Health Care Reform – What Role will the Hospital Play?

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In recent years, we have undertaken a number of initiatives to lay the foundation for rewarding health care providers and suppliers for the quality of care they provide by tying a portion of their Medicare payments to their performance on quality measures.

The overarching goal of these initiatives is to transform Medicare from a passive payer of claims to an active purchaser of quality health care for its beneficiaries.

- The Centers for Medicare and Medicaid Services
Healthcare reform has now been in the works for several years…

PPACA Progress

- Patient Protection and Affordable Care Act (PPACA) passed in March
  - Extended coverage for adult children up to age 26
  - Required HHS and states to review “unreasonable” premium hikes

- Pioneer ACOs launched Jan 1 as value-based care activity continues
- MA plan payments adjusted
- Supreme Court ruling impacts ACA provisions
- Value-based demonstrations continue as Medicaid bundled payment and Medicare value-based purchasing programs launch
- Additional rules on reinsurance, risk adjustment, and risk corridors released in fall
- Individual mandate, subsidies, and guarantee issue take effect
- Medicaid eligibility to expand
- Employer requirements to offer coverage take effect

Implementation Activity

- Minimum MLR requirements kicked in
- Medicare Part D “donut hole” closed

2010
- Grants for exchange planning and establishment awarded

2011
- States finalize exchange operational planning by end of 2012 – or accept federal fallback
- States define essential health benefits package

2012
- Health plans file products with state insurance commissions by midyear
- Enrollment on the exchanges begins

2013
- Rolling enrollment in the Medicare Shared Savings Program

Sources: CMS, KFF;
Momentum behind the “volume-to-value revolution” is growing – the market is demanding change.

Population Health and Lifestyle Managers rotating over $1 TN towards higher value.
Establishing a baseline: what we now know to be true

✓ 2014 is different than 1994 – those who dismiss the current value revolution as a retread of the ’90s face a rude awakening

✓ The innovation/diffusion gap is a mile wide – game changing ideas are already out there in pockets across the country

✓ There are evolutionary pathways for health systems leading to even stronger business designs than those of the past

✓ Value-based care models, which require coordinated care and focus on outcomes, are becoming increasingly common

✓ What used to be a population of patients in employer selected health plans is rapidly becoming a market of customers with a retail mindset demanding new services and experiences that are not currently abundant in the market

✓ Disruptive innovators from neighboring industries (e.g. tech and retail) are hungrily eyeing the healthcare space

✓ There is much risk and uncertainty, but also a growing industry appetite to expand the opportunity space.

✓ For action-oriented value creators the path is clear and compelling
There are three waves of transformational change reshaping healthcare...

**WAVE 1**
PATIENT-CENTERED CARE
2010-2016

**WAVE 2**
CONSUMER ENGAGEMENT
2014-2020

**WAVE 3**
SCIENCE OF PREVENTION
2018-2025

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…fueling development of new patient / consumer-centered business designs

<table>
<thead>
<tr>
<th>BUSINESS DESIGN</th>
<th>WAVE 1</th>
<th>WAVE 2</th>
<th>WAVE 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>PATIENT-CENTERED CARE</td>
<td>2010-2016</td>
<td>CONSUMER ENGAGEMENT</td>
<td>2014-2020</td>
</tr>
<tr>
<td>SCIENCE OF PREVENTION</td>
<td>2018-2025</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FROM
- Physician-centered
- Transactional, isolating
- Sick-care
- Inaccessible
- Patient turnover-volume
- Unwarranted variation

TO
- Patient-focused
- Care team managed
- Health and well-being
- Convenient and 24/7
- Patient health-value
- Evidence-based standard
Population health players are working to create tailored solutions to meet the needs of various components of the population health pyramid.

**Severe mental/neurological illness**
- **Expenditure**: $258 BN
- **Population**: 12.9 MM
- **PMPY**: $19,929

**Chronic with extensive social needs**
- **Expenditure**: $136 BN
- **Population**: 15.4 MM
- **PMPY**: $8,864

**Early stage behavioral and risk factors**
- **Expenditure**: $150 BN
- **Population**: 51.3 MM
- **PMPY**: $2,929

**Acute episodetic care**
- **Expenditure**: $255 BN
- **Population**: N/A
- **PMPY**: N/A

**Frail elder**
- **Expenditure**: $125 BN
- **Population**: 7.7 MM
- **PMPY**: $16,433

**Poly-chronic/complex**
- **Expenditure**: $334 BN
- **Population**: 29.0 MM
- **PMPY**: $11,506

**Early stage chronic**
- **Expenditure**: $80 BN
- **Population**: 18.1 MM
- **PMPY**: $4,418

**End of life/long-term care**
- **Expenditure**: $158 BN
- **Population**: 4.7 MM
- **PMPY**: $33,259

**General healthy**
- **Expenditure**: $185 BN
- **Population**: 121.7 MM
- **PMPY**: $1,520
The top 5% of spenders drive 45%-50% of total medical spend and are the major utilizers of both emergency room and inpatient services.

Cumulative medical spend

Average 2012 PMPY by percentile

<table>
<thead>
<tr>
<th></th>
<th>1st percentile</th>
<th>2nd percentile</th>
<th>3rd percentile</th>
<th>4th percentile</th>
<th>5th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Commercial</strong>&lt;sup&gt;1&lt;/sup&gt;</td>
<td>$128k</td>
<td>$46k</td>
<td>$32k</td>
<td>$26k</td>
<td>$21k</td>
</tr>
<tr>
<td><strong>Medicare</strong>&lt;sup&gt;2&lt;/sup&gt;</td>
<td>$207K</td>
<td>$118k</td>
<td>$93k</td>
<td>$78k</td>
<td>$68k</td>
</tr>
</tbody>
</table>

Source: Commercial Sample – MarketScan Commercial claims data; Medicare Sample – Medicare 5% sample.
Note: Only those Medicare patients with both Parts A and B were included in the analysis. 1. Trended to 2012 using 7% annual inflation rate. 2. Trended to 2012 using 5% annual inflation rate; just Medicare Parts A and B, no Rx spend included.
Managing these complex patients to improved outcomes involves a very different type of care coordination, care management, and care delivery.
This has significant implications for sites and types of services being consumed...

<table>
<thead>
<tr>
<th>Primary Care</th>
<th>Specialists</th>
<th>Emergency</th>
<th>Ambulatory</th>
<th>Hospital</th>
<th>Post-Acute</th>
<th>R(x)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current fee for service silos</td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
</tr>
<tr>
<td>Integrated episode, condition and disease ecosystems</td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
</tr>
<tr>
<td>Population health and condition management</td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
<td><img src="image" alt="Diagram" /></td>
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</tbody>
</table>
...and will create winners and losers in the process; hospitals and surgical specialists stand to lose the most relative to today’s FFS model.

Impact of care models on medical expenditures

- **$2.0 T**: Current expenditures
- **$1.7 T**: Future expenditures with care models
- % Change: (15%)
- **Legend**
  - Hospitals
  - PCP
  - Medical specialists
  - Nursing home/home health
  - Rx
  - Med equip & non-durable med prod.

Impact of care models on physician specialties

- **$597 B**: Current expenditures
- **$574 B**: Future expenditures with care models
- **Types of Physicians**
  - Gen surg.
  - Cardiology
  - CV surgery
  - Cardio int.
  - Orthopedic surg
  - Gastroent.
  - OB/GYN
  - ER medicine
  - Neurology
  - ENT
  - Cardiologist
  - Endocrinologist
  - Oncology
  - Pulmonology
  - Internal medicine
  - Pediatrics

1 Excludes other non-IHM spend (e.g., private insurance, dental, gov't) which represent $0.3T in spend and are not impacted by care models.

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The impact a population health manager can deliver: CareMore outcomes

1. 40,000 Members in 2010 (20% chronically ill)
2. 7 Different programs for different needs
3. 80% Reduction in amputations
4. 56% Reduction in CHF readmissions
5. 50 Decrease in mental health hospitalizations
6. 30% Fewer bed days per 1,000 patients (1,016 vs. 1,450)
7. 7x Amount healthcare costs skyrocket in last year of life
8. 10% → 60% Improvement in % of patients that die at home
9. 80% Members who have referred friends
10. >95% Year-to-year retention

CareMore’s per person medical costs are 20% lower than other health Insurers with a 70% loss ratio, competitive premiums and richer benefits

These successes drove WellPoint to acquire CareMore for $800 million

Note: CareMore’s medical loss ratio is 68%, vs. industry average of ~85%

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What does this mean for hospitals?
Hospitals must play “value offense” to thrive

Health system options palette
Over time the hospital is likely to become a cost center or service provider to disease and population managers

<table>
<thead>
<tr>
<th>Time</th>
<th>Profit</th>
<th>FFS dominant</th>
<th>FFV dominant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DO NOTHING</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Today – (2014-2015)</td>
<td></td>
<td>Reducing fixed costs</td>
<td>Shift to value-based models and assume clinical risk</td>
</tr>
<tr>
<td>Today – (Ongoing)</td>
<td></td>
<td>Aggressively manage variable costs</td>
<td>Consolidate and integrate</td>
</tr>
<tr>
<td>Long-term – (2015+)</td>
<td></td>
<td></td>
<td>Productize and compete on value</td>
</tr>
</tbody>
</table>
While fee-for-value (FFV) is the ultimate goal, most hospitals are still early in the journey and require approaches to efficiency enhancement that are beneficial under both FFS and FFV models.

### Provider Migration to Value

<table>
<thead>
<tr>
<th>FFS Model</th>
<th>Intersection of FFS and Value</th>
<th>FFV Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit cost</td>
<td>Episode cost</td>
<td>Total cost of care</td>
</tr>
<tr>
<td>Reactive care delivery</td>
<td>Aggressive management</td>
<td>Prevention</td>
</tr>
<tr>
<td>Transaction model</td>
<td>Coordinated care model</td>
<td>Outcomes model</td>
</tr>
<tr>
<td>Quantity focus</td>
<td>Performance and efficiency focus</td>
<td>Quality focus</td>
</tr>
<tr>
<td>Provider discretion</td>
<td>Pathways</td>
<td>Protocols</td>
</tr>
<tr>
<td>Individual provider efficiency</td>
<td>Collective efficiency across care continuum</td>
<td>True patient-centered care</td>
</tr>
<tr>
<td>Volume-driven payment</td>
<td>Bundled payment</td>
<td>Full population risk</td>
</tr>
</tbody>
</table>

**FFS Model Intersection of FFS and Value**
- Provides immediate FFS impact, but diminished returns in repeated iterations
- Positions the organization for the future while favorably impacting performance today
- Enhances position for future FFV model, but hurts FFS business

**FFV Model**
- Total cost of care
- Prevention
- Outcomes model
- Quality focus
- Protocols
- True patient-centered care
- Full population risk
In a value-based world, providers have a range of options of where to play

### Value-based delivery offerings

<table>
<thead>
<tr>
<th>Product</th>
<th>Pop’n Health Mgr.</th>
<th>Condition Manager</th>
<th>Episodic Manager</th>
<th>Fee-for-Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A superior holistic patient experience that delivers better outcomes, lower cost through engagement and care coordination</td>
<td>An EBM care experience that engages/steers complex &amp; chronic patients to cost &amp; quality endpoints</td>
<td>A comprehensive care experience oriented to deliver a high quality outcome at a defined price point</td>
<td>Execution of an activity for a designated patient with differentiation based on service efficiency, integration</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Price</th>
<th>Risk adjusted, PMPM reimbursement with performance incentives</th>
<th>Risk adjusted, PMPM reimbursement with performance incentives</th>
<th>Risk adjusted bundled payment</th>
<th>Fee-for-service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>Distribution options: • Direct to market (ER, Indiv.) • ACO • Traditional Payer</td>
<td>Distribution options: • Pop’n Hlth. Mgr. • ACO • Traditional payer</td>
<td>Distribution options: • Condition Mgr. • Pop’n Hlth. Mgr. • ACO • Traditional payer</td>
<td>Distribution options: • Episodic Mgr. • Condition Mgr. • Pop’n Hlth. Mgr. • ACO, trad’l payer</td>
</tr>
<tr>
<td>Promotion</td>
<td>Patient experience, outcomes and value-oriented branding Sub-brand of Payer, ACO</td>
<td>Patient experience, outcomes and value-oriented branding</td>
<td>Patient experience, outcomes and value-oriented branding</td>
<td>Consumer-focused emotional and/or credential-based branding</td>
</tr>
</tbody>
</table>
The challenge for today’s health systems involves carefully balancing clinical transformation with shifts into risk and population management.

New risk contracts fail to return significant margins without clinical transformation.

Clinical transformation allows value creation to accrue predominantly to the payer.

Optimal value creation and value capture.
Retailers, payers and wellness companies are increasingly focusing on the bottom of the pyramid while providers dominate the top... for now
Six BIG questions
every health system leader should be considering
1. Are we playing offense or defense?
2. Do we know where our capability gaps are and how to close them?

Do we know what the most important value-added activities are?

Are we ruthlessly objective about what will take?

- Delivered via ecosystem
- Open architecture
- Relentless innovator
- Information enabled and predictive
- Total health and wellness focus
- Always engaged
- 100% available and social
- Magnetic for consumer
- Superior results
- Strong brand
- Culture centered around a service mentality
- Vibrancy
3. Do we really have the consumer in focus?

1. Scope and scale of consumer engagement?

2. Value and power of the integrated consumer value chain – 1 + 1 = ?

3. Likely value chain organizers – what will it take – who will be trusted?

4. Dimensions of competition – anywhere, anytime, personalized?

5. Role of health status and benefits coverage in shaping value chain leadership?
4. Are we prepared to play in a multi-chain world?

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solo-sport orientation</td>
<td>Ecosystem-based</td>
</tr>
<tr>
<td>Wholesale</td>
<td>Retail</td>
</tr>
<tr>
<td>Sickness</td>
<td>Total health &amp; wellness</td>
</tr>
<tr>
<td>Reactive</td>
<td>Predictive/preventative</td>
</tr>
<tr>
<td>Body part or diagnostic code</td>
<td>Whole person</td>
</tr>
<tr>
<td>Physical</td>
<td>Virtual/anywhere/real-time</td>
</tr>
<tr>
<td>Transactional</td>
<td>Relational</td>
</tr>
<tr>
<td>One-size-fits-all</td>
<td>Personalized</td>
</tr>
<tr>
<td>Opaque</td>
<td>Transparent</td>
</tr>
<tr>
<td>Individual/expert</td>
<td>Crowd</td>
</tr>
</tbody>
</table>

My value chain

Collaborative consumer value chain
5. Have we really considered the compete or converge question?

Extra-industry players

Health retailers and e-retailers

Tech, consumer goods and services

Race to capitalize on higher value consumer relationships

Traditional healthcare players

Providers

Health plans
6. Are we moving fast enough?

The leader advantage is expanding, fueled by new technology, capital markets, and hare earned lessons.

Today-player questions

- Is the cost of inaction on the rise?
- Is there an inflection point where we can’t catch up to the leaders of the pack?
- If one of these models entered our markets, could we respond?
Key Takeaways
Consumers are value-starved …

**Access**
- I can get care anytime, anywhere – issues get caught early
- I was able to afford a plan that meets my needs
- I can easily find the lowest cost, highest value options

**Affordability**
- I no longer find dealing with healthcare so aggravating
- I am able to connect with others who have interests/issues like mine
- I can make better health decisions thanks to easy data access

**Information**
- Reward programs keep me motivated and help keep coverage affordable
- My wages are higher since my employer’s health costs are lower
- I understand how much coverage my family and I need

**Transparency**
- I have a clear plan for improving my health
- I am the biggest driver of my health and understand the benefits of being proactive
- I no longer forget to take medications or to get screenings

**Professional**
- Life needs/hassles
- I no longer find dealing with healthcare so aggravating
- I am able to connect with others who have interests/issues like mine

**Emotional**
- I no longer find dealing with healthcare so aggravating
- I can make better health decisions thanks to easy data access
- Information

**Social**
- I can get care anytime, anywhere – issues get caught early
- I was able to afford a plan that meets my needs
- I can easily find the lowest cost, highest value options

**Health needs/hassles**
- I have a clear plan for improving my health
- I am the biggest driver of my health and understand the benefits of being proactive
- I no longer forget to take medications or to get screenings

**Health Improvement**
- I no longer find dealing with healthcare so aggravating
- I can make better health decisions thanks to easy data access
- Information

**System needs/hassles**
- I can get care anytime, anywhere – issues get caught early
- I was able to afford a plan that meets my needs
- I can easily find the lowest cost, highest value options
… the opportunity map is large and compelling
… the solution landscape is robust and but remains unorganized

<table>
<thead>
<tr>
<th>Example enablers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail Clinics</td>
<td>Health clinics located in convenient retail locations that treat minor illnesses and provide preventative health care services</td>
</tr>
<tr>
<td>Virtual Care</td>
<td>Delivery of professional healthcare services through online channels</td>
</tr>
<tr>
<td>Monitoring Devices</td>
<td>Tools that monitor consumer activities and biometrics in a more real-time environment</td>
</tr>
<tr>
<td>Navigators/Advisors</td>
<td>Resources who become consumer advocates, helping them interact with the healthcare system and its constituents in an efficient, organized manner</td>
</tr>
<tr>
<td>Wellness Programs</td>
<td>Programs constructed to encourage behavior change/reinforcement (e.g., smoking cessation, fitness, nutrition, diabetes management, etc.)</td>
</tr>
<tr>
<td>Health Content</td>
<td>Providing consumers content pertinent to their health and wellness needs</td>
</tr>
<tr>
<td>Gamification</td>
<td>Creation of games and competition where objectives include motivating consumer to perform activities that benefit their health</td>
</tr>
<tr>
<td>Social Networks</td>
<td>Making the consumer a part of a larger group or support system – connecting them to similar types of consumers or special interests</td>
</tr>
<tr>
<td>Reminders/Engagers</td>
<td>Tools that assist consumers in remembering when and how to engage in their healthcare</td>
</tr>
<tr>
<td>Rewards/Incentives</td>
<td>Ability to reinforce consumer actions through positive incentives and negative disincentives</td>
</tr>
</tbody>
</table>
Population health managers are growing at the expense today’s FFS profit centers

**Outlook for traditional players in a value-based population management ecosystem**

<table>
<thead>
<tr>
<th>Service</th>
<th>Outlook</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>↓↓</td>
</tr>
<tr>
<td>Outpatient</td>
<td>↓↓</td>
</tr>
<tr>
<td>Emergency Department</td>
<td>↓↓</td>
</tr>
<tr>
<td>Retail</td>
<td>↑↑↓</td>
</tr>
<tr>
<td>Primary care hubs</td>
<td>↑↑</td>
</tr>
<tr>
<td>Direct primary care</td>
<td>↑</td>
</tr>
<tr>
<td>Virtual web based health models</td>
<td>↑↑</td>
</tr>
<tr>
<td>Convenient care clinics</td>
<td>↑↑↓</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>↓</td>
</tr>
<tr>
<td>Specialty care offices</td>
<td>↓</td>
</tr>
<tr>
<td>Ambulatory center</td>
<td>↑</td>
</tr>
<tr>
<td>LTC facilities</td>
<td>↑</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>↑↑</td>
</tr>
<tr>
<td>Home health care</td>
<td>↑↑</td>
</tr>
</tbody>
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**TO**
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- Patient health-value
- Evidence-based standard
Across the country, innovative care models have been successfully implemented, and are delivering significant savings and improved outcomes.

<table>
<thead>
<tr>
<th>Organization</th>
<th>Program</th>
<th>Description</th>
<th>Savings / Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>HealthPartners</td>
<td>Patient Centric Medical Homes</td>
<td>Implementation involved care management through phone, computer &amp; face-to-face coaching as well as increased access to PCP</td>
<td>• 8% of total cost savings over 4 years&lt;br&gt;• 20% cost savings for behavioral patients over 4 years</td>
</tr>
<tr>
<td>CareMore</td>
<td>Extensivist</td>
<td>Medical &quot;Extensivists&quot; Care for High-Acuity Patients across Settings leading to reduced hospital use</td>
<td>• MLR performance in the 65-70% range&lt;br&gt;• 56% reduction in CHF hospitalizations&lt;br&gt;• 30% fewer bed days per 1,000 patients&lt;br&gt;• 50% fewer mental health hospitalizations&lt;br&gt;• 50% reduction in ESRD hospital admissions in 5 months</td>
</tr>
<tr>
<td>Cigna</td>
<td>Diabetes Disease Management</td>
<td>Patient-focused disease management plan including telephonic coaching, mailings and remote monitoring</td>
<td>• 24.7% reduction in total costs over one year&lt;br&gt;• PMPM costs decreased from $554 to $417</td>
</tr>
<tr>
<td>Healthways</td>
<td>High-Risk Population Health</td>
<td>Multi-component intervention involving identification of high risk members, clinical/psychosocial approach, and internet-enhanced care coordination</td>
<td>• 35.7% reduction in PMPM expenses (not including drugs) over 1 year</td>
</tr>
<tr>
<td>Boeing</td>
<td>Intensive Outpatient Care Program</td>
<td>Employees with multiple severe health conditions were matched with physicians and nurses who communicated and coached with them on all aspects of their conditions</td>
<td>• 20% cost savings due to fewer hospitalization and ER visits over 2.5 years</td>
</tr>
</tbody>
</table>

Sources: 1) Health Partners; 2) Oliver Wyman; 3) The Everett Clinic