Health Care Reform Beyond the ACA

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October 5th, 2017
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Health Care Reform
Beyond the ACA
The Next Generation of Medicare Risk,
High Deductibles, and Physician Integration

Ken Leonczyk, Jr. – Senior Director
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1. Unpacking the Political Process

2. The Next Era of Health Reform

3. Adapting Provider Strategy to New Market Realities
Health Care Squarely in the Hands of the GOP

Congress, Executive Branch, and Majority of States Now in Republican Control

Majority of Americans Hold GOP Responsible for Health Care

64%

Individuals who believe “President Trump and Republicans in Congress are now in control of the government and they are responsible for any problems with the ACA going forward.”

An Ambitious Three Part Agenda

GOP Laid Out Three Phases to Health Care Reform

A Three-Staged Approach to Repeal and Replace the ACA

1) Budget Reconciliation

Process: Requires simple majority in House and Senate

Proposed Target Areas:
- Repeal ACA taxes, employer and individual mandates
- Replace insurance subsidies with refundable tax credits
- Reform Medicaid financing
- Increase contribution limit of health savings accounts
- Allocate funds for state innovations
- Require continuous coverage insurance incentive

2) Administrative Action

Process: Federal agencies issue regulation through rulemaking

Proposed Target Areas:
- Shorten individual market enrollment period and limit special enrollment
- Loosen restrictions on actuarial value of individual market plans
- Enable state flexibility through waiver process
- Approve state Medicaid eligibility changes (e.g. work requirements, premiums)

3) Additional Legislation

Process: Requires simple majority in House, super-majority in Senate

Proposed Target Areas:
- Allow insurance to be sold across state lines
- Expand use of HSAs
- Allow formation of Association Health Plans
- Reform malpractice regulation
- Streamline FDA processes
- Expand flexibility of state use of federal dollars


1) Telephone survey of 1,171 adults age 18+ living in the US.

Future of Repeal Legislation Now Unclear

Ready to Move On From Repeal-and-Replace?

Senate Leadership Ready to Move on to Other Priorities

“This is clearly a disappointing moment…I regret that our efforts simply were not enough…we look forward to colleagues on the other side suggesting what they in mind [for health care]…now it is time to move on…”

Senate Majority Leader Mitch McConnell (R-KY), July 27th statement before the Senate

“Until there’s something that can get us 50…I think we’ve had our vote and we’re moving on to tax reform. Everybody wanted to give…the bipartisan approach a chance. People not have that opportunity.”

Sen. John Thune (R-SD), Republican Conference Chairman

Three Potential Legislative Paths Forward

1. Senate Republicans Renew Effort

2. Bipartisan Health Reform Effort

3. GOP Shifts Focus to Non-ACA Legislation


GOP Reform Efforts

Four Key Principles Guiding GOP Reform Efforts

1. Reduce Federal Entitlement Spending

Focus more aggressively on reducing federal health care spending

2. Devolve Health Policy Control to States

Reduce federal role in health care; provide states more autonomy to make decisions, cut spending

3. Embrace Free Markets and Consumer Choice

Use free-markets to promote private sector competition in payer, provider markets

4. Promote Transparency of Cost and Quality

Mandate greater consumer choice and shopping at the point-of-care and point-of-coverage through improved transparency

Source: Health Care Advisory Board interviews and analysis.
Regulatory Agenda Taking Center Stage

Administration Has Considerable Leeway to Alter ACA Trajectory

Meet the Key Players

**HHS Secretary: Tom Price**

- Six-term Representative from Georgia; retired orthopedic surgeon
- Sponsor of the Empowering Patients First Act
- Confirmed by 52-47 vote

**CMS Administrator: Seema Verma**

- National health policy consultant from Indiana
- Helped shape Medicaid expansion in IN, OH, KY, TN
- Confirmed by 55-43 vote

Potential Administrative Actions

- End cost-sharing reduction payments
- Delay Cadillac Tax
- Eliminate, delay, or modify Innovation Center programs (e.g., CJR1)
- Reduce enforcement of insurance mandates
- Narrow scope of essential health benefits
- Allow Medicaid eligibility, cost-sharing reform through 1115 waivers

ACA Leaves Enormous Amount to the Secretary’s Discretion

1442

Times the ACA says “the secretary shall” or “the secretary may”

For Providers, a Relatively Limited Impact

Despite Political Significance, Exchanges Only a Small Segment of Market

Approximate Coverage of US Population by Payer Sector

*As of March 2016*

- **~11.5M** Individuals with insurance through public exchanges
- **~153M** Individuals with employer-sponsored insurance

**Employer-Sponsored Insurance (47%)**

**Medicare (17%)**

**Medicaid and CHIP (19%)**

**Off-Exchange Plans (4%)**

**Public Exchanges (4%)**

**Uninsured (9%)**

**Other (1%)**

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1) Comprehensive Joint Replacement.


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1) Student, IHS, CH+.

Confronting a Larger Problem

Last Era of Health Reform Expanded Coverage and Increased Spending

Coverage Expansion to Millions…

22M

HHS estimate of adults who gained coverage as a result of the ACA

US Adult Uninsured Rate

Q3 2013: 18.0%

Q1 2017: 11.3%

...Drove Spike in Health Care Spending

$44.6B

Estimate of increase in hospitals’ net income due to new coverage under the ACA, 2014-2016

National Health Expenditures

Actual Spend FY2010-2015, Projected FY2016-2025, in billions

The Next Era of Health Care Reform

Four Key Forces Shaping the Next Era of Reform

1. Direct reimbursement pressure
2. Federalism and state-based coverage reform
3. Dilution of employer-sponsored insurance
4. Deregulation and the new era of competition

Source: Health Care Advisory Board interviews and analysis.
**Unpacking the Political Process**

**The Next Era of Health Reform**

**Adapting Provider Strategy to New Market Realities**

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**Guess What’s Not Getting Repealed**

Even Under Repeal, Majority of Obama-Era Cuts Would Have Remained

"Productivity" Adjustments and Other Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>ACA IPPS¹ Update Adjustments</th>
<th>ACA DSH² Payment Cuts</th>
<th>MACRA³ IPPS Update Adjustments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2017</td>
<td>($32B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2018</td>
<td>($48B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2019</td>
<td>($60B)</td>
<td>($71B)</td>
<td></td>
</tr>
<tr>
<td>2020</td>
<td>($82B)</td>
<td>($94B)</td>
<td>($103B)</td>
</tr>
<tr>
<td>2021</td>
<td>($82B)</td>
<td>($94B)</td>
<td>($103B)</td>
</tr>
<tr>
<td>2022</td>
<td>($82B)</td>
<td>($94B)</td>
<td>($103B)</td>
</tr>
<tr>
<td>2023</td>
<td>($82B)</td>
<td>($94B)</td>
<td>($103B)</td>
</tr>
<tr>
<td>2024</td>
<td>($116B)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2025</td>
<td>($143B)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1) Inpatient Prospective Payment System; year-over-year estimates based on CBO total projected payment reductions, 2016-2025.
2) Disproportionate Share Hospital; repealed for non-expansion states under BCRA.

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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.”

CMS Officials

No Relief Ahead

New Administration Continuing to Pursue Cost Cutting Goals

House Budget Proposal Would Make Substantial, Additional Medicare Cuts

<table>
<thead>
<tr>
<th>Year</th>
<th>2018</th>
<th>2021</th>
<th>2024</th>
<th>2027</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Medicare dollars cut in House budget proposal&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$487B</td>
<td>$3B</td>
<td>$17B</td>
<td>$55B</td>
</tr>
<tr>
<td>$8B</td>
<td>$24B</td>
<td>$31B</td>
<td>$88B</td>
<td></td>
</tr>
<tr>
<td>$122B</td>
<td>$8B</td>
<td>$102B</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hospital 340B Program Also Attracting Scrutiny

Number of Hospitals Participating in 340B

<table>
<thead>
<tr>
<th>Year</th>
<th>2010</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,365</td>
<td>2,140</td>
<td></td>
</tr>
<tr>
<td>45% of hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2018 OPPS Proposed Rule to Cut 340B Payments

<table>
<thead>
<tr>
<th>Current Reimbursement: Average Sales Price + 6%</th>
<th>Proposed Reimbursement&lt;sup&gt;1&lt;/sup&gt;: Average Sales Price – 22.5%</th>
</tr>
</thead>
<tbody>
<tr>
<td>$900M Total cut to 340B reimbursement</td>
<td></td>
</tr>
</tbody>
</table>

Payment Reform Marches On

With MACRA<sup>1</sup> Underway, 2017 a Pivotal Year

Bipartisan Support Guarantees Continued Implementation

| 92-8 Senate vote on MACRA | 392-37 House vote on MACRA |

Physician Leaders Praise Transition Year

“[These] actions help give physicians a fair shot in the first year of MACRA implementation. This is the flexibility that physicians were seeking all along.”

Dr. Andrew Gurman, President of the AMA

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<sup>1</sup> Medicare Access and CHIP Reauthorization Act.
<sup>2</sup> The Merit-based Incentive Payment System.
MACRA Dealing Physicians in on Risk

Greater Payment Updates, Bonuses Depend on Payment Migration

**Annual Provider Payment Adjustments**

<table>
<thead>
<tr>
<th>Period</th>
<th>MIPS Bonuses/Penalties</th>
<th>APM Bonuses/Penalties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015 – 2019</td>
<td>+/-4% Max adj. 2019</td>
<td>5% Annual lump-sum bonus from 2019-2024 (plus any bonuses/penalties from Advanced Payment Models themselves)</td>
</tr>
<tr>
<td></td>
<td>+/-9% Max adj. 2022</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$500M Additional bonus pool for high performers</td>
<td></td>
</tr>
<tr>
<td>2020 – 2025</td>
<td>Payment rates frozen</td>
<td></td>
</tr>
<tr>
<td>2026 onward</td>
<td>0.25% annual update (MIPS track)</td>
<td>0.75% annual update (Advanced APM track)</td>
</tr>
</tbody>
</table>

Baseline payment updates:
- 2015 – 2019: 0.5% annual update (both tracks)
- 2020 – 2025: Payment rates frozen (both tracks)
- 2026 onward: 0.25% annual update (MIPS track)
- 0.75% annual update (Advanced APM track)

**Changing the Calculus Around ACO Participation**

MACRA Already Moving the Dial on Participation in Downside Models

Model Selection Determines MACRA Track Qualification

<table>
<thead>
<tr>
<th>Model</th>
<th>Eligible for APM Track</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPS</td>
<td>No Risk</td>
</tr>
<tr>
<td>MSSP Track 1</td>
<td>Upside Risk</td>
</tr>
<tr>
<td>MSSP Track 1+</td>
<td>Upside &amp; Downside Risk</td>
</tr>
<tr>
<td>MSSP Track 2</td>
<td></td>
</tr>
<tr>
<td>MSSP Track 3</td>
<td></td>
</tr>
<tr>
<td>NGACO</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Model</th>
<th>Participants</th>
<th>Share/Loss Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSSP Track 1</td>
<td>428</td>
<td>50%</td>
</tr>
<tr>
<td>MSSP Track 1+</td>
<td>6</td>
<td>50%</td>
</tr>
<tr>
<td>MSSP Track 2</td>
<td>36</td>
<td>60%</td>
</tr>
<tr>
<td>MSSP Track 3</td>
<td>45</td>
<td>75%</td>
</tr>
<tr>
<td>NGACO</td>
<td></td>
<td>80% or 100%</td>
</tr>
</tbody>
</table>

**Participants in downside ACO models, 2016**
- 40

**Participants in downside ACO models, 2017**
- 87

**Percent increase in downside ACO model participation, 2016-2017**
- 117%

1) Relative to 2015 payment.
2) Next Generation ACO.

Source: The Medicare Access and CHIP Reauthorization Act of 2015; CMS, Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model (APM) Incentive under the Physician Fee Schedule, and Criteria for Physician-Focused Payment Models, April 25, 2016; Health Care Advisory Board interviews and analysis.

Future of Bundled Payments In Question

CMS Poised to Iterate on Voluntary Programs, Scale Back Mandatory Ones

Cardiac EPMs¹ Cancelled

- **Mandatory** bundling for CABG and AMI², originally slated to go into effect July 2017
- Proposed rule released on August 15th would cancel programs entirely

CJR³ Scaled Back

- **Mandatory** bundling for hip and knee replacements, originally in 67 markets
- Proposed rule would make participation in 33 markets voluntary, cancel planned expansion to SHFFT⁴

What’s Next for BPCI⁵?

- **Optional** bundling program; providers may opt into any of 48 different conditions across four risk models
- Current Models 2, 3, and 4 extended through September 30th, 2018

GOP Historically Opposed to CMS’s Mandatory Models

“CMMI has overstepped its authority and there are real-life implications—both medical and constitutional. That’s why we’re demanding CMMI cease all current and future mandatory models.”

Letter from GOP Lawmakers, including current HHS Sec. Tom Price to CMS, September 2016

Impact of Price Cuts and Payment Reform Adds Up

Medicare Payment Cuts Threatening Future Margins

CBO Analysis of Impact of Medicare Payment Cuts¹

- **60%** Projected increase in the share of hospitals with negative profit margins by 2025²
- **(0.2%)** Projected average hospital profit margin in 2025²

MACRA Poised to Further Exacerbate Financial Pressures

RAND Analysis of Change in Utilization and Spending Under MACRA³

- **($22B)** Spending decrease in “medium-prospectiveness”⁴ scenario
- **($250B)** Spending decrease in “high-prospectiveness”⁴ scenario

1) Episode Payment Models.
2) Coronary artery bypass graft and acute myocardial infarction; MS-DRGs: 280-282; 246-251; 231-236
3) Comprehensive Joint Replacement.
4) Surgical hip/femur fracture treatment; MS-DRGs: 480-482.
5) Bundled Payments for Care improvement.

1) Focusing on 3,000 acute care hospitals subject to ACA’s Medicare payment cuts.
2) Assuming hospitals continue at 2016 levels of productivity.
3) RAND Corp. Projections, April 7, 2017.
4) Model factors in changes in physician behavior and potential financial gains/losses for providers if they increase/decrease their level of financial risk.


Employer Health Spending Continues to Grow

Employer Health Benefits
Clearly Not a Legislative Target

“Cadillac Tax” Delayed
- 40% excise tax assessed on employee health benefit spend exceeding $10,200 for individuals, $27,500 for families
- Originally proposed in ACA to begin in 2018; effective date postponed to 2020

Cap on Tax Exclusions Dropped
- Limit on existing tax exclusions for employer contributions to health plans
- Model proposed in “A Better Way;” absent from House’s AHCA and Senate’s BCRA

Even Without Regulatory Pressure, Employers Still Have a Cost Problem

~47% US population covered by employer-sponsored insurance

Average Annual Growth Rate Among Private Business’s Health Expenditures
FY 2014-2017

Cost-Shifting Remains the Dominant Response

Migration to High Deductible Health Plans Well Underway

ESI Average Deductible for Single Coverage¹
By Plan Type, 2009-2015

Percentage of Covered Workers with Annual Deductible of $2,000 or More³
By Firm Size, 2009-2016

1) Among covered workers with a general annual health plan deductible.
2) Includes HDHP/SO.
3) For single coverage.


## Cost-Shifting Reaching Its Limits

### Employers Increasingly Looking to Supplement Cost-Shifting Strategies

**Cost Shifting Causing Consumers to Forgo Care, Increasing Bad Debt...**

<table>
<thead>
<tr>
<th>Spending Reductions Following Implementation of HDHPs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>25%</strong> Reduction in physician office spending</td>
</tr>
<tr>
<td><strong>18%</strong> Reduction in ED spending</td>
</tr>
</tbody>
</table>

**Increasing Bad Debt as Consumers Face Growing Financial Exposure**

- **61%** Of those reporting difficulty paying medical bills used up all or most of their savings, 2016
- **20%** Increase in bad debt among Minnesota Hospital Association Members, 2014-2016

...But Not Incentivizing Shopping

"[We found] that spending reductions are entirely due to outright reductions in quantity. We found no evidence of consumers learning to price shop after two years in [a HDHP]."

*The National Bureau of Economic Research*

"Consumers want to make better choices. They want to save money. They just want someone else to do the work and show them how."

*Chief Innovation Officer, Global Benefits Consulting Firm*

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**Spending Reductions Following Implementation of HDHPs**

- **25%** Reduction in physician office spending
- **18%** Reduction in ED spending

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- **20%** Increase in bad debt among Minnesota Hospital Association Members, 2014-2016

Our Leadership Challenge

Delivery System Transformation Central to Future Success

- **Rebuild Health System**
  - Unsustainable fixed costs
  - Insufficient scale, market relevance
  - Unrealized system advantages

- **Transform Care Delivery Model**
  - Continued site-of-care shifts
  - Greater total cost of care accountability

- **Reduce Cost of Operations**
  - Outsized pharma cost growth
  - Rapid workforce growth

**Value Potential**

**Time**

**High**

**Low**

**Near-Term**

**Long-Term**

Labor and workforce costs

**Labor Force Reaches Unprecedented Heights**

Job Growth Rises to Meet Demands of Reform, Coverage Expansion

**Hospital Jobs in Millions, By Year**

More people—15.5 million—now work in health care than live in the state of Ohio...

-Based on job numbers, no sector is healthier than health care."

*Politico*
Competition for Physician Assets Heating Up

Physicians Have Growing Number of Alternatives to Employment

Four Main Alternatives to Health System Employment

1. Large Independent Groups
   - 25%
   - Growth in median medical group size, 2013-2015
   - 35%
   - Physicians currently part of a group of 100 or more

2. National Practice Companies
   - Privia Medical Group
   - Common investment duration for private equity firm
   - $400M Venture investment in Privia for care delivery innovation, primary care expansion, 2016

3. Private Equity Firms
   - 3-5 years
   - $250M Invested by equity firm Summit Partners in DuPage Medical Group, a 459 physician multispecialty group in Illinois

4. Health Plans
   - 75%
   - Markets for which United subsidiary Optum aims to provide primary care and ambulatory services
   - 40%
   - Surveyed independent groups who reported interest in acquisition by health plans


Providers Move Up the Value Chain

But Health Plan Ownership Entails Distinct Challenges

Growth in PSHP¹ Enrollment

Millions

<table>
<thead>
<tr>
<th>Year</th>
<th>Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>12.4</td>
</tr>
<tr>
<td>2011</td>
<td>12.7</td>
</tr>
<tr>
<td>2012</td>
<td>12.9</td>
</tr>
<tr>
<td>2013</td>
<td>13.7</td>
</tr>
<tr>
<td>2014</td>
<td>15.3</td>
</tr>
</tbody>
</table>

Far From a Slam-Dunk Investment

Modern Healthcare

“Health Systems With Insurance Operations Stumble in 2015”

Catholic Health Initiatives

“Catholic Health Initiatives to Divest Health Plan Operations”

Neighborhood Health Plan

“Neighborhood Health Plan Batters Partners HealthCare’s Finances in 2014”

Mountain States Terminating CrestPoint Health Insurance Plans for Employees, Medicare Advantage”

¹) Provider sponsored health plan.

Risk Demands Substantial Scale

Benchmarks Heard in the Research

<table>
<thead>
<tr>
<th>Absolute minimum population size to transition risk contract to downside risk, depending on risk tolerance of organization</th>
<th>Minimum population size required to ensure baseline viability of a provider-sponsored health plan</th>
<th>Target population size to ensure consistent profitability and market relevance of a provider-sponsored health plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,000-5,000</td>
<td>40,000-50,000</td>
<td>100,000-250,000</td>
</tr>
</tbody>
</table>

1) Based on 15.66% of anticipated annual health expenditures; assumes annual per-capita health expenditure of $5,141.

136,336
Average enrollment in core line of business for 25 highest-performing PSHPs

10%
Average market share in core line of business for 25 top-performing PSHPs

$329M
Minimum risk-based capital for 250,000-member provider sponsored health plan


Rebuild Health System

No Shortage of M&A Activity

Providers Actively Building Scale Through Consolidation

Hospital M&A Activity

<table>
<thead>
<tr>
<th>Total Deal Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>66</td>
</tr>
</tbody>
</table>

Number of Hospitals Part of a Health System

| 2,716 | 3,198 |
| 2005 | 2015 |

Not Exactly Delivering on the Value Proposition

Horizontal, Vertical Consolidation Have Added Cost to the System

Reduced Hospital Competition Significantly Correlated with Increased Price

Percent Increase in Hospital Price Compared to Markets with Four or More Hospitals

<table>
<thead>
<tr>
<th>One Hospital</th>
<th>Two Hospitals</th>
<th>Three Hospitals</th>
</tr>
</thead>
<tbody>
<tr>
<td>$2,000</td>
<td>$1,450</td>
<td>$2,000</td>
</tr>
<tr>
<td>15%</td>
<td>6%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Physician-Hospital Integration also Driving Up Prices

Physicians Practice Prices Increase After Health System Acquisition

<table>
<thead>
<tr>
<th>Primary Care Physicians</th>
<th>Specialists (e.g. Cardiologists)</th>
<th>Average Price Increase per Patient per Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>12%</td>
<td>34%</td>
<td>$1,450</td>
</tr>
</tbody>
</table>


Online Marketplaces Flourishing

New Exchanges Enabling Consumers to Shop for Range of Services

Consumer-Oriented Marketplaces Span a Variety of Health Care Needs

Honor

Connects home health professionals with seniors in need of care

Funded by $20M in venture capital investment

Amwell

Offers on-demand telemedicine via video or phone to serve needs including urgent care, therapy, and chronic care management

Reported 100% total growth in visits in 2015

ZendyHealth

Allows consumers to shop based on their own preferred price for bundled procedural episodes

80% of consumer proposed prices are accepted within two days

MediBid

Brings patients options for high-end surgeries through an online marketplace in which they can bid for care

Typically offers a 50% average discount over insurance-negotiated prices

Innovations Crowding Onto the Field

Disruptive Services and Tech for Consumer Use (Existing and In Development)

**Inexpensive, rapid care at a ‘provider’ site**

- SmartChoice MRI
- Right Care
- PediaQ
- Mend
- OrthoNow

**Retail Clinics**
- Walgreens
- CVS Health
- Wal-Mart

**Physician hailing**
- Pager.com
- Heal
- Dispatch Health
- MedZed (pediatric house calls)

**Remote diagnosis and link to clinicians**
- Opternative: iPhone eye exam, e-mail RX
- Google contact lens: glucose monitoring
- EpiWatch: predicts seizures
- MoleMapper: cancerous mole screening
- Iphone-directed walk tests, cognition, fine motor skill, tremor evaluations

**Patient apps for condition self-management**
- Iodine’s Start app: Tracks depression symptoms and drug efficacy
- OneDrop: diabetes tracker
- ACC’s Statin intolerance self-checker

25%
Consumers used a retail clinic in 2015—up from 15% in 2013

Path Forward Not Dependent on Politics

No-Regrets Priorities for Next Era of Health Care Reform

**Accessibility**
- Multi-channel navigation platform, including search, price estimation, and triage/scheduling helps streamline transactions
- Development of diverse network of access points (e.g., urgent care, retail, enhanced access to specialty care, primary care) to meet varied consumer access demands

**Reliability**
- Organization-wide commitment and investment in service delivery and quality improvement drives broad engagement in delivering superior outcomes
- High-reliability approach to both service delivery and clinical quality ensures baseline of performance

**Affordability**
- Willingness to partner with lower-cost providers offers patients affordable options, helps prevent markets from becoming overbuilt
- When markets are already overbuilt, commitment to scale back excess capacity ensures affordability in the long-term