THE ECONOMICS OF CHANGE:
CHALLENGES AND OPPORTUNITIES

Ian Morrison PhD

www.ianmorrison.com

Twitter@seccurve
BIG POTENTIAL

Smile: It’s Contagious

Not Survival of the Fittest. Survival of the Best Fit

Get Linked to the Right People
“Light up Together”
The Power of Inclusion
WISDOM FROM GERGEN

• Major Uncertainties and Economic Challenges (especially the Deficit and Debt)
• International Challenges
  – American Leadership in the Post World War II Order
  – Syria, North Korea and Iran will come to a head soon
  – Global Trade Wars in the offing
• The Trump Factor
  – “Moral Tone for the Country”
  – Wide range of possibilities but President will likely be there until 2020
  – Elections Matter
• Hope for the Future and Help is on The Way
  – Macron, Trudeau
  – Women Ascendant in Political Leadership
  – Veterans: Modest, Brave, Patriotic, Bipartisan, Disciplined and Moderate
OUTLINE

• The Economics of Change: Challenges and Opportunities
  – Political and Policy Uncertainty
  – Unaffordability for Business, Government and Households
  – Scale, Consolidation and Disruption
• Strategic Implications
POLITICAL AND POLICY UNCERTAINTY
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

SOURCE: Axios interpretation of KFF data, July 2017
### Top Half Of The Income Distribution Are Mostly Privately Insured, Bottom Half Are Mostly Publicly Insured, 2015

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Number of Households (millions)</th>
<th>Any Health Insurance (percent)</th>
<th>Private Health Insurance (percent)</th>
<th>Government Health Insurance (percent)</th>
<th>Uninsured (percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than $25,000</td>
<td>52.0</td>
<td>85.2%</td>
<td>30.8%</td>
<td>66.6%</td>
<td>14.8%</td>
</tr>
<tr>
<td>$25,000-49,999</td>
<td>65.3</td>
<td>87.5%</td>
<td>53.2%</td>
<td>50.8%</td>
<td>12.5%</td>
</tr>
<tr>
<td>$50,000-$74,999</td>
<td>55.1</td>
<td>90.4%</td>
<td>70.4%</td>
<td>34.6%</td>
<td>9.6%</td>
</tr>
<tr>
<td>$75,000-$99,999</td>
<td>43.1</td>
<td>92.7%</td>
<td>79.7%</td>
<td>27.2%</td>
<td>7.3%</td>
</tr>
<tr>
<td>$100,000 or more</td>
<td>103.3</td>
<td>95.5%</td>
<td>87.4%</td>
<td>19.1%</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

**SOURCE:** US Census Bureau, cited in Federal Reserve, 2017
Percentage of U.S. Adults Without Health Insurance, 2008-2017

- **Mar 2010**: ACA signed into law
- **Oct 2013**: ACA exchanges open
- **Jan 2014**: Individual mandate takes effect; Medicaid expanded in 24 states and D.C.
- **Apr 2014 - Jul 2016**: Medicaid expanded in 7 more states
- **Nov 2016**: Trump elected, promises to “repeal and replace” ACA
- **Jul 2017**: GOP-lead attempt at “skinny” repeal of ACA fails

Gallup-Sharecare Well-Being Index
STATES THAT EXPANDED MEDICAID SAW THE GREATEST REDUCTIONS IN UNINSURED LOW-INCOME ADULTS AGES 19–64

Notes: Low-income defined as living in a household with income <200% of the federal poverty level. States are arranged in rank order based on their current data year (2016) value. Louisiana expanded its Medicaid program after January 1, 2016. For the purposes of this exhibit, we count the District of Columbia as a state.

Data source: U.S. Census Bureau, 2013 and 2016 1-Year American Community Surveys, Public Use Micro Sample (ACS PUMS).

NOTES: Coverage under the Medicaid expansion became effective January 1, 2014 in all but seven expansion states: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2016), and Louisiana (7/1/2016). Seven states that will have Republican governors as of January 2017 originally implemented expansion under Democratic governors (AR, IL, KY, MA, MD, NH, VT), and one state has a Democratic governor but originally implemented expansion under a Republican governor (PA). *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers.
PAYMENT TO COST RATIO (ILLUSTRATIVE)

Source: Morrison Estimates, in other words a good guess
PAYMENT TO COST RATIO (ILLUSTRATIVE)

Source: Morrison Estimates, in other words a good guess
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.

(1) Includes Medicaid Disproportionate Share payments.
(2) Includes Medicare Disproportionate Share payments.
A POLARIZED ELECTORATE: BECOMING MORE POLAR

The 2017 political typology: Anchored by Core Conservatives, Solid Liberals

Typology groups as a percentage of ... (%)

<table>
<thead>
<tr>
<th>Group</th>
<th>General public</th>
<th>Registered voters</th>
<th>Politically engaged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Core Conservatives</td>
<td>13</td>
<td>15</td>
<td>20</td>
</tr>
<tr>
<td>Country First Conserves</td>
<td>6</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Market Skeptic Reps</td>
<td>12</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>New Era Enterprisers</td>
<td>11</td>
<td>11</td>
<td>9</td>
</tr>
<tr>
<td>Bystanders</td>
<td>8</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>Devout and Diverse</td>
<td>9</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Disaffected Democrats</td>
<td>14</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Opportunity Democrats</td>
<td>12</td>
<td>13</td>
<td>13</td>
</tr>
<tr>
<td>Solid Liberals</td>
<td>16</td>
<td>19</td>
<td>25</td>
</tr>
</tbody>
</table>

Strong approval for Trump in the two conservative groups; nearly all Solid Liberals strongly disapprove

% who ____ of the job Donald Trump is doing as president

Source: Survey conducted June 8-18 and June 27-July 9, 2017.
PEW RESEARCH CENTER
THE PARTISAN DIVIDE ON HEALTHCARE

Figure 3:
Voters' Evaluations of How Well the ACA is Working

Source: Harvard/Politico October 2016
Figure 12

Majority of Trump Voters Have Favorable Opinion of Many ACA Provisions

AMONG TRUMP VOTERS: Percent who favor each of the following specific elements of the health care law:

- Allows young adults to stay on their parents’ insurance plans until age 26: 83%
- Eliminates out-of-pocket costs for many preventive services: 75%
- Creates health insurance exchanges where small businesses and people can shop for insurance and compare prices and benefits: 72%
- Closes the Medicare prescription drug coverage gap: 71%
- Provides financial help to low- and moderate-income Americans to help them purchase coverage: 68%
- Gives states the option of expanding their existing Medicaid program to cover more low-income, uninsured adults: 66%
- Increases Medicare payroll tax on earnings for upper-income Americans: 62%
- Prohibits insurance companies from denying coverage because of a person’s medical history: 60%
- Requires employers with 50 or more employees to pay a fine if they don’t offer health insurance: 49%
- Requires nearly all Americans to have health insurance or else pay a fine: 16%

NOTE: Some items asked of half samples. Question wording abbreviated. See topline for full question wording.
SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted November 15-21, 2016)
Over Half of the Public Holds a Favorable View of the ACA, Marking the Highest Level of Favorability Measured Since 2010

As you may know a health reform bill was signed into law in 2010, known commonly as the Affordable Care Act or Obamacare. Given what you know about the health reform law, do you have a generally favorable or generally unfavorable opinion of it?

SOURCE: Kaiser Family Foundation Health Tracking Polls
Health Care Is A “Budget Buster” At The Federal Level

Where the Costs Are
Social Security and Medicare as a share of GDP are growing much more rapidly than Medicaid, which would actually fall under the Senate proposal.

*Includes refundable tax credits, food stamps, welfare, veterans pensions, and the Trouble Asset Relief Program; excludes ACA subsidies and Children's Health Insurance Program Sources: Congressional Budget Office; Committee for a Responsible Federal Budget (Medicaid estimates)
Before Repeal and Replace: Medicaid Projected to Reach 110 Million

Projected Medicaid Enrollment

Past and Projected Numbers of Medicaid Enrollees by Category, 2000-2026

SOURCE: LP Analysis based on Medicaid Spending and Enrollment Detail for CBO’s March 2016 Baseline.
Note: Enrollment numbers are “total ever enrolled.”
REPUBLICAN REFORM PRINCIPLES

• Make Consumers Responsible
• Make States Responsible
• Make Price and Quality Transparent
• Make Insurance Cheaper
• Make it More Market Oriented with Less Regulations
• Make Medicare Modern (Maybe Later)
• Make Medicaid a Managed Care Program
• Make the Deficit and Debt Go Down
• But........Don’t get Rid of Guaranteed Issuance
• And don’t throw 20 million off the insurance rolls
MAKE INSURANCE CHEAPER

• Cheaper for whom?
• More competition, maybe....
• Get Rid of the Lines
• But the key is what is covered and how much providers are paid
• State High Risk Pools Cut off the tail of high spenders a tiny little bit but at a high cost
• Change the Essential Benefits to “Remove the Frills”
• Lower the Actuarial Value of the Plans
• Change the Age Bands
• Remove Guaranteed Issuance (This is the Big One)
• Remove Lifetime Caps
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

Guaranteed Issuance

Subsidies to Medicaid and Exchanges

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
• Use Executive Orders
  – Association Health Plans
  – “Across State Lines”
  – 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 in Tax Reform
• Don’t enforce the Law
• “The Secretary shall”.....Maybe Not
• Waiver Authority to states
  – Fees for Medicaid
  – Work Requirements
  – Short term plans
  – Essential Benefits/Life time Caps?
• New DHHS Head
• Position this as Repeal and Replace, short term
• Go for Block Grants long term
• Irony: 2018 Signups went well 12.2 million and 80% can get plans for less than $75 per month, 11 million will effectuate

Sources: Charles Gaba ACA Signups, @Aslavitt, Leavitt Partners
## Medicaid Expansion Matters: Some Did, Some Didn’t and Among Those Who Did Some Red Some Blue

<table>
<thead>
<tr>
<th>State</th>
<th>Population</th>
<th>Medicaid Pre ACA</th>
<th>Medicaid Post ACA November 2017</th>
<th>Exchange Enrollment 2018 Paid QHP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oklahoma</td>
<td>3,921,000</td>
<td>790,051</td>
<td>793,326</td>
<td>131,657</td>
</tr>
<tr>
<td>Nebraska</td>
<td>1,876,100</td>
<td>244,600</td>
<td>240,981</td>
<td>75,934</td>
</tr>
<tr>
<td>Kansas</td>
<td>2,865,000</td>
<td>378,160</td>
<td>387,500</td>
<td>88,902</td>
</tr>
<tr>
<td>Arkansas</td>
<td>2,945,300</td>
<td>556,851</td>
<td>905,869</td>
<td>63,364</td>
</tr>
<tr>
<td>Colorado</td>
<td>5,509,200</td>
<td>783,420</td>
<td>1,352,546</td>
<td>155,125</td>
</tr>
<tr>
<td>Arizona</td>
<td>6,890,200</td>
<td>1,201,770</td>
<td>1,728,003</td>
<td>155,125</td>
</tr>
</tbody>
</table>

Source: Charles Gaba ACA Signups, 2018 and KFF 2018
A quarter of all newly insured in the US are Californians.

California received $20 billion per year of net new federal money ($15 billion for Medicaid expansion, $5 billion in exchange subsidies) these numbers are growing each year.

Roughly a third of Californians are on Medi-Cal (40% in LA County, over 50% in much of the Central Valley).

California has maxed out Medicaid matching dollars using provider taxes and waivers.

Currently 65% of Medicaid is paid by the Federal government (historically that was less than 50%).

California has about the lowest rate of provider reimbursement for Medicaid.

Kaiser has doubled its Medicaid enrollment program wide since 2013 to 942,000 (up from 377,000 to 709,000 in California alone).

In California 40% price differential North to South on commercial rates.

HMO higher performing on Value than PPO.

Medical groups are key to value.

Covered California is the highest functioning exchange in the country, but dependent on the flow of federal dollars for subsidies.

Sources: KFF, CHCF, Covered California 2017, Kaiser Permanente
Primary Care Physicians and Specialists
by California Region, 2015

<table>
<thead>
<tr>
<th>Region</th>
<th>PCPs</th>
<th>Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inland Empire</td>
<td>35</td>
<td>64</td>
</tr>
<tr>
<td>San Joaquin Valley</td>
<td>47</td>
<td>76</td>
</tr>
<tr>
<td>Northern and Sierra</td>
<td>50</td>
<td>108</td>
</tr>
<tr>
<td>Central Coast</td>
<td>52</td>
<td>110</td>
</tr>
<tr>
<td>Orange County</td>
<td>48</td>
<td>112</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>54</td>
<td>113</td>
</tr>
<tr>
<td>San Diego Area</td>
<td>50</td>
<td>112</td>
</tr>
<tr>
<td>Sacramento Area</td>
<td>64</td>
<td>138</td>
</tr>
<tr>
<td>Greater Bay Area</td>
<td>50</td>
<td>104</td>
</tr>
<tr>
<td>California</td>
<td>50</td>
<td>104</td>
</tr>
</tbody>
</table>

*The Council on Graduate Medical Education (COGME), part of the U.S. Department of Health and Human Services, studies physician workforce trends and needs. COGME rates include estimates of nonphysician practitioners (NPs) and other specialists.*

Physicians, by Practice Setting and Region
California, 2015

<table>
<thead>
<tr>
<th>Region</th>
<th>Solo</th>
<th>Small/Medium Group</th>
<th>Large Group</th>
<th>Kaiser</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Central Coast</td>
<td>34%</td>
<td>45%</td>
<td>13%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Greater Bay Area</td>
<td>21%</td>
<td>27%</td>
<td>24%</td>
<td>17%</td>
<td>11%</td>
</tr>
<tr>
<td>Inland Empire</td>
<td>26%</td>
<td>28%</td>
<td>24%</td>
<td>16%</td>
<td>69%</td>
</tr>
<tr>
<td>Los Angeles County</td>
<td>33%</td>
<td>28%</td>
<td>20%</td>
<td>13%</td>
<td>6%</td>
</tr>
<tr>
<td>Northern and Sierra</td>
<td>30%</td>
<td>99%</td>
<td>15%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Orange County</td>
<td>36%</td>
<td>38%</td>
<td>15%</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>Sacramento Area</td>
<td>14%</td>
<td>34%</td>
<td>20%</td>
<td>5%</td>
<td></td>
</tr>
<tr>
<td>San Diego Area</td>
<td>23%</td>
<td>31%</td>
<td>24%</td>
<td>9%</td>
<td>12%</td>
</tr>
<tr>
<td>San Joaquin Valley</td>
<td>24%</td>
<td>42%</td>
<td>14%</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>California</td>
<td>27%</td>
<td>31%</td>
<td>21%</td>
<td>13%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Notes: Data include active MDs providing at least 30 hours of patient care per week, and are based on a supplemental survey that elicited responses from 10% (approximately 1,300) of the active patient care physicians whose licenses are due for renewal between March 2015 and December 2015. Percentages are percentages of physicians who provided a practice type. Small/Medium Group excludes all practices with no more than 10 physicians, excluding Kaiser Permanente. Other includes community clinics, public, tribal, rural clinics, military facilities, VA medical centers, and other settings. One percent of respondents to the supplemental survey did not provide a practice setting.

Source: Advisory Supplemental Survey (private tabulation), Medical Board of California, 2015.
WHAT MAY NOT CHANGE AS MUCH:
PAYMENT AND DELIVERY REFORM

- Shift from volume to value
- ACOs
- MACRA
- Bundled Payments
- Payment reform in public and private sector
- Managed Medicaid, but more state flexibility
- Increased transparency on cost and quality
- Medicare Advantage growth
- Consolidation of providers (hospitals, specialists, and alternate site)
- Disruptive primary care models
- Population health and continuum of care
PAYMENT REFORM PROGRESS REPORT

• Mostly FFS with Tricks
• If providers and plans just share all the savings with each other how have you helped me as a taxpayer, a patient, and employer, or an enrollee?
• And have you advanced quality, outcomes, patient experience, provider experience or made them worse?
• Nichols reviewing Payment Models:
  – Improvement in care and cost performance takes time
  – Identifying target patients may be more important than PCMH for all (although all may eventually appreciate it some day)
  – Savings may result in unexpected places such as post-acute care
  – Bending the cost curve is hard work and requires up front investment, planning and commitment
  – Savings are still small from win-win models which may encourage policymakers to eventually seek more top down “balloon in the box” type models

UNAFFORDABILITY
SERVING SHALLOW-POCKETED CONSUMERS
FIVE DIMENSIONS OF CONSUMERISM

• Increased use of transparency and consumer navigation tools to guide choices, particularly when those choices have significant financial incentives attached, such as in narrow networks, reference pricing, high-deductible health plans, tiered benefit designs and so forth.

• Importance of consumer experience to providers and plans, both in terms of patient acquisition, retention and loyalty, as well as patient satisfaction (which increasingly carries dollars with it in terms of patient experience measures in value-based payment).

• Rising Consumer Importance of meeting consumers’ expectations (particularly tech-savvy Millennials), all of whom increasingly have ever higher expectations of service industries driven by their positive experience with high-technology–enabled consumer offerings such as Netflix, Amazon, Uber and Airbnb.

• Consumers need to be more proactive and engaged in their own health and wellness and take more personal responsibility for their health and lifestyle choices. As one doctor asked me recently, “When are the patients going to be accountable?”

• Rising out-of-pocket cost burden being placed on consumers going forward – and the battle that ensues for wallet share in the wellness, health and health care fields that are now colliding.
Average Annual Premiums for Single and Family Coverage, 1999-2017

* Estimate is statistically different from estimate for the previous year shown (p < .05).
DEDUCTIBLES CONTINUE TO RISE FOR EMPLOYER SPONSORED COVERAGE 2006-2017

Figure 7.X1
Average General Annual Health Plan Deductible for Single Coverage, By Firm Size, 2006-2017

* 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. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.
PERCENTAGE OF COVERED WORKERS ENROLLED IN A PLAN WITH A GENERAL ANNUAL DEDUCTIBLE OF $1,000 OR MORE FOR SINGLE COVERAGE, BY FIRM SIZE, 2006-2015

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

NOTE: These estimates include workers enrolled in HDHP/SOs and other plan types. Average general annual health plan deductibles for PPOs, POS plans, and HDHP/SOs are for in-network services.

MORE THAN ONE-QUARTER OF INSURED ADULTS WERE UNDERINSURED IN 2016

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

* Underinsured defined as 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.


### UNDERINSURED RATES BY SOURCE OF COVERAGE

<table>
<thead>
<tr>
<th>Percent adults ages 19–64 insured all year who were underinsured*</th>
<th>2003</th>
<th>2005</th>
<th>2010</th>
<th>2012</th>
<th>2014</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>12%</td>
<td>13%</td>
<td>22%</td>
<td>23%</td>
<td>23%</td>
<td>28%</td>
</tr>
<tr>
<td><strong>Insurance source at time of survey</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employer-provided coverage</td>
<td>10%</td>
<td>12%</td>
<td>17%</td>
<td>20%</td>
<td>20%</td>
<td>24%</td>
</tr>
<tr>
<td>Individual coverage^</td>
<td>17%</td>
<td>19%</td>
<td>37%</td>
<td>45%</td>
<td>37%</td>
<td>44%</td>
</tr>
<tr>
<td>Marketplace^^</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>—</td>
<td>44%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>22%</td>
<td>16%</td>
<td>32%</td>
<td>31%</td>
<td>22%</td>
<td>26%</td>
</tr>
<tr>
<td>Medicare (under age 65, disabled)</td>
<td>39%</td>
<td>24%</td>
<td>45%</td>
<td>32%</td>
<td>42%</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Firm size (base: full- or part-time workers with coverage through their own employer)^^^</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2–99 employees</td>
<td>—</td>
<td>14%</td>
<td>16%</td>
<td>26%</td>
<td>26%</td>
<td>22%</td>
</tr>
<tr>
<td>100 or more employees</td>
<td>—</td>
<td>11%</td>
<td>16%</td>
<td>16%</td>
<td>14%</td>
<td>22%</td>
</tr>
</tbody>
</table>

* Underinsured defined as 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. ** Adults with coverage through another source are not shown here. Respondents may have had another type of coverage at some point during the year, but had coverage for the entire previous 12 months. ^ For 2014 and 2016, includes those who get their individual coverage through the marketplace and outside of the marketplace. ^^ Adults enrolled in marketplace coverage are not shown for 2014 because no one in the sample would have had marketplace coverage for the full year. ^^^ Does not include adults who are self-employed. — Data not available.

## ADULTS WITH HIGH DEDUCTIBLES REPORTED PROBLEMS GETTING NEEDED CARE BECAUSE OF COST

### Percent adults ages 19–64 with private coverage who were insured all year

<table>
<thead>
<tr>
<th>Problem</th>
<th>No deductible</th>
<th>Deductible $3,000 or more</th>
</tr>
</thead>
<tbody>
<tr>
<td>Had a medical problem, but did not go to a doctor or clinic</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Did not fill a prescription</td>
<td>14</td>
<td>23</td>
</tr>
<tr>
<td>Skipped a medical test, treatment, or follow-up recommended by a doctor</td>
<td>8</td>
<td>32</td>
</tr>
<tr>
<td>Did not see a specialist when you or your doctor thought you needed to see one</td>
<td>5</td>
<td>20</td>
</tr>
<tr>
<td>At least one cost-related access problem</td>
<td>22</td>
<td>47</td>
</tr>
</tbody>
</table>

Data: Commonwealth Fund Biennial Health Insurance Survey (2016)

COST-RELATED ACCESS BARRIERS IN THE PAST YEAR

*Had a medical problem but did not visit doctor; skipped medical test, treatment or follow up recommended by doctor; and/or did not fill prescription or skipped doses

Source: 2016 Commonwealth Fund International Health Policy Survey
DOES SATISFACTION MATTER? COMPARED TO WHAT?

General Impression of Health Insurance
(Top-2 Box %)

Satisfaction with your insurance benefits
- 2010: 77%
- 2012: 79%
- 2013: 84%
- 2014: 81%
- 2015: 79%
- 2016: 77%

Satisfaction with out of pocket costs for prescription medications
- 2010: 62%
- 2012: 66%
- 2013: 72%
- 2014: 66%
- 2015: 67%
- 2016: 66%

Satisfaction with out of pocket costs for health care services
- 2010: 58%
- 2012: 59%
- 2013: 66%
- 2014: 62%
- 2015: 61%
- 2016: 61%

Insurance plan meets my/my family’s needs very/extremely well
- 2010: 58%
- 2012: 66%
- 2013: 69%
- 2014: 66%
- 2015: 55%
- 2016: 56%

Only 47% of Exchange based plan holders feel their plan meets needs very or extremely well

Prepared for: Strategic Health Perspectives
Source: Q600: How satisfied or dissatisfied are you with each of the following?; Q185: Thinking now about all the different components of your health insurance plan, how well does your plan meet your/your family’s health needs?

Significance tested at 95%
CONSUMERS EMOTIONS TOWARDS HEALTHCARE THEY RECEIVE
Not much change nationally, but Californians are significantly more positive in 2016

Some change towards the positive, but 1 in 4 consumers remains powerless

Consumer Emotions Towards Healthcare They Receive

<table>
<thead>
<tr>
<th>Empowered</th>
<th>Hopeful</th>
<th>Relieved</th>
<th>Accepting</th>
<th>Neutral</th>
<th>Resigned/Given up</th>
<th>Powerless</th>
<th>Depressed</th>
<th>Angry</th>
</tr>
</thead>
<tbody>
<tr>
<td>13%</td>
<td>17%</td>
<td>18%</td>
<td>37%</td>
<td>37%</td>
<td>27%</td>
<td>21%</td>
<td>10%</td>
<td>13%</td>
</tr>
</tbody>
</table>

California 2016 in Red

Base: All US Adults (2014 n=2501, 2015 n=5037, 2016 n=30052)
Source: Q90 How would you describe your feelings about the health care you receive today, including how much you pay for it and the benefits you receive? Please select all that apply.
PHYSICIANS TOO FEEL POWERLESS IN CURRENT SYSTEM

One in four physicians is depressed or angry about the health care system today – no change since last year. Almost half now feel Powerless

Physicians’ Emotions Towards Current Health Care System*

Base: All Physicians (2016: n=599; 2015: n=626)
Q1850: How would you describe your feelings about the health care system today? Please select all that apply.
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”

EMPLOYERS: STAY OR GO?
FEWER EMPLOYERS ARE LOOKING FOR AN EXIT; 88% CONTINUE TO FEEL RESPONSIBILITY FOR EMPLOYEE HEALTH NEEDS

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

- My company is actively exploring ways to get out of providing health insurance to our employees

- My company feels it is worth it to pay the penalty associated with not providing employee health benefits rather than providing health benefits to our employees.*

* Asked only of Employers with 50 or more employees
Base: All Employer Health Benefit Decision Makers (n=340)
Q800: Please indicate your level of agreement with the following statements. Do you strongly agree, somewhat agree, somewhat disagree or strongly disagree?
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).

Percentage of Covered Workers Enrolled in an HDHP/HRA or HSA-Qualified HDHP, 2006-2017

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

NOTE: Covered workers enrolled in an HDHP/HRA are enrolled in either an HDHP/HRA or a HSA-Qualified HDHP.

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)

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

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

SCALE, CONSOLIDATION AND DISRUPTION
MERGER MANIA: SOME EXAMPLES

• National Faith Based Systems coming together with non-overlapping geographies
  – Catholic Health Initiatives-Dignity Health $28 billion
  – Bon Secours-Mercy $8 billion

• Regional Powerhouses Aligning
  – Advocate-Aurora $11 billion
  – UNC-Carolinas Health (JV) now Atrium $14 billion

• Vertical Integration Insurers/Provider/Retail Pharmacy
  – CVS-Aetna $264 billion
  – CIGNA Buys Express Scripts $67 billion
  – United Health (Optum)-DaVita Physicians $200 billion ($5 billion)
  – Wal-Mart in talks with Humana
  – Welsh Carson-Humana-Kindred ($4 billion)

Sources: Modern Healthcare, Industry Press Releases
DISRUPTORS AND ENABLERS

• Disruptors
  – Amazon (ABC)
  – CVS Aetna
  – Apple, Google
  – Health 2.0
  – Disruption from within e.g. Kaiser, Providence

• Technology Enablers
  – Ubiquitous smartphones
  – AI and Machine Learning
  – Speech driven solutions for consumers and providers
  – Big Data
  – Cloud Solutions
  – Open Data and API
### 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.

<table>
<thead>
<tr>
<th>Revenue:</th>
<th>Pharmacy benefits</th>
<th>Retail/pharmacy</th>
<th>Health insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CVS Health</strong></td>
<td>$120 billion</td>
<td>$81</td>
<td>$23B (cross-segment sales)</td>
</tr>
<tr>
<td><strong>Aetna</strong></td>
<td>$63</td>
<td>$81</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>$183 billion</td>
<td>$162</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Revenue:</th>
<th>Pharmacy benefits</th>
<th>Retail/pharmacy</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>UnitedHealth</strong></td>
<td>$60</td>
<td>$149</td>
<td>$48B (cross-segment sales)</td>
</tr>
<tr>
<td><strong>$24</strong></td>
<td>$24</td>
<td>$24</td>
<td></td>
</tr>
</tbody>
</table>

---

- 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 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%.

Express Scripts share rose 18% premarket Thursday, while Cigna shares are inactive.

Source: WSJ, March 8th, 2018
AMAZON, BERKSHIRE HATHAWAY, JP MORGAN

• 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?
• JP Morgan CEO reassured banking clients in health insurance this is just a GPO deal
• 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
• You need CMS as the big dog changing the game at scale
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**

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

* = One model is shown 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

---

DISRUPTOR IMPLICATIONS

• Simple is Complex: It takes massive back end sophistication
  – Consumer Engagement
    • Aon Consumer Survey found 41% of Millennials say: “I have stopped trying to figure out what I should pay for medical services and just pay the bill when it comes.”
  – Benefit Design that makes consumers default to the right thing
  – Advanced Technology that support simple consumer facing solutions

• Meet People in their Lives
• Leverage Social Determinants of Health
• Use digital technology to help not hurt
• Innovation at Scale
• Focus more on helping the sick and the poor, not just delighting the rich and the well
• Disrupt yourself
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
• Anticipate belt tightening in the eco-system, generally as margins tighten
• Expect even more consolidation as weaker players capitulate
• Anticipate mixed signals on volume to value from CMS: “we support but we don’t mandate”
• 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 Red States to pick up on Conservative forms of Medicaid expansion
• If it gets Bluer: Do the math to see if you would actually be better off than your current deal
• If it gets Redder: More devolved to the states and “Block Grantanistas” Plotting but not Succeeding
• Flexibility without money is not flexibility
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
NO MATTER WHAT: PURSUE THE VALUE AGENDA

• Focus on getting the cost structure down
  – Culture: Make it everyone’s problem
  – Engagement with medical staff on physician sensitive preferences
  – Cost Discipline as a strategic priority
  – Drive care to lower cost settings
  – Waste avoidance, clinical standardization and variation elimination
  – Labor substitution such as scope of practice extenders, telehealth and alternate sites
  – Strategy versus Operational Excellence

• Quality
  – Lead don’t follow
  – Tie brand and reputation efforts to true scientifically defensible outcome measures
  – Work together to make everyone better

• 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 integrate with others
NO MATTER WHAT: PURSUE THE VALUE AGENDA

• Integrate for Higher Performance
  – Across the continuum of care: Brad Gilbert “When I left it just stopped.”
  – Across Stakeholders: Plans and Providers
  – Across sites of care: Alternate site, ambulatory, retail, telehealth and the home
  – With physicians: New Models and New Partners to engage physicians in total costs of care
  – Integrate Behavioral Health and Medical Care
  – Go Direct with employers.......on their terms with competitive prices, specific outcomes, and member responsiveness

• Be Inclusive
  – Engage all stakeholders
  – Innovate Together
  – Cover All Californians