung et al JAMA Pediatr, 2014 Jul:168(7):649-56

# CVS-Aetna becomes CVS Health

## Different Mix

CVS and Aetna together will offer a mix of drugstores, pharmacy-benefit management and insurance, but they won't have a foundation of doctors.

Revenue: ■ Pharmacy benefits ■ Retail/pharmacy ■ Health insurance



Other companies, including UnitedHealth Group, have a different mix. UnitedHealth includes a growing number of physician practices, plus an insurer and pharmacy-benefit manager.



\*Doctor practices included

Source: S&P Capital IQ

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- Retail Pharmacy with Clinic Footprint acquires national insurer with ACO and data expertise
- Vision of local footprint for chronic care management and health and wellness
- Execution risk
- "Beyond Pink Eye"
- Health and Wellness as Substitutive versus Additive to Medical Care
- Specialty pharma and PBMs are in cross-hairs of national employers
- Intense competition for wallet share of shallow pocketed consumers
- Whose problem does this solve?



# Cigna Buys Express Scripts



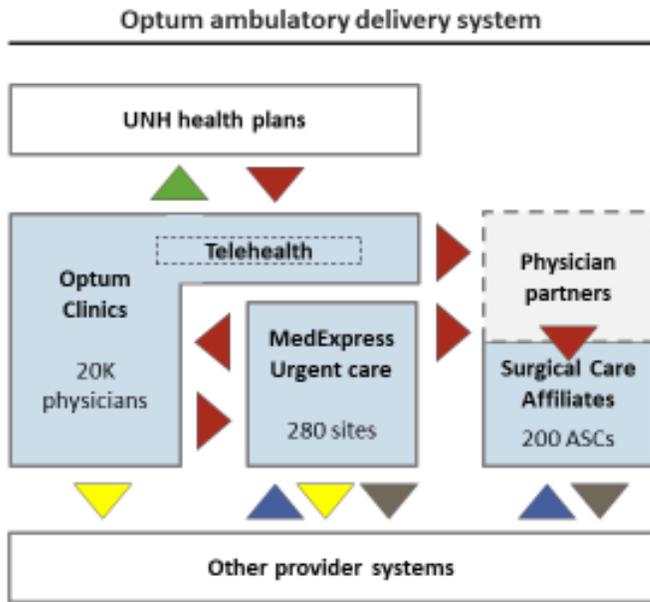
- CIGNA agree to buy Express Scripts for a total of \$76 billion (\$52 billion in cash and stock , \$15 Billion in assumed debt)
- “When we think about Express Scripts, it has PBM capabilities, but it has 27,000 individuals and a significant number of consumer touchpoints around health and well being,” Cigna CEO David Cordani said in an interview Thursday morning. “It expands our service portfolio beyond that of a PBM.”
- Cigna began exploring the tie-up seriously late last year, Mr. Cordani said. One of the drivers for the deal is its ability to broaden Cigna’s offerings and reach. “Having the capabilities to serve an individual whether they are healthy, healthy at risk, chronic or acute is important,” he said.
- Cigna shareholders will own about 64% of the combined company, which will retain Cigna’s name, and Express Scripts shareholders will own about 36%.

# Haven: Amazon, Berkshire Hathaway, JP Morgan Chase

- Big Brands come together and announce joint venture to disrupt healthcare for own employees, insurers stock price hit immediately
- But.....
  - 1 million lives is less than 1% of privately insured spread all over the country
  - Can they really scale technology and innovation in an industry that has resisted it?
  - What can they do about price, absent concentrated local clout?
- Long history of “Cranky, Confused, Aimless and Spineless Employers”
- Employers own the margin in healthcare
- But they struggle to apply power in collective action and reluctant to risk their own brand in being tough on healthcare
- They can innovate and pilot
- Atul Gawande will attract followers and partners
- You need CMS as the big dog changing the game at scale

# Optimize

## Optum's emerging ambulatory system offers multiple strategic benefits



### Synergies

- Visibility and branding
- New patient referrals/steerage
- Shift to lower-cost site
- Referral agreements / soft negotiating leverage
- Local market competitive price "ceiling"

## Optum has substantial geographic overlaps across ambulatory assets



Share of population of Hospital Referral Regions with Optum Health delivery sites (%)

Markets with...	Clinics and IPAs	Urgent care	ASCs	Total
All three delivery models		12		12
Two delivery models*	12	21	21	27
One delivery model only	2	12	17	31
<b>Total</b>	<b>26</b>	<b>45</b>	<b>50</b>	<b>70</b>
No Optum presence		30		30

\* = One model is show in column title, other models may be either of the two others. In the "clinics" column, the 12% includes regions where there are clinics and either urgent care or ASCs

"Hospital referral regions" (HRRs) are aggregates of Hospital Service Districts where patients are referred for tertiary services (cardiovascular and neurological). There are 306 HRRs in the US.

Source: Optum websites, press releases, Census, Recon analysis

## Strategic Plans: 10 Common Themes

- Strategic Growth
  - Acquisitions of geographically contiguous assets
  - Partnerships across continuum and with other players
  - Grow market share/catchment at expense of nearby competitors
- Consumer Engagement
  - Consumer as decision-maker
  - Role of Patient Satisfaction in Payment
  - Enhance consumer/patient experience
  - Consumer facing tools and technologies
- Physician Relationships
  - Clinical and Economic Integration
  - Three Buckets of Physicians and the “Docking Opportunities”
  - Acquiring and growing practices
  - Improving physician relationships

# Strategic Plans: 10 Common Themes

- Quality and Patient Safety
  - Pick an “operating system” for quality e.g. Lean, Six Sigma, High Reliability
  - Develop focused initiatives
  - Pick Measures and Accountability Path
  - Develop Governance framework e.g. Clinical Councils, Physician Compacts
- Innovation at Scale
  - Electronic Health Records as “table stakes”
  - Investment in new ventures
  - Big Data and Analytics Initiatives
  - Virtual Health

# Strategic Plans: 10 Common Themes

- Culture/People
  - Values Based Culture
  - Triple Aim
  - Best Place to Work
  - Engaged Workforce
  - Respect, Reliability, Resilience
- Value/Affordability
  - For consumers: Low Out of Pocket Costs, Convenience and Reputation
  - For Public Purchasers: MACRA and stars and bars
  - For Private Purchasers: ACOs, narrow networks centers of excellence
- Clinical Differentiation (Everyone Focusing on the same things where the money is currently)
  - Orthopedics
  - Cancer
  - Cardiovascular
  - Precision Medicine (AMCs)

# Strategic Plans: 10 Common Themes

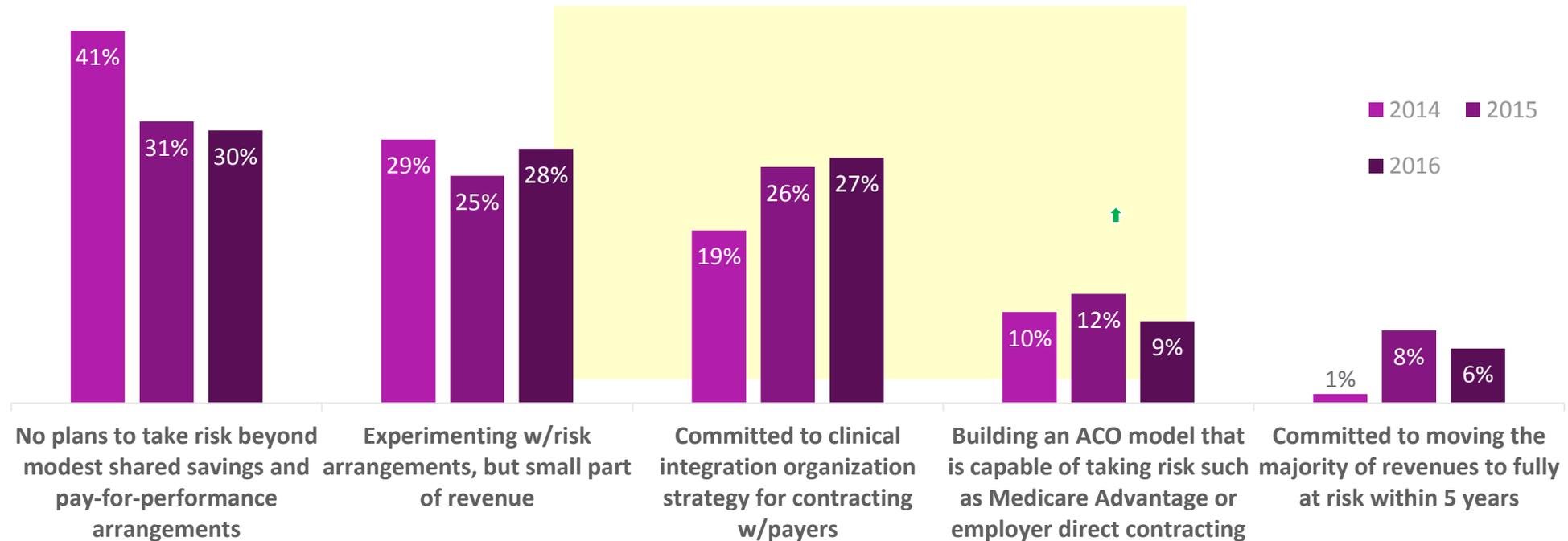
- Financial Sustainability
  - Medicare/Medicaid/Bad debt hydraulics: permanent Impairment in Payer Mix
  - “Make Money on Medicare”
  - “No Margin, No Mission”
  - Recognize price cross subsidy from privates may not be sustainable
  - “Best Year ever in 2015...sours in 2016 and beyond...margins tighten in Trump era”
- Population Health and Risk (NB This is the differentiator in the strategies across health systems)
  - If Risk
    - Own Health Plan or Partnership
    - Direct Contracting with Employers
    - Medicare Advantage Direct
  - If Population Health
    - Invest in Pop Health Analytics and Infrastructure
    - Partner
    - Care Coordination
    - Social Work not Medical Care

# RISK-BEARING STRATEGIES VARY CONSIDERABLY

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

SHP HOSPITALS 2016

## Hospital Risk Management Strategy

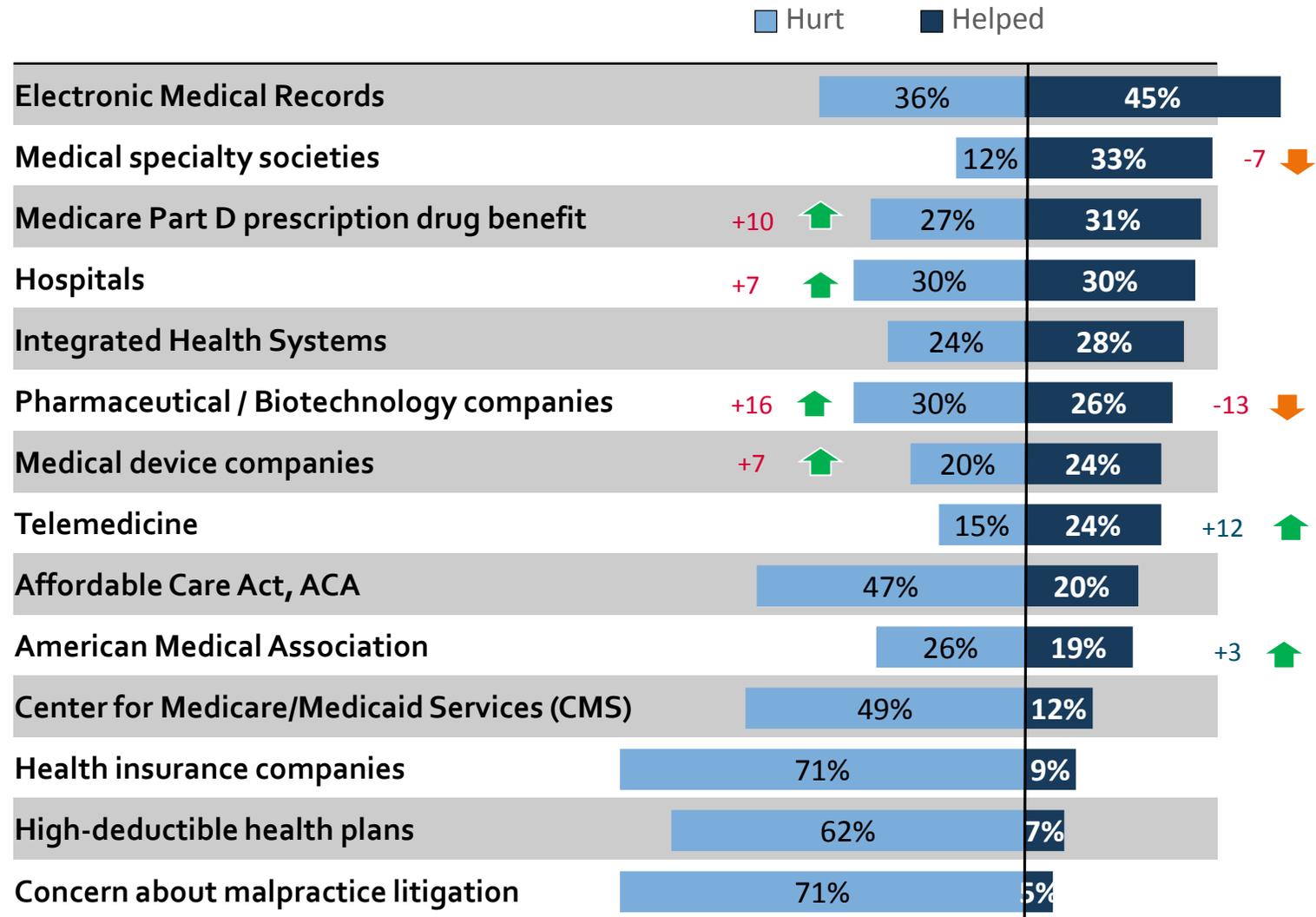


Base: All Hospital-Based Execs (2016: n=205; 2015: n=200; 2014: n=202)

Q980: Which of the following best describes your hospital's/hospital system's "risk bearing" strategy?

# Physicians View of Trends that have Helped or Hurt Quality

## Physicians View of Helped/Hurt Ability to Provide Quality Patient Care



Base: Office-Based Physicians (2016: n=452; 2015: n=476; 2014: n=466; 2013: n=432; 2012: n=461; 2011: n=377)  
 Q815: In recent years, has each of the following helped or hurt your ability to provide quality patient care?



# Médecins Sans Hôpitaux: Doctors Without Hospitals

**Exhibit 7. Distribution of Physicians by Practice Ownership Structure**

	2012	2014	2016
<b>Wholly owned by physicians</b>	60.1% <sup>a</sup>	56.8%	55.8% <sup>a</sup>
<b>At least some hospital ownership</b>	23.4% <sup>b</sup>	25.6%	25.4% <sup>b</sup>
Wholly owned by hospital	14.7%	15.6%	16.1%
Jointly owned by physicians and hospital	6.0% <sup>b</sup>	7.3%	6.2%
Unknown whether wholly or jointly owned	2.6%	2.7%	3.1%
<b>Direct hospital employee</b>	5.6% <sup>a</sup>	7.2%	7.4% <sup>a</sup>
<b>Wholly owned by not-for-profit foundation</b>	6.5%	6.4%	6.7%
<b>Other<sup>2</sup></b>	4.4%	4.0%	4.7%
	100%	100%	100%
<b>N</b>	3466	3500	3500

Source: Author's analysis of AMA 2012, 2014 and 2016 Physician Practice Benchmark Surveys.

Notes: <sup>1</sup> Significance tests are for year to year changes, within category. 'a' is p<0.01 and 'b' is p<0.05.

Indications in the 2012 column are tests for 2012 and 2014; in the 2014 column for 2014 and 2016; and in the 2016 column for 2012 and 2016. <sup>2</sup> Other includes wholly owned by an HMO/MCO and fill-in responses.

# Médecins Sans Hôpitaux: Doctors Without Hospitals (some examples)

- **One Medical** is a nationally growing member-based primary care practice
- **Oak Street Health** is a venture backed primary care service in Illinois and Indiana with growing footprint in the Midwest focused on vulnerable elderly populations.
- **Core Institute** is a private equity backed orthopedic, neurology and spine health practice based in Phoenix and expanding to other markets such as Michigan.
- **Optum** is the rapidly growing \$100 billion revenue health services company buried inside the behemoth \$200 + billion United Health Group
- **Investor Backed Ambulatory Services** are growing in many states especially where there is no Certificate of Need legislation.
- **Physician Led ACOs** are proliferating and seem to do better than hospital led ACOs
- **Physician Outsourcers** such as Envision, Team Health, MedNax, AMN are for profit health service companies.

# WHAT POPULATION LEVEL ANALYTICS REVEAL

- **The 5/50 Problem**
  - 5% account for 50% of spending
  - 1% account for 20%
  - Bottom 50% account for about 2%
- **Segmentation of populations**
- **What you will find ...**
  - HONDAS
  - Behavioral health
  - End-of-life care
  - Cancer
  - Frail elderly
  - Social work not medical care
  - Specialty pharmaceuticals

# The End Game

- Integrated Care
  - Integrated Health Systems of different flavors built around Medical Groups
  - “Fair share” of Medicaid and the Uninsured allocated through auto-enrollment
  - Targeted total cost of care targets tied to economic growth
  - Increased focus on population health
  - Large Self-Insured Employers given flexibility
- Medical Darwinism
  - 50+ million uninsured
  - Best care in the world based primarily on ability to pay
  - Doctors walk away from the poor
  - Widening performance disparities within and between states
- Single Payer
  - “You are not Canadian”
  - FFS Hamster Care
  - Massive transfer of income from rich to poor
  - Reduce the prices and incomes of all actors through government monopsony
  - “Balloon in a Box”
  - Change the mix: Get Rid of the Specialists
  - Good Luck With That

# Battle of the Consumer Health Giants

- Health and Health care is reformulated by massive presence of consumer focused, national technology enabled brands who focus on prevention, wellness, digital and retail primary care for the high deductible marketplace
  - Google Health owns health search and navigation and AI based provider support
  - Apple owns self monitoring health technologies through watch, phone and new peripheral devices in the Apple phone ecosystem
  - Amazon Alexa MD provides simple AI driven symptom, consult, RX to door solutions for many common acute conditions (Included in Amazon Prime Plus Membership)
  - CVS Health Last Mile manages most chronic conditions through technology enabled analytics, monitoring and retail presence especially for older and lower income patients
  - 23 and Me owns genetic testing and supports both consumer demand and research innovation
- Acute Care and Procedure Care are Sold on a Spot Market based on price and quality
  - Haven pioneered the navigation tools for the procedure market in 2020
  - Provider networks bid for consumer access to plans and consumer giants
- Medicare, Medicaid and Employer Sponsors all contract with consumer giants as front end consumer facing service providers
  - Niche subscription offerings emerge such as One Medical, Oak Street Health, and other Dual Eligible plans
  - Many large employers internalize primary care offerings/clinics using national consumer giants as a base

# Balloon in a Box: Medicare Advantage for All

- Medicare Advantage reaches 60% of seniors by 2022
- Migration of Medicaid Managed Care to Medicare Advantage platform
- Exchange, Small Group, non subsidized individual market and residual uninsured folded in over a five year period from 2020-2025
- Consumer choice of highly regulated MA plans sold through healthcare.gov or state exchanges
- Medicare Advantage Buy Ins Allowed incrementally by age and employment Status throughout 2020s
- Large Employers Allowed ERISA Waiver if they meet Federal Standards but Tax Deductibility of health benefits is phased out by 2030 causing many employers to cash out to defined contribution for the MA Marketplace
- All hospital systems have coalesced into walled gardens of EPIC enabled virtual Kaiser like fortresses selling PMPM risk adjusted contracts and branding on science, service, technology outcomes and US News and World Report Reputation metrics of their captive doctors
- Starting in 2025, states and feds set risk adjusted total cost of care targets for all programs including ERISA sponsored segment

# Texas for All

- ACA Repealed and not Replaced when Trump is Re-elected in a major victory
- A Free for All “Market” based on ability to pay
- Medicaid Block Granted to states with per capita caps
- Pre-Existing condition protections remain in place but massive prices attached and subsidies greatly reduced
- “Safety Net” is charity, volunteerism, and bare bones Medicaid for neediest only
- Medicare Advantage for seniors
- No tax deductibility for employer sponsored coverage beyond catastrophic plans
- Blue States hit wall of raising state income taxes to sustain Obama era coverage, eventually rolling back Medicaid expansion
- A good job at least guarantees some bad coverage
- Slogan: “you really should have taken better care of yourself”

# No Matter What: Pursue The Value Agenda

- Focus on getting the cost structure down in healthcare delivery
  - Culture: Make it everyone's problem
  - Engagement with medical staff on physician sensitive preferences
  - Cost Discipline as a strategic priority
  - Waste avoidance, clinical standardization and variation elimination
  - Labor substitution such as scope of practice extenders, telehealth and alternate sites
- Partnering for Long Term Risk Delegation
  - Gov. Leavitt "25 Years in to a 40 Year Journey to Value"
  - Medicare Advantage for All?
  - Managed Medicaid for more?
  - Self Insured Employers: Will they go direct?
- Focus on 5/50
  - Segmentation and Analytics
  - Social Determinants of Health
- Scale
  - Scale matters in health insurance, PBMS, Supply Chain, Capital Creation but is it key for providers?
  - For providers: You need to be **big where you are** but be prepared to partner with others
  - Local Terroir varies